permanent method, but it takes more time. It is, however, well worth while if such treatment can be obtained in view of the distress suffered by many of these patients—distress far beyond the mere inconvenience, for the situation arouses to some extent the original feeling of shame.

Domiciliary Treatment of Tuberculosis

Q.—*Is there any antibiotic treatment which is worth trying in general practice for a case of chronic fibrocaseous pulmonary tuberculosis? The patient I have in mind is a man of 55 with chronic cavities and a positive sputum; he has been treated with P.A.S. for a long time. Could streptomycin be given while he is at home, or would "aureomycin" or "chloromycetin" or any other antibiotic be worth a trial?*

A.—Streptomycin is the only antibiotic that might benefit the patient, but this should not be given at home unless there are facilities for determining the streptomycin sensitivity of the tubercle bacilli in the patient's sputum. An exception to this general rule is the use of the drug as a palliative measure in cases of painful tuberculous laryngitis. From the description of the case it is unlikely that any permanent benefit will result from the use of streptomycin.

Treatment of Defective Fat Absorption

Q.—*Is "sorethitan mono-oleate" of proved value in the treatment of deficient fat absorption? Is it safe to take over long periods at the dose recommended—6 g. daily? My particular interest is in cases of subtotal gastrectomy with failure to gain weight.*

A.—Sorbitan polyoxyethylene mono-oleate (Tween 80) appears to be effective in improving fat absorption in certain cases, including the post-gastrectomy syndrome (C. M. Jones, P. J. Culver, G. D. Drummey, and A. E. Ryan (1948), *Ann. int. Med.*, **29**, 1), although it seems unlikely that the effect is due to any change in emulsification, since this is commonly normal in such cases. Extensive studies on the toxicity of this substance have also been carried out by P. J. Culver in Boston and by L. Emmett Holt, jun., in New York. In human subjects 4.5–6.0 g. per person per day have been administered for periods of up to two years and no ill effects could be demonstrated. Similar investigations were carried out in children; 50 mg. of "Tween 80" per gramme of fat ingested caused no demonstrable ill effects in premature infants. Care should be taken to see that unspecified impurities are not present with the sorbitan polyoxyethylene mono-oleate, since these may be toxic.

Artificial Parthenogenesis

Q.—*I should be interested to know whether any experiments on artificial parthenogenesis have been, or are being, carried out in this country.*

A.—It is not clear whether the questioner is referring to experiments on artificial parthenogenesis in mammals or in invertebrates. Very little work has been done anywhere on artificial parthenogenesis in mammals, but a great deal has been done on artificial parthenogenesis in invertebrates such as the sea-urchin. A useful and comprehensive review of this work was published in the British journal, *Biological Reviews* (1941, **16**, 291), by Dr. Albert Tyler.

Dioxyamidopyrine in Asthma

Q.—*A new proprietary for the relief of asthma is said to contain dioxyamidopyrine. Is this drug likely to lead in some cases to agranulocytosis? What is the action of the drug, and have any clinical trials been reported?*

A.—The proprietary preparation which this correspondent probably has in mind is made up of a large number of ingredients, and no clinical trials with it have been reported in the literature. Some of these ingredients are of known value in relaxing bronchial spasm, while others are valueless in this respect. This type of polypharmacy is to be deprecated. Reliance should be placed on official preparations of adrenaline, ephedrine, isoprenaline, or theophylline and ethylenediamine, each of which will be found to be just as effective as—and usually cheaper than—proprietary preparations containing many ingredients. One of the constituents of this particular preparation is a small dose of dioxyamidopyrine. It is true that amidopyrine has been found on occasion to produce agranulocytosis, and has in consequence acquired an unenviable reputation. However, the danger of using amidopyrine is probably considerably exaggerated. At one time almost all patent headache powders, which were consumed by thousands of people daily, contained a little amidopyrine, and yet agranulocytosis remained uncommon. Still, there is no point in including amidopyrine in prescriptions when other analgesics will do equally well without incurring this objection.

Thrush and Myasthenia Gravis

Q.—*Can you suggest any treatment for a thick white deposit on the hard palate and tongue of a woman aged 60 suffering from myasthenia gravis? Her symptoms are well controlled by prostigmin, but the condition of the oral mucous membrane has been present for about four years, and does not react to any ordinary local treatment.*

A.—It is difficult to recommend treatment for this condition in the absence of a precise diagnosis. The description suggests extensive thrush, which occurs in debilitated states, and which may here be related to the dysphagia. In some elderly patients this infection may clothe the entire buccal mucosa with a thick white deposit which is most resistant to treatment. Swabbing the mouth gently but thoroughly with a 5% solution of sodium metabisulphite and afterwards with borax, soda, and glycerol is usually effective. The possibility of leukoplakia must be considered; and, if lichen planus seems likely, a trial of arsenic is worth while.

NOTES AND COMMENTS

Prophylaxis Against Syphilis.—Dr. ARTHUR S. WIGFIELD (Worcester) writes: In your answer under this heading ("Any Questions?" July 22, p. 231) it is stated that "even 200,000 units to 300,000 units (of penicillin) taken by mouth within a few hours has been reported as preventing infection." If this report relates to clinical experiment it seems pertinent to ask by what method these "protected" patients were shown to be incubating syphilis. While not wishing to dispute the veracity of such an assertion, I would nevertheless like to express my doubts of the wisdom of making it under the heading of "Any Questions?" The answers to "Any Questions?" are primarily of general interest. Your brief dissertation on the prophylaxis against syphilis is presumably designed not for competent venereologists but for general practitioners. How many general practitioners will now administer 300,000 units of penicillin by mouth in order to allay the fears of apprehensive patients? If none, why mention this dangerous practice without due warning? The danger of such a procedure would seem to be not so much the possibility of masking syphilis as the creation of a fool's paradise in which further transmission of the disease might occur. In mentioning the "best" prophylaxis against syphilis the total dose of four million units of penicillin should be coupled with a reasonable duration of its administration—i.e., seven to fourteen days. It is difficult to escape the conviction that such "protected" patients should be regarded as sero-negative primary cases and followed up for two years. Is it not wiser to persuade these patients to refrain from coitus for three months and ask them to report for examination then?

Corrections

Dr. J. W. DUNDEE (Walton, Liverpool) has written to point out that in the Medical Memorandum "Acquired Sensitivity to Thiopentone" (August 5, p. 332) the dose of thiopentone given at the first operation was 0.3 g., not 0.3 mg.

In the report (August 5, p. 358) of a discussion at the Section of Tropical Medicine during the Annual Meeting of the B.M.A. in Liverpool we wrongly attributed Colonel E. H. Vere-Hodge's remarks to Dr. R. F. Vere-Hodge. Colonel Vere-Hodge has written to point out that his statement that santonin was non-toxic was qualified by the words "in therapeutic doses."

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