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NO. 8

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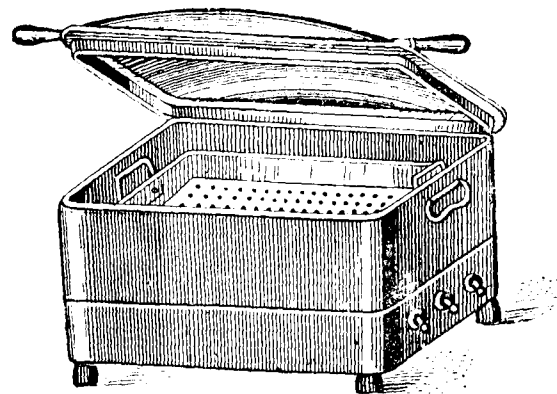
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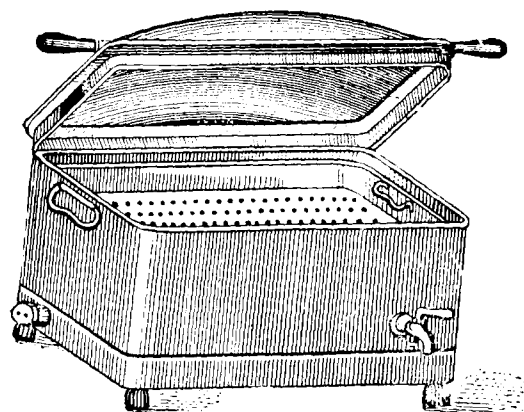
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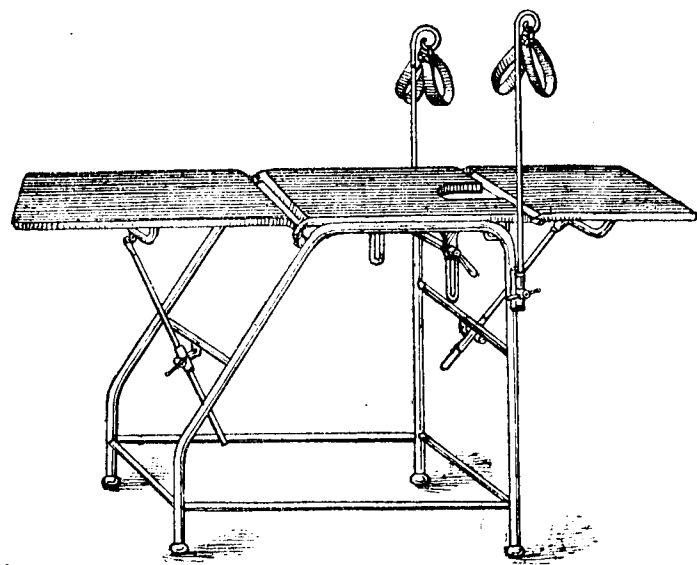
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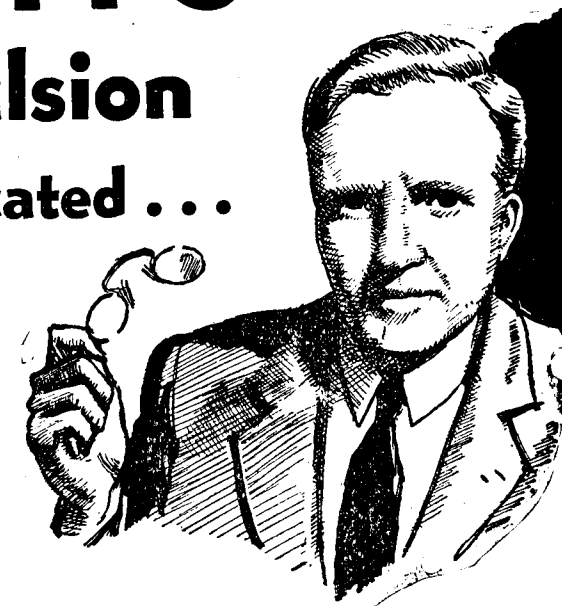
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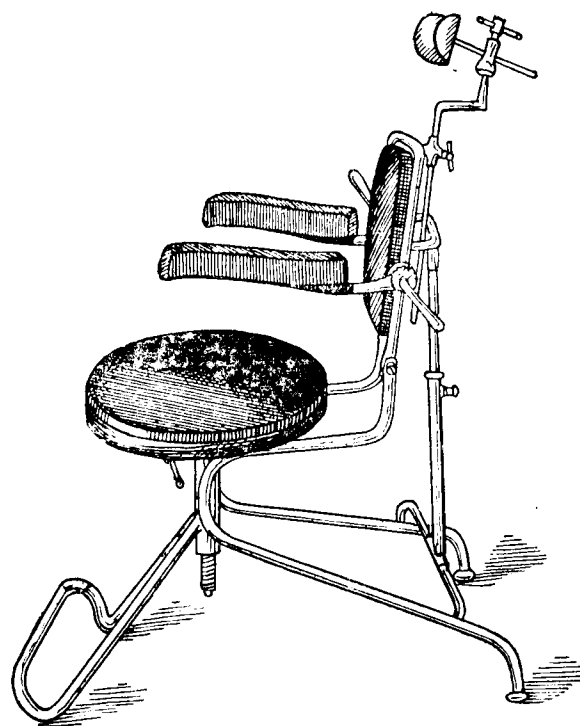
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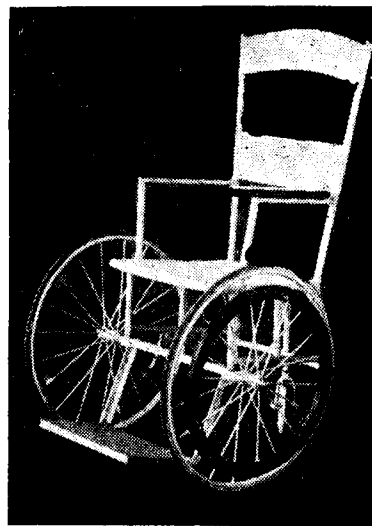
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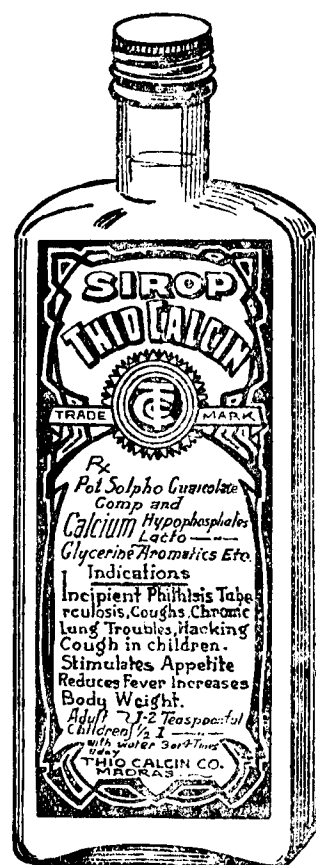
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Associated Editor : Dr. P. R. Venkappaya.

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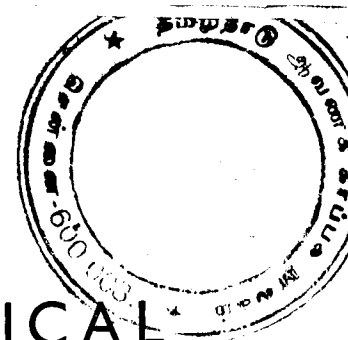
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MEDICO-SURGICAL SUGGESTIONS

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Original Article

B. COLI INFECTIONS OF THE GENITO-URINARY TRACT

BY DR. M. RATHNAVELU, L.M.S.

*Hony. Asst. Surgeon, Venereal Department, Govt. General Hospital,
Madras.*

B. Coli produces pyuria and infects the urinary tract, especially the bladder and kidneys. The B. Coli group is as large and as complex as the streptococcus group and it includes members which differ widely in pathogenicity. It may be found in the urinary bladder and it is as it were saprophytic there. It may give rise to non-specific urethritis in both sexes.

Modes of infection—In health, B. Coli are confined to the intestine. The modes of infection to other parts of the body than the bowel are three-fold.

1. The direct route, by the immediate transference from the bowel to the infected area; 2. by the lymphatics and 3. by the blood stream. Infections of the urinary tract occur directly through the urethra. B. Coli cystitis frequently follows as a result of septic catheterisation and is more common in women than in men. In acute Pyelitis, the infection proceeds through the blood stream to the kidney and then to pelvis. In acute primary infections of the urinary tract, which are very common in both sexes, the mode of entry of the bacillus to the pelvis of the kidney is problematical.

Sites of infection—The intestines, gall-bladder, appendix, diverticuli-periclon, peritoneum and urinary tract are the usual sites of infection! Other sites of B. Coli infection are the uterus, fallopian tubes and rarely the middle ear, the pleura, the bronchial tract, bone and joints are infected. The urinary tract is infected more frequently. Urine is sent for culture to isolate the causative organism for preparation of auto-vaccine, using catheter specimen. B. Coli in the urine may signify one of the following conditions; (i) bacillus may be eliminated from the body through the kidney without infecting either the organ or of the urinary tract and this

process may be intermittent and of brief duration; (ii) *B. Coli* may be excreted with pus from an infected kidney or from some focus of infection adjacent to the urinary tract, as prostate, urethra and pericolic tissues. (iii) Pyelitis, cystitis and pyelo-cystitis; (iv) Bacilluria.

Acute cases—In the majority of cases the infection appears in the pelvis of the kidney and some may be vesical in origin. It begins with high fever as 103° to 105° F, preceded by rigors. Usually the symptoms are abrupt and severe, but not alarming. There may be pain and tenderness in the loin and one or other kidney may be tender under bimanual examination. In cases of bladder infections, symptoms of dysuria are present as frequency, pain and stranguary.

The urine shows a great variation in its features. There may be hæmaturia. *B. Coli* infection may be the cause of many obscure cases of hæmaturia. The amount of pus may vary in amount. It may be abundant or scanty. In advanced severe cases, parts of the bladder mucus membrane may be separated in sloughs, but these are rare. Like the pus, *B. Coli* may be present in varying degrees in the urine, in some they are so plentiful as to constitute the greater part of the total sediment. The color and amount of the urine depend on the degree of fever and the amount of fluid ingested. Constipation is very common. The infection takes a dramatic course in children. There is a maximum rise of temperature as 105° or 106° F. with long intermissions and produces a minimum of serious effect upon the vital organs. The child is very ill during the pyrexial stage and is comparatively well as the temperature falls.

The course of the disease varies greatly. Early diagnosis followed by efficient treatment cuts short the course of the infection and the pus and *B. Coli* disappear from the urine in 1 to 2 weeks. Some cases run a prolonged period of many weeks in spite of early diagnosis and efficient measures of therapy. Relapses are very common. Of complications, prostatitis is the most common, epididymitis and urethritis are rare.

Recurrent cases may occur. The condition of the patient and the urine appears normal between the attacks. Recurring hæmaturia is sometimes due to this condition.

