COMING EVENTS

Biology as a Career.—The Institute of Biology is arranging a one-day discussion in Birmingham on October 4. Speakers will include Sir Harold Himsworth on careers in medical research, Professor J. F. Danielli on biology in universities, G. A. C. Herklots (secretary for colonial agricultural research at the Colonial Office) on careers in the Colonies, and Sir William Slater on opportunities in agricultural research. Full details of the conference may be obtained from the general secretary of the Institute, Tavistock House South, Tavistock Square, London, W.C.1.

National Safety Congress.—The public safety sessions of the 1952 congress will be held in Central Hall, Westminster, S.W.1, on October 7, 8, and 9, organized by the Royal Society for the Prevention of Accidents. The comprehensive fee covering all sessions of the congress is £3 13s. 6d. for registered members and £4 14s. 6d. for non-members. Part-time attendance per session will cost £1 5s. and £1 10s. respectively. The programme includes discussion of trends in road safety, and road safety and the vehicle. Full details and application forms from the secretary of the Society, Terminal House, 52, Grosvenor Gardens, London, S.W.1.

Middlesex Hospital Medical School.—The annual dinner of the school will be held at Savoy Hotel (Victoria Embankment entrance), London, on Friday, October 3, at 7 for 7.30 p.m.

SOCIETIES AND LECTURES

A fee is charged or a ticket is required for attending lectures marked ●. Application should be made first to the institution concerned.

Thursday, July 31

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, London, W.C.—5 p.m., three-dimensional surgical film in colour: *"Radical Resection for Carcinoma of the Stomach."*

Tuesday, July 29

OXFORD UNIVERSITY.—At Sir William Dunn School of Pathology, 2.30 p.m., *"The Isolation of the Tubercle Bacillary Protein Fraction and its Ability to Sensitize Cells,"* by Dr. Florence B. Seibert (University of Pennsylvania).

APPOINTMENTS

WELSH REGIONAL HOSPITAL BOARD.—*Consultant Physician, Newport and East Monmouth and North Monmouth Hospital,* Aneurin Hughes, M.B., B.S., M.R.C.P.Ed. *Assistant Psychiatrist (S.H.M.O.), Morgannwg Hospital,* H. Dale Beckett, M.R.C.S., L.R.C.P. *Consultant Pathologist, Cardiff Hospital,* B. J. Stephens, M.D. *Consultant Pathologist, Wrexham, Powys and Mawddach Hospital,* L. Wise, M.B., Ch.B. *Consultant Radiologist, Rhymney and Sirhowy Valleys Hospital,* Gwenllian B. Davies, M.R.C.S., L.R.C.P., D.M.R. *Consultant Psychiatrist, Penyval Hospital,* I. M. Davies, M.R.C.S., L.R.C.P., D.P.M.

BIRTHS, MARRIAGES, AND DEATHS

BIRTHS

Caldwell.—On June 24, 1952, at Foresterhill, Aberdeen, to Margaret, wife of Dr. John S. Caldwell, of Dunleigh, Aberlour, Banffshire, a daughter.

Harris.—On July 14, 1952, to Juliette, wife of Dr. L. H. Harris, of 6, Lambolle Road, London, N.W., a brother for Adrian.

Herbert-Burns.—On July 6, 1952, at 18, Edward Road, Dorchester, to Joan (formerly Jolly), and Dr. Jack Herbert-Burns, a sister for Hugh, Susan, and Rosanne.

MARRIAGES

Sterland—Helmer.—On July 12, 1952, at Louth, Lincs, Frank Kenrick Sterland, A.M.I.C.E., to Mary Helmer, M.B., B.S.

DEATHS

Baird.—On July 18, 1952, at a London nursing-home, Stephen Young Baird, M.B., Ch.B., of Assam, India, formerly of Glasgow.

Ballantyne.—On July 16, 1952, Simon Alexander Ballantyne, M.B., F.R.C.S.Ed., of 39, Belvedere Road, Coventry, aged 74.

Camac.—On July 19, 1952, James Camac, M.B., B.Ch., of Church Gresley, near Burton-on-Trent, Derbyshire, aged 55.

Chisholm.—On July 21, 1952, at 34, The Broadway, Withington, Manchester, Lancs, Catherine Chisholm, C.B.E., M.D., F.R.C.P.

Herbert.—On July 18, 1952, at Uplands, Coach Road, Wollaton, Nottingham, George Heywood Herbert, M.R.C.S., L.R.C.P., late of Uttoxeter, Staffs.

