problem, since these metals are self-sterilizing in the presence of moisture unless the surface is grossly soiled, as the interior of such an instrument may well be by accumulated secretions. The instrument should therefore be thoroughly cleansed with water: for additional safety in immediate use it may be washed through with a phenolic disinfectant such as 2% lysol, care being taken to remove all traces of this with water before further use. Hypochlorite disinfectants cannot be used for brass instruments, since they react with this metal. A flute could best be disinfected by exposure to formaldehyde vapour. Bagpipes present a special problem, and the common assumption that whisky vapour in the user's breath maintains them in a sanitary condition should not be relied on. The bone mouthpiece is detachable and could be boiled. The bag itself is made of sheepskin, and might suffer from chemical treatment: on the other hand, it can be filled with boiling water after detaching the mouthpiece and reeds, and is in fact usually so treated from time to time with a boiling sugar solution to maintain its condition.

Haloed Moles

Q.—*Recently I have seen a young man who has multiple pigmented moles on his trunk which are surrounded by a disk of normally coloured skin. The interesting point is that the disk is clearly demarcated at the margin by the brown of sun tan which covers the rest of his body. There is no change in skin texture or hair follicles at the margin, and in some places there is a disk with only a faint brown speck at its centre. In other places a large naevus gives rise to a very thin band of pink skin surrounding it. The man stated that these rings appear each year, only becoming obvious when he has a sun tan. Why should a localized naevus so influence the surrounding cells that they are unable to make the usual pigment response to light?*

A.—The development of a halo of non-pigmented skin round a pigmented naevus is not uncommon, and when present is usually persistent. The absence of pigmentation is accentuated when exposure to the sun increases the pigmentation elsewhere. The cause is unknown, but the whole is part of a pigmentary dysfunction. Various theories have been put forward; see the 1929 Lettsomian Lectures by Dr. H. W. Barber.

Children's Ankles

Q.—*What are the significance and treatment of a postural valgus deformity of the ankles in young children?*

A.—The deformity is usually at the tarsal joints rather than at the ankle itself. In young children just beginning to walk some degree of valgus is very common, but it is often corrected spontaneously as the child grows. Persistent valgus in slightly older children varies in degree from a mild type which is of little significance to the severe deformity that is associated with structural flat foot, predisposing in adult life to the development of osteoarthritis of the tarsal joints.

In children between 1 and 2 years no treatment is advised. Between the ages of 2 and 10 the usual practice is to prescribe an adjustment to the shoes in the form of a rise of between $\frac{3}{16}$ in. and $\frac{1}{4}$ in. (5 or 6 mm.) at the medial side of the heel. This is effected by inserting an appropriate wedge of leather, base medially, between the layers of the heel. In children over 4 this may be supplemented by special exercises supervised by a physiotherapist and designed to strengthen the muscles of the foot. The efficacy of these measures is unfortunately open to doubt. There are surgeons who believe that the foot might as well be left alone. Certainly if a foot is destined to become markedly valgus it is doubtful whether any simple treatment will prevent it. Secondary osteoarthritic changes developing in later life may cause sufficient disability to justify operative treatment.

Chloramphenicol and the Widal Reaction

Q.—*What effect has chloramphenicol therapy on the Widal reaction? Please include references to any experimental work on this subject.*

A.—There are few reports in the literature on the effect of chloramphenicol on the Widal reaction. Good and Mackenzie (1950) and Medina *et al.* (1950) mention results of titrations, but details are not given. Marmion (1951), summarizing all available foreign literature, states that most workers have found that chloramphenicol interferes little if at all with the production of agglutinins.

Many sera from bacteriologically proved cases of enteric fever treated with chloramphenicol have been titrated at the Army Central Medical Laboratory, M.E.L.F. Patients had all been inoculated with T.A.B. vaccine, and hence only O titrations were performed. Although a rise in serum titre was not found in every case, the results indicated that chloramphenicol does not interfere markedly with agglutinin production. Wilson (1945) and Mole (1948) investigated the agglutinin titre in the serum of inoculated persons with enteric fever who had not been treated with chloramphenicol. Their results were very variable; steadily rising titres were not the rule. Agglutinins are probably an incomplete index of the state of immunity, and the high incidence of relapses in cases treated with chloramphenicol suggests that the drug interferes in some way with the immune response, possibly by curtailing the antigenic stimulus.

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NOTES AND COMMENTS

The Electrified State.—Dr. A. C. PORTEOUS (Wootton Bridge, I.O.W.) writes: With reference to your consultant's answer to this question ("Any Questions?" September 20, p. 678), while not denying the possibility of static electricity as a cause of the phenomenon observed, on the occasions on which I have observed similar sensations I have always found, on examining a patient, the cause to be the same: in two or more instances a live flex to a bedside lamp, wound round the metal bedpost, produced the vibration. A few days ago I shocked a patient with the observation that her bed was electrified, and sure enough she was found to be lying on an electric blanket. On switching off the current in these cases the effects disappeared. It would be interesting to learn whether your correspondent has eliminated the domestic electricity supply as a cause in his patient with Parkinsonism.

Throat Pack for Facio-maxillary Surgery.—Dr. J. W. HALLAM and Dr. I. LEWIS (Liverpool) write: While agreeing with your expert's views ("Any Questions?" September 20, p. 677) in answering this question, we are of the opinion that however carefully the pack is manipulated the main cause of soreness is brought about while the pack and tube are in position; the activities of the operator causing movement of the head (and pack and tube), traumatizing the posterior pharyngeal wall. This can be overcome by the anaesthetist limiting the head movement, a practice which will also be appreciated by the surgeon or dental surgeon.

Correction.—We very much regret that in some copies of last week's *Journal* Dr. T. D. S. Holliday's name was misspelt at the head of the article "Bilateral Giant Renal Calculi" (p. 702).

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