Any Questions ?

We publish below a selection of those questions and answers which seem of general interest. It is regretted that it is not possible to supply answers to all questions submitted.

Testicular Hormone in Corticotherapy

Q.—*Is it justifiable to administer testicular hormone during corticotherapy as an anabolic counter to the protein catabolic effect of corticosteroids and to combat osteoporosis ?*

A.—The use of testosterone in combating osteoporosis is theoretically desirable, but it cannot be administered in sufficient dosage without undesirable androgenic effects, especially in female patients. Several synthetic substances have been developed—for example, 17α-ethyl-19-nortestosterone and androstenediol—which have the desirable anabolic properties with respect to protein and calcium with less androgenic effect than testosterone. Nevertheless, in useful dosage some androgenic effect is evident. The use of an oestrogen, such as stilboestrol or ethinyl oestradiol, should be considered as an adjunct to the treatment in a post-menopausal woman. None of these supplementary measures should be used as a routine, but only in special circumstances after careful appraisal of all the relevant factors in a particular patient. This usually means answering the question: Is the nature and severity of the disease worth the risk of high dosage therapy ? Extra care is obviously necessary when the more complex methods of management are still thought to be desirable, and the patient should be seen frequently and the necessary adjustments of dosage made.

Bathing after Meals

Q.—*It is said to be unwise to bathe until at least an hour has elapsed since a meal. Is this correct and, if so, what is the physiological reason ?*

A.—This old warning still persists, but it is evidently often neglected, and most children (and many adults) bathe immediately after a meal without any obvious ill effects. If it had any physiological basis, it probably lay in the following beliefs: (1) that the full stomach dragged on the diaphragm and impeded respiration; (2) that the peripheral musculature was relatively anoxic and, hence, liable to cramps, the bulk of the blood having been centred in the mesenteric area for digestive purposes; (3) that blood coagulability showed a post-prandial rise. Surely not very convincing theories.

Sedimentation Rate in Paget's Disease

Q.—*Is the sedimentation rate raised in uncomplicated Paget's disease ?*

A.—The sedimentation rate appears to be raised in a number of cases of active Paget's disease, and is usually normal in patients in whom the disease is quiescent. However, Paget's disease of bone occurs in an age group where there are often multiple pathological lesions, and it is always difficult to say a patient has only one disease. Recent published studies of this include Grainger and Laws,[1] and Rosenkrantz *et al.*[2] There appears to be little correlation with the extent of the bone change.

REFERENCES

[1] Grainger, R. G., and Laws, J. W., *Brit. J. Radiol.*, 1957, **30**, 120.
[2] Rosenkrantz, J. A., Wolf, J., and Kaicher, J. J., *Arch. intern. Med.*, 1952, **90**, 610.

Susceptibility to Sunburn

Q.—*What can be done to protect a patient who is very susceptible to sunburn ?*

A.—Acquired light sensitivity may be a symptom of general disorder, particularly porphyria, systemic lupus erythematosus, and perhaps vitamin deficiency and certain drug sensitivities. For this reason a patient such as the one quoted should be investigated for any possible underlying disorder. If no abnormality is found, protection from the sun may be achieved in a variety of ways.

First, it may be possible gradually to acquire light tolerance again by progressive treatment with a carbon-arc lamp. A second method is by the administration of drugs of the antimalarial group which diminish light sensitivity during the time of their administration. Of these drugs the most satisfactory at present seems to be chloroquine, which may be given in divided doses up to 400 or 500 mg. daily. Some prefer to give a combination of chloroquine, "plaquenil" (hydroxychloroquine sulphate), and mepacrine with the object of achieving the same therapeutic effect with fewer side-effects. Thirdly, the skin may be protected with local applications. Many of these are on the market and most of them are satisfactory and harmless. The usual substances prescribed are creams or lotions containing 10% of tannic acid or 5 to 10% *para*-aminobenzoic acid. The protection of the skin from light by local applications has been well reviewed by R. G. Harry.[1]

REFERENCE

[1] Harry, R. G., *Modern Cosmeticology*, 1955. Leonard Hill, London.

Intra-arterial Blood Transfusion

Q.—*What are the common indications for and the technique and dangers of intra-arterial blood transfusion ?*

A.—There are very few indications for intra-arterial transfusion; indeed, some would say there are none. It has been claimed that in subjects exsanguinated to the point of death intra-arterial transfusion would save life when intravenous transfusion would not, and that the advantage may lie in the fact that the coronary circulation is filled directly when blood is introduced into the arterial side of the circulation. From experimental work it seems clear that profound exsanguination alone is not an indication for intra-arterial transfusion. In dogs bled to hypotensive levels, coronary flow and arterial pressure respond equally rapidly whether blood is given intravenously or intra-arterially.[1] It seems that the arterial route should be considered only when the heart is arrested or when, as during cardiac surgery, the circulation has been interfered with. Unless the systolic pressure is very low, considerable pressure will be required to force blood rapidly into the artery. Some form of rotary pump is the best equipment for the purpose. The main complications of intra-arterial transfusion are, first, embolism, and, secondly, when an artery in a limb is used, gangrene of the extremity.

REFERENCE

[1] Case, R. B., Sarnoff, S. J., Waithe, P. E., and Sarnoff, L. C., *J. Amer. med. Ass.*, 1953, **152**, 208.

Correction.—Dr. PETER DELLER (London, S.W.1) writes: "In my letter of last week (*Journal*, May 3, p. 1067) I referred by a slip of the pen to 'the late' Mr. T. B. Layton. Mr. Layton is, of course, very much alive, and I tender him humble apologies for a gross exaggeration." We should like to add our apologies to Dr. Deller's, for not noticing this mistake.

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