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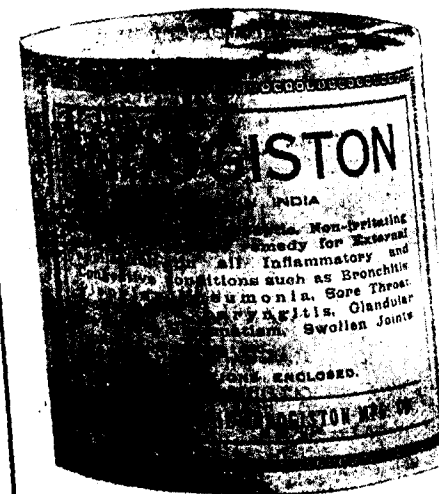
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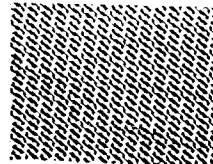
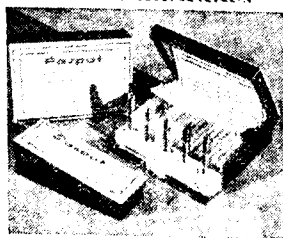
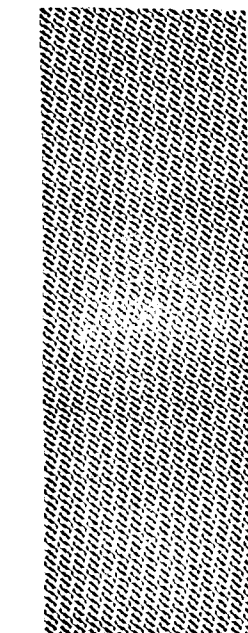
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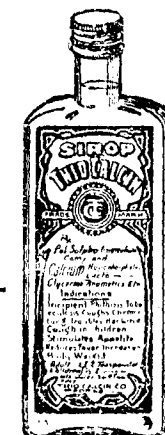
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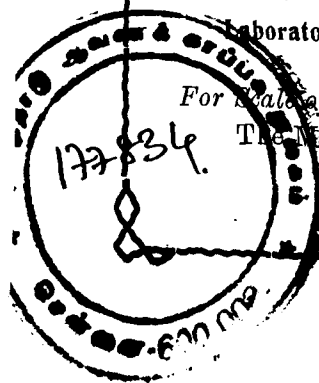
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APRIL 1936

Pitfalls in Ophthalmic Practice

BY

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BEFORE any discussion is taken up on the mistakes that are commonly met with in the everyday practice of ophthalmology, the first point that should be stressed is the fact that eye affections are, in the majority of cases, secondary, that is, they are either a localized manifestation of some general diseases or an extension from the neighbouring structures.

The lid and conjunctiva.—A patient comes to a doctor complaining of trouble in his eyes. On examination the doctor finds the skin of the eye is excoriated, eczematous and the conjunctiva red and discharging. The diagnosis is chronic conjunctivitis with secondary blepharitis and immediately the doctor rushes on and prescribes the usual treatment for these local conditions. If he were only a little more careful in his examination, he would probably find that the patient was suffering from a generalized affection of the skin, for instance impetigo, furunculosis or ringworm, or some such affection of the scalp and forehead as seborrhoea or acne rosacea. In these cases the eye is either being showered with micro-organisms, or infection is carried to the eye by infected fingers. Unless the skin condition is attended to, the eye will fail to improve with treatment or may even actually get worse.

Another common cause of chronic conjunctivitis and blepharitis especially of the angular type is an infected tear sac. Until this is removed, (for there is really no other alternative way of

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dealing with an infected sac) the conjunctival condition will evade all treatment. Chronic conjunctivitis causing a great deal of discomfort in the eye with very few objective signs can often be traced to a patient's occupation requiring exposure of the eyes to dust, glare and irritants over a prolonged period. Times without number such cases have been diagnosed as trachoma or granular lids. The patient is given various kinds of treatment consisting mostly of applications of caustics and irritant drugs. A pair of protective goggles, a mild salve or lotion and a few drops of liquid paraffin daily are all that are required to cure the trouble.

Granules and follicles. Much confusion centres around these two terms. Granules or follicles are collections of lymphoid tissue in the sub-epithelial layer of the conjunctiva. The presence of these without any symptoms is of absolutely no significance and requires no treatment. Granulosis may be a localized manifestation of a general lymphoid hyperplasia and is physiologically present in young children in whom we also find a hyperplasia of similar tissues, namely spleen, thymus, tonsils and adenoids. The same condition is found in older children of a 'tuberculous diathesis'. Phlyctenulosis is a condition of the same group but with more serious ocular manifestations.

Spring catarrh or vernal conjunctivitis is due to constitutional causes of the same type. In the treatment of this disease attention should be paid to the constitutional causes. Plenty of good food, sunshine, fresh air, the eradication of septic foci in the teeth or tonsils. The eye itself requires little or no treatment.

Trachoma is an exception to the above types of eye disease. The aetiology of the disease is still unknown but the consensus of opinion regards it as an infectious disease in which the infective organism, which has not yet been discovered, is supposed to lurk in the 'trachoma granules'. The presence of these granules has been the causation of the various kinds of destructive measures employed in the treatment of trachoma, namely, the eradication of granules by expression, cauterisation or application of caustics such as copper sulphate and silver nitrate

solutions. Nowadays, more attention is paid to the building up of the patient's own defences and destructive treatment has been discarded in favour of milder applications, namely, 0.5 per cent copper sulphate drops and weekly painting of the eyelids with 1 per cent to 2 per cent silver nitrate solution. This treatment should be carried out over a period of at least six months.

Copper sulphate stick has long been regarded as a specific in the treatment of trachoma. Nothing can be said too strongly to condemn this practice in India; copper sulphate destroys the raw and young corneal tissues and hence its use is absolutely contra-indicated in the presence of corneal ulcers which are frequently met with in the course of the disease.

One of the sequelæ of trachoma is entropion of the eyelids with trichiasis. A simple removal of the misdirected eyelashes is only a temporary measure for if the hair follicle is not destroyed the condition recurs in the course of a few weeks. The hair follicles can be very easily destroyed by the galvanic needle cautery and in the case of extensive trichiasis a Webster's mucous graft operation should be carried out. The latter is a very simple operation and the result is very satisfactory.

The use of pads and bandages in affections of the conjunctiva is very limited, especially in India. Whenever there is the least suspicion in septic conditions, their use is contra-indicated, for a pent-up discharge aggravates the condition in the former case and in the latter case prolonged apposition of raw surfaces gives rise to symblepharon.

Before the discussion on the lids and conjunctive is brought to a close, attention should be drawn to two other conditions, namely, acute inflammation and chronic blepharitis. In dealing with acute inflammation about the face and especially near the eye, the multiplicity of venous channels and the proximity of the cranial sinuses make any surgical interference an anxious process. Hence an extremely conservative attitude is usually necessary to allow the infection to localize in cases of acute styes, infective chalazion, acute dacryocystitis and lid abscesses.

Blepharitis. This disease is often treated for months without any benefit whatsoever. The infection lies at the root of the

eyelashes. Small hard scales or crusts adhere very firmly to the eyelashes and surrounding skin and unless these crusts are softened with an alkaline lotion and then carefully removed with a swab stick no applications can get at the site of the microorganisms. In all affections involving the lid margins or the conjunctiva, never forget to investigate the refraction of the eyes and to rectify any error found to be present.

Foreign body in the eye.—This is often a very deceptive ailment. A gritty sensation without any foreign body being present when there is ingrowing eyelashes or loss of corneal epithelium. Corneal abrasions, epidemic superficial punctate keratitis, phlyctenular keratitis, dendritic ulcers or herpes of the cornea give rise to a gritty sensation on account of the irritation produced by every winking movement over the exposed nerve endings. A drop of 0.5 per cent alkaline fluorescein is all that is necessary to reveal the nature of the complaint as if there is a raw surface it stains bright green with this drug. In those cases in which the history is more definite a careful search should be made in the fornices of the conjunctiva for the presence of a foreign body.

The removal of foreign bodies from the eye should always be done under a local anaesthetic and particular care should be taken in cases in which they have to be removed from the cornea, owing to the danger of a corneal opacity and, as a result, interference with vision. The abrasion left after removal of a foreign body from the cornea gives rise to a gritty sensation. This along with the presence of a corneal opacity gives the patient a false impression that the foreign body still remains. To obviate this, two important post-operative precautions should always be carried:—

(1) Never throw away the foreign body until it has been shown to the patient and his friends who accompany him.

(2) Keep the eye firmly bandaged for some hours after the operation.

Ulcer serpens, also known as hypopyon ulcer.—In the treatment of this serious ulcer of the cornea two factors of vita-

importance are often lost sight of, namely, the cause and the intraocular tension of the affected eye. The commonest causes of hypopyon ulcer are an infected tear sac, purulent conjunctivitis and a retained foreign body. Unless the cause is removed, all treatment must necessarily be in vain. Deep inflammation of the cornea is attended as a rule with iridocyclitis and the nature of the aqueous humour changes at once to an exudation. This increased viscosity of the aqueous causes a rise of intraocular tension in most cases and unless this tension is lowered by repeated paracentesis one cannot expect the ulcer to heal.

Cataract. True cases of cataract demand no urgent treatment but a host of different eye diseases are labelled 'cataract'. To quote a few examples:—

(1) With advancing age the refractive index of the lens increases and more light is reflected back from its surface, thus giving the characteristic grey appearance which is seen in the pupils of old people. Unfortunately these cases are often diagnosed as cataract; this causes unnecessary anxiety to the patient as the lens may be absolutely normal.

(2) The patient is suffering from chronic simple glaucoma which is slowly and insidiously leading towards irrecoverable blindness from optic atrophy. The family doctor after a cursory examination of the eyes assures the patient that he is getting cataract as his vision is slowly disappearing and it is too early to do anything to improve the sight and nothing advised as long as any vision is left. Later, when the real cause of the loss of vision is discovered by an oculist, it is too late to do anything, for the patient is blind for ever, the result of glaucoma and not of cataract.

(3) A young child with a grey pupil is brought for treatment and the doctor diagnoses his case as one of cataract and treatment is deferred. A few months later the same child is seen with a huge glioma (retinoblastoma) covering half his face and eating into his brain, presenting a most dreadful sight which the unfortunate parents have to endure until death.

supervenes. It is 'criminal' to diagnose cataract without a proper examination of the eyes, in the dark room.

With regard to the treatment of cataract, two points should be carefully observed :—

(1) The congenital and infantile varieties of cataract should be operated upon as early as possible in the child's life, otherwise there is the risk of amblyopia ex-anopsia developing.

(2) Immature senile cataract. The conservative method is to wait until the cataract is mature but the word maturity is fast losing its previous significance. Nowadays, when useful vision is lost expert ophthalmic surgeons frequently remove immature lenses by intra-capsular methods, without leaving any after-cataract; in the hands of experts the operation gives the most perfect results.

