ANY QUESTIONS?

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

Symptomless Cardiac Hypertrophy

Q.—*Is a hypertrophy of the heart commonly found in men aged between 40 and 50 who are apparently healthy in other respects, and what is the most likely cause?*

A.—Cases of true but symptomless hypertrophy of the heart in men aged 40 to 50 determined by clinical, radiological, and electrocardiographic assessment are not uncommonly seen in cardiac clinics but are probably rarely seen in general practice. It is usually an expression either of increased heart work or of a developmental anomaly, and it is abnormal.

Generalized cardiac hypertrophy is associated with a "non-coronary" cardiomyopathy, most examples being idiopathic. Occasionally some special association can be made out, such as malnutrition—for example, alcoholism—or a history of some past infective process involving the myocardium—that is, a "myocarditis" due to a viral, bacterial, rickettsial, or protozoal agent. In the African native endomyocardial fibrosis (E.M.F.) is an important cause; it may involve both ventricles and sometimes the atria too. Since its classical description in the Uganda native by Davies and his colleagues[1 2] the condition has been reported in many other parts of the world, occasionally in white subjects too. It should be noted that bradycardia, as in heart-block, can also cause apparent enlargement of the radiological heart shadow.

Dominant left-heart hypertrophy also has many causes and may be detected before symptoms become manifest in conditions such as arterial hypertension and ischaemic heart disease (including anaemia), or in association with aortic coarctation, patent ductus arteriosus, or minor degrees of aortic or mitral valve damage. Lone mitral stenosis, which can be almost asymptomatic, is associated with a normal-sized left ventricle, but the left atrium is dilated and thickened. Hypertrophy predominating in the interventricular septum below the aortic valve is a well-known developmental entity called "obstructive cardiomyopathy" or "asymmetrical hypertrophy of Teare." It is, however, generally found in adolescents.

Likely causes of a hypertrophy predominating in the right heart and without symptoms in men aged 40 to 50 would be a congenital anomaly such as atrial septal defect or cor pulmonale due to repeated subclinical pulmonary embolism (primary pulmonary hypertension is virtually confined to females). Right atrial hypertrophy and dilatation suggests Ebstein's anomaly of the tricuspid valve, which may be symptomless even in the elderly. It is unlikely that hypertrophy secondary to the lung changes of mitral or aortic valve disease would be symptomless, and in any event the left heart would also be involved.

Finally, one must always bear in mind myxoma of the atria, which may cause periodic obstruction at the tricuspid or mitral valve with dilatation and hypertrophy of the chamber containing the mass. Nevertheless, such tumours not infrequently turn up at routine necropsy in quite elderly patients—for example, one aged 95 years—dying of other causes.

The precise assessment of symptomless hypertrophy of the whole heart or of one or more of its chambers is an important matter, and it is obvious that expert specialized examination may be required to determine its likely cause.

REFERENCES

1 Davies, J. N. P., M.D. Thesis, 1948. Bristol University.
2 Ball, J. D., Williams, A. W., and Davies, J. N. P., *Lancet*, 1954, **1**, 1049.

Fractured Neck of Femur in the Elderly

Q.—*What is the best treatment for elderly patients with a fractured neck of femur who are considered to be unfit for pinning because of dementia or feebleness?*

A.—I would doubt whether there was ever an occasion when a person suffering from dementia or feebleness was unfit for treatment by pinning of a fractured neck of femur. The reason for saying this is that there can be no question that survival is more likely if the hip is pinned than if it is not. Moreover, the management of such patients unpinned is almost impossible, since they must be on skin or skeletal traction and remain on this for at least three months, with little prospect of success when it is a fracture of a neck of femur.

Thus the avoidance of operation would mean an extremely heavy nursing problem for several months with no prospect of even alleviation of the hip condition at the end of it. Pinning of the hip, on the other hand, makes nursing a simple problem. The next day the patient can be sitting in a chair and, even if there is no prospect of walking again, he or she is much more easily nursed and presents almost no problems compared with a patient with a persisting fracture.

