Any Questions?

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

Risks of Infection from Home Dialysis Unit

Is there any likelihood of a "home renal dialysis unit" installed for a patient in a refreshment house causing cases of serum hepatitis (homologous serum jaundice) among customers?

Although documented cases are few, clinical hepatitis and Australia (hepatitis-associated) anaemia may occur amongst the social contacts of home dialysis patients. In some reported cases there had been no risk of accidental inoculation with blood products from the patient. The recognition of transmission is difficult because of the possibility of non-symptomatic cases and the long incubation period. Customers of a "refreshment house" where home dialysis is carried out run a similar, but lesser risk to staff eating food from a kitchen in a dialysis unit—a situation considered in the report prepared by the advisory group under the chairmanship of the late Lord Rosenheim. It would, therefore, be foolhardy to dismiss the possibility of transmission of serum hepatitis to customers, though the likelihood must be extremely small and no such cases are recorded. Advice at this time must be tempered with extreme caution.

If the patient is known to be negative for H.A.A. and to come from an uninfected unit, it is only necessary to maintain surveillance of the antigen status of the patient and to take routine precautions for the disposal of blood-contaminated refuse and for any person associated with the performance of dialysis and food handling to take care with hand washing. If the patient is a known carrier of H.A.A. he should not be involved in the preparation or handling of unwrapped food. The need for assistance with the carrying out of his dialyses should be reduced to a minimum and reversed-barrier nursing techniques employed. Assistants should not be involved in food handling until they have completed the standard decontamination procedure, namely, changing outer clothing and washing. In general, advice at the present time is to separate, both in distance and in time, the handling of food and the performance of dialysis.

3 Cottart, Y. E., British Medical Bulletin, 1972, 28, 156.

Encephalitis from Psittacosis

A man who breeds parrots has a severe encephalitis due to psittacosis. He has made a full and complete recovery, and his antibody titre has risen from four to 64. Is it safe for him to continue looking after his parrots, and will his antibody level be maintained?

It is, of course, never safe for anyone to handle diseased birds. The birds in the patient's flock may all—or most of them—be infected. This need not mean they are all infectious. They can be tested by skin or serum tests but the handling of the material in the laboratory is dangerous. Second attacks of psittacosis are rare and probably result from massive doses of the infecting organism. The patient's antibody titre will probably decline slowly but immunity does not depend on any exact level of antibody. A thorough examination of the flock and thorough disinfection of the aviary is required. If the breeding is part of the patient's livelihood perhaps he might then carry on. If it is only a hobby he should give it up. The fact that he developed encephalitis may mean he is unduly sensitive to this infection.

Severe Headache Accompanying Orgasm

A patient of 50 complains that for the last few months orgasm has been associated with a severe, gripping pain which seems to encase her whole head. It lasts for about ten minutes, after which she drops off to sleep. Though intercourse is not very frequent it has now become something of an anxiety. Is this a recognized phenomenon?

This is not a recognized phenomenon. The symptom requires further investigation directed perhaps towards such things as cervical spondylosis, since there may be acute flexion of the neck during intercourse, and to sinusitis, hypertension, and possibly cerebrovascular disease. During orgasm in women the systolic pressure may rise 30 to 80 mm Hg and the diastolic by 20 to 40 mm Hg and the pulse rate may rise to 110 to 180 beats per minute. Vascongestion is a feature and might affect cerebral, scalp, and nasal vessels. It might be wise therefore to assume that something is happening during orgasm which is raising a presently subclinical disorder to a clinically apparent level.

Prolonged Use of Disodium Cromoglycate

A young man with asthma has been greatly helped by two Spincaps of disodium cromoglycate (Intal) daily for four years. Is such prolonged use hazardous, and will he ever be able to dispense with this treatment?

No ill effects, local or constitutional, have yet been reported in patients receiving disodium cromoglycate (D.S.C.G.), but, since this drug has been in general use for no more than five years, it cannot be assumed that none will become evident with very long-term use. In the case mentioned, it would be advisable to find out whether it is isoprenaline or the D.S.C.G. in Intal Co. (or both) which are producing the benefit. In general, it is better to dissociate the bronchodilator effect of the sympathomimetic amine from the protective effect against bronchoconstrictor stimuli of D.S.C.G. This can be done using D.S.C.G. alone (Intal plain), and giving separately a bronchodilator aerosol such as salbutamol (Ventolin) or orciprenaline (Alupent) with instructions that it should be used only if required several minutes before the use of the Spinhaler. The indications for its use are: (i) if there is actual wheezing at the time the inhalation is due; and (ii) prophylactically in the few cases in which the use of the Spinhaler induces bronchoconstriction.

Since the effect of D.S.C.G. consists in temporary protection against some bronchoconstrictor stimuli, the underlying liability to asthma is unlikely to be affected. But the course of asthma is unpredictable, and some patients experience remissions for long periods without ascertainable cause. The use of D.S.C.G. does not diminish the desirability of investigation of possible environmental factors and appropriate management of these and other factors.
Fly-blown Mutton

In fly-blown cooked mutton how long does it take at room temperature between being fly-blown and the emergence of maggots? Can larvae in fly-blown fresh mutton survive cooking at 425°F for 20 minutes, then at 350°F for a total time of 2 hours in the oven?