Glaucoma. Acute glaucoma is a condition of surgical emergency and no time should be lost in carrying out treatment. The commonest type of glaucoma seen in India is the chronic simple primary type. It is a very insidious disease and its diagnosis is often one of extreme difficulty. There are three cardinal signs, increased intra-ocular tension, depression of the visual fields and the presence of glaucomatous cupping. The measurement of tension requires a special instrument which is costly, extremely delicate, very easily gets out of order and requires expert handling. The fundi of the eyes show pathological changes in the way of glaucomatous cupping only when the disease is far advanced, and even then it usually requires an expert to diagnose the changes in the optic discs.

The easiest method of making an early diagnosis of glaucoma is by mapping out the fields of vision. As the disease advances the fields show a progressive depression commencing first in one or both nasal quadrants and the vertical depression of the blind spot. The central vision usually remains unaffected until the disease is very far advanced. The treatment for this type of glaucoma is always surgical and the best of the many operations for this disease in India is Elliot's sclero-corneal trephining.

One special variety of chronic simple glaucoma is common in Bengal and in the last year has occurred amongst Bengalis in the United Provinces, Bihar, and Burma and is a symptom of epidemic dropsy. Epidemic dropsy is very commonly called beri-beri by the public but is an entirely different disease; it is due to a toxic cause and is not an avitaminosis. This epidemic dropsy gives rise to a temporary glaucoma without any signs of inflammation and, provided the fields of vision are normal, general treatment is all that is required; this consists of a complete stopping of rice as an article of diet, the administration of drugs such as ephedrine and if possible complete change of climate from the epidemic area. The bowels should also be kept freely open. Local applications such as myotics to reduce tension are absolutely useless and should not be prescribed. Eserine is an irritant and sets up an inflammation and so makes operation more and more difficult should this be required later.

Strabismus or squint. The general practitioner's knowledge of the causes of this condition is very meagre and this is the explanation why so few cases among Indians come to eye hospitals for early treatment. The following points should be borne in mind :—

(1) Concomitant convergent strabismus is the commonest variety of the condition.

(2) Unless the squinting eye is treated very early it becomes amblyopic, that is, an eye with permanent partial sight.

(3) Errors of refraction are a common cause of the condition. If the eyes are examined under atropine as soon as the deformity is observed and the error of refraction fully corrected by glasses, the squint in most cases will be cured without operation.

(4) There is very little hope of regaining normal vision for a squinting eye if treatment is commenced when the child is older than six years. The affected eye can always be put straight by a simple operation in the hands of an expert.

Dark-room examination. This consists of the examination of the eye by oblique illumination and with the ophthalmoscope.

The corneal loupe and the condensing lens are used for the detection of small opacities, ulcers, foreign bodies and keratitis precipitates of the cornea, also for minute changes in the iris and the lens. If a slit lamp and corneal microscope are available more minute changes in the cornea, iris, anterior chamber and lens can be detected. To examine the media the pupils should be dilated with homatropine and the plane mirror of the ophthalmoscope should be used. Minute opacities in the media are usually seen by this method. If these opacities change their position when the eye is moved they must either be in the aqueous or in the vitreous; if stationery, they must be in the lens. By this method dislocation of the lens and retinal detachment can also be easily diagnosed. The ophthalmoscope is necessary to diagnose diseases of the retina and choroid.

Direct Ophthalmoscopy. To carry out this examination efficiently a mydriatic is required. The following points are worth observing when conducting this examination:—

(1) Direct ophthalmoscopy should never be carried before first examining the eye by oblique illumination and with the plane mirror. This prevents unnecessary waste of time as it gives a bird's-eye-view of the whole eye, as, if the media are not clear, it is useless to carry out direct ophthalmoscopy.

(2) The highest convex lens should always be in the sight hole to start with and the strength of the lens should be slowly wheeled down until the fundus is in focus. In this way all the structures from the cornea down to the fundus in turn come into focus, and this prevents any structure from being overlooked. It has the further advantage of giving one an idea as to the depth of the object in focus and is extremely useful in the detection of retinal detachment, changes in the vitreous, intra-ocular tumours, papilloedema, glaucomatous cupping, etc. It also gives a fair idea of the refractive index of the eye.

(3) The ophthalmoscope should be brought as close to the eyes of the patient as possible. Frequently cases are seen in which the media appeared to be clear but the fundus could not be seen. These are usually cases of high myopia and in

inexperienced hands the fundi are better examined by indirect ophthalmoscopy.

(4) Examination of the periphery of the fundus should not be omitted as very often the earliest evidence of diseases lies there, namely, retinitis pigmentosa, retinal detachment, etc. It is a good plan to examine the optic disc first of all, then the macula and lastly the periphery.

Refraction. The work of refraction is intimately connected with mydriatics and retinoscopy. Without these, only simple presbyopic glasses should be prescribed. Up to the age of 16 years the best mydriatic is atropine and preferably should be prescribed as an ointment. For older patients homatropine is sufficient. Atropine should never be *prescribed* for patients over forty years of age because of the risk of glaucoma. Retinoscopy is very essential in cases of astigmatism and one should think twice before prescribing astigmatic glasses with the axis asymmetric. No age is too young to have glasses if there is an error of refraction. Young children and illiterate people who do not know the alphabet can have correct glasses prescribed with the help of an "E" chart and retinoscopy by a refractionist.

Conclusion:—Success in the practice of ophthalmology is to a large extent a matter of careful attention to detail. Before operations, examination of the urine for albumin and sugar, the eradication of focal sepsis, and proper sterilization of the field are essential. In cases of operation on the eyeball, proper anaesthesia (conjunctival and retrobulbar ciliary blocking) and fascial akinesia guard against serious complications like escape of vitreous, etc. A small peripheral button-hole iridectomy (except in cases of patients with one eye where complete iridectomy is indicated) prevents prolapse of the iris after cataract operations. Careful examination of the pupil reactions, the determination of perception and projection of light and colour vision save the surgeon from operating in cases of cataract in which optic atrophy is present, and in which no vision can be restored.

The eye is a delicate organ and as such it should be handled with extreme gentleness and care. The mildest medicines, namely normal saline lotion and boric lotions, liquid paraffin drops and boro-vaseline should as far as possible only be prescribed.

(From the "Indian Medical Gazette" April 1936)

Minor Surgery in the Anal Region

(From the *Clinical Journal London*, January 1936)

It has been authoritatively stated that no less than 40 per cent of the population suffer at some period of life from an anorectal complaint. Though distressing to the patient, the illness in the vast majority of cases is of a minor nature, and calls for treatment by the general practitioner in his consulting-room. Operations are being rapidly replaced by various ambulatory injection treatments, and there appears to be a need for an outline of these modern ideas.

Internal Haemorrhoids

Internal haemorrhoids constitute the bulk of these disorders, and are so prevalent that the patient's diagnosis is sometimes accepted and astringent ointments prescribed, without examination of the rectum—a procedure which would not be even contemplated in other regions, and which leads sometimes to considerable regret. No student would put his hand up a patient's trouser leg to feel for and diagnose varicose veins, yet how often is a diagnosis of a varicose condition of haemorrhoidal veins attempted solely by a digital examination of the rectum. A simple tubular proctoscope and good illumination are as essential for diagnosis as for treatment.

Clinically, internal haemorrhoids fall into three groups, representing stages of development and chronicity, and requiring different treatments.

1. In the first stage, or non-prolapsing group, the piles are small, impalpable and bleed profusely.

2. In the second stage that of spontaneous reduction—the piles are fully developed and prolapse on defaecation with spontaneous reduction. A certain amount of fibrosis has occurred, so that bleeding is intermittent, but not profuse, and the piles are just palpable.

3. In the third stage—that of manual reduction—the piles are becoming fibrotic and may be thrombosed. They prolapse on defaecation, coughing or exercise and require digital replacement. Haemorrhage is uncommon owing to the fibrosis.

Seven, or rarely 8, internal haemorrhoids are possible corresponding to the tributaries of the superior haemorrhoidal vein, but there are three main radicals which are always affected primarily and will be found in the most advanced condition. With the patient in the lithotomy position they will be found at 3, 7 and 11 o'clock positions respectively. The smaller radicals become varicose later, so that a patient may have severe haemorrhage with three third-stage haemorrhoids; removal of these will not affect his bleeding, which comes from a third-stage incipient haemorrhoid lying between the older ones.

Injection treatment is painless and the patient can be promised relief from haemorrhage, but nothing more, though one hopes, and often succeeds in so fibrosing the haemorrhoid, that a slight degree of prolapse is also cured, and the feeling of fullness in the rectum and the mucoid discharge considerably improved. It follows that injection treatment is ideal for first and early second stage, but in the latter group experience alone will indicate the amount of prolapse that can be cured, though cessation of haemorrhage can always be obtained.

The third-stage haemorrhoids require operation, which can be done in almost every case under low spinal or local anaesthesia, but should operation be refused the haemorrhage can again be controlled by injection. The best solution is 5 per cent. phenol in almond oil. Three c. c. should be injected through a well-illuminated proctoscope at the top of the pile, just where the haemorrhoid begins to form a ridge in the rectal mucosa. The injection should be into the submucous tissue, and perivascular fibrosis, is the object in view, not an intravascular. A great

help is a long needle, shouldered, so that the operator knows how much of the needle is under the mucosa. These are supplied by Messrs. Allen & Hanbury to Mr. Milligan's design for the ordinary record syringe or a complete injection needle and syringe as devised by Mr. Gabriel may be used. Only one haemorrhoid should be injected per week, as the subsequent thrombosis and swelling may be of some moment and may seriously inconvenience the patient.

A gentle attempt must be made to reduce strangulated and thrombosed haemorrhoids. Failing this, cold compresses of carbolic lotion (1 in 40), or biniodide of mercury (1 in 1000) applied 4th hourly, with complete rest in bed, will relieve the condition. When sepsis is present, a short preliminary course of fomentations is indicated before the cold compresses. Later an examination will indicate the treatment to be adopted for permanent cure.

The contra-indications to injection treatment are advanced cardiac, pulmonary, or hepatic lesions, pelvic tumours such as the pregnant uterus, or local sepsis in the rectum.

The complications are associated with faulty injection and sepsis. The injection must be into the submucosa; the position can be verified by slightly moving the needle when it will be seen to be just under the mucosa, and the subsequent injection will be painless. Some haemorrhage is not uncommon, but when excessive the puncture spot must be caught with artery forceps and tied with catgut. The injection must be stopped if the mucosa becomes white over the site of the injection, as too much solution may cause sloughing and necrosis, leading to a painful, intractable ulcer.

Abscess formation is exceedingly rare, and when it occurs, a tense, tender swelling forms, giving rise to throbbing pain and demanding immediate incision through the mucosa.

As regards cure, after injection or operation there is always the difficulty of other veins becoming varicose in later life, but by injection a patient can be assured of a minimum of three years freedom from symptoms, and he is always more ready to

undergo another series of injections than to submit to another operation.

External Haemorrhoids

External Haemorrhoids, arise just outside the anus and are covered by squamous epithelium. There are 4 varieties, as follows:

Dilated anal veins, well seen as a temporary condition in the second stage of labour, usually form a ring round the anus but are sometimes pendulous, forming a true external haemorrhoid. These must never be injected, as necrosis with painful, prolonged ulceration is almost certain to follow. If pedunculated they can be excised under local anaesthesia after transfixion and ligature, but a groove must be cut in the skin for the ligature, or severe pain will ensue.