Chronic cases—may arise (i) as the result of acute attacks not having completely resolved; (ii) insidiously (iii); due to instrumentation or operations upon the urinary tract or (iv) due to stricture urethra or enlarged prostate or (v) as secondary infections in cases of renal or vesical calculus or of tuberculosis.

The symptoms vary greatly in these chronic cases. General toxic symptoms may predominate in one group or local symptoms may be prominent in another group as increased frequency of micturition with stranguary, pain during or after the act and referred pain and discomfort in the vesical area. In a third group there

may be very little impairment of health, general or local, save for the state of bladder—neurasthenia in the mind of patient.

The urine varies greatly as the symptoms in chronic infections. The reaction is generally acid, there is characteristic fishy odour, the pus may vary in amount, may be very considerable or very little, but the condition of the patient is not in proportion to the degree of pyuriamucus is in excess, the *B. Coli* is constantly present, varying in quantity as the pus. Hæmaturia is rare in chronic cases, but is readily produced by instrumentation, which flares up of the chronic state, followed by rigors, high fever, severe malaise and relative anuria.

Bacilluria is the term applied to a urine which is loaded with bacilli, but contains no pus, or at most a few leucocytes seen on microscopic examination. It is a state of kidney elimination of bacilli rather than a condition of bacillary infection. It has a short duration and the urine has a characteristic appearance, shimmering when agitated and viewed by transmitted light. Fishy odour is present here also.

B. Coli septicaemia is rare unless it occurs as a terminal event, which is very common. It is not always fatal.

TREATMENT.

General—In acute cases, complete rest is essential. In chronic cases, it is better to avoid cold and fatigue. As the intestine is the chief source of infection, it is to be attended to primarily. The bowel contents have to be altered in such a way that they no longer serve as medium for the growth of the bacilli. This is best attained by a diet which is low in total protein content. In acute cases, calomel is very useful combined with salines. In chronic cases, laxative is enough. A cachet containing salol grs. x, Hydrarg cum creta gr. ½ given with water, between meals, two or three times daily is the best intestinal antiseptic. A course of high colonic irrigations is indicated if mucus persists in the stools in spite of the above measures or it may be given as a preliminary treatment to be followed by them. In acute infections with pyrexia, alkalies as soda bicarb and Pot. citras are very useful and should be continued till the urine has been alkaline for 3 or 4 days. Hexamine acts best in the urinary tract infections, when the urine is acid. So Acid Sodium phosphate is given along with Hexamine. Cystopurin Hexamine Sodium Acetate grs. xxx; Helmitol-Hexamine with citrate grs. xv to xxx and Caprokol-hexylresorcin'grs. ii to x, are useful.

B. Coli infections of the urinary tract clear up entirely with cytotropine (Scherring) or a course of Amphotropin injections (Bayer). In the case of obstinate feverish pyelitis, intravenous injection of 10 to 20 c.c. Amphotropin is very effective. Even a big dose of 40 to 60 c.c. of Amphotropin is injected intravenously in severe chronic cases without producing any untoward effects on the

kidneys. In large doses, the disinfectant action sets in suddenly and feverish pyelitis and cystitis which had defied every kind of therapy for a long time, could be improved immediately. The patient should take a large quantity of fluids during the Amphotropin treatment to flush out the urinary tract and to dilute any urinary substances that are likely to cause irritation and thus prevent the occurrence of painful tenesmus. The turbidity of the urine clears up rapidly and the pus in urine disappears with 2 or 3 injections of Amphotropin.

Local treatment.—B. Coli infections of the urinary tract last several weeks and may clear up entirely with lavage or irrigation with oxycyanide of mercury 1 in 6000. There may be a recurrence if the focus of infection is in the pelvis of the kidney.

Specific therapy.—B. Coli vaccine supplements the general and local treatment. In sub-acute cases, vaccines are given starting with small doses as .05 million at an interval of 5 to 7 days according to the nature and severity of the reaction. In chronic cases vaccines are very useful. In some it produces dramatic result, but in others it has very little effect. Stock vaccine is of very little use. Fresh urine has to be sent for culture to prepare a course of auto-vaccine which is the best. Prophylactic treatment by Coli vaccines may be tried before the operation of prostatectomy in cases of infected urine. A graduated dose of 5 to 250 m. auto-vaccine is given with good results.

References—

Price—Medicine.

Taylor—Medicine.

Selected Articles

NOTES ON THE TWENTY COMMON SKIN DISEASES

BY E. ROSANOVE, M.B., B.S., M.R.C.P.,

Clinical Assistant to Dermatologist, Alfred Hospital, Melbourne.

Dermatology has over 350 distinct clinical conditions, but an examination of published statistics shows that a thorough knowledge of, at most, twenty conditions will make us 75 per cent proficient in skin diseases. It is even possible to become almost 50 per cent proficient by studying only seven diseases, but this is not at all recommended, as it leaves out such common occurrences in general practice as hives, warts and scabies.

Goodman has published statistics of the ten most common skin diseases. These were taken from the attendances at several large clinics over many years, and included over 973,000 patients.

Herman Lawrence gives a very interesting analysis of the incidence of skin diseases in Australia, covering nearly 30,000 cases.

Twiston Davies in a recent article, gives his analysis of the frequency of skin diseases in the British Isles. These cases include his

own and cases attending three large London Hospitals. They differ very little from the other classifications; and he states that nearly 80 per cent of all cases could be included under twenty headings.

What are the twenty most common conditions? Although the order of frequency in the above lists varies, the list of diseases is remarkably constant. It is very noticeable that in the Australian list the "epithelial triad," namely keratosis, rodent ulcer and epithelioma, figure prominently.

In every list eczema is first. Let us compare the average order of frequency in Goodman's American analyses with Lawrence's Australian list:

LAWRENCE.	GOODMAN.
1. Dermatitis and Eczema.	1. Eczema.
2. Seborrhoea.	2. Acne.
3. Rodent Ulcer.	3. Scabies.
4. Keratosis.	4. Seborrhoea.
5. Acne.	5. Impetigo.
6. Psoriasis.	6. Psoriasis.
7. Impetigo.	7. Dermatitis venenata.
8. Epidermophytosis.	8. Urticaria.
9. Rosacea.	9. Tinea.
10. Pruritis.	10. Alopecia.
11. Scabies.	11. Pruritis.
12. Naevi.	12. Verrucae.
13. Alopecia Areata.	13. Ecthyma.
14. Verrucae.	
15. Furunculosis.	
16. Epithelioma.	
17. Urticaria.	
18. Papillomata.	
19. Lupus Erythematosus.	
20. Sycosis.	

Lawrence's list includes all the conditions in Goodman's and Davies' statistics (except pediculosis and ecthyma), and, as it includes the "epithelial triad" which is so common in our dermatological work in Australia, I intend to take him as our guide. The list, however, may, with advantage, be reduced to nineteen by omitting lupus erythematosus. The diagnosis of this condition may be difficult, the treatment certainly is, and it is not sufficiently common to warrant much study by the general practitioner.

I am not going to attempt a full description of each condition, but a few notes on each may be of interest.

1.—ECZEMA.

At the head of every list is eczema. Lawrence settles the vexed question of terminology by putting eczema and dermatitis together, apparently using the terms synonymously.

Eczema or dermatitis? Confusion originally arose through Hebra, of Vienna, and his school using the term *eczema* to denote a common polymorphous affection which could at any time be produced in any person. Nowadays the term is limited to a disease which cannot be produced artificially, as it implies the existence of a predisposition. Eczema is definitely related to the sensitiveness of the patient. Andrews defines *eczema* as "a form of cutaneous reaction to local irritants in a hypersensitive individual, or as a manifestation of endogenous toxins in a predisposed area." Norman Walker, however, states that the term *eczema* is a cloak for ignorance. He cites the old name of *eczema marginatum* of the groin, which is now known to be a fungus infection due to the *epidermophyton*. It has been said that the term *eczema* should be considered as a dermatological rubbish heap from which clinical entities are continually being rescued.

In order to produce a cutaneous reaction, it is necessary to have: (1) a predisposition in the skin to react; (2) a determining cause.

The predisposition may vary enormously. Some people react violently to the mildest of irritants, and others only weakly to very strong irritants.

The determining cause may be exogenous or endogenous. It is impossible, clinically or histologically, to distinguish between a reaction produced by an exogenous cause from one produced by an endogenous cause. Therefore Darier says that there are no boundaries between an artificially produced dermatitis and a true *eczema*. So he sees no reason for withholding the name of *eczema* from any dermatitis or *eczematisation* whether of artificial or spontaneous origin. He applies the term to all inflammatory skin reactions in sensitive persons, characterised by a series of elementary lesions which combine or co-exist in spots or patches, whether due to an exogenous or endogenous cause.

Norman Walker directly opposes this view. He advises the use of the term dermatitis, and thus admit our ignorance of the cause; when the cause is known, he recommends the term *venenata*. *Venenata* means poison, and this is used here in its broadest sense, including soap, sugar, plants, etc. Walker includes the occupational dermatoses in this group.

All of them are called by Darier *eczema*, and by Walker dermatitis. I think the problem is solved by Andrews. All forms of the characteristic skin inflammation due to known causes he labels dermatitis, but distinguishes each by a separate adjective, e.g., dermatitis *venenata* is limited to the reaction due to plants; dermatitis *medicamentosa*, that due to drugs; industrial or occupational dermatitis is self-descriptive. Eczema is therefore limited to that type of chronic skin reaction in a sensitive individual of unknown etiology, whether exogenous or endogenous.

A discussion of the treatment of *eczema* is too large for the scope of this article. In infantile *eczema*, I would like to stress the good results obtained with crude coal tar in one or two per cent. strength in zinc cream. A very recent development in the treatment of *eczema*, which I am investigating at present, is the use of vitamin therapy in acute or chronic *eczemas*. This followed on an article by Conel, who reported excellent results after using vitamins A and D in doses of 5000 international units per day for three or four weeks. I use radiostoleum in doses of half a drachm night and morning for adults, and fifteen minims night and morning for children. So far I have obtained marvellous results in a large number of cases, and not so good results in others. The treatment is applicable in all cases, whether of exogenous or endogenous origin.

2.—SEBORRHOEA.

This term, which means hyperactivity of the sebaceous glands, includes *seborrhoea capitis* (dandruff), *seborrhoea corporis* and *seborrhoeic dermatitis*. McLeod states that the "greasiness of the skin acts as a predisposing factor by rendering the soil more fertile for the growth of the causal microbe." The microbe is the *pyrosporon* of Malassez, which is also known as the bottle or flask bacillus on account of its shape. McLeod and Dowling, after much difficulty, succeeded in getting a culture of this bacillus, and in proving that it was the causal microbe.

The dry, infected scales of dandruff drop on to the greasy body, and there produce patches of *seborrhoeic dermatitis*. Naturally these occur most commonly in the mid lines of the front and back of the chest.

