Amnesia is poor, however. Although early reports do not include cases in which either mother or child has shown significant ill effect, it is clear that the method is not without danger. When the dose is sufficient to give maximum relief the patient often has convulsions, but their incidence is reduced by preliminary medication with barbiturates, which is advised as part of the routine. It is also important to exclude a drug idiosyncrasy by skin and eye tests before beginning the intravenous drip. If the risks are to be reduced to a minimum it would seem necessary for a skilled observer to be in constant attendance during the several hours of treatment, ready always to stop the infusion and to administer antidotes (phenobarbitone and adrenaline). For further details reference might be made to papers by F. M. Allen (*Amer. J. Surg.*, 1945, **283**, 290; *Cur. Res. Anesth.*, 1946, **25**, 1) and by K. Johnson and C. R. A. Gilbert (*Cur. Res. Anesth.*, 1946, **25**, 133).

Curare and Smooth Muscle

Q.—*What is the effect of curare on smooth muscle, with special reference to uterine muscle?*

A.—The general view is that curare has no action on smooth muscle, but there is evidence that this requires modification. Cross and Cullen (*Anaesthesiology*, 1945, **6**, 231) found that "intocostrin" (1 mg. per kg.) caused peristalsis to cease for some time and brought about a loss of intestinal tone. These observations were made in unanaesthetized dogs with fistulae. Curare is believed to act on skeletal muscle by blocking the action of acetylcholine on the motor end-plate, and, since the intestine and other forms of smooth muscle such as the uterus also appear to contract by acetylcholine action, it is likely that they will be paralysed to some extent as well. Normally, smooth muscle is unaffected by doses which paralyse skeletal muscle, but it is reasonably certain that occasional subjects will be found in whom the smooth muscle is also affected. Whitacre and Fisher (*Anaesthesiology*, 1945, **6**, 124) describe the successful use of curare with cyclopropane anaesthesia in 100 operations for caesarean section. They make no mention of an effect on the uterus.

Profuse Sweating in Acute Rheumatism

Q.—*Can you suggest any treatment for profuse sweating in a case of acute rheumatism? A stout and flabby man aged 28 has had recurrent attacks of acute rheumatism lasting three months, with profuse bouts of sweating, tachycardia, and slight pyrexia. There is gross involvement of the endocardium of old standing. The pyrexia has settled and remained normal for over a month, and the heart rate at rest is 72, rising to 90 on effort, but the bouts of profuse sweating continue and cause anxiety.*

A.—It is difficult to suggest any line of treatment in this case, but rest in bed or on a couch on a sunny balcony or similar situation for a long period appears to be advisable. No evidence is supplied on the sedimentation rate, which would be a guide to the presence of any active infective process. Endocrine disturbance is possibly responsible, but any specific line of treatment for this is hardly possible, though small doses of thyroid might be useful. General light massage may be helpful, and ultra-violet irradiation given cautiously, and beginning with very small exposure, should be tried. Vitamin C is usually deficient in these rheumatic conditions, and should be supplied. It is not stated whether salicylates are still being given; they might account for excessive sweating and should be stopped.

Lacrimal Hypersecretion

Q.—*What is the best treatment for excessive secretion from the lacrimal gland as the result of exposure of the eye to cold or wind, especially when accompanied by high relative humidity? There is no sign of conjunctivitis or blockage of the nasal duct.*

A.—Treatment is unsatisfactory. The excessive watering is probably due to hyperactivity of the lacrimal gland induced by the stimuli mentioned. Protective glasses may help. Drops of zinc sulphate 0.25% may likewise be useful where watering is persistent.

NOTES AND COMMENTS

Skin Graft for Leg Ulcer.—Dr. D. REID TWEEDIE (Sungei Siput, N., Perak) writes: In the reply (Jan. 24, p. 183) to the question on this subject there is no mention of penicillin dressings. I have yet to find the tropical ulcer, even of many years' duration, which does not respond to penicillin lotion. The first dressings are strong. 20,000 units per ml., and the later ones weak, 5,000 units per ml. The base soon becomes pink and healthy and in a few weeks granulates to the surface; then a whitish epithelium grows in from the edge and the ulcer is healed.

Aseptic Inoculation Technique.—Dr. R. S. TAYLOR (Paris) writes: With reference to the question and answer under this heading (Feb. 28, p. 425), many years ago, perhaps thirty, I saw in the *Journal* a method of sterilizing syringe and needle at the bedside with primitive materials—viz., a teaspoon, some oil (olive for preference, butter if nothing else), a candle, a bread crumb.

Put the bread crumb in the oil in the teaspoon and hold over the candle till the bread crumb chars. The oil may then be sucked into the syringe as many times as necessary. I have not tried to make a culture from a syringe or needle treated in this way, but do not think that any germ, even one which apparently enjoys being boiled, would consent to function after being charred. The syringe may be cleared of oil with a little ether.

Cataract.—Dr. E. E. D. GRAY (Anerley, London, S.E.) writes: I was interested in the questions and answers about cataract (March 13, p. 531). I have had operations on both eyes for cataracts. One result is unsatisfactory but the other is excellent. I am not able to give an opinion on parts (*a*) and (*b*), but about part (*c*) I can speak from experience. I can see 6/9 and J1 and I do not suffer from eyestrain on reading. As a physician I have no difficulty in using an ophthalmoscope. I am therefore able to do my ordinary work.

Car driving by day is a simple matter. I can judge distance by the size of familiar objects. Driving by night is altogether different. The familiar objects are not visible and I cannot judge the distance in front of me of the tail-light of a car or lorry. The lights also dazzle me. However, in the depth of the night when there is no traffic and the street lights are extinguished I can use my headlights and driving is almost as easy as in daylight. However, I avoid night driving as far as possible.

Nocturnal Frequency in Elderly Men.—Dr. E. GALLOP (London, S.W.) writes: The influence of habit is not mentioned in the answer to this query (March 13, p. 532). In the absence of obvious prostatic enlargement, infection, or loss of elasticity in an ageing bladder wall it is a factor which should not be disregarded. The timing of micturition is an easily conditioned reflex, but a few broken nights will upset it and nocturnal frequency soon becomes established, and then the bladder has to be retrained. This means putting up with discomfort for a few nights, which many will not tolerate when relief is so easy. A dose of a bromide and belladonna mixture on retiring will help as a urinary sedative until the new habit is formed.

Polish Children's Hospital.—The Polish Red Cross Society has decided to build a large modern hospital for children on the heights of Rabka near the Tatra mountains. The deplorable ravages wrought by the war in Poland have particularly affected the children, and such is the poverty of the land that no public or private funds are available for this necessary work. The Polish Red Cross Society is therefore appealing for funds, which may consist of money or of goods such as bedding and clothes. Any donations will be used exclusively for constructing and equipping this hospital, and they will be gratefully received by Mrs. J. Gorska, Polish Red Cross Society, 35, Roland Gardens, London, S.W.7.

Correction.—The remarks attributed to Dr. Irene Yates in the report of a meeting of the Section of Psychiatry of the Royal Society of Medicine (March 20, p. 558) were made by Dr. Sybille L. Yates.

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