correctly, but people with defective colour vision cannot. Anyone passing this test should be able to interpret colour-coded electrical wires, but it is possible that some people with minor degrees of colour defect who fail the Giles–Archer test may be able to perform a practical task satisfactorily.

REFERENCE

1 Giles, G. H., *Diopt. Rev. Brit. J. physiol. Opt., N.S.*, 1940, **1**, 23.

Contaminated Well-water

Q.—*How can the water in an open and contaminated well be made fit for consumption after it has been covered? After disinfection, should the well-water be chlorinated in the storage tank, and by what method? Is there a simple way of testing the safety of water for drinking?*

A.—It is assumed that the contamination is bacteriological. Before any action is taken a sample of water should be submitted to the nearest public health laboratory together with full details of the problem. On the results obtained the director of the laboratory will be able to advise generally, and in particular on whether or not it might be wiser to abandon the well. In any event if it is decided to continue this source of supply every effort must be made to trace the source of contamination and effective steps taken to eliminate it. Chlorination or other treatment of the well-water will then depend entirely upon bacteriological reports on subsequent samples.

If the local medical officer of health, in consultation with the director of the public health laboratory, advises that after the removal of the source of pollution the supply can be made potable consideration should be given to the possibility of treating the supply through small domestic filters which are manufactured specially for this purpose. The names and addresses of manufacturers of such equipment are published in a Ross Institute bulletin.[1] This bulletin also outlines simple methods of ascertaining the correct dosage of chlorine and testing for residual chlorine.

REFERENCE

1 *Small Water Supplies*, Bulletin No. 10, 1964. The Ross Institute.

Recurrence Rate in Rodent Ulcers

Q.—*Are there any statistics to show the recurrence rate in rodent ulcers that have been treated early and were apparently cured?*

A.—The short answer to this question is that not more than 10% of rodent ulcers recur after apparently successful treatment by irradiation. There is a need, however, to consider recurrences in relation to the site involved and also to the time after treatment. The slow growth of these neoplasms can give rise to recurrence 15 or more years after apparent cure—though this must be very rare indeed.

Detailed statistical analyses of this subject are few in number.[1–3] The main reasons for this lack of data are that basal cell carcinoma is not a lethal tumour, and the numbers of patients attending hospitals after treatment outgrew the available follow-up facilities. Priority for routine follow-up was therefore given to other types of cancer. This clinical decision was supported by the General Register Office, which after 1951 no longer sought routine follow-up data for patients registered as having basal cell carcinoma of the skin.

Unpublished data from the Christie Hospital, Manchester, suggests a probable maximum recurrence rate for all sites of less than 10%.

REFERENCES

1 Champion, R., and Gibb, R., *Brit. J. plast. Surg.*, 1952, **4**, 263.
2 Churchill-Davidson, I., and Johnson, Ethel, *Brit. med. J.*, 1954, **1**, 1465.
3 Belisario, J. C., *Cancer of the Skin*, 1959. Butterworth, London.

Congenital Absence of Both Kidneys

Q.—*What are the chances of further children with congenital absence of both kidneys being born to parents who have had one child with this abnormality? There is no family history on either side of such an occurrence.*

A.—No systematic studies of the genetics of this malformation have yet been made, but the risk of recurrence is probably small. A few instances of two affected sibs are known[1 2] but these are exceptional.

REFERENCES

1 Baron, C., *Amer. J. Obstet. Gynec.*, 1954, **67**, 667.
2 Schmidt, E. C. H., Hartley, A. A., and Bower, R., *Arch. Path.*, 1952, **54**, 403.

Notes and Comments

Coconut Water as Intravenous Infusion.—Professor K. RAJASURIYA (Faculty of Medicine, University of Ceylon) writes: With reference to the answer to this question ("Any Questions?" 28 August, p. 525), we in Ceylon have used coconut water for intravenous therapy in several cases of severe dehydration or toxaemia following acute dysenteries, gastro-enteritis, typhoid fever, etc., with no untoward effects.[1] There do not appear to be any risks in the use of this fluid provided the solution is not too rapidly infused. Its high concentration of calcium and magnesium is believed to increase the body tolerance to the relatively high potassium levels. The only factor that precludes the more widespread use of this fluid is the fact that the extraction and preparation for infusion takes a little time and labour. If it can be bottled and kept available for immediate use it is the cheapest intravenous fluid available here for the conditions listed above, one pint (0.6 litre) costing the equivalent of eightpence.

