MISCELLANY

OF

THE TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION

(REGISTERED)

APRIL 1935

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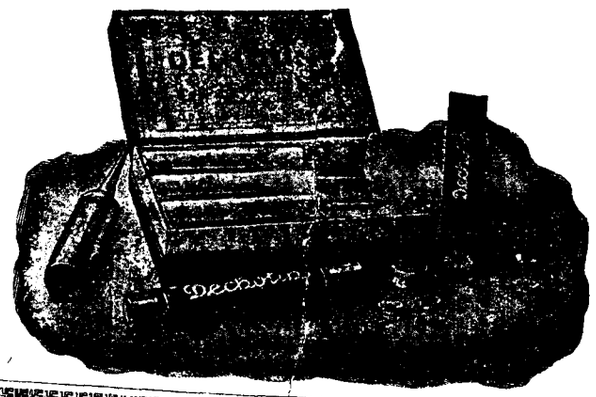

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ECZEMA.

The term Eczema is often very losely employed even by skin specialists and the modern tendency to call it by the general name 'Dermatitis' is equally vague. Like many other skin diseases eczema has its own peculiar clinical characteristics, by which it must be distinguished from other skin diseases. It consists of circumscribed areas of small or large extent which are slightly raised, dull red in colour and studed, sometimes closely, sometimes sparsely, with pinhead-sized crusts or with weeping points. On pinching up these areas between the finger and thumb, they are found to be two or three times the thickness of the surrounding normal skin. It is this thickness of the skin which is the most characteristic and distinctive feature of eczema and one which helps most to distinguish it from other forms of dermatitis. The weeping points or the small adherant crusts are also essential.

Redness is common to all forms of Dermatitis, but eczema, can be differentiated from the flat-topped papule of lichen planus, the silvery-scaled patch with bleeding points on scrapping of psoriasis, the apple-jelly nodule of lupus vulgaris, the dull-red stippled patch of lupus erythematosus, and the burrow of scabies, by the thickness of the skin. Patches of eczema give rise to burning, tingling, and itching, which are agravated by irritation especially scratching and cause weeping.

In infants the red swollen areas with weeping pin-points are often seen on the cheeks, forhead and chin and in advanced cases, on the limbs and trunks, particularly in the bends of elbows and knees. In adults they are often symetrical on the arms and legs with patches on the face, trunk, hands and feet. They may also be limited to the scalp, aural region, or the scrotum. In typical cases the three main features (*i. e.*) redness, swelling and pinhead oozing are clearly seen.

Eczema is not a hereditary disease nor is it caused by disturbed metabolism but is invariably the result of an irritant. The irritant may be very mild and does not affect ordinary skins.

Eczema can be cured if it can be merely protected from local irritants or from scratching and even from too assiduous cleaning of the area, but dressed with lead lotion during the weeping stage and dusting powders during the scaling period.

(Clinical Journal April '35)

Autotransfusion for Puerperal Mastitis.

The orthodox method of treating this condition has been by supporting the breasts with bandages and applying Icebag. The method has been quite satisfactory except that it takes some time to relieve the condition. To hasten recovery Autotransfusion is the method of choice. Blood from the patient's vein is taken and put in directly under the gluetus muscles. The course of treatment recommended is three injections at intervals of 12 hours each, the quantity being 20, 40, and 60 CCS respectively, but it looks that smaller doses (10 to 20 CCS) are often adequate. If further injections are required 3 to 5 CCS are sufficient. Bandaging and Icebag may also be applied to keep the patient comfortable.

(From the Clinical Journal April '35)

Simple Remedies for some Lung Diseases.

Maurice Davidson states that one of the simplest and most effective remedies for the type of cough associated with dryness of the Pharynx and Fauces and sticky mucus in the upper air passages, is a combination of Soda Bicarb and Sodi Chloride, the action of which is greatly helped by taking a hot drink immediately afterwards.

He also advices good Brandy in the treatment of pneumonias and would rely on it were he restricted to one drung only for that group of diseases. It is interesting to note, he also recommends ice-cream, *ad libitum* a treatment which he finds especially useful in children (In India we might prefer the Ice-Cream to Brandy reserving the later for crisis or collapse. Ed.)

Intravenous Charcoal for suppurative conditions.

E. St. Jacques, of Montreal, describes the use of charcoal in various suppurative conditions, acute and chronic, such as furunculosis, puerperal infections, acute arthritis, cholecystitis and erysipelas. He uses a 2% suspension in distilled water of chemically pure animal charcoal, as finely powdered as possible. This is injected intravenously, usually every other day (although in certain instances of severe infection it has been repeated daily, night and morning, in doses of 2 to 5 C. Cm. It is very important to see that the plunger of the syringe and the needle are lubricated with sterile liquid paraffin as the charcoal suspension easily causes blockage. Another way to avoid this difficulty is to draw 2 to 3 C. Cm. of blood into the syringe after puncture of the vein, and then inject the mixture of blood and charcoal suspension The method is reported as being completely devoid of danger or of any unpleasant after results such as headache, rigors or shock. A feature of the results obtained (a series of 150 patients is now reported) is the rapid relief of pain in certain conditions such as prostatitis and epididymitis, and the fall of temperature within 48 hours in patients with localizing collections of pus.

(From the Practitioner April '35)

Soma-Kalpa Powder, when mixed with 10 grains of Sodium-Bicarbonate doubly intensifies its action. So the former acts in lesser dosage (Dose 10 grains).

Theocin-Sodium-Acetate :—1½ grains single dose daily, is well worth a trial in paroxysms of Asthma.

Salyrgan :—If the first intramuccular injection fails to cause good diuresis, that means that it is not a case for Salyrgan treatment. So don't repeat the injection. R. S.

Collosol Iodine in the Treatment of the Pneumonias.

(By R. V. Murphy. Irish Journal of Medical Science. October 1934)

This treatment was introduced in 1929 July. Till now there is a total of ninety cases treated with nine fatalities. Though the

number is small, the preponderence of successes during a period of two and a half years, endorsed as it is, I believe, to a great extent by the experience of my colleagues, justifies some broad conclusions suggested in this article, which is confined solely to the consideration of this intravenous treatment.

The total amount of iodine in the blood is not more than 2 mg. of which only a portion is active. 10 C. C. of an 8 per cent solution of Collosol iodine contain 80 mg. of iodine. It would appear therefore, that the iodine delivered in this form directly into the blood stream replenishes a failing reserve and is immediately available. Certainly in actual practice collosol iodine has proved itself to be a detoxifying agent of great range and potency—presumably where a shortage of iodine is responsible for the breakdown of the mechanism of immunity. In the strength and dosage here employed the preparation is apparently free from danger of any kind.

The treatment should not be given up too soon. Every case of actual or suspected pneumonia under my care is given this 8% solution intravenously. Several thousand injections have been given and I have never met with a single contraindication.

Cases of pneumonia and broncho-pneumonia so far encountered include every variety of primary, secondary and post operative-types simple and complicated, and embrace also every bacteriological type.

Most of the cases under the treatment reached the stage of crisis within 3 days or less, others reached slowly, but even when the recovery was delayed to a late and protracted lysis, as a rule, the early mitigation of the toxaemia was a definite welcome phenomenon.

The straight case of uncomplicated pneumonia is expected to yield to treatment in about 24 to 48 hours. A slow and poor response in an uncomplicated case should, I think, be taken as evidence of the presence of some hidden tuberculous or other infection which has flared into activity.

Cases in private practice respond more readily than most hospital cases and those coming under treatment early generally do much better than those that come under it late.

I use collosol iodine as a prophylactic agent. I used the preparation in the infuenza epidemic of 1933 and found it suitable for influenzal pneumonia also though it did not have any beneficial effect on the infuenza itself.

(Indian Medical Gazette. April 1935)

Instead of collosol iodine simple aqueous solution of iodine 1/5th of a grain to one C. C (with 1/5th gr. of Pot. Iodide)-dose ½ to 1 C. C–according to age, may be used diluted with 2 C. C of pure redistilled water. The results have been found to be very satisfactory. The injection may be repeated daily in the mornings intrvenously. This is far cheaper and more effective. If collosol iodine is to be used 5 C.C. of the 2% solution supplied in ampoules is preferred.

T. S. B.

For Burns.

If you have an emergency burn and have no tannic acid to make a solution for spraying or painting, make a strong decoction of tea. The tannic acid in this solution is sufficient for this purpose.

(Medical Suggestions Nov. 1934)

The Nature and relief of some Common Gastric Symptoms.

(Adapted from the Clinical Journal February 1935.)

If physical signs may be called the morbid anatomy of bedside medicine, symptoms are its morbid physiology, and they usually precede the development of signs.

Appetite, hunger, satiety and repletion are all normal sensations, and in part, at least, appreciated by the stomach itself. But hunger-pain, flatulence, heart-burn, acid regurgitation, water-brash and hiccups, are pathological symptoms and require treatment.

Hunger-pain.

Hunger-pain is felt in the epigastrium. It is fairly strictly localized. It develops characteristically between two and three hours after the last meal, and endures for an hour or so unless relieved by food, fluid or alkaline medicines. Cold, fatigue, mental worry and tobacco tend to increase it.

It is most frequently encountered in cases of duodenal ulcer, but occurs with some gastric ulcers, and occasionally with early growths of the stomach. It is also, however, registered in some cases of gall-bladder and appendicular disease.