Throbotic piles or anal haematomata are not thrombosed external haemorrhoids; they are extravascular clots appearing suddenly at the anal verge as painful ovoid swellings of a distinctly blue colour. Treatment consists in removal under local anaesthesia of an ellipse of skin over the swelling and the expression of the clot, or in expectant measures with cold compresses of lotio plumbi C opio.

Redundant skin tag may assume a large size and often are contributory causes to pruritus ani. Excision under local anaesthesia is indicated.

Sentinel piles associated with fissures are oedematous skin tags, and they should be excised when treating the fissure.

In making a diagnosis one must bear in mind the occasional occurrence of the soft fibro-lipoma or molluscum fibrosum, the condylomata of syphilis, warts and the early squamous carcinoma.

Anal Fissure

Anal fissure is a triangular-shaped ulcer, having its apex somewhere near Hilton's line and its base at the anal verge. It is not due to tearing down of an anal valve, but is caused by a scybalous mass of faeces splitting the epithelium by extreme distension where it is least supported by the external sphincter.

This sphincter consists of two muscular slings surrounding the anal canal, joined imperfectly by interdigitation as they arise from the central point of the perineum anteriorly, and still less perfectly as they blend with the ano-coccygeal raphe behind. Consequently almost all fissures are found in the mid-line posteriorly, 1 per cent. occurring in the mid-line anteriorly in males and about 8 per cent in females, owing to weakening of the perineum by childbirth. A chronic ulcer follows the splitting of the mucosa, since each subsequent defaecation tears the fissure apart and the inflammatory oedema, affecting the skin, forms the sentinel pile which hinders drainage of the ulcer.

Multiple fissures are occasionally observed and indicate a stenosis of the anal canal, either congenital or acquired from diversa causes. They are often associated with the condylomata of syphilis.

Severe pain after defaecation is the main symptom, incapacitating the patient for 2 to 6 hours, becoming somewhat easier as chronicity develops, but complicated by serous discharge, pruritus and sometimes by abscess formation. Bleeding is an early slight symptom, but constipation in a severe form is almost invariable owing to the fear of defaecation.

The patient seeks urgent relief of his pain and must not leave the surgery until this is attained. A cocaine ointment is the only surface treatment of any use, but is poor and requires frequent application. By far the best treatment is injection of the following solution, known as A. B. A., put up by Messrs. Allen & Hanbury in 2 c. c. and 5 c. c. ampoules;

Anaesthesin	...	...	3 per cent
Benzyl alcohol	...	...	5 per cent
Ether	...	...	10 per cent

Dissolved in sterilized olive oil.

This formula has lately been improved and, though similar in action and usage, the solution is even more effective. It is marketed under the trade name of "proctocaine".

To fill the syringe the ampoule should be placed in hot water and a wide-bore neeble used, the injection being made

with a fine hypodermic needle, 1 c. c. immediately under the fissure and then, with the finger in the rectum, 2 c. as far round as possible into the sphincter on either side. The sentinel tag can now be excised to obtain good drainage, and a complete examination made of the rectum. The relief of pain is immediate and lasts from 7 to 14 days, during which time the constipation can be corrected, soft motions being ensured by the use of liquid paraffin, supplemented, if necessary, by stronger aperients. The fissure is thereby given a chance to heal and correct bowel action established, the only surface treatment necessary being an ichthyol or similar stimulating ointment.

Chronicity of the fissure is an indication for operative treatment, and is shown by palpable induration, a well-formed sentinel pile or the external sphincter showing transverse fibres in the floor of the ulcer. A tightly contracted and spastic sphincter becomes indurated if the condition persists, and will require stretching under low spinal or general anaesthesia, but in all cases, unless an immediate operation is decided upon, the period of waiting must be relieved and the emptying of the bowel facilitated by a preliminary injection of A. B. A.

Prolapse of the Rectum

Prolapse of the rectum is a complaint of many patients, but true prolapse is relatively uncommon, so that it is essential to see the protrusion of which the patient is complaining before considering treatment.

Partial prolapse consists of mucous membrane only and can be felt to consist of two thin layers of tissue. It is not uncommon in children up to the age of two years, and is spontaneously cured as the child gets older, merely requiring careful supervision of the bowels and the formation of regular habits with avoidance of constipation and straining. A small, regular dose of petroleum emulsion and strapping the buttocks together just behind the anus with a piece of 2-in. strapping are helpful. If these methods fail, linear cauterization of the mucous membrane under general anaesthesia will effect a cure. In adults the condition is almost always due to haemorrhoids, which will

require operation, but a pure mucous membrane prolapse can be relieved by injection treatment.

Complete prolapse occurs most commonly in elderly women, and is often associated with a weak mental condition, which negatives extensive operative procedures. Injection treatment is worth a trial even in advanced cases, as no operation has yet been devised which gives completely successful results. Using a long proctoscope a series of injections of 5 per cent phenol in oil are given into the mucosa, beginning as high as possible and injecting about 2 c. c. at each puncture, so that the whole circumference of the bowel is injected progressively down to the anus. This will require several sessions, using up to 15 c. c. each time. The lax mucosa becomes fixed to the rectal wall. To help to fix the rectum itself a peri-rectal injection of the following solution is necessary :

Quinine sulph	...	12 gr.
Acid sulph dil	...	30 m.
Aqua dest	...	30 m.
Sterilize.		

With the finger in the rectum as a guide, 3 c. c. of this solution should be injected with a $3\frac{1}{2}$ -in. needle through each of three punctures situated about an inch from the anus, two laterally and one posteriorly. Regulation of the bowels with defaecation in a supine position on a slipper bed-pan must be insisted upon, and the patient taught to contract his sphincter and levator ani muscles 12 times thrice daily, to restore the muscle tone. The treatment needs carefully following up by injection of any recurrences. Surprisingly good results can be obtained.

Sometimes, in the third stage, haemorrhoids become so hard and fibrosed as to form pale, rounded, fibrous polypus with a long pedicle, which can be transfixed and ligated and then removed. Adenomata, on the other hand, are bright red, soft and bleed easily and require the same treatment, but in an adult any thickening of the pedicle would suggest the possibility of malignancy, and the advisability of referring the case to hospital. All adenomata must be sent for section, as they all seem to

become malignant sooner or later, and, conversely, nearly all carcinomas begin as adenomata.

Another type of prolapsing tumour is the hypertrophied anal papilla, normally seen as a small, pale sessile structure, arising from the anal valves and representing remnants of the ectodermal membrane which closed the anus in early life. When hypertrophied they become elongated and nipped by the external sphincter, forming another type of fibroid polypi easily amenable to excision.

Pruritus Ani

Pruritus ani constitutes the most troublesome anal complaint, and its treatment is still very unsettled. The urine must be examined for glycosuria and a careful search made for a local cause, such as lack of cleanliness, mucoid leakage at the anus, short fistulae, redundant skin tags and especially thread worms, which are by no means uncommon in the adult. After dealing with local causes there still remains a large percentage of cases with persistent pruritus and a sodden, excoriated anal skin. The intake of protein and all so-called "heating" foods should be reduced. The patient benefits by a short rest in bed. The anal skin must be washed after defaecation and calamine lotion applied. Daily lavage of the rectum with sodium bicarbonate, 1 in 500, using about 2 pints, is useful together with a small dose of bromide at night.

The whole affected skin area may be undermined by injections of A. B. A. or proctocaine, beginning posteriorly, but carefully avoiding any raising of the skin by the injection. If 4 punctures are made, 3 c. c. should be injected through each in a fanshaped manner, covering a broad band of skin, and a series of injections, more anteriorly, should be given every third day until the area is covered. In this way a chance is given for the skin condition to recover, and the patient's general condition improves with relief of the itching, but a permanent cure cannot be promised. X-Ray therapy is useful as a last resort.

Peri-Anal Suppuration.

Peri-anal suppuration does not come within the scope of minor surgery except in so far that every abscess in this region must be opened at once and a large, round opening made into the skin over the abscess to obtain efficient drainage. These abscesses are egg-shaped, and the best way to drain an egg is that practised at the breakfast. Short dorsal fistulae and blind fistulae can occasionally be cured by swabbing along the entire length with pure phenol or by diathermy, but the only sure method is operation.

It is evident that much can be done in the consulting room to relieve those unfortunate patients who have an anal complaint, and, as pain and discomfort are such prominent features, the slight trouble involved is amply repaid by the gratitude of the patient.

(From the 'Clinical Journal' London, January 1936)

The Trichinopoly District Medical Association

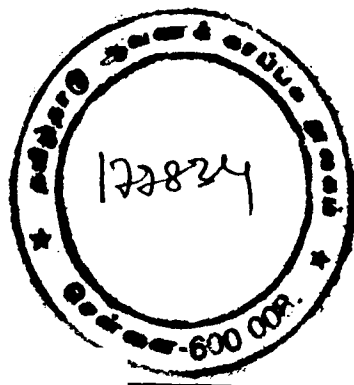
(REGISTERED)

A monthly meeting of the above Association was held at 5 p.m. on Sunday the 26th April '36 in the Coronation Gardens Trichinopoly when about 30 members were present. Rao Sahib Dr. T. C. Joseph Municipal Health Officer was 'At Home' to the members and Dr. T. S. Balasubramanyam, M.B.B.S., presided.

Dr. M. Balammal, M.B.B.S., delivered an interesting lecture on 'Placenta Praevia' in which about half a dozen members took part.

The president made of a remarks summing up the lecture and the discussion after which the meeting terminated at a late hour with a vote of thanks to the Host, the Lecturer and the owners of the Gardens.

TRICHINOPOLY, }
22nd May '36.



