

he states that I have attempted "to divorce it (the thalamic dysfunction syndrome) . . . from environmental factors"; whereas in my paper I stated clearly that "the thalamic dysfunction state may be regarded as a response of the organism to stresses of various kinds" (i.e., environmental stress, conflicts, toxins, and so on).

With regard to his remarks about the morphine and cocaine addiction syndromes, if Dr. Kirman were to go to the trouble of consulting any of the standard psychiatric textbooks dealing with the subject, he would find it stated that alkaloid addiction differs in a number of important respects from alcoholism. This last-named toxin, incidentally, is a cortical depressant rather than a true euphoriant of the type described in my article, in addition to being chemically and pharmacologically unrelated to the agents under consideration. Finally, while admitting "the limited value of present methods" (i.e., of psychiatric treatment), he is apparently unable to suggest any alternative or more effective form of treatment than that suggested in my article. In other words, his criticism is the purely destructive kind which questions everything but decides nothing, containing not one single constructive contribution to the problem under discussion. I should, of course, welcome any constructive suggestions or comments on the new concept of affective disorders put forward in my paper and the pharmacotherapy of these conditions. But it is a pity that Dr. Kirman did not take the trouble to read the paper through properly before erupting so impulsively into print.—I am, etc.,

London, S.E.6.

G. TAYLEUR STOCKINGS.

Bornholm Disease in the Tropics

SIR.—Only a few weeks before the outbreak of Bornholm disease at Aden described by Drs. W. M. Jamieson and D. M. Prinsley (July 12, p. 47) there was an outbreak of an unusual nature in a Naval barracks at Singapore (June, 1946). The distinctive features were as follows: (1) It was larger than any recorded to my knowledge (over 100 cases). (2) It was explosive—more than seventy of the cases occurring in the first twenty-four hours. (3) It was sharply limited to European ratings in the Naval establishment concerned, the majority of cases occurring among men who fed at one end of a mess hall, but who worked and slept in different places over a wide area. (4) The primary lesion appeared to us to be in the parietal pleura, and in several cases a well-marked pleural rub ensued. Features 2 and 3 do not seem consistent with a contact infection, and contamination of food was suspected, possibly by flies. Otherwise signs, symptoms, course, and complications were as normally described.

There had been an outbreak of poliomyelitis at Singapore earlier in the year, during which a few civilians admitted to the fever hospital were regarded as probably suffering from Bornholm disease, but previously this does not appear to have been recognized in Malaya. A Dutch colleague, however, stated that he was familiar with the symptoms in sporadic cases in the Netherlands East Indies.

I was recalled to U.K. before our outbreak had entirely subsided, but a colleague remained to follow up the cases and we intended to produce a joint report for publication on his return. Unforeseen circumstances have so far prevented this partnership from delivering the goods.—I am, etc.,

Milsted, Kent.

J. VINCENT SMITH.

The "Costoclavicular Syndrome"

SIR.—The greatest number of cases complaining of this condition are women, and the production of minor degrees of this condition may be by the shoulder strap of the brassiere. I have had three such cases in recent months, in which symptoms have been functionally relieved by doing away with the shoulder strap. The present passion for "uplift," no doubt encouraged by film stars, is not without its physical disadvantages.—I am, etc.,

Sunderland.

W. GRANT WAUGH.

What is Folic Acid?

SIR.—In the article by Prof. L. S. P. Davidson and Dr. R. H. Girdwood entitled "Folic Acid as a Therapeutic Agent" (May 3, p. 587) it is stated that free folic acid is pteroylglutamic acid, and in its conjugated form is pteroylheptaglutamic acid. Your leading article (p. 604) stated, "Folic acid does not occur

free in foods but as a conjugate with hexaglutamic acid, known as pteroylhexaglutamylglutamic acid. . . ." Wilkinson *et al.* in their article in the *Lancet*, 1946, quoting from Angier *et al.* (1946), hold that synthetic folic acid is a compound of 2-amino-4-hydroxy-6-methyl pteridine and *p*-aminobenzoylethylglutamic acid.

There seems, therefore, to be a difference of opinion as to what folic acid really is, both in its free and conjugated form.—I am, etc.,

Dublin.

ALFRED R. PARSONS.

REFERENCES

- Angier, R. B., *et al.* (1945). *Science*, **102**, 227.
— (1946). *Ibid.*, **103**, 667.
Wilkinson, J. F., *et al.* (1946). *Lancet*, **2**, 156.

Hypertrichosis of the Lanugo Hair in Malnutrition

SIR.—With reference to Lieut.-Col. S. K. Roy's very interesting letter on achromotrichia in tropical malnutrition (March 22, p. 392), I should like to be permitted to call attention to a little-known condition also found in some cases of malnutrition, especially in children—viz., hypertrichosis of the lanugo hair.

This condition generally affects the lanugo hair of the legs, especially the extensor surfaces. The hair becomes much thicker, longer, and at times darker. It is often seen in times of war in children who, used to an abundant, well-balanced diet, have been placed suddenly, for reasons of necessity, on an insufficient diet particularly poor in animal proteins and fat. On giving the child again a proper diet the condition rapidly ameliorates and finally disappears.

It is interesting to note that the condition is well known to women of the working classes in the South of Europe. A woman who, for reasons of work or some other reason, has put her children in charge of neighbours or relations, will often complain on her return home that the children have not been well looked after and have been starved, "as shown by the thick hair on the children's shins."

The subject of lanugo hypertrichosis in general, as well as lanugo alopecias, is an interesting one, but is beyond the scope of this letter. I might mention, however, a peculiar form of lanugo hypertrichosis of the arms and legs which occurs in certain individuals every summer (summer lanugo hypertrichosis), in others (very few) every winter (winter lanugo hypertrichosis). The subject has been dealt with briefly in my little book *Diseases of Africa* recently published (Apollon and Co., Rome).—I am, etc.,

Lisbon.

ALDO CASTELLANI.

Treatment of Hydrocele by Injection

SIR.—For many years several sclerosing substances have been used in the treatment of hydroceles with varying results. In a recent follow-up of patients suffering from hydroceles treated at this hospital in 1944, 1945, and 1946, 46 patients have been treated by injection of quinine urethane. Six patients have not been traced. Of the 40 patients traced all (with the exception of one still under treatment) have been successfully treated. Some of those treated have had hydroceles of long standing, some had previously been treated by repeated aspirations, and nearly all attended hospital seeking operative treatment. The average age of patients is 55 years, the youngest being 38, the oldest 68.

TECHNIQUE

The technique used is of the simplest kind and could be carried out in a doctor's surgery using ordinary aseptic precautions. The patient lies on the operating table, the scrotum is exposed, and the portion of the skin to be punctured is sterilized with either spirit or iodine. With a 20-ml. syringe and a size 24-in. (6.3-cm.) 18 B.W.G. bored needle the hydrocele fluid is aspirated, the utmost care being taken that the point of the needle does not injure the testicle. When all the hydrocele fluid has been withdrawn the syringe is removed leaving the needle *in situ*, the greatest care being taken that the point of the needle remains within the hydrocele sac. 1-2 ml. quinine urethane (already loaded in a 2-ml. syringe) is then introduced and the needle withdrawn. In the majority of patients little or no pain is experienced. In sensitive patients a small wheel of local anaesthesia is used where the needle is to be introduced.

The patient is again seen in a week or a fortnight's time. The local reaction varies in different patients. In some it has been necessary to aspirate when the reaction has been severe. In six patients it has been necessary to repeat the injections, in four patients the injection has been repeated twice. Patients are seen at intervals as required until the treatment has been completed. When the treat-