Questions and Answers

Is Topical Ether Therapy Effective for Herpes Simplex?

Q Recurrent fever blisters precipitated by such conditions as solar exposure and the common cold are a bothersome problem, and effective treatment would be a boon. Albert Sabin, MD, some time ago cited the effectiveness of ether as the best topical therapy for herpes simplex discovered to date. However, it is virtually impossible to obtain ether in quantities or in a container suitable for home use. In a recent QUESTIONS AND ANSWERS (*JAMA* 235:1059, 1976), fluorohydrocarbons, specifically trichlorotrifluoroethane, were said to be virtually identical to ether in their topical effect on the skin and were available in 120-ml containers. Is this substance as effective as ether in the treatment of herpes simplex?

G. A. SCHUMACHER, MD
Burlington, Vt

A I never "cited the effectiveness of ether as the best topical therapy for herpes simplex discovered to date." In my editorial on the "Misery of Recurrent Herpes: What to Do?" (*N Engl J Med* 293:986, 1975) and in a subsequent reply to various letters (*N Engl J Med* 294:339, 1976), I stressed only the need for a properly controlled study of the effectiveness of ether because (1) it has been reported to give good results in patients, and (2) as a penetrating lipid solvent, it could inactivate herpesviruses by acting on the lipid-containing envelope of the virus rather than on the nucleic acid in its core. In my reply to subsequent correspondence, I said that it is highly probable that some other lipid-solvent drugs such as chloroform, acetone, and ethyl chloride may have comparable effects. I have no personal knowledge of trichlorofluoroethane (*JAMA* 235:1059, 1976) and can express no opinion as to whether it would have the desirable virus-killing, skin penetrating, and local anesthetic properties of ether. I see no reason why a physician cannot supply a screw-capped or cork-stoppered vial containing 30 to 60 ml of ether directly to the patient.

ALBERT B. SABIN, MD
Medical University of South Carolina
Charleston

When Can Patients With Genital Herpes Resume Sexual Activity?

Q I advise patients with genital herpes to refrain from sexual activity from the time they note the initial erythema until complete reepithelialization of the ulcerated area occurs. This recommendation is based on my assumption that herpesvirus can still be recovered from the sites of the lesions even though the ulcerations appear healed. When does a patient become free of the herpesvirus and, presumably, able to resume sexual intercourse?

FREDERICK A. PEREIRA, MD
Rochester, NY

A Your advice to your patients is sound. We have isolated herpesvirus from swabs of vulvar epithelium even before erythema is noted. This has been possible from a few patients who subjectively note a change in sensation of the skin area that will ultimately acquire vesicles and ulcerate within 24 to 48 hours.

We have not followed the time course of virus shedding until ulcerations heal; therefore, I am unable to state when a patient will become virus free. However, based on our experience of positive virus isolations prior to lesion development, I would guess that virus may be present until complete reepithelialization. In addition, we have obtained positive virus isolations blindly by swabbing the vagina in some patients with vulvar and perineal lesions. Whether there were microscopic lesions in the vagina at some different stage of development was not known. It is possible that lesions at any stage of development may be present high in the vagina and remain asymptomatic. Therefore, I would prefer to see that all known lesions are healed before suggesting that the patient is no longer infectious to the other partner. Another useful suggestion is to use condoms during intercourse, particularly for lesions that are healing on the shaft or glans penis. This should prevent contact with infectious virus.

MARVIN S. AMSTEY, MD
University of Rochester School of Medicine and Dentistry
Rochester, NY

Headache Associated With Barometric Pressure Change

Q Our locality, which has an altitude of 1,500 m, is subject to frequent, abrupt barometric pressure changes. Some patients seem to be extremely sensitive to these changes, as suggested by the headaches they have concomitantly that are moderately severe, usually bilateral and frontal. The headaches disappear with weather stabilization or a return to earlier pressure. Some get relief with drainage from the nose. Have other clinicians seen this reaction? What treatment is suggested?

FRANK E. ROBERTS, MD
Reno, Nev

A You do not make it clear just what form of headache you are describing, but since the headaches are severe, I will assume they are vascular or migrainous. Vascular headache is a prominent symptom, often acute, in mountain sickness, but it usually requires an exposure to altitudes of 2,400 m or above before mountain sickness appears. The headache associated with mountain sickness is aggravated by head movements, particularly coughing or straining or head jolts, suggesting intracranial as well as extracranial vasodilation. It is not the immediate result of hypoxia and does not respond quickly to oxygen, but the symptoms are probably related to vasodilation, brain edema, and anoxia. Some diuretic agents have proved helpful in this situation. It has also been reported that intake of cold fluids and carbohydrates may have a protective effect.[1]

I have made some observations on effort migraine,[2] which is more frequent at high altitude or when temperature and humidity are high. It is recognized that lack of training is a major precipitating cause of effort migraine. One might speculate that your patients are predisposed to some form of effort migraine by virtue of their chronic ex-

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posure to high altitude.

Finally, several European and Israeli investigators have noted changes in headache patterns associated with barometric pressure. I have always assumed that these represent nonspecific stimuli to the vasomotor system, altering vasomotor tone, and acting as a headache trigger. Your description of nasal drainage suggests that this may also be the case in Reno. Therapy with medication such as cyproheptadine hydrochloride (Periactin), 4 mg three times daily, which tends to interfere with the actions of vasoactive amines, may be helpful.