P. A. S. RAGHAVAN.
Secretary.

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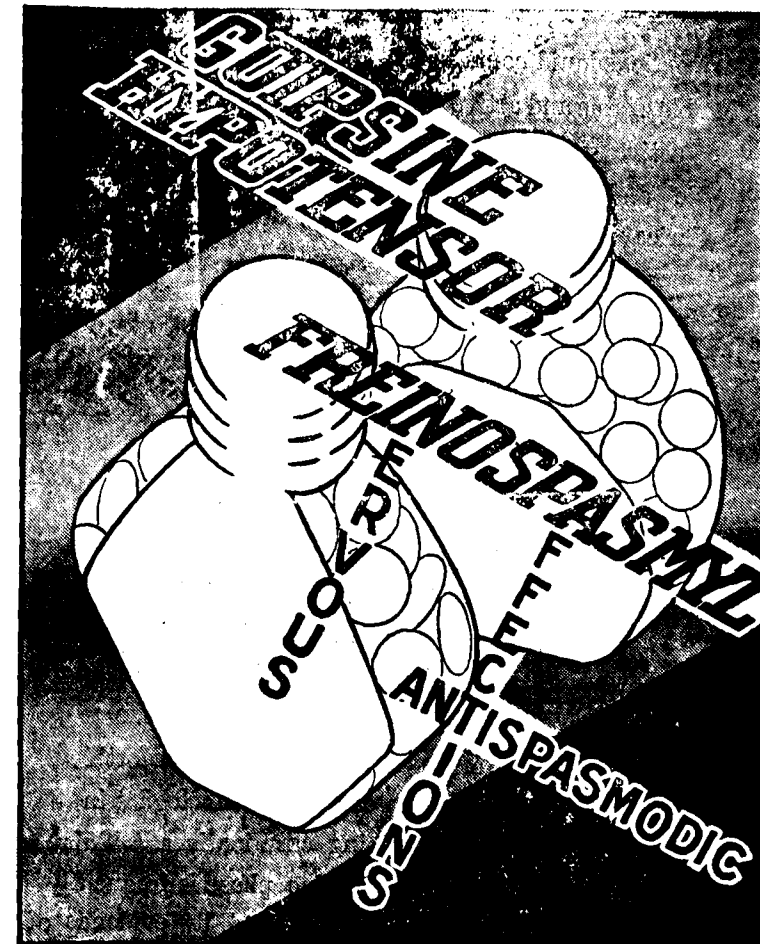
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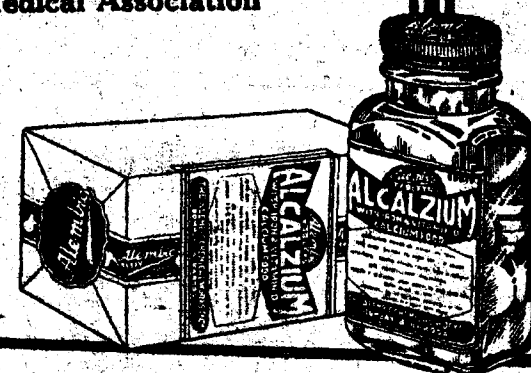
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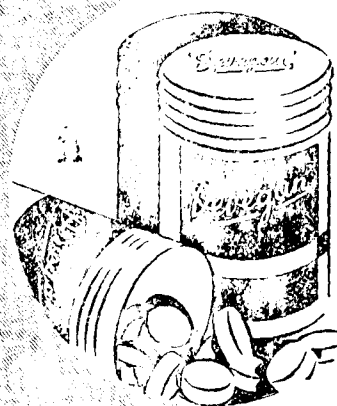
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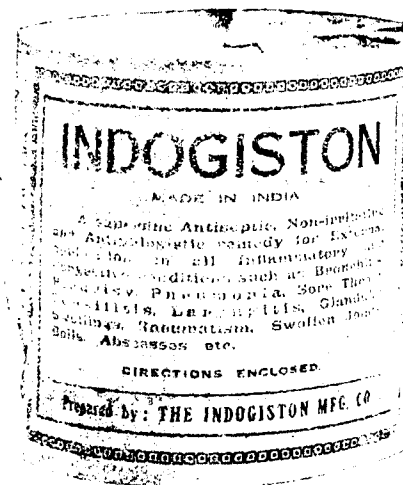
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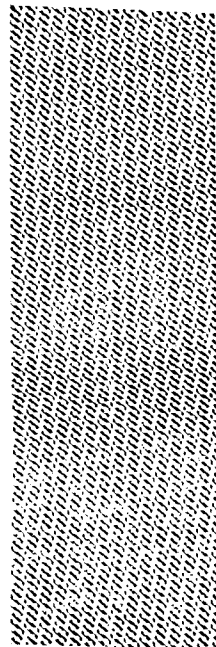
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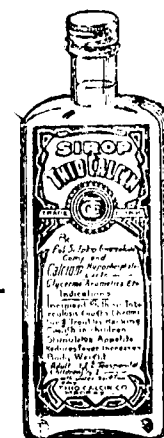
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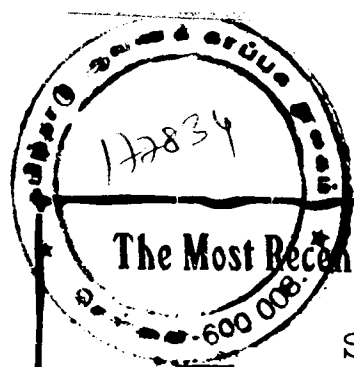
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MAY 1936

Dysphagia

By ROBERT HUTCHISON, M.D., LL.D., F.R.C.P.,
Consulting Physician, London Hospital.

BEFORE dealing with the causes of difficulty in swallowing it will be well to remind you of the mechanism of normal deglutition. This, you will remember, consists of a voluntary and an involuntary stage. The bolus of food having been prepared by chewing and moistened by the saliva is pushed back by the voluntary closure of the lips and heaving up of the tongue. It is thus brought into the pharynx, where the involuntary stage of the process begins. The bolus is now grasped by the constrictors of the pharynx, whilst at the same time the soft palate is raised to shut off the nose, and the larynx closed and drawn up in order to prevent food entering the air-passage. This ends the buccopharyngeal phase.

The food then enters the oesophagus, solids being carried down by peristalsis whilst liquids are rather squirted through, and with the relaxation of the cardia the stomach is entered.

Difficulties in the above process may be due either to pain, paralysis or actual obstruction, acting separately or in combination and may be classified for clinical purposes thus :

1. Difficulty in the act of deglutition from—
 - a. Mechanical causes, e. g. retropharyngeal abscess, lack of saliva, etc.
 - b. Paralysis, e. g. facial, bulbar, post-diphtheritic myasthenic.
 - c. Pharyngeal growth.
 - d. Affections of the larynx.

2. Obstruction in the oesophagus from—
 - a. Congenital malformation.
 - b. Foreign bodies.
 - c. Cicatricial contraction:
 - i. The effect of caustics.
 - ii. The effect of ulceration (traumatic, peptic, tuberculous, syphilitic).
 - d. Pouches:
 - i. Pulsion pouches.
 - ii. Traction pouches.
 - e. Spasm:
 - i. At orifice, Plummer-Vinson syndrome.
 - ii. At cardia (cardiospasm, achalssia, oesophagectasia).
 - f. Carcinoma.
2. Pressure on the oesophagus from without by—
 - a. Thyroid tumours.
 - b. Mediastinal growths.
 - c. Thoracic aneurysm, etc.

In most of the above instances difficulty of swallowing is not the only or even the presenting symptom, so it will be necessary to deal only with some of them.

1. (a) Retropharyngeal abscess is an occasional cause of dysphagia, especially in childhood, the difficulty being due partly to mechanical obstruction, partly to pain. The diagnosis is easily made by examining the pharynx.

(b) Facial paralysis may produce a certain degree of dysphagia by interfering with the formation of the bolus, but this is never the presenting symptom. The control of the muscles of the palate and pharynx is mostly exerted through the accessory part of the eleventh nerve, and interference with this may easily interfere with swallowing. Hence the dysphagia in post-diphtheritic paralysis and, from disease of the nucleus, in bulbar palsy. In myasthenia gravis, also, dysphagia is sometimes an early symptom.

(c) A pharyngeal growth may, like retropharyngeal abscess, interfere with swallowing, partly mechanically and partly from pain. Such a growth is commonest in the deep part of the pharynx, originating from the pyriform fossa and is chiefly met with in men.

(d) Laryngeal tuberculosis produces dysphagia mainly by causing pain, but the symptoms and signs of advanced pulmonary tuberculosis will usually be present as well. In carcinoma, on the other hand, dysphagia may be the only symptom. The growth starts from the mucous membrane over the posterior wall of the cricoid, and curiously enough it is relatively common in women of early middle life (35 to 45); in men it occurs at a later age. Both laryngeal tuberculosis and carcinoma are diagnosed by the laryngoscope.

2. Obstruction in the oesophagus. This is by far the commonest cause of dysphagia as the presenting symptom. In young children it may be due to a *congenital narrowing*, sometimes situated at about the level of the tracheal bifurcation, but often at the cardia. In such cases liquids may go down easily enough, and symptoms may arise only when the child reaches an age to be taking solid food.

Foreign bodies, such as a piece of impacted bone, are a common cause of difficulty in food passing through the oesophagus. The diagnosis can often be made from the history, but such a cause should always be thought of if the patient complains of persistent oesophageal pain. The oesophagoscope here is an invaluable diagnostic aid.

Scarring of the oesophagus may cause obstruction. It is usually the result of the swallowing of a corrosive fluid, and occurs chiefly at the level of the left bronchus and lower end of the oesophagus as these are the sites where the fluid most comes into contact with the wall.

Scarring from local ulceration is much less common, but traumatic, tuberculous or syphilitic ulcers may all occur. Peptic ulceration at the lower end is also probably commoner

than is realised, and may cause obstruction partly from cicatrization and partly by inducing spasm.

In all these cases the diagnosis is best made by the oesophagoscope.

Oesophageal pouches are a rare cause of difficulty in deglutition. They are of two kinds, "pulsion" pouches and "traction" pouches. The pulsion pouch is really a hernia of the hypopharynx coming through the inferior constrictor, and is met with chiefly in elderly men. As the pouch enlarges it passes down along the left side of the oesophagus, and can sometimes be felt as a swelling in the neck. When distended with food it presses upon the oesophagus and causes obstruction.

The traction pouch is rarer, and is brought about by the pulling of a healing tuberculous gland on the anterior wall of the oesophagus at the level of the tracheal bifurcation. As the pouch is drawn out of the oesophagus upwards as it were, its mouth is below the level of its fundus and so there is no accumulation of food in it. Traction pouches therefore are not likely to cause obstruction. Both varieties of pouch are to be diagnosed by an X. ray examination.

Spasm may occur either at the entrance to the oesophagus or at the cardiac orifice. Both are rare. Spasm at the entrance is a main factor in the dysphagia which occurs in the 'Plummer-Vinson syndrome'—that curious combination of hypochromic anaemia, atrophy of the mucous membrane of the tongue and throat and dysphagia, which is sometimes met with in middle-aged women.

Spasm at the lower end of the oesophagus used to be known by various names—cardio spasm, Oesophagectasis, etc.—but is now usually spoken of as "achalasia" of the cardia because failure to relax appears to be the cause of the obstruction, not an actual spasm. The point, however, is not one of much importance except theoretically. Such cases occur at any age and in either sex. At first the symptoms are intermittent, consisting in the occasional regurgitation, of saliva and food but as time goes on the obstruction becomes more permanent and finally dilatation of the oesophagus results.

It must be remembered also that true spasm of the cardia—not merely achalasia—may be excited by organic disease in its neighbourhood, such as ulcer or growth, and be a factor in producing the dysphagia associated with the presence of these.

Of all causes of dysphagia when it is the sole or presenting symptom *cancer of the oesophagus* is by far the commonest. It is met with chiefly in men, and is characterized by a gradually increasing difficulty in swallowing. The lower end of the oesophagus is the usual site for a growth, but it may also occur high up about the level of the tracheal bifurcation. On Xray examination the obstruction is seen to be irregular, not smooth as in achalasia, and in contradistinction to what obtains in achalasia, there is little dilatation of the oesophagus.

Pressure on the oesophagus from without may cause dysphagia, but rarely as the presenting symptom. Aneurysm as a cause is now not often met with, mediastinal growths seem rarely to press upon the oesophagus, and thyroid tumours are more likely to cause dyspnoea than dysphagia.

