

ANY QUESTIONS ?

We publish below a selection of questions and answers which are of general interest.

Progressive Muscle Wasting

Q.—What is known about the possible causes of progressive muscular atrophy? I understand that thyrotoxic myopathy is similar to a progressive muscular atrophy except that the changes are reversible under suitable treatment. What other toxins or drugs are known to produce similar degeneration of the anterior tracts of the spinal cord?

A.—Progressive wasting of muscles may occur in disease affecting the anterior spinal roots, the motor fibres of peripheral nerves, or the muscles themselves, and may also occur in non-neurological conditions such as arthritis of various types. The term "progressive muscular atrophy" used by the questioner is, however, usually confined to the form of motor neurone disease in which the anterior horn cells are predominantly involved. The cause of this disease is unknown, although its remarkable frequency amongst the Chamorro population in the island of Guam raises the possibility of either a genetic factor or an exogenous toxin. Thyrotoxic myopathy is considered to be due to the effect of thyroxine on muscle¹ and there is no evidence of disease of the anterior horn cells in this condition. There is usually recovery of muscle power and bulk when the thyrotoxicosis is adequately treated. Similarly a myopathy occasionally occurs as a result of corticosteroid administration with recovery when the drug is stopped.

REFERENCE

- ¹ Havard, C. W. H., Campbell, E. D. R., Ross, H. B., and Spence, A. W., *Quart. J. Med.*, 1963, 32, 145.

Effect of Toxic Stress on Arrested G.P.I.

Q.—Is there any recorded evidence that patients with therapeutically arrested G.P.I. may develop psychotic attacks and/or pareses while under stress from influenza or other "toxic" agent?

A.—It is reasonable to suppose that a patient who is suffering from residual dementia after the arrest of general paralysis might suffer exacerbation of symptoms and signs as the result of severe illness of the kind outlined. I know of no specific reference to this fact in the literature. The development of pareses in such a case would be likely to be related to the active disease and not to past syphilis.

Diethylpropion in Obesity

Q.—Can "tenuate" safely be used in the treatment of obesity, and is it effective?

A.—"Tenuate" (diethylpropion) is an appetite-suppressant drug which is chemically related to the sympathomimetic

amines amphetamine, phentermine, and phenmetrazine. The place of such drugs in the treatment of obesity has recently been well and succinctly reviewed by Macgregor.¹ Briefly, they should be used only as an adjunct to dieting; no drug is by itself of value in the treatment of obesity. Experience with anorectic agents has shown that their effect in reducing appetite is short-lived, and that after 6 to 10 weeks the amount of weight loss diminishes and may even be replaced by a gain in weight.²

The chief disadvantage of all the drugs of this type is that they have a central nervous stimulating effect which may cause insomnia and a pleasurable sensation of excitement. The danger of addiction is therefore great, and a specific type of psychosis due to addiction to drugs such as amphetamine and phenmetrazine is now recognized.^{3,4} The claim that diethylpropion is less apt to cause excitement than the other appetite-suppressants of this type may be justified. Insomnia is seldom a problem with the usual dose of 100 mg. daily, and acute symptoms of central nervous stimulation have not so far been recorded. Nevertheless, cases of addiction to diethylpropion have been reported.^{4,5}

The drug must therefore be used with care and only for short periods. It should be prescribed only for obese patients who genuinely wish to reduce and are prepared to co-operate in a regime in which dietary restriction is most important and drugs play a secondary role in helping over the difficult hurdle when the restricted diet is becoming difficult to adhere to. It should never be prescribed as a "slimming pill," and, in view of the danger of addiction, requests for repeat prescriptions should always be very carefully considered.

REFERENCES

- ¹ Macgregor, A. G., *Prescribers' Journal*, 1963, 3, 25.
² Seaton, D. A., Duncan, L. J. P., Rose, K., and Scott, A. M., *Brit. med. J.*, 1961, 1, 1009.
³ Kiloh, L. G., and Brandon, S., *ibid.*, 1962, 2, 40.
⁴ Oswald, I., and Thacore, V. R., *ibid.*, 1963, 2, 427.
⁵ Clein, L. J., and Benady, D. R., *ibid.*, 1962, 2, 456.
⁶ Kuenssberg, E. V., *ibid.*, 1962, 2, 729.

Encopresis

Q.—What is likely to be the prognosis in a 5-year-old boy with encopresis of psychological origin? He is also destructive. His mother is neurotic and unintelligent. The father is more sensible but cannot handle the child. He has been in hospital for training, but is no better.

A.—The literature on this subject has been meagre. An early study by Shirley¹ on 70 patients indicated psychodynamic factors in all cases. Burns² divided his cases into three groups: (1) untrained children; (2) neurotic cases; and (3) dys-

rhythmic or vasovagal conditions. A few treatment cases have been written up; one of note is by Warson *et al.*³

Anthony⁴ made a comprehensive study of encopretic children. Of 76 cases investigated 30 were of the "continuous" group—i.e., incontinence was persistent throughout the child's history; 30 were of the "discontinuous" group (they were continent for a while during and after the usual training period); and 16 were of the subgroup "retentive" (they showed pseudo bowel control but were in fact severely constipated with overflow).

