

Notes and Comments

Desensitization to Procaine.—Dr. R. A. CAWSON (Department of Dental Medicine, Guy's Hospital, London S.E.1) writes: It is difficult to imagine how this problem can arise nowadays ("Any Questions?" 2 May, p. 1168). For dental purposes lignocaine is more effective than procaine and is not prone to cause hypersensitization. This is confirmed by Calnan and Stevenson,¹ who, like most dentists, find it to be a safe local anaesthetic. If for any reason lignocaine is not favoured, other newer local anaesthetics such as "citanest" (also unrelated to procaine) are worth a trial. One would have thought that procaine is relatively rarely used nowadays since better agents are available. The practical answer to the problem of hypersensitization to procaine therefore is simply to use another local anaesthetic.

It is sometimes forgotten that on the rare occasions when a patient complains of a reaction following a local dental anaesthetic this may possibly be an effect of a preceding application of a surface anaesthetic. The more effective of these agents contain amethocaine (a procaine derivative) which can certainly cause skin sensitization in dentists using them and could presumably cause other reactions in the patient. Finally, it may be asked whether "collapse" after administration of procaine was in fact a hypersensitivity reaction. It is possible that this may be so, but the usual cause of sudden loss of consciousness after a local anaesthetic is, of course, fainting. Incidentally, in two patients recently seen and who gave reliable histories of reactions strongly suggestive of reactions to a local anaesthetic it was not found possible to induce a reaction to the agents concentrated either on patch testing or injection.

OUR EXPERT replies: I agree with everything that Dr. Cawson has written, but he has not answered the question that was asked. Calnan and Stevenson's article referred to the various types of dermatitis arising in the dental profession, and specifically excluded reactions encountered in patients receiving anaesthetic injections. Lignocaine, which is now used in preference to procaine, may cause reactions in patients (Noble and Pierce).²

REFERENCES

- 1 Calnan, C. D., and Stevenson, C. J., *Trans. St. John's Hosp. derm. Soc. (Lond.)*, 1963, 49, 9.
- 2 Noble, D. S., and Pierce, G. F. M., *Lancet*, 1961, 2, 1436.

Mongolian Blue Spots.—Dr. A. HINCHLIFFE (Bristol 16) writes: In the answer to this question ("Any Questions?" 16 May, p. 1303) the expert states that the term refers to pigmentation in the skin of the lumbar or sacral region of the neonate. Recently, working in an obstetric unit for "Cape coloured" and African mothers in Capetown I observed the patches of blue skin pigmentation not only over the lumbo-sacral regions of the neonate but also (less frequently) on the limbs and in one case the forehead. The patches were apparently more common in the "coloured" neonates (who were of multiracial descent, rather than of immediate mixed parentage), but this was probably because they were more easily seen in these lighter coloured babies.

OUR EXPERT replies: Dr. Hinchliffe is quite correct in observing that the pigmentation in Mongolian blue spots is occasionally seen on the limbs or elsewhere. There do not appear

to be any reliable data on the different incidence of the pigmentation areas in the different types of racial admixture.

Action of Room-deodorizers.—Mr. D. W. PLAISTOWE (Industrial Manager, Airwick Limited, Slough) writes: Another answer to the one given ("Any Questions?" 7 March, p. 616) is provided by the principle on which "airwick" odour-counteractants work—that of odour pairing. The phenomenon of odour pairing may be found in the work of the Flemish scientist Henrick Zwaardemaker,¹ who published a report in 1895 in which he listed pairs of odours which had mutually odour-cancelling effects. Some of the pairs listed were cedar-wood and rubber, paraffin and rubber, rubber and wax, etc. In an earlier work E. Aronsohn reported² that the odour of camphor was cancelled by that of oil of juniper. Other independent investigators have since observed and reported evidence of this phenomenon. . . .

REFERENCES

- 1 Zwaardemaker, H., *Die Physiologie des Geruches*, 1895. W. Engelmann, Leipzig.
- 2 Aronsohn, E., *Arch. Anat. Physiol., Physiol. Abthlg.*, 1886, 321.