The time between the laying of eggs and the emergence of maggots will depend on several factors: (1) the type of fly, (2) the type of meat, and (3) the ambient temperature. At an ambient temperature of 60°F, the eggs of the common bluebottle should hatch immediately or within two days of laying. The grub or maggot would last 5-10 days and the fly would emerge a week after this. At warmer temperatures these times would be shorter and at lower temperatures development would not proceed as far as the fly stage. The larvae would not survive these cooking temperatures and times provided the meat reached 140°F (60°C) throughout. This will depend on the size and shape of the joint. A temperature of approximately 118°F (48°C) kills the larvae.

Control of Menopausal Flushes

An obese patient aged 60 has been having oestrogen therapy for seven years to control menopausal flushes. Withdrawal bleeding has occurred—investigations were negative—and she has had superficial thrombophlebitis in the calf. Without oestrogen her hot flushes are frequent and distressing. What can be done to relieve her symptoms?

It might have been better if this patient had not been allowed to continue her oestrogen replacement for so long. It is a common experience to find hot flushes disabling after long courses of oestrogen. These hormones should be used very sparingly, over a few months only, in the lowest possible dose compatible with reducing the symptoms to a reasonably acceptable level—not to banish them entirely. The success of therapy can be most simply estimated by counting the number of flushes occurring over a given period of time, aiming at perhaps 3-4 flushes during waking hours. Attempts should be made regularly to tail away the oestrogen dosage to nil.

Apart from oestrogen there is no direct way of controlling hot flushes. Sedatives, antidepressants, hypnotics, and simple psychotherapy may all help to make the symptom more bearable. There are the only forms of management available. As a practical policy here it is suggested that diabetes should be excluded and that one episode of superficial thrombophlebitis should not be accepted as a total contraindication to oestrogen therapy. The oestrogen of choice may then be restarted in minimal dosage to see the effect on veins and to get the number of flushes down to about 5-6 per day by very slight increases in the dose. Once this is achieved the dose should be reviewed monthly to try to stop treatment with oestrogen altogether. Other treatments should be dealt with in the same way after the oestrogen is eliminated in an attempt to wean her away from drug support.

Sleepiness When Driving

What advice should be given to a middle-aged man who has difficulty in keeping awake when driving? He has already had one accident from this cause.

A common cause of sleepiness at the wheel is the effects of medication—for instance, barbiturates and other psychotropic drugs, antihistamines, and hypotensive agents. Other causes are driving after drinking alcohol or immediately after a heavy meal, driving long hours at night when the patient is more used to being in bed, motorway driving with its attendant monotony, and petit mal. If these causes have been eliminated then the patient can be advised that whenever he feels drowsy he should stop his car in a safe place and take a short walk. However, as the patient has already had one accident, the possibility of narcolepsy cannot be excluded. If this is suspected then the patient should be advised not to drive.

Strength of Total Hip Replacements

Now that total hip replacement are done on comparatively young patients, how much strain can a prosthesis be reasonably expected to withstand? For instance, can a previously active middle-aged man return to squash, hiking and dinghy sailing with reasonable safety?

Total hip replacement is a very satisfactory operation but I do not believe it can be expected to stand up to the violence of active sport. In general it has been used for patients with a built-in mechanism to slow them down, for example, older people or those with generalized arthritis. Patients can often walk two or three miles in reasonable comfort at reasonable speeds but this is a little different to hiking. I think that squash and certainly sailing in a dinghy are certain to be a danger to the prosthesis. In any case the patient is most unlikely to be nimble enough to enjoy either of these activities. Total joint replacement is an immensely valuable procedure but it does not restore the patient to normal and the replacement is vulnerable to undue stress.

Contact Lenses

Are contact lenses suitable for people who require bifocal lenses? What special problems or difficulties are likely to arise in people who have not previously used contact lenses?

In general contact lenses do not fully answer the problem for those who require two-vision correction, such as is obtained with bifocal spectacle lenses. There are several forms of bifocal hard corneal lenses but the success rate varies considerably. The main reasons for failure are that special experience in fitting this type of lens is necessary, that all prescriptions cannot be dispensed in this form, and, furthermore, the manufacture of small corneal lenses of this type is technically difficult. There are some eye anatomical shapes and lid apertures which cannot be fitted with bifocal hard lenses of any type. This is particularly true for large prominent eyes. The alternative ways of achieving near vision while wearing contact lenses are the ordering of supplementary spectacles to be worn with the contact lenses when necessary, or for the non-dominant eye to be given a contact lens of near correction power. While this form of optical correction is not possible in spectacles because of the prismatic effects induced such problems do not arise when made in contact lens form.

With bifocal contact lenses or the reading contact lens in one eye the special problems that can arise are due to the additional thickness and size of the lens form. When bifocals are prescribed this can often be due to the use of a ballasted lens, not necessarily round, to maintain the lens in the same position, irrespective of eye movements. The reading portion is also necessarily very small, sometimes not larger than 2 to 3 mm. The use of one eye for near and the other for distance sometimes involves problems of binocular vision. Thus there are many problems associated with bifocal and other forms of multivision contact lenses. In aphakia, however, when corrected by suitable contact lenses some near vision is always possible, even without deliberate bifocal lens design.

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