The categories have bearing on prognosis. Those in the continuous group have been denied any training, and come from families with many social problems and with "couldn't care less" attitudes. They usually respond in three to five months when habit training is instituted by a kindly person. Children of the discontinuous group are in general deeply disturbed and require intensive psychotherapy. Usually upbringing has been over-controlled, and protection from rigid authoritarian mothers is considered part of the therapeutic programme.

An important variable is expressed in the child's attitude to his faeces, which in his fantasies become animistic and endowed with special feelings. Negative attitudes make psychotherapeutic approaches difficult. This becomes part of the psychiatric assessment. Encopresis is usually one symptom among other features of disturbed behaviour. Disturbed behaviour such as destructiveness tends to diminish as the child grows older. The remaining encopresis is likely to disappear at puberty, but discontinuous cases which have been untreated or who have failed to respond to psychotherapy are apt to develop severe compulsive neurosis with rituals and phobias.

REFERENCES

- ¹ Shirley, H. F., *J. Pediatr.*, 1938, 12, 367.
² Burns, C., *Brit. med. J.*, 1941, 2, 767.
³ Warson, S. R., Caldwell, M. R., Warinner, A., Kirk, A. J., and Jensen, R. A., *Amer. J. Orthopsychiat.*, 1954, 24, 402.
⁴ Anthony, E. J., *Brit. J. med. Psychol.*, 1957, 30, 146.

Polio and Pregnancy

Q.—If oral poliomyelitis vaccine is contraindicated in the first trimester of pregnancy what should be done to protect an expectant mother who has been in close contact with a case of poliomyelitis? Should she be given gamma-globulin?

A.—The questioner presumably has in mind a patient who has not been fully immunized against poliomyelitis; no additional protection would be needed for an immunized person. Advice against the use of live poliomyelitis vaccine in early pregnancy is based on prudence and not on evidence that it is dangerous. Poliomyelitis, on the other hand, is generally considered¹ to carry a special risk for the pregnant woman, and is probably associated with a high rate of foetal loss.² On balance, there seems

little doubt that an expectant mother who has been in close contact with a case of poliomyelitis should be given live vaccine without delay, since this may prevent her from becoming infected with virulent "wild" virus. Alternatively, she could be given gammaglobulin, but if she were already infected, which is quite possible, it would probably do no good and the large intramuscular injection might even be harmful.

REFERENCES

- ¹ Rindge, M. E., *New Engl. J. Med.*, 1957, 256, 281.
² Manson, M. M., Logan, W. P. D., and Loy, R. M., *Report on Public Health and Medical Subjects*, 1960, No. 101. H.M.S.O., London.

Action of Thyroid on Euthyroid Patient

Q.—Does thyroid extract have a stimulant action on a euthyroid person? If so, would it gradually suppress production of the thyroid-stimulating hormone? Could a person who had taken 2 gr. of thyroid extract daily over a long period without signs of hyperthyroidism still have been euthyroid in the first instance? If so, could it be withdrawn gradually without ill effects, or would production of thyroid-stimulating hormone have been permanently suppressed?

A.—Thyroid extract when given to a euthyroid person in doses equivalent to the normal rate of production of thyroxine—i.e., 2 to 3 gr. daily—has an initial slight stimulant action. This ceases to be apparent after a few weeks owing to the suppression of thyroid-stimulating hormone (T.S.H.). This depresses the secretion of thyroxine by an amount approximately equivalent to the dosage given. Therefore a euthyroid person taking 2 gr. of thyroid extract over a long period would not show signs of hyperthyroidism. When the hormone is withdrawn the production of T.S.H. recovers—though rarely, and after many years of treatment with larger doses this may not be so.¹

REFERENCE

- ¹ Fraser, R., and Garrod, O., *Brit. med. J.*, 1955, 2, 1484.

Hereditary Baldness

Q.—Is there any treatment for hereditary baldness? Are local applications of any benefit?

A.—By hereditary baldness is understood the male-patterned baldness, also known as calvities, which involves chiefly the top and front of the scalp. Although this is often hereditary it is by no means always so.

It is very doubtful whether any type of treatment influences this condition. Local applications are probably quite without effect. It is sometimes thought that local treatment for the control of dandruff has an effect in delaying the loss of hair, but this is not at all certain. Massage with the finger-tips may be harmful and actually increase the loss of hair, but deep massage, in which the whole scalp is moved over the cranium without surface

friction, is believed by some to be useful. Ultraviolet light, electrical stimulation, and similar treatments are valueless.