The importance of *seborrhoea capitis* lies in the fact that it is a very common cause of premature baldness. *Seborrhoea* invariably precedes acne, and the treatment of the *seborrhoea*, especially of the scalp, is essential in order to get the best results in acne.

A sulphur and salicylic acid ointment of each three per cent., together with a spirit shampoo for the scalp, will clear every case of dandruff; but it is important to continue with the treatment once weekly, may be for years, as re-infection is so common, especially from brushes and combs, which should be regularly sterilised. For the severe weeping condition behind the ears, daily painting with 2 per cent silver nitrate solution, or with tincture of iodine (which is more painful), is effective.

3.—RODENT ULCER.

Rodent ulcer is the common name for a basal-cell epithelioma which may be a rodent ulcer, or a small nodular tumor which may later ulcerate, or it may be a superficial pagetoid type. In each case there is a characteristic rolled pearly border, which surrounds the whole or part of the lesion. This border may be hidden under a crust, and not seen until the crust is removed.

Rodent ulcers often arise from keratoses. This is very common in Australia. Removal of the dry scale will sometimes show a rodent with an incipient pearly border.

Basal-cell epitheliomata are differentiated from squamous-cell epitheliomata as follows:—

(1) *Distribution*.—Rodent ulcers are found mainly on the forehead, temples, eyelids, nose and upper lip; whereas squamous-cell occur on mucous membranes, muco-cutaneous junctions and the extremities.

(2) *Duration*.—Rodent ulcers are slow growing, usually taking years to reach the size of a pea. Any tumor which reaches this size or larger within twelve months is almost certain to be a squamous-cell epithelioma.

(3) *Edge*.—The pearly rolled edge is very rarely seen in squamous-cell epithelioma, but it is characteristically seen in rodent ulcer.

(4) *Inflammation*.—There is usually some reaction in squamous-cell, but not in basal-cell tumors.

(5) *Glands*.—These are not involved in rodents, but when a squamous-cell becomes very large the glands may be involved. Rodent ulcers are not malignant as the tumor is limited by the basal layer of the epidermis, which remains intact, and metastases do not occur.

(6) *Age*.—Both usually occur in the fourth decade or later, but they may occur earlier. I have seen a rodent ulcer in a boy of twelve.

(7) *Histology*.—The two conditions are distinctive on section. Rodents show an intact basal membrane, whereas in the squamous-cell the malignant cells have broken through the basal layer and invaded the corium.

The relative frequency of rodent ulcers in Australia is due to the prolonged and continued effect of the actinic rays of the sun on the unprotected skin. The colored races are sufficiently protected by the pigment melanin in the skin. Tanning after sun bathing is Nature's protective effort. Similar actions and results occur in people subject to prolonged, or multiple, unprotected exposures to X-rays.

Herman Lawrence considers that the relative low humidity of the atmosphere is also an important factor.

The treatment of rodent ulcers is by radium or X-rays. Radon seeds, which unfortunately are only available to a very few men, are probably the most satisfactory method of applying radium. They are safe, and the dose can be estimated very accurately. In London any dermatologist can ring up the London Radium Institute and get the number of radon seeds he needs at a very low cost.

X-rays in large doses, two or three pastille doses once a fortnight, will give excellent results, but care must be taken that the surrounding skin is protected, and that the edges get their full dose.

4.—KERATOSES.

The importance of keratoses lies in the fact that rodent ulcers usually arise from them. Any keratolytic ointment, such as salicylic acid or resorcin is merely palliative. Best results are obtained with radium or carbon di-oxide snow.

5.—ACNE.

This very common complaint is definitely curable. It is important to realise that a young girl or boy with an acne vulgaris of the face, even if the lesions are not very profuse or noticeable, is highly sensitive of the disfigurement. Many of these cases develop a neurosis about it, they refuse to go out, and feel that people think they are suffering from some horrible disease. It is, therefore, very unwise to suggest to them that they should not worry about it, that the condition will get better anyway when they get older, about 25 or so. But what of the intervening years?

The treatment is certainly usually prolonged, and should be intensive, but in almost every case it is curative, and in every case the improvement is very great.

As I said before, seborrhoea invariably precedes acne, and the treatment of the scalp is very important in every case. The hyperactivity of the sebaceous glands of the face or back in acne is checked by fractional doses of X-ray. The local condition is treated by lotions containing sulphur, and if pustular, some mercury is added. Thorough washing with soap before applying the lotion is important. The comedones (blackheads) should be expressed regularly with a comedo extractor.

In the more severe types with scarring, an ointment containing resorcin and salicylic acid, commencing with a weak strength and gradually increasing up to 6 per cent of each, will be found very effective, but must be used cautiously. This dries the skin thoroughly, and makes it peel.

General treatment consists in dietetic control, avoiding especially chocolates, rich cakes, pastry and all spicy foods; fresh air and exercise; regulation of the bowels, and the administration of an iron and mag. sulph. mixture.

In the cases that develop continuous crops of pustules, I find good response to a 5 per cent ointment of oleate of mercury, and injections of manganese butyrate, which I think are better than either a mixed staphylococcal or acne vaccine.

That type of acne in young girls which is limited to the chin area is almost certainly associated with an utero-ovarian disturbance. In these cases suitable endocrine therapy is indicated in addition.

At the end of a few months most cases of acne are cured. Relapses occasionally occur, and these are treated in the same way, usually only a very short course of treatment is then necessary.

I feel convinced that most acne could be prevented. At puberty there is hyper-activity of all the glands, including the sebaceous glands. This is the precursor of acne. The scalp should be carefully shampooed at least once a week, and any dandruff thoroughly treated. The face should be washed each night with soap, and any blackheads expressed with a comedo extractor. Excessive greasiness of the face should be treated with a calamine and sulphur lotion.

Let me repeat that no case of acne should be neglected or given up as hopeless. The enormous number of people that you see in the streets every day (if you look) with acne, is astonishing. Most of them, surely, must apply for help to their local doctor. Do not tell them that it will disappear in time without any treatment. Apart from anything else, it is not always true.

6.—PSORIASIS.

This very tantalising condition can be relieved each time an attack occurs, but we certainly cannot do anything to prevent an attack recurring.

The scales on patches most commonly found on the extensor surfaces, which, on scratching, produce a shiny silvery area, and which, on further mild scratching, will bleed easily, make the diagnosis fairly easy. It is often difficult to distinguish it from psoriasiform seborrheids, but this does not give the typical silvery shining scaling. Syphilis is renowned for its tendency to imitate innocent dermatological lesions, and it may be a trap in both the above conditions. You will get a positive blood test in a surprising number of cases.

A help in the diagnosis of psoriasis is the presence of a thimble-like pitting of the finger nails. This is not always present, but when it is, Dowling considers it to be pathognomonic of psoriasis. I have certainly not seen it in any other skin condition. Sometimes only one nail may show the sign.

Psoriasis of the scalp is easy to miss. It may be there only, or it may be on the body as well, when the diagnosis is easy. It should be differentiated from seborrhoea capitis. Psoriasis of the scalp occurs in heaped up discrete patches with normal areas in between; seborrhoea, on the other hand, consists of a more generalised diffuse affection of the scalp, and is considerably more greasy looking.

Psoriasis of the hands and face is very rare. The action of sunlight is, as a rule, beneficial to psoriasis, and therefore it is much more common on the covered areas.

Psoriasis of the nails is a very obstinate form. It must be distinguished from a fungus infection of the nails. This is best done by a microscopic examination of a scraping which has been allowed to soak in liquor potassae for at least 24 hours. The presence of psoriasis elsewhere is confirmatory evidence.

7.—IMPETIGO.

This is a superficial mixed infection, streptococcal and staphylococcal, of the skin. The honey-colored moist-looking crusts are very distinctive and sufficiently common to be recognised easily.

A common error in diagnosis is to mistake the circinate type of impetigo for ringworm. The latter, however, will give a positive result on a microscopic examination for fungus, and it does not show the typical honey-colored crusts.

As impetigo is highly infectious, no child with this condition should be allowed to go to school until it is quite cured.

The routine treatment of impetigo is to clean each lesion with a mild antiseptic, remove the crusts gently with olive oil, and apply a two per cent. ammoniated mercury ointment. This should be repeated at least three times a day. Probably better results are obtained with the local application of lotio acriflavine 1-1000 soln. instead of the ointment.

Recently the treatment of impetigo by an occlusive dressing has been advocated. Undoubtedly this method greatly shortens the duration of an attack, and therefore the necessary absence from school. The lesions are cleaned and the crusts removed as before, then they are completely covered with adhesive plaster or elastoplast. The plaster is left on for three days, removed and, if necessary, reapplied for another three days. At the end of that time most cases are cured.

Hollander and Hecht aimed at producing an occlusive dressing which could be easily applied, and which did not need adhesive tape. They suggested metaphen 1-500 in collodion. After cleaning the surrounding skin with soap and water and drying thoroughly, several layers of the metaphen-collodion are applied. The layers are removed in 24 hours and fresh layers applied. This is repeated on the third day. On the fourth day the whole preparation is removed, together with the underlying encrustations. If the surface of the lesion is still moist the mixture is applied for another three days.

8.—EPIDERMOPHYTOSIS.

This term is usually limited to ringworm of the toes and groin. A few words about other ringworms may not be out of place.

Fortunately *ringworm of the scalp* is comparatively rare in Australia, and also the cases are milder than are seen abroad. We find, therefore, that it is not absolutely necessary to epilate in every case of tinea of the scalp. Most cases clear up fairly quickly with local treatment. Its infectivity is well known, and the importance of preventing spread in the rest of the family or the school need not be stressed here. Care should be taken in the continuous wear of skull caps, the individual use of a towel, and preventing an infected child sleeping with other children. It is interesting to note that there is

an immunity to ringworm of the scalp after puberty, cases after about 15 being almost unknown.

The presence of one or more round patches, which are usually scaly, but may be reddened or have follicular pustules in which the hairs are broken off just above the skin surface, should lead to a diagnosis of tinea of the scalp. The diagnosis can always be verified by a microscopical examination of the fungus. Remove two or three infected hairs, place them on a slide with a few drops of 15 per cent. potassium hydroxide, warm over a flame and the mycelium and fungus may be seen. Ringworm of the scalp examined under ultra-violet light through a Wood's filter will produce a green fluorescence. This is made use of both in diagnosis and as a final test for cure.

The treatment of tinea of the scalp by oral administration of thallium acetate, a heavy toxic metal, is not recommended.

Tinea barbae is not very often seen. It occurs as deep nodular suppurative lesions in the area of the lower jaw or in the upper part of the neck, but it may also be seen as dry scaly bald patches. By the way, any lesion on the body which has multiple foci of suppuration may be taken as almost certain to be a fungus infection.

Tinea barbae must not be mistaken for *sycosis vulgaris*, which occurs on the upper lip and bearded area, and in which the lesions are pustules and papules pierced on the centre by a hair.