OUR EXPERT replies: It is true that the high calcium level (about twice the normal serum level) and magnesium level (about ten times that in normal serum) may explain the lack of evidence of potassium poisoning after coconut water infusion. This is particularly so in cases of dehydration due to diarrhoea, where there is already some potassium depletion. Professor Rajasuriya's experience in 26 cases without untoward effects is valuable, as is his advice against rapid infusion. The therapy possibly still has a place in areas where more conventional preparations are unavailable, so long as its risks are fully understood.

REFERENCE

1 Rajasuriya, K., Hamza, M. H. M., and Selvaratnam, S., *Ceylon med. J.*, 1954, **2**, 251. No. 4 (New Series).

Left-handedness and Stutter.—Miss M. COURTMAN-DAVIES (the College of Speech Therapists, London N.W.8) writes: I was very interested in the answer to the question on this subject ("Any Questions?" 18 September, p. 691) and would endorse much that your expert says. Two points would seem worth making. Firstly, that Dr. Gavin Andrews and Mrs. Mary Harris, in their recent survey[1] into stammering children in Newcastle upon Tyne, found no evidence to support the supposition that handedness or crossed laterality is related to stammering. None of the 80 stammerers they examined was a converted sinistral. Secondly, I feel that the role of the speech therapist in dealing with the young stammering or apparently stammering child needs defining a little more clearly.

No speech therapist would attempt any direct work on speech with such a young child (or indeed with an older pre-school child), but it is often very helpful for the worried parents of the apparently stammering young child to see a speech therapist in order to discuss with her their doubts and fears in regard to their child's speech. As the writer infers, a secondary stammer may develop at this young age, and it is possible for this to occur partly as a result of parental anxiety or the hesitations and prolongations that constitute a normal stage in speech development. If parents are given the opportunity to discuss with a speech therapist what should be expected of their child's speech development at this stage, reassured and cautioned about drawing attention to repetitions, the period of apparent stammer will often pass away quite quickly. Continued unallayed parental anxiety, particularly when there has been stammering in the family, may, however, have the effect of focusing parents' attention on speech and thus canalizing the stammer.

OUR EXPERT replies: The question of handedness in relation to stammer was considered in the review of Dr. Gavin Andrews's and Mrs. M. Harris's book[2] and also in a leading article on stammering.[3]

REFERENCES

1 Andrews, G., Harris, M., Garside, R., and Kay, D., *The Syndrome of Stuttering*, 1965. William Heinemann Medical Books Ltd., London.
2 *Brit. med. J.*, 1965, **2**, 414.
3 Ibid., 1965, **2**, 491.

Correction.—We much regret several printer's errors and omissions in the preliminary communication "Studies on Antibody Levels during Vaccination of Rhesus Monkeys against *Plasmodium knowlesi*" by Drs. G. A. T. Targett and A. Voller (6 November 1965, p. 1104).

On p. 1104 line 7 for "Tobie and Coatney, 1961" read "Tobie and Coatney, 1964."

On p. 1106 a note should be added: "This work was carried out at the National Institute for Medical Research, London, and at the London School of Hygiene and Tropical Medicine."

Dr. Voller's address should read: "Nuffield Institute of Comparative Medicine, Regent's Park, London."

In the reference "—— Williams, K., Voller, A., and Billeweiz, W. (1965)" for "Unpublished observations" read "*Trans. roy. Soc. trop. Med. Hyg.*, **59**, 395."

After the reference "Tobie, J. E., and Coatney, G. R. (1961). Ibid., **11**, 128" insert "—— —— (1964). *Amer. J. trop. Med. Hyg.*, **13**, 786."