is curious how the old tradition of patients having "excruciating pain" after operation for haemorrhoids still persists, but each additional patient successfully dealt with on modern lines should help gradually to kill this myth.

Exact Control in Diabetes

Q.—*On the assumption that it is impossible to stabilize exactly a diabetic who is having insulin, is it better to aim for slight hypoglycaemia rather than slight hyperglycaemia in order to avoid complications and prolong life? Is prolonged slight hypoglycaemia detrimental to health in any way?*

A.—It is true that it is impossible to imitate exactly the normal physiological control of carbohydrate metabolism by means of injected insulin, but the object of treatment should be not to produce a state of either slight hypoglycaemia or hyperglycaemia but rather, if possible, so to arrange the diet and insulin that the blood sugar is within normal limits at the time of maximum insulin acion. The duration of this period of normoglycaemia will, of course, depend upon the type of insulin and number of injections given daily.

It is difficult to say whether the diabetic whose blood sugar is constantly slightly below normal is better off than the one who is always a little hyperglycaemic; but, as it is impossible to be sure that the hypoglycaemia will always be slight, it is probably safer to err a little on the side of excess, or, in other words, it is safer to have the urine tests sometimes green rather than always blue. This is particularly true in elderly patients with evidence of coronary artery disease.

There is no evidence that prolonged slight hypoglycaemia is detrimental to health, but it is quite impossible to maintain this state with any degree of safety in the diabetic patient. There is always the danger, if an attempt is made to do so, that the patient will sooner or later have a severe attack of hypoglycaemia.

Failure to Settle at Night

Q.—*A healthy boy aged 6 has a fear of going to bed. When persuaded to go to bed at 7.30 p.m. he lies awake and often comes downstairs to the living-room at any hour up to 11 p.m. or into his parents' room later in the night with a request for a drink or something. He is very intelligent, has been at school a year, and is happy. He has a brother aged 3 of whom he has no need to be jealous. The father is a professional man and happily married. The boy himself does not know why he cannot get to sleep. He has his brother in the room with him and a night-light by request. His parents are immediately available if he wants them. Should I administer a barbiturate or should I seek psychological help? The trouble now has been going on for some months.*

A.—If the child stays awake and gets up because he cannot bear to give up the pleasures of the day, firmness is needed. If it is badly received, it may be tempered with a barbiturate for a couple of weeks. The questioner's account of the case is, however, clear, and one has to accept his first sentence at its face value. The cause of the fear of going to bed has eluded a careful doctor and intelligent parents; therefore they should seek for help, and from whom better than from a good children's psychiatrist? Nevertheless, one cannot help wondering whether there are not other clues in this admirable clinical précis—e.g., "He is very intelligent," but has he done enough in the day to be mentally tired at bedtime? "He has a brother aged 3 of whom he has no need to be jealous." Is there insecurity here? For it would have been simpler to say, "Of whom he is not jealous."

Salivation in Glaucoma

Q.—*A patient with glaucoma suffers from excessive salivation. What drugs are available for dealing with the salivation without affecting the eye condition?*

A.—On the assumption that the excessive salivation is due to the drops the patient is using for his glaucoma, it may be worth while trying a different method of treatment. Pilocarpine drops are more apt to produce salivation than eserine, and the tendency to salivation may perhaps be inhibited if systemic absorption of the drops is avoided by taking care that none pass into the mouth via the lacrimal duct and the nose; this may be achieved by compressing the lacrimal sac at the root of the nose when the drops are put into the conjunctival sac. If in spite of these measures the salivation still persists, it is a moot point whether the systemic use of atropine or its derivatives would be justifiable. In addition to influencing the salivation there would be many other effects, some of them highly undesirable—and this quite apart from the danger of precipitating acute glaucoma from the cycloplegic effect that these drugs all have. If such drugs are to be used, hyoscine-N-butylbromide ("buscopan"), with its poor cycloplegic effect, might be considered. It should, however, be appreciated that excessive salivation is a symptom, and no treatment should be undertaken until an accurate diagnosis has been reached.

Obstinate Sycosis Barbae

Q.—*What treatment is advised for a case of sycosis barbae of 20 years' duration? Epilation, local penicillin, chloramphenicol, chlortetracycline, oxytetracycline, and x-ray therapy have all been tried without success.*

A.—This is evidently an extremely difficult case. The questioner makes no mention of a search for chronic infection in the nose, accessory sinuses, or the mouth. Any of these sites may provide a reservoir of infection by which the skin disease is perpetuated. If this has not already been considered, a scrupulous search should be made in these areas. Even in the absence of clinical signs of infection, mild degrees of chronic rhinitis—for example, from smoking—may enable staphylococci to be carried in the nose and to reinfect the skin.

There are three usual local applications which have not been mentioned: the old and well-tried Dalibour water (copper and zinc sulphates lotion, *B.P.C.*), "graneodin" ointment (neomycin 2.5 mg. and gramicidin 0.25 mg. per g.), and "quinolor" compound ointment. Any of these local applications gives occasional success where others have failed.

NOTES AND COMMENTS

"Approved Names."—In the supplementary list of "approved names" printed in our issue of June 16 (p. 1423), sodium calcium-edetate, a substance which has been recommended for the treatment of lead poisoning, was stated to be obtainable from manufacturers of laboratory reagents. We now understand that Riker Laboratories Ltd. are the sole suppliers of this substance for therapeutic, as distinct from commercial or chemical, purposes. They market sodium calcium-edetate under the proprietary name of "calcium disodium versenate."

Corrections.—In discussing the very variable results with topical hydrocortisone, Dr. G. B. Mitchell-Heggs is reported (*Journal*, July 21, p. 152) as suggesting that this was "possibly owing to the deficiencies in the various preparations. . . ." The word "deficiencies" should have read "differences."

In Dr. John Bullough's letter (*Journal*, August 11, p. 360) the dosage of rectal thiopentone was wrongly printed as 1 gr. per 50 lb. (23 kg.) instead of 1 g. Dr. Bullough omitted to give the reference to the technique he described in 1952—this should be Bullough, J., *Lancet*, 1952, **2**, 999.

All communications with regard to editorial business should be addressed to THE EDITOR, British Medical Journal, B.M.A. House, Tavistock Square, London, W.C.1. Telephone: EUSTON 4499. Telegrams: *Aitiology, Westcent, London.* ORIGINAL ARTICLES AND LETTERS forwarded for publication are understood to be offered to the *British Medical Journal* alone unless the contrary be stated.
Authors desiring REPRINTS should communicate with the Publishing Manager, B.M.A. House, Tavistock Square, W.C.1, on receipt of proofs.
ADVERTISEMENTS should be addressed to the Advertisement Director, B.M.A. House, Tavistock Square, London, W.C.1 (hours 9 a.m. to 5 p.m.). Telephone: EUSTON 4499. Telegrams: *Britmedads, Westcent, London.*
MEMBERS' SUBSCRIPTIONS should be sent to the SECRETARY of the Association. Telephone: EUSTON 4499. Telegrams: *Medisecra, Westcent, London.*
B.M.A. Scottish Office: 7, Drumsheugh Gardens, Edinburgh.

Br Med J: first published as 10.1136/bmj.2.4989.430-a on 18 August 1956. Downloaded from http://www.bmj.com/ on 21 April 2024 by guest. Protected by copyright.