MISCELLANY

OF

THE TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION

(REGISTERED)

JULY 1935

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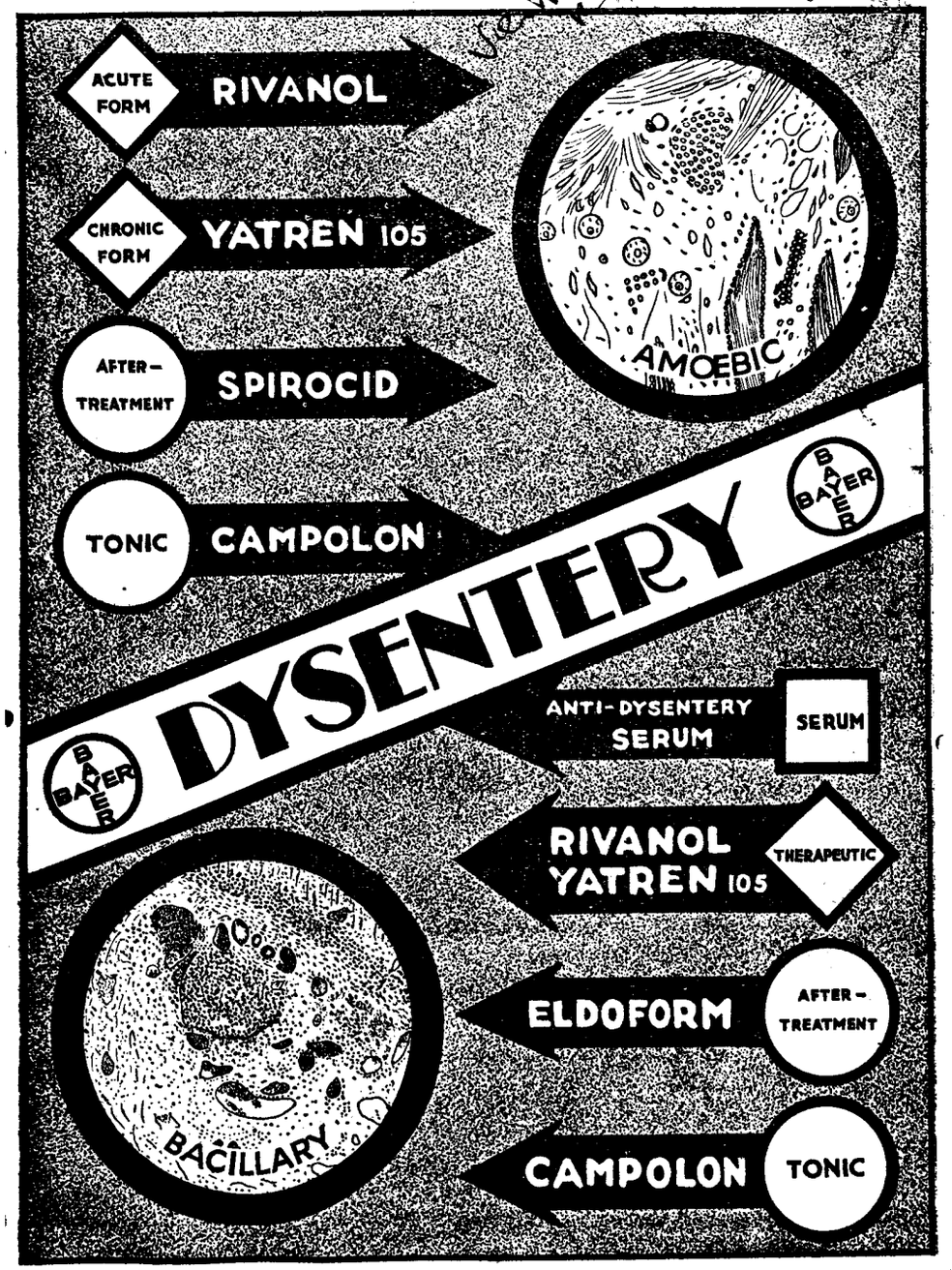

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Epilepsy and its treatment.

(Adapted from 'The Practitioner' July 1934, P. 37.)

EPILEPSY is common in birds and mammals. Heredity is a factor in the transmission of the disease but it is not great as is usually supposed. The malady may begin at any period of life, but occurs with greater frequency in early childhood, with the onset of puberty, and in old age. It is generally classified as *organic or symptomatic* epilepsy and *idiopathic* epilepsy. Epilepsy-like phenomena which follow local diseases of the brain, kidney, thyroid and liver, and those occurring in infantile malnutrition, infection and intoxication are called symptomatic or organic epilepsy.

