ammonia, but this is not a suitable procedure when access to a well-equipped laboratory is not available.

The best account of the subject yet written is the classical monograph by Waldenström, published in *Acta Medica Scandinavica*, 1937, Supplement, **82**. An inquirer with a laboratory would also find the following references useful: Watson, C. J., *J. clin. Invest.*, 1934, **14**, 106; 1935, **14**, 116; 1937, **16**, 383. Waldenström, J., *Acta med. scand.*, 1934, **83**, 281; *Dtsch. Arch. klin. Med.*, 1935, **178**, 38. Roth, E., *Z. klin. Med.*, 1935, **129**, 123. Dobriner, K., *J. biol. Chem.*, 1936, **113**, 1. Turner, W. J., *Arch. intern. Med.*, 1938, **61**, 762. Vahlquist, B., *Hoppe-Seyl. Z.*, 1939, **259**, 213. Rimington, C., *Biochem. J.*, 1943. **37**, 443. Petrie, E., *British Medical Journal*, 1948, **1**, 926.

Dicoumarol in Disseminated Sclerosis

Q.—*Would there be any justification for using dicoumarol in a case of disseminated sclerosis?*

A.—Dicoumarol has been employed to treat disseminated sclerosis because it was suggested that the pathological basis of the disease was a tendency to spontaneous clotting in the blood vessels of the nervous system. This hypothesis has not been generally accepted, and many remain unconvinced that dicoumarol is of any value; moreover, it is not free from risk.

Irregularity at the Menarche

Q.—*Is any treatment required for irregular menstruation in young girls? A healthy girl of 14 started menstruating 18 months ago. The cycle was at first six to seven days every four to eight weeks. Latterly, however, the monthly pattern seems to be lost. She may lose continuously for two or three weeks, then be clear for a week or ten days, then start again. Her general health seems unaffected, and there is no sign of anaemia and no pain. She leads an active life. Is treatment indicated? Can her mother be assured that the girl will grow out of it?*

A.—Menstrual irregularity of this and other types is common at this age, but shows a strong tendency to natural cure within months, or one or two years at the most. If the bleeding is not so heavy as to produce constitutional upset or to interfere with ordinary activities, there may be no need for any special treatment. Thyroid 1 gr. (65 mg.) daily for two or three months often seems to stabilize the cycle in these cases, and calcium might also help. The bleeding is probably anovular in type, but may be a manifestation of either hypo-oestrinism or hyper-oestrinism. If sex-hormone therapy becomes necessary, either of these two possibilities would therefore be covered by giving ethinyl oestradiol, 0.05 mg. twice daily by mouth, administration starting on the second or third day of menstruation and continuing for 20 days. During the last seven days of this treatment ethisterone, 10 mg. three times a day sublingually, should be given as well. The next period is likely to start a few days after the completion of this treatment, and, when it does, repeat the course, giving it three times in all.

Femoral Thrombectomy

Q.—*Is femoral thrombectomy ever undertaken in this country? What are the indications and the possible dangers, and what results have been obtained in any published series of cases?*

A.—Femoral thrombectomy is undertaken in this country, but is not yet established as a regular procedure, many surgeons being content to rely upon Leriche's procedure of procaine block of the lumbar ganglia and the combined administration of heparin and dicoumarol. In certain conditions—for example, after prostatectomy, hysterectomy, haemorrhagic lung infarcts, etc.—one fears to use the anticoagulants in the fullest doses; in these cases ligation of the femoral veins is strongly indicated, and if a clot is encountered at the level of the ligature it must be completely removed above the ligature or it will propagate upwards and manufacture emboli. The removal is done from the iliac veins with forceps such as those designed by Trendelenburg for pulmonary thrombectomy, coupled with a sucker tube with an expanded end. Confirmation that the whole clot has been removed is supplied by the finding in the fragments extracted of the characteristic cap at the end of the clot.

Placental Implants for Rheumatoid Arthritis

Q.—*During a recent visit to Pistány, Czechoslovakia, I was given the opportunity of seeing the operation of placental grafting for rheumatoid arthritis and allied conditions. Is this operation performed in England? If so, what results have been obtained?*

A.—This procedure, which is an empirical one, is not performed in England. The underlying idea is that certain of the hormones which are elaborated in the placenta during pregnancy are of value in the treatment of rheumatoid arthritis. By implanting placental tissue it is hoped that the action of these hormones may be prolonged beyond what might be hoped of injection therapy.

"Rheumatoid Rectal Neuralgia"

Q.—*Is there such a thing as rheumatoid rectal neuralgia? This diagnosis was made recently in a case in which there were no physical signs and the only symptom was rectal pain. I have been unable to find any reference to it in the textbooks.*

A.—There appears to be no scientific justification for the diagnosis of "rheumatoid rectal neuralgia" as an explanation for symptomless rectal pain. The writer has recently heard of this diagnosis being made by a proctologist, but on inquiring the grounds for this opinion he discovered that the word "rheumatic" (or "rheumatoid") was being employed in the mediaeval sense—that is, as a synonym for "painful."

NOTES AND COMMENTS

Jelly-fish and Weever-fish.—Dr. H. S. RUSSELL (Bradford) writes: The answer to the request for advice in treating jelly-fish and weever-fish stings ("Any Questions?" October 1, p. 767) appears to me to be somewhat incomplete. On a recent holiday in Suffolk my small son, aged 11, trod on some stinging fish while coming ashore from a bathe, presumably a lesser weever-fish being responsible. When seen 5 minutes afterwards there was a definite puncture mark seen above the left little toe, with an urticarial weal—radius ½ in. (1.25 cm.)—around it. Intense pain was complained of. A small amount of "anthisan" cream happened to be available and was rubbed into the affected part, which ended the incident completely in about two minutes without any sequelae. May I add that I saw an experienced nurse last night who had a wasp sting while visiting. A little anthisan cream rubbed in at once stopped the pain, though it did not prevent the "lump" from developing. I think these antihistamine chemicals applied locally in good time save a great deal of trouble to all concerned.

Corrections

The address from which information may be obtained about the Commonwealth Fund fellowships offered by the Commonwealth Fund of New York (November 5, p. 1060) is 35, Portman Square, London, W.1, not Portland Square as printed.

Dr. MAX REISS (Bristol) writes: I would be glad if you would correct a misquotation in the issue of November 5 (p. 1041), in the report of the meeting of the Section of Physical Medicine of the Royal Society of Medicine. The report states: "Dr. Max Reiss said that he and Hempel were probably the first to use corticotropic hormone in the treatment of rheumatoid arthritis. . . ." This should read: "Dr. Max Reiss said that he and Hemphill were probably the first to use corticotropic hormone in the treatment of human subjects, and published in 1942 the results of investigations carried out on a group of cases suffering from involutional melancholia (*J. ment. Sci.*, **88**, 559)." It is important that this correction should be made, as to suggest that I have treated rheumatoid arthritis is misleading.

Dr. T. M. Montford should have been described as part-time Medical Officer of Health to the Castle Donington Rural District Council in the *Journal* of November 12 (p. 1089).

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