after a large retinal haemorrhage, provided that the eye is in other ways healthy. Among elderly patients a few mobile anterior vitreous opacities are almost the rule, and are sometimes obtrusive, but most people can learn to ignore them when they are assured that the floating dots do not mean cataract. Myopes are especially liable to vitreous opacities, which cannot be dispersed by any medical or surgical means.

Use of Methonium Compounds in Emphysema

Q.—*I understand that hexamethonium bromide is now used in the treatment of emphysema. I should be most grateful for some details.*

A.—The action of hexamethonium bromide in emphysema is very complex. Its use was first suggested in those cases in which pulmonary hypertension had developed, with the object of reducing this and the consequent strain on the right ventricle. As a ganglion-blocking agent, it probably also has some effect on bronchial muscle tone and bronchial secretion. Since the pulmonary artery pressure is usually raised only in the acute exacerbations of bronchitis and bronchopneumonia which punctuate the course of emphysema, and it is rarely raised in ambulant patients, the action of hexamethonium bromide on the pulmonary circulation is unlikely to be of any value in the long-term management of emphysema. A controlled study has indicated that more patients with severe emphysema claimed relief of dyspnoea when receiving hexamethonium than when receiving a placebo, but on the other hand many of them suffered unpleasant side-effects, and it is doubtful whether the degree of symptomatic relief is more than would be obtained by the use of the usual antispasmodic drugs. On the whole, the use of hexamethonium bromide in emphysema must be regarded as under investigation, and certainly cannot be regarded as an established procedure.

Aching Testicles after Mumps Orchitis

Q.—*Two of my patients, men in their thirties, suffered from unilateral orchitis following mumps about a year ago. There is atrophy of one testis in each case. Both complain of periodical aching and discomfort in the external genitalia, especially when cold and tired. Examination is negative. Is this a common condition, and how long is it likely to last?*

A.—The pain of mumps orchitis usually goes as the swelling subsides and atrophy ensues. It is not common for it to persist for a year, although another patient recently seen still complains of an occasional ache in the testis many years after mumps. It is likely that these symptoms will disappear, but their duration cannot be foretold. Reassurance may well help.

Epidemiology of Herpes Simplex

Q.—*What is the relationship between the viruses of herpes simplex and herpes zoster? How is infection with the virus of herpes simplex spread? Is there any cross-immunity between the two viruses?*

A.—The viruses of herpes simplex and herpes zoster both produce vesicular lesions which, to the naked eye and on microscopical examination of sections, have the same structure and appearance. However, the lesions due to herpes simplex virus usually appear at mucocutaneous junctions, especially about the lips, the nose, and occasionally the genitals, whereas the lesions of herpes zoster usually occur on an area of skin or mucous membrane corresponding to the distribution of sensory nerves derived from the posterior spinal root ganglia or corresponding ganglia of cranial nerves. The viruses are of similar size as determined by electron microscope and produce similar intranuclear inclusions in infected cells. The viruses are serologically and immunologically quite unrelated. An attack of zoster confers no immunity to the virus of herpes simplex.

Infection with herpex simplex virus is usually acquired during the first five years of life through direct or indirect contact with infected parents or older siblings. After the primary infection the child tends to harbour the virus for many years, perhaps for life, and may suffer from recurrent clinical attacks of "cold sores"—the local manifestation of herpetic infection. Such a person serves as a source of spread by direct contact or by infected saliva.

Snoring

Q.—*A healthy man of 45, with no abnormality of the air passages, snores excessively. Is there any effective treatment for this condition? Would a dental plate extending over the soft palate be any help?*

A.—Snoring in adults occurs usually when the lower jaw drops, the mouth opens widely, and the tongue falls back. As this is much more likely to happen when lying on the back than on the side, the classical remedy of sewing some hard object to the back of the pyjama jacket is often effective. There would be no value in the suggested dental plate extending over the soft palate, as this could not be tolerated by the wearer. A bandage to support the chin and keep the mouth closed would be much more effective.

Swimming-baths in Convalescence from Poliomyelitis

Q.—*I should be very grateful for some advice on the use of swimming-baths to help patients with paralysis due to poliomyelitis.*

A.—Treatment in a warm swimming-bath is of value in certain patients with residual paralysis following anterior poliomyelitis, the warmth increasing the circulation and exercises under water helping to counteract the effects of gravity on the weak muscles. Such treatment is of most value for muscles which have begun to contract voluntarily but cannot yet contract against resistance. In addition the warmth and buoyancy are often valuable in obtaining freer movements in muscles which have improved beyond this stage, and the attraction of exercises in a swimming-pool as opposed to ordinary active exercises may be encouraging to patients who need prolonged physiotherapy.

NOTES AND COMMENTS

Sulphone Poisoning.—Dr. M. H. A. JAMISON (Northern Rhodesia) writes: With reference to the reply on "Sulphone Poisoning" ("Any Questions?" April 30, p. 216) I would be glad of other practitioners' views on the use of B.A.L. (dimercaprol) as an antidote for sulphone poisoning. Over the past three years I have used it in five cases of severe sulphone toxaemia. The first patient had a severe hepatitis with deep jaundice and was obviously dying, to whom I gave B.A.L. as a last resort. The response was dramatic. My other cases were not so severe nor was the action so marked, as I had administered B.A.L. at an earlier stage.

Correction.—Dr. K. DOUGLAS SALZMANN writes: In my article on "Obstetrics in General Practice" (July 2, p. 18) it was erroneously stated that, in four general-practitioner maternity units in the Oxford area, Stallworthy reported among 1,097 cases an uncorrected foetal mortality rate of 22 stillbirths per 1,000. This figure represented stillbirths and neonatal deaths combined. The comparable figure for Dellwood (1950 and 1951) was not 12 stillbirths per 1,000, but 21 stillbirths and neonatal deaths per 1,000.

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