The treatment of *tinea barbae* is by X-rays. Fractional doses will give an excellent result. Locally, a mild antiseptic ointment, such as 5 per cent. ammoniated mercury, should be used.

Tinea circinata.—On the body, ringworm is found as round scaly patches with vesiculation around the borders. The lesions, which are usually multiple, are often accompanied by local erythema, and heal in the centre as they spread in the margins.

The treatment is simple. They respond readily to the local application of tincture of iodine or Whitfield's ointment.

Probably the most common form of tinea nowadays is that of the *toes and groin*. This infection is due to the *epidermophyton* fungus, and occurs, as a rule, primarily between the toes, especially the third and fourth toes. From there it is transferred manually to the groin, where it is known as *Dhobie's itch*. *Epidermophytosis* between the toes is commonly picked up in gymnasiums, bathing sheds, baths, etc. This condition is extremely prevalent in America, and is more common in Sydney than in Melbourne.

The lesions consist of an itchiness and fissuring between the toes. It may last for years, the patient thinking that he has a soft corn and not realising that he has a definite disease. In more severe cases, there is a vesiculation and maceration of the epidermis.

The treatment of this condition may at times be a thorough test for the ingenuity of the dermatologist. The feet should be washed thoroughly and dried, and various antiseptic preparations tried, such as Whitfield's ointment, iodine, methyl violet 2 per cent, acriflavine. X-rays are beneficial, and may be given in fractional doses. In the groin care should be taken to shield the testicles thoroughly, as they are very sensitive to X-rays.

9.—ROSACEA.

Most commonly seen in middle-aged women, this condition is important on account of the disfigurement. There are three stages:—

(1) The development of flushing of the face, perhaps after meals.

(2) The persistence of the redness of the skin of the face and nose, with telangiectases, and often papules and pustules.

(3) The development of marked bulbous growths on the nose, known as *rhinophyma*. Fortunately this is rare. The latest opinion in regard to *rhinophyma* makes it doubtful whether it is a stage of *rosacea*. It is now considered that it is probably an independent condition.

Rosacea is commonly associated with gastric disturbances, and in every bad case a test meal should be done. Usually a *hypochlorhydria*, and rarely a *hyper-chlorhydria*, will be found.

Many cases are associated with endocrine conditions, especially ovarian, and in these cases ovarian extract is of benefit.

Nasal infection is often the cause, especially in pustular cases.

Exposure, as in sailors and farmers, is a common cause.

An important point in the diagnosis is to realise that a severe *rosacea*-like condition may be caused by the *demodex*. This is a mite which may be seen microscopically in scrapings taken from a case. This type will as a rule clear up with strong sulphur ointments used carefully.

The treatment of *rosacea* will therefore follow the cause. The diet must be regulated, and I am convinced that many cups of strong tea daily is of as much etiological importance as alcohol. Locally, calamine and sulphur lotion is good. X-ray therapy is sometimes beneficial, and ultra-violet light is useful in the pustular cases.

In *rhinophyma*, only surgery, or surgical diathermy, is of any use. The results are good.

10.—PRURITIS.

This term is limited to an itching that is not accompanied by a dermatosis. It may be local or general.

Pruritis is due to so many constitutional conditions that a very thorough overhaul is necessary. Consider the pruritis that you get in diabetes, blood disorders, nervous, renal and hepatic disorders especially with jaundice; arteriosclerosis, in pregnancy and tuberculosis, in intestinal toxæmia and senility, and you will realise that

these causes must all be eliminated before you treat a case as essential pruritis.

Then you must eliminate any external cause such as pruritis due to the underclothes, or soaps, or dandruff, or chemicals such as dyes or insecticides; or sensitisation to pollens or plants.

Probably the most common cases of pruritis that we see are the local cases about the genitals and anus. Apart from the general conditions mentioned above, it is important to eliminate such local causes as fissures, haemorrhoids, proctitis, skin tags, polypus, and ulcers. Constipation, colitis, and genito-urinary diseases as prostatitis, cystitis, urethritis, and endometritis are causes of this very troublesome condition.

Correct any of the above that may be present, and a cure is in sight. Locally, any anti-pruritic ointments or lotions are useful. Fractional doses of X-ray will often give very good results where other methods fail. Local injections are sometimes used. Sedatives for rest and sleep are often essential.

11.—SCABIES.

Remember that scabies is no respecter of persons, and even the most fastidious may be infected from the blankets at an hotel. Any irritating rash with a history of two or more cases in the house is almost certainly scabies. The typical lesion, the burrow, the linear track of vesicles in one of which the acarus may often be found, is most commonly seen in between the fingers, but is also very often seen on the ulnar side of the forearm just above the wrist. Other lesions are usually around the umbilicus, about the genitals, the anterior folds of the axillae, the buttocks, but never on the face.

In the treatment of scabies, the importance of the correct use of sulphur ointment is never properly stressed. Remember that a sulphur dermatitis can be just as irritating as, and certainly more difficult to cure than, the original scabies. On no account should the sulphur ointment be used for more than four days. This must be accompanied by strict attention to bathing and sterilising all clothes and blankets, not forgetting such articles as gloves, scarves, etc. If at the end of four days the irritation has not disappeared, use only calamine lotion for a week or so before attempting another course of sulphur. Repeatedly cases of sulphur dermatitis are seen due to the continuous use of sulphur ointment for a month or even longer.

12.—NAEVI.

These are divided into two groups—the vascular and non-vascular. There are four types of vascular naevi. These are (1) the stellate or spider naevi, (2) the port wine stain or strawberry naevi, (3) the cavernous naevi, (4) the lymphangiomas.

The spider naevus.—This is most commonly seen on the face, as a small area of tiny capillaries radiating from a central blood vessel. Destruction of the central blood vessel by the cautery, diathermy,

or carbon di-oxide snow will cure this condition with very good cosmetic results.

The port wine stain.—This is also known as naevus flammeus, and is usually seen in children on the face or neck, although it may be found anywhere on the body, even on the mucous membranes of the mouth. The size varies, and they may be multiple, and the color may range from pink to red.

The treatment of this type is by carbon di-oxide snow, radium, or dessication. Andrews strongly advises the use of air-cooled ultra-violet light in this type. He recommends the use of blistering doses at three-weekly intervals for months.

The cavernous naevus.—These are raised angioma which occur in children at or shortly after birth. In adults they are varied by the admixture of fibrous tissue. They are mainly seen on the head or neck, and may be nodular or lobulated.

The treatment is difficult. Radium may be used in small doses at long intervals, starting in early infancy or childhood.

The lymphangiomas.—There are two kinds of lymphangioma—(1) lymphangioma simplex or circumscriptum, which consists of a group of vesicles containing lymph, and are found on the thighs, upper arms, axillae, and mucous membranes of the mouth, and (2) lymphangioma cavernosum, in which there is a large dilatation of cutaneous lymphatics. Radiation has little effect on the lymphangioma. Best results are obtained by surgical diathermy or carbon di-oxide snow.

The non-vascular naevi.—These include all the moles, either fleshy, hairy, pigmented or not; the pigmented macules and patches; and the linear naevi. The treatment of moles is always of some concern. Many are very disfiguring, and excellent cosmetic results are obtained by removal by diathermy followed by a small dose of X-rays, which tends to prevent recurrences, the formation of cheiloids, and the development of malignancy. The heavily pigmented moles should not be treated light-heartedly; they have a strong tendency to become malignant. Cases are seen where they have been removed by surgical incision, only to start rapid growth again within three or four weeks.

The linear naevi are difficult to treat. Occasionally X-rays are effective, but the best method is by electro-dessication.

13.—ALOPECIA AREATA.

This condition occurs as discrete bald patches, usually oval or round on the scalp, but it is also seen on the beard area, and at times in the axillae and pubic regions. The patches may spread and even cause complete baldness. There are no subjective symptoms. The onset may be acute or it may take some weeks to develop. The diagnosis must be made from tinea of the scalp. In alopecia areata the hairs at the periphery of the lesion are broken off, thin and partially

depigmented. They are known on account of their appearance, as "point of exclamation hairs." In tinea the hairs are short, thick, and stunted. A microscopic examination of a scraping from the lesion will show the fungus in tinea.

Alopecia areata almost always gets well, although it usually takes six to nine months. It has been known to take years, a case being reported where it took seven years. If cicatricial changes occur in the skin, that is, if the hair follicles are destroyed, then the condition becomes incurable.

The treatment consists of the local application of irritants such as phenol, lysol, silver nitrate, capsicum, terebinth, etc. Ultra-violet light is beneficial, local application being given weekly for three or four months. The general health should be improved, and on the theory that the condition may be of endocrine origin, polyglandular preparations are often used. Any obvious septic foci should be cleared up.

14.—VERRUCAE.

Warts are due to an ultra-microscopic virus, and are self-infective. As an example, a wart on the side of a finger will often cause the formation of new warts on the contact areas of the adjoining finger. Papilloma on the soles of the feet are warts which cause much pain on account of the continuous pressure.

The treatment of warts is at times very difficult. Of the local applications, which must be used with great care, the only safe and effective remedies are glacial acetic acid tri-chlor acetic acid. X-rays will remove warts, but this method is often impracticable on account of the multiplicity of the warts. It is very useful in the plantar warts of the feet. The best method of removing multiple warts on the hands is to destroy them by diathermy under a general anaesthetic, taking great care to do them so that they will not cause scarring after they heal. The lesions are afterwards treated with one dose of X-rays, which tends to prevent recurrences.

You have no doubt heard of the numerous old-fashioned remedies for curing warts. Possibly a great number of these cures are due to the fact that many cases clear up spontaneously. A renowned European dermatologist seriously claims that he can cure warts by auto-suggestion. For this reason intra-muscular injections of bismuth, or even distilled water, are sometimes given with effect. A useful internal remedy is green iodide of mercury pill, one-sixth of a grain three times a day; its effect is doubtful, but it is worth trying.

Senile or seborrhoeic warts may be treated with salicylic ointment. If this is not effective, they may be curetted off, and the base treated with tri-chlor acetic acid.

15.—FURUNCULOSIS.

Remember that good results are sometimes obtained in these cases with auto-haemotherapy. A course of injections of a good stock

staphylococcal vaccine is probably more effective than an autogenous one.

J. Ferguson Smith, over a series of cases of furunculosis, showed that "toxoid is a more potent and reliable means of raising the antibody content of the blood than are vaccines, but the therapeutic effects of either are at least doubtful." He states that local treatment alone gave just as good results, although there is no question that the anti-staphylococcal power of the blood was markedly increased by the vaccines and toxoid.

16.—EPITHELIOMA.

Epithelioma of the skin is rare, compared to rodent ulcer. The differential diagnosis between the two has been discussed under the heading of rodent ulcer. It is well to remember that any malignant growth that is larger than the size of a pea within twelve months is an epithelioma, and not a rodent.

17.—URTICARIA.

