each one had one session of hydrocortisone therapy. All have shown marked symptomatic improvement which began a few days after the injection. In the case of the patient with the shortest history of the condition the result was dramatic. On admission to hospital she was passing urine every 30 to 45 minutes during the day and night. Other methods of treatment in the preceding two years had produced amelioration of symptoms for a few days only. For four months after the hydrocortisone injection she micturated every two to three hours during the day and once or twice at night. Recently there has been a gradual recurrence of the original complaint.

The total duration of the remission produced by hydrocortisone is not known, but it is to be expected that, when symptoms recur, further infiltration will again be effective, as is the case with other chronic inflammatory conditions. The results obtained with these patients would appear to justify a more extended trial of local hydrocortisone for Hunner's ulcer, especially in the early case before diffuse fibrosis has developed. Since this investigation began Schulte and Reynolds (1956) have reported satisfactory results of a similar technique using hydrocortisone and hyaluronidase.

I am grateful to Professor Charles Wells for his encouragement and for permission to carry out this procedure.

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OBSERVATIONS ON THE FOOD HABITS OF MYOPIC CHILDREN

BY

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In the course of an inquiry into the development of myopia in children, which included questions about their diet, I was struck by the number of children who have rigid likes and dislikes of certain foods to the extent of consistently refusing some items.

The main sources of first-class protein are milk, cheese, meat, fish, and eggs. Over a period all the children attending a school clinic for refraction were asked whether they consistently refused one or more of these foods. The refusal to take milk as such or as a mainly milk drink was counted as an absolute refusal. It is interesting in this connexion to find a number of children who refuse their school milk—thereby providing others with a double or sometimes treble portion.

It was possible to divide the children into groups of myopes who were rapidly deteriorating, slowly deteriorating, or stationary. A fourth group consisted mainly of hypermetropes with a few emmetropes.

Results

Tables I, II, and III show that myopes are more fussy about some of their food than other children. This was noted as a generalization by Miller (1940), though not in rela-

TABLE I.—Refusals of Protein Sources

	Active Myopia Rate > 1 D per Annum		Active Myopia Rate 1 D per Annum		Stationary Myopia		Others	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
No.	9	26	42	59	27	49	73	76
No. of refusals . . .	5	17	20	30	12	22	18	32
Refusals per head . .	0.55	0.65	0.47	0.50	0.44	0.45	0.24	0.42

TABLE II.—Percentage of Children Refusing Protein Sources

	Myopes (264)	Others (149)
Refusal of milk	16%	5%
" " cheese	18%	14%
" " meat	3%	4%
" " fish	12%	8%
" " eggs	4%	2%

The percentage figures shown in the different categories are not mutually exclusive.

TABLE III.—Percentage of Children Refusing Two or More Sources

	Active Myopes	Stationary Myopes	Others
No.	136	128	149
Percentage refusing two protein sources	11	7	5

tion to these particular items. With increasing fussiness there is an increase in the activity of the myopia. The boys with highly active myopia show a refusal rate more than twice that of boys who are not myopic, and the girls a rate over 50% higher. Double refusals are twice as frequent amongst active myopes as amongst others.

That girls are more particular than boys about their food is well known, and in all these groups this is confirmed, though it is small in stationary and slowly deteriorating myopes. Though the rate of refusal is higher in girls than in boys in each group, it does not equal the rate of refusal for boys in the next group with a higher rate of myopic change.

Between the ages of 8 and 17 the refraction of girls changes more often than that of boys (Brown, 1938). My own figures agree substantially with this observation. The Chart shows the mean proportional changes in refraction per annum of male and female myopes aged 8 to 16. Between the ages of 9 and 13, and again between 14 and 16, myopia in girls increased at a faster rate than in boys.

Proportional change in refraction of myopes per annum.

The percentage refusing a particular source of protein do not provide any conclusive information. The most striking difference is in milk consumption. Over three times as many myopes refused milk as others.

Conclusion

It must not be concluded that myopia in children is associated dietetically exclusively with a different pattern of protein consumption, still less with a deficiency in the accepted sense of the word. There is evidence (to be published later) that other food factors are implicated, and in most individual cases the food pattern is in no way basically abnormal even though the myopia may be increasing rapidly.

Before coming to a conclusion on the exact significance of these findings, the unusual growth of myopes (Gardiner, 1954, 1955) must be linked with more detailed dietary intakes (to be published). None the less, the positive finding in this investigation is that myopic children are more particular about their sources of first-class protein than other children. There is an indication that this may be connected with their

myopia because girls are more prone to pick and choose than boys and because the more active the myopia the higher the rate of refusal per head.

Summary

The refusal rates of items of first-class protein are shown to be higher in myopic children than in other children.

It is debatable whether this is connected with their myopia.

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Medical Memorandum

Dissecting Aortic Aneurysm Presenting as a Cerebral Catastrophe

It is a well-known fact that a dissecting aneurysm of the aorta can present in many guises, and neurological symptoms and signs are by no means rare. More commonly, however, it is the spinal cord and the pelvic nerve plexuses which are affected, and thus a flaccid paralysis involving one or both lower limbs is a more familiar picture in these patients.

