a matter of some individual variation and the treatment may be worth a trial. Ganglion-blocking agents, such as hexamethonium bromide, have also been used with some success. With many of these drugs the dose should be gradually increased in the hope of finding a dose which will give significant relief of symptoms without side-effects.

Local bathing with formaldehyde, 3–5%, gives temporary benefit, the soles being immersed in this solution for from five to ten minutes once daily. Irritation or sensitivity is not likely to arise if the liquid is confined to the soles and kept away from the sides and dorsa of the toes. A powder consisting of zinc oxide and talc with 5% sodium hexametaphosphate dusted on the feet in the morning is often helpful.

In a fair proportion of cases the above treatment, though not entirely successful, will reduce the symptoms and give reasonable relief from the complaint. In the most difficult cases lumbar sympathectomy may be undertaken.

Safety First

Q.—*Is it usual practice to set up an intravenous-drip apparatus, with needle in situ, in every case before a forceps delivery under either pudendal block or general anaesthesia?*

A.—It is not usual but may be regarded as desirable by some obstetricians. There are also some motorists who fasten their safety belts when making a 100-yard journey.

Drugs Causing Leucopenia

Q.—*What type of drugs are apt to cause leucopenia, and how do they cause it?*

A.—This subject has been dealt with by Israëls.[1] About 30 drugs are known to cause leucopenia. These include the well-known ones like amidopyrine, some sulphonamides, the antithyroid drugs, and chloramphenicol. In addition, practically all the tranquillizers have been involved at some time or other, including chlorpromazine, imipramine, and meprobamate. The anti-insulin drug tolbutamide has also been known to cause trouble. More recent reports have involved sulphasalazine, used for ulcerative colitis, and "atromid," the drug for reducing blood cholesterol. Of course, all the drugs being used in the treatment of reticuloses and malignancy, particularly the nitrogen-mustard group and the anti-folic acid group, will cause leucopenia.

This latter group of drugs causes leucopenia by direct inhibition of formation of white cells, and will eventually cause aplastic anaemia. The cause of the leucopenia in most of the other drugs is thought to be a sensitivity reaction. There are good reasons for this, because if only a little is given the white cells disappear rapidly from the circulation but granulocyte formation continues in the bone marrow. If the drug is persisted with eventually inhibition of marrow formation of granulocytes occurs as well. It is odd that, in spite of all these risks, acute agranulocytosis is now seen only rarely.

REFERENCE

[1] Israëls, M. C., *Proc. roy. Soc. Med.*, 1962, **55**, 36.

Notes and Comments

Restless Leg Syndrome.—Dr. S. BEHRMAN (London W.1) writes: Your expert states ("Any Questions?" 25 July, p. 239) that treatment of this disorder is "unsatisfactory." Provided other painful conditions of the legs and anaemia have been eliminated, "restless legs," like other manifestations of dyslysis, respond dramatically to phenobarbitone and most other anticonvulsants.[1] Dosage and times of administration have to be determined by trial. This response to anticonvulsants does not by any means imply that dyslysis is an epileptic phenomenon.

REFERENCE

[1] Behrman, S., *Brit. med. J.*, 1958, **1**, 1454.

Mongolian Blue Spots.—Dr. E. S. BENJAMIN (Groote Schuur Hospital, Capetown) writes: I was interested to read Dr. A. Hinchliffe's remarks (27 June, p. 1692) on Mongolian blue spots. Recently at a dermatological clinic in Capetown I observed a Cape-coloured male child of 4 months with very extensive blue pigmentation dating from birth, involving the sides of the back and chest, buttocks, abdomen, and thighs as far as the knees. The lesions were flat and unaccompanied by symptoms. These are probably also a variant of the Mongolian blue spot.

OUR EXPERT replies: Dr. Benjamin's remarks are of considerable interest in the context of Mongolian blue spots, and I am sure that he is right that the extensive blue pigmentation that he observed is a variant of the classical Mongolian blue spot. What one would like to know is what is the evolution of these patches of pigmentation—that is, whether they disappear or whether they get involved in increasing pigmentation, so that the original "blue" area becomes indistinguishable from the rest of the skin.

Correction.—We regret that in the article "Hormones and the Kidney" by Dr. H. J. G. Bloom and Mr. D. M. Wallace (22 August, p. 476) the name of the first author in the fifth and sixth references was wrongly given as Bartter, F. C. These references should have read as follows:

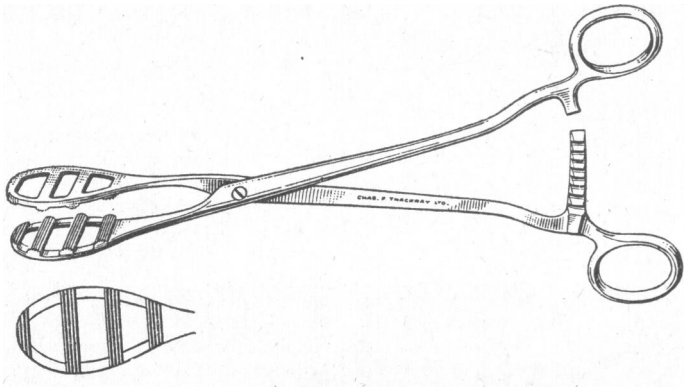
Bloom, H. J. G., Baher, W. H., Dukes, C. E., and Mitchley, B. C. V. (1963a). *Brit. J. Cancer*, **17**, 646.

—— Dukes, C. E., and Mitchley, B. C. V. (1963b). Ibid., **17**, 611.

NEW APPLIANCES

A New Lung-grasping Forceps

Mr. J. M. ANDERSON, F.R.C.S., Western District Hospital, Glasgow, writes: An original design of instrument for grasping lung is illustrated in the accompanying figure. The new forceps is heavier than that commonly used for grasping lung, but it holds lung tissue securely and without troublesome bleeding.



The construction is of a ratchet-type holding forceps with an axial hinge at the junction of the proximal two-thirds and the distal third of each limb. The two grasping jaws are pear-shaped and carry ribbed bars which interdigitate except at the tips, where they appose. Each jaw is 4.5 cm. in the long axis and 2.5 cm. in the widest transverse axis. The four bars are evenly spaced and are 0.4 cm. broad. The overall length of the instrument is 24 cm.

A gentle bite with this instrument permits worth-while retraction and subsequent reinflation of the grasped lung when necessary. Firm retraction during mobilization for resection is eminently satisfactory.

I am grateful to Mr. J. Hutchison, of Stobhill General Hospital, Glasgow, for advice on the final model; and to Mr. J. W. Jackson, of the Middlesex Hospital, London, for early encouragement in the development of this instrument. Messrs. Chas. F. Thackray Ltd., Leeds, have generously modified early models, and now manufacture the instrument.