Recent investigations point to the conclusion that all epilepsies are the result of one and the same underlying fault in metabolism, and that local lesions of the brain, uraemia, and intoxications act as secondary factors in raising the epilepsy-producing potentiality of this metabolic fault. It seems that the community might be divided into three classes: (1) Those in whom no trace of metabolic fault is present—they cannot be provoked into epilepsy by local lesions of the brain or other organs or intoxications: (2) Those in whom the metabolic fault is present in minor degree—in them a second factor such as disease of the brain will cause epilepsy: (3) Those with the fault in high degree—they are idiopathic epileptics. The clinical facts that make the above hypothesis acceptable are: (1) The periodicity of the attack and their association with sleep and moments of bodily and mental inactivity when oxidative processes are deemed to be low: (2) Occurrence of fits in certain cases for a few days followed by freedom from attacks for months and years, the explanation being that the fault was present in sufficient degree only at the period when the fits occurred: (3) epileptic women are

BERIBERI.

BERIBERI is a vitamin B deficiency disease characterised by cardiovascular changes, oedema and polyneuritis.

Historically, it is a very ancient malady. It appears in Chinese writings of the early seventh century and also in Japanese literature of the ninth century. The first indubitable descriptions are, however, not found before the seventeenth century. An early account by a European was written by Malcolmson in 1835. About the middle of the nineteenth century the publications multiplied rapidly, largely by reason of work by Europeans studying the problem in Asia both on the mainland and Japan and on the island of the Straits and in the Philippines.

Originally believed to be caused by an infective agent, the disease has now been definitely placed as a nutritional disease and could be prevented by proper adjustment of the dietary.

The accessory food factor that is responsible for beriberi is the water-soluble antineuritic B vitamin which in nature is usually associated with a closely related substance called the antipellagra vitamin (B_2 or G). These water soluble vitamins are contained in vegetables, fruits, milk, yeast, kidney, liver, brain and whole grain. Recent studies seem to indicate the possible existence of seven components in the B complex.

Clinically, beriberi presents itself in two fairly distinct forms: one in which polyneuritis predominates, the other in which oedema is the outstanding feature. In the former a differential diagnosis between beriberi, and polyneuritis from other causes is sometimes required. There is also some similarity between alcoholic multiple neuritis and the deficiency disease. It is well known that steady drinkers in whom alcoholic multiple neuritis later develops rarely partake of an adequate amount of a proper kind of food.

Oedematous cases of beriberi can be distinguished by the fact that pressure on the calf muscles produces severe pain; it has also been noticed that beriberi patients have difficulty in rising from a squatting position. If the diagnosis proves doubtful, the therapeutic test may

decide. Under the specific therapy—the administration of foods that contain vitamin B—beriberi patients promptly recover.

Nutritional or war-oedema is allied to beriberi in that it is also a deficiency disease. It results from living on a diet containing too little protein and an excess of fluid and salt. Polyneuritis is not common in war oedema. Some cases of war oedema are probably due to an acute glomerulonephritis.

Patients with beriberi, usually complain of dyspepsia. They seldom have spontaneous pain but they lose all appetite, acquire a loathing for food and have a sense of fulness in the stomach, which, in the more severe cases, may pass into nausea and vomiting.

The first characteristic symptom as a rule seems to be weakness in the legs; later a moderate oedema, paralysis of the legs and general nervous disturbances such as irritability, headache, and dizziness are added. Changes in the skin, in the form of hemorrhagic exudates, often appear. Fever is usually absent unless complications ensue. Palpitation on exertion and shortness of breath are present and become more marked as the disease progresses. The heart is usually enlarged, especially towards the right, but the oedema is out of all proportion to the clinical evidence of cardiac changes during life.

With respect to the changes in the heart, the recent studies of WENCKEBACH are interesting. He found the right heart extraordinarily overfilled, the muscle being stretched and flattened out. These pathological changes throw light on the sudden deaths that are so common in beriberi. The vascular symptoms often closely resemble those of aortic insufficiency.

As long as fashion rules the day, sporadic cases of beriberi are likely to occur.

They may show only an incomplete picture of the disease, but, if the true cause of the symptoms is not recognised, the trouble may be ascribed to primary myocardial disease with inevitable failure of treatment.

The period of vitamin shortage that an individual may safely endure is variable, being influenced by several factors. It is quite possible, although by no means proved, that the oedema of wet

beriberi is due to a shortage of protein. This should suggest a multiple deficiency in this type of the disease.