The following case emphasizes that aortic aneurysm can closely mimic apoplexy or subarachnoid haemorrhage.

CASE REPORT

A collier aged 54 had enjoyed good health all his life until at 2 a.m. on September 30, 1954, while working on night shift in a coal-mine, he suddenly collapsed, became unconscious, and was admitted to hospital in deep coma. His blood pressure was 160/90 mm. Hg. The left pupil was larger than the right, all abdominal reflexes were absent, and there was a bilateral extensor plantar response. He had a left-sided hemiplegia, more marked in the face and arm than in the leg. The cerebrospinal fluid was clear, under normal pressure, contained 1 lymphocyte per c.mm., and 55 mg. of protein per 100 ml.; the globulin was slightly increased. Both the Wassermann reaction and the Lange colloidal gold curve were negative. Thirty-six hours after admission he regained consciousness, although weakness of his left arm and the left side of his face persisted for a further three days. By the evening of October 5 he felt much improved. At no time did he complain of any pain in his chest. At 10 p.m. he suddenly collapsed in bed and died almost instantaneously.

Necropsy Findings.—A dissecting aneurysm of the thoracic aorta was revealed. There were two large rents in the intima, measuring 17 and 10 mm. respectively, situated about 2 cm. above the aortic valve. From that point dissection had taken place upwards along the arch of the aorta as far as the origin of the left subclavian artery. The dissection had extended upwards into the innominate, the left common, and, to a less extent, the left subclavian artery. The innominate artery was partially, and the left common carotid artery almost completely, obstructed by prolapse of media and intima into the lumen of the vessel due to pressure of blood clot. Finally, dissection had also extended downwards and burst into the pericardial sac, which contained 600 ml. of partially clotted blood. There was widespread atheroma of the thoracic aorta with ulceration of the intima in two places. The heart showed a moderate degree of left ventricular hypertrophy, and there were numerous fatty plaques of atheroma in both coronary arteries. The abdominal aorta likewise contained atheromatous patches, but there was no ulceration. The lungs

and abdominal viscera were congested. The brain and meninges showed no demonstrable disease. A Kahn test of the blood obtained after death was negative.

COMMENT

Shennan (1934) produced a very comprehensive review of altogether 300 cases of aortic aneurysm, including 17 cases of his own. He quoted a total of nine cases with cerebral symptoms due to compression or thrombosis of one or both common carotid arteries. Since then several excellent papers have been published on the subject. Weisman and Adams (1944) described 11 cases of dissecting aneurysm with neurological complications. Most of these cases presented with a flaccid paralysis of one or both lower limbs due to occlusion of the common iliac arteries. Only one of their cases showed blockage of one of the carotid arteries; this patient had presented with mental confusion and dysphasia, but not hemiplegia. Baer and Goldburgh (1948) found hemiplegia due to occlusion of one of the common carotid arteries in 2 out of 44 cases of dissecting aneurysm. MacCuish (1953) described a patient who, like the present case, showed sudden coma and hemiplegia as the presenting features.

The comparative rarity of cerebral symptoms in these cases, though dissection commonly extends along the whole course of the aorta, is attributed by Weisman and Adams to the good collateral circulation produced by the circle of Willis. In the present case both the innominate and left carotid arteries were partially occluded; this may account for the severity of the cerebral signs. Partial recanalization of the innominate artery and establishment of a collateral circulation via the vertebral arteries may explain why our patient recovered consciousness and why his hemiplegia gradually wore off until eventually he died owing to rupture of the aneurysm into the pericardial sac.

Schnitker and Bayer (1944) seek the origin of dissecting aneurysm in a localized patch of medial degeneration and not in a primary defect of the intima, as is thought by many. The aetiology in the present case, however, was almost certainly atheromatous; the presence of plaques of atheroma in the aorta, the patient's age, and the negative serological tests all support this view.

A very unusual feature of the case under discussion was the complete absence of pain in the chest, which has been described as the first symptom in practically all the hitherto published cases. A correct ante-mortem diagnosis was thus rendered even more difficult in the present case.

My thanks are due to Dr. C. W. Healey, under whose care the patient was admitted.

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Two food taboos encountered by the East African Medical Survey during a survey of the dietary pattern in Kwimba District, Sukumaland, are described in the *Annual Report of the East African Council for Medical Research 1954-5*. Two series of observations were made during the survey, the first in August, September, and October, the second in March and April, on account of the seasonal rains. Dr. H. Trant led the team. The taboos concerned a "mud" fish and goats' milk. Dr. Trant notes: "The former is not eaten at all by women and the latter is used only for newborn babies as a first day's food. Very occasionally a small boy herding goats may take a drink of milk, but if this is known he is always held up to derision. One authority has suggested that this is really a 'snob' prohibition which came into common custom at the time when the people concerned started to own cattle."