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Correspondents should give their names and addresses (not for publication) and include all relevant details in their questions, which should be typed.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.

Hazards of the Diabetic Mother

Q.—*What hazards must a diabetic woman face if she is to have a family? How can they be prevented or minimized? Are there any absolute contraindications to childbearing in a diabetic mother?*

A.—Provided that the diabetes can be carefully controlled throughout pregnancy, the diabetic woman takes no great risk by becoming pregnant; the maternal mortality rate is in the region of 1 to 2% at the most. As suggested above, careful control of the diabetes is the most important measure to minimize the risks, and should be associated with careful antenatal care. The presence of serious complications, such as albuminuria, hypertension, and serious retinitis, are contrary indications to pregnancy from the mother's point of view, and a strong family history of the disease, especially if it is on both sides of the family, from the point of view of the child.

Lying and Thieving Children

Q.—*Why do some children make a habit of lying and stealing, and how should they be treated?*

A.—To know that a child steals and lies is just a beginning. Details of various examples and both their immediate and their long-term setting need to be known.

Stealing may be clever and secret or it may be obvious; it may be rare or frequent; what is stolen may be always the same or it may seem to be indiscriminate. Stealing may be solitary or it may be with others. It may be what would be called larceny, burglary, or robbery in an adult. It may be to satisfy an obviously frustrated desire for possession. It may be an imitation of adults or other children, perhaps to obtain the open favour of someone. It may be due to jealousy with or without vindictiveness to the person stolen from. It may be the one aspect of behaviour that leads to the discovery of some degree of mental defect. In the most serious and prolonged thieves it is usually associated with a history of major thwarting of good personal relations in early life, and such a thief has difficulty in making good personal contacts later.

What seems to be lying may simply be due to immaturity in speech and immaturity in developing concepts of truthfulness. It may be part of a phase of general negativism in which the truth is often reversed. It may be boastful exaggeration. It may consist of fabrications to hide anxiety or guilt, or it may be a way of showing anger by making false accusations. The developing child bases many of his standards on imitation, and when grown-ups lie or have difficulty in talking to the child about the relationship of fact and fancy the child soon picks up the adult's habits. This is often seen, for instance, in parents' attitudes to the truth about sexuality, fairy stories, Father Christmas, etc.

In general, the treatment of stealing and lying should be, first, by coming to an understanding oneself, and, secondly, by helping the child to come to an understanding himself of what is happening. If the stealing or lying has been present for long, the child will probably have forgotten its origin, even if he did understand what was going on when he began to steal or lie. On the basis of understanding can be built hope of developing better ways of gaining ends than by continuing to steal and lie. Rewards and approval for progress will help, but the rewards should not just be for progress in losing bad habits. Rewards should be for progress in discovering better ways of coping with the problems which previously were dealt with by dishonesty and deceit.

Aminophylline and Adrenaline

Q.—*I have seen it stated in a medical journal that adrenaline administered before aminophylline will double the toxicity of the latter drug. Is this true?*

A.—The accepted and widely used treatment for status asthmaticus has been for many years, essentially, subcutaneous adrenaline until the patient is obviously adrenaline-resistant, followed by intravenous aminophylline (0.25 to 0.48 g.). The intravenous aminophylline *must* be given slowly, preferably over 5 to 10 minutes, for acute collapse may occur if it is given too rapidly. No deaths have been recorded following this treatment in status asthmaticus, nor has the writer seen collapse occurring when this treatment was properly carried out. The deaths that have been recorded following intravenous aminophylline have been in patients with cardiac damage—that is, when there was evidence of previous coronary disease or severe myocardial damage—but, as far as the writer is aware, previous adrenaline had not been given. It is known that in mice ephedrine will double the toxicity of aminophylline, but one does not know how far such studies in animals are applicable to man. In any case, the recommended therapeutic dosage of aminophylline in man is so far below its lethal dose that such a synergistic toxic effect should not be of any practical importance.

Spinach

Q.—*What is the nutritive value of spinach and "spinach beet"? Are they good for children?*

A.—Both real spinach and the green tops of the "spinach beet" are very rich sources of carotene, from which vitamin A is formed in the body. They are also among the best vegetables for iron, and are good sources of vitamin C. Since the body's demands for vitamins and minerals are increased during growth spinach would seem to be particularly valuable for the nutrition of children, provided they can be persuaded to acquire a liking for its somewhat bitter taste.

Fibre-glass

Q.—*In what processes is fibre-glass used? Is it hazardous to health in any way?*

A.—Fibre-glass consists of fine, flexible glass fibres having a high tensile strength, which increases rapidly as the diameter of the fibres decreases. Staple fibres may be manufactured from which yarn is made and used in much the same way as any other textile material. Uses of fibre-glass mentioned by Fairhall[1] are as curtains and hangings, separators in storage batteries, filter media in filter presses, as a reinforcement for plastics, and as a filling for pillows and mattresses. It is also used as a filter for blood plasma, as surgical suture material, as a tracer thread which is opaque to *x* rays in surgical sponges, and for lightweight artificial limbs. Rock or mineral wool, sometimes included with fibre-glass in the term "glass-wool," is composed of fine interlaced mineral fibres and is used as an insulating material.

The sharp ends of the fibres cause redness and irritation of the skin, and sometimes small papules. These effects are transitory and are caused by fibres adhering to the skin. Friction which tends to rub them in, or excessive perspiration, will increase the irritation, but unless the fibres are rubbed into the skin they are removed easily by washing. There is no evidence of injury to the lungs among workers in the mineral or glass-wool industries.