In an obstinate chronic urticaria, it is important to eliminate the following etiological factors: (1) nervous states such as strain, worry, shock, and hysteria. (2) Digestive troubles such as dyspepsia, dilated stomach, diseases of the liver and intestines, and constipation. (3) Toxic predisposing causes such as intestinal fermentation, renal or hepatic insufficiency, gout, and pregnancy. (4) Infective causes—the eruptive or intermittent fevers. (5) Blood disorders.

An acute attack of urticaria will benefit from a dose of castor oil or saline purgative. A hypodermic injection of adrenalin will give relief, and soothing lotions may be applied locally. In the diet, the following foods are best avoided: Fish, oysters, eggs, cheese, berry fruits, tomatoes, pastries, savories, alcohol, tea, and coffee.

In a great number of cases there is an associated nervousness, anxiety, or shock, so that sodium bromide is definitely indicated. The extravasation of serum occurring in the lesions may be checked by the administration of calcium lactate. This may conveniently be given with the bromides. I have had good results in obstinate cases by giving ephedrine in $\frac{1}{4}$ to $\frac{1}{2}$ grain tablets three times a day.

18.—PAPILLOMA.

This heading arises from the fact that one school of dermatologists does not subdivide the naevi into vascular and non-vascular. They only admit the vascular naevi, and do not include the moles, etc., amongst the naevi. I think they are wrong, as the two groups are definitely related histologically, both groups containing what are known as naevus cells. They are both congenital new growths which may be evident at birth, or may not appear until later in life.

The papillomata are treated surgically, or better still by diathermy. A method of treating plantar warts has recently been suggested by Pritcher. He combines the use of carbon di-oxide snow and diathermy. His method obviates the pain caused in

anaesthetising the site of the wart. There is no after pain, and the patients are able to remain on their feet and attend to their work.

19.—SYCOSIS.

The popular name for this condition is barber's rash. This is a misnomer, the term probably arises from the technical name of sycosis barbae.

As the name implies, this rash is limited to the beard area, and is most commonly seen on the upper lip. From there it may spread rapidly over the rest of the face. The condition is a staphylococcal infection of the hair follicles, and spreads into the deep layers of the dermis, thus causing abscesses which rupture and form nodular lesions. In the centre of these lesions there is a hair which can be removed with a gentle pull.

The condition is usually difficult to treat, and relapses occur frequently. The question of shaving is always arguable. Some say that if the patient were to grow a beard the spread of the infection into the neighboring follicles would cease and the condition would be cured. On the other hand, others maintain that shaving facilitates treatment, and the advantage so obtained more than counterbalances the spread of the infection by shaving.

An antiseptic shaving soap should be used. The hair in the centre of the pustule should be gently pulled out, and a lotion applied. The best results are obtained with a lotion of brilliant green half per cent. strength in 50 per cent. spirit solution. The great objection to this lotion is the bright green color. At times a 2 per cent. mercury ointment well rubbed in is sufficient to clear the trouble.

Favorable results may be obtained with vaccines, toxoids, and colloidal manganese injections. Very definite results are obtained with X-rays. Used carefully, it is claimed that X-rays will shorten the duration of sycosis by half.

FLAT AND PAINFUL FEET

BY R. BROOMHEAD, Leeds.

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The term "flat feet" is in many ways a bad one as it implies that because feet are flat they necessarily require treatment. Flat feet often cause no symptoms, whilst many painful feet are not in the least flat. Patients usually consult a doctor because their feet are painful and not because they are flat. The term "foot-strain" is more accurate and should convey the impression that there is some derangement of the longitudinal arch of the foot. However, "flat feet" is a convenient term to cover a number of conditions and it is probably better retained.

When a foot is at complete rest its form is determined by the shape of the bones which are attached to one another by ligaments; when standing, the form of the foot is maintained partly by the

ligaments and partly by the tonic contraction of the muscles; during exercise, its form is controlled almost entirely by muscular action, and the ligaments play only a small part. If the muscles lose their tone the ligaments are stretched and pain is felt at their bony attachments. In patients with naturally loose ligaments, or whose ligaments have been lengthened by training, e.g., ballet dancers and chorus girls, the feet are flat when standing, and there is no pain unless either the feet become stiff, or the muscles weaken to such an extent that the scaphoid and other bones on the inner side of the foot press against the shoe when walking.

Why do people have painful feet? Either because the ligaments are being unduly strained, or because there are adhesions in the feet causing limitation of movement, pain being caused by any attempt to pass beyond that limit.

As mere flatness is not important why should notice be taken of the condition? Because if the arch is not restored the patient will walk badly, and the feet will probably become fixed, and therefore painful and flat.

Derangement of the long arch of the foot may be divided as follows:—

(a) **Congenital.**—There are two types of congenital flat feet, one a congenital deformity noticeable at birth, and the other a congenital predisposition which results in the feet becoming flat after the child has begun to walk. The former variety is often associated with a calcaneus deformity and is due to the feet being cramped in utero. As a rule the mother or nurse can replace the arch by daily manipulation which must restore the equinus, invert the foot, and push the scaphoid outwards so that the long arch is reformed. Occasionally the feet require moulding and plaster in full inversion and dorsiflexion for a few weeks. The prognosis is very good, although it is advisable to raise the inner border of the shoes for a few months when the child begins to walk.

The second type of congenital flat-foot is found in patients brought for consultation between the ages of four and twelve. The feet are long although the children are not necessarily tall, there is often a family history of one or other parent having the same condition. Patients can usually form an arch when on tiptoe, and the feet are only flat when the child is standing "easy." Occasionally there is pain and tenderness under the scaphoid, but parents are worried by the shape of the foot and because the child walks badly with everted feet rather than because he complains of pain.

Certain of these cases can be cured by remedial and walking exercises, but if the foot shows little sign of improving after three to six months of such treatment, manipulation followed by plaster in full inversion and dorsiflexion with the arch restored, should be advised. The plaster should be kept on for six or eight weeks, and

its removal should be followed by a fortnight's massage and remedial exercises. The child may then walk in shoes which have the inner borders of the soles and heels raised $\frac{1}{4}$ – $\frac{1}{3}$ inch. The exercises must be continued for several months after walking has recommenced.

(b) *Acquired flat feet* are best considered as acute and chronic:—

I. Acute.—The acute flat or painful foot either follows infection by the gonococcus or by an organism of the rheumatic group, or it may be the result of a patient walking too soon after a prolonged illness without adequate remedial treatment.

When due to infection the primary lesion must be treated by vaccines and by attention to the original focus. Locally, rest and warmth are required, although, after the first week or two, counter-irritation by Scott's dressing is very useful in gonococcal cases. When the acute condition is subsiding care must be taken to maintain the mobility of the foot by movements and massage preceded by immersion of the feet in paraffin wax baths. It is advisable to raise the inner border of the shoes when patients begin to walk in order to protect the ligaments on the inner side of the foot.

Treatment of the second variety is by prevention rather than by cure. The patient should be given such exercises and electrical treatment as will restore muscle tone before he is allowed to walk in shoes altered in the usual way. When the condition has developed, remedial exercises may be tried, but as a rule the feet have to be plastered in inversion for three or four weeks so that the arches may regain their former shape and the ligaments their original length. After-treatment is the same as for patients with foot-strain.

II. Chronic.—1. *Spasmodic flat-foot.*—The first variety of chronic acquired flat-foot to be considered is that found in boys between the ages of 14 and 18 and known as spasmodic flat-foot. The condition is confined almost entirely to the age period mentioned, for it is noticed in children who have been left school 12–18 months and who have been employed at work requiring prolonged standing. On examination, the feet—the deformity is usually bilateral—are held everted and abducted. The peronei can be felt as tight bands behind the external malleoli, and the outer dorsi-flexors of the feet and toes project like tight cords. Dorsi- and plantiflexion of the ankle are full although any attempt to invert the foot is strongly resisted. If the patient's attention be distracted and foot can be fully inverted and the deformity corrected—the manoeuvre, however, causes such extreme pain that most patients will cry. The patient stands with everted feet. He can stand on his toes but not on the outer borders of his feet, a test which distinguishes peroneal spasm from bony ankylosis; for a patient with ankylosed feet can do the second exercise owing to lateral mobility of the ankle.

The treatment of spasmodic flat-foot is as difficult as the diagnosis is easy. The following methods have been tried:—

(a) Manipulation under gas anaesthesia once or several times followed by massage and exercises; a form of treatment which may be successful but as a rule only in the early cases. It is based on the assumption that the spasm is due to a traumatic arthritis of the subastragaloid joint and that manipulation will improve the arthritis and therefore reduce the spasm.

(b) The patient is given an outside iron, a valgus T-strap, and a flat-foot adjustment which he wears for 12–18 months when the spasm may have disappeared. This treatment is based on the assumption that the arthritis requires rest.

(c) The foot is manipulated under either anaesthesia and is fixed in plaster in full dorsiflexion and full inversion for six to eight weeks, a period which is followed by gentle massage and exercises and the wearing of a shoe raised on the inner border, an elongated heel, and possibly an outside iron.

(d) The peronei are tenotomised, or, preferably, an inch or more is resected from each tendon. After-treatment is as in (c).

(e) The musculo-cutaneous nerve is injected with alcohol or is frozen. Such treatment interrupts the nerve supply to the peronei and enables the tibial muscles to control the foot and to maintain it in the corrected position as the peronei recover. After-treatment consists of wearing an altered shoe.

(f) The hypothesis has been advanced that the spasm is due to sympathetic stimulation. In order to eliminate the spasm the dorsal ganglion of the foot has been resected to destroy the sympathetic centre and the stimuli which proceed from it. The spasm disappears almost miraculously for seven to ten days but always recurs.

The results of treatment by operations on nerves are not good.

(g) In some cases the anterior end of the os calcis is fused to the outer part of the scaphoid. Resection of the fusion has resulted in marked improvement and should be advised.

2. *The static or postural flat foot.*—The static variety of flat foot occurs mainly in adults. The length of the foot is normal but the longitudinal arch is lost, and although there is usually no pain the foot feels weak. There is no limitation of movement and no tenderness. Patients are relieved by wearing a flat-foot adjustment and by foot exercises and massage.

3. *Paralytic flat foot*—due to nerve disease. The flat foot due to disease of the nervous system is always associated with a lower neurone lesion—usually anterior poliomyelitis. Patients do not complain of pain and they require very little attention for the flatness of the foot. Treatment as a rule has to be directed to stabilising the foot if it is flail or to improving the circulation by a sympathectomy if it is cold and has trophic sores.

4. *Foot strain.*—Foot strain is the condition found in adults in whom the longitudinal arch is being stretched owing to muscular weakness. The first ligament to feel the strain is the astragalo-scaphoid or spring ligament, which becomes painful at one of its bony attachments, usually the anterior where it is fixed to the scaphoid. The anterior end of the ligament is generally tender and there is often some local œdema. As the foot becomes more everted the os calcis presses against the external malleolus and causes pain on the outer surface of the heel. Later still the muscles of the leg tighten in an attempt to prevent the foot ligaments from being stretched. Chronic muscle strain occurs, and results in pain where the muscles become tendinous; in this particular case in the middle of the anterior tibial compartment. On examination, the shape of the foot is good; tenderness is found at the points mentioned; movements of the foot may be normal or limited. If movements are normal the arch should be supported by raising the inner border of the shoe $\frac{1}{3}$ inch, by prolonging the heel on the inner side, and by restoring the muscle power with massage and exercises. If there is limited movement such treatment should follow a preliminary manipulation under gas anæsthesia.

