Any Questions?

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

Hypotension and Pregnancy

A healthy married woman of 29 has recently been found to have hypotension—B.P. 80/60. She is now pregnant. Are there any particular complications to be guarded against?

Usually women with a low blood pressure suffer no special complications during pregnancy. The emphasis is on the adjective "healthy". A generally accepted low normal blood pressure is 90/60 mm Hg and until the systolic falls to about 50 mm Hg a normal cerebral blood flow is likely to be maintained.[1] It is possible that in the erect position this woman's blood pressure may be raised above the figure given.[2] There are many potential errors in the recording of the blood pressure by the sphygmomanometer, and the question does not reveal if there have been several readings nor whether the patient was sitting, standing, or lying when the reading of 80/60 was recorded.

Because of hypotension, if this is finally accepted in this case, there might be an increased tendency for faintness in early pregnancy. Later there is the possibility of the "supine hypotensive syndrome" occurring as the woman lies on a hard couch, because the uterus may occlude the inferior vena cava and so reduce cardiac input and output.[3] A theoretical problem might be how to interpret a rise of blood pressure late in pregnancy. If the blood pressure rises by 20 points to 100/80 mm Hg is this to be classed as pre-eclampsia of hypotension? Arguments are still heard about this but few obstetricians nowadays would worry about this diagnosis until the blood pressure reached 140/90 mm Hg whatever the previous apparently normal blood pressure had been. This woman should have an uneventful pregnancy and labour as regards the blood pressure, and her hypotension should cause no problems except the minor ones suggested.

[1] Stead, E. A., in *Cecil-Loeb Textbook of Medicine*, 12th edn., ed. P. B. Beeson and W. McDermott. Philadelphia, Saunders, 1967.
[2] Browse, N. L., *The Physiology and Pathology of Bed Rest*, Springfield, Thomas, 1965.
[3] Hytten, F. E., and Leitch, I., *The Physiology of Human Pregnancy*. Oxford, Blackwell, 1964.

Unusual Sweating Pattern

A patient has recently had pleuro-pneumonia with pericardial involvement thought to be of virus origin. Laboratory tests have not been able to confirm this. The patient has recovered, apart from regular heavy night sweats. These affect him above the umbilicus—mainly the head, neck, arms, and hands. Is there any neurological explanation for this particular distribution?

The patient's profuse night sweats probably mean that his temperature is still fluctuating. Many people sweat less on the lower than on the upper limbs or on the face, and this can make the assessment of normal sweating on the lower limbs, especially in the elderly, particularly difficult. It could be the explanation in this patient. Nevertheless, the sweating on the upper half of the body is so profuse that it raises the question whether there is a degeneration of the sympathetic supply to the lower part of the body. This could be due to a polyneuropathy, for instance, that associated with diabetes, but occasionally degeneration occurs in the intermediolateral cell columns of the spinal cord where the cell bodies of the pre-ganglionic sympathetic fibres are situated. It commonly presents with loss of sweating and, in the male, of sexual activity, but can also progress over years or decades to cause orthostatic hypotension.[1] [2] It is likely that the infection is not the cause of the sweating pattern, but rather the means of revealing it. Special tests of sweating and vasomotor activity and of post-ganglionic function could help the anatomical diagnosis.

[1] Johnson, R. H., Lee, G. de J., Oppenheimer, D. R., and Spalding, J. M. K., *Quarterly Journal of Medicine*, 1966, **35**, 276.
[2] Thomas, J. E., Schirger, A., *Archives of Neurology*, 1970, **22**, 289.

Holiday First-aid Box

What equipment and drugs should be included in a first-aid box for a group of, say, six people whose holiday travels will take them from Sweden to Turkey? The party will be unaccompanied by a doctor.

No two experts would agree on the answer to this question but the following is suggested:

Triangular bandages—2
Wound dressings (B.P.C. compressed)—4 (1 large, 1 medium, 2 small)
Bandages B.P.C., 2 in (5 cm)—2
Crepe bandages, 3 in (7·6 cm)—2
Assorted adhesive dressings—1 tin
Scissors—1 pair
Tweezers (flat ended)—1 pair
Paper tissues—small pack—1
T.C.P. small bottle, 6 oz (170 ml)—1
Calamine lotion, 8 oz (227 ml)—1 bottle (or cream)
Soluble aspirin—25 tablets
Soluble codeine comp.—25 tablets
Senna (Senokot)—25 tablets
Antihistamine cream—1 tube
Streptotriad—50 tablets

It is essential that one member of the party should take charge of the first-aid box and know how to use or dispense its contents.

Treatment for Tinnitus

Is there any treatment for tinnitus associated with eighth nerve deafness?

Tinnitus is a symptom and not a disease, and full examination by an otologist must be done in every case to rule out the possibility of eighth nerve tumour. Tinnitus presents a difficult problem and no specific treatment is effective, though the following suggestions may be helpful. Reassurance is important as many patients believe the noises are due to some serious ailment or that they are going to lose their hearing or their mind. Mild sedation is useful where noises interfere with sleep, but the doctor should take care that patients do not become addicted to the drugs. Psychotherapy may be useful in depressed patients. Patients should be advised to avoid excess of aspirin, alcohol, coffee, and cigarettes. Some patients have been helped by having distracting sounds in the bedroom—such as a loud ticking clock or a radio with an automatic time switch, which turns off when one is asleep. If no cause is found, the patient has to learn to live with the sounds and to ignore them.