Protective measures in handling fibre-glass are directed towards avoiding accumulation of fibres on the skin. Loose overalls with no constricting bands at the neck, wrists, waist, or ankles should be worn and laundered frequently, preferably at the works. Adequate washing facilities, including shower-baths, should be provided, and lockers in which

street clothes may be hung separately from work clothes are essential so that outdoor clothes will not collect glass fibres. Calamine lotion to which has been added 1% phenol relieves the skin irritation. Goggles should be worn to protect the eyes when fibre-glass is used for overhead work. In the factory sweeping should be done by vacuum cleaners, and waste material should be kept in covered bins.

REFERENCE

1 Fairhall. L. T. (1949). *Industrial Toxicology*, p. 73. Williams and Wilkins, Baltimore.

Anosmia after Respiratory Infection

Q.—*A lady of 68, who has had many attacks of influenza since 1918, has made an uninterrupted recovery from her last attack two months ago, except for persistent anosmia. What is the cause and treatment of this condition?*

A.—Persistent anosmia is a fortunately uncommon sequel to a severe upper respiratory tract infection. As in such cases there is no hindrance to the entrance of vapour to the olfactory part of the nasal mucous membrane, one can only conclude that the cause is due to a fibrosis or other affection of the olfactory nerve endings in the nasal mucous membrane. It is worth while trying a course of shrinking drops for the nose, such as 0.5% ephedrine in normal saline, instilled into the nose in the head-low position twice daily for three months. This will shrink up the nasal mucous membrane and so permit the maximum amount of vapour to enter the olfactory epithelium. If, after three months of regular treatment, there is no improvement, then it is unlikely that the sense of smell will ever return.

Hookworm Disease and Duodenal Ulcer

Q.—*In this district hookworm disease and peptic ulceration are both very common. Peptic ulcers that come to operation for one reason or another are nearly always pyloric or duodenal. It seems likely to me that this is more than a coincidental association. Has any work been done on such an association or on hookworm as a causative factor in chronic peptic ulcer?*

A.—As far as can be discovered, no work has demonstrated a causal relationship between hookworm infestation and duodenal ulcer. Although there are areas in the world in which both conditions occur commonly, the geographical distribution of the two is generally quite distinct, peptic ulcer occurring most commonly in populations in whom ankylostomiasis is rare or absent. Conversely, in the areas of heaviest hookworm infestation, peptic ulcer, in the sense generally understood, is extremely rare—e.g., tropical Africa.

On the other hand it is well recognized that ankylostomiasis may give rise to symptoms similar to those of duodenal ulcer. In particular, discomfort and pain in the epigastrium and the right side of the lower chest, sometimes relieved by food, is common to both conditions, as is melaena. Pathologically, extravasations of blood are often seen in the duodenal mucous membrane in heavy hookworm infections, and these may be large enough to appear as mucosal cystic haematomata, which may well break down and form small superficial ulcers; but these are quite dissimilar in pathological appearance to chronic peptic ulcers. There may also be quite marked duodenitis, possibly simply as a result of the irritation caused by the presence of many worms, but possibly also having some more specific causation.

While it is possible that the presence of hookworm might aggravate an existing duodenal ulcer, a causal relationship between the two is unlikely.

Herpes Complement-fixation Test

Q.—*What is the herpes complement-fixation test? What are its uses?*

A.—The herpes complement-fixation test has been used experimentally for identifying the virus of herpes simplex, the causative agent of fever blisters; or for determining the existence of specific antibodies against that virus. At present it is of use in research rather than for clinical diagnosis. The isolation of virus from a presumed herpetic lesion is a more reliable diagnostic method.

Ice Hockey Accidents

Q.—*Are there any injuries peculiar to ice hockey which a medical man should be prepared to treat?*

A.—In spite of the speed of the game, accidents in ice hockey are relatively infrequent. There is no single injury which is peculiar to the game—almost any type of injury may occur. The commonest are the usual injuries to ankles and knees. Serious cuts from the blade of the skate do happen, but are not frequent.

Can it be Hysterical?

Q.—*What treatment would alleviate periodic bursts of spasmodic unproductive cough, lasting a few minutes and occurring about twice a week, in a woman of 42? They date from the curettage of a tuberculous abscess in the neck four years ago, but the scar is supple and apparently not attached to deeper structures. The bursts are initiated by quite trivial causes, such as laughter, and even come on without any noticeable cause at all.*

A.—It is very difficult to answer a question of this kind without seeing the patient, but usually patients with this type of symptom turn out to be hysterical. Such a diagnosis, of course, should not be made until definite organic lesions have been excluded by physical examination, radiograph of the chest, blood sedimentation rate, and, if possible, sputum examination. Although cough will occasionally occur from stimuli to branches of the vagus, it seems improbable that this will be the explanation in the case mentioned. Should it be agreed that the case is hysterical the usual search should be made for the precipitating cause and this relieved if possible. The actual symptom may be relieved by some form of strong suggestion. Possibly infiltration of the scar with procaine might serve, but it will have to be accompanied by firm assertion that the cough will be cured.

NOTES AND COMMENTS

Shining Eyes and Lion Men.—Dr. D. J. B. WILSON (High Wycombe) writes: The illuminating reply by your expert ("Any Questions?" October 25, p. 952) to the query about the nocturnal glow from the eyes of certain animals does not explain the curious differences of colour—red, green, yellow, etc.—varying with the species. The tapetum, or layer of pigments behind the retina in the *Felidae*, for instance, is a crystalline substance with the quality of reflecting light strongly from another source. But differences in the colour of the light reflected from the eyes of different species are due, at least in part, to the number and arrangement of the blood vessels in their eyes. Thus when these vessels are few the glow is whitish, but a more generous supply gives a reddish glow. Although the tapetum is absent in the human eye, it may well be that the injected retinal vessels of the notorious "Lion Men" can under certain conditions be viewed as red points when caught in a beam of light, the more so if a mydriatic has been instilled.

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