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.

Smallpox Revaccination

Q.—*On what evidence should the success of a revaccination for smallpox be judged? Is the reaction, whatever it is, usually accelerated and by how much? Why is it unnecessary to record on an international certificate that revaccination has been successful?*

A.—A revaccination which is successful is one which results in an immunity-stimulating response and not merely an allergic response. It is often difficult to distinguish these, partly because in order to do so accurately and consistently it is really necessary to inspect the lesion daily from the second day after revaccination. This being usually impracticable a rather arbitrary distinction has to be made. Some authorities insist that an unequivocal vesicle is the minimum reaction for evidence of virus growth and therefore stimulation of immunity.

Almost all responses to revaccination are "accelerated." The acceleration is not usually in the incubation period (which indeed may be prolonged) but in the development of the response—papule, vesicle, drying-up, and scab follow each other more rapidly than after primary vaccination. It is generally agreed that any reaction, whatever its appearance, which has reached its maximum and is beginning to subside by the fourth day should be regarded as an allergic and not an immunity-stimulating response. If there is a definite scab on the seventh day, when most revaccinations are conveniently inspected, there has probably been true vesiculation: it should be remembered, however, that allergic reactions are usually itchy, and scratching may result in a scar.

It is because of these difficulties, (*a*) in inspecting a revaccination on several occasions in the first week and (*b*) in deciding the significance of the very varied responses, that W.H.O. decided on the omission on the international vaccination certificate of the record of the reading of a revaccination.

Big Boy, Small Genitalia

Q.—*A boy nearly 11 years who is large for his years, both in height and girth, is already starting to grow pubic hair but his genitalia are small. Would testosterone be indicated?*

A.—Since the boy is already growing pubic hair it may be taken that the testes are beginning to secrete effective amounts of testosterone, and there could therefore be no indication for testosterone therapy. It seems probable that the genitalia appear smaller than they really are because of being buried in pubic fat, and one would conclude that the only treatment required is dietary to reduce the excess weight.

Removing Wrinkles

Q.—*Is there any application which will remove wrinkles in the skin?*

A.—Most of the measures recommended for wrinkles are somewhat hazardous and should not be employed except by an expert. Trichloroacetic acid, phenol, and surgical dermabrasion are measures which have been employed with some success. There is a good article on the subject by S. Ayres.[1]

REFERENCE

[1] Ayres, S., *Arch. Derm.*, 1962, **85**, 385.

NOTES AND COMMENTS

Puberty Gynaecomastia.—Mr. H. DODD (London W.1) writes: All the boys under my care with this condition have responded completely in three months to thyroid extract 1 gr. (65 mg.) morning and evening. I have never had reason to consider operation (see "Any Questions?" May 26, p. 1496).

OUR EXPERT replies: I think it is safe to conclude that Mr. Dodd's patients must have had the minor form of puberty gynaecomastia which regresses spontaneously anyway. There is no reason to believe that treatment with thyroid hormone would affect this condition; certainly hyperthyroidism is not such a cause of gynaecomastia, and I find it hard to believe that all these patients were hypothyroidal. The major form of gynaecomastia never regresses spontaneously and is not affected by medical treatment.

Hypotension from Imipramine.—Dr. FREDA S. REED (Maidstone, Kent) writes: In "Any Questions?" (May 19, p. 1430) your expert replies to a question concerning hypotension due to imipramine. The question states that the patient had for four years had a blood-pressure of 200/100 mm. Hg, that treatment was changed to imipramine because of depression, and blood-pressure thereupon fell to 130/80 mm. Hg with the attendant symptoms of hypotension. The questioner then goes on to say, "She is now back on 'rauwiloid' . . ." Your expert suggests that the depression may have been the cause of the hypertension in the first place. Would he not consider that the question implies that the patient was originally treated by rauwiloid for a prolonged period and this may have been the cause of the depression and may do so again unless this possibility is borne in mind?

OUR EXPERT replies: Dr. Reed's comments are certainly relevant to the question of why the patient was depressed but not to the question as asked. The questioner asked for an explanation for the fall in blood-pressure which followed the administration of imipramine. Even if the depression were due to the previous administration of rauwiloid (and we are not told whether the patient was receiving rauwiloid at the onset of her depression) we still have to explain why she was hypertensive and why the hypertension, which presumably had not responded to rauwolfia, responded to imipramine. As I pointed out in my reply this situation has been met before in depressed hypertensive patients treated with imipramine, and the explanation offered is that indicated in my reply. In the future management of this patient, however, the possibility of further depressive symptoms attributable to rauwiloid should certainly be borne in mind, and if, as we are told, "she is now asymptomatic with a blood-pressure of 150/85" there would seem to be no indication for continuing with rauwiloid.

Correction.—The name of Surgeon Vice-Admiral W. R. S. Panckridge, C.B., Q.H.P., should have appeared under the heading K.B.E. (Military Division) and not K.B.E. (Civil Division) as printed in the list of Birthday Honours (June 9, p. 1617).

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