It is interesting that in all cases of oesophageal obstruction the food seems to the patient to stick at a high level than the site of the block. Regurgitation of saliva and froth are sometimes more complained of, at first at least, than actual difficulty of swallowing. In certain cases the patient suffers from cough and difficulty of breathing after food, so that asthma or dyspepsia may be simulated, and a complaint of shortness of breath after meals should always make one suspicious of the oesophagus.

The X-rays and the oesophagoscope have made the diagnosis of the different forms of oesophageal obstruction a comparatively easy matter at the present day.

A Test for Typhoid.

(From the 'Antiseptic' April 1936)

The Test:—Make a 1—1000 solution of Pot-per-mang in distilled water.

Dilute freshly passed urine with distilled water to 1 in 6. Divide this in two test-tubes; one of which should be used as control.

Mix 5 to 10 drops of the solution of 1 oz. permanganate, in one of the test tubes and shake it well. If the diluted urine in the test tube turns yellow it is positive.—? Why? What happens?

'Tabloid' Bland Pill and Copper.—The administration of iron in one of its various forms is a therapeutic measure of long tradition, but recently it has been suggested that the therapeutic action of the iron is enhanced by the addition of minute quantities of copper. Further, it is claimed that, as copper appears to be necessary for the synthesis of haemoglobin, iron is only fully utilised when small traces of copper are present, and that the beneficial action of iron preparations is due to the presence of traces of copper either in the product or in the patient's food. For those physicians, therefore, who favour the addition of copper to iron, many preparations which contain both are available.

(From the 'Antiseptic' of April 1936.)

1. Reports from various European clinics indicate the value of thymophysin (a combination of thymic and pituitary extracts) to increase the force, frequency and duration of feeble labour pains, especially during the first stage but also in the second stage when the pains have stopped.

2. The preparation is administered intramuscularly, preferably in the gluteal region. In my experience, it is best to begin with a smaller dose of 0.5 c.c. followed by a second similar injection or by a dose of 1 c.c., if the first does not prove effective.

3. The use of thymophysin not only hastens and facilitates normal delivery by aiding dilatation of the passages but also lasts into the third stage, so as to promote expulsion of the placenta.

4. The most favourable type of case is primary inertia. When the uterine musculature is exhausted by prolonged labour, the preparation proves ineffective. In such cases, the mother should be given a rest before labour is resumed. Then thymophysin may prove of value.

5. It does not appear to injure the mother or child.

6. Results are sufficiently encouraging to justify other physicians having the facilities to employ the preparation and observe their results. In the meantime, final judgment as to its value should be withheld.

(From American Journal of Obstetrics and Gynecology)
(January 1930)

Do You Know?

(From Science News—Letter).

Mushrooms contain Vitamin D, a German physiologist has discovered.

MANY cases of "leucorrhea" due to the Trichomonas Vaginalis will respond to salt douches. The proportion is one part of sodium chloride to four parts of water.

Vitamin-E may be effective in the prevention of "habitual-abortion". This vitamin is obtained in large amounts from wheat germ from which an oil is cold-pressed. It does not, however, cure human sterility.

Cesarean Operation

Julius Caesar, contrary to widespread belief, was not born by means of a Cesarean operation. Neither did he have anything to do with the enactment of the old Roman law that forbade burial of a woman who died in pregnancy before the body of the unborn child had been removed by surgery.

The old myth about Caesar and his birth is exploded by Dr. John Harold Couch of Toronto General Hospital and Herbert Newell Couch, assistant professor of Greek at Brown University, Providence, R. I.

A reason for the persistent linking of Casarean operation, performed on a dead mother, and the cognomen of Caesar, which is derived from the verb *caedo*, to cut, was attached to the newborn child for that reason. Another Roman family, bearing the name *Caeso*, may have derived their cognomen from the same cause. Such a method of assigning names would be entirely in harmony with the early Roman traditions. In fact, Pliny is the authority on this assumption, for in his *Natural History* he remarks that certain people were born by an incision of the mother and that 'the first of the Caesars' was said to have been born in this manner".

No one knows just who the first of the Caesars was, but he was not the Julius of historic fame.

Injection Treatment of Internal Hemorrhoids

The injection treatment of internal hemorrhoids is a recognized and efficient therapeutic procedure. Two solutions are in common use. It is not our intention to discuss their relative merits but to point out the difference in technic.

1. Quinine and urea hydrochloride (five to ten per cent):—

The injection is made directly into the pile mass, first entering its base and carrying the needle to its centre. From 1 to 1½ c.c. of the solution is used. Enough should be used to distend the mass without making the surface white and shiny. After the injection has been completed the needle should be kept *in situ* for one minute to minimize seepage and bleeding.

2. Phenol (five per cent) in Wesson's Cooking Oil. The injection is not made in the center of pile but submucously. It is made into the loose mucous membrane of the submucosa. An injection properly made will reveal the "striation sign". The mucous membrane covering the mass is reddish-purple or dark blue. After the injection the color becomes grayish. Pinkish

threads, representing the superficial capillaries, now become visible on the mucosa. This is called Blanchard's striation sign. This sign will not occur if the injection is made into the muscular layer or in the center of the pile.

When injections are made into the mucous membrane (instead of under the mucous membrane as they should be made), a white bleb will appear. A bleb calls for stopping the injection. If not stopped, superficial necrosis will follow. If the mass does not distend after the injection (as it should) it may signify that the needle has been inserted too deeply into a vessel in the pile mass. If oil appears in the speculum it means that the pile has been "transfixed". When injections are properly made no bleeding usually follows after the withdrawal of the needle.

A. S. Morely now uses five per cent phenol in almond oil injected submucously. (Formerly he advocated stronger phenol solutions but there were too many complications.) Any vegetable oil can be used. Mineral oils being non-absorbable cannot be used. Vegetable oils are absorbable.

(From the *Doctor and Oil Quarterly* April 1936)

Vitamin Preparations

We used to be told, years ago, that five vitamins were essential for the maintenance of life—namely, A, B, C, D, and E. L. S. D.—the last being by far the most important! Of late, recent discoveries have so enlarged the number of vitamins known that we will soon have exhausted our own alphabet and may eventually have to float a loan from the Greeks. As a general rule, it may be said that, with the exception of cod-liver-oil or halibut-liver-oil, it is more physiological, and more economical, to get our vitamins from the butcher, the grocer, and the dairyman than from the chemist. Yet there is no doubt that in certain circumstances some of the highly concentrated vitamin preparations, especially those of A and E, are very helpful. Though a good mixed diet is not deficient in any of the

vitamins, yet there are occasions when for some special purpose we wish to give larger quantities of one or other of these principles than are ordinarily contained in the diet. Moreover, owing to poverty or other causes, a good mixed diet may not easily be obtainable. It is worth remembering, however, that, even in the case of A and D, natural sources, such as the fish oils, may have an advantage over the artificially concentrated products. Even yet we do not know all there is to know about cod-liver-oil, and recent researches suggest that there is some subtle difference between the vitamins contained in this and other fish oils and the artificial preparations. Nevertheless, when all is said and done, occasions do arise when these latter may be extremely useful.

(From the *British Medical Journal* March 28th, 1936.)

Pertussis

(From 'The Review of Therapeutics' May 1936)

Gurwitsch (Brijaansk) recommends either injections, which produce a very beneficial effect on the symptoms through the hyperaemia caused in the bronchial mucous membrane. This he found in the treatment of 100 children with severe whooping-cough.

Dosage depends on the age of the child. Children up to one year are given $\frac{1}{2}$ to 1 c.cm. either puriss alone or with olcum olivarum, intramuscularly; children between one and seven years receive 1 to 2 c.cm., older children 2 to 3 c.cm. A minimum of 2 doses and a maximum of 5 injections must be given, and the initial dose must always be small. Usually vomiting stops after the first injection, and the attacks become less frequent. After every injection the condition of the patient shows an improvement. In 10 to 15 per cent. of the cases the treatment fails, but usually complications with pneumonia or Influenza exist in these cases.

(*Klin. Med. (Russ.)*, 1934, page 942)

Tetanus

Cole (Cambside) has been able to save 11 out of 19 cases of serious tetanus, by injections of Curare. All other treatment had failed in the case of a 39 years--old workman. The spasms, with opisthotonus, continued notwithstanding anti-toxin, (2,00,000 units intravenously and 4,000 units subcutaneously, in centre of the infected lesion of the finger), paraldehyde, morphia, avertin, etc. The patient seemed lost. He was then given 32 milligrammes curare subcutaneously every six hours (How often?—The Ed.) The condition improved two hours after the first injection.)

(*Lancet*, 1934, 11, 9.)

Gastric Ulcer Ag. No. 2

Semskow (Leningrad, Metschnikow Hospital) reports very good results from his nilas argenti treatment in gastric ulcer.

R/Solut. Nitrat. argenti aquos. 0.1. 200-0.

S. A tablespoonful 2 or 3 times daily half an hour before meals, for 4—6 weeks.

At first the patients are kept entirely in bed; the pain and hyperacidity have usually disappeared after 7—10 days, and then the patients need rest only after meals. The diet consists at first of milk, raw eggs, butter and rusks. Milk puddings and porridge are given after 10 days. Ordinary food, without meat, bread or coffee, can be gradually introduced after 3—4 weeks. (*Wratsch. Gazet.*, Vol. 33, No. 9)

About Gargling

By DR. W. HASE.

Kirschner who, along with Uffenorde, condemned many years ago the practice of gargling during inflammations of the throat, has recently, on account of *Liebermann's* article, repeated even more strongly, his condemnation. "It is an offence to modern surgical theories". Gargling does not give rest to the

inflamed areas, but causes pain, while the value of antiseptic gargles is exceedingly small.

We have tried to ascertain by means of X-Rays the extent to which gargling reaches the throat, given an average capacity for gargling. The tests were made as follows:

We placed the head in the position for gargling, and then applied to each tonsil a piece of cottonwool soaked in Iodipin. An X-Ray photograph from the same aspect was then taken while gargling with thin liquid Barium (according to *Snow* and *Stern*) and in this photograph the shadow of the gargle appeared just to touch the shadow of the tonsils at the top.

This proves that, in the most favourable case, the gargle reaches the front of the palate and the top of the tonsils, but does not touch the back of the oral and pharyngeal cavities and the tonsils proper.

This result is better comprehended if the act of gargling is carefully observed. The gargling noise is caused by rapid movements of the uvula, as in pronouncing "RRR". The tongue is pressed firmly to the soft palate. Uvula, palate and tongue thus close the back of the mouth, and this confines the movement of the gargle to very small limits. Small quantities of gargle which might pass this barrier are either swallowed, or the act of gargling is interrupted by an insuppressible reflex of coughing and choking. The former result is not in agreement with the principles of gargling, even if a non-poisonous gargle is used. Every body who has used a gargle during a severe attack of sore throat knows how painful and therefore unfavourable the second event can be.

Some people, however, have an ability to gargle which is above the average. On the occasion we saw an X-Ray photograph where the shadow of the gargle touched the epiglottis, but this caused the above-mentioned reflex action, which the person concerned would probably have been careful to avoid if he had a severe sore throat.