Of the sources of vitamin B for clinical use, yeast and wheat germ are the best. Liver, kidney and brain are richer than muscle in vitamin B. The whole grains, because of their content of germ, contain appreciable amounts in contrast to the highly milled products such as white flour and degerminated corn meal. Among the fruits and vegetables, tomatoes, raw cabbage, fresh spinach and legumes have been found to contain more than orange or lemon juice, onions, cauliflower or lettuce. The vitamin in the egg is located in the yolk. Milk, although a good source of the pellagra preventive substance, does not contain a large amount of vitamin B.

(Abstracted from J.A.M.A., June. 16, 1934.)

The Treatment of Whooping-Cough.

(From the British Medical Journal, Vol. I 30th March, 1935, p. 657.)

When an infant or young child who has not previously suffered from whooping-cough develops a persistent, troublesome cough with scanty clinical signs of bronchitis, and if within two or three days the cough. which is worse at night, tends to occur in paroxysms giving rise to suffusion or blueness of the face and occasionally terminates by a vomit, suspect infection with H. *Pertussis*. If in such a case there is a history of recent, intimate contact with whooping-cough then the clinical diagnosis may be aided by examination of the blood picture or confirmed by the isolation of the Bordet-Gengou bacillus.

The presence of a leucocytosis (commonly 15,000 to 25,000 white cells per c.mm.) with a well-marked relative lymphocytosis (from 50 to 70 per cent of lymphocytes) is highly suggestive of whooping-cough.

It must be remembered that in infants and in adults the typical whoop may not appear throughout the whole course of the illness; bacteriological aid would simplify the diagnosis of such cases.

General Treatment.

Most clinicians with an extensive experience of whooping-cough are of the opinion that when the primary essentials of medical care

have been arranged for the patient we have practically exhausted our effective therapeutic armament. Vaccines, drugs, and ray therapy may be regarded as adjuvants to be given a trial when special indications arise.

When whooping-cough is suspected the patient should be confined to bed and strictly isolated from other members of the family who have not already suffered from the disease. Isolation should be enforced for a period of five weeks dating from the onset of symptoms. The bedroom, with a sunny exposure for choice, should be kept freely ventilated, but at an equable temparature around 60 degree F. If the weather is cool the child is clothed in flannel and a binder firmly applied round the abdomen is of supportive value during the strain of coughing. Some trustworthy individual should be constantly in attendance to support and to comfort the child during the paroxysms of coughing and to have a receptacle ready for the vomit.

Provided the attack is afebrile, uncomplicated, and not unduly severe, the child may be allowed out of bed about the third day of the whoop. When the paroxysms exceed thirty in the twenty-four hours, or when there is a previous history of chest trouble, confinement to bed until convalescence is well established is advisable. If the weather is equable and sunny the patient should spend most of his time in the open air, precautions being taken to avoid contact with susceptible children. The clothing should be light, and mild exercises should be encouraged. The bowels should be regulated by occasional doses of syrup of figs or liquorice powder.

Importance of Diet

The dietetic management of a case of whooping-cough is of the utmost importance. In severe attacks, particularly if improperly handled, the persistent vomiting results in a serious degree of malnutrition. The secret of feeding is to give small amounts at frequent intervals. Large meals should be avoided, and food administered preferably about ten minutes after a paroxysm. For babies "feeding by the clock" may have to be adjusted to the necessities of the case. If vomiting and loss of weight continue then the interval between feeds should be decreased and the bulk of such feed lessened. Various modifications of the diet may be necessary.

nearly always free from epilepsy during pregnancy, it being supposed that the foetus corrects the metabolic fault of the mother.

This evidence of a metabolic dyscrasia is not very clear or convincing. In epilepsy, when the attacks are frequent the alkali reserve is increased and there is great variation in the value of the blood pH from day-to-day. O. Foester states that in epileptics hyperventilation of the lungs by so simple a method as making the patient breathe deeply as fast and as long as he can, will bring about an attack at once by the excessive removal of carbon dioxide. It has been noted that a condition of *status epilepticus* develops in patients not previously epileptic by the use of alkalies in the treatment of gastric ulcer. Epilepsy is incompatible with acidosis and this may account for the rarity of epilepsy in diabetics. The good effect of a ketognic diet seems to suggest that alkalosis plays some part in the production of epilepsy.

