should be regulated by the results. It should be maintained for several months after improvement and only gradually reduced. Attention should also be paid to diet and to ensuring an ample fluid intake.

Rash After Alcohol

Q.—*A healthy woman aged 35 has complained for the past four years of a blotchy, burning erythematous rash on both sides of the neck and, when severe, in the interclavicular area about 20 minutes after taking even minimal amounts of alcohol in any form. Rarely the rash may also be caused by emotional distress. Can anything be done to prevent this?*

A.—This may be purely an emotional reaction in which one of the trigger mechanisms to set it off may be alcohol. Such peculiar personal reactions are known to occur. However, a careful clinical overhaul and certain investigations may be indicated to exclude such disorders as Hodgkin's disease, carcinoid, phaeochromocytoma, and cholinergic reactions. All these upon occasion can be reactive to alcohol, giving itching or erythema and urticaria or pain. It may be necessary to consider the problem in that context, though it is not suggested by the little information given. Treatment generally calls for avoidance of the cause.

Rapid Onset of Pregnancy Toxaemia

Q.—*I understand that the onset of eclampsia can be rapid in about 15% of cases. Can toxaemia of pregnancy also be rapid in onset? I had a patient who five days before term and four days after her previous examination developed a retroplacental haemorrhage, a blood-pressure of 150/100, and urine loaded with albumin.*

A.—Any of the acute manifestations of toxaemia of pregnancy may develop very rapidly. Only about 50% of cases of accidental haemorrhage are known to have shown hypertension before the onset of this complication, although most of the severe examples belong to this group. It is for this reason that pregnant women should not only be examined weekly from the 34th week but should also be warned about abnormal symptoms that may betoken the development of complications, and asked to report their occurrence to their doctor at once.

Myxoedema After Oophorectomy

Q.—*A woman aged 49 had a hysterectomy and bilateral oophorectomy for menorrhagia. Six months later she developed acute myxoedema, which has responded to thyroid therapy. Is this a recognized complication or is it coincidental?*

A.—Myxoedema is not a recognized complication of hysterectomy and oophorectomy, and it should be regarded as most probably coincidental. However, the development of some degree of hyperthyroidism after oophorectomy is a distinct possibility, as a result of the removal of the inhibitory influence on the anterior pituitary of the ovarian hormones. It may be that in the patient referred to an unnoticed phase of hyperthyroidism has been replaced by one of hypofunction due to exhaustion atrophy.

Physiotherapy in Chest Diseases

Q.—*At what stage in the course of uncomplicated lobar pneumonia and bronchopneumonia ought breathing exercises and physiotherapy to be given? What form of physiotherapy, apart from breathing exercises, ought to be given? In collapse of lung, bronchiectasis, and immediate post-operative chest cases ought physiotherapy, postural drainage, and breathing exercises to be administered routinely from the start?*

A.—In the treatment of uncomplicated lobar pneumonia and bronchopneumonia the patient should be encouraged to perform breathing exercises and to cough at the earliest possible moment. After the acute phase vigorous physiotherapy—i.e., postural drainage, percussion, and vibrations—are added to clear the secretions and to help regain full expansion of the affected lung. In collapse of the lung and bronchiectasis, postural drainage, percussion, and breathing exercises are begun immediately. The patient should learn the drainage positions and practise them at home. Thoracic cases requiring surgery should have pre-operative as well as post-operative breathing exercises, and if necessary postural drainage.

Polymyositis

Q.—*What is the treatment for polymyositis and what is the prognosis?*

A.—Polymyositis is of several different sorts, and in a middle-aged man with a skin rash a rigorous search should be made for neoplasm. In the idiopathic type corticosteroids have been used with a certain amount of success, and some people have claimed that anabolic steroids in addition to prednisolone may tide the patient over the crises. In many instances, particularly in children, the disease runs a self-limited course, and it is important to prevent contractures by adequate splinting during the acute stage. It has also been claimed that chelating agents (EDTA) are useful. In the generalized form without skin lesions the prognosis is, generally speaking, worse, and death may ensue either from general weakness and inanition or from heart failure.

NOTES AND COMMENTS

Ganglion-blocking Drugs and Impotence.—Dr. R. H. JOBSON (Presteigne, Radnorshire) writes: With reference to this question and answer (" Any Questions, February 4, p. 374) might I point out that this unfortunate side-effect does not seem to occur when guanethidine is employed? My experience is limited, but its use in conjunction with mecamylamine would seem to be distinctly helpful. The guanethidine also counteracts the constipating effect of the mecamylamine.

OUR EXPERT replies: There is a good deal of truth in Dr. Jobson's comment, but this does not alter the fact that some interference with sexual function is part of the price that has to be paid for adequate control of severe hypertensive disease. Guanethidine is not a ganglion-blocking agent but a drug which selectively inhibits peripheral sympathetic nerve endings, and it therefore interferes with ejaculation rather than with erection. Consequently patients on guanethidine are less likely to complain of failure of sexual function than those who are receiving one of the ganglion-blocking agents such as pempidine or mecamylamine. It has, however, been my experience, and this is confirmed by others,[1] [2] that many patients with severe hypertension who are given sufficient guanethidine to reduce their blood pressure to reasonable levels are conscious of failure of ejaculation. As Dollery and his colleagues say,[2] " Some unfortunates exchange impotence with ganglion-blocking drugs for failure of ejaculation with guanethidine."

REFERENCES

[1] Leishman, A. W. D., Matthews, H. L., and Smith, A. J., *Lancet*, 1959, **2**, 1044.

[2] Dollery, C. T., Emslie-Smith, D., and Milne, M. D., ibid., 1960, **2**, 381.

Correction.—The caption to Fig. 6 in the article on fistula-in-ano by Mr. A. G. Parks (February 18, p. 463) should have read: " A segment of the *internal* sphincter . . ."

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