Moreover, we have been able to demonstrate the presence of Iodine to the urine of people with exceptional gargling

abilities 2—4 hours after they had gargled with 20 per cent. Iodine potassium. This proves that in "deep" gargling some of the liquid must be swallowed.

Gargles are sometimes supposed to have curative properties, not only through their mechanical action, but also by reaching the walls of the throat by diffusion when some of the fluid is swallowed during the process of gargling, or with the saliva. Possibly this is desirable, but gargling is certainly not the best way to achieve it. Instead of swallowing the gargle, it is far better to use tablets which dissolve slowly in the mouth. Suitable antiseptic medicaments can also be introduced to the affected parts by means of a spray, by instillations, injections, or painting, without any risk of exposing the disease throat to useless, painful and harmful massage and vibrations.

1. X-ray photographs show, when taken during the process of gargling with opese substances, that gargles normally only reach the front of the palate, and the top of the tonsils, but not the tonsils proper or the back of the throat.

2. For this reason alone, gargling for sore throats must be condemned as inefficient.

3. Gargling is contrary to all surgical principles, which demand, as the first condition of successful treatment, the immobilisation of the inflamed regions.

The Trichinopoly District Medical Association

(REGISTERED)

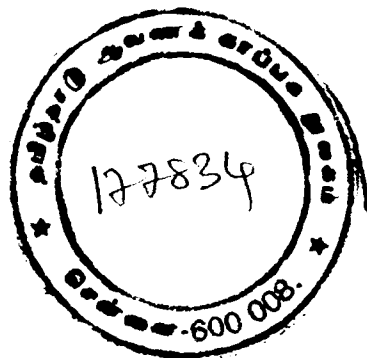
A monthly meeting of the above Association was held at 5 p.m. on Sunday the 31st May '36 in the E. R. High School Teppakulam, Trichinopoly when about 25 members were present. Dr. R. Kalamegham, B.A.M. B.B.S., was 'At Home' to the members and Dr. V. Iravatham of Thirukkattupally presided.

Dr. R. Sambasivan, M.B.B.S. delivered an interesting lecture on 'Pitfalls in Practice' and said that with the advancement of Therapeutics Pitfalls were getting fewer. He instanced cases of sloughing after Quinine injections which were now entirely replaced by the safer and shorter course of Atebrin treatment. Risky intravenous injections of rectified Tr. Iodine had been replaced by the comparatively innocuous and colossal iodine and the dangerous arsenicals had been replaced by safer intramuscular arsenical and Bismuth preparations. He also explained the risks of giving pure undiluted glycerine for Enema and hypnotics in children. He also spoke a few words as to how Practitioners should behave with patients and co-practitioners. The Chairman in his concluding remarks impressed up on the necessity of Medical men undergoing training before starting practice and the need for continuous study of medical literature to keep abreast of the times.

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

TRICHINOPOLY, }
31st May 1936. }

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Secretary.



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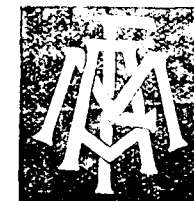
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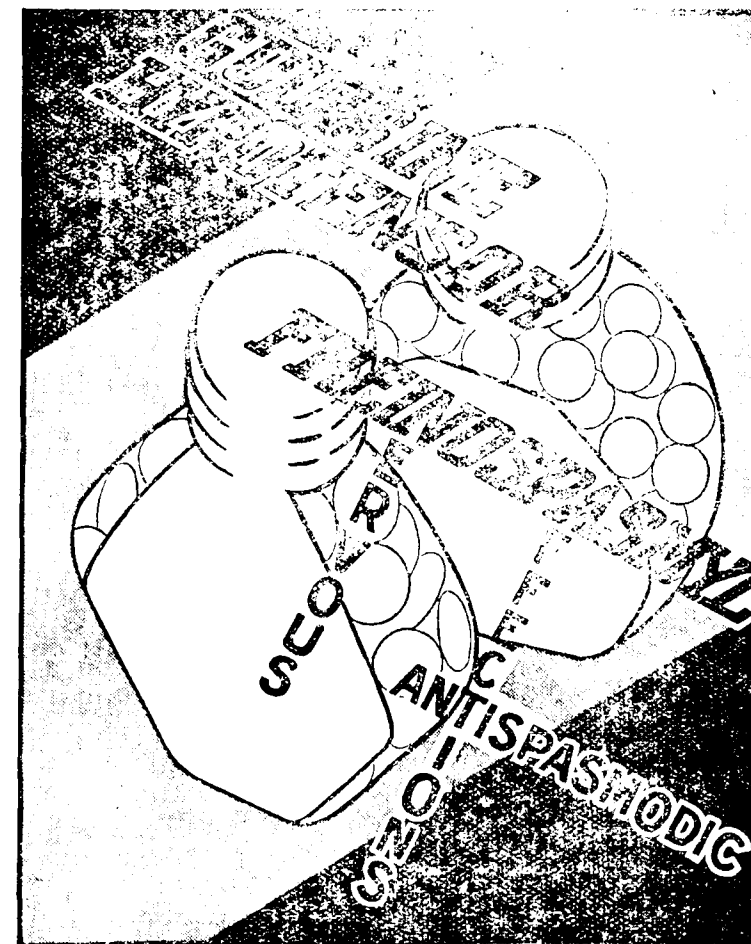
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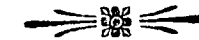
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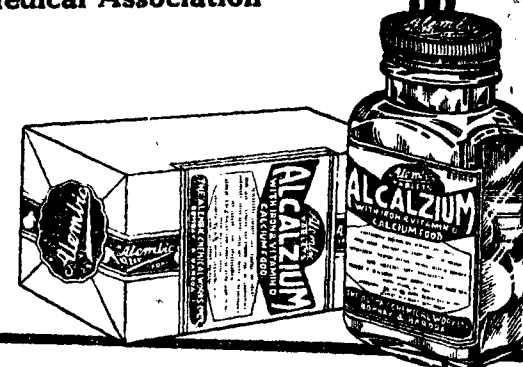
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foeces etc.
Blood sugar
estimated
and
gastric contents
analysed*

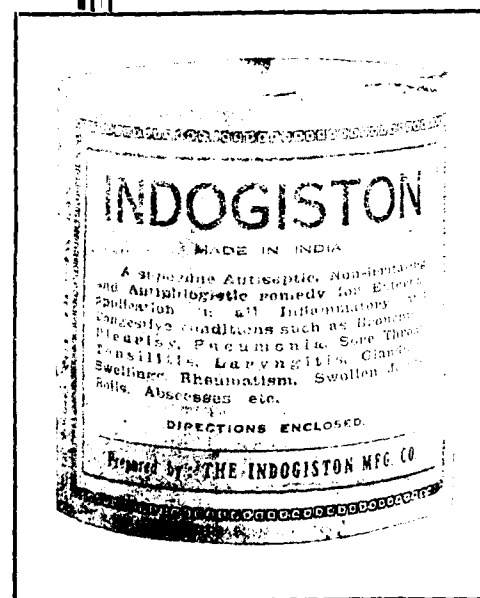
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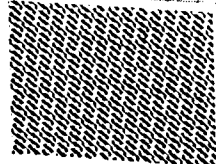
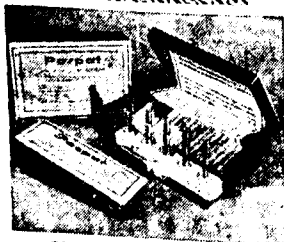
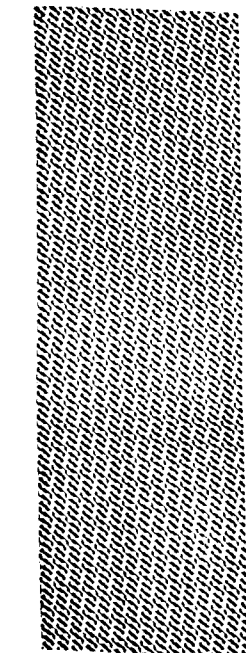
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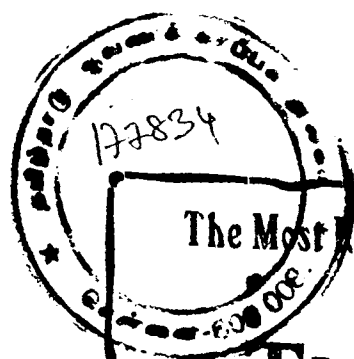
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(REGISTERED)

JUNE 1936

Physical Medicine To-day

(BY SIR LEONARD HILL, LL. D., M. B., F. R. S.)

The meeting this week of the sixth International Congress of Physical Medicine affords an opportunity to review a branch of medicine with which a good deal of quackery has been, and still is, bound up. Lord Horder accepted the presidency of this congress and Lord Dawson opened the first afternoon session, but owing to the taint of quackery many leaders in the profession have hitherto been sceptical. Thus it comes about that even in modern textbooks of gynaecology no mention is made of the treatment of cervicitis by diathermy, while in many treatises dealing with diseases of the skin the curative value of ultra-violet rays is almost ignored. In articles which not long since appeared in this and other medical journals on the treatment of carbuncles and written by surgeons on the staffs of great teaching hospitals, no mention was made of the fact that incipient boils and carbuncles can be made to abort by an intense local dose of ultra-violet rays. With wider knowledge of physical medicine much suffering could be prevented.

Since 1901 Bernhard at St. Moritz has shown that wounds, no less than the lesions of surgical tuberculosis, are best treated by isolation and open air, and yet how few surgeons have followed his example. We cannot here make use of the long hours of Alpine sunshine, but it is easy to imitate its effects by means of incandescent lamps hung in a cradle. How potent is the effect of irradiation of the skin with light is shown in the case of rickets. Vitamin D, necessary for proper growth of bones and good health, is formed from its precursor ergosterol in the

fat of the skin by the action of the shortest rays of sunlight. These rays are screened off in summer by smoke, walls, glass, and clothes. It is want of education, and of the means for giving children artificial sun baths or adequate supplies of Vitamin D in their food, which prevents the disappearance of rickets.

People who defame science for leading to the discovery of engines of war fail to take advantage of these findings, which show how to make children healthy and save life. By treatment with light, weakly marasmic children are made strong, while experience shows that for lupus vulgaris, alopecia areata, and some forms of eczema, etc., there is no better treatment than that by ultra-violet rays. Chronic ulcers treated with elastoplast bandages, a weekly irradiation with ultraviolet rays and finally injection of the varicose veins healed without exception; years of suffering are thus ended by modern means of healing. It has been shown at the St. John Clinic that many cases of rheumatic trouble in women have their origin in cervicitis, a condition often unsuspected by the family doctor and one which can be healed by pelvic diathermy. So, too, with menopausal troubles and rheumatic conditions due to endocrine disturbance, these may be similarly relieved. Many a woman whose life is a burden through backache may thus be restored to health.

