longest period for which it is likely to be useful to continue such treatment: it should usually achieve its effect in a week. The dangers of this treatment are acidosis and renal damage. Acidosis is not likely to be produced if renal function is good, but hyperpnoea should be watched for, and the alkali reserve estimated should it occur. Some degree of renal damage, if only temporary, is indicated by the presence of large numbers of casts in the urine, and this finding contraindicates long continuance. If the infection is, as stated, due to *B. coli* alone, and unaccompanied by any other lesion of the urinary tract, it should also respond to sulphanilamide.

### Cumulative Effects of Phenobarbitone

**Q.**—*In a reply to a question on the treatment of whooping-cough (Aug. 12, p. 230) you advise phenobarbitone gr. 1/4 b.d. for a child of 1 year, provided cumulative effects are watched for. What are the cumulative effects? I have given it to adults for years and never seen any. Secondly, what dose would you consider safe for a child aged 1½ years, and for one aged 2 years, who are suffering from insomnia? They are active, intelligent children, quite healthy, and in London. They sleep in surface shelters, and keep both the mothers and others awake, to the distress of the mothers. The ordinary bromide and chloral mixtures—e.g., N.W.F.—have been useless, and I have been afraid to push the phenobarbitone further than 1/4 gr., as my experience with this drug in infants is limited.*

**A.**—Cumulative effects of phenobarbitone are dizziness, lethargy, weakness, and inability to concentrate. In addition symptoms of idiosyncrasy are more prone to arise if the drug be given over a period of weeks. These are fever, itching, erythematous rashes, nausea, vertigo, diplopia, ataxia, and slurred speech. I should not use phenobarbitone as a hypnotic in young children. Its action as a hypnotic is relatively feeble. For the children in question 10 gr. bromide and 5 to 7 gr. chloral should succeed.

### A Case for Investigation

**Q.**—*A woman aged 59, since x-ray treatment of hyperthyroidism 4 years ago, has complained of severe paroxysms of headache and abdominal "spasms." The heart beats violently in the attacks. The noises in the head, and headaches, compel her to hold her head. She is incapacitated by the illness. She sleeps very little. No collapse after the attack (cf. adrenosympathetic). Functions normal except severe constipation. On examination she is well covered, is garrulous, and has patchy hyperaemia on chest. Pulse 108; B.P. 170/100. No tremors; no sweating. Routine urine examination normal. Amino-acids nil. Blood sugar 68 (repeated). I should particularly like to know whether the symptoms could be attributed to the hypoglycaemia, and whether this has been known to follow x-ray treatment of hyperthyroidism. There is no anaemia and no evident hypothyroidism. Vitamins in urine have been estimated, and this will be repeated after test dosage.*

**A.**—It is not clear why elaborate vitamin studies should have been made in a case of this kind. The first question is whether the patient is suffering from hyperthyroidism, which might well account for her present symptoms; for this purpose the basal metabolic rate and the serum cholesterol are the relevant tests. Parathyroid tetany is unlikely to be present, but this possibility could be excluded by examination of the serum calcium. Hypoglycaemia is not known to follow *x*-ray treatment of hyperthyroidism. In any event hypoglycaemic attacks should not be diagnosed unless (1) the fasting blood sugar is below 60 mg. per 100 c.cm., (2) the blood sugar is below 50 mg. per 100 c.cm. in an attack, and (3) the symptoms are relieved dramatically by the administration of glucose. Other possibilities in this case are psychoneurosis, Ménière's syndrome, migraine, and paroxysmal hypertension; in fact the range is too wide to give help without seeing the patient. As she has been ailing for some years it would seem wise to get a second opinion from a medical consultant who can view biological data and vitamins in their proper perspective.