It is my experience, however feeble or elderly the patient, pinning, which is nowadays a very small operation with very small risks, is the better procedure. It has been well said that one must ask if a patient is fit enough not to have operation rather than whether the patient is fit enough to have an operation.

Compulsive Eating

Q.—*Are attacks of compulsive eating of chocolate and other confectionery a common psychoneurotic manifestation, and what can be done to cure the condition?*

A.—No figures are available giving the incidence of compulsive eating of chocolates and other confectionery, but it is a familiar though not an everyday psychoneurotic symptom. It appears in men, in children, and most frequently in pregnant women.

There is no precise remedy. While the character of the compulsion is important, the focus of attention should be on the person affected. It is likely that the trouble began as an attempt to alleviate unhappiness such as loneliness or a phase of depression. The patient should be asked about the emotional atmosphere when the consumption of chocolate became excessive. A compulsion such as this may mask a deeper trouble. Consequently the patient should be seen by a psychiatrist, who will make at least a tentative diagnosis. If the general practitioner can attend the consultation it could be helpful, though in certain circumstances his presence might hinder frank discussion.

Should psychotherapy be advised, as is likely, this may take the form of explanation or suggestion, possibly with hypnosis. Alternatively an intravenous injection of barbiturate or of Methedrine may be used to bring about the release of repressed feelings. During the period of unconsciousness suggestions can be made that the patient will in future dislike the taste of chocolate. More protracted forms of treatment such as analysis will be required if there are additional symptoms.

Notes and Comments

Harvest Bugs.—Mr. W. B. ROANTREE (Deal, Kent) writes: With reference to your expert's answer to this question ("Any Questions?" 15 May, p. 1296), as one with many years of subjective experience with the trombiculids in question, I should like to point out that a longer protection than that afforded by D.M.P. will be obtained by the use (if necessary to the whole body) of a thin inunction of benzyl benzoate emulsion.[1] This should be allowed to dry before dressing, and will confer complete or almost complete protection for a couple of days or longer. A suitable 25% emulsion is obtainable commercially for the treatment of scabies.

REFERENCE

1 Roantree, W. B., *Lancet*, 1960, **2**, 49.

Herbal Cure for Renal Calculi.—Dr. I. B. ZAYID (High Wycombe, Bucks) writes: I was very interested to read this note ("Any Questions?" 12 June, p. 1544). Two years ago in Jordan I saw a woman aged 35 years with severe bilateral nephrocalcinosis attributed to an overdosage of intravenous calcium therapy. She was developing chronic renal failure with blood urea of around 180 mg./100 ml. She began taking a cupful of lithospaston infusion three times a day, and within three to four weeks the *x*-ray showed almost complete disappearance of the calcific shadows in her kidneys and almost normal blood-urea level. We tried this infusion on four patients—three with renal calculi and one with a ureteric calculus—and after two weeks the calculi remained unchanged. I wonder if the cause of this patient's nephrocalcinosis was relevant to her most remarkable recovery with this herbal administration in contrast with the standard renal calculi.

Correction.—There were three errors in the article "A New Haemoglobin in a Thai Family. A Case of Haemoglobin Siriraj-β Thalassaemia" by Dr. S. Tuchinda and his colleagues (19 June, p. 1583). On page 1584 the final part of the second paragraph in the second column should have read "... but the hybrid of $\alpha_2$canine and of β_2Siriraj moved more slowly than $\alpha_2$canineβ_2A, indicating that the abnormality in haemoglobin Siriraj was located in the β-chain." On page 1585 the first paragraph in the second column should have read as follows: "It was surprising that on tryptic digestion of the new haemoglobin no peptide val-his-leu (thr pro glu)-lys was found. The sequence glu+-lys−-lys− does not seem to be a substrate for tryptic digestion. Even by varying the *p*H (usually 8.2) from 9 to 7.5 and by doubling the time of digestion, only the peptide val-his-leu (thr pro glu)-lys-lys could be obtained."