

dose is appropriately adjusted, but it is hard to see what the indications are for its use when other reasonably effective sedatives are available which rarely involve any risk at all.

It would therefore seem that chlorpromazine is not a suitable drug with which to treat a 3-month-old infant for any length of time.

Ultra-high-temperature Treatment of Milk

Q.—Does the ultra-high-temperature treatment of milk affect its nutritional or other qualities in any way that would make it unsuitable for use in infant feeding ?

A.—All available evidence suggests that ultra-high-temperature milk is just as suitable for infants as other forms of milk that had undergone heat treatment, such as pasteurization, evaporation, or sterilization. Moreover, in colour, flavour, and many nutritional properties ultra-high-temperature milk would appear to be more akin to pasteurized than to sterilized milk, and bacteriologically it should be superior to both.^{1,2}

REFERENCES

- 1 Ministry of Agriculture, Fisheries and Food, *Report on the Heat Treatment and Aseptic Filling of Milk*, undated.
- 2 *J. Soc. dairy Technol.*, 1965, 18, 58, 65, 85.

Corticosteroids and Impotence

Q.—Can regular maintenance doses of corticosteroids cause impotence in a man ?

A.—There is no reason to suppose that a maintenance dose of corticosteroid which is not giving rise to symptoms of corticosteroid excess could cause impotence. It is true that impotence may be a feature of Cushing's syndrome, and so might occur when corticosteroid therapy is producing Cushingoid side-effects.

Tay-Sachs Disease

Q.—What is the aetiology of Tay-Sachs disease, and is there any treatment ?

A.—Tay-Sachs disease is due to an inborn error of metabolism transmitted as a Mendelian-recessive trait. The precise nature of the metabolic error is not known ; it is one of the lipidoses, and the defect is presumably one of intracellular metabolism. There is no known treatment. The condition is also known as amaurotic family idiocy or cerebromacular degeneration.

Although the error is inborn, it is not clinically manifested in most cases at birth, so that the child initially develops normally and then deteriorates. The time of onset of the disease is different in different families, and this has led to a subdivision of this form of lipidosis depending on the age of onset and speed of progress. It is usually held that there is some difference in the nature of the metabolic defect in the different forms of the disease. It is also usually considered that the infantile form of the disease is commoner in Jewish populations of East European origin, though many cases have been reported in non-Jewish families.

As with other diseases transmitted in this way parental consanguinity is an aetiological factor, being much commoner than in the general population. Although there is no specific treatment genetic advice may be given. The risk of a further child being affected is one in four—i.e., a risk that most parents would not wish to take.

Concentrated Intravenous Pyelograms

Q.—What is the technique and what are the contraindications of the large dose or intravenous drip of radio-opaque material for concentrated intravenous pyelograms ?

A.—There is no doubt that 20 ml. of radio-opaque medium are insufficient to produce clear definition of the calices in some patients, whereas an extra 10–20 ml. will give excellent contrast in most cases. For this reason some urological departments are using 40 ml. contrast medium for all routine pyelograms. In certain special instances much larger doses, up to 100 ml., are given by intravenous drip.¹ The technique is simple. For example, 100 ml. of contrast medium can be mixed with 200 ml. of 5% glucose-saline, which is then run into a vein rapidly in about 10 minutes. If there has been adequate restriction of fluids during the previous 24 hours the sudden diuresis following the infusion can produce excellent pyelograms.

Iodine reactions are much less of a problem to-day with the modern tri-iodine compounds than they used to be, and in general it can be stated that patients are either sensitive or not sensitive to iodine, so that in the vast majority of cases the actual dosage is unimportant. There are therefore no contraindications for large doses, and in cases where poor definition is noted in the 15–20 minute film a further injection of 20 ml. of medium will usually procure improved contrast.

Whether there is any great advantage in a drip infusion of large doses of contrast medium as opposed to an initial 40–60 ml. injection is debatable.

REFERENCE

- 1 *Brit. med. J.*, 1965, 1, 740.