Howard.—On July 13, 1952, at 3, Stanley Road, Leicester, Thomas Howard, M.B., B.Ch., J.P., formerly of Portland, Dorset, aged 84.

Longridge.—On July 13, 1952, at his home, Upmead, Kersbrook, Budleigh Salterton, Devon, Charles John Nepean Longridge, M.D., F.R.C.S., M.R.C.P.

Any Questions?

Correspondents should give their names and addresses (not for publication) and include all relevant details in their questions, which should be typed. We publish here a selection of those questions and answers which seem to be of general interest.

Pets in Bed

Q.—*Some of my patients share their beds with their dogs and sleep with the animals almost face to face. The animals also receive their food from the same plates as the family does. Is there any risk to the health of the owner?*

A.—There are certain conditions affecting dogs and cats which are communicable to man and are therefore a source of danger. Tuberculosis is by no means uncommon in the dog, and about 70% of the recorded cases are due to the human type. The pulmonary lesions are particularly liable to break down, with the formation of "vomicae": the organisms may then be shed into the bronchi and be discharged in the sputum. A second bacterial disease which is potentially dangerous is leptospirosis: young dogs are susceptible to *L. icterohaemorrhagiae* and *L. canicola*—both types are probably voided in the urine. Amongst fungous diseases, some dermatomycoses may be transmitted to man by contact with infected dogs and cats, especially *Microsporum* infection from the cat.

Certain animal parasites which infest dogs may also constitute a danger to human beings. The most important is a small tapeworm of dogs, *Echinococcus granulosus*, whose larval stage (hydatid cyst) can develop in man and other animals. Man acquires the infection through the ingestion of the ova of the tapeworm, usually by hands contaminated as a result of fondling dogs whose coats have become soiled with infected faeces. In some of the great pastoral countries the incidence of this tapeworm in dogs and of hydatid disease in man is relatively high, but fortunately in Britain infestation of dogs with *Echinococcus granulosus* is probably very low, and cases of hydatid disease in man are infrequent. Other animal parasites communicable to man and of lesser importance include *Dipylidium caninum*, a common tapeworm of the dog and cat which utilizes fleas and lice as intermediate hosts for the larval stage. Man (usually children) may become infected with the adult stage of this tapeworm by the accidental ingestion of fleas or lice infected with the larval stage. Amongst ectoparasites which are transmissible from dogs to man, *Sarcoptes scabiei* var. *canis* has occasionally been responsible for a mild form of scabies in the human host.

The foregoing remarks are not intended to raise any unnecessary scare, but the facts do indicate that over-familiarity with domestic pets is to be deprecated.

Inoculations for Travellers

Q.—*What inoculations are recommended for passengers and crew in a ship going to South America via Madeira?*

A.—The essential inoculations for passengers and crew in a ship going to South America via Madeira are smallpox and yellow fever vaccination. It would also be desirable to give a course of T.A.B. inoculations against enteric fever. *Information on this matter can always be obtained from the consulates of the countries to which the traveller is going.* The certificates of vaccination against smallpox and yellow fever must be on the international form (obtainable from travel agencies), and the doctor's signature on any certificate should be endorsed by the local medical officer of health or other responsible body. There are approved centres in this country, indicated on the "Notes to Travellers" issued by the Passport Office, where yellow fever vaccination is done free of charge.

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When vaccination against both smallpox and yellow fever has to be done the Ministry of Health recommends that:

1. Whenever possible yellow fever inoculation should precede primary vaccination against smallpox.
2. There should be an interval of at least four days between yellow fever inoculation (when given first) and primary vaccination against smallpox (when given subsequently).
3. If primary vaccination against smallpox is done first, there should be an interval of 21 days from the date of the vaccination before the yellow fever inoculation is given.
4. Where there is evidence of previous successful vaccination against smallpox, yellow fever immunization and re-vaccination against smallpox may be carried out at the same session, but, if time permits, yellow fever immunization should always precede re-vaccination by at least four days.

Poliomyelitis in Medical and Nursing Staff

Q.—*In a large ward with acute poliomyelitis cases (first 20 days of illness) what are the risks of infection for nurses and doctors and their families? What precautions are worthwhile besides hand-washing?*

A.—The risk of contracting paralytic poliomyelitis by nurses and doctors in intimate contact with cases in an *infectious diseases hospital* must be very small indeed. In the writer's experience, covering a number of years with hundreds of cases treated in the acute stage of the disease, not a single instance of clinical infection of staff has occurred. Nor has a case occurred where a medical-practitioner or nurse contact could be suspected of having conveyed infection to relatives or friends. There appears to be no evidence that families of staff of such hospitals are at greater risk than others. From the Ministry of Health statistics, however, it seems that there is some risk of infection in *general hospitals,* involving both staff and patients; there is also support for the belief in the comparative safety of the work in the infectious diseases hospitals.