The treatment of hunger-pain includes the treatment of the underlying cause, but suitably frequent feeds and alkalis play an important part in all those conditions in which the cause cannot be eradicated.

Flatulence.

Stomach-wind or bowel-wind:—(We are here concerned with the 1st). The eructated gas is usually odourless, but in certain conditions it may be foul. When the smell is of "rotten eggs" or sulphuretted hydrogen, gastric stasis with protein decomposition is always present, and the symptom is therefore of real diagnostic value in pyloric stenosis or obstruction.

Odourles flatulence may be due to trivial functional disturbances or serious organic disease. Repeated and noisy eructations are always due to air-swallowing.

In gall-stones and cholecystitis it is a more pronounced feature, and "bursting flatulence" is a frequent complaint in the dyspesias of gall-bladder disease.

The habit of air-swallowing or aerophagy is initialled by forcible attempts to relieve a gastric discomfort by eructation, the act being preceded by gulping of air. Peppermint drops or bicarbonate of soda in hot water help to alleviate transitory post-operative flatulence and the flatulence due to the disturbed gastric motility or organic disease.

Heart-burn.

This is one of the most elusive of dyspeptic symtoms. The sensation is characteristically one of burning in the course of the gullet. It may be, but is not necessarily, eased by food or alkalis. It is not a symptom of organic disease, but is an association of hurry and worry, of carbohydrate excesses and of anaemic dyspepsias.

Sodium bicarbonate and Alocol—(a proprietory preparation of aluminium hydroxide)-probably by relaxing the cardia, give the best help; but dietetic adjustments and improvements in general and nervous health also play their part.

Acid Regurgitation.

It is the only direct symptom of gastric hyperacidity. The treatment is the treatment of the underlying cause, such as duodenal ulcer, tobacco excess or rushed irregular meals, combined with alkaline therapy.

Water-Brash.

By water-brash we imply the sudden arrival in the mouth and gullet of large quantities of clear, tasteless watery secreation. It is to be distinguished from the excessive and stringy mucoid secreation of alcoholic oesophagitis. It occurs more frequently in duodenal ulcer than in any other dyspeptic disease, and may, perhaps, be regarded as an exaggeration of the "mouth-watering" which is proverbially associated with hunger, but better manifest in dogs than men.

Hiccups.

Hiccups are usually due to trivial causes and regarded as a domestic joke. They may also be of evil import as accompaniments of acute abdominal catastrophes and uraemia.

Gastric lavage in cases of dilated stomach may put a stop to them. In the unexplained and long-continued hiccups of old people, oil of cajuput, tincture of iodine, etc., by the mouth, are usually ineffectual. An ice-cold application to the epigastrium sometimes succeeds. The induction of violent sneezing (not applicable in abdominal cases or the presence of exhaustion) is a remedy as old as the Socratic Dialogues, and is sometimes most effective. Stronger remedies may, however, be necessary, not excluding heroin and morphine.

Differential Diagnosis and Treatment of "Retention of Urine."

At the beginning one has to distinguish Retention of urine from anuria. "Retention may be defined as a gradual accumulation of urine in the bladder with inability to evacuate it normally *per urethrum*. This would mean that the kidneys continue to secrete. In anuria on the other hand the kidneys do not function so that the bladder is empty and the products of body metabolism continue to circulate in the blood thus paving the way for the onset of uraemia. Clinically in cases of anuria we find the patient on the stage to coma due to uraemia, and bladder is not palpable in the hypogastrium. In the case with retention it is common to see the bladder distended so as to occupy the hypogastrium instead of being a pelvic organ as in normal cases. Onset of uraemia is very late in coming. If bladder cannot be palpated we can have evidences of extravasation into the peritoneum or extraperitoneally.

In some more cases with retention we find that while the bladder is distended the patient passes urine without any effort by him and it continues to fall in drops. The distended bladdcr may be tender. Such cases are those of "Retention with overflow or Retention with incontinence.". The explanation for this state of affairs is this: there is complete retention for some time and then the intravesical pressure increases beyond a certain point when the urine is propelled through the stricture.

True incontinence is found in cases where there is no accumulation of urine, but any small quantity of urine that is collected in the bladder is immediately sent out, without any difficulty and this is not under the control of the patient. Such a condition is found in cases with sphincter paralysis.

The causes for rention is enumerated under 2 heads.

1. Nervous causes.
2. Mechanical causes.

We will dismiss nervous causes as being comparatively easy after enumerating the following conditions.

1. *Nervous causes*:—

(*a*) Compression paraplegia of the spinal cord. This condition is diagnosed by the presence of paraplegia with a history and clinical findings of injury to spine or Pott's disease of the vertebra.

(*b*) Tabes dorsalis is diagnosed by the ataxia, Argyl Robertson pupil, and history of specific infection.

(*c*) Reflex spasms of the sphincter vesica is present in a good number of cases of operations on the retum and anus, vagina and lower abdomen.

(*d*) Myelitis is diagnosed by its classical symptoms of alteration in sensory reactions, girdle pains, increased reflexes above the level of the lesion while reflexes are abolished at the level of the lesion, and complete paralysis of the part below the lesion.

(*e*) Hysterical is diagnosed only after excluding all other causes after a careful examination.

2. *Mechanical causes*:—The cause for this may be

(*a*) in the lumen of the urethra,
(*b*) in the wall of the urethra,
(*c*) outside the wall of the urethra.

Factors in the lumen of the tube are;—

1. Villous papilloma of the bladder obstructing the inner opening of the urethra giving a history of recurrent haemorrhage and intermittant obstruction.

2. Blood clot after trauma in the lumen of the urethra obstructing urinary flow.

3. Calculi completely obstructing the meatus. The history here is, a sudden obstruction to urinary flow while in the act of passing urine, followed by the passage of a few drops of blood. The calculi may be palapated by passing a sound.

Commonest factor in the wall of the urethra is stricture after an old inflamation usually gonorrhoeal. The history here is of an young man with a history of old gonorrhoea and passing urine with difficulty in a thin stream. Passage of an olivary ended bougie detects the site of stricture.

The commonest factor outside the wall of the urethra is a prostatic involvement. It may be inflamatory or neoplastic.

Inflamatory states of the prostate are acute prostatic congestion or a prostatic abscess. Rectal examination reveals the extent of prostatic congestion and the tenderness that is present. In an abscess the fluctuant feeling is present.

Neoplastic states are :—

(*a*) Adenoma of the prostate. The prostate may be enlarged but this may not be felt per rectum The prostate is felt to be freely movable and not fixed as in cancer of the organ.

Cancer of the prostate is found in old men.

Treatment. The two ideas with which we must treat a case of this sort are

1. prevent further injury in relieving the bladder
2. prevent infection.

In the first case injury is avoided by the use of soft rubber catheters. Hamilton Bailey is decidedly against the passage of silver catheters and accuses them as the 'notorious maker of false passages.'

For preventing infection the same author is of opinion that a catheter should on no account be tied in into the bladder. With both these objects in view the best course to adopt in cases that have been observed and treated conservatively and found not to improve is to do a Suprapubic puncture and relieve the conditton after which the cause must be tackled.

Conservative Treatment. Catherisation under the strictest aseptic precautions twice daily, warm sitz baths, warm enemata and and fomentations to bladder region.

The following mixture given thrice daily.

Hexamine	gr. 45
Tint Hyoscya	dr. 1½
Aqua $CHCl_3$ ad	oz. 3
Ft. mist No. 1.	
Acid sodi phosph	gr. 45
Aqua ad	oz. 3
Ft. mist No. 2.	

Sig :—One ounce of Mist No. *2* to be followed by one oz of mist No. 1 half an hour after. Thrice daily. Hexamine does not act as a urinary antiseptic in the urine unless it is acid to litmus. The action of hexamine is to liberate formaldehyde in the acid urine and formaldehyde is an antiseptic. To acidfy the urine the acid phos mixture must be given early enough to render the urine acid so that when hexamine reaches the bladder the urine is acid already.

The reaction of the urine may after 4 days or more be made alkaline and at the same time antiseptic. This could be effected by giving the following mixture containg acid benzoic which is an urinary antiseptic even in alkaline urine.

Ammoni benzoas	gr. 45
Aqua $CHCl_3$ ad	oz. 3
Ft. Mist.	

One ounce T. D. S.

MEDICAL NEWS.

Madras Medical Council

An extraordinary meeting of the Madras Medical Council was held at the office of the Surgeon-General. Among other items the following were considered.

(1) *Alleged infamous conduct* in professional respect of Dr. K. K. The charge was soliciting private practice by distribution of handbills etc. in Chodavaram about October 1933, a practice discreditable to the profession of medicine, and which tends to lower its dignity. He pleaded guilty to the charge. The Council accepted the plea and let him off with a warning.

(2) *Bogus Medical Degrees.* The President informed the Council that for conducting prosecutions against holders of bogus medical degrees, he found the proceedure adopted by the Bombay Medical Council was the simpler one. He explained that in Bombay if the council recommends action to be taken, the case is reported to the Government is accordance with the provisions of Section 7 of the Indian Medical Degrees Act, 1916. If Government then deem fit they direct the District Magistrate concerned to take action or the

Solicitor to the Government in the city is instructed to take action. The Council decided that this proceedure be adopted in future.

Bombay Medical Council.

German Doctors in Bombay. The question of restriction the practice of medicine and dentistry to nationals of India, which arose as a result of a number of German-Jewish doctors setting up practice in Bombay, came up before the Bombay Medical Council in Feb. 35.