For generations counter-irritation has been used; the scarification, blisterings, and burnings of older times are now replaced by intense local doses of ultra-violet rays, followed by elastoplast bandaging of the irradiated part. Such treatment proves of value for sciatica and for asthma. Asthmatic patients at the same time may be treated with inhalations and given remedial breathing exercises, the last being a potent means of relief. It is of interest to note that a deep effect of irradiation has been shown recently in the discovery that the air tubes of the lung are reflexly congested, and so narrowed, by heat rays acting on the skin, the converse effect being produced by cooling and in some people by irradiation with bright sources of heat. Ultra-violet rays, administered by suitable small water-cooled mercury vapour lamps,

afford the most successful method of treating tuberculosis of the mouth, larynx, and iris. Such irradiation is a simple and effective means of taking away the pain that often follows extraction of teeth, while sinusitis is best treated by infra-red irradiation. Baths, whether given by hot water, steam, foam, or incandescent lamps preventing loss of body heat except by the face and lungs, produce flushing and sweating of the skin, and bring more blood and lymph to the subcutaneous tissues. The tissues are thereby softened and pain relieved. Passive movement and massage can then be carried out, and the result is an increased oxygen supply to the part crippled by rheumatism, with swollen joints, unable to do hand work, or to walk without distress, if treated by immersion of the affected parts in a paraffin wax bath are often so much relieved that hand work and walking again become easy. The wax bath kept at a temperature of 130 degree F., coats the immersed limb with a thin film of solidified wax, and the vapour of sweat forming beneath this prevents all danger of burning. In the case of joints left stiff and immobile after active disease has subsided the orthopaedic surgeon restores movement by manipulation, carried out when needed with the aid of an anaesthetist. A gymnasium fitted with rowing machine, stationary bicycle, ship-wheel, etc., is of the greatest value for teaching patients how to make stiff parts mobile. It requires to be more widely known that immediate treatment of many minor injuries by manipulation will bring speedy relief of disability. The modern orthopaedic surgeon thus fulfils the claims made by osteopaths. In place of baths and irradiations electrical treatment may be used to prepare affected parts for passive movements and massage; it is the combination which gives relief.

The quack secures results by impressive and mysterious means, for the influence of suggestion is great. Instrument makers naturally seek to produce and sell costly machines, and these impress the patient. Be it noted, however, that a mercury vapour lamp costing £10, mounted on a simple iron stand, effects all that a similar lamp does when fitted with a reflector and chromium plated stand and costing, say, £30. So, too, with

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electric heaters; these are cheap when sold for domestic use, but when fitted with reflectors on plated stands and endowed on paper with a special curative radiation they are priced at £ 10 or more. Similarly, high-frequency ultra-short wave apparatus, credited with specific actions on tissues not obtained by diathermy, are sold for some hundreds of pounds, while laboratory tests show them to have no other effect than that of heat. Much has been made of radium pads, but scientific evidence is lacking as to the beneficial influence of minute traces of radium salt contained in such pads. The brick walls of houses give off rays from traces of radio-active elements, and cosmic rays ceaselessly bombard us from space, but with what, if any, effect we know not. On the other hand, potent is the effect of heat in the modern treatment of general paralysis of the insane, and of gonococcal infections, when the whole body temperature is raised to 105 degree F, or more by baths or electric means of heating. To clean the body of a gonococcal infection by such means is one of the most recent triumphs of physical medicine, but great care is obviously required.

A great hope for the future lies, then, in the development of this side of medicine, and for this purpose university chairs and adequate means of teaching are required and, above all, the co-operation of physicists with medical scientists, to carry on research and expose all false claims.

(From the 'British Medical Journal' May 16th, 1936)

Pyrexia of Obscure Origin in Children.

(Adapted from the 'Clinical Journal' May 1936)

Sudden rises of temperature in children who were more or less convalescent is very common, and in a high proportion of these no cause was discovered. Some were associated with slight coryza, or constipation, and others with slight redness of the fauces and tonsils. I should like to emphasize the fact that in many faucial and tonsillar infections, even severe ones, there is no soreness of the throat. It is possible for a more emotional crisis to provoke a rise of temperature in an unusually nervous child.

Abortive Attacks of the Specific Fevers.

It is a possibility which it is well to bear in mind. Poliomyelitis is one which is particularly likely to escape recognition, Influenza is another infection, which in a mild form may be unrecognizable clinically, but may cause transient pyrexia.

Chronic Intestinal Dyspepsia.

Pyrexia persists for a longer period. A low grade pyrexia, in which the temperature seldom rises above 100 degree and may never even reach this level, is often due to chronic intestinal dyspepsia. The breath is offensive and the tongue furred. The abdomen may be large, and the stools, which often contain mucus, are offensive. These periodic bouts of pyrexia, last from three to ten days. In some children these are always preceded by the passage of mucus in the stools, in others mucus follows the attack, and in some there is vomiting.

Tonsillar Infection.

Another common cause of low continued fever is tonsillar infection. The tonsillar glands are almost invariably palpable.

Chronic Sinusitis.

Chronic sinusitis will also cause prolonged low grade pyrexia, without any local pain to direct attention to the site of the infection.

Subacute Otitis.

A subacute infection of the middle ear may also produce a similar pyrexia, and in many cases there is no earache.

Tuberculosis

Diagnosis may be difficult. Caseous mesenteric glands may cause fever, irregular in type with a few or no symptoms, and the glands are by no means always palpable. A radiogram of the abdomen may show calcification of one or more glands, and suggest that other glands are still the seat of active tuberculosis. A small focus in the lung, with infection of the bronchial or mediastinal glands, may produce continued pyrexia. Here radiography may give valuable help. Tubercle bacilli may be found occasionally by means of a faecal swab or in the faeces, but a more reliable though slower means of diagnosis is to wash out the stomach in the early morning and inject a guinea-pig with the centrifugalized residue.

Rheumatism

Rheumatism may cause a long period of low fever. A systolic murmur may be audible at the apex.

Enteric Fevers

Continued fever of higher grade may be due to typhoid or one of the paratyphoid fevers. In children these are more difficult to diagnose than in adults. Constipation is commoner than diarrhoea, a rash is often absent. Disease may be milder in every respect. Widal reaction is positive by the fourteenth day. A study of the temperature chart is often helpful. The step-like rise followed by a period of continued or slightly remittent fever, and ending with a gradual drop showing greater and greater remissions or even intermissions, each stage lasting about a week, may lead to diagnosis late in the disease.

Pneumonia

Pneumonia may cause high continued fever with no physical signs, but the flushed face, rapid shallow respirations, expiratory grunt and the movement of the alae nasi should lead to a correct diagnosis. If any doubt exists a radiogram will reveal the presence of a patch of deep-seated consolidation.

Some little time ago I had a girl in my ward whose temperature, after remaining about 102 degree for ten days, fell by crisis. There were no respiratory signs or symptoms and little

constitutional disturbance but owing to the character of the fever pneumonia was suspected. A radiogram showed a large shadow extending outwards from the right hilus and appeared to confirm the diagnosis. About a fortnight later she had a second attack similar to the first, and came back for further investigation. Her Mantoux reaction was strongly positive and a guinea-pig inoculated with the stomach washings contracted tuberculosis. The case was one of epituberculosis, a small tuberculous focus in the lung with a surrounding non-tuberculous region.

Lymphadenoma

Lymphadenoma may give rise to obscure pyrexia, when the external lymphatic glands are not involved. Careful palpation of the abdomen may, however, reveal enlargement of the mesenteric glands, or a radiogram of the chest may show that the mediastinal glands are grossly enlarged. Later in the disease the spleen is usually palpable. The blood-count is not characteristic, but sometimes eosinophilia is present, and later anaemia and leucopenia are usual.

Streptococcal and Meningococcal Septicaemia

Streptococcal and Meningococcal Septicaemia may cause a long period of remittent or intermittent pyrexia. In the former there is often a leucocytosis, a positive blood-culture, and often a palpable spleen.

Pyelitis

One of the commonest causes of prolonged pyrexia, though it should not be an obscure one, is pyelitis. It is most likely to escape recognition, because routine examination of the urine is often omitted, and if there are only a few drops, microscopic examination will show the presence of pus and motile bacilli. Recurrent attacks are generally due to some congenital abnormality of the urinary tract.

Renal Calculus.

A rather unusual case of continued fever occurred in my ward last year. A girl was admitted with catarrhal jaundice and recovered, but soon after she had an irregular fever of 100°

to 101° alternating with periods when the temperature seldom rose above 99°. There were no symptoms, no constitutional disturbance and no albuminuria. All investigations gave negative results, until one day she had haematuria, and uroselectan showed a stone in the right kidney with great dilatation of the pelvis, and at the operation a pyonephrosis was found.

Perinephric Abscess.

Perinephric abscess is commoner in children than in adults. Fever and leucocytosis are present from the beginning. Albuminuria may be present at an earlier stage of the illness and direct attention to the site of the sepsis.

Pylephlebitis.

Seldom diagnosed during life.

Leukaemia.

Leukaemias often cause irregular pyrexia, and cases of lymphatic leukaemia may be difficult to diagnose when none of the superficial lymphatic glands are enlarged and the white cell-count is not raised. The anemia should arouse the suspicion of a blood disease and lead to a differential blood-count, when will be found a relative and generally an absolute increase in the large or small lymphocytes.

Malignant Subtertian Malaria, Malta Fever and Kala-azar.

These diseases must be recognized or excluded by appropriate tests.

Finally I must admit that cases occur from time to time in which every investigation gives a negative result and yet complete recovery takes place.

Breast-Feeding

(Adapted from the 'Clinical Journal' of 'May' 1936)

There are few conditions of the mother and child in which artificial feeding is essential, but the desire to breast-feed is necessary for success in lactation and those from whom such advice is sought, be they relatives, nurses or doctors, must have the ability to give helpful advice. In these days of advertisements and samples it is only too easy for mother and doctor to believe that the infant would do better on this or that dried milk or patent food, while so far no posters have been prepared indicating the advantages of breast-feeding. What are these advantages to the infant?

1. Breast milk not only contains protein, fat and carbohydrates in correct proportions for the human infant, but contains a biological factor which is absent from cow's milk or its dried derivatives. This factor is concerned with immunity to infections. Workers have shown that otitis media and respiratory infections are less likely to occur in the breast-fed baby.

2. In addition to this protective factor, breast milk contains protein, fat and carbohydrate in proportions suitable for the infant. The protein is more readily digested, and forms a finer curd than that of cow's milk, and the fat is in a finer state of emulsion than cream of cow's milk, both factors tending towards greater digestibility.

3. Breast milk is practically sterile. The temperature is just right for the infant.

4. Breast-fed babies show a better general nutrition and a steadier average gain in weight than bottle-fed babies.

5. The most important advantage is that the infant who is breast-fed receives definite periods of handling and mothering.

From the mother's point of view there are also advantages. Even two or three breast feeds daily with additional bottles are better than none.

The advantages to the mother are as follows:

1. It is the simplest of all methods because the milk is already prepared and warmed.

2. The supply of breast milk varies with the child's requirements and strength of suckling

3. Breast milk is practically sterile. Breast abscesses are not a cause for weaning, provided no sinus is discharging at or about the nipple. In fact adequate evacuation of the breast is essential when abscess occurs as the infection lights up first in a badly drained part of the gland.