There are many cases of foot strain where active treatment must be preceded by a period of rest, particularly where pain is accompanied by marked swelling. The work of many such patients requires much standing or walking, and any further strain on the feet by exercises resembles the flogging of a tired horse. Complete rest in bed for a fortnight is usually an adequate preliminary to the commencement of remedial treatment.

Remedial Exercises.—In flat feet, exercises are given first with the patient sitting on a couch. He is taught to turn the feet inwards and to practice clawing the toes. When these exercises are being well done, the patient is taught to pick up objects, *e. g.*, marbles and pencils from the floor with his toes. A few days later, standing exercises may begin, rising on tip-toes, standing on the outer border of the feet, and clawing the toes round the edge of a book. Finally, he is taught to walk with toes turned in, on the outer borders of his feet, and on tip-toe. He can also do special exercises with apparatus in a gymnasium if one is available. In addition, he should always concentrate on walking with his feet parallel, and when sitting should cross his ankles so that the feet are turned in.

Should instep supports be prescribed? Metatarsal pads are a great help, but supports, particularly metal ones, worn inside the shoe to lift the longitudinal arch do more harm than good. If the longitudinal arch has fallen, anything that projects into the foot will press against the scaphoid or the head of the astragalus and will cause discomfort through pressure. Cases which are well treated in the massage department and are carefully followed show

that the best method of treatment is to alter the patient's shoes and to give graduated remedial exercises.

5. *Adhesions of the feet.*—Many patients have pain when walking and during passive stretching of the extensor tendons of the toes, accompanied by limitation of all movements of the joints. Although the feet are shapely they are tender to pressure on the dorsum over the extensor tendons, but tenderness is absent where typically present in cases of foot strain. Such feet become œdematous towards the end of the day or after use, and the swelling is most marked on the dorsum. The condition may be unilateral following injury, *e. g.*, sprained ankle, or bilateral after a mild general infection or after standing or working in a damp place.

Manipulation in such cases followed by active movements and exercises will result in a cure in six to eight weeks; this type of foot is very common and responds better than any other to manipulative treatment.

6. *Traumatic flat-foot*—Traumatic flat-foot may follow a fracture. It occurs most commonly after fractures of the os calcis and the metatarsals, and may follow unreduced fracture dislocations of the ankle or fractures of the mid-tarsal bones. A corrective osteotomy may cure the pain of an unreduced fracture-dislocation of the ankle, but the other injuries usually require an arthrodesis of some of the joints, or, in the case of the metatarsals, a reversal of the injured bones. Relief may be obtained, however, by giving the patient a surgical boot made to fit a cast of the foot.

7. *Osteo-arthritis.*—Painful feet may be caused by chronic osteo-arthritis. Such cases are demonstrated by the appearance of lipping on the radiograph. They respond well to manipulation followed by contrast bathing, diathermy, and radiant heat.

8. *Bony ankylosis.*—Flat feet which are ankylosed are seen in old people whose occupation has involved much standing, *e. g.*, waiters. Bony flat feet are often painless, but they may be causing symptoms because of painful corns over areas of pressure. When symptoms are present the best treatment results from wearing special shoes made to fit casts of the patient's feet.

METATARSALGIA. Pain under the front part of the foot is usually accompanied by dropping of the anterior arch. Symptoms are due either to strain on the ligaments, to adhesions, or to pressure of the heads of the metatarsals on the interdigital nerves or on the underlying skin. Metatarsalgia therefore is not one lesion only but a term covering several causes of pain in the anterior part of the foot.

In the cases where there are adhesions, pain is accompanied by swelling and by limitation of movement; pain is caused on stretching the extensor tendons of the toes, and there is not much change in the shape of the anterior arch. When symptoms are due to falling of the arch accompanied by overstrain of the ligaments and by

pressure on nerves or skin, the forefoot is markedly flat and the heads of the metatarsals are tender on pressure. Corns are present under the heads of the first and fifth metatarsals, and sometimes under the heads of the others.

Treatment where there are adhesions is by manipulation followed by remedial exercises and massage. As a rule foot supports or alterations to shoes are not required.

Where the anterior arch has dropped, it must be restored in order to relieve pressure on the heads of the metatarsals. The arch can be supported by a sling holding its two outer pillars together or by a pad underneath pushing the bones into place. A sling is easily fixed by using 1 inch strapping and passing it from the dorsum of the foot round the neck of the fifth metatarsal across the sole and back to the dorsum round the neck of the first metatarsal. Such a sling should be applied twice or three times weekly and can usually be dispensed with after two or three months. A well-fitting metatarsal pad should be worn. The pad should lie just below and behind the necks of the metatarsals and should press upwards into the foot so that the arch is corrected and weight is taken off the heads of the bones. If the above treatment is insufficient, a metatarsal bar should be worn for three to six months. The bar which is made of leather $\frac{1}{3}$ inch thick, is fixed to the sole of the shoe just behind its tread to transmit the weight of the body through the necks of the metatarsals; the heads of these bones are thereby relieved from weight-bearing. The use of contrast baths is advisable in all these measures to improve the circulation. If the above-mentioned treatments fail, shoes should be made to fit casts of the foot taken with the arch moulded and restored.

In certain severe cases where the deformity is fixed and the head of each metatarsal is covered by a corn, and where all other methods have failed, operative treatment can be of the greatest value. The operation consists of reversing the metatarsals subperiosteally so that the prominent part of the head of the bone projects upwards instead of downwards into the sole of the foot. In this way pressure on tender corns is avoided and the patient is saved much suffering.

Extracts

THE MICROSCOPIC EXAMINATION OF FAECES FOR HELMINTHIC INFECTION

I. S. HILMY: *J. of Egyptian Med. Assn.*

The specific diagnosis of helminthic infection of man is accomplished by the detection of the eggs or larvae of the parasites or by finding the adult worms themselves.

1. *The direct smear method*: This is the simplest method to perform but the most difficult for examination. A small amount of

faeces is emulsified in a drop of saline and a cover-slip is placed upon it. The emulsion must be homogenous, of such a consistency to allow a clear view of the objects expected, and coarse matter must be removed by the edge of the cover-slip before placing it on the slide. The low power of the microscope must be used to spot any infection present. Higher magnifications should only be used to ascertain the exact nature of anything suspicious which has already been found under the low power. The lower down in the alimentary canal the parasites live, the less evenly distributed are their eggs in the faeces. In the lower most parts of the large intestine and in the rectum, eggs of parasites which may be present are found mainly on the surface of the formed faeces. Mucus or blood in the faeces must also be examined. Many smears have to be prepared and examined before a definite result can be given, especially in mild infections.

2. *Washing and Sedimentation*: The whole bulk or a part of the faeces is broken up in water, thoroughly shaken and left to sediment for 5 minutes to one hour. Soluble matter and small particles left in suspension in the supernatant fluid are removed by decanting. This process may be repeated and a smear is prepared from the sediment, after stirring by means of a glass rod. To effect a rapid sedimentation of the diluted faeces, a part of it is centrifuged at a low speed and the smear is prepared after stirring the sediment.

3. *Combined Straining and Sedimentation*: This consists of emulsifying and diluting the faeces in a sufficient quantity of water and then straining it before sedimentation through a sieve to separate the coarse particles which it usually contains. Wire gauze of 100 meshes to the linear inch is quite satisfactory. In the standard method of Lane, 0.5 cc. of faeces is emulsified and suspended in water, strained, and then centrifuged for one minute at 1500 revolutions per minute. The centrifuge tube is stoppered tightly by means of a cork plug on which the sediment rests. The sediment is then transferred to a watch glass, water added to make it up to 25 drops of a suitable pipette. When it is mixed well, one or two drops are smeared on a glass slide and examined. The number of eggs in the entire 0.5 cc. of stool can thus be calculated. Schistosome eggs are usually detected by the sedimentation methods if normal or hypernormal salt solution is used in place of water. Equal parts of ether and hydrochloric acid is a suitable diluting medium in detecting schistosome eggs.

4. *Fuelleborn's method* for schistosome eggs: This method is based on Khalil Bey's discovery that the eggs of schistosome will readily hatch by osmosis when they come in contact with water. Fuelleborn selects a part of the faeces, emulsifies and dilutes it in a sufficient quantity of 2.5 per cent sodium chloride solution, leaves it in a dark place to settle down for five minutes, pours off the supernatant fluid, adds distilled water to the sediment and then exposes

it to bright light. After 15 minutes the supernatant fluid is examined by a hand lens for the presence of miracidia.

5. *Rectal swab method* for schistosome eggs: A rubber finger is used, by means of which a specimen of faeces is secured from the rectum, and a smear prepared from it for examination.

6. *Adhesion method of Pepper*. This method is based on the property of hookworm eggs to adhere to glass when they come in contact with it. A specimen of the sediment of faeces, after being washed, is placed on a glass slide and left for a few minutes. The glass slide is then carefully immersed in water and is carefully removed from it so that all debris is left in the water. On examination of this slide, a number of hookworm and certain other nematode eggs will be found in a clean watery medium sticking to the glass.

7. *Adhesion method of Lane*: Lane centrifuges the strained suspension of faeces in centrifuge tubes open at one end and closed tightly by a cork stopper at the other end. The cork stopper is removed slowly and the sediment allowed to pass on to the slide, which is immersed in water after 5 minutes, without soiling the fingers.

8. *Floatation method of Bass*: An amount of faeces is suspended in 9/10 concentrated sodium chloride solution, left to settle for some time, and a drop is pipetted from the surface of the supernatant fluid and examined.

9. *Floatation method of Caldwell and Caldwell*: The faeces is first treated with an equal amount of 30 per cent antiformin for one hour. This assists in the breaking up of the faeces and releases the eggs readily from the attached debris. Concentrated sugar solution is then added and the surface film is picked up for examination.

10. *Floatation method of Khalil Bey*: The suspension of faeces in concentrated sodium chloride solution is strained into an Erlenmeyer flask till the level comes up to its neck. A larger concentration of the floated eggs is thus obtained in the narrow neck of the flask.

11. *Levitation method of Willis*: A brass tin of one ounce capacity and 3 cm. diameter is taken, $\frac{1}{6}$ of an ounce of faeces is put into it, emulsified, and diluted with concentrated salt solution up to the brim; a glass slide is placed on the tin so that the entire surface of the suspension is in contact with the slide. This is left for about 10 minutes, after which the slide is carefully raised, inverted and examined.