The matter was first discussed by the council in September last and was referred to the Government of Bombay. In reply the Government suggested that as the question affected the whole of India, a representation might be sent to the Government of India and the All India Medical Council.

When the Chairman called for suggestions, Dr. P. T. Patel said that, according to personal knowledge, some medical practitioners in Bombay not only collaborated with the German-Jewish doctors, but actually acted as touts for them. He suggested that effective warnings against such practice should be issued. The Chairman said that if any specific cases were brought before the Council action could be taken. The Council then accepted the suggestion of the Government and decided to refer the matter to the Government of India and the All India Medical Council.

(The Medical Bulletin 16th February 1935)

On Longivity.

He Forgot. He brushed his teeth twice a day with a nationally advertised tooth paste.

The doctor examined him twice a year.
He wore rubbers when it rained.
He slept with windows open.
He struck to a diet with plenty of vitamins A to Z.
He relinquished his tonsils and traded in several worn out glands.
He golfed—but never more than eighteen holes.
He got at least eight hours of sleep every night.
He never smoked, or drank or lost his temper.
He did his daily dozen, daily.
He was all set to live to be a hundred.

The funeral will be held next Wednesday. He is survived by eighteen specialists, four health institutes, six gymnasiums, and numerous manufacturers of health foods and antiseptics.

He had forgotten about buses at street crossings.

"To what do you attribute your longivity"? inquired the long man.

"To the fact" replied the old man, conclusively "that I never died."

The Trichinopoly District Medical Association.

(REGISTERED.)

A monthly meeting of the above Association was held at 4-30 p.m., on Saturday the 20th April '35, at the Government Head Quarter's Hospital, Trichinopoly when about 35 members were present. Dr. R. Doraiswamy was "At Home." Capt. Sangham Lal, F.R.C.S.I.M.S., District Medical Officer, Trichinopoly, presided.

Dr. T. S. S. Rajan demonstrated a case of stricture of the Oesaphagus. The patient an average built young man of 30 complained of trouble in swallowing which started without any apparent cause 7 or 8 years ago. He developed acute obstruction 4 days back. Stomach tube could be passed upto the obstruction, when an opening will be patent enough to admit fluids. X-ray showed a bag shapped dilatation above the stricture. One or two members suspected it might be a case of 'Spasmodic stricturc' and some 'diverticulum.'

Dr. Kalmegham then demonstrated a case from the Head Quarter's Hospital, operated upon for Sub-phrenic abscess and which later on was found to communicate with the stomach as evidenced by colouring matter given by mouth coming from the operated wound.

Dr. M. R. Subramanyam of Valliyanai read a short and interesting paper on 'Brachial Block Anaesthesia' explaining thc anatomy of the Brachial region and said that this form of Anaesthisia was very useful and simple with a little care. He gave details of a case he had operated recently.

In his concluding remarks Capt, Sangham Lal, congratulated Dr. M. R. Subramanyam, on the neat paper read before the Association and the courage with which he undertook the operation in a rural area with limited facilities.

In proposing a vote of thanks to the Host, Lecturer aud the Chairman of the evening, the Secretary wished that more Rural Practioners would come forward with case notes and cases.

The meeting then terminated at a late hour.

TRICHINOPOLY,
Dated 20th April 1935.

P. A. S. Raghavan,
Secretary.

MISCELLANY
OF
THE TRICHINOPOLY DISTRICT
MEDICAL ASSOCIATION
(REGISTERED)

MAY 1935

For free and private circulation only.

THE TREATMENT OF ASTHMA.

(Adapted From "The Practitioner" May 1935.)

Diagnosis :—

A good clinical history is essential :—It can be considered under the following heads :—

1. Onset
2. Cause
3. Season and Time
4. Locality
5. Periodicity
6. Family History
7. Previous Treatment

Physical examination should be thorough and conditions such as mitral stenosis, with failing left ventricle, carcinoma of the lung and uraemia, all of which may be accompanied by broncho-spasm, should be excluded. The presence of fever with severe asthma, not responding to adrenaline, is probably not true asthma at all, but a case of acute bronchitis with broncho-spasm. The nose should be looked at for gross disease; the typical chest deformity of the chronic asthmatic is obvious; the muddy complexion, thickened eczematous skin and boggy nasal mucous membrane of the marked allergic cases are also striking. The type of breathing, whether abdominal or thoracic, should be noticed ; it is worth while to measure the chest expansion.

Clinical Types.

1. *Allergic Type*:—Condition commonly dating from childhood; positive family history of allergy; sputum mucoid; skin tests commonly positive ; low gastric acidity.

2. *Bronchitic Type :*—It is caused commonly in later life; attacks related to "colds" and bronchitis; usually worse in the winter months; sputum purulent during attacks.

3. *Neurotic Type :*—Associated with worry or emotion;

4. *Nasal Type :*—Associated with gross nasal disease, sensitive nasal mucous membrane.

5. *Adam's Toxic Type*;—Long History. Usually associated with hypochlorhydria.

6. *Drug Sensitive Type*:—Aspirin is the most common drug; antipyrine, quinine, cocaine, morphine, ipecacuanha and other drugs have been recorded.

Treatment of the Acute Attack.

Drugs :—1. *By Injection* :—Adrenaline, m 5 to m 10 of the 1/1000 solution injected subcutaneously. If no relief is obtained in 20 minutes the needle should be inserted into a vein and m 2 injected every 3 minutes to a maximum of m 15 in all (Hurst.) Caffeine sodium salicylate gr. 1 by injection is often helpful in conjunction with adrenaline.

2. *By Mouth*:—Ephedrine gr. ½ to gr. 2 and the following mixture:—

Pot. Iod.	7½ grains.
Tinct. stramon.	15 minims.
Tinct. lobelia ether.	15 ,,
Tinct. camph. co.	60 ,,
Spirit ammon. aromat.	20 ,,
Aq. chlorof. ad.	1 ounce.

Sig :—This mixture may be given four-hourly until the attack abates.

3. *By Inhalation* :—(a) Bronchovydrin. (b) Various drugs may be given, but the mixture of watery vapour of adrenaline, 1/1000 solution, with an oily vapour of pine oil is most useful.

4. *Elimination Treatment*:-At the onset of a severe attack, and if the patient be not exhausted from a long attack, an emetic, such as antimony wine ½ ounce, or apomorphine gr. ¼ is certainly most valuable. Forty-eight hours of starvation is a good way of helping the patient to get over a bad attack. During this time he may have fruit drinks with glucose ad lib., The bowels should be made to act with calomel and a dose of salts.

General Treatment with Attacks.

The patient should keep a record of attacks and wheezing in a small exercise book, one page being kept for recording the details and the time of attacks, and the opposite page for noting any predisposing causes, such as bronchitis and diet. These books are found most helpful.

Mode of living:—A tepid bath should be taken each morning and at least an hour's sharp walking exercise should be taken daily, preferably in the morning.

Bedroom:—The head of the bed should be placed under the window, which should be kept open at the bottom except on wet or windy nights.

Diet:—The teeth should be put in order. The two main meals should be breakfast and lunch, with a light supper not latter than 7 p. m. For children tea should be the last meal, with a glass of orange juice in water taken at bedtime. On empirical grounds cooked milk in any form should be prohibited for some weeks ; fatty and stodgy foods should be avoided. Any special article which the patient knows will produce an attack should, of course, be excluded. A starvation day on Fridays, when fruit only is allowed, is very helpful.

Nose :—Gross abnormalities should be treated surgically.

Drugs :—Stramonium mixture given above may be taken night and morning, and the dose gradually reduced as the asthma improves. A tablet of ephedrine taken at night is also helpful, but should be stopped gradually as soon as the patient begins to get better nights. For patients who get fullness after meals, flatulence and mild eczema, the following digestive mixture is helpful :—

Acid hydrochlor. dil.	....	30 minims.
Glycerini pepsini.	....	60 - ,,
Calcii chloridi.	....	10 grains.
Glucos liq.,	....	120 minims.
Aq. ad.	....	1 ounce.

Sig :—To be taken in a full glass of water, flavoured with orange juice and sugar, as a drink *with* meals three times daily.

Breathing Exercises:—Examples of simple exercises may be found in a booklet recently published by the Asthma Research Council "Remedial Breathing Exercises in Asthma, 1934."

Non-specific desensitization:—The following methods are most useful:—(a) Intramuscular injection of typhoid vaccine (T.A.B.) containining one thousand million B. *typhosus* and five hundred million each of *Para* A and B per c. c. m. Three injections of 0. 25. c. c m., 0. 5. c. c.m, and 0·5 c. c. m. at weekly intervals are given. (b) Auto-heamotherapy. Blood is withdrawn in a syringe from a vein in the arm and immediately injected into the muscles of the buttock, 5 c. c. m., 10 c. c.m., and 15 c. c.m. are the usual doses.

Treatment of Special Types of Asthma.

Bronchitic type.

Here vaccines in small doses are valuable. It must be stressed that the asthmatic is more sensitive than normal people to vaccines, and that dosage should be very small. Any definite local reaction, and most certainly any general reaction (shivering, malaise, fever, cough etc) should be avoided. As a stock vaccine, mixed vaccine containing about 80 million mixed organisms per c. c.m. is useful. The following dosage may be used in an average case:—0. 05. c. c.m., 0. 1. c. c.m., 0. 2. c. c.m. at weekly intervals; 0. 3. c. c.m , 0. 4. c c.m., 0. 5. c. c m. at fortnightly intervals 0. 5. c. c.m. repeated at three weekly intervals throughout the year.