"Acid" for Treating Scurvy

Q.—In accounts^{1,2} of Cook's first voyage reference is made to "acid" in the treatment of scurvy. What was this acid ? As many of the crew are said to have fallen victims of the "flux" (presumably dysentery), what orthodox treatment was there for the flux at that time ?

A.—When Joseph Banks^{1,2} describes the sad case of seaman Tupia, "Tupia had for the last few days bad gums, which were very soon followed by livid spots on his legs and every symptom of inveterate scurvy," and goes on to include acid amongst the medicines resorted to, he is probably referring to a gargle of "elixir of vitriol" (sulphuric acid), which had been introduced to the Navy by Dr. John Huxham. Huxham died in 1768, the year in which the *Endeavour* set sail. He has this to say about his prophylaxis:³ "I commonly gave *Elixir vitrioli* with the tincture of the bark . . . which is an excellent anti-putrescent Alexipharmac."

Elsewhere he advises a "frequent and free use of vinegar in the seamen's diet." That Cook did take quantities of vinegar with him, at least on his second voyage, is attested by the rather disparaging remarks about its effectiveness which he communicated to the Royal Society in 1776.⁴

Almost the whole repertory of medicines was brought to bear against the fever and internal upset associated with dysentery. Bleeding, drinks of boiled milk and water, decoctions of rice, linseed, gum arabic, and Peruvian bark were used in the first instance, followed by purges, emetics, and finally restoratives. A "dry vomit" concocted by Dr. Thos. Marryat (1730–92) was a combination of tartar emetic and vitriol. The so-called "putrescent matter," which in Cullen's view infiltrated the blood-stream, was in his opinion to be eliminated by diluents and anti-septics. "The chief of these are acids of all kinds, when sufficiently diluted, and which are, in several respects, remedies adapted to continued fevers. Those especially in use are the Vitriolic and Vegetable."⁵

The outbreaks of dysentery in the 18th century are vividly described by Creighton.⁶ Newcastle, Plymouth, Liverpool, and London were towns particularly hard hit—Newcastle in 1758–9,⁷ London in 1762 and 1779–81.

REFERENCES

- 1 *The Endeavour Journal of Joseph Banks*, vol. 2, edited by J. C. Beaglehole, 1962. Trustees of the Public Library of New South Wales.
- 2 *The Journals of Captain James Cook. The Voyage of the Endeavour*, edited by J. C. Beaglehole, 1955. Cambridge University Press, London.
- 3 Huxham, J., *Essay on Fevers*, 1750. Austen, London.
- 4 *Philosophical Transactions*, abridged edition, vol. 14, 1809. London.
- 5 Cullen, W., *First Lines of the Practice of Physic*, vol. 1, 1777. Murray, London.
- 6 Creighton, C., *A History of Epidemics in Britain*, vol. 1, 1891, vol. 2, 1894. Cambridge University Press.
- 7 Wilson, A., *An Essay on the Autumnal Dysentery*, 1761. London.

Notes and Comments

Haemorrhage after Tonsillectomy.—Dr. F. E. BENNETTS (All Saints' Hospital, Chatham, Kent) writes: I was interested in your expert's reply to Mr. Rice's comment (20 November, p. 1230) on the question of haemorrhage after tonsillectomy ("Any Questions?" 23 October, p. 986). While applauding your expert's views on the prevention of post-operative haemorrhage by surgical means, I must as an anaesthetist take issue with him on his condemnation of halothane as an anaesthetic agent for tonsillectomy. With suitable premedication return to full consciousness is delayed when this agent is used, though tranquil return of the vital protective reflexes is even quicker than when ether is used. The nausea and vomiting with consequent increase in venous pressure and peripheral vascular dilatation, all characteristic of ether and possibly implicated in post-operative haemorrhage, are avoided. Those who have abandoned the often difficult and occasionally dangerous older methods of anaesthesia for the use of halothane in the intubated patient for the operation of adenotonsillectomy will have had few regrets, and, I believe, given good surgical technique, fewer post-operative bleeds.

Correction.—We much regret that in our issue for 27 November (pp. 1263 and 1318) we incorrectly referred to Lord Florey as Sir Howard Florey.