cases in which the wife has conceived after her husband has been subjected to prostatectomy. If it were not for the fact that the wives of most men undergoing prostatectomy are themselves past child-bearing age, such cases would probably be more numerous. It must be remembered, however, that many surgeons divide the vasa in order to reduce the incidence of post-operative epididymitis, and that this leads to sterility. It cannot be said that any one technique of prostatectomy is recognized as being superior to all others. What form of operation is carried out will depend on the state of the patient and on the surgeon's personality, although Retropubic prostatectomy and the Harris technique are both excellent operations for certain patients, but they should not be used as routine measures.

Coronary Thrombosis and Air Travel
Q.—Are there any objections to air travel for patients with a history of coronary thrombosis some years ago?
A.—Provided oxygen is used for flight above 10,000 feet (3,000 metres) there should be no greater risk to a subject well recovered from a coronary thrombosis in this mode of travel than in any other, and fatigue is likely to be considerably less.

Thrombophlebitis Migrants
Q.—What is the treatment for repeated attacks of thrombo-
phlebitis over a period of 18 months involving the superficial veins of arms and legs in a woman of 48? The erythrocyte sedimentation rate is 11 mm. in one hour, and the blood pressure 140/90 mm. Hg. Has she had previous infection. Section of an infected vein has shown well-organized thrombus. Sulphonamides, large doses of vitamins, and the usual treatment for phlebitis have been unsuccessful. What further treatment could be tried, and what is the prognosis?
A.—This patient seems to be suffering from thrombophlebitis migrans, although the usual associated pyrexia and low blood pressure seem to be absent. Dicoumarol is very useful in this rebellious complaint, and should be administered so as to keep the prothrombin time double the normal and maintained in for three to six months. The condition is as a rule not disabling, and the patient should, if possible, be ambulatory; this can be attained by supporting the legs with elastic bandages. A long holiday in a warm place is often beneficial. The disease is not usually dangerous and burns itself out in time, but rarely it may progress to a malignant thrombophlebitis in which the largest vessels may become involved and even arteries be blocked, with consequent cardiac damage or loss of limbs.

Quinine Test of Liver Function
Q.—I have seen a reference to an article by Pallardo on the quinine test for liver function, for which he claimed good results. I should be grateful for details of procedure, the field of application, interpretation of results, and relative merits compared with other liver function tests.
A.—The quinine test for liver function was described by Pallardo in 1947 (Sem. med., 54, 721), and depends on the detection of quinine in the urine after oral administration of the drug. Quinine sulphate 0.2 to 0.25 g. is given to the fasting patient immediately before a meal is eaten, and 30 minutes, two hours, and 12 hours afterwards. The three specimens of urine are tested for quinine with the Tanret reagent, which is prepared as follows. Dissolve 1.35 g. of mercuric chloride in 25 ml. of water, add to this solution 3.32 g. of potassium iodide dissolved in 25 ml. of water, then make the total solution up to 60 ml. with distilled water and add 20 ml. of glacial acetic acid to the mixture. After the Tanret reagent is added a positive reaction is indicated by the development of turbidity. Normal subjects give negative reactions under these conditions. The test is positive in the urine from a high proportion of cases of liver damage, irrespective of the cause, although occasional negative findings are also recorded in conditions such as cirrhosis and infective hepatitis. The test may also be positive in cholecytis and hepatic carcinomatosis, which would appear to limit its value in differential diagnosis. The author claims that it is a sensitive index of liver damage.

NOTES AND COMMENTS

Enlarged Liver after Amoebic Dysentery.—Dr. C. E. J. Cropper (Ronkswood, Worcester) writes: I should like to submit some comments on the article entitled "Enlarged Liver after Amoebic Dysentery" (Any Questions? August 20, p. 448). It appears to me that the writer was presented with a common, and in this case simple, problem to which he himself provided the solution by his demonstration of the evidence of amoebic liver involvement during the course of metronidazole. The discovery of amoebic dysentery and the response to this infallible therapeutic test can surely leave little doubt about the diagnosis. Incidentally, in general experience, leucocytosis is frequently absent in amoebic hepatitis. There is no mention, either in the story itself or in the reply, of sigmoidoscopy. It is disturbing to find so essential a diagnostic procedure ignored in this way. If this neglect of sigmoidoscopy is widespread, innumerable cases of amoebiosis originating in both world wars are certainly undiagnosed. The author himself (Ronkswood, Lancet, 1945, 2, 460). In the tropical section of this hospital, in the first six months of this year no less than nineteen cases with negative stools but with dysenteric symptoms were revealed by the finding of these "pin-point craters." In the great majority of cases both symptoms and lesions cleared up without amebic treatment. There is, in my opinion, no answer to the problem of amoebiosis in this and many other countries except the adoption of sigmoidoscopy as a simple out-patient procedure.

Wax in the Ears.—Mr. F. K. Hayman (Sharnbrook, Bedford) writes: Your correspondent (Any Questions? October 1, p. 767) asks about any prophylaxis against wax in the ears. I have found that a good deal of so-called wax is composed of bits of hair, dandruff, ordinary dust, etc., bound together by soap—shaving or tooth—insufficiently rinsed off, and probably pushed in by the towel. I have often found a soapy turbidity in the water used for syringing, and have cautioned such patients not to allow soap to enter the meatus if possible, and in any case to rinse out the ears very thoroughly.

Dichloracetylene Poisoning.—Dr. C. F. Scurr (London, S.W.) writes: Your answer upon this subject (Any Questions? September 24, p. 17) is incorrect. Had the question been referred to an anaesthetist instead of an industrial toxicologist a more adequate answer would have been given. Dichloracetylene is a product of the decomposition of trichloro-hydroxy with alkali under certain conditions. Large amounts of it are found in saliva, being inhaled in a closed- circuit anaesthetic apparatus. A detailed account of the toxic effects and necropsy findings is given by Humphrey and McClelland of the British Medical Journal (1944, 1, 315) and by Carden (ibid., 1944, 1, 319).

Correction
Dr. Sidney G. Hamilton (Woolacombe, N. Devon) writes that in his letter on "Antihistamine Drugs in General Practice" (Points from General Practice, October 12, p. 309) he used the words "phenacine and codone" compounded in the seventh line from the end of the paragraph should read "pyranazine maleate."