Aetiology and Treatment of Peptic Ulcers.

The strepto-coccus is the chief offender and is usually derived from septic foci in the teeth, tonsils, and prostate. B. Coli also produce peptic ulcer, as also introduction of undiluted gastric juice and HCl, into the stomach and duodenum Absence or diminution of alkalinity in the gastric juice also cause peptic ulcers. People with a short stomach and hypersecretion and hypermotility have a tendency for these ulcers. It is commoner in people with ambition, highly strung nerves, and heavy smokers (which causes hypersecretion of gastric juice).

Treatment of Haematemesis.

Haematemesis is more common in acute ulcers than chronic ulcers, and must be treated by starvation for 24 hours or more till haemorrhage stops, when iced water may be given for another 24 hours. Then citrated milk or milk and eggs may be given. Iced milk is preferable, an ounce an hour to begin with and then gradually increased. Morphia in $\frac{1}{4}$ gr., doses must be given and repeated every six hours if the patient is restless. 2% rectal glucose 8 oz, every 4 hours, should be given. Adrenalin in 1 cc doses by mouth and glucose 50% solution orally may also be given.

Concealed haemorrhage may be evident from blood in the vomit and stools, lowered blood-pressure, weak rapid and thready pulse and cold clammy perspiration.

Medical Treatment of Chronic Ulcers

Intense milk and alkaline treatment. Alkaline powder is Bismuth carb, Soda-Bicarb, Mag. Carb-Pond and Creta Prep in the proportion of 1:3:3:3.

1st Week. 8 oz., milk with 10 grs., of sodii citras every 2 hours followed by 1 dr. of alkaline powder in water and 2 drs. of the same before bed time.

2nd Week. 2 pts, milk and 3 eggs divided and given every 3 hours, followed by alkaline powder.

3rd Week. In addition to diet of 2nd week, milk pudding, fish and potatoes followed by alkaline powder after diet. 4th and 5th weeks gradual resumption of normal diet avoiding tough foods, nuts, salads, alcohol and raw vegetables and fruits.

Other methods of treatment are with injections of streptococcus vaccine, Proteins and emetine and administering Mucin (3 dr.) with meals and 30 grs., per day in tablet form and Aluminium Hydroxide Tablets.

(From the Clinical Journal April '35.)

Gall-Stones and Cholecystitis.

(Adapted from the Clinical Journal March 1935)

SYMPTOMS.

The symptoms are best considered under the following headings:

1. Mechanical.
2. Reflex.
3. Inflammatory.

Mechanical Symptoms.

At any time a gall-stone may become impacted at the entrance of the cystic duct, in the cystic duct or in the common duct, or in the absence of stones, inflammatory thickening may cause temporary obstruction. This results in a typical attack of colic, which is sudden in onset, increases in severety in waves, causing vomiting when it reaches its maximum and then disappears rather suddenly. The vomiting is first of stomach contents, then of bile. The pain, at first, is widely distributed, then slowly becomes localized to the right hypochondrium, but in severe attacks the patient either rolls about in bed or walks round the room. The temperature and pulse remain normal, rigidity is absent; but tenderness may be present, especially in the midline just below the xiphisternum. Colic may occur at any time, but generally several hours after a meal when the stomach is empty, and frequently commences at night, but may be precipitated by exercise or by saline aperients.

Reflex Symptoms

Dyspepsia with marked flatulence and epigastric fulness occurs while eating or soon after meals, and may cause the patient to take small meals, and so may account for definite loss of weight. Occasionally the pain appears 2—3 hours after meals and may resemble that caused by a duodenal ulcer, but the attacks lack the sharpcut periodicity of those due to ulcer. 80% of gall-stone cases have achlorhydria or hypochlorhydria. At times discomfort is felt in the right iliac fossa, and may be thought to be due to chronic appendicitis, or may radiate across the lower abdomen and suggest disease of the colon, or across the chest on the left side and resemble cardiac symptoms.

Inflammatory Symptoms

An inflamed gall-bladder soon becomes surrounded by adhesions, and the danger of rupture into the general peritoneal cavity is remote. At the onset of inflammation the pain gradually increases, becomes accurately localized over the gall-bladder, persists for several days and only gradually subsides. It is accompanied by tenderness, rigidity, and occasionally by an inflammatory mass of adhesions in the right hypochondrium. Shoulder-tip pain, due to the inflammation spreading to the diaphragm, may be present, and spasm of this muscle may cause diminished air-entry into the lower lobe of the right lung.

Chronic inflammation

This affects adjacent organs by direct lymphatic spread, and distant organs by acting as a focus of infection. Cholecystitis is always accompanied by hepatitis, often by chronic pancreatitis, and may be the cause of myocarditis, secondary anaemia, phlebitis and iritis.

Stone in the common bile-duct :—

Stones in the common bile-duct generally cause mechanical, reflex and inflammatory symptoms. The pain is often frequent, severe, sudden in onset and cessation, but may leave no residual tenderness. Chills and fever, are suggestive, or when the liver becomes enlarged and tender, cholangitis is present and adds greatly to the severity of the illness. Jaundice occurs only in 40 per cent. of cases with stones in the common bile-duct, and may occur when stones are confined to the gall-bladder and is then due to inflammatory œdema of the ducts. Progressive painless jaundice is not due to gall-stones, and if associated with a distended gall-bladder, is almost certainly due to a carcinoma of the head of the pancreas or of the bile-ducts.

Diagnosis.

A carefully taken history is important. When the symptoms are mechanical in origin the diagnosis is usually obvious, and further investigation for diagnostic purposes is unnecessary. With inflamatory symptoms the diagnosis may prove simple but occasionally surprising mistakes are made, and this generally happens when the symptoms are purely reflex and the clinical diagnosi

must be uncertain, and can be proved only by further investigation, and in rare cases only by laparotomy.

Several aids to the diagnosis of gall-stones have been discovered. The most important is cholecystography, which is correct in 90—95 per cent of cases.

Treatment.

The immediate treatment of gall-stone colic is to give 1/3, to ½ gr., of morphia with 1/100 gr. of atropine and not ¼ gr., of morphia as is commonly given and fails to relieve the pain. Following the attack the patient is kept at rest and on light diet for a few days. Watch is kept for evidence of inflammation or jaundice.

Acute cholecystitis is treated by rest in bed, fluid diet and local applications of warmth. Spreading peritonitis, as shown by the increase in the area of tenderness and rigidity, will call for immediate operation. As a rule it is unwise to operate when the temperature and the white blood-count are rising. The liver is protected by adequate doses of glucose before and after operation and by avoiding chloroform anaesthesia.

Mild inflammation of the gall-bladder may respond to medical treatment, but once the wall becomes thickened or stones have formed the only cure is cholecystectomy.

A new method of Artificial Respiration.

(Adapted from the 'Clinical Journal' May '35.)

The technique is as follows:—

1. The subject is placed in the prone position on a hard surface as in the Schafer method. It is well to place a folded coat or small pillow beneath the clavicles and upper chest.

2. Sitting on a low chair or kneeling, the operator puts one hand beneath each anterior superior spine and lifts the pelvis well off the ground, so that the back arches and the abdomen sags downward,

3. The operator lowers the subject to the floor slowly to his original position. If maximum respiratory exchange is desired, the Schafer procedure of pressing downward and forward and compressing the chest over the lower ribs is then carried out.

4. This procedure is repeated from six to ten times per minute.

Influenza—(The change in its aspect).

(Adapted from the 'Practitioner' May '35.)

Symptons.

(1) *Depression*, (2) Marked frontal *headache*, (3) Pain and stiffness in the *back of the neck*, so frequent as to be pathognomonic. (4) *Abdominal pain*, (5) *Pelvic pain*, (6) *Thoracic pain*, (7) *Dreams* at night, always unpleasant, (8) *Loss of appetite* (9) *Sweating* (10) *Legs* are as tired when he gets up in the morning as they were when he went to bed. (11) *Giddiness* or "swimmy" feelings, (12) *Shortness of breath* on exertion. (13) *Palpitation*. (14) *Backache*:—Generally low down, (15) A curious *numb feeling*, or pain, across the *bridge of the nose*, (16) Pain and tenderness over the temporo-maxillary joint and sides of the *face*. (17) *Insomnia*.

Signs

(1) The patient looks ill. (2) The tongue is evenly coated. (3) Tachycardia is usually pronounced. Pulse is scarcely ever bounding and strong. (4) Temperature. Nine out of ten have no rise of temperatare. (5) Sweating. (6) In a few cases a burst of fine crepitations may be heard on inspiration at one or both bases.

Treatment.

Retirement to bed in a room is essential. Ventilation should be urged. Calomel is best as a preliminary to other medicines. S. U. P. 36, is of definite use in cases with a temperature, but not otherwise. It lowers the temperature and starts the patient getting well. Two or three injections may be necessary. The following is a favourite prescription:—

Tinct. aconiti	....	1 minim
Spts. aeth. nit.	....	15—25 minims
Aq. chloroform	ad	½ ounce

Sig:—To be taken every 4 hours.

If the headache is troublesome in spite of this mixture, aspirin and Dover's powder, may be given at night, or four hourly. Large linseed poultices or hot bottles relieve the pain in the back, and the sweating must be dealt with by constant sponging and changing of night-clothes. In the later stages, when the " sinking through the bed " and profund depression persist, valerian in big doses, with or without bromide, and a bitter tonic, is almost as sure a specific as the aconite mixture in the early stage.