The variable progress of the condition makes local treatment rather difficult to assess. It is clear, however, that there is no form of treatment which is sufficiently effective to have gained general acceptance.

Diet in Osteoarthritis

Q.—Is there any rational basis for dietic measures in osteoarthritis, and, if so, what should they be?

A.—There is little confirmed basis for any particular diet in osteoarthritis except a good normal and adequate diet. However, many people feel that obesity, by adding to the weight and stress on already damaged joints—particularly weight-bearing joints such as hip or knee—is deleterious, and it is orthodox practice to prescribe a weight-reducing diet for patients with degenerative hip disease or

knee disease, since they are mostly grossly overweight. Other than this, the diet should contain adequate vitamins and a normal balance of proteins, carbohydrates, and fats. There is no indication at all for any of the crank diets so often prescribed.

Eczema and Hay-fever

Q.—A patient with severe eczema is marrying a girl who suffers from hay-fever. He has no family history of allergy, but the girl's mother has hay-fever and her brother has a recurring allergic rash. What are the chances of the children inheriting an allergic tendency?

A.—The main risk here is the inheritance of the hay-fever type of allergy, which is present in the girl. There is a considerable risk, perhaps as high as one in two, of any children of the marriage inheriting hay-fever from the mother.

NOTES AND COMMENTS

Withholding Iron During Periods.—Professor J. B. CHATTERJEA (School of Tropical Medicine, Calcutta) writes: I read with interest the discussion relating to iron therapy during periods ("Any Questions?" August 3, p. 302). On the basis of a paper published by Stallworthy the question was: "It has been stated¹ that in the treatment of menorrhagia iron should be given only between periods, since it sometimes increases the loss if given during the period. Does this view still hold good, and for all types of iron administration?" Your expert answered: "The answer to the question is that this view still holds good . . . as a general guide, practitioners are advised not to prescribe oral iron during the menstrual period." It further stated that in some women menstrual flow may be increased by oral iron but not by parenteral iron.

I beg to submit that our experience does not quite support these statements. It is rather difficult to reconcile the idea that the effect of oral iron, if any, on menstrual flow should be different from that of parenteral iron. Also I do not know of any work in which it has been shown on objective data that oral iron increases the menstrual flow. The paper of Stallworthy¹ referred to in the question is perhaps based on his impressions, which do not appear to have been critically evaluated. If the period lasts for only three to four days withdrawal of iron therapy during this short period does not really affect the desirable erythropoietic response. If on the other hand the period lasts for 7–10 days, which is not unusual in a number of menorrhagic women, withdrawal of iron for such a long period is perhaps not justified. I would conclude by submitting that the recommendation for withdrawal of iron therapy during periods does not appear to be justified, particularly if it is meant to be a general guide to the medical practitioners.

OUR EXPERT replies: Professor Chatterjea has not made a dogmatic statement on the effect of oral iron on the menstrual flow and nor did I. I wrote that iron "sometimes" increases the loss and that many women can take iron without it increasing the amount of loss, while Professor Chatterjea states

"our experience does not quite support these statements." Any conflict of opinion on the relative incidence of difficulty due to oral iron will remain unsettled until a prospective study has been made of this problem and the results critically evaluated, as suggested by the Professor. I understand that a study has been planned at Oxford to investigate, among other things, the possible effect of iron on the menstrual flow.

REFERENCE

- ¹ Stallworthy, J. A., *Brit. med. J.*, 1950, 1, 831.

Erythromelalgia.—Dr. D. WISE (London N.3) writes: The age and sex of your questioner's patient are not mentioned ("Any Questions?" November 23, p. 1321), but if it is a young man or boy I think a careful search for angiokeratoma corporis diffusum is advisable. I found only three young men in whom the diagnosis of erythromelalgia had been made during a ten-year period at the Johns Hopkins Hospital. One man had earlier suffered from frostbite, a second man probably had polyarthritis, and the third was a typical case of diffuse angiokeratoma.

A family with diffuse angiokeratoma recently examined by me was originally published under the diagnosis of erythromelalgia.¹ The attacks of pain in the extremities of patients with diffuse angiokeratoma sometimes start before the inconspicuous skin lesions are detectable, and in such cases the diagnosis is most easily made by slit-lamp examination for the characteristic corneal epithelial dystrophy.² Women with diffuse angiokeratoma rarely have pain in the extremities, but we have now seen two such cases.

OUR EXPERT replies: Dr. Wise is an authority on the rare disease of angiokeratoma corporis diffusum, and he is, of course, quite right to emphasize that this strange vascular disorder may be a cause of the rare syndrome of erythromelalgia. I should perhaps have mentioned it in my answer to the question.

REFERENCES

- ¹ Cross, E. G., *Canad. med. Ass. J.*, 1962, 87, 1.
² Wise, D., Wallace, H. J., and Jellinek, E. H., *Quart. J. Med.*, 1962, 31, 177.