12. *Direct centrifugal floatation method of Lane*: The centrifuge tube is filled to the brim with emulsion of faeces, a thick coverslip placed on the top of the tube, which is centrifuged for one minute at 1,000 revolutions per minute. The coverslip is then lifted and examined.

DIAGNOSIS AND TREATMENT OF DOUBTFUL MAMMARY TUMOURS.

(M. C. TODD AND E. K. DAWSON: *Lancet*.)

Among the mammary lesions which may give rise to difficulty in diagnosis are: (1) benign tumours; (2) chronic infections; (3) cystic changes; (4) early carcinoma; (5) acute carcinoma; (6) pregnancy and lactation tumours; (7) fat necrosis.

Of the benign tumours, fibro-adenomas are the most common. When solitary, such tumours are not difficult to diagnose; when multiple and diffuse, especially in older patients, they may be associated with cyst formation or with undetected malignancy and may constitute a greater diagnostic problem. This form of tumour usually yields to conservative treatment, and shows no more tendency to malignant change than any other portion of the glandular tissue of the normal breast. If malignancy does develop, it is in the form of a sarcoma and its detection is relatively simple. A second type of benign tumour is the papilloma. This is regarded as an epithelial hyperplasia and the outcome is uncertain. The formation of large blue dome cysts is an indication of regression, but with this exception papillomata are to be looked upon with suspicion.

The hard fixed tumour not infrequently formed by chronic mastitis may be clinically similar to carcinoma. The axillary nodes are usually enlarged. Though softer than in the presence of carcinoma. Malignancy may also be simulated by chronic tuberculous or syphilitic infection.

Cystic changes in breasts may give rise to considerable uncertainty, especially in diagnosis since they are apt to appear at an age when carcinoma is to be suspected in all doubtful lesions. Again, whether a single cystic mass or the diffuse, lumpy breast be clinically evident, one cannot definitely rule out the co-existence of a malignant tumour.

Unfortunately the usual clinical signs associated with mammary cancer are significant of extensive malignant spread, and the early malignant lesion, whether developing in a pre-existing benign tumour or normal breast tissue, may give little or no evidence of its presence. Among the types of early cancer are early malignant change in a benign papilloma, early duct cancer, a very small cancer in a breast otherwise normal to palpation, early carcinoma associated with cystic change, and finally malignant tumours of the skin with secondary invasion of the underlying breast tissue. One of the rare forms of malignant growth is the so-called acute carcinoma which simulates infection. It is usually a diffuse carcinomatosis and extremely difficult to detect before treatment. However, a careful history may eliminate other possibilities, especially if malignancy is borne in mind. Infection in the breast is rare aside from that connected with pregnancy and lactation.

Treatment of these doubtful tumours is practically always surgical. Local excision suffices for fibro-adenoma in a young patient and possibly for some of the chronic infections. Obviously, if the excised tissue proves malignant on histological examination, radical mastectomy should be carried out at once. Simple mastectomy is advisable in all cases when there is doubt as to the existence of malignancy except in the case of acute carcinoma and lactation tumours, where surgery should be limited to biopsy by electric cautery. With simple mastectomy, malignancy can be detected in the great majority of instances, if present, thus allowing the surgeon to proceed immediately with radical removal. If the nature of the lesion cannot be determined, there still remains the choice of completion of the radical operation, a two-stage procedure (waiting for the pathological report), and irradiation without further surgery. The two-stage procedure is adequate in many cases, and if the second stage is not delayed too long, there is little to be feared from the dissemination of malignant cells in the few instances in which this procedure is called for. Radical mastectomy is obviously indicated where there is reasonable assurance that the lesion is malignant. Collected statistics have shown that the highest survival rates are found where this is done at an early stage, hence no patient should be denied this advantage. Irradiation should be reserved for those cases in which the diagnosis of malignancy is ascertained but the choice between surgery and irradiation is one which must be made for the individual case.

Medical News and Notes

ATEBRIN-MUSONAT. According to J. A. Carman and R. P. Cormack in the *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1936, xxix, 381, the introduction of Atebrin-Musonat represents a definite advance in malaria therapy. It is not possible to rely wholly or even largely upon any anti-malaria drug which can be given only by the mouth. Atebrin is now considered by a large percentage of malariologists to be a valuable remedy for oral administration but attempts to give it by the parenteral route have sometimes led to disquieting results. Atebrin-Musonat appears to be perfectly safe when given into either vein or muscle, and thus makes it possible to give the basic remedy in cases where vomiting is troublesome or where the presence or imminence of pernicious symptoms demands more expedition than is possible by the oral route. There is already a good deal of evidence that Atebrin treatment is followed by a much lower relapse rate than can be hoped for after quinine and the authors' experiences gained in Kenya indicate that three intramuscular injections of 0.375 gramme (grains 6) may be expected to give the same results as a 5-day course of Atebrin by

mouth. Few practitioners in the tropics will take the responsibility of treating subtertian malaria with quinine for less than 14 to 28 days or even longer, and any patient who has had several courses of that kind will hardly hesitate to welcome a plan of treatment involving nothing more than 3 or 4 injections and some degree of after-stiffness, with a short 5 days on Plasmoquine during convalescence. Atebrin-Musonat is better given intramuscularly than intravenously, and none of the patients treated by the authors returned with a relapse.

MORE VITAMINS. As days go on, additions are being made to the vitamin alphabet. Vitamin F and vitamin K are the latest of these. *Vitamin F* deficiency results if unsaturated fatty acid is excluded from the diet. In animals deficiency of this vitamin produces a syndrome which includes scaliness of the skin, swelling of the tip of the tail which eventuates finally in necrosis, marked accumulation of dandruff in the hair on the back of the neck, alopecia, irregular ovulation in the female, haemorrhagic spots and sores over the skin surface, albuminuria, haematuria, and marked kidney lesions, cessation of growth, and death. Before the animals reach a moribund condition, supplementing the diet with a small amount of linoleic or linolenic acids, or preferably both, results in the complete extinction of all the symptoms. The normal function of the liver is in part concerned with the desaturation of fats the better to meet the requirements of the various cells of the body abounding in unsaturates; and contemporary food trends, through the large scale introduction of vitamin-depleted, fatty-acid extinguished fat supplies, directly violate and oppose the physiological activities of the body. *Vitamin K* possesses curative properties against a deficiency disease resembling scurvy in chicks but which cannot be prevented by ascorbic acid. This vitamin constitutes the anti-haemorrhagic factor (or factors) in the diet. It is fat-soluble, and occurs in hog liver, and in certain vegetables like tomatoes and orange peel. Cod liver oil is practically devoid of it. There is an enormous retardation of the clotting of the blood of chicks suffering from haemorrhagic diathesis. It is not definitely known out how far these two vitamins are essential in the human economy, as the experimental work hitherto done concerns the lower animals.

SELF-PERFORMED OPERATIONS. J. G. Frost and C. C. Guy of Chicago review the recorded cases of auto-surgery, in the *Journal of A. M. A.* May 16, 1936, which fall into one of four major groups: (1) surgeons who have operated on themselves, (2) normal minded individuals who have been forced by severe pain or in the absence of medical attention to perform autosurgery, (3) the sexual pervers and those suffering from an acute psychosis, intense sexual excitement, or anger, resulting in self-inflicted mutilations or amputations, usually of the genitalia, and (4) those who, because of

utter ignorance or feeble-mindedness, have attempted the surgical correction of some obvious disease or abnormality.

SIR ALDO CASTELLANI. The man who won Italy's war with Ethiopia was spotted by doctors as being an Anglicised Italian Knight Commander of the order of St. Michael and St. George, Sir Aldo Castellani, whose wife is English. He set up six air-conditioned hospital ships for sun-stroke cases. He proceeded to inoculate every Italian to land at Massawa or Mogadiscio with the vaccine he himself had discovered in British employ for prevention of typhoid, paratyphoid and cholera. Sir Aldo shipped to East Africa tons of quinine for malaria, gangrene, and snake bite, and 18000 hospital cots. He covered suspected water holes with petroleum, fumigated camps, provided good drinking water, dotted Eritrea with hospitals and laboratories. The Italian Army fought under unprecedentedly thorough medical case. Sir Aldo, arriving in Addis Ababa, made his health report on the Italo-Ethiopian War thus:—Malaria: a few deaths. Dysentery: one epidemic in Southern Somali land, no deaths. Typhus, typhoid fever, relapsing fevers: no deaths. Beriberi and scurvy: no white cases. Cholera and plague: not one case. Chief mortality was next to Ethiopian bullets, from sunstroke, which was eliminated by prompt treatment of the first symptoms.

MALABAR DISTRICT MEDICAL ASSOCIATION. A meeting of the above association was held on the 7th June at the Hacket Wilkins Memorial Hall, Calicut, with Major J. F. Shepherd, I.M.S., District Medical Officer, in the chair. Dr. P. B. Menon, L.R.C.P. & S., L.R.F.P.S., delivered a lecture on "making an anatomy". The following office bearers were elected. Major J. F. Shepherd, I.M.S., president, Dr. N. Achuthan, M.B.B.S., Vice-president; Dr. P. Balakrishna Menon, M.B., B.S., L.O., Treasurer, Drs. C. K. Menon, M.B., B.S., N. Govindan, C. M. Leelavathy, and P. B. Menon, L.R.C.P.S., L.R.F.P.S., were elected members of the committee. Dr. P. Balakrishna Menon was "at home" to the members.

The same association met again on the 5th July with Major J. F. Shepherd, I.M.S., in the chair. Dr. C. M. Leelavathy demonstrated a rickety child of four years. Dr. Berotta demonstrated a case of tumour in the abdomen, diagnosed as hydronephrosis. Dr. C. K. Menon showed a case in which the bile duct was opened and gall-stones removed. Dr. K. A. Abraham showed a case of myeloma of the left jaw. Dr. N. K. Koya demonstrated a case of osteogenic sarcoma of the left shoulder of three months duration. Dr. N. Achuthan showed a case of musculospiral nerve injury and injury of the knee cap, both of which were treated by plaster of Paris splinting. Dr. P. Balakrishna Menon delivered a lecture on "the treatment of the common eye complications of venereal diseases met with in general practice". Dr. P. B. Menon was "at home" to the members.

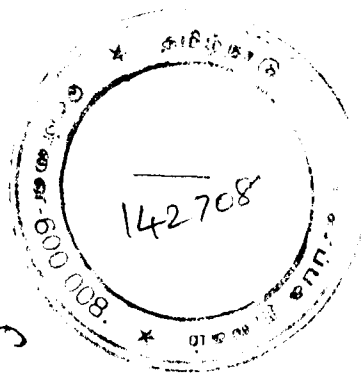
RAMNAD DISTRICT MEDICAL ASSOCIATION. The monthly meeting of the above association was held at Kanadukathan on the 19th July under the presidency of Dr. B. V. Varadachari, B.A., M.B., C.M., District Medical Officer. Dr. Miss Ivatts was "at home" to the members. Dr. T. S. Shetty showed a big myxomatous tumour of the hard palate removed from a girl of 14, and a case of subperiosteal abscess. Dr. M. K. Sambasivan M.B., B.S., of Kumbakonam delivered a lecture on "non-padded plaster casing in the treatment of fractures", with demonstrations. Capt. G. S. K. Aiyar also spoke on the same subject. The function terminated with dinner.