Tinct. val. ammon	.... 20—25 minims
Pot. brom	.... 10—15 grains
Infus-amara (Hewlett)	.... 20 minims
Aqua. ad.	.... ½ ounce

Diet :—Plenty of drinks, home-made lemonade, barley water, orange-juice and water, beef tea, chicken broth, and milk and soda.

Prophylaxis :—Anti-influenza, mixed vaccine given once a week for three weeks.

VAGINAL DISCHARGES

(Adapted from The Practitioner October, 1934.)

Physiology of the Vagina.

The Doderleins bacillus which is a normal content of the vagina, ferments directly or indirectly the glycogen in the vaginal epithelium and liberates lactic acid which prevents growth of extraneous organisms and thus prevents an infective vaginitis. The glycogen content depends upon ovarian activity probably controlled by the hormone, oestrin.

Pathology :—The well known vaginal discharge, which consists of white coagulated material, results from over-activity of the glycogen-containing vaginal epithelium. When the activity of this epithelium is low, the vaginal acidity falls, foreign organisms infect the vagina and by producing a low grade vaginitis, cause a leucorrhoeal discharge. An important point to be emphasized is, that many cases of leucorrhoea are due to a low grade vaginitis, the discharge arising not as previously supposed, always from an endocervicitis but from a transudation through the vaginal epithelium. The leucorrhoea

associated with infection of the vagina with the *Trichomonas vaginalis* with thin yellow foamy discharge and the peculiar red stippled appearance of the vaginal walls, is easily recognised. The trichomonas arise when some constitutional disturbance which upsets the normal biological reactions of the vagina is present.

Investigation :—The history should be taken with care. In gonorrhoea, scalding micturition is a prominent symptom, the discharge may be described as greenish yellow and there is usually a history of severe vulvitis and there may be Bartholin's abscess. In trichomonas cases discharge often develops during hot weather and is often first noticed at the conclusion of a menstrual period.

Examination :—A good light is essential. Examine the vulva, vagina and cervix in turn. At the vulva, a urethritis or bartholinitis is almost pathognomonic of gonorrhoea. Inflamation of the vulva, particularly of the inner surfaces of the labia may be found in leucorrhoea and gonorrhoea apart from such conditions as pruritus and diabetes. The vaginal contents can be examined as the speculum is being introduced.

A thin watery yellow discharge is characteristic of vaginitis. Thick white curds of leucorrhoea are due to overactivity of the epithelium as described. Frank pus is found with pyogenic infections and when mixed with mucous is pathognomonic of endocervicitis. The vaginal walls show red patches in senile vaginitis, while in the infective forms found during the child-bearing period of life, the vagina is reddened diffusely, and minute red areas which bleed easily are scattered profusely over the vaginal walls, particularly in the region of the posterior fornix. Inspection of the cervix is necessary if pus or muco-pus is seen to be discharging from the cervical canal and a diagnosis of infection of the cervical canal can then be safely made, such conditions as pyometra, septic endometritis of course being excluded.

Treatment :—

It is manifestly absurd to treat a vaginal leucorrhoea by applying antiseptics to the cervical canal, just as it is useless to hope to cure endo-cervicitis by vaginal douches alone. For endocervicitis the accepted treatment is to swab the cervical canal with strong antiseptics such as iodized phenol.

With vaginal leucorrhoea, treatment must be both general and local. Attention must be paid to the general health in every case Iron, aloes and tonics should be used when indicated and open-air exercises, games and gymnastic exercises encouraged. Local treatment depends essentially upon vaginal irrigations. At least a quarter of an hour should be spent over the douche, for the object of the douches is not solely to irrigate away discharge but to apply chemicals to the vaginal walls. The most servicable solution to be used is one of lactic acid made up of 1 drachm of the B. P. Codex preparation of lactic acid to a pint of warm water. Mathews Duncann's solution of 40 grains of alum and 20 grains of zinc sulphate to the pint of warm water is excellent, particularly after preliminary irrigations with lactic acid. With refractory cases, pessaries of gelatin containing 1 per cent picric acid as suggested by Goodally may be tried. Silver preparations are strongly recommended by many authorities.

Treatment of Bronchitis and Broncho-Pneumonia in Children.

(Adapted from the Indian Medical Gazatte May 1935.)

Bronchitis.

Treatment:—The two main principles in the treatment of acute bronchitis are, to maintain the patient's strength and to help to get rid of the thick, sticky bronchial secretions. The atmosphere of the room should be cool but not chilly. Windows should be open but the child must be kept out of a draught. The clothing and bed cloth s should be sufficiently warm, but not tight or heavy enough to impede the breathing The diet must be light and nourishing, and is best given in small quantities at frequent intervals. In older children sipping hot sweetened lemon or orangeade is useful in relieving a 'tight' cough. When the child's breathing sounds wheezy, the cough hard and croupy, and the chest full of dry ronchi, a moistened atmosphere gives great relief. It is sometimes sufficient to burn a small cresoline lamp in the room, but in severe cases a half steam tent is required. A three-sided screen or clothes-horse and a number of blankets and safety-pins are all that are necessary for the purpose. Electric bronchitis kettles are now available, in which

Friar's balsam with water in the proportion of one drachm to the pint should be boiled. The spout of the kettle is placed well out of reach of the child's hands. The jet of steam must also be directed away from the face and a receptacle should be provided under the end of the spout to catch any drips, A steam, tent is also extremely valuable when as often happens, a spasmodic laryngitis is associated with the bronchitis. Directly the spamodic or dry stage of the bronchitis is over and moist sounds appear in the chest, the steam kettle should be abandoned, and after twenty-four hours the tent removed from the child's cot.

[Fumigating the room by throwing powdered Benroic acid (Sambarani) in smouldering embers will serve the purpose as well. Ed.]

External applications have their value, but if incautiously used may do more harm than good.

The old fashioned inunction of camphorated oil should not be despised; it is at any rate far better treatment than heavy overheated poultices tightly surrounding the chest. Compresses, if used, should be loosely applied to the back only, at a temperature easily bourne by the child; antiphlogistine retains its heat well, but some doctors may prefer linseed poultices.

Certain drugs are useful at various stages of the disease, but over-medication in infants may upset the digestion dangerously. At the onset of bronchitis a single dose of Dover's powder (one grain for each year of the child's age), together with a mild aperient may abort the attack. During the dry stages the cough may be loosened by the following mixture:—

Potassium citrate	....	...	gr. iiss
Ipecacuanha wine	....	....	m., ii
Spirit of nitrous ether	....	....	m., iiss
Compound Tincture of camphor		....	m., iiss
Syrup of tolu	...	...	m., x.,

Sig:—Every four hours for a child of one year, and double this dose for a child of three to five years.

When the cough becomes loose, potassium bicarbonate, squill and ammonium carbonate will help to clear the secretions from the

bronchial tubes. For a child of one, the following is a useful prescription :—

Carbonate of ammoniun	....	....	gr. ss.
Oxymel of squill	...	....	m. vi.
Bicarbonate of Potas	....	....	gr. iiss
Glycerine	....	....	m. x.
Water to :—	....	....	3. i.

Sig :–Four-hourly

If the secretions are copious, two or three minims of tincture of belladonna may be added, as this tends to lessen them.

When an asthmatic element is suspected, antispasmodics should be given :—

Iodide of potassium	....	....	gr. ss. to i.
Tincture of stramon	....	....	m. iss.
Sal volatile	....	...	m., iii

Sig :–In syrup and water, three-hourly to a child of one year and increasing the dose according to the age.

After the acute stage is over and the child is convalescent a troublesome cough may remain, and for this cubebs, (5 minims of the tincture, for a child of one) or codeine (gr. 1/20) are both useful remedies. It is important to insure complete recovery, and a change of air may be required to achieve this.

In most cases the course of the disease is quite straight-forward but in young infants considerable areas of pulmonary collapse may follow obstruction of one of the larger bronchi by secretions. In an endevaour to prevent this, babies with bronchitis should not be allowed to remain too long in one position, and it is well to take them out of their cots and nurse them from time to time. Bottle feeds should always be given on the lap. The secretions may be so tenacious that feeble infants are unable to dislodge them and are in danger of respiratory failure. When such a collapse occurs the baby should be rapidly transferred to a mustard bath (one ounce of mustard to 1 gallon of water at 100 degree F.), and given brandy and other stimulants. An injection of strychnine (gr., 1/400) with adrenaline (m ii of a 1 in 1,000 solution), and camphor and ether (Curschamann's solution m v) is suitable for a child of three months and can be repeated at four hourly intervals.

Treatment :—Nursing is of primary importance, and the doctor who feels that he must do something, often, does too much. Excessive medication may easily provoke vomiting and diarrhoea. The child is best nursed propped up in bed, but his position should be frequently changed. The room should be well ventilated, and in warm weather the child is best placed on a balcony, but it may be difficult to make the parents approve of this treatment. Coverings should not be too heavy ; a two-piece pneumonia jacket tying at the sides and over it a light flannel nightshirt with long sleeves, loosely fastened at the back, will cause the least disturbance. Warm antiphlogistine poultices to allay pain, or cold compresses to encourage aeration of the lungs and avoid pulmonary collapse may be applied to the back and kept in position by a loose many tailed bandage. Proper hygiene of the nasal passages is also necessary. They should be kept free by alkaline irrigation and some antiseptic nasal oil. The child should be encouraged to drink plenty of water or sweetened fruit juices. Food should be light, nourishing, and given at two hourly intervals. Feeds known to have suited the infant before the illness should be continued. Breast feeding should not be interrupted and if suckling appears to exhaust the child too much, some of the milk will have to be drawn off and given with a spoon. In older children a distended abdomen must be met by light diet for a few days : whey, peptonized milk, veal tea, jellies, fruit juices and the like. Evacuation of bowels must be attended to. Flatulence may be severe in infants and is best treated by a simple rectal washout or turpentine enema.