4. After the feeding there are no bottles to wash or teats to boil—and adequate cleansing takes time. There is no extra cost of milk and feeding bottles.

How can we judge of the milk supply? If the child is contented, gaining weight—even slowly—and having normal stools, there is no indication for weaning. If the infant appears hungry and is not gaining well, the mother is urged to rest for a short period daily, to increase her fluid intake, especially of water, and just before each feed, and adjustments are made in the method of nursing the infant to ensure adequate sucking and stimulation of the breasts. Gentle massage is particularly valuable if they have not been adequately emptied, and are tending to become hard and knotted with blocked ducts.

On many occasions where the mother and child were both suffering from the worry associated with insufficient breast milk, I have found that a temporary complementary feed has been discarded after a few days, as the breast-milk supply has improved quickly after this short period of peace for mother and child.

A few "dents" may be of value. Do not wean the baby immediately he vomits or has diarrhoea on the grounds that the breast milk is not suiting him. During an acute gastro-enteritis no food is suitable for baby, but as soon as he can tolerate anything more than glucose water or albumin water, diluted breast milk (expressed by hand and diluted with warm boiled water to the strength required) is the best feed he can have.

Do not wean on account of any infection in the child. While he is ill the protective factor in the milk is of the greatest value.

Do not be in a hurry to give an artificial feed directly after birth.

The first secretion from the breast (colostrum) is readily absorbed, and prepares the gastro-intestinal canal for its work of digestion. Breast milk may be delayed for three or four days or more and is best stimulated by regular suckling on the part of the infant.

Weaning may be begun gradually at five or six months, and should be carried out over a period of three to four months.

A Crusade against Acute Rheumatism

By W. T. RITCHIE, O.B.E., M.D., F.R.C.P. ED.

Rheumatism may be defined as a disease probably infective, at times acute, at others latent, quiescent, subacute, or chronic of which the chief manifestations are carditis and chorea in children of school age, acute poly-arthritis and carditis in adolescents and young adults, and subacute and chronic inflammatory heart disease, fibrositis, and chronic arthritis in later adult life. The term "acute rheumatism" is not synonymous with, and is not restricted to, rheumatic fever, but includes other acute manifestations such as chorea and carditis. Rheumatic fever in itself is seldom a cause of death.

Acute Rheumatic Carditis

Acute rheumatic carditis is a frequent but not inevitable manifestation of acute rheumatism.

The immediate prognosis in acute and subacute rheumatic carditis is usually favourable. The illness may be protracted for months, fever and arthritis may recur, and the aortic as well as the mitral valve may become incompetent. Nevertheless the patient may be expected to recover from the acute illness. Virulent cases simulating subacute bacterial endocarditis, running a speedily fatal course, and developing in some instances a terminal haemorrhagic eruption, are rare. In patients who are apparently making a satisfactory recovery from uncomplicated rheumatic fever a latent carditis is slowly developing, and may

not be noted until months or years later. Moreover, rheumatic carditis developing insidiously and slowly in childhood or adolescence may be a complication and sequel of an apparently trivial rheumatic illness, such as "growing pains" or a mild febrile disorder which was thought to be influenza. Rheumatism often sails under an influenzal flag.

Chronic Mitral Disease.

If the patient survives the acute stage he gradually passes into the third phase of the disease, that of chronic mitral stenosis and incompetence without myocardial failure.

Even though the heart may have remained efficient for ten or even twenty years after having been damaged by acute rheumatism, it often begins to fail at about the age of 40. Approximately one-half or two-thirds of those who have suffered from acute rheumatism become cardiac cripples before the age of 50. Like a tuberculous focus in the lung or elsewhere a rheumatic cardiac lesion may have been "quiescent" and not "healed". In the course of years it "flares up" every now and then, and ultimately kills. The final failure may be brought about by excessive physical stress, intercurrent infections, either acute or chronic, reinfection of the heart, or the development of auricular fibrillation. It is usually mitral valvular disease of rheumatic origin which slowly converts a healthy child or adolescent into a chronic cardiac cripple who drifts in and out of the medical wards again and again. During the last phase of his illness when the sufferings of the cardiac cripple call for alleviation, digitalis, strophanthus, theobromine, theocine, urea, organic mercurial compounds, and other remedies are often of the greatest benefit. All efforts, however to cure rheumatic heart disease are fore-doomed to failure; our aim should be to prevent the disease.

Early Manifestations.

The first manifestations of acute rheumatism do not usually appear in infancy nor in pre-school life. Acute rheumatism as a rule first shows itself in school children and adolescents.

Incidence in Adults.

It is not only in children that rheumatic heart disease is frequent, but is common in adults also.

Problem of Causation.

Many of the manifestations of acute rheumatism point to its being an infective disease. According to one school of thought, embracing Coburn, Swift, and Klinge, an acute rheumatic illness is a reaction to an antigen-antibody complex in a hypersensitive individual. The alleged hypersensitivity is not an inborn error, but like an undue susceptibility to tuberculosis, is acquired, and is the expression of faulty reaction to environmental factors, the precise nature of which is still unknown. According to another theory the subject of acute rheumatism is either highly susceptible to a specific virus or has received a massive infection with that virus. A modification of this theory presupposes symbiosis of a specific virus with streptococci.

The two diseases resemble each other in several respects. Bad environment and malnutrition are important factors in the causation of both diseases. In both the upper respiratory tract is probably the chief portal of infection, whence it becomes disseminated. In both diseases there are exudative processes, and also cellular reactions within connective tissue which eventually heal.

Rest and Residential Treatment

Those who are suffering, or have recently suffered, from acute rheumatism, but who are not yet affected with rheumatic heart disease, need a long course of treatment. It is doubtful whether uncomplicated cases of acute rheumatism are always given a sufficiently long period of rest. Every frank case of acute polyarthritis should have three months' complete rest under skilled nursing, in the hope of thereby lessening the risk of carditis. Other rheumatic manifestations, such as erythema nodosum and chorea, which are apparently trivial but in reality serious, need a similar period of rest of which he is in need, but also a measure of education tempered to his capacity.

After the acute phase of the rheumatic illness has passed an attempt should be made to eliminate infective and toxic foci in mouth, nasal sinuses, and elsewhere, in order that the risk of reinfecting a damaged valve may be lessened.

Necessity for After-care

Like the tuberculous or syphilitic subject the rheumatic patient should remain under medical observation for several years. Having once been frankly rheumatic he may, indeed often does, suffer from time to time from further rheumatic manifestations needing prompt treatment. The rheumatic child who does not continue under medical care is just the type of case in which, some years later, gross mitral valvular disease and a failing heart are discovered.

Prevention

It is not enough to care for cardiac cripples and treat patients suffering from acute rheumatism. We must try to prevent the occurrence of these conditions. The pre-rheumatic subject presents a most difficult problem. Better personal and social hygiene has lessened the ravages of tuberculosis, but has not yet had any appreciable influence upon rheumatism.

The frequency with which acute rheumatism is preceded by acute tonsillitis indicates the great importance of preventing tonsillar infection, while chronic nasal and nasopharyngeal catarrh and mouth-breathing should not be neglected.

(From the 'British Medical Journal' April 4th 1936)

The Trichinopoly District Medical Association

(REGISTERED)

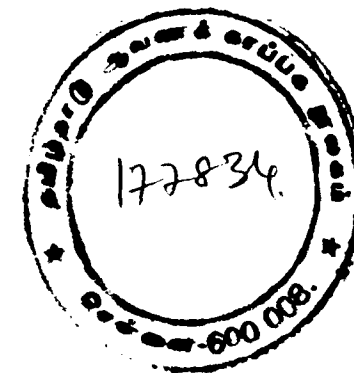
A monthly meeting of the above Association was held at 5 P. M. on Saturday the 27th June '35 in the E. R. High School, Teppakulam, Trichinopoly when about 25 members were present. Dr. R. Srinivasan of Kulitalai was 'At Home' to the members and Capt. Sangham Lal, I.M.S., F.R.C.S., District Medical Officer, Trichinopoly presided.

After the demonstration of a few X-Ray films and discussion of interesting cases, Dr. R. Kalamegham delivered a very interesting lecture on 'Diphtheria.' He explained the various types of the disease and stressed that treatment consisted of early and massive doses of serum. Half a dozen doctors took part in the discussion that followed.

With a vote of thanks to the Chair, Host and the Lecturer of the evening the meeting terminated.

TRICHINOPOLY, }
30-6-1936. }

P. A. S. RAGHAVAN,
Secretary



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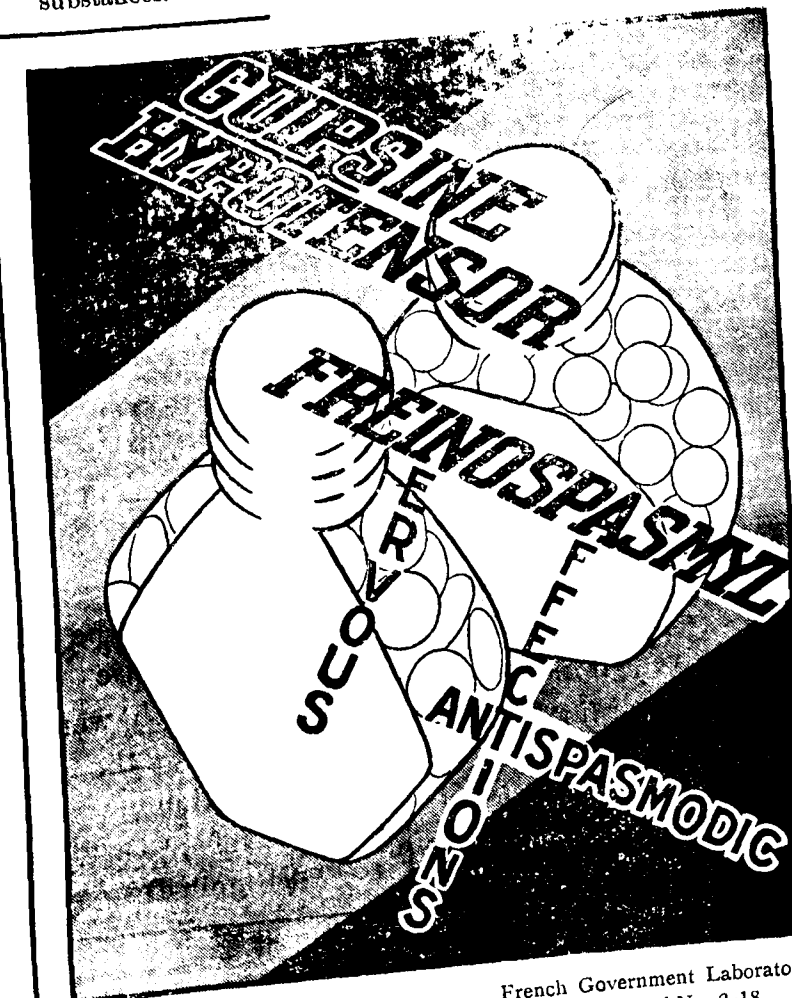
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