# ANY QUESTIONS ?

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

## Site of B.C.G. Vaccination

**Q.**—*What are the clinical disadvantages of giving B.C.G. vaccine into the buttock?*

**A.**—B.C.G. vaccine is always given by the intradermal route, and the discomfort and irritation that would be produced by a chronic superficial local lesion in the buttock, together with the probability of local secondary infection, preclude the use of this site.

The optimum site for B.C.G. vaccination is in the deltoid region. When a less exposed site is required the vaccine can be given into the skin on the ventro-lateral aspect of the upper one-third of the thigh. This site should never be used in children under 2 years of age because of the risk of regional adenitis and occasionally abscess formation due to constant mild skin infection caused by irritation from wet napkins.[1 2]


REFERENCES

[1] Gaisford, W., and Griffiths, M., *Tubercle (Lond.)*, 1954, **35**, 7.

[2] *Bull. Wld Hlth Org.*, 1955, **12**, 143.


## Surgery for Hallux Rigidus

**Q.**—*What operative treatment for hallux rigidus will achieve the best results? What degree of disability is likely to remain and for how long is the patient prevented from walking?*

**A.**—Hallux rigidus should be treated by arthrodesis of the first metatarso-phalangeal joint. There should be no disability after a correctly carried out procedure, provided that the patient avoids exceptionally high-heeled shoes.

Walking can be allowed in a below-knee plaster after the wound has healed. Walking without plaster should be possible eight weeks after the operation if satisfactory fusion can be demonstrated.

## Prognosis in Rhesus Baby

**Q.**—*What would be the prognosis for a baby born of an Rh-negative mother in the following circumstances? The father is aged 40 and Rh positive CDe/CDe. The mother is aged 36 and Rh negative cde/cde. They have two children. The birth of the first in 1954 was uneventful. The second, born in 1957, required an exchange transfusion immediately after birth.*

**A.**—Since the father is homozygous for the D antigen all his offspring will be rhesus positive. Since the second child required exchange transfusion it is probable that subsequent children will be affected to at least a similar degree.

The prognosis and management of a third child can be gauged to some extent not only by the previous history of the mother but also by the titre of rhesus antibody in the mother's serum—the lower the titre using an antiglobulin test the better the outlook—and also by the level of bilirubin in amniotic fluid at about the 33rd to 35th week of pregnancy.

The recent development of techniques for foetal transfusion *in utero* as well as the judicious induction of premature labour have improved the outlook for badly affected infants. Thus it is very probable that a third infant in this case will be affected, but the prognosis cannot be assessed in the individual case without further information, which may become available only as pregnancy progresses.

## Sanitary Towels for Girls

**Q.**—*What is the best kind of protection for schoolgirls to use during menstruation? Are internal tampons advisable?*

**A.**—The best kind of protection to recommend for schoolgirls during menstruation is the wool sanitary towel with a comfortable and well-fitting sanitary belt. Towels should be changed frequently, and facilities should be available in all schools for the supply of fresh towels and the disposal of soiled ones.

Internal tampons have been shown to be harmless, and there is no doubt that many young girls use them. Indeed, provided there is no difficulty in inserting and removing them, and provided they are not neglected or left in too long, there seems no objection except emotional prejudice against young girls using them. They are particularly valuable towards the end of menstruation, when swimming and athletic sports may be indulged in.

## Reactions to Tetanus Toxoid

**Q.**—*Is there any danger in giving further prophylactic doses of (a) tetanus toxoid and (b) oral poliovaccine to schoolboys who do not know whether they have been fully immunized but in fact are so already?*

**A.**—Children are fully immunized against tetanus if they have had a primary course of three doses of tetanus toxoid with intervals of 6 to 12 weeks and 6 to 12 months respectively between the injections. They should have further reinforcing doses every 6 to 12 years or immediately after sustaining certain types of wounds if the previous reinforcing dose was given more than 12 months previously.

It may be considerably cheaper and administratively simpler to immunize all children in a school irrespective of their previous immunization history rather than inquire or search the records to find out which are already fully immunized. Nevertheless, this practice cannot be justified as being in the children's interests. Immunization against tetanus cannot be regarded as an absolutely reaction-free procedure. Admittedly, an immediate type of reaction resulting in general collapse within 5 to 10 minutes after injection is rarely encountered, but cases have been reported in Service men who suffered no ill-effects after previous injections of tetanus toxoid.[1] Local reactions, on the other hand, are frequently seen.[2] They consist of swelling around the injection site (sometimes involving the whole limb), induration, erythema, pain, tenderness, and regional adenopathy. These develop on the second or third day after immunization and reach a maximum by the fourth to seventh day. They may well be due to a mixture of Arthus-type reaction and delayed-type sensitivity produced by previous injections of tetanus toxoid.[3]

The problem of side reactions after tetanus toxoid is only a minor matter compared with the need for all persons to be actively immunized against the disease. Nevertheless, unnecessary and indiscriminate injections of toxoid to fully protected persons will lead to an increase in the incidence and severity of allergic reactions. If there is no evidence available to indicate whether a child has been previously immunized he should, of course, start on a primary immunization course. All immunized persons should be aware that they have been protected and be in possession of information to that effect.

Oral poliovaccine may be given to fully protected schoolboys without danger, except when a vaccine containing traces of penicillin is given to penicillin-sensitive persons.


REFERENCES

[1] Brindle, M. J., and Twyman, D. G., *Brit. med. J.*, 1962, **1**, 1116.

[2] Schneider, C. H., *Med. J. Aust.*, 1964, **2**, 303.

[3] Eisen, A. H., Cohen, J. J., and Rose, B., *New Engl. J. Med.*, 1963, **269**, 1408.


# Notes and Comments

**Oxygen and Premature Infants.**—Dr. R. M. FORRESTER (Consultant Paediatrician to the Royal National Institute for the Blind) writes: I should like to comment on your expert's views ("Any Questions?" 20 November, p. 1229) on oxygen and premature infants. Retrolental fibroplasia has not disappeared. At the Royal National Institute for the Blind we learn only about those cases referred for help by local authorities, but even we know of 41 authentic cases of retrolental fibroplasia with birth dates from 1955 onwards. The paediatrician in the premature unit has to tread a tightrope, but the dangers of a fall on either side should be recognized. Would it not have been more correct to say oxygen should be available for the treatment of all small premature infants rather than that it is essential for their treatment? Many of us here helped to raise very small infants without added oxygen or regrets.

**Correction.**—Dr. P. D. MARSDEN and Professor M. S. R. HUTT write: May we correct an omission in our paper, "An Investigation of Tropical Splenomegaly at Mulago Hospital, Kampala, Uganda" (*Brit. med. J.*, 1965, **1**, 89)? On p. 90 in the last paragraph of the second column the serum globulin is described as having a mean value of 2.74 g./100 ml. and the normal for Kampala out-patients is quoted as 1.86 g./100 ml. (figure supplied by A. G. Shaper and P. Leonard). Both these values in fact refer to the serum gamma-globulin, the word gamma having been inadvertently omitted.