TINNEVELLY DISTRICT MEDICAL ASSOCIATION. This association held its monthly meeting at Courtallum on the 25th July. After a bath in the waterfalls and light refreshments the meeting commenced at 11 a.m. with Lt. Col. T. S. Shastri, I.M.S., District Medical Officer, in the chair. Dr. G. Parthasarathy, M.B., B.S., of Tenkasi showed a case of congenital pulmonary stenosis. Dr. A. L. Ananthanarayana Iyer, M.B., B.S., of Tenkasi showed cases of mitral stenosis, aortic regurgitation with aneurysm of the aorta, chancre of the lip, and of myxoedema. Dr. K. Gopal Rao, L.M.S. read notes of a case of lymphosarcoma of the axilla and a case of intussusception due to tumour of the caecum operated on by Lt. Col. Shastri at the Headquarters Hospital. Dr. K. Padmanabha Ayyar, L.M.P. of Tenkasi read a paper on "alkalinity of blood in relation to health and disease". Dr. S. N. Rangachari was thanked for organising the function. A health exhibition was also held in Tenkasi on the same day.

THE TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION. A monthly meeting of the above Association was held at 5 p.m. on Saturday the 22nd inst., in the Ceylon Labour Commission Office, Race Course, Trichinopoly when about 45 members were present. Mr. N. H. M. Bowden, Ceylon Emigration-Commissioner was 'At Home' to the members. After a sumptuous 'Tea' the Doctors were taken round the Colony by Mr. Bowden and shown the various places of interest such as the resting-ward, the fly-proof-kitchen-room, the Sanitary-cooking room, the dininghall where about 150 emigrants are fed at a time. The Doctors were well impressed with what they saw and appreciated the care taken by the Commissioner to look after the interests of the Emigrants. Then the gathering assembled in the meeting-hall. In the unavoidable absence of Dr. Norman, the Secretary proposed Capt. Sangham Lal, I.M.S., District Medical Officer to the Chair. Capt. Sangham Lal requested Mr. Bowden to speak a few words about the working of the Ceylon Labour Commission. Mr. Bowden spoke for half an hour as to how the emigrants were recruited and how they are sent to the Ceylon Tea estate and gave a very interesting account of the Ceylon Emigration. On the occasion Mr. Bowden issued printed account of the working of the Institution with beautiful blocks and sketches and distributed to all

the members. Then Capt Sangham Lal called upon Dr. V. Iravatham of Thirukktupally to speak on 'The experiences of a Practitioner in Burma'. Dr. Iravatham spoke for half an hour. In his humorous speech he gave very interesting account of the history of Burma about the people and their customs, and the places of interest in Burma. He mentioned in his speech that there was good scope for young and adventurous doctors, a good field for practice in Burma. Capt. Sangham Lal in his concluding remarks thanked Mr. Bowden for his kind invitation and thanked him for taking such kind interest in the welfare of the Ceylon-emigration. He congratulated Dr. V. Iravatham for his excellent, interesting and humorous speech about Burma. He also gave some of his experiences during his short stay in Burma during the time of rebellion. Then the Secretary proposed a hearty vote of thanks to the host, the Lectures and the members and the meeting came to a close at about 8 p.m. after a very enjoyable evening.

POLLACHI MEDICAL ASSOCIATION.—To perpetuate the memory of the late Dr. N. A. Venkatachalam Ayyar, a meeting of the private medical practitioners in Allopathic system was held last evening in the Government Hospital with Major Cox, District Medical Officer, Coimbatore in the chair. Captain C. S. Suryanarayana Sarma, Civil Assistant Surgeon, Pollachi in his introductory speech stressed the importance of a Medical Association in a place like Pollachi. Major Cox also explained to the members about the importance of such Medical Association and how the members of the Medical profession would be much advanced in medical science and improve their status and professional integrity through such associations. A Medical Association was then formed with Major Cox as the President, Office bearers were also elected.



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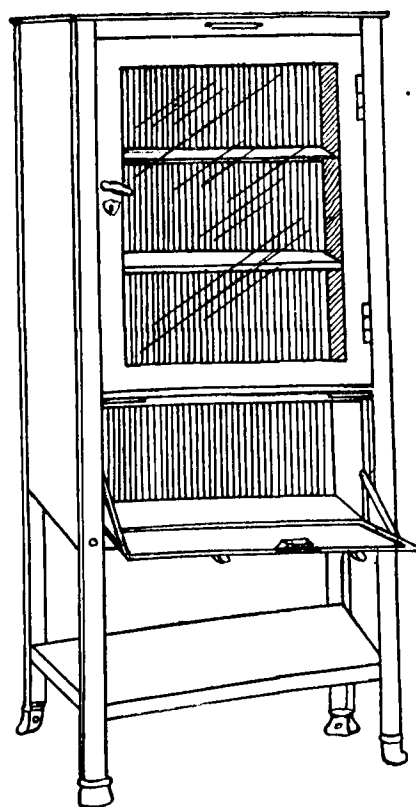
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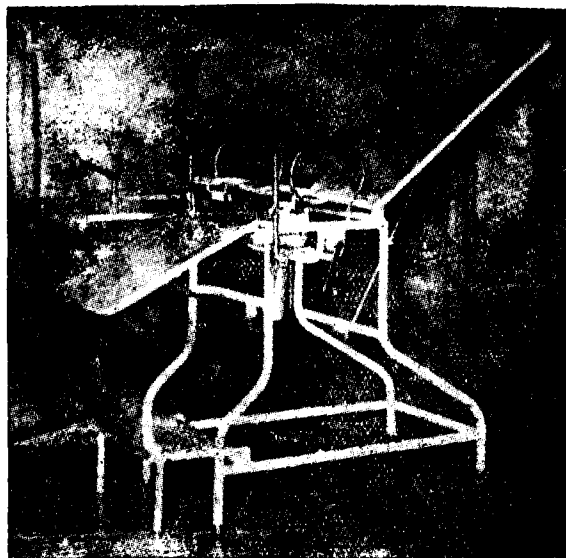
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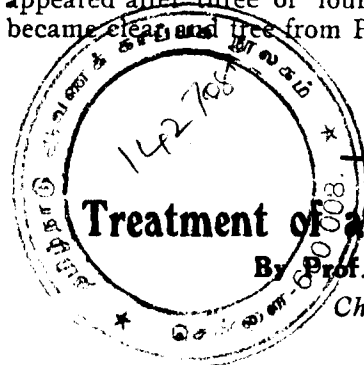
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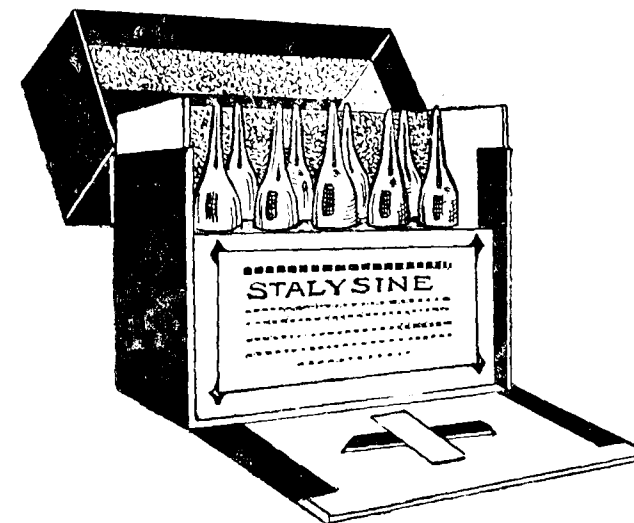
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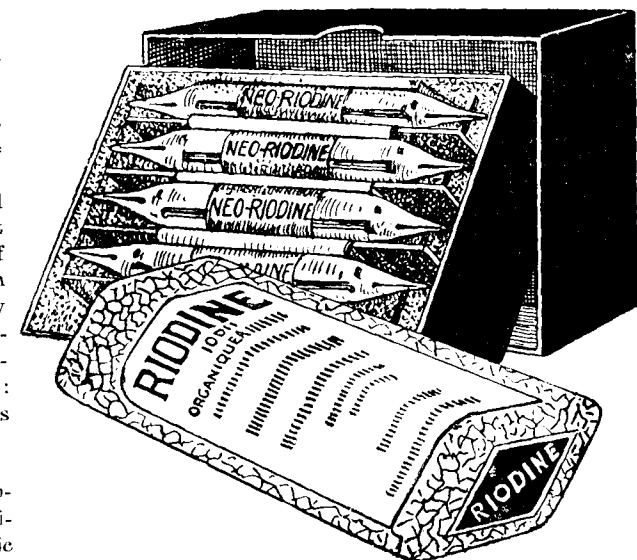
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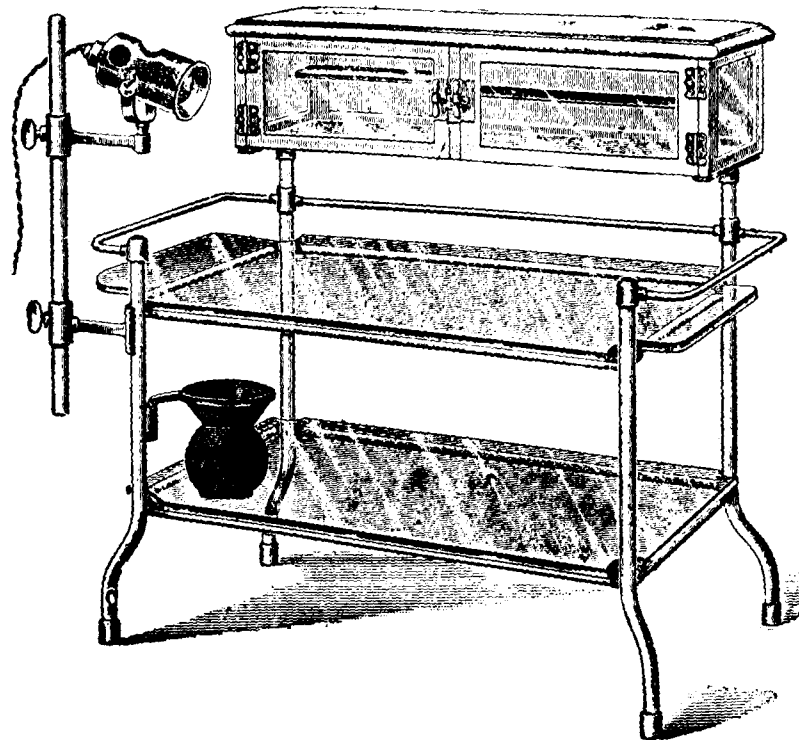
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