A sudden drop in blood pressure precedes or accompanies an attack of epilepsy. This is seen clinically as a momentary facial pallor. It was observed by Foster Kennedy as a sudden blanching of the brain when a general epileptic convulsion occured during an operation in which the surface of the brain was widely exposed. Epilepsy seems to be a protective phenomenon to avert a dangerously falling blood pressure and dangerous alkalosis as the muscular convulsion with the arrest of respiration, concentrates the carbon dioxide ratio and lessens the alkalosis. Epileptics belong to the vagotonic group of Eppinger and often manifest such vagotonic phenomena as urticaria, asthma, and migraine.

The hypothesis that the epileptic attack is an expression of excitation of the brain has been abandoned, and, with Hughlings Jackson, it is regarded as due to loss of function, local or general in the brain. The positive events such as hallucinations and convulsions are regarded as release phenomena in lower regions of the nervous system following loss of function of the higher regions.

Treatment:—Epilepsy is fostered by inactivity of mind and body and warded off by activity. Hence, the excitation theory of the later Victorian period, which advocated rest and quiet, has given place to one of activity of body and mind. When such conditions as

rickets, renal diseases &c. are present, they must be *corrected*. A ketogenic diet. rich in protein and fat and deficient in carbo-hydrate is definitely beneficial. The medicinal treatment of epilepsy consists in the exhibition of luminal, bromides, and paraldehyde, and in rare cases, of zinc and belladonna. To get the maximum benefit, the drug must be administered before the anticipated attack, and if the remedies are not effective in ordinary doses, they will not be effective even in larger dosee. Luminal is the drug of choice and the maximum dose for the 24 hours must not exceed 3 grains. Bromides may be used when luminal fails or as an adjunct to luminal: the maximum useful dose of bromide is not more than 30 grains per day for an adult. Where these fail, zinc oxide 3 to 5 grains doses, in capsules, and Tincture-Belladonna in 10 minim doses, may be tried. Paraldehyde in four drachm doses dissolved in twice the amount of olive oil per rectum is effective in cases of *status epilepticus*.

Habitual use of Barbituric in India.

Abstracted from I. M. G. April 1935.

"(1) The use of barbituric acid derivatives has greatly increased in India during the last few years. These compounds have powerful hypnotic and pain-relieving properties being only second to opiates in this respect. (2) The fact that this group may produce toxic effects even in therapeutic doses and are cumulative in their action has not been sufficiently appreciated by the medical profession. (3) Their repeated use is harmful and dangerous, definite pathologigal changes being produced in vital organs. No tolerance is developed and any increase of dose may give rise to dangerous syptoms and even fatal results. The margin between toxic and therapeutic doses is very narrow and certain individuals are particularly susceptible to the action of these drugs. Caution is therefore recommended in their use. (4) Habit formation has occurred with these drugs in Indian subjects, but the desire for the repetition of the dose is more for relief of symptoms than anything else. They do not appear to produce euphoria, like opiates, hemp drugs and alcohol. Abstinence symptoms are not produced and habit can be easily broken."

The milk may be diluted, boiled and citrated or peptonized; whey and albumen water may have to be temporarily resorted to. In the worst cases, mouth feeding may require to be supplemented by rectal or intravenous saline to which 5 to 10 per cent of glucose has been added. Lavage of the stomach twice daily with 0.6 % solution of sodium bicarbonate is a useful measure when vomiting is frequent and persistent

With older children large meals must be avoided, but no material alteration in diet is necessary. Milk, eggs, butter, fish, chicken, meat, and vegetable soups are better than an excess of potato, bread, milk-puddings, jams, and similar starchy or saccharine foods. Biscuits, rusks, oatcakes, or other dry crumbly foods should be avoided. Fresh orange juice drinks sweetened with 5 to 10 % of glucose may be freely administered. A prolonged convalescence, with if possible a change of air, is advisable.

Vaccine and Serum Therapy

Very conflicting reports have been published regarding the value of vaccine treatment. It is generally agreed that no improvement can be expected to follow vaccine therapy unless the initial injections have been given during the catarrhal stage of the disease. This method of treatment has been given a prolonged trial in the wards of the Edinburgh City Hospital.

Drugs.

In spite of the numerous drugs that have been recommended for the treatment of whooping-cough, the writer, after an extensive experience of many preparations including belladonna, antipyrine, bromoform, benzyl benzoate, ether, and adrenaline, is of the opinion that none cane be looked upon as a specific.

In a mild attack there is no need for medication. If desired a simple expectorant mixture may be administered thrice daily :

R/	Tinct. camph. co.	....	m, iv
	Vin. ipecac.	....	m. iij
	syrup. scillae	....	m. x
	Aq.	....	q.s.

