same time providing additional outlets in play or other acceptable activities, with all possible warmth of parental comfort. If home measures fail, the trouble is likely to be resolved without long treatment by psychiatric advice and child psychotherapy, unless there are special complications.

**Terminating an Artificial Pneumothorax**

Q.—What is the usual method of ending an artificial pneumothorax? Can refills be discontinued suddenly, or should they be “talled off”? In the case I have in mind the pneumothorax has been maintained for three years, and the disease shows no signs of activity at present.

A.—The time and method of terminating an artificial pneumothorax depend very much on the condition of the lung before the treatment was started. Frequently the pneumothorax terminates itself by an obliteration fibrosis which gradually reduces the pleural space. When this does not occur spontaneously the cessation of artificial pneumothorax refills requires considerable care and judgment. It is not advisable to stop refills suddenly, but gradually to increase the interval between the refills and, if necessary, to reduce the amount of air introduced into the chest at each refill. Opinions differ as to the length of time an artificial pneumothorax should be maintained, but much depends on the size of cavitation and positive sputum previous to the induction. Cases in which these are present usually require longer treatment than those in which one or other or both have never been manifest. In any event, it is beneficial to maintain an artificial pneumothorax for three years and contemplate cessation of treatment in the spring of the fourth year, so that the patient has the advantage of the summer months in which to reach stabilization. In those with considerable infiltrations before induction, it is best to allow the treatment to continue until it terminates by contraction of the chest wall and obliteration of the pleural space by fibrosis. It is, however, important to avoid a complete atelectatic lung which will not re-expand, and which usually calls for a thoracoplasty to close the pleural space.

**Tremor of Hands**

Q.—A young woman has a constant fine tremor of her fingers and hands which is aggravated by excitement. There is no relevant personal or family history. Please advise me as to the cause and treatment.

A.—The most probable cause to be suspected is a masked hyperthyroidism. Careful records of the pulse rate and of the weight are advisable, and also an estimation of the basal metabolic rate. An “essential” tremor is also possible; this is usually slower and coarser than in hyperthyroidism, and no tachycardia or increased metabolic rate occurs. There is no treatment for “essential” tremor; tremor due to thyroid overactivity responds to appropriate therapy.

**Staining Films of Vaginal Discharge**

Q.—What is the best method of making and staining routine films of vaginal discharge when trichomonas is sought, if circumstances are against the preparation and examination of the more usual wet films?

A.—The Giemsa’s stain is the most suitable; the film should have been fixed in acetic acid. Fluid vaginal secretion or a swab kept moist in a small volume of saline can be kept for several hours before the examination of wet films, without loss of motility; this is the method usually preferred unless circumstances absolutely preclude it.

**Ringworm of Scalp**

Q.—What is the best line of treatment, short of depilation by x-rays or thallium acetate, for ringworm of the scalp? May I have details of the dosage and application of phenylmercuric nitrate and chloride?

A.—There is a good review, with bibliography, of the use and dangers of the phenylmercuro compounds in the treatment of infection and fungous diseases by E. A. J. Byrne (Journal, Jan. 18, p. 90). For ringworm of the scalp of small-scope type in children, treatment must be accurate, diligent, and arduous, and is then attended only with a small percentage of successful results after long periods of treatment, according to most authors. Schwartz in the U.S.A. reported more success with 5% salicyl amide in a carboglass base (J. Amer. med. Ass., 1946, 132, 58), but the supply is restricted in this country. Currently in a saturated solution in a carboglass base has also been recommended.

**NOTES AND COMMENTS**

**Poliomyelitis and Chlorination of Water**—Dr. CLEMENT FRANCHI (London, W.) writes: The fact that chlorine in a strength of 0.2 p.p.m. destroys poliomyelitis virus in 10 minutes (Aug. 23, p. 317) interests me because my father, the late Dr. Alexander Francis, told me that when he had been superintendent of a hospital in Queensland, 55 years ago, he found that the administration of chlorine water by mouth produced dramatically good results in patients with typhoid fever. He had a large number of cases to treat, as typhoid fever was then endemic in Queensland. There is no evidence that poliomyelitis virus often gains entrance to the body by the alimentary canal and is discoverable in the faces of patients and carriers, and there seems a good case for regular oral administration of chlorine water to patients in the early stages of the disease and to contacts and suspected cases. There is also no reason why chlorine water should not be sprayed up the nose and used as a gargle. The fact that London water was chlorinated during its probably prepoliomyelitis typhoid epidemic, and it would be interesting to know if the incidence of poliomyelitis in the present epidemic bears any relation to the areas in which the water supply is chlorinated. Poliomyelitis epidemics have occurred with much greater severity both in the States and in Australia than in the present outbreak in Britain, and here again the question of chlorination of the water supplies may be an important factor.

**Chemical Contraceptives**.—Dr. Marie C. Stopes (Dorking) wri es: The question raised in the answer (Aug. 16, p. 282) to the question on the above subject? No jelly can be reliable for several chemical and physiological reasons which I have set out fully in my textbook, Contraception, its Theory, History, and Practice, for several years, was printed and now is available again. Olive oil, however, is quite both cheap and most effective as a contraceptive when used as a sponge. As contraceptives were high priced, as well as unsatisfactory, I founded the Mothers’ Clinics years ago, and we supplied them for 1. 2d, a box of 12 gready “souables” which are cheap and effective for use with caps.

**Universities and Colleges**.—Dr. J. D. ScoHIE (Stonehouse, Lanarkshire) writes: May I voice my disapproval of the terms of a recent advertisement in the B.M.A. Applications in the B.M.A. for non-medical registrar and it was stipulated that the applicant “must hold the M.R.C.P. diploma or the M.B. of a University.” Realizing that any body is at liberty to lay down the qualifications which he must possess in order to profit, how shall the public know which the accurate as of differentiating from university and college men? To M.B. and college diploma have this in common, that they both come up to the requirements laid down by the G.M.C., and surely these shall be used in an interview usually determines the most suitable applicant. Furthermore, the M.R.C.P. is generally considered to be the highest qualification in medicine, obtainable by examination and should not be considered to be equivalent to the M.B. If this sort of thing was carried to logical conclusion preference would be given to the graduates of the greater universities over the smaller.

**Correction**.—There was an error in our first leading article in the issue of Sept. 6 (p. 374). Referring to the General Medical Council I erred in the phrase “but the great majority of its members are not chosen because they represent the universities and medical corporations which grant qualifications” should read “are chosen.” Out of the 40 members of the G.M.C. 27 are chosen by these bodies.