Angular Stomatitis

Q. — Can you describe the aetiology and treatment of a recurrent painful fissuring of the angles of the mouth? The condition has persisted for four months and does not respond to antibiotics, emollient creams, or vitamin-B therapy. The patient is a married woman of 32, otherwise healthy. The fissure occasionally heals, when the skin at the red margin of the lip has an unhealthy pallor, but after a few days a crack appears, which gradually deepens. This does not normally extend beyond the red margin. Is the condition infectious, and may it be familial in origin?

A. — In the absence of nutritional disturbances and of local infective causes, which appear to have been considered, a common cause of angular stomatitis is faulty alignment of the teeth and jaws. This faulty “bite” may occur with both natural and artificial teeth, and can usually be corrected by dental attention. The maladjustment of the teeth causes a folding of the skin at the angles of the mouth, with consequent maceration and infection. Some individuals, and particularly seborrhoeic subjects, are more prone to trouble from this source. It is important to exclude any chronic infection in the nose or throat, accessory sinuses, or jaws.

With artificial dentures, an allergic sensitivity to the material of the denture may determine an angular stomatitis without necessarily producing inflammation inside the mouth. This is particularly likely to happen if the dentures are not removed at night. Less commonly, sensitivity to lipstick may also be responsible.

A gentian violet cream at night and fractional doses of x rays are useful local measures, but cure depends upon removal of the cause.

Temperature and Humidity of Operating Theatres

Q. — What is the optimum temperature and humidity for an operating theatre?

A. — I am not aware of any physiological investigation into the optimum temperature and humidity for an operating theatre, but experience in the dressing station of the Burns Unit of the Birmingham Accident Hospital suggests that a temperature of 72° F. (22.2° C.) and a relative humidity of about 50 to 55 is satisfactory both for an exposed patient and for the staff. For a very sick patient who has to be exposed for a long time the temperature is sometimes increased to 74° F. (23.3° C.).

The “Dumping Syndrome”

Q. — What precisely is meant by the term “dumping syndrome” after partial gastrectomy? Are there any specific signs and symptoms by which it is recognized, and are the x-ray findings characteristic of the condition?

A. — The term “dumping syndrome” is better called “post-gastrectomy syndrome.” It covers a number of quite different phenomena. There are three main groups of these: vaso-vagal attacks, hypoglycaemic attacks, and “neurotic” attacks.

Vaso-vagal attacks come on a few minutes after the ingestion of food and are characterized by faintness, sweating, pallor, a feeling of warmth, nausea, palpitations, and a sense of epigastric fullness. These are probably due to over-distension of a small stomach remnant and the drag of this and the anastomotic loop on the gastro-oesophageal junction, the stimulus being conveyed by the splanchic nerves. Some distension of the proximal loop with bile may be a subsidiary factor. Hypoglycaemic attacks occur two to three hours after the taking of a meal and are due to the rapid emptying of the stomach remnant into the jejunum of unacclimated and undigested food. The third group is characterized by vague and indeterminate symp-