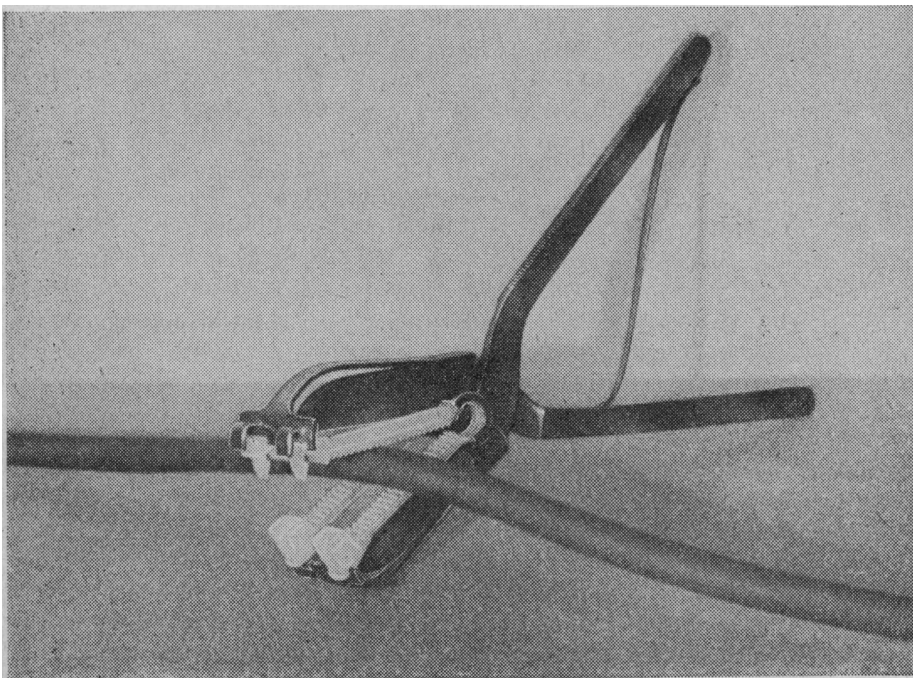
Correction.—We regret that in Sir Herbert Seddon's paper on "Volkman's Ischaemia" (20 June, p. 1587) in Fig. IV the top photograph is described as the state of affairs before correction of the contracture. In fact both photographs were taken after correction, one to show the hand open and the other showing it closed.

NEW APPLIANCES

Combined Umbilical Scissors and Cord Clamp

Dr. T. C. MAYER, of Ilford, Essex, writes: It is present obstetric practice at all deliveries, whether vaginal (with or without

forceps) or caesarean section, to clamp the umbilical cord in two places and cut between them with a pair of scissors. The clamps



usually used are pairs of Spencer Wells forceps or the new type disposable plastic clamps.

Such a series of actions is necessarily time-consuming at the very moment when valuable seconds could be spent in infant resuscitation or maternal haemostasis. This procedure can be reduced to one simple action by means of a combined instrument consisting of a pair of scissors that have clamps affixed to each side of the blades.

An instrument such as this has been used during the course of several months in my obstetric practice by midwives, who have found it satisfactory at all times.

The instrument as shown in the photograph consists of a pair of scissors the blades of which are kept apart by means of a spring strip between the handles. On each side of one blade is attached a hemispherical cup into which fits the hinged end of the clamp. Also to each blade is attached a T-shaped piece supported at the base of its vertical limb. The horizontal arms hold the free ends of the open clamp.

In the action of closing the instrument upon the umbilical cord the horizontal arms of the T-shaped member close the open clamps, the scissor blades simultaneously cutting between them. When pressure on the handles is released the instrument opens and the clamped foetal and maternal ends fall free from the hemispherical cups, since the clamps are no longer supported by the horizontal arms.

The instrument has been designed for use with disposable umbilical-cord clamps; further information may be obtained from Messrs. Chas. F. Thackray Ltd., Leeds 1.