

and taking into consideration the interpupillary measurement. Such tables form a useful basis for prescribing, but in every case the problem must be considered on its own merits and no hard and-fast rule connecting sphere and prism should be slavishly followed.

### Food Allergy

**Q.**—An infant of 13 months who had a very severe attack of gastro-enteritis just after birth suffers from extreme collapse followed by vomiting and diarrhoea almost immediately after being given egg, even in minute amounts; the attack lasts about eighteen hours. On several occasions, unrelated to any specific food, he has had a cutaneous eruption similar to lichen urticatus; otherwise he is perfectly healthy. How should he be treated? Is there any danger in immunizing against diphtheria and/or pertussis, and what preparation should be used?

**A.**—Symptomatically, elixir "benadryl," 0.5 to 2 mg. per lb. body weight daily, divided into four doses, is likely to help the irritation. Thermal factors, environmental factors, and food allergy all play a part in this disorder. Investigation is by trial dieting, eliminating and later reintroducing suspected foods, as skin tests in this condition are not reliable. Treatment consists in elimination of any proved food allergen. Immunization of an allergic child with diphtheria toxoid and pertussis vaccine is without risk.

### Small Stature

**Q.**—Can anything be done about a girl aged 17, just over 5 feet (152 cm.) in height, who appears to have stopped growing? She is at school and her general health is good. Both sides of the family are above average height.

**A.**—In most girls the epiphyses are united at the age of 17, and in many at the age of 15. Growth is therefore unlikely in this case under any treatment. The usual treatment when the epiphyses are ununited—as can, of course, be seen by x rays—is by thyroid extract and injections of anterior pituitary growth hormone. On the whole the latter is clinically disappointing and does not fulfil the high expectations of animal experiments.

### Diaphragm Pessary

**Q.**—When fitting a diaphragm pessary how is the size required by a particular patient decided? How often is it advisable to check the fitting—with special reference to a patient who has had a child (by normal delivery) two months ago?

**A.**—It is customary to choose the largest diaphragm pessary which will reach from the posterior fornix into the small sulcus behind the pubic bone. It should fit tightly but stay up when the patient bears down. By no means all women can wear this type, and a sloping anterior vaginal wall is a frequent contraindication. A "Dumas" type of pessary is then required. Relevant information will be found in the article on contraception in Butterworth's *Encyclopaedia of General Medicine*. The woman could be fitted in the puerperium, but it is often advisable to refit after three or four months, or when the baby is weaned.

### Enteritis and Steatorrhoea

**Q.**—For some years a patient has had alternating attacks of diarrhoea and constipation, diagnosed as intestinal carbohydrate dyspepsia. Two months ago there was an attack of acute enteritis with pale, fatty, liquid stools. Improvement has taken place on a fat-free diet, but the stools remain pale and he has lost weight. He has previously been treated with arsenic for the control of a long-standing dermatitis herpetiformis. Has this any bearing on the present condition? What treatment should be prescribed?

**A.**—It is not rare for an attack of acute enteritis to be followed by a period of steatorrhoea. This seldom lasts more than a few weeks, and in most instances the bowel habit and the character of the stools rapidly return to normal. The cause of this transient defect in fat absorption is unknown, but it is noteworthy that tropical sprue may be a sequel of the acute enteritis known as hill diarrhoea. It has been suggested that changes in the flora of the bowel may be responsible for these attacks.

While steatorrhoea continues, it is wise to restrict fat. Symptomatic improvement has followed nicotinic acid (50 mg. four

times daily), and folic acid (20 mg. daily) is worth a trial. In sprue neither of these substances causes a significant increase in the absorption of fat, but this has been noted after full doses of yeast extract. It is improbable that arsenic plays any part in the causation of the symptoms. These therapeutic suggestions are made on the assumption that organic disease of the bowel has been excluded.

### Treatment of Obesity

**Q.**—Do you consider ammonium chloride a better treatment for obesity than thyroid?

**A.**—These substances act quite differently. Ammonium chloride is a diuretic and is given because adiposity is often associated with some element of water retention; and also because low-calorie diets are effective up to a certain point, when the weight becomes stationary and no further progress is made until diuretics are given to remove an accumulated retention of fluid. Thyroid acts by increasing the metabolic rate, but as its main effect is on protein its use is not logical in the absence of evidence of associated thyroid deficiency. It is dangerous in larger doses where fatty infiltration of the heart is suspected. In moderate doses it is used as an adjunct to therapy even in the absence of a lowered basal metabolism, and it may be of some help as an auxiliary method of treatment.

### Tobacco and Poliomyelitis

**Q.**—Is there any evidence that non-smokers are more susceptible to poliomyelitis than smokers? Children are non-smokers and are very susceptible.

**A.**—A very large number of possible factors influencing susceptibility to the virus of poliomyelitis have been studied in the U.S.A. and other countries where the disease is endemic and there have been many epidemics. It is unlikely that if tobacco smokers were less susceptible to poliomyelitis virus than non-smokers (other than children) it would have gone unnoticed.

## NOTES AND COMMENTS

**Angina Pectoris.**—Dr. C. W. F. MCKEAN (London, W.1) writes: Your questioner (Sept. 13, p. 439) should be reminded to do a W. on his patient, as the atypical angina pectoris he describes—substernal pain radiating to the arm, but less severe and of longer duration than true angina of effort—in the absence of hypertension, arteriosclerosis, or valvular disease, is one of the ways in which specific aortitis may present itself.

**Funds for X-ray Plant.**—As a result of an appeal for funds (Sept. 20, p. 476) to provide an x-ray plant for the London Missionary Society £54 15s. has been subscribed. The Victoria Hospital, Kingston-on-Thames, kindly provided an x-ray diagnostic unit, and another £250 is still required to meet the cost of overhauling the unit and its transport to India. Contributions would be gratefully received by Dr. Cecil Cutting, London Missionary Society, 42, Broadway, London, S.W.1.

### Corrections

It was Prof. Lambert Rogers who introduced Dr. Alfred Blalock, professor of surgery at Johns Hopkins University, Baltimore, for admission to the Honorary Fellowship of the Royal College of Surgeons of England, and not Prof. H. W. Rodgers as reported in the *Journal* of Sept. 27 (p. 505).

A small, but vital, printer's error crept into the summary of Dr. McWhirter's paper on carcinoma of the breast (*Journal*, Oct. 4). At p. 542, column 2, line 18, "the first-year" should read "the five-year survival rate was 50.1%."

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