

Any Questions ?

We publish below a selection of those questions and answers which seem of general interest. It is regretted that it is not possible to supply answers to all questions submitted.

Weight-reducing Peptic Ulcer Diet

Q.—What principles should govern the dieting of an overweight woman with a gastric ulcer so that weight is reduced?

A.—This is a difficult problem. Most patients on a gastric diet who have to feed every two or three hours will increase in weight, as the usual procedure is for them to eat carbohydrate-containing foods between meals. It is possible to give a 1,000–1,200 calorie diet and to fulfil the underlying principle of frequent feeding. This involves, however, the use of food which the patient cannot often carry. On the whole it is probably better to separate the treatment of the problems in time.

Acetone Fumes

Q.—Is the inhalation of acetone fumes harmful, and in what way?

A.—Acetone is a mild narcotic and an irritant affecting mucous membranes. In industry its narcotic effect is rarely powerful enough to produce unconsciousness, but Ethel Browning reports¹ that repeated exposure may cause drowsiness. Acute poisoning is a very rare event: symptoms include nausea, vomiting, fainting, and collapse, with no apparent permanent injury after recovery. The maximum allowable concentration is 1,000 parts per million.

REFERENCE

- ¹ Browning, E., *Toxic Solvents*, 1953. Arnold, London.

Routine Electrocardiography

Q.—What is the usefulness of routine electrocardiography in detecting early myocardial insufficiency and in determining life expectancy in apparently fit subjects?

A.—It is very difficult to answer this question without knowing more precisely what the questioner means by "myocardial insufficiency." Assuming that he is referring to ischaemic heart disease, a cardiogram can show a cardiac infarction which may clinically have been silent. The cardiogram, however, will often fail to show cardiac ischaemia unless the examination is made after effort. In this case a flat depression of the S-T segment of $\frac{1}{2}$ mm. or more usually indicates the presence of ischaemia. Other features such as anaemia, however, must be excluded.

Considerable variations in the normal T wave occur with age, race, haemoglobin level, electrolyte disturbances, endocrine factors, hypoventilation, and circulating catechol amines. Great care should therefore be taken in interpreting T-wave changes as evidence of disease. In general it is wise never to make a diagnosis of heart disease on the cardiogram alone without a full history and physical examination. The cardiogram is essentially an investigation which is complementary to history, physical examination, and other tests, and should not be allowed to stand alone. In some instances, of course, as in the case of gross ventricular hypertrophy or obvious cardiac infarction, a diagnosis can be made solely on the cardiogram, but such a diagnosis must necessarily remain incomplete without full clinical examination.

The presence of atrial fibrillation generally indicates organic heart disease, but this is not invariable. In the absence of thyrotoxicosis, rheumatic heart disease, constrictive pericarditis, or cardiomyopathy atrial fibrillation is likely to be due to chronic ischaemic heart disease, unless it is of the idiopathic variety in which no organic heart disease can be discovered. The presence of left bundle branch block

usually means organic disease, generally either ischaemic or due to cardiomyopathy.

In summary, the cardiogram is an uncertain method of diagnosing early myocardial disorder, and a normal cardiogram at rest should never be taken as necessarily excluding organic heart disease. Conversely, minor T-wave changes at rest should be interpreted with great caution since these may be quite benign and of no significance. Considerable experience together with full knowledge of the patient is needed to interpret accurately such changes. The cardiogram should never be relied on solely as evidence of disease or be the lone arbiter of a patient's fate.

NOTES AND COMMENTS

Contraindications to Immunizations.—Dr. H. G. CALWELL (Whitehead, Co Antrim, N. Ireland) writes: I should like to hear your expert's views about pregnancy as a contraindication to vaccination against yellow fever. He does not mention it in his reply to the inquiry about contraindications to various immunizations ("Any Questions?" July 7, p. 70), except in smallpox vaccination. Some authorities regard pregnancy as an almost absolute contraindication to yellow-fever vaccination, and the Air Ministry warns¹ expectant mothers very strongly against this vaccination and disclaims responsibility for any ill-effects that may follow if they persist in having it done during pregnancy. In view of this conflict of opinion further information would be welcome.

OUR EXPERT replies: To my knowledge there is so far no evidence anywhere that women given yellow-fever vaccine during pregnancy have come to any harm, nor have their children suffered in any way. The reason why some authorities regard pregnancy as a contraindication to yellow-fever vaccination is entirely a theoretical one. A few infants under the age of about 9 months have developed a more or less mild (never yet fatal) encephalitis a variable time after the subcutaneous injection of yellow-fever vaccine. Because of the lack of post-mortem virological examination there has been no proof that there was ever a causal relationship between the vaccination and the encephalitis, but the suspicion remains. If therefore (the argument runs) there is potential danger to the young infant from the living attenuated yellow-fever virus injected into it, what is more probable than that the even younger infant (the foetus) may be damaged by the injection of the virus into its mother? The cautious, therefore, recommend no yellow-fever vaccination during pregnancy: the sceptical proceed with vaccination in pregnancy when necessary and until further evidence is forthcoming.

REFERENCE

- ¹ *Guide to Families Proceeding Abroad*, A.M. 207, 14th edition, 1961. Air Ministry Movement Section, London.

Correction.—In "Any Questions?" (August 25, p. 560) we referred to calcium sodium versenate as a chelating agent for multiple sclerosis. We are reminded by the manufacturers, Riker Laboratories, that the word "versenate" is a registered trade mark.

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