When the paroxysms are frequent and severe, resulting in considerable exhaustion and loss of sleep, a sedative or antispasmosdic drug should be prescribed. One or other of the following sedatives may be prescribed four-hourly, syrup of codeine phosphate 10 minims Dover's powder, ½ grain, with potassium bromide 2 grains. If necessary the dose may be cautiously increased until either improvement ensues or the child becomes drowsy. Phenobarbital (luminal) in doses of 1/6 grain to ¼ grain three times daily occaasionally results in a rapid amelioration of symptoms; because of its toxcity this drug should be employed with discretion. Belladonna is probably the popular drug in the treatment of whooping-cough ; in the dosage commonly prescribed it is quite ineffective. In an endeavour to control the paroxysms, belladonna must be pushed to the physiological limit. Commence with three drops of the tinture three times daily; then providing no idiosyncrasy is prsent, promptly change to four-hourly administration, followed by a daily increase of one drop per dose until dilatation of the pupils, flushing of the cheeks, and dryness of the mouth indicate that the limit of safety has been reached. During convalescence the patient should take codliver oil and malt with some preparation of iron, the syrup of the iodide of iron is excellent.

Prophylactic Measures.

Whooping-cough is most highly infectious during the catarrhal or pre-paroxysmal stage. To control the spread of infection the patient must be isolated early in the catarrhal stage of the illness, and herein lies the importance of early diagnosis. Every precaution should be taken to prevent young children, in particular, from being needlessly exposed to infection with H *pertussis*, Practically all the deaths from whooping- cough occur during the first three years of life.

Prophylactic vaccination is of value not so much in preventing the development of the disease as in modifying the severity of the subsequent attack. Five subcutaneous injections of 1,000, 2,000, 4,000, 8,000, and 8,000 millions Bordet-Gengou bacilli should be given on alternate days to contacts who have not previously suffered from whooping-cough. The injection of serum or of whole blood of a canvalescent or those, who had wooping-cough at some time in their life has been reported as resulting in complete or partial protection in a large proportion of cases,

For children under 4 years of age 5 c. cm of serum or 20 c cm. of whole blood should be injected intramuscularly.

In spite of the multiplicity of remedies recommended in the treatment of wooping-cough, an effective therapeutic agent has yet to be found.

KERNIG'S SIGN IN INFANTS.

In infants under a year Kernig's sign is very rarely obtainable; in children between one and two I have quite often found it not present but I have always found it in children over three. It is important that its absence should not be thought to exclude meningitis.

Head-retraction may also be absent in infants. Head rigidity would be better. In any patient with headache or delirium the head should be pulled forward to see if the chin will touch the chest. If it will not, there is intra-cranial pressure, and Kernig's sign should be looked for.

BY WALTER BROAD. M. D. CAMB.F.R.C.P. LOND.,

(Adaped from the Lancet March 3Cth 1935, p. 745.)

Digitalis in Pneumonia.

The question is still undecided whether the action of digitalis benefits patients suffering from lobar pneumonia or not. It is clearly settled that this drug can produce an effect upon the heart in pneumonia and certain observers, analysing series of alternate cases, have asserted that such action is on the whole *harmful*. In a recent careful study of what is a complicated problem, A. E. Cohn and W. H. Lewis (American Journal of Medical Sciences, April, 1935, clxxxix, 457) fail to confirm this pessimistic conclusion. They have analysed 1,456 cases of lobar pneumonia treated at the Hospital of the Rockefeller Institute for Medical Research during the years 1911—32. They selected eight unfavourable factors in the outcome of the disease (age, type of pneumococcus, type of work, alcoholism, bacteriaemia, number of lobes involved, cardio-vascular affections, and complications) and the mortality rates are discussed in relation

to these factors with the effect of digitalis as they appear to act in each group. They conclude that giving digitalis does not appear to influence the course of events in lobar pneumonia. The outcome in this disease depends entirely upon the "severity of the disease," which means in effect the number of unfavourable factors present. The action of digitalis in patients with auricular fibrillation or auricular flutter appears to be beneficial, although their evidence leaves it uncertain whether the action of the drug precipitates the occurance of auricular fibrillation or not. A further point brought out in the present series is that heart block did not occur during the febrile period in pneumonia except in such patients who had received sufficient digitalis to bring it about. With these possible exceptions the present analysis does not confirm the view that digitalis does harm in pneumonia. On the other hand save in the cardiac complications mentioned above, the drug does not appear to produce any beneficial influence.

