Hormone Treatment of Mastitis

Q.-What are the relative merits of oestrogens, progesterone, and testosterone in the treatment of chronic mastitis? What is the recommended dosage of each?

A.—The optimum and, in fact, the only logical treatment of chronic mastitis is testosterone if we subscribe to the generally accepted view that this condition is due to excessive stimulation of the breast tissue by an abnormally high level of oestrogens. If the dose of testosterone is large—e.g., 600 mg. by implantation or 25 mg. daily by injection—the function of the ovary is completely suppressed and the breasts tend to atrophy. Smaller doses, varying with individual cases, will produce a more normal state of wire without the disadvantage of producing hirsutism and virilism. These changes are produced by inhibition of the secretion of the pituitary gonadotrophic hormones. A more direct local action, antagonistic to oestrogens, appears to be produced by local injection of testosterone in the form of an ointment, some 50 mg. a week or less being adequate. Oestrogens and progesterone are sometimes prescribed on the theory that before menstruation tension is felt in the breast region when the breast structure, ducts and acini respectively, are not completely developed. This may be the case in a small proportion of patients.

Incision of the Hymen

Q.—What is the most suitable local anaesthetic for division of a tough hymen? How much should be used and at what point should it be injected? What is the best technique immediately and post-operatively?

A.—A 1% solution of procaine could be used to infiltrate the posterior and lateral tissues of the introitus and lower vagina at the level of the attachment of the hymen, and incisions could then be made postero-laterally. If the indication is dyspareunia or apureunia, however, this operation is not recommended. Incision of the hymen alone gives unsatisfactory results, because in many cases the whole introitus rather than the hymen appears resistant and nearly always there is an element of vaginismus, at any rate, by the time the patient seeks advice. Moreover, the woman who suffers long-standing apureunia is usually so nervous and apprehensive that it is unwise to attempt any procedure under local anaesthesia.

Apareunia in recently married women without gross vaginismus is mainly due to ignorance; a little instruction and perhaps the daily use of graduated vaginal dilators by the patient herself for a few weeks is all that is required. When, however, the difficulty is long standing and vaginismus is present it is usually necessary to carry out a digital dilatation of the introitus and vagina (this involves stretching or tearing the hymen) under general anaesthesia. After this the patient is instructed in the use of vaginal dilators daily for three weeks. The object of this is not to dilate the vagina further but to allow the patient to convince herself that any previous obstruction to coitus has been removed and to restore her confidence. The tendency to muscle spasm persists for a time, but this can be overcome by leaving a large-size dilator in the vagina for 10 to 15 minutes. Relaxation of the pelvic floor muscles is also favoured by telling the woman to concentrate on forcibly abducting the thighs when she is lying in the dorsal position with the knees flexed.

Erythema Nodosum and Ringworm Infections

Q.—Is erythema nodosum a recognized accompaniment of animal ringworm infections? A young farm labourer had minimal ringworm affecting principally the forehead, and painful shins. The lesions on his shins were undoubtedly those of erythema nodosum.

A.—Erythema nodosum is one of the recognized patterns of allergic reaction to ringworm infections—an "ide" reaction, more common with the animal large-spore ringworms than with other types of infection.

Snoring

Q.—A man aged 30 who is about to get married snores loudly. He sleeps with his mouth shut, he has no obvious clinical obstruction in the upper respiratory tract, and he seems healthy. Is there a remedy?

A.—Snoring is in most cases due to the tongue falling back during sleep. In the absence of nasal obstruction or disease the usual cause is sleeping on the back. An 'o'd and simple means of avoiding this is to strap a small hard object on the middle of the back, so that the sleeper turns for comfort on to his side. The causes and treatment of snoring were discussed by the Section of Laryngology of the Royal Society of Medicine last year, and a report of this discussion appeared in the Journal (1947, 2, 835).

NOTES AND COMMENTS

Embalming.—Dr. P. W. Hampton (Onchan, Isle of Man) writes: Your correspondent (July 31, p. 279) who wishes for a simple method of embalming might be interested in the way in which it is done in the transpacific emigrant trade. It is part of the contract that the body of a Chinese passenger dying en voyage shall be returned to the Celestial Empire for burial. A layer of ashes from the stake-hole is spread at the bottom of the coffin and chloridore of lime (chlorinated lime) is liberally sprinkled over this. The body is then laid top and formalin (40% formaldihyde solution) is injected at various points next and left side. The coffin is closed and buried three or four places, and both thighs. Formalin is then poured into the open mouth and sprinkled all over the body; then chloridore of lime again, and finally the coffin is filled with ashes. A four-ounce syringe is used with a wide-bore needle, and a quart jugful of formalin is sufficient. Of course this method is impracticable if the relatives wish to view the body at the end of the voyage. I have embalmed seven Chinese on a voyage from British Columbia to Hong Kong and can vouch for the soundness of this method.

Corrections


In the article entitled "Modern Therapy of Benign Tertian Malaria" by Dr. J. F. Monk in the Journal of June 26 there is a misprint at the foot of p. 1224. The dose of quinine in the quinine-pamaquin regime should be 10 gr., not 10 g.