Drugs should not be given to reduce the temperature. Should it rise about 105 degree F., tepid sponging is the correct treatment. Tepid sponging may also soothe a restless child to sleep. A dose of brandy has often an equal effect but in bad cases during the early stages, opium in the form of Dover's powder may be required. Wheezy breathing, or an associated 'croup' is greatly relieved by a steam tent as described above. Continuous oxygen and carbondioxide (5 per cent) tends to diminish a spasmodic cough but its greatest use is in the presence of cyanosis. To be effective it must be given by a nasal catheter, the gas being bubbled through warm water, contained in a Woulfe's bottle, at the rate af 20 or 30 bubbles

a minute. A little 2 per cent cocaine ointment on the catheter may be required in older children. Oxygen through a funnel is ineffective and merely a placebo for the relatives. The early stages of cardiac failure can be treated with small doses of digitalis 2 to 3 minims of the tincture six-hourly for a child of two years, but some authorities have no faith in this. If the child shows signs of collapse, stimulants will be required, such as brandy by the mouth and injections of camphor and ether (Curschmann's solution, minims 5 to 10), these can be alternated every four hours. Strychnine, adrenaline or coramine are other useful stimulants. Alkaline expectorants should be given when the bronchial secretions are sticky, and belladonna may give great relief should they become excessive.

Specific serum therapy has not been attended with sufficient success in children with broncho-pneumonia to warrant its routine use. Incomplete expansion of part of the lung from unresolved pneumonia is best treated by oxygen and carbon dioxide (7 per cent) inhalations from a gas bag. Strict attention must be paid to proper convalescence and if there is any residual inflammation the child should be sent to the seaside.

The Trichinopoly District Medical Association.

(REGISTERED.)

A monthly meeting of the above Association was held on Saturday the 18th May '35, at 5 P.M., in the E. R. High School, Teppakulam, Trichinopoly, when about 30 members were present. Dr. C. Somasundaram of Puvalur, was, 'At Home' and Dr. R. Kalamegham, B.A. M.B.B S., presided.

Dr. T. S. S. Rajan showed a small boy aged 10 on whom he had operated upon for Hydronephrosis. The removed matter resembled a big bag with the kidney substance embedded in its wall. He demonstrated the old case of stricture of Oesaphagus shown in the previous meeting and which showed some improvement. He also showed a case of multiple arthritis in a girl of 10 sent over for X-Ray and demonstration by Dr. V. Iravatham of Thirukkattupally.

A case of Electric Burns treated with cod-liver-oil-ointment in the Government H'd Qrs Hospital, Trichinopoly was also demonstrated.

After demonstration of cases there was discussion in which many members took part.

Dr. K. S. Narayanan of Madura then delivered an interesting lecture on "Peroral Endoscopy" explaining the technique, indications and its usefulness for diagnosis and treatment. He also demonstrated a number of latest instruments and explained their use.

An oxygen generator (Manufactured by the B. C. P. W.) was demonstrated. The generator is available for hire from the Trichy Medical Union Limited

With a vote of thanks to the Lecturer, Chairman of the evening, the Host, and the Manager of the premises the meeting terminated.

Correction

In the April Issue of the 'Miscellany' on page 4, instead of 8% solution of Collosal Iodine, please read, 0·8% and on page 5 instead of 2% Collosal Iodine please read 0·2%

TRICHINOPOLY,
Dated 24th May, 1935

P. A. S. Raghavan,
Secretary.

MISCELLANY

OF

THE TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION

(REGISTERED)

JUNE 1935

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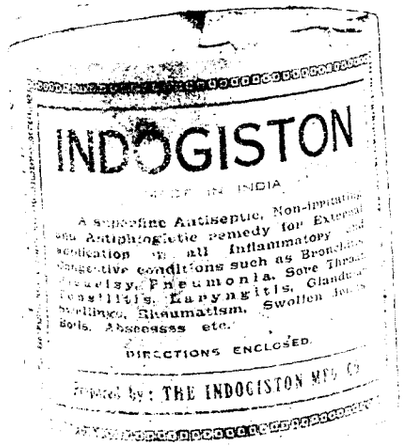

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SPRUE.

Sprue is characterised by the passage of bulky, frothy, white stools, chiefly in the early morning, by soreness of the tongue, flatulent dyspepsia, much wasting, muscular weakness and by anaemia of the megalocytic type.

The skin often shows pigmented patches and discolouration especially on the forehead and cheeks.

Pyrexia is absent, a subnormal temperature being the rule and the involvement of the spinal cord sometimes found in the true megalocytic anaemia of Addison does not occur.

Cramps and tetany have been noted by a number of observers and oedema of the feet may be found, as indeed it may, in all profound disorders of nutrition.

The disease however is not always found in this typical form and in cases where sprue is known to occur, recurrent apyrexial diarrhoea should always be treated with suspicion.

Sometimes it happens that a case shows symptoms mainly of a gastric type suggesting a diagnosis of carcinoma of the stomach: or a suspicion of pernicious anaemia may on occasions be aroused, but the evening intestinal flatulence and morning diarrhoea are generally in evidence, though perhaps not prominently so, even in mild cases.

Sprue arises as a functional breakdown in the gastro-intestine and any factor or factors depressing its secretory or absorptive function will predispose to it.

Non-gastric affections such as malaria may depress gastric secretion, whilst residence in a humid climate involves an increased distribution of blood to the skin at the expense of the splanchnic vessels—a state of affairs which if unduly prolonged, appears likely to depress alimentary function.

The acidity of the stomach contents, due to the secretion of HCL plays an important part in killing noxious micro-organisms such as the cholera vibrio.

Normally the intestinal contents are acid from the cardia to just above the ileo-caecal junction, (but in sprue the acidity is below normal).

The tongue which in the early stages shows patchy areas of inflammation, is generally fissured with thinning and atrophy of the mucous membrane, with destruction and disappearance of the fungiform and filiform papillae.

The R. B. C. count may be as low as 1,000,000 (normal count is 5,000,000) and in advanced cases the blood picture may be indistinguishable from that of a true pernicious anaemia.

Tuberculous diarrhoea may be mistaken for it, but in this country where tuberculous diarrhoea is caused by the human type of bacillus, there is generally co-existing lung affection.

For a final establishment of the diagnosis, certain laboratory tests are essential—these include the ordinary blood film, R. B. C. count and PH estimation.

Treatment.

1. The gastro-intestinal tract must be rested as much as possible a diet containing unusable residues and irritating substances being omitted.

2. A high protein, low fat, low carbohydrate diet must be given.

3. Demonstrable deficiencies must be made up, by the administration of irradiated ergosterol, calcium, and hydrochloric acid.

4. Active treatment of the anaemia must be undertaken.

The treatment in detail is as follows;—

In order that the food given may be reduced to a minimum, the patient must remain at absolute rest in bed during the early weeks of the treatment.

Great precautions should be taken to render the patient free from danger of chill, as, on account of the lack of fat in the abdominal wall and mesenteries, the internal organs are poorly insulated.

Diarrhoea is to be controlled. (Bismuth)

Overloading of the stomach is to be avoided especially in the early stages and non-bulky feeds should be given at frequent intervals.

A high protein, low fat, low carbohydrate diet is then administered, the fat chiefly junket and custard and the carbo-hydrate in monosaccharide form—as glucose, fruit and fruit juice.

Rusks—ordinary bread with crusts removed, baked thoroughy in an oven.

It is more important to get rid of the flatulence than to secure rapid increase in weight. (Medicinal charcoal)

The most satisfactory result of adequate treatment is a disappearance of the profound asthenia commonly met with. Patients whose disease becomes quiescent but not cured on account of inadequate treatment do not lose this asthenia. We may take it therefore that an increased sense of well-being and of fitness to do things on the part of the patient is a very good sign.

If however the weight does not increase after a time, insulin may be given twice daily with an increased ration of glucose.

In order to combat the anaemia, *liver* should be administered, in some form. (It acts as a specific)

If HCL is deficient in the fractional testmeal, give ½ to 1 dram of acid Hydrochlor dil in a wineglassful of water t. d. s. Irradiated ergosterol and calcium should also be given daily.

If constipation should develop during the course of treatment, liquid paraffin should be employed—not purgatives, nor irritating suppositories.

Condiments like pepper, mustard, chillies, sauces, chutneys, curries and spiced food, fatty fish, oils, raisins and pastries must be cut out and oversmoking must be avoided.

It has been shown that sprue patients are particularly liable to relapse after attacks of bronchitis, influenzal colds and other respiratory affections.

(*From 'Antiseptic March' 35.*)

Method of Making Quinine Tasteless.

In spite of great advances made in the treatment—clinical and prophylactic—of malaria, Quinine still holds the field. But the taste of quinine is its greatest drawback, difficulty is felt in administering it to children. To hide its taste various devices have been made. The substitutes of bitter quinine are costly, which the lower classes of people in India can ill afford. Sugar coated pills are in the market. These are not so efficacious. The other method of giving quinine in emulsion form hides the taste to a considerable extent. But the emulsion itself becomes difficult to swallow.

