then doses of potassium chloride up to 18 g. (240 mEq.) a day may be needed: these cannot always be tolerated. Intravenous therapy should be avoided if possible, because of the risk of cardiac arrest, and not more than 2 g. (27 mEq.) potassium should be added to a litre of fluid. It often takes several days to repair the potassium deficit.

Finally, it is worth remembering that potassium deficiency potentiates the action of digitalis, and there is evidence that it may precipitate hepatic failure in patients with liver disease.

Permanent Freckles

Q.—How often should lactic acid or carbon dioxide snow be applied to permanent freckles in advancing age, and for how long?

A.—Lactic acid or carbon dioxide snow¹ (30 seconds' firm pressure in the first instance) should be applied once. No furtherointments or applications are necessary, ordinary washing being undertaken. The result will be peeling at the site of the freckle. Treatment should be repeated if it does not remove the freckle. The result of further exposure to sunlight will be further freckles unless some protective cream is used. There are many such protective creams on the market.

REFERENCE
¹ _Brit. med. J._, 1959, i, 386.

Vitiligo

Q.—What is the best treatment for vitiligo? How far have preparations containing aminoidin and amamin been successful?

A.—There is no very satisfactory treatment for vitiligo. Preparations containing aminoidin and amamin in the hands of some observers have produced moderate success in something like 50% of cases, but it is a treatment that is not without drawbacks and the results from the cosmetic point of view are by no means perfect. The drug is toxic when taken internally. Subsequent exposure to sunlight produces an acute reaction in the vitiligo areas which is followed by a mottled pigmentation emanating from hair roots, and this is probably in the main the result of the surface inflammatory reaction rather than a specific pigmentation from the drug.

NOTES AND COMMENTS

Ringworm.—Dr. C. J. LA TOUCHE (Leeds) writes: I have read with much interest the correspondence on ringworm ("Any Questions?", _British Medical Journal_, 6 December, 1958, p. 1424; "Notes and Comments, January 31, p. 316, and March 14, p. 736), in which Dr. J. Martin Beare supported your expert in his condemnation of the use of x rays for the treatment of tinea capitis due to _M. canis_. It is of course by no means proved that tinea capitis due to _M. canis_ is not transmitted from child to child when the opportunities arise. Sending treated children to school with additional precautions is hardly a fair test of infectivity, while comments would suggest that this practice entails at least the risk of occasional spread. Dr. Beare's concluding remarks advocating the control of the animal reservoir (cats and dogs) of infection in connexion with the spread of this type of microsporosis should be taken seriously. Articles on this subject have already been written.¹ ² For those who have no time for delving into literature but are nevertheless tempted to follow Dr. Beare's advice and go "cat-hunting" the following data may serve as encouragement: in 1950, the number of families for individuals representing families presenting with _M. canis_ infection (tinea capitis or tinea glabrosa, or both) at the skin department of the General Infirmary at Leeds was 54. In the subsequent years, 1951, 1952, 1953, 1954, 1955, 1956, 1957, and 1958, the numbers were respectively, 34, 35, 12, 12, 28, 6, 5, and 2, and this year (up to date) 0. During the whole of this period, whenever a case of _M. canis_ infection was being investigated, every attempt was made, with the help of the public health authorities, to trace the infection to its source, a procedure which frequently resulted in the "bagging" of one or more infected felines. This gradual elimination of the animal reservoir of infection, which included also a small number of infected dogs, is considered by those concerned to be a major factor in the elimination of this infection in the human population of Leeds.

REFERENCES
² Report by M.R.C. Medical Mycology Committee, ibid., 1956, i, 963.

DRS. A. GIRDWOOD FERGUSSON and W. A. DEWAR (Glasgow) write: We would agree with your expert ("Notes and Comments," _British Medical Journal_, 31 January, p. 316) and with Dr. J. Martin Beare ("Notes and Comments," _British Medical Journal_, 14 March, p. 736) in their assessment of the ecology of _M. canis_ with regard to geographical factors, for we did not in fact suggest that in the west of Scotland the fungus behaves in any unusual fashion. We do, however, disagree with our views on the management of the infections, and we doubt whether x-ray epilation in competent hands is really such a hazardous procedure as some would suggest. We also doubt whether _M. canis_ can be regarded as non-contagious to their children. We would point out that over the past 11 years all possible small animal contacts in our cases of ringworm have been carefully examined clinically and by Wood's light, and in our "zoology" we have found relatively few infected animals. Furthermore, in more recent years we have co-operated closely with veterinarians, and it would appear that in this region small animals and domestic pets show a surprisingly low incidence of infection.¹ With regard to duration of infection prior to first attendance at hospital, we noted this point in order to draw attention to the remarkably long duration of some such infections and to suggest that _M. canis_ scalp infection is by no means always such a mild and short-lived condition as some believe. We would suggest that if infected children carry into school Dr. Martin Beare's advice that they should not take part in group games, but that they may go to school with a cover of some greasy ointment on their infected heads, then they may become at least as socially unacceptable and as (socially) upsetting as they would if they allowed them to return to school with a healthy scalp and the incipient "crew cut" of regrowth after x-ray epilation.

REFERENCE

Migraine in Pregnancy.—Dr. P. M. ELWIN (Bridgeton, Somerset) writes: In your issue of March 7 ("Any Questions?", p. 662) there is a question about the treatment of migraine in pregnancy. Your expert recommends preparatory ergotamine, and in his final sentence states: "Still safer is ergometrine..." Surely he has missed the point of the question, which was about treatment in pregnancy. As both drugs have a strong oxytocic action, they are highly dangerous in pregnancy, especially ergometrine. Dihydroergotamine has much less oxytocic action, and is probably safer, but there is still some risk of causing abortion or premature labour in a susceptible patient.

Correction.—In the note on "H3" ("Any Questions?", March 28, p. 872) it should have been stated that dimethylaminoacetone was marketed as a "psychic energizer."

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