The lack of authoritative evidence about the mode of spread of poliomyelitis makes it impossible to dogmatize about prophylaxis. In the light of infectious diseases hospital experience, in contrast with that of the general hospital, it would be reasonable to assume that the practice of bed isolation, aseptic technique, and adequate spacing with reasonably free ventilation may be the decisive factor. Hand-washing is most desirable. Masks, if intelligently used, could possibly help where there is contact with cases in the first 10 days of disease, but there is no evidence that danger exists when they are not used.

Infantile Eczema

Q.—*A boy aged 2 years has suffered from infantile eczema for the last 12 months, and the condition has not responded to treatment in hospital. Are there any recent advances in the treatment of this condition? What are the broad principles upon which treatment should be conducted?*

A.—There have been no recent advances in treatment for infantile eczema. Authorities differ in their approach to the problem. It is reasonable to accept that the subject of infantile eczema is a highly sensitive child from both the physiological and psychological point of view, his sensitivity being perhaps enhanced because of his inheritance and by the circumstances of his environment. In addition to such general sensitivity some authorities would suggest that there is also specific sensitivity of an allergic character and particularly to foodstuffs. The writer does not subscribe to this view. Such infants awakening to human existence are particularly susceptible to emotional influences, and a condition of eczema naturally arouses anxiety and alarm in the mother and often in the household. The intelligent infant may turn this position to its advantage to gain its desired ends. The experience of teething frequently determines the onset of eczema in these infants, and waxing and waning of the affection may persist through this period. However, habit may seriously enter into the picture and create further difficulties. The sensitive skin itself is readily provoked by exposure, change of temperature, rough clothes, soap and water, and other external factors.

The broad principles of treatment follow understanding of these aspects of the problem. The general management of the child is of first importance: handling must be firm but tactful, and discipline and routine must be maintained. Anxiety and emotional unrest must be countered or removed. Sedatives must be used to reduce the sensitivity of the child —to raise the threshold of reaction and relieve itching and ensure rest. Bromides, chloral, or phenobarbitone are the most desirable for the purpose, and they must be continued as long as the child is in the eczematous phase. Lassar's paste, with 2% crude tar, is usually the most effective local application; it should not be cleaned off the skin unnecessarily. Restraint must be employed with discretion. There is usually no objection to the use of a cardboard cuff over the elbow to limit the range of movement.

Alopecia Areata

Q.—*Have there been any recent advances in the treatment of alopecia areata? I have a patient, a young unmarried girl, in apparent good health, who has developed two bald patches in the last month. What is the prognosis?*

A.—The answer to the first question is no. In broad terms alopecia is a symptom consequent upon local or general injury. Recovery is the rule when the effects of the injury have passed. Some individuals and some families are much more susceptible to this pattern of reaction than others, and this is a matter to be taken into consideration in making a prognosis. The outlook in a first attack in a healthy adult without obvious provocative cause and with a negative family history is likely to be good. In most patients the symptom appears to be dependent upon emotional factors.

NOTES AND COMMENTS

Recurrent Iritis.—Dr. B. E. W. MACE (London) writes: With reference to the question on "Recurrent Iritis" ("Any Questions?" June 21, p. 1366), another possible cause of iritis of the type described is ankylosing spondylitis, and it would be worth while obtaining an *x*-ray picture of the sacro-iliac joints. There is now adequate evidence of an association between these two conditions, and a series of cases, in which iritis was the presenting sign, has recently been published (Birkbeck *et al., Lancet,* 1951, 2, 802).

Corrections

In the second part of the Refresher Course article by Professor B. G. Maegraith on "Clinical Effects of Exposure to Heat and Sunlight" there is a prescription for a "sun-tan" oil (June 28, p. 1404). The first constituent of the oil should be menthyl salicylate, *not* methyl salicylate.

In the report (*Supplement*, July 19, p. 54) of Mr. J. R. Nicholson-Lailey's speech to the Representative Body, when he moved the approval of the Reports of Council under "Science," the word "free" was omitted from the penultimate sentence, which should have read: "It was a matter of regret that the honoraria to lecturers had had to be discontinued and also the free postal service from the library."

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