suggested that serum hepatitis is the more severe. The chances of cirrhosis in a previously healthy subject are probably in the region of 0.5–1%, but this figure may be higher after subsequent attacks.

Oil at Work

Q.—*I have a patient whose normal work is that of machine-tool setter, but he has developed what appears to be a sensitivity to the oil used. He was put on another job for eight months, but the condition recurred as soon as he returned to his original work. Is there any means of either desensitizing this patient or otherwise protecting him against the oil? What is the legal position in regard to a claim for compensation?*

A.—The question does not state what form the sensitivity to the oil took. One may assume that it was a form of contact dermatitis—that is, an erythematous or eczematous reaction in the areas of skin contaminated by the oil. Even this association and the recurrence on return to tool-setting are not, of course, proof that the oil was responsible; on occasion, for example, men who work in oil use over-drastic forms of cleansing (sometimes including strong disinfectants) and produce acute skin irritation in this way. Direct incrimination of the oil is possible by application of test patches after subsidence of the rash, using dilutions initially—for example, 1:100 of the oil in liquid paraffin—and full-strength oil only if this gives a negative result.

Oil itself is seldom a sensitizing agent. Its effect on the skin is usually to produce a folliculitis by action on the sebaceous follicles. Modern cutting oils, however, often contain additives, which may be skin irritants or sensitizers. Sometimes overheating of oil produces irritating degradation products. Each situation therefore requires detailed investigation. Desensitization is usually out of the question. Personal protection of forearms with "oil-sleeves," and the body with an apron, is often useful, especially for the control of folliculitis. Protection of the hands, if these tend to be involved in an acute skin reaction, is not feasible, since barrier creams are readily penetrated by oils, and gloves cannot be used for fine work like tool-setting.

Oil dermatitis is a prescribed disease under the Industrial Injuries Act, 1946. It may therefore attract injury benefit for incapacity for work and for disablement benefit for "loss of faculty" after the injury benefit period is over. For a person whose loss of faculty causes financial loss there is available an additional benefit termed Special Hardships Allowance. Full details and leaflets about these benefits are available on request at all offices of the Ministry of Pensions and National Insurance.

Contraindications to Phenylbutazone

Q.—*What are the contraindications to phenylbutazone? Is a regular blood count an essential precaution when using this drug, and, if so, how often should it be done and what should it consist of?*

A.—In a certain number of patients phenylbutazone appears to exert a powerful analgesic effect, but in many the dosage required to produce this causes undesirable and even dangerous toxic complications. The incidence of these complications has been as high as 30–50% in most published series. The main toxic effects are malaise, fever, skin rashes, and sore throat, occasionally accompanied by agranulomatosis, which may be fatal; oedema from salt retention, which may precipitate cardiac failure; dyspepsia, occasionally accompanied by gastric bleeding which may be serious; and disturbance of blood clotting.

The main contraindications to the use of phenylbutazone are: leucopenia, or known idiosyncrasy to drugs; reduced cardiac or renal reserve; a history of dyspepsia or peptic ulceration, and thrombo-embolic phenomena. The incidence of complications appears to increase with age, so that this drug should generally not be given to elderly patients, particularly since renal and cardiac reserve is usually reduced in old age.

Though a white cell count should be done before starting treatment with phenylbutazone, repeated counts during treatment are of little value, since the onset of agranulomatosis is usually sudden and heralded by the onset of symptoms such as malaise and sore throat rather than by changes in the white cell count. If striking symptomatic relief is not obtained with a dosage of less than 600 mg. per day, treatment should be discontinued. All patients receiving phenylbutazone therapy should be instructed to stop the treatment immediately on the appearance of any untoward symptoms, since the drug is excreted slowly and it may take several days for both therapeutic and toxic effects to wear off.

Value of Pneumoperitoneum

Q.—*Is it established beyond doubt that artificial pneumoperitoneum has a beneficial effect in pulmonary tuberculosis? Please cite a few key references.*

A.—To establish beyond doubt that a method of treatment is beneficial usually requires a carefully designed and controlled trial. This may not be so if the results are dramatically better than anything that has gone before, as were, for instance, the results of treating tuberculous meningitis with streptomycin. But pulmonary tuberculosis is a variable disease, and we know of no carefully controlled trial of artificial pneumoperitoneum which gives an unequivocal answer to the question asked. The results reported in different series vary with the type of case treated, the criteria of success, and the length of follow-up. In certain larger series figures for "success" (variously defined) lie mainly between 30 and 60%. Reports up to 1945 are summarized by Mitchell and his colleagues,[1] who add 710 cases of their own with "satisfactory results" in 45%. Morris and Bogen[2] report a 10-year follow-up of 200 patients, 35 of whom had tuberculous peritonitis or enteritis and the rest far advanced pulmonary disease; 55% were dead and only 40% of the survivors were working. Crenshaw and Gross[3] achieved "success" in slightly under 50% of cases, mostly moderately or far advanced, apparently followed up for at least five years.

REFERENCES

1 *Amer. Rev. Tuberc.*, 1947, **55**, 306.
2 *J. Amer. med. Ass.*, 1952, **149**, 1120.
3 *Dis. Chest*, 1952, **22**, 91.

Masks to Prevent Farmer's Lung

Q.—*Would a smog mask or any other filtering device protect farmers against the contraction of farmer's lung?*

A.—It is reasonably certain that farmer's lung is due to the inhalation of dust from mouldy hay or straw. The actual cause, however, is not definitely known. There is no doubt that farm workers can avoid the condition if they wear a light mask such as is used in a hospital operating theatre when they are employed on work such as threshing or feeding their cattle with mouldy hay.

Correction.—There was a misprint in D. S. R.'s appreciation of the late Dr. Marjorie Back (*Journal*, October 2, p. 817). The word "clerical" in the tenth line should have been "clinical."

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