of partial gastrectomy. The use of frequent small protein meals will help to prevent this. There is no evidence that the vagus plays any part in the control of internal secretions from the pancreas, so that vagotomy would not be expected to affect the diabetes.

### E.S.R.

**Q.**—*What is the basis and value of the erythrocyte sedimentation rate?*

**A.**—Many factors influence the rate at which the red cells sediment in plasma, but the most important is the concentration of the asymmetric macromolecules, especially fibrinogen, and to a lesser extent the $\alpha_2$ and $\gamma$ globulins.[1] As almost all infections, acute or chronic, are associated with a rise in $\alpha_2$ and $\gamma$ globulins, and as most wasting and destructive diseases tend to be associated with an increase in fibrinogen, it is not surprising that a raised E.S.R. is not itself of any great diagnostic value. Like fever, leucocytosis, increase in blood viscosity, and the presence of C-reactive protein, it is a manifestation of the body's reaction to injury. Its greatest value, therefore, is as an indicator of progress in chronic diseases like tuberculosis and rheumatoid arthritis, in which it waxes and wanes with the disease activity.

REFERENCE

[1] Hardwicke, J., and Squire, J. R., *Clin. Sci.*, 1952, **11**, 333.

### Post-anal Dimple

**Q.**—*A boy aged 2 months has a small opening in the midline about 1 in. (2.5 cm.) posterior to the anus. He also has a depression like a small dimple about ½ in. (1.3 cm.) posterior to the opening. The boy's brother aged 18 months and his mother have similar depressions posterior to the anus. What is the aetiology of the condition, and is it hereditary? What is the treatment?*

**A.**—Small pits and dimples in the midline posterior to the anus are not uncommon. They are congenital in origin, resulting from imperfect fusion of the skin and subcutaneous tissue in this region. They are not strictly hereditary, though showing a tendency to run in families. These pits require no treatment, and rarely, if ever, give rise to trouble. They must be distinguished from a pilonidal sinus, which is an acquired lesion resulting from penetration of the skin by hairs. Pilonidal sinus is very rare before puberty, and in a typical case is easily recognized by the facts that at least one of the openings is in the midline and a tuft of hairs is often seen protruding from this opening.

There is a rare form of congenital midline sinus which communicates with the theca. There is usually no difficulty in distinguishing this lesion from the two mentioned above, since its opening lies higher up over the sacrum.

### Significance of a Murmur

**Q.**—*Can a systolic murmur in a child of school age, unassociated with any symptoms or signs of heart disease, be dismissed as physiological when it is uninfluenced by exercise and position of the body?*

**A.**—The effects of exercise and position of the body are not of very great help in deciding whether a murmur is physiological or not. The chief use of these manœuvres is in bringing out a mitral diastolic murmur previously inaudible or in abolishing the murmur of a "venous hum" by laying the patient flat. Attention to the length of the murmur is important in telling whether it is organic or not, because all the physiological bruits are ejection in type. If the murmur is pan-systolic then it is almost certain to be organic. Furthermore, the intensity of the murmur is important because the majority of loud murmurs are organic in origin. It should, however, be remembered that there is a tendency for the inexperienced auscultator to exaggerate the loudness of cardiac murmurs. It can, however, be quite difficult even for an experienced cardiologist to decide whether a particular murmur is organic or not, and in case of doubt referral to a cardiac unit is strongly recommended.

## NOTES AND COMMENTS

**Routine Folic Acid in Pregnancy.**—Dr. A. D. PROWSE (Mitcham, Surrey) writes: In "Any Questions?" (May 26, p. 1495) your expert stated that "the use of folic acid as a routine antenatal supplement is justified both in theory and practice" in this country. Folic acid not only masks the haematological changes of vitamin-$B_{12}$ deficiency but precipitates its central nervous system complications, so the recommendation of three months' administration of this drug seems hard to justify. The basic assumption is that vitamin-$B_{12}$ deficiency is so rare in pregnancy as to be discountable, yet Baker *et al.*[1] could quote four authorities for their statement that "several workers have reported a progressive lowering of serum vitamin $B_{12}$ levels during normal pregnancy," even though this "is not normally of such a degree as to produce a frank deficiency state." The incidence of megaloblastic anaemia of pregnancy may be as high as 3%, but what are the relative dangers to mother and foetus when this state occurs? Although it needs prompt diagnosis and treatment neither is difficult, and the incidence of complications due to it must be small in patients who are given adequate antenatal supervision. There seems, therefore, to be a considerable risk that subacute combined degeneration of the cord will be substituted as a rare complication of pregnancy for a less rare, temporary, and easily treatable megaloblastic anaemia (unless every patient who has had a partial gastrectomy, and every mild malabsorption syndrome, etc., is successfully eliminated from the queue when tablets are handed out at antenatal clinics). Until the dangers to mother and baby in those 3% who develop frank megaloblastic anaemia of pregnancy are shown to be so great as to justify this it would be better to restrict the use of folic acid in pregnancy to the following conditions: (1) megaloblastic anaemia of pregnancy; and (2) a severe anaemia, discovered late in pregnancy, in the absence of diagnostic facilities, with concomitant administration of vitamin $B_{12}$ by injection to "protect" the C.N.S.

OUR EXPERT replies: The questions raised by Dr. Prowse were dealt with in some detail by Francis and Scott,[2] who pointed out that the diagnosis of megaloblastic anaemia of pregnancy is not infrequently missed, with potentially dangerous consequences, even by skilled observers. This risk is considerably greater than that of masking serious deficiency of vitamin $B_{12}$ by giving folic acid in late pregnancy. Far from excluding patients who have had gastro-intestinal reactions or have malabsorption syndromes from the "queue" for tablets, one should recognize that they have a special need for haematinic supplements and would probably benefit from iron, folic acid, and vitamin $B_{12}$ as well.

REFERENCES

[1] Baker, S. J., Jacob, E., Rajan, K. T., and Swaminathan, S. P., *Brit. med. J.*, 1962, **1**, 1658.

[2] Francis, H. H., and Scott, J. S., *Lancet*, 1959, **2**, 1033.

**Corrections.**—In the medico-legal section of the *Journal* of July 7 (p. 64) it was stated that a charge was made of driving a car without due care and attention contrary to section 6 (1) of the Road Traffic Act. This should have read "section 3 (1)."

In Professor Andrew Kay's article on "Management of Obscure Alimentary Bleeding" (June 23, p. 1709) the test used for occult blood was referred to as the "orthotoluidine test." This should have read "orthotolidine test." We apologize to our readers for this error.



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