### Clicking Jaw

**Q.**—*A girl of 16 has in the past three months developed a persistent and very audible clicking on the right side of the jaw, which occurs when her mouth is about half open. What treatment is advised and what is the prognosis?*

**A.**—This patient would be well advised not to seek treatment. A clicking jaw can be cured by operative removal of the cartilaginous meniscus of the temporo-mandibular joint, but an operation of this severity is hardly indicated for so trivial a symptom as a click. I gather that there is no limitation of movement of the jaw.

Such patients are sometimes helped by manipulation under an anaesthetic, but if there is no limitation of movement of the joint then manipulation would be only a form of suggestion therapy. The patient should be reassured, told that there is nothing seriously wrong with the joint, and that many people have clicking jaws. It is very likely that the click will disappear in time.

### Tough Hymen

**Q.**—*An engaged girl with a tough crescentic hymen which admits only a small finger is apprehensive about her defloration. She refuses surgical defloration. Are there any surface analgesics that could be used to reduce the pain, and, if so, which is recommended?*

**A.**—Hymenectomy is rarely necessary as a preparation for marriage even in cases of very small hymeneal aperture, and the patient is probably wise to refuse surgical defloration. The fact that an anaesthetic is required for the operation suggests to the patient that defloration must be an extremely painful process; this is confirmed by the discomfort after the operation and often gives rise to protracted vaginismus and dyspareunia. Furthermore, a number of cases of failure to consummate the marriage have been encountered even after hymenectomy.

Most girls can undertake the stretching of the hymen themselves in preparation for their marriage. Not only is the patient able by this means to discover that this is quite a painless procedure, but she also learns something about the anatomy of the introitus and the direction of the vagina and how to relax the spasm, which is the result of apprehension. The girl is instructed to wash her hands thoroughly and cut her nails short and then to insert one finger-tip with the aid of a lubricant jelly, exerting steady pressure round the circumference of the hymen. This is usually found to be carried out most easily in the squatting position during, or after, a hot bath. After repeating this frequently for a few days she will find that she can readily insert the tips of two fingers, and finally three, without the least discomfort. The use of an analgesic ointment—5% xylocaine ointment—is required only rarely.

However, if the girl does not wish to undertake the stretching of the hymen, xylocaine ointment may be applied prior to intercourse. It is wise to advise her to allow some minutes to elapse for the action of the analgesic to take place and to remove the ointment before intercourse, unless the husband is using a sheath, otherwise the penis will also be affected. Penetration is facilitated by the use of a lubricant jelly.

### Cleido-cranial Dysostosis

**Q.**—*A young child has been diagnosed as suffering from cleido-cranial dysostosis. What disability is this likely to lead to and what is the long-term prognosis? Are there any special hazards against which the child should be guarded, and is there likely to be any associated mental disability?*

**A.**—Cleido-cranial dysostosis is unlikely to lead to any disability, and, it is said, many of the patients are unaware of their deformity. The long-term prognosis is therefore perfectly good. There are no special hazards against which an affected child need be guarded, apart perhaps from the effects of dental abnormality, for which some dental or orthodontic treatment may be necessary. There is unlikely to be any associated mental disability, and intelligence is likely to be normal.

The condition is hereditary, although it may occur for the first time in a family, all the other members being unaffected. Various degrees of the disease may be found; in the simplest cases only absence or partial absence of the clavicles is present. Defective development of the membrane bones of the skull may also occur and lead to enlargement of the head with a bulging forehead and a small face. The supra-orbital ridges are prominent and there may be a slight degree of exophthalmos. The palate has a high arch. Abnormal development of the teeth is very common. The first dentition may be delayed and the permanent teeth may fail to erupt and occasionally remain embedded in the jaws. Other bony deformities have also been described in association with the abnormalities of the clavicles and skull, but these are less usual. However, their presence might influence the otherwise good prognosis.

### Treatment of Morphine Addiction

**Q.**—*What is the best treatment for morphine addiction? Has the introduction of nalorphine altered the outlook in any way?*

**A.**—Morphine may be withdrawn from the addict either rapidly or slowly. The best technique is probably to combine relatively rapid withdrawal with the administration of methadone (amidone) in order to relieve symptoms during the period when severe abstinence symptoms develop. The subsequent withdrawal of methadone is accompanied by less severe symptoms than those which result from the withdrawal of morphine. In this method the dose of morphine is reduced until the patient is stabilized on the minimum daily dose which prevents abstinence symptoms. This is usually about 120 mg. (2 gr.) a day. Methadone is then substituted in a dose of 1 mg. of methadone for each 4 mg. of morphine. After a period which may vary from 3 to 7 days according to the severity of the case the methadone is withdrawn by reducing the dose over a period of about a week.

Successful withdrawal must be followed by intensive psychotherapy and constant supervision. Relapse is frequent.

Nalorphine administered to an addict precipitates the abstinence syndrome and has been used in this way to unmask secret addicts. Its administration to addicts is, however, dangerous and should never be attempted without the patient's consent. It has no place in the therapy of addiction.

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**Correction.**—In the summary of the paper on "Treatment of Ophthalmic Zoster with Prednisone," by A. Barham Carter and J. E. Royds (*Journal*, September 28, p. 746), the word "prednisone" in the fourth line should have been "antibiotics."



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