(Practitioner July 1935.)

Treatment of Constipation.

A plea for the same approach to a case of constipation as to any other complaint or disease, including a naked-eye examination of the stools, is made by G. Evans (St. Bartholomew's Hospital Journal, May, 1935, xlii, 154) in order that primary types of this disorder may be clearly differentiated from those in which constipation is but a symptom of some other, often more serious, malady. Some elementary facts of physiology must be taught to the patient with constipation, such as, that the normal state of the bowels is full, not empty, and that what matters is not the contents of the intestine but the health of the mucous membrane, which is best maintained by contact with food residues. The importance of establishing the daily routine of defaecation is stressed. The patient with constipation must arrange his day so that he has no pressing occupation for at least three quarters of an hour after beginning breakfast, at the end of which period it is the best time for him to go to stool. A glass of water on going to bed and another before breakfast is advised and if the stools are still hard with this a teaspoonful of paraffin oil daily or on alternate days is recommended. In case the bowels do not act, the

patient is given a low residue diet and if there is any evidence of spasticity of the bowel, tincture of belladonna 7½ minims, is given three times a day. The patient reports on the third and fourth day and if by this time the action of the bowels is excessive the paraffin is stopped, the belladonna reduced and residue is added to the diet. Fatigue is reckoned as an important cause of constipation and a day in bed will sometimes restore bowel function to normal. For the type of constipation associated with a delay in the passage of food residues along the whole length of the colon a tonic is recommended such as tincture of nux vomica, combined with 5 to 10 minims only of liquid extract of cascare. The type of trouble associated with hard faeces in the rectum, which should normally be empty, is treated by a full residue diet containing plenty of cellulose, as in fruit, vegetables, and brown bread, while agar is a useful adjuvant.

(From the 'Practitioner' July 1935.)

Diet in Disease.

1. *Diabetes*:—In chronic Diabetics, restrictions in quantity and quality of carbohydrates with insulin give better results than either of these alone.

The following are allowed:—Fish, meat, chicken, sweetbread, boiled eggs, cream, butter, curds, jawari or bajari flour instead of wheat, almond nuts, soya beans, cabbage, lettuce, spinach, tomatoes, acid fruits, grapes, honey and alkaline waters. In addition to restricted diet, patient should have regualr exercise, hot bath, and periods of rest, (suitable to his restricted diet), fair amount of sleep, less worries the better. Boiled preparations are preferable, as digestion as a rule is not good.

2. *Constipation*:—Sticky and concentrated diet is the common cause. Inadequacy of digestive juices makes the system sluggish, Leafy vegetables like cabbage, spinach, salads, celery, carrots, tomatoes, turnips among vegetables, papaya, figs, prunes among fresh fruits, nuts, wholemeal bread, and honey are indicated. Regular exercise, plenty of drinking water between meals, outdoor life, fair amount of milk, butter and cream are very helpful. Laxatives do more harm than good.

Regular habits and observance of "of early to bed and early to rise", gets a favourable response. Food with roughage sweeps the inside like a broom. Rendel Short considers sticky and concentrated diet as a cause of appendicitis.

3. *Gout and High Blood Pressure*:—Moderation is the keynote, both as regards quality and quantity. Live a simple life in thought and deed. More of vegetable diet, should be taken. Avoid meat; proteins in the form of milk, eggs and fish allowed. Avoid rich spicy dishes and pastry. Use of alkaline natural waters like Evian, very helpful, village and open air life more conducive to health.

4. *Diarrhoea and Colitis*:—Begin with a dose of castor oil or liquid paraffin.

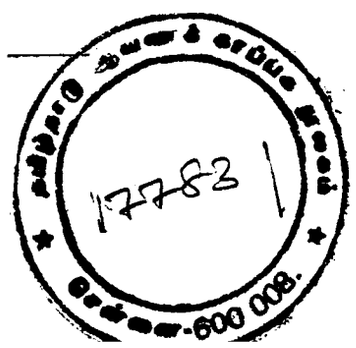
Fruit juices of sweet limes, oranges, pomegranate, cocoanut water, and glucose are allowed. Gradually add milk to the dietary modified by addition of lime water or citrate of soda, albumin water, rice water, barley water, and gradually come to arrowroot, sago, tapioca, curds, whey, fruit jellies. Remember what is irritant on the surface is irritant within.

5. *Typhoid*:—Fruit juices, glucose and sponge baths do the needful. Gradually add as under 4. Bloated stomach warrants restricted diet. Pump in as much as is utilised.