DONALD J. DALESSIO, MD
Scripps Clinic
La Jolla, Calif

1. Appenzeller O: Altitude headache. *Headache* 12:126-129, 1972.
2. Dalessio DJ: Effort migraine. *Headache* 14:53, 1974.

Transient Ocular Muscle Imbalance in Middle-Aged Woman: Differential Diagnosis

Q A few weeks ago on awakening one morning, a 48-year-old woman noted double vision in the left eye only. Within two hours the double vision disappeared, but for a short period thereafter, there was blurred vision in the eye with drooping of the upper lid. Tests done that afternoon showed 20/30 vision in the left eye with correction and 20/20 in the right eye. No scotoma or distortion of vision was evident. The next day left eye vision had improved to 20/25, but the patient noted persistent mild blurring of vision. Examinations by a retinal specialist and a neurologist were within normal limits. The patient did not have brain scans or skull roentgenograms. There is no history of trauma, and results of a recent physical examination were normal. At present her vision is no longer blurred, and left eye visual acuity remains at 20/25. I am assuming that it originally had been 20/20, though I had not seen the patient before this episode. What is your consultant's opinion regarding diagnosis and further studies?

MD, Pennsylvania

A The symptom of double vision usually indicates imbalance of synergistic movements of the two eyes. In your patient, however, there is some confusing information. Monocular double vision, ie, double vision seen out of one eye alone, is secondary to intrinsic ocular disease, related to abnormalities of the cornea, lens, or retina. The difficulty arises in history taking. When patients complain of double vision in "the left eye only," they have often not checked by occluding one eye at a time. Most often they conclude that the double vision is in "the left eye" because it is most prominent in left gaze. However, in your patient, there was noticeable drooping of the lid, and her symptom of blurred vision may, in fact, represent only resolving double vision. It becomes rather critical to know whether this double vision was, in fact, strictly monocular or double vision noted to be greatest on left gaze associated with a left ptosis.

The differential diagnosis of transient ocular muscle imbalance, therefore, should include disorders of the ocular muscles due to thyroid ophthalmopathy, disorders of the myoneural junction, such as myasthenia gravis, disorders affecting cranial nerves III, IV, and VI, and disorders intrinsic to the brain stem's central mechanisms of ocular control. It is only through establishing an anatomical localizing diagnosis that one can even speculate on etiology,[1] and I would have to make a number of assumptions.

However, on face value, a two-hour episode of double vision associated with mild drooping of the lid and mild discomfort in the eye that goes into spontaneous and complete remission may be the first sign of myasthenia or a cranial neuritis and inflammatory disease or even neoplasm. The subsequent course of illness should help to define the cause. Roentgenograms of the sinuses and polytomes through the parasellar area should be obtained for the sake of completeness.

NORMAN J. SCHATZ, MD
Wills Eye Hospital
Philadelphia

1. Schatz NJ: NOAO *Symposium on Neuro-Ophthalmology*. St Louis, CV Mosby Co, 1976, vol 8, pp 79-83.

Lecithin for Hyperlipemia: Harmless but Useless

Q Some of my patients consume lecithin daily because they have seen reports in the lay press that it is effective in the prophylaxis and treatment of hyperlipemia. Is there scientific evidence to support this theory?

FRITZ F. BLUMENTHAL, MD
Middleton, NY

A Lecithin has been touted by the health food industry as effective in lowering serum cholesterol levels and preventing heart disease. There is no scientific evidence at this time to support either of these contentions. Moreover, this substance is not an essential nutrient in man, as it is synthesized within the body in adequate amounts. Lecithin can be ingested with safety in reasonable amounts, but there is no nutritional or medical reason for supplementation of the diet with it.

DEAN C. FLETCHER, PHD
Washington State University
Pullman

Q&A LOG.—*A periodic listing of unpublished questions selected from the thousands received annually from physicians by the American Medical Association. All receive a direct mail reply, those listed below from the AMA resource indicated.*

Question	Inquiring Physician
Library and Archival Services (Processed by research staff with MEDLINE assistance. Photocopies of source documents are available for a nominal charge.)	
Applications of serum carotene test	MD, Pennsylvania
Patent ductus arteriosus: Causative factors	J. Grossman, Mountain Home, Tenn
Ondine's curse	S. Mamick, Welch, WVa
Rebuttal for religion-based blood transfusion refusal	J. Thomas, Greensburg, Pa
Chronic appendicitis: Diagnosis	MD, Michigan
Zinc therapy of benign prostatic hypertrophy	A. Sobul, Federal Way, Wash
Neonatal acne vulgaris	G. Gorlick, Los Angeles
Metal clips in bilateral partial tubal excision	D. Gibbs, Cortland, NY
Scoliosis: Causes and therapy	C. Levein, Brooklyn, NY
Medical uses of biofeedback	E. Frank, Los Angeles
Incidence of colon cancer after incidental appendectomy	F. Brigham, Comfort, Tex
Causes of iritis	D. Jennings, Williamsport, Pa