If the bigger variety of myrobalans (Hindi-Har, Tamil-Kadukka) is roasted in ghee, finely powdered, and mixed with quinine in equal quantities it will remove the bitterness of quinine without in any way affecting its effectiveness. If quinine mixture has to be taken its bitterness can be avoided by keeping a grain or two of the roasted myrobalan powder in the month before taking the mixture. There is another advantage of taking quinine in this form. It avoids the necessity of a laxative, so essential in the treatment of malaria, myrobalan being a well known laxative. The preparation is very cheap while it is more potent than other tasteless preparations of quinine for then actual quinine is administered which is decidedly more potent than the other tasteless preparations of it.

None who so took quinine complained of cinchonism. Myrobalans appear to have some influece in controlling cinchonism. These powdeis have by preference been given to those people who refused to take quinine for fear of its 'hot effects' as they call it. They have been given these powders and told that quinine is not being given. This point needs elucidation by more extensive trial.

(From 'The Antiseptic' May '25.)

Bismuth in Syphilis

Bismuth has remarkable effect on the surface lesions but its action on the spirochætes is less pronounced than that of arsenobenzene.

Its advantages are:—

1. Low toxicity and its better toleration by the patient and can be given to hepatics and cardiacs and in many renals.

2. It renders the Wasserman Test negative, especially in those cases that have remained persistently positive despite energetic arsenical and mercurial medication—arseno—resistant cases.

3. It brings about *in vivo* an involution of the spirochætes, which finally leads to their destruction and a complete loss of virulence.

4. Its real place in treatment seems to be as an adjuvant to salvarsan, and as a substitute for it in cases with intolerance of the arsenicals.

5. Its value as a remedy is less than that of arenobenzene and greater than that of mercury.

6. It is indicated in cases, where arsenic and mercury are both badly borne.

Where arsenic and mercury are contra-indicated, by intolerance or otherwise, metallic bismuth is the only spirillicide available. In some cases under treatment with arsenic compounds Wasserman remains positive for many months, but quickly changes to a negative under bismuth treatment.

In a report* of over 100 cases of interstitial keratitis as a manifestation of congenital or acquired syphilis treated with bismuth, it is stated that marked improvement followed in every instance.

Bismuth is said to have the interesting property (which arsenic has not) that it can be recovered from the cerebrospinal fluid after one or two doses. It can thus be inferred that together with arsenic, it forms a most important protection for the central nervous system against the attack by spironem pallidum.

Toxic Phenomena produced by Bismuth.

Bismuth produces, if given in larger doses than the patient can tolerate, much the same toxic effects as the mercurial preparations,

(i. e.) fever, pain, stomatitis, and albuminuria. The first sign of the saturation of the system with bismuth is a staly blue line at the margin of the gums particularly at the incisor teeth. Severe bismuth poisoning may occur in spite of the absence of blue line on the gums, and the Jarisch Herxheimer reaction is possible.

Toxic symptoms may be evidenced by a gum line, gingivitis, stomatitis of varying degrees, gastro-intestinal and renal changes and involvement of the central nervous system. Intravenous injection of sodium thio-sulphate will relieve these symptoms.

The anti-syphilitic action of bismuth is not open to doubt, the results reported and obtained do not seem to show that its specific action is in any way superior to that of the older drugs. It should always be considered as an useful supplementary acquisition. It affords one more weapon with which to combat syphilis.

Mode of Administration.

The greater majority of bismuth preparations are either watery or oily solutions or suspensions. The preparation generally preferred is one of insoluble bismuth metal in fine suspension in isotonic glucose solution. The soluble compounds are absorbed too rapidly and the oily suspensions too slowly; metallic bismuth is the least toxic and most satisfactory, and the deep subcutaneous route is the best. For an average adult male the dose is 0·2 to 0·3 gm., once or twice a week until signs of intolerance appear ; usually a total of 2—4 gm , is given in 10 or 12 injections. There is a difference of opinion as to weekly and total dosage of bismuth.

During the course of Bismuth therapy, oral hygiene should be strictly employed. The teeth should be brushed daily with 10% hydrogen peroxide in warm water. The urine should be tested for albumin after the third dose. If positive, the treatment should be stopped until the urine is free from albumin.

Bismuth is particularly useful in patients who are intolerant of arsenic. It is not so potent a spirochaeticide as the salvarsan preparation but it is probably more potent than mercury and in many cases better tolerated than either salvarsan or mercury.

Large quantities can be given without giving rise to intolerance,

Tertiary lesions of the mouth and tongue, and the symptoms of tabes respond particularly well to bismuth therapy. It is valuable in cases of nephritis, jaundice and advanced organic disease where mercury and arsenic may not be suitable, also in late syphilitic cases which have become resistant to arsenic and mercury. Yaws, the granulomatous disease caused by the *spirochaeta pertenius*, responds like syphilis to treatment with bismuth.

Preventions and Control of Metallic Intoxication.

1. All injections should be given *very slowly*. According to Heyman and Hirschfeld, syndrome designated as "speed shock" results from too rapid injections.

2. After intramuscular injection, massage of the site immediately following the injection, will minimize the discomfort and help the dissipation of the bismuth compound.

3. Strict attention should be paid to oral hygiene.

4. The urine should be tested for albumin after the third injection. If possible, the treatment should be suspended until the urine is albumin-free.

5. Any signs of *stomatitis or gingivitis* may be rapidly controlled by the intravenous injection *Thiostab* (Boots) which is a stable sterile solution of Sodium Thiosulphate in water ready for use. The dose is from 0·45-0 90 gm., according to the severity of the case.

It is now admitted by authorities that combined preparation of bismuth and arsenic is more potent than either drug alone, and is free from danger if given in therapeutic doses.

(From 'Indian Journal of Venereal Diseases' March 1935.)

Concentrated Saline in Cholera.

Dr. Y. S. Narayana Rao of the King Institute Guindy, raises the issue (I. M. G. May '35.) as to how much, collapse in cholera, is attributable to the loss of salts and to the loss of fluids in the blood. Sir. Leonard Roger's treatement for cholera is with the *hypertonic* saline, but not with normal or hypotonic saline which are not

useful and sometimes even harmful. The salts are excreted proportionately in greater quantities to the fluid lost, and death could be prevented if the body salts were raised to 1%, even though large quantities of body fluid have drained away. The greater loss of the body salts is due to their having to neutralise the cholera toxins. The replacement of these salts in the form of intravenous injections of 20 C. C. of a 20% saline solution, produces, diuresis within a few minutes and shows that the salts are more important than the fluid. This method of treatment is not only simple, but will be available under all conditions.

The advantages of this method are :—

1. The sterile concentrated saline can be easily stored in 20 C.C. ampoules and very easily used without any risk of sepsis.

2. There is no fear at all of oedema of the lungs resulting from excess of fluid.

3. The reaction is less likely to occur.

4. Recurrance of large motions with collapse is not likely in this method.

5. Due to viscosity of the blood the salts are less likely to be drained off.

6. The strain on the kidney is less and it is ideal to keep it so, it being the only excretory organ functioning, as the skin is practically inactive. Uremia may be lessened if not avoided.

(This method will come in handy and is well worth a trial when opportunity occurs, and reports forwarded. Ed.)

Iron in Anaemia.

The dosage given in the B. P. represents the average dose given to adult patients. Experience shows that under certain conditions very much larger doses of certain drugs can be given with advantage. In spite of the large amount of work which has been done in recent years on the treatment of anaemia, and on the indications and dosage of iron, it is surprising to find how little care is often taken in deciding whether a case is one which will benefit with iron or with liver, proprietary preparations combining the two together being very

popular. The dosage of iron is generally quite insufficient, complicated organic preparations are too often ordered instead of the simple inorganic preparations, which are also the most effective, *and iron injections have not yet passed into the oblivion they deserve.*

Anaemia as a cause of symptoms is far more common than is generally recognized, and many middle-aged women with chronic ill-health, which is often ascribed to the menopause, are really suffering from an easily curable anaemia. The vast majority of cases, including those which follow haemorrhage, respond with great rapidity to efficient treatment with iron. When thirty grains of iron et ammonium citrate are given three times a day, the haemoglobin generally increases by about one per cent a day, and still more rapidly if the anaemia is severe ; for example, a youth of twenty with splenic anaemia who came in with 14 per cent haemoglobin was prepared for operation by giving him this dose of iron ; his haemoglobin percentage rose to 76 in 45 days.

Though there is a popular notion that iron causes indigestion and leads to constipation there are very few people who cannot take thirty grains of iron et ammonium citrate in half a an ounce of water three times a day after meals as long as is necessary without unpleasant results. The anaemia, which is always present after haemorrhage from an ulcer and which delays healing if left untreated, rapidly responds to this treatment and so far from irritating the gastric mucous membrane the iron appears to have a directly favourable action on the ulcer and the associated gastritis. In a recent case the haemoglobin percentage, which, two months after a haemorrhage, was only 48 rose to 87 in 25 days.

The anaemia in carcinoma of the stomach and colon often improves very quickly and no case should undergo operation with less than 80 per cent haemoglobin. Only if the haemoglobin is very low is it necessary to hasten matters by one or more preliminary transfusions.

Liver and stomach are quite useless in all anaemias except Addison's (pernicious) anaemia and some closely allied megalocytic anaemias, such as that of sprue, and it should be reserved for such cases.

