It is claimed that 75% or more of persistent enuretics are cured by this treatment, but it is extremely difficult to assess the long-term results. It is a method worth trying in an older child, in whom other methods have failed, and in whom organic lesions have been excluded. It is not a very practical form of treatment for use in the management of enuresis in general, and one defect is that a satisfactory and durable form of electrode has not yet been perfected.

**References**


**Cyanosis of a Finger**

**Q.**—Two middle-aged women suffer from periodic cyanosis of a finger. The first has also mitral stenosis with attacks of decompensation. In both the whole of one finger goes almost black, starting at the base. The condition clears spontaneously. What is the explanation and treatment?

**A.**—Cyanosis of a single digit is almost always due to a localized defect in its arterial blood supply. Arteriograms in such patients have often shown disease in the digital vessels either with thrombosis extending over the variable extent of one or both arteries. Under these circumstances the circulation is adequate under favourable circumstances, but should anything occur to slow it anoxia will occur and result in cyanosis. Nervous or humoral vasoostriction due to cold or emotion may be the precipitating factor or sometimes other things such as posture (particularly elevation), infection, arterial spasm, muscular strain in either of the patients mentioned might be thrombosis due to some degree of arteriosclerosis in the vessel, or in the case of the patient with mitral valvular disease to embolism.

Treatment may be necessary to preserve the digit. This should be on general lines at first; local warmth and protection with gloves, and general warmth of the body to maintain vasodilatation. Venodilator drugs such as the ergot alkaloids may be necessary. Smoking should be prohibited. In severe cases sympathomectomy may help to avoid gangrene and a surgical opinion should be obtained. Local nerve blocks are dangerous and to be avoided.

**Whooping-cough at High Altitudes**

**Q.**—In Nairobi, which is 5,500 ft. (1,700 metres) above sea level, we have recently had a large number of cases typical of whooping-cough, apart from the fact that the "whoop" has been uncommon. It is said that this lack of whoop is due to altitude. Is this true?

**A.**—Little has been written on the severity or mildness of whooping-cough in patients living at high altitudes, and the present commentator has no experience of this. He has, however, experience of whooping-cough treated for short periods in a decompression chamber in an atmosphere equivalent to a height of 12,000 ft. (3,660 metres). Although critical controlled experiments have not yet been made, there is little doubt that a proportion of patients, at least 25%, experience striking benefit from such treatment. The exact reason for this is still unknown, but it seems to have some relation to the rarefaction of the air and possibly to the deeper breathing temporarily induced. The factor of altitude per se is unlikely, however, to operate to the same extent in places like Nairobi, where the respiratory function of the inhabitants has become accommodated to high altitudes. Nevertheless other features of the climate, such as dry clear air and warm sunny days, may well restrict the formation of the copious viscid bronchial mucus which is the chief cause of severe coughing, whooping, vomiting, and pulmonary collapse in whooping-cough.

A less likely explanation of the mildness of the outbreak is concerned with the bacterial factor. The infecting strain of *H. pertussis* may possibly not be a highly virulent one; or the outbreak may even have been due to *H. parapertussis*, which is usually associated with mildness in whooping-cough, but is uncommon in most places. Again, many of the children may have been recently immunized against whooping-cough.

**Notes and Comments**

**Cheese Dreams.**—Drs. J. C. Russell and F. E. James (Chipping Norton) write: May we be allowed to comment on your "Can's answer?" ("Any Questions?" December 24, 1955, p. 1575)? Not only insufficiently masticated cheese may cause dreams but many other foods such as lobster, prawns, meat, plus pickles if taken before retiring. It seems reasonable to suggest that gastric distention is insufficient to awaken the patient, but it is sufficient to decrease the depth of sleep and thus allow dreaming. Any cause of physical discomfort can lead to a similar situation. We have recently had a healthy male patient, 74 years of age, who reported dreams from an ingrowing thumb, a symptom which he had never previously experienced. Careful history-taking elicited the fact that on two or three occasions each night he experienced an unpleasant dream, awoke, arose, and emptied his bladder and on retiring again fell asleep again. He had other symptoms and signs of an enlarged prostate gland and doubtless discomfort from a dis tended bladder caused a decrease in the depth of sleep and consequent dreaming.

**Position of the Head after Head Injury.**—Major A. C. White Knox, Principal Medical Officer, the St. John Ambulance Association, London, writes: I note your column "Any Questions?" (of December 31, 1955 (p. 1632), the questioner stresses the need for a handbook of first aid to provide rules for the guidance of non-medical workers on this subject. I should like to bring to your notice the St. John Supplement, which has just been issued to all St. John members, stressing the following important points:

1. Ensure that air can enter freely into the lungs. (2) If breathing has stopped, turn into the prone position and commence artificial respiration. (3) If breathing is noisy (bubbling through secretions), turn the patient into the prone position. Support the patient in this position with a pad in front of the chest. If no pad is available draw up the patient's upper knee. If the patient is on a stretcher, raise the foot of the stretcher about 12 in. (30 cm) to drain secretions. (4) If breathing is not obstructed, lay the patient in the most comfortable position with due regard to injuries present and be prepared, if necessary, to modify the position should breathing become difficult. (5) Under all tight clothing, keep the neck and chest, and waist. (6) Keep a continuous and careful watch on the patient. Do not leave him until he has been placed in the charge of another responsible person.

I trust that this will clarify the situation for lecturers and students of the St. John Ambulance Association.

**Correction.**—The name of Sir Henry Halford was wrongly spelt as Holford in the last section of Sir Zachary Cope's Gideon Delacour Lecture (January 7, p. 1).

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