### Falling Hair

**Q.**—*A married woman of 38 has been going grey for the past 6 years and the hair is continually falling out. There is no excessive seborrhoea, although the scalp is dry. She is perfectly healthy except that her periods are irregular and scanty. Can you suggest a remedy for this condition?*

**A.**—Loss of hair may be attributed to both general and local causes. Thus the sudden loss of hair after fevers and the less abrupt thinning accompanying debilitating conditions are well known. Changes in the hair in certain hormonal diseases represent a part of the symptom-complex, as in myxoedema, where the phenomenon may render a patient almost unrecognizable. Men tend to become bald, women do not—a sex distinction which may be relied upon, with, of course, certain exceptions, to base a reassuring prognosis in women where the hair is falling out and where there is fear, without reason, of the onset of complete baldness. If seborrhoea is present, even if only represented by dryness or a little dandruff, the outlook is favourable, and with treatment a considerable improvement may be expected. Pomades and lotions are not favoured because of their messy nature, but this disadvantage can be avoided by applying a *small quantity* of an ointment containing 6% sulphur and 3% salicylic acid, a soft base to the ounce—i.e., arachis oil and vaseline. This is well rubbed into the scalp one night in the week and washed out the next morning, a simple procedure easily carried out provided only a small quantity of the pomade has been used and well rubbed into the scalp. A resorcin lotion applied every morning enhances the result, but this is unsuitable for light or grey hair as it stains a yellow-brown. The application of ultra-violet radiation, or high frequency, the hairdresser's "violet-ray," is no better than a thorough brushing. Women's hair was more healthy and profuse before the change of fashion shortened it, because the prolonged nightly brushing and attention improved and maintained its condition. It is well, however, always to inform the patient that hair coming out following the application of a pomade or a shampoo is to be disregarded, as it is only the loose hair which has been cast.

## LETTERS, NOTES, ETC.

### Yeast in Furunculosis

Dr. M. A. COOKE (Bradford) writes: I was interested to read the letter of Dr. Watson Smith concerning the use of yeast in furunculosis (Aug. 19, p. 256). There is little doubt of its usefulness in certain cases of furunculosis and other skin lesions. Its action has been variously ascribed to its fermentative properties, to its vitamin B content, and also to its nuclein fraction. Supporters of the latter theory claim that yeast is as active therapeutically after it has been heated to 130° C. for about an hour. Concerning the local action of yeast, this has for some time been used in "face-packs"; not, however, with very marked results. This latter fact may be a result of the comparatively inert form of the yeast. I certainly agree with Dr. Watson Smith that brewers' wort is the most therapeutically active form; patients who have taken it not only appear to recover more quickly, but also testify to feeling brighter. It is, of course, difficult to exclude the psychological factor in view of the difficulty of arranging suitable controls. It is possible that it would be more efficacious if applied locally in the actively fermenting form. With reference to the analogy to penicillin, Gram-stained preparations of yeast almost invariably show staphylococci in addition to the various yeasts and fungi always present. This, however, would not exclude the fact that yeast may contain a fraction lethal to these and other organisms under certain conditions of purity and acidity. Certainly, as Dr. Watson Smith states, the pharmacological action of yeast offers many riddles to solve.

### Wasp and Bee Stings

Dr. H. S. RUSSELL writes: The answer to the question about relief of pain (Aug. 26, p. 295) omits reference to the most effective method—1 c.cm. intradermal wheal of novocain adjacent to and including the sting. Relief is complete, immediate, and lasting.

### ? Case of Alkaptonuria

"GAMMA" writes: I was interested in the "Any Questions?" answer about a vaginal discharge (Aug. 26, p. 296). Would it be possible for the inquirer to test the urine for homogentisic acid, as it sounds like a case of alkaptonuria which has not been diagnosed hitherto? If this is the case, it is not the discharge which is staining the underclothes but the urine, which after the birth of the child tends to leak away more than it did and so now attracts attention.

### "Vitamin B Deficiency in Allergic Patients": Correction

Dr. ARTHUR F. COCA, Medical Director, Lederle Laboratories, New York, writes: Referring to my previous communication [July 22, p. 128] concerning the article by Drs. McSorley and Davidson, I have to apologize for overlooking the fact that they were referring to the anti-anaemic liver extract, not the preparation of vitamin B complex.

### Correction

In our column of Medical News (Aug. 26, p. 294) Miss Florence Horsbrugh, M.P., was reported as stating that more than 300,000 beds in maternity homes have been provided during the war. The figure should of course have been 3,000.

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T. J. Smith and Nephew Ltd., Neptune Street, Hull, have issued a pamphlet *Plaster of Paris in the Treatment of Burns*. This, they state, has been compiled with the help of surgeons with experience of war and civilian casualties, and it includes references to recent literature on treatment of burns. So far as restricted supplies allow, a copy will be sent to any doctor on request.