(From the Lancet 22nd December 1934, p. 1379.)

TIT-BITS

Urotropine.

Urotopine is used as an urinary antiseptic in doses of 5 to 15 grains, after making the urine acid by the administration of acid sodium phosphate.

Urotropine is used as a biliary antiseptic in doses of 50 to 100 grains after making the urine alkaline by the administration of Sod. Bicarb. previously. It is administered in the same doses as an antiseptic in Sinus and Menengeal infections.

Salyrgan.

Salyrgan contain 33·9% mercury. Dose 1 c. c. of 10% solution (½ gr. of mercury.) This is inadmissible when there is haematuria, copious albuminuria and when there is suppression of urine.

Two days prior to injection a mixture is given to acidify the urine; for example :—

Calici chloridum Amm. Chloridum	aa.....		3 i
Ext. Glycerrhizae liquidum			3 iss
Spts. chloroform	....	....	m XL
Aqua ...	....	ad.	iv
M. Ft. mistura	...		¼ part 4 times a day.

On the third morning 1 c. c. of salyrgan is injected intramuscularly. Diuresis usually occurs between 3 and 12 hours after the injection, and ceases within 24 hours. If there is no diuresis after the second injection it should be discontinued. The signs of intolerance to this drug are haematuria, increased albuminuria or diarrhoea.

The effect of Ovarian Hormone on the Coagulation Time of Blood; In Hemophilia.

The fact that hemophilia is inherited by men only would probably lead to the hypothesis that women must have a substance which inhibits the occurrence of this disease.

Some were able to obtain a considerable change in coagulation time of the blood by means of the injection of ovarian hormone. This change varied in males and females but was the same in young and sexually immature animals.

Therefore the conclusion is that ovarian hormone itself does not produce this change, but rather that it mobilizes a substance from the ovary which in turn influences the coagulation of the blood.

Dose of ovarian harmone :—25—50 Rat Units, Subcutaneous.

(Journal of the Orgonotherapy' January & February '35.)

The Pupillary test for the Diagnosis of Pregnancy.

The technique of the test is quite simple. Several drops of whole blood were mixed with an equal amount of normal saline solution and the mixture was then instilled into the conjunctival sac of the patient from whom the blood had been taken. In some instances rapid blood clotting caused inconvenience, so a 10 per cent solution of sodium citrate was satisfactorily substituted for the normal saline solution. One drop of 10 per cent sodium citrate solution mixed with 5 or 6 drops of the patient's blood was instilled into one eye, the other eye being used for control observation and comparison. The test requires about two minutes and the reaction usually lasts for about five minutes. The patient suffers little inconvenience.

Both eyes should be compared to determine if any change occurs on one side as contrasted with the other. A definite alteration in the size of the pupil of the tested eye without a similar reaction on the opposite side constitutes a positive reaction.

(Journal of 'The Orgonotherapy' January & February '35.)

Tetanus.

Peyre draws attention to the good results of *Couvy's* method; which is little known when compared with the ordinary serum treatment which is given subcutaneously, intravenously or spinally, and the sedative, symptomatic treatment with Hydrat. Chloral, Avertine, Somnifen, etc. *Couvy's* treatment consists of three intravenous injections in one day: the first one consists of 20 C. Cm. antitetanus serum, the second one (after 1—2 hours) of 0·5—1·5 grammes hexamine, the third one ($1\frac{1}{2}$ hours after the second one) of 60—120 C. Cm. Anti-Tetanus serum. 94% of the 17 cases (two navel infections) treated in this manner, recovered. The action of hexamine is supposed to consist of changing the permeability of the meningeal membranes, and this enables the immunising substances of the antiserum to penetrate into the cerebrospinal fluid. The hexamine also mobilises the toxins which are fixed in the nerve-cells. Chloroform also possesses these qualities, and according to *Dufour* it strengthens the action of the antitoxin. In any case, however, the antitoxic serum has to be injected before the chloroform anaesthesia.

Application of Eye Drops.

A small strip of white blotting paper inserted under the upper eyelid remains unstained when a coloured solution is dropped into the eyes in the usual way.

This proves that the ordinary method of dropping a medicament into the eyes does not guarantee that it reaches the whole surface of the eye and especially not the inside of the upper eyelid. Drops and ointments which have to reach the entire conjunctiva must, therefore, be applied to the lateral side of the upper eyelid which has been folded back.

Diagnosis of Fractures of the ribs with the aid of a Stethoscope.

The ordinary symptoms of a fracture are often difficult to find in rib fractures, and examination by X-Rays usually necessitates the transport of the injred person to a hospital.

An important aid to the diagnosis in these cases is the auscultation of the injured part of the thorax; it must never be neglected because of the possibility of a punctured pleura or lung.

The crepitation of the fragments can be heard immediately by stethoscope in the neighbourhood of the fractures, if there is a rib fracture. The crepitation always appears in the same phase of the respiration and can easily be distinguished from pleural and pulmonary noises which are not localised so exactly.

Abortive Treatment of Measles with Omnadin.

The eruptive stage of measles can, according to *Valdes*, be prevented by giving Omnadin at the onset of the initial symptoms. He gave 2 C. Cm Omnadin daily in a case which presented all the symptoms (fear of light, flow of tears, nasal catarrh, cough) and the appearance of Koplik's spots on the mucous membranes of the cheeks. By the third day all initial symptoms had disappeared, the temperature remained normal and no trace of exanthema was observed. Cases of measles without exanthema are unknown, and therefore the course of the illness as described above has to be attributed to the early use of Omnadin. Omnadin is derived from extracts of non-pathogenic germs and lipoid substances from bile and other secretions. The cause of its activity cannot be traced; but it is probably due to non-specific anti-allergic properties.

The Trichinopoly District Medical Association.

(REGISTERED)

A monthly meeting of the above association was held at 5 p m., on Saturday the 22nd June '35, at the E. R High School, Teppakulam, Trichinopoly, when about 35 members were present. Dr. L. R. Fernandez was 'At Home' to the members. Dr. M. Balammal, M.B B.S. presided.

A large tumour removed from the abdominal wall of an young woman aged 23 by Capt. Sangham Lal, I M.S., District Medical Officer, that morning in the Government Head Quarter's Hospital, Trichy, was demonstrated. The point of interest in the case was, the rapid growth of the tumour (5 months) and the difficulty to locate its origin, whether intra or extra peritonial, before operation.

Dr. R. Sambasivan, M.B.B S., demonstrated a clear case of pre-systolic-murmur and explained that many other conditions of the heart were labelled pre-systolic murmur, and hence this demonstration of a clear case of pre-systolic-murmur.

Dr. N. C. Subramanyam, B.A.M.B.B.S., read an interesting paper on 'Haemorrhages during pregnancy' and explained the various conditions when bleeding could occur, and the necessary treatment to be adopted for each condition. This was followed by discussion led by Dr. Mrs. M. Monsingh and many members took part.

In her concluding remarks Dr. M. Balammal, gave her views on the various points discussed. She also read case notes of a case of concealed intra-uterine-menstruation (Haemato-metra) due to obliteration of the OS on account of previous ulceration and the treatment adopted by her.

With a vote of thanks to the chair, the Host, the Lecturer, and the Manager of the premises the meeting terminated.

TRICHINOPOLY,
29th June 1935.

P. A. S. RAGHAVAN,
Secretary.

Specific Treatment of Tuberculosis with a new Tuberculosis Vaccine "AO".

Tuberculosis vaccine is a preparation of tubercle bacilli originated by Arima, Aoyama and Ohnawa in Osaka, Japan and licensed by the Japanese Government in 1927. According to the originators, AO is made from Tubercle bacilli of the human type. It is sterile, consists of the native protoplasm of the bacilli, is easily absorbed, is completely innocuous, is derived from strongly immunizing strains of bacilli, and has a uniform potency. It is sterile and there is no danger of infection. As it consists of the native protoplasm of the bacilli, it is able to immunize the innoculated organism in the same way as the organism is immunized by infection with live tubercle bacilli. As it is easily absorbed, it acts quickly as an antigen by causing the production of antibodies in the innoculated organism. The easy absorbability is brought about by the autolytic changes which, during the cultivation, take place in the bacilli, which are devoid of waxy substances. AO is innocuous, as its use in 40,0000 patients in different parts of the world upto the end of 1932 shows. No ill effects have resulted from its administration upto the time of writing. Because this vaccine consists of specially selected, strongly immunizing, strains of bacilli, it is remarkably effective. Its potency is constant, as its efficacy is measured by a special immunobiologic method and is expressed in antigen units (AE.) The application of AO is threefold: it may be used for prophylaxis, diagnosis and therapy.

HANFORD S. McKEE.

Reprint from The Canadian Medical Assocciation Journal, July–1934 Vol. 31 No. I.

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Correction.

The abstract from the article on the treatment of "Bronchitis and Broncho-Pneumonia in children" appearing in the 'Miscellany' May 1935, was taken from the 'Practitioner' January 1935, but not from the 'Indian Medical Gazette' May 1935 as printed by mistake. (Ed.)

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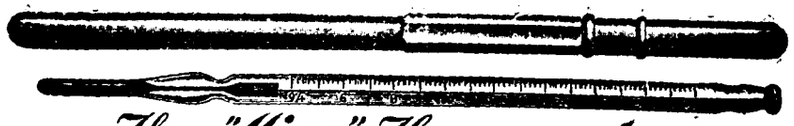

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