6. *Pneumonia*:—Supporting diet, soups, egg fillip, liquid peptonoids, Brands essences, milk in various modified forms as under 4. Support strength from first day, Rest in bed conserves strength.

7. *Phthisis or Wasting Disease*:—Easily digested food selected from above, and milk in its various modified forms as above, accompanied by fruits, creams, butter in small feeds at short intervals.

(Antiseptic June 1935)



Emetine in Peptic ulceration.

A. E. Olop. (Med. Record., November 7th, 1934, p 472.) treated over 400 cases of gastric and duodenal ulceration by intravenous injections of emetine hydrochloride. In each case relief was complete in periods ranging from three days to one week. There were thirty recurrences, and in each there was a history of alcoholic excess. The dose is about 1 grain of the salt, which is dissolved in 6 c. cm. of trebly distilled water Saline solution seemed to cause irritation. One injection into the median basilic or cephalic vein is given on alternate days, until six have been administered. Then follows an intermission of a week, when the injections can be repeated. Olpp has never found it necessary to go beyond nine. The patient should always have an empty stomach at the time of injection, as otherwise he is very likely to vomit Occasionally there may be slight dizziness or nausea, but this can usually be prevented in subsequent injections by the prior administration of half a drachm of sodium bicarbonate in a little water.

There have not been any severe reactions, despite this method having been employed in at least three instances where cardiac trouble was present. While the injections are being given the patient is kept on a bland salt-free diet of milk, eggs, cream, cheese, custards, white bread and cream soups. Alcohol in any form is strictly prohibited:—(B. M. J.)

Chronic Nasal discharge in children.

Dr. M. O. Abdeen (Otolaryngologist, Government Hospital, Alexandria, Egypt) writes that the treatment of such children should be general and local.

General treatment:—(1) Carbohydrates and salt should be limited in their food. (2) Clothing should be just sufficient to keep them warm, as these children are usually over-clothed. (3) To be in the open air as much as possible. (4) General ultra-violet treatment to be given. (5) The following to be taken t. d. s. Tinct. iod., 2 minims, syrup pruni, 1 drach. Iodine, if tolerated, could be increased, and haliverol, 2 minims, taken after meals.

Local treatment;—(*a*) By the physicians: Painting upper lip (as such patients usually have excoriations of their upper lips,) also inside of nose, with 5% silver nitrate followed by white precipitate ointment every second day. (*b*) By the parents. The nose is to be tickled to induce sneezing to clear the nose, as most children do not clear their noses properly. After the nose is cleared use the following drops twice daily, with head low down for the drops to reach the adenoids: adrenaline 2 drachms, argyrol 5 grains, aq., ad. I. ounce. Four drops in each nostril morning and evening. If tonsils or sinuses are diseased they should, of course, be treated, and the possibility of diphtheria should not be overlooked.

Sepsis and the Skin.

(By JOHN T. INGRAM, M.D., M.R.C.P., LOND.)

SEPTIC affections of the skin are worthy of more attention and better treatment than is generally bestowed upon them. We usually know the cause of these troubles. But we find that fashion and fad often govern much of our practice, and there are as many medical and quack remedies for such simple infections as boil and impetigo as we might expect for an obscure and hopless disease of unknown aetiology.

I wish first to draw attention to a few practical points in regard to the common simple skin infections.

Simple Infections.

Impetigo:—A superficial streptococcal infection is often secondary to parasites, particularly to pediculosis capitis, in children. Impetigo is a vesicular and bullous eruption, and it is therefore irrational to treat it with a white precipitate or any other ointment. An ointment cannot intermingle with the infected fluid, and will ride on that fluid insted of sitting on the infected surface. Treatment should be by means of a paste which absorbs the infected fluid, and so comes into direct contact with the infected surface.

R/	Hydrarg Ammon	....	gr. x.
	Acid Salicilic,	....	gr. x.
	Zinc Oxide,	....	
	Amylum	aa	gr. cxx.
	Paraff. Moll.	ad.	oz. i.

Fissures are the seat of streptococcal infections, but fissures are rarely primary. When they are primary, they readily respond to simple cauterisation with silver nitrate or chromic acid, provided this is done thoroughly. Fissures are, in the great majority of cases, secondary to eczema or other skin disorders, and disappear without any specific treatment for the fissures if the underlying eczema is treated. Thus a little white precipitate in a tar ointment will more commonly clear, and clear permanently, than will cauterisation.

