In short, the use of ultraviolet irradiation is tending to be confined to dermatology, in which it is found of value in various skin conditions. If vitamin D is needed it is far quicker to give it by mouth than to elaborate it in the skin by means of ultraviolet irradiation. There is no evidence that the deposition of melanin in the skin is in any way harmful.

Chrysanthemum Sensitivity

Q.—A nurseyman is sensitive to chrysanthemums, contact with blooms and leaves producing an intense skin irritation. The juice does not seem to be irritant, as, for example, when taking chrysanthemum cuttings. Local applications of antihistamines help slightly. Barrier creams are not efficient. Is there any method of desensitization, or should I indicate preparation and dosage. Otherwise what treatment is recommended?

A.—Chrysanthemum sensitivity is well documented, although not quite so common as sensitivity to Primula obconica. Much good can be done in prevention by the proper use of barrier creams—for example, “innoxa BW.2.”—or rubber gloves when handling the plants, but it is essential that these creams are used correctly in accordance with instructions and the gloves should be washed thoroughly after use. The slightest contamination of the inside of the gloves will make things much worse. Desensitization can be carried out, usually beginning in early spring. Suitable extracts with instructions can be obtained from Messrs. C. L. Bencard Ltd., 24-30 Minerva Road, London, N.W.10. The results are variable and the injections may need to be repeated yearly.

Dribbling in a Two-year-old

Q.—Can you suggest the cause and treatment of excessive salivation in my son aged 2 years 3 months? He is a mentally normal, healthy boy. All 20 milk teeth are completely erupted (since 2 years 1 month) and are sound. The tonsils are not enlarged and he is not a mouth-breather. He does not suck his thumb or fingers, but tends to keep his mouth open a lot, talking or laughing. He dribbled excessively as he cut each tooth, and still soaks through five or six thick towelling bibs each day. I have tried the psychological approach (leaving off bibs and telling him he is a big boy now and does not need them) without effect. I should be grateful for any suggestions in this minor but troublesome matter.

A.—Dribbling may arise from excess salivation, from difficulty in swallowing, or from a combination of these factors. From the description given it can be accepted there is no local buccal-pharyngeal irritation or infection, and no evidence of muscular incoordination affecting swallowing. Examination should exclude the presence of a sharp tooth and post-nasal obstruction. It is assumed the child is not being given any medication, that there is no suggestion of macroglia, and that the diet is normal in all respects. Occasionally air-swallowing is accompanied by excessive salivation, but not in such persistently marked degree as the question suggests. However, this possibility deserves consideration, more especially if the child is characteristically hyperactive and can be highly sensitive to stimulants, for example, chloral hydrate. Often there is no recognizable cause. In that event symptomatic relief can sometimes be obtained by giving tincture of belladonna. A suitable commencing dose would be 3–5 min. (0.2–0.3 ml.) thrice daily.

Contraceptives in the Tropics

Q.—What is the most suitable contraceptive for use in the Tropics? Are there any difficulties in storage?

A.—Generally the most suitable method for contraception in the Tropics is for the woman partner to use a vaginal diaphragm (Dutch cap) or cervical cap in combination with a spermicidal paste or jelly. To preserve the rubber, the cap should be kept buried in French chalk when not in use, and a small tin box makes a suitable receptacle. The more popular and reputable spermicidal pastes are satisfactory for use in the Tropics, but if, in any doubt over a particular one, the manufacturer or chemist concerned would give advice on request. Soluble pessaries with a gelatin base are unsuitable because they melt in the heat, but foaming pessaries, which depend on moisture to activate them, could be used if desired in conjunction with a cap.

NOTES AND COMMENTS

Local Analgesics for Scalds.—Dr. G. C. Milner (Peterwood, Kent) writes: With reference to local analgesics for scalds (“Any Questions?” August 7, p. 374), for the unbroken skin immersion of the part in cold water will immediately relieve the pain. But if it needs to be kept in for about half an hour, and the water kept cold.

Dr. E. P. Carmody (St. Leonards-on-Sea) writes: Working in a laboratory bending glass tubes, etc., burnt fingers were of common occurrence and it was the rule to have a bottle of amyl salicylate handy. This applied at once was not only definitely analgesic, but prevented blisters.

Recurrent Folliculitis.—Dr. Mair E. M. Thomas (Public Health Laboratory, Edmonton) writes: The reply given in your “Any Questions?” section (Journal, August 14, p. 422) to an inquirer about persistent staphylococcal folliculitis prompts some amplification. Firstly, in the treatment of the skin area involved, plain “elastoplast” adhesive applied directly to the pustules and furuncles, if discrete, often produces quicker healing with less pain than do wet “antiseptic” dressings. Secondly, whereas Staphylococcus pyogenes hardly ever be harboured by local antiseptics, vaccines, toxoids, tin or manganese preparations, sulphonamides or oral penicillin, success usually follows the use of high intramuscular doses of an antibiotic to which the organism is sensitive. Suitable intramuscular dosage would be, for example, one million units of penicillin daily for a week or 1 g. of streptomycin daily for the same period. Thirdly, the source of repeated infection is usually the patient’s own nose, but may also be the nose of one or more of his household contacts or infected clothing or soft furnishings. Therefore a search for and, if need be, treatment of carriers of the same phase type of staphylococcus, and wholesale cleaning of clothes and premises, should accompany any specific antimicrobial treatment of the patient.

Our Expert replies: The treatment of staphylococcal pyodermia is certainly very unsatisfactory and there is plenty of room for personal preferences. I am not particularly keen on elastoplast on an area such as the buttocks, particularly when there are ulcers and lesions. Although the nose is a very potent source of infection for boils on the exposed parts of the body I am not sure that it has much to do with folliculitis on the covered parts such as the buttocks.

Correction.—In the article entitled “Selection of Students in India” (Journal, August 28, p. 489) Professor S. S. Misra’s qualifications should have included the degree of M.D. and the diploma of M.R.C.P.

Refresher Course Books.—The first two volumes of collected articles from the Refresher Course for General Practitioners published in the Journal are now available. The first volume contains 55 articles and the second 60. Each article has been revised by its author. Copies of both volumes may be obtained, price 25s. (postage Is.) each, direct from the Publishing Manager, B.M.A. House, Tavistock Square, London, W.C.1, or from book-sellers. The second book of “Any Questions?” is also available, price 7s. 6d. (postage 6d.).