

Current Practice

NEW APPLIANCES

An Easily Operated Incontinence Clamp

Dr. L. E. EDWARDS, University College Hospital, London, writes: The penile clamp has a definite place in the management of urethral incontinence. Properly applied, a clamp should prevent dribbling, and be more comfortable to wear and easier to manage than urine-collecting machines. However, most of the available types of penile clamp require for their management and correct operation a degree of manual dexterity and co-ordination that the tremulous geriatric does not possess. Some clamps have large projections that make them uncomfortable to wear, while others, if inaccurately closed, seem either to lock on or to fly open and fall off.

A new and simple pattern of penile clamp is described. The prototype was made by hand from a block of perspex for an elderly professional gentleman who had to live in a nursing-home because he could not manipulate any of the existing clamps.

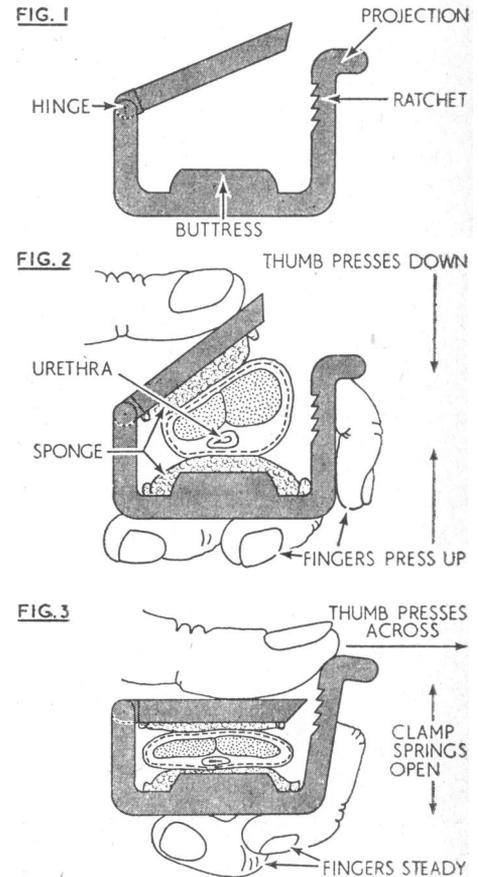
The clamp is best described by reference to the drawings. Fig. 1 shows the clamp to consist of a wide U, with a flat piece hinged to one end, and the other bent to make a small projection. The angled tip of the flat moving piece engages the notches on the inner surface of the free limb of the U. A small buttress is fixed to the cross-limb of the U, and this serves to compress the urethra

directly when the clamp has been applied. The application of the clamp is easily carried out as shown in Fig. 2, the movement being one of pressing the two parts together. The ratchet locks, and the tightness is adjusted according to how many notches are passed. The sponge padding makes for greater comfort and for an even distribution of the compression. Fig. 3 shows the mechanism of undoing the clamp, which is pressure applied by the thumb against the small projection. The ratchet is released, and the spring of the sponge causes the two compressing parts to fly apart.

This type of clamp, which was devised and first used at University College Hospital, has since been employed by several patients with post-protectomy dribbling, and by a patient with incontinence due to cauda equina paraplegia.

I would like to thank Mr. D. R. Davies, consultant surgeon at University College Hospital, for his advice and encouragement; Mr. F. S. Bailey, of Harrow, for his constructive comments; and Mr. F. Dettmar, of the Aids to Daily Living Department at St. Pancras Hospital, for allowing me to use the workshop there.

The clamp is supplied by the Genito-Urinary Manufacturing Company Limited, of 28a Devonshire Street, London W.1. It is made in both perspex and pressure-moulded polyethylene, and is completely washable.



ANY QUESTIONS?

We publish below a selection of questions and answers of general interest.

Tranquillizers for the Elderly

Q.—What is the best type of tranquillizing drug for attacks of agitation in old people with liver damage?

A.—The phenothiazine drugs have a reputation for causing cholestatic jaundice, and, though many of them are less apt to do so than chlorpromazine, the group as a whole is contraindicated in liver disease. Rauwolfia and its derivatives are unsuitable for the elderly because of the risk of causing severe depression. Non-phenothiazine tranquillizers such as hydroxyzine or meprobamate have low general toxicity and do not cause liver damage, so these as well as methylpentynol or methylpentynol carbamate can be used but are only mild in action.

The barbiturates are not favoured as central nervous system depressants by geriatric physicians, because they so often increase or precipitate mental confusion in older people. They are detoxicated in the liver, and must therefore be used with even greater care than

usual in cases with liver damage. In such circumstances the duration of action of the longer-acting drugs like phenobarbitone will not necessarily be much prolonged, but their cumulative effect must be considered, and they are better not used. The duration of action of the shorter-acting barbiturates may be much prolonged. If a barbiturate has to be used amylobarbitone sodium or quinalbarbitone sodium might be the one of choice.

In liver disease the potency and duration of action of all sedative drugs may be greater than expected, so it is appropriate to use the lowest standard dose, or less, until its action has been observed.

Paraldehyde and Plastic Syringes

Q.—Are there any plastic syringes which can be used with paraldehyde?

A.—Most of the plastic disposable syringes now available are attacked by

paraldehyde. If, however, the drug is drawn up into the syringe and immediately injected, the amount of reaction between the drug and syringe is likely to be negligible. Nylon syringes are also available, and these can be resterilized by autoclaving. Richards and Whittet¹ found little damage to these syringes after paraldehyde had been left in them for one week, but the odour of the drug tended to remain even after washing.

REFERENCE

- ¹ Richards, J. M., and Whittet, T. D., *Chem. and Drugg.*, 1958, 169, 16.

Hyperpigmentation from Sunlight

Q.—Exposure to sunlight causes patches of pigmentation in some people. What is the treatment for this, and why does it occur?

A.—Localized patches of hyperpigmentation, or freckles, indicate increased melanocytic activity after exposure to sunlight. Most affected individuals do not develop melanin pigmentation easily and may to some extent be intolerant of sunlight, requiring either very gradual exposure