Fissures between the toes are almost invariably due to ringworm infection, and the chronic eczematisation which often accompanies that infection. Whitfield's benzoic and salicylic ointment and, later, tar ointments are indicated here.

Fissures about the angles of the mouth and nose mean intranasal, sinus, or dental infection or irritation, in the great majority of cases. Chronic fissures at the angles of the mouth are often symptomatic of gastric and blood diseases, particularly of achlorhydric anaemia. Fissures are symptomatic and not primary, in spite of the fact that they can themselves give rise to very serious secondary troubles, as lymphangitis, adenitis, abscesses, elephantiasis, erysipelas, and septicaemia.

The treatment of cellulitis and abscess formation does not call for comment from me except to recall the value, in the later stages, of general ultra-violet light therapy, which is not practised sufficiently. The very great value of codliver oil to restore the balance between connective tissue and epithelium should be stressed.

Whitlows:—Dry heat is always better than wet, macerating heat, and finds an important place in the treatment. The minimum of surgical interference is desirable; extensive incisions, squeezing, probing, scraping, dilatation with sinus forceps, cauterisation, packing with antiseptics and such violent, primitive, and barbaric measures, which can be witnessed daily in most casualty departments, should be forbidden. Radiant heat, occasional swabbings with a *mild* antiseptic lotion, rest, and a simple and reasonable incision when the lesion is pointing is indicated & if fomentations are employed, they should be applied every ten minutes for an hour. Soaking in hot lotions is desirable, however, when such lesions are discharging for short periods.

Boils and Carbuncles.

The simple superficial pustule demands to be left alone and to be sealed-in with collodium is the best treatment. Rest, dry heat, tonic therapy or other symptomatic measures may be indicated.

For extensive areas of superficial pustules so called Bockhart's impetigo-painting with malachite-green is invaluable and causes no irritation.

Hydrag. Perchlor	½ per cent
Brilliant Green	½ per cent
Indust. Spirit	99 per cent

Bengal Chemical.

CALCUTTA.

Mr. P. R. Y. Iyer of the above company demonstrated a cinema film of the working of their company, in the Gaiety Theatre, Trichinopoly at 3 P. M., on 30—7—35. There was a large and appreciative audience consisting of about 40 medical men, members of the staff and students from the Holy Cross women's college, the National and St. Joseph's colleges. The manufacture of the various medicines, surgical requisites bio and chemical laboratories were vividly shown.

At the conclusion of the show, Prof. P. E. Subramanya Iyer, M A., of the St. Joseph's College thanked the organisers for giving them this opportunity of learning the advances in modern science and the success of an Indian Industry started on a modest scale by Sir P. C. Ray an eminent educationist and scientist. With the distribution of literature, soaps and samples the function terminated.

P. A. S. RAGHAVAN.

The Trichinopoly District Medical Association.

(REGISTERED)

A monthly meeting of the above association was held at 5 P. M., on Saturday the 20th July 35. at the E. R High School, Teppakulam, when about 45 members were prsent. Dr. C.E.R. Norman, F.R.F.P. &S., D.P.H., L.A.H., C.H.,Chief Medical Officer, S I.Ry. and President of the Association presided and Dr N. C. Subramanyam B.A, M.B.B.S., was "At Home" to the members.

The Secretary moved the following resolution which was carried unananimously:-

'This Association requests the District Medical Officer, Trichinopoly and the President, District Board, Trichy, to issue a general circular to their medical sub-ordinates permitting them to attend meetings of the District Medical Association, which will be held on Sundays, Penultimate Saturdays or on Holidays, so as to obviate the necessity of applying for permission each time'

Dr. B. S. Viswanathan, L. M. & S, of Coimbatore delivered an interesting lecture on 'MODERN TREATMENT OF TUBERCULOSIS' and discussed the different methods of treating the disease at various stages. He also demonstrated an 'Artificial Pneumo-thorax' apparatus and explained its technique. He showed a number of skiagrams of 'Tubercular lung' at various stages of treatment

Dr. Rajan demonstrated a case of acute Pulmonary Tubercular lung which showed remarkable improvement under 'Pneumo-thorax treatment'. Then an interesting discussion followed in which many members took part.

Dr. Raghavan demonstrated a 'Collosal Transfusion Ampoule' and explained the technique of its use and said it was ready and simple to use.

With the chairman's concluding remarks and a vote of thanks to the Host, the Lecturer and the Manager of the premises the meeting terminated at a late hour.

TRICHINOPOLY,
23rd July 1935.

P. A. S. RAGHAVAN,
Secretary.

MISCELLANY JULY 35

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