There is always a certain risk of infection in travelling with any baby, and every effort should be made to fully breast-feed a baby who will have to travel, particularly to the tropics. Apart from this risk, 6 weeks or so of age is as convenient an age as any at which to travel with a baby.

The baby should, of course, not wear clothes of nylon or other poorly absorbent material. Light washable cotton is probably best. The cot sides should be such as to allow some movement of air around the baby, and the mattress of a firm material such as sponge-rubber. Bathing twice daily is advisable, followed by careful drying and powdering with any good baby-powder.

Care of Napkins

Q.—*Zinc and castor-oil cream is excellent for nappie rash but very bad for the nappies, leaving brown stains on boiling. Can you suggest a stain-free cream?*

A.—There are a number of proprietary and other applications on the market for the prevention and treatment of napkin rashes. They all have their devotees and a vogue which often does not last very long. A simple water-repellent barrier cream or a silicone ointment is probably as useful as anything, and does not stain. Lanoline is also quite effective and clean to use.

Some people do not like the stock zinc and castor-oil ointment, but it has been well proved and does not usually cause stains. It is possible that in an ointment that has been kept too long the oil may come out of the mixture and cause a yellowish stain, or that heat or reaction with urinary constituents may cause the zinc oxide to stain brown. Napkins should never be dried without washing, and they should always be well soaked on removal and before washing or boiling. A useful trick is to put a thin layer of fluffed-out cotton-wool over the area of the ointment, which does not then adhere to the napkin. Another solution is to use one of the several types of disposable napkin now available.

Anaesthesia in Hepatic Disease

Q.—*What anaesthetic is advised for a laparotomy and liver biopsy in a fat, ill, jaundiced patient with a poor myocardium, and probably also hepatic disease? Is pethidine contraindicated in all cases of jaundice?*

A.—The diagnosis of the type of jaundice is almost always possible by clinical and biochemical means, with, if necessary, needle biopsy of the liver performed under local analgesia. The patient described in this question should not have a laparotomy for the purpose only of liver biopsy, and any intervention should be of the life-saving order. If laparotomy does prove essential, the anaesthetic should be entrusted to a real expert conversant with modern methods. It is now possible to anaesthetize the patient with liver disease for abdominal surgery by using only a small dose of pentothal (of the order of 100 mg.) and continuing with nitrous oxide, oxygen, and muscular relaxants such as suxamethonium. It is extremely important to avoid undue haemorrhage or any hypotension, for these are apt to do more damage to the liver than the anaesthetic. Morphine is absolutely contra-indicated, and pethidine, which is almost completely destroyed by the liver, should be given only with caution and in very small doses.

Nitroglycerine Intoxication

Q.—*Several patients of mine are either quarrymen or miners who use gelignite. They all complain of nausea and headache lasting for about three hours, which begin as soon as they open the tins of gelignite and start handling it. There is apparently no question of their hands becoming contaminated and the gelignite being ingested: the symptoms start as soon as the tins are opened. What accounts for the symptoms?*

A.—Gelignite, blasting gelatine, and dynamite all contain gun-cotton gelatinized with nitroglycerine as the basic constituent. In gelignite the relative proportions are nitroglycerine 60, collodion cotton 5, potassium nitrate 27, and wood meal 8. Nitroglycerine is absorbed through the skin and by inhalation as well as by ingestion, and even when much diluted with air the vapour has a powerful pharmacological action.

The symptoms and treatment of nitroglycerine intoxication are described in detail by Hunter.[1]

REFERENCE

[1] Hunter, D., *The Diseases of Occupations*, 1955. London.

Malaria in the Mediterranean Littoral

Q.—*To what extent is malaria now a hazard to travellers visiting countries bordering on, or islands in, the Mediterranean, Adriatic, or Aegean seas? Is malaria prophylaxis advised?*

A.—The incidence of malaria in these regions is now very much less than it was during and shortly after the last world war. Antimalarial campaigns have been carried out with vigour in most areas and in some of these can be said to have been wholly successful. In other regions, however, there is still a small risk of contracting the disease. In large towns in these regions the risk of contracting malaria is so small that most visitors would be inclined to accept it rather than carry out anti-mosquito measures. Those staying for a prolonged period in rural and semi-rural areas during the summer months, however, would in general be advised to sleep under a mosquito net and to take the usual anti-mosquito precautions.

NOTES AND COMMENTS

Do Corpses Sink or Float?—Mr. J. ELLUL (Royal University, Malta) writes: In answer to this question ("Any Questions?" June 15, p. 1429), your expert stated: "A living person can float in fresh water with his lungs expanded but will sink on expiration; in sea-water, which has a specific gravity of 1026, the same person will float irrespective of the state of his lungs." This latter statement was tested out by 25 medical students in 21 ft. (6 m.) of Mediterranean sea. The results were unequivocal. A living person will sink in sea-water if his lungs are in a state of full expiration. Rock bottom was reached every time the experiment was tried, and rather strenuous effort was required to reach the surface again.

OUR EXPERT replies: I have no doubt that intentional full expiration in sea-water would result in a person sinking. Nevertheless most of us can float on the surface of sea-water inspiring and expiring in a normal manner. I am grateful for this experimental evidence at a time when new methods of underwater escape are being developed.

Correction.—The maternal mortality rates given in the annotation "Obstetrics in Nigeria" (*Journal*, September 14, page 635) should have been 9.5 and 7.8 per 1,000 total births. We regret the omission of decimal points.

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