tongue as a result. If the patient bites his tongue whether he wears partial dentures at night or not, it might be worth trying a small rubber gag. If this is done, however, care must be taken that a device is attached, or a flange of sufficient size fitted, to prevent any possibility of swallowing it. A frequent cause of irritation in the mouth of patients with their own incisors but no posterior teeth is a slight hingeing action owing to the back of the denture falling down, and attention to the denture may assist.

Interlocking Inoculations

Q.—*Is there any disadvantage in interlocking poliomyelitis and diphtheria inoculations — e.g., one for poliomyelitis followed by one for diphtheria in 2–4 weeks, and so on?*

A.—There is no disadvantage, either from the point of view of reactions or from the immunity produced, if these inoculations are interlocked.

Treatment of Neuropathic Keratopathy

Q.—*What is the treatment of neuropathic keratitis after alcoholic injection of the Gasserian ganglion?*

A.—The treatment of neuropathic keratitis (more correctly described as neuropathic keratopathy) consists in (1) simple preventive measures, and (2) more drastic methods necessary when there are signs of early pathological change in the cornea.

The simple preventive measures include the wearing of a pair of glasses with protective sides, or, better still, a specially constructed transparent eye-shield which excludes all air from the eyeball. In addition, "paroleine" eye drops should be used several times throughout the day. The danger of serious involvement of the cornea is considerably reduced if the treatment is carried out efficiently for the first four or five weeks after alcohol injection of the Gasserian ganglion.

Tarsorrhaphy should be undertaken without delay if there are signs of involvement of the cornea, and the eyelid should remain closed for a period of at least six months and sometimes up to one year. The tarsorrhaphy need not be complete, but it should give coverage to the affected part of the cornea.

Eventually the corneal tissues appear to become adjusted to the new condition of metabolism, and if precautions are taken against trauma and exposure to dust and cold winds the affected eye may eventually keep well. In intractable cases the wearing of a contact lens may spare the patient a permanent tarsorrhaphy.

Vaginal Specimens for Cytological Examination

Q.—*What is the best method of obtaining a specimen of vaginal mucous membrane for cytological examination and diagnosis of a patient's endocrine state?*

A.—Hormonal diagnosis, based on vaginal cytology, makes use of exfoliated vaginal cells rather than biopsy specimens from the vaginal wall. To obtain the vaginal cells either a glass tube with a rubber bulb attached, whereby secretions from the upper third of the vagina may be aspirated, or a cotton-wool applicator on a stick may be used. Advocates of the aspiration method claim that its use preserves the distinct arrangement of cells, if one exists (e.g., clumping in the progestational phase), which the use of a cotton-wool applicator may fail to do. This point, however, is disputable, provided the cotton-wool applicator, after insertion into the vagina, is then *rolled* rather than rubbed on to a glass slide. By the aspiration method the secretions are squirted on to the slide. For detailed cytological study the preparation must not be allowed to dry but must be fixed immediately in equal parts of absolute alcohol and ether. The slides may remain in the fixative for many days or may be stained within two hours. For determination of the pyknotic index, however, and for less detailed study, allowing the slides to dry before fixation, contrary to what has often been stated, does not prevent satisfactory diagnosis by vaginal cytology. For cancer detection immediate fixation is essential. For a detailed exposition of diagnosis by vaginal cytology the reader is referred to the book by de Allende and Orias.[1]

REFERENCE

1 de Allende, I. L. C., and Orias, O., *Cytology of the Human Vagina*, 1950. Hoeber, New York.

Chiari–Frommel Syndrome

Q.—*What is the most appropriate form of replacement therapy in the so-called Chiari–Frommel syndrome (galactorrhoea, amenorrhoea, loss of libido, and loss of weight with evidence of uterine-ovarian atrophy)? The patient has an excessive production of pituitary gonadotrophins accompanied by a paucity of gonadal hormones.*

A.—In the Chiari–Frommell syndrome there is under- not over-production of pituitary gonadotrophins, with the exception, it is generally believed, of prolactin. There is no really effective treatment for the condition, though with cyclic oestrogen and progestogen therapy uterine growth and withdrawal bleedings can be induced. Treatment with norsteroid progestogens, either norethisterone ("primolut N"[1]) or norethynodrel ("enavid") might be tried. The steroid could be given either cyclically in a dose of 10–20 mg. daily for 20 days, repeating from the fifth day of each subsequent withdrawal bleeding, for perhaps six cycles in the first instance, or continuously, starting at 10 mg. daily and increasing by 10 mg. a day every two weeks until 40 mg. daily is reached, for, say, six months so as to produce a "pseudopregnancy." It is possible, though certainly not probable, that normal menstruation might then be resumed.

REFERENCE

1 "To-day's Drugs," *Brit. med. J.*, 1958, **1**, 1297.

Melanin in Substantia Nigra

Q.—*Is the pigment of the substantia nigra melanin? A patient with a recent Parkinson syndrome has developed more recently evidence of metastatic melanoma. Is this associated in any conceivable way?*

A.—The pigment in the substantia nigra is considered to be melanin. The development of metastatic melanoma in a patient with a "recent Parkinson syndrome" is interesting, but it is difficult to suggest a direct association between the two conditions.

Correction.—In the summary of Dr. J. P. Bound's paper read at the Joint Annual Meeting (*Journal*, September 12, p. 424) it is stated that Dr. Bound comes from Liverpool. In fact, he comes from Blackpool.

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