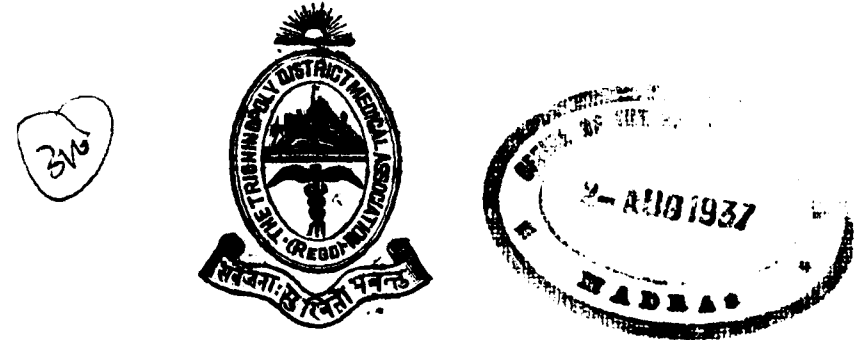


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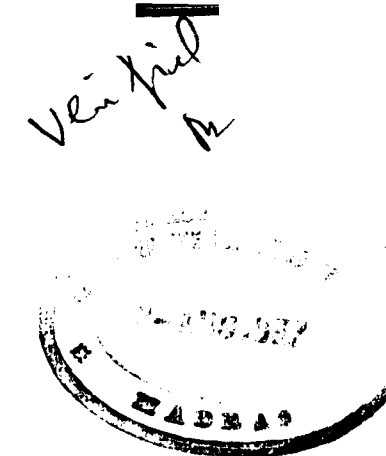
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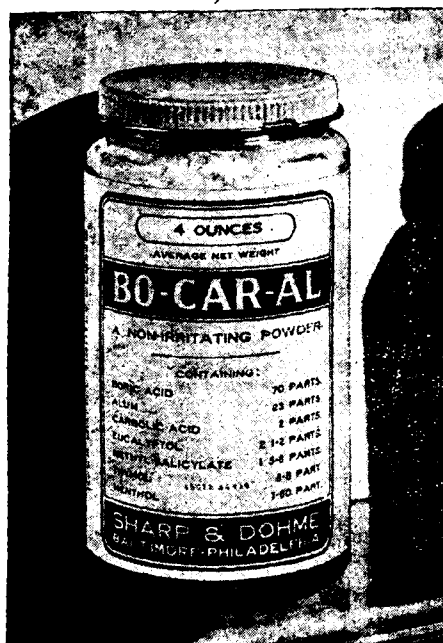
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APRIL 1937

**Organisation of Maternity and Child Welfare Work
in the Madras Presidency.**

The organisation of Maternity and Child Welfare work in this presidency has naturally been based on the findings of experience gathered in urban and rural areas of this presidency. As regards urban areas we have the experience of about 18 years, but of only a few years as regards rural areas. A policy has thus been evolved only during the past few years and further expansion and development is possible to an unlimited extent. No step taken so far has been retraced however, indicating that the foundations have been rightly laid.

The aim of Maternity and Child Welfare is the establishment of the health of the individual from his very earliest days beginning this with the ante-natal period. The particular period for which the Maternity and Child Welfare Service as such is responsible ends with the fifth year, when the individual with foundations of health well-laid, is handed over to the School Medical Authority. Through this safeguarding the health of the individual in successful maternity and child welfare safeguards the health of the community also. During this long period of six years the workers establish a most useful contact with the mothers and fathers of the nation, educating their outlook, widening their views on community life and needs and helping them in that most difficult of all tasks, the bringing up of a healthy and dutiful citizen. Mother craft and father craft are thus learnt automatically even by the lowliest parents who

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recognise besides the "Rights" of the child entrusted to them regarding him no longer as personal property to be used at will. Where parents have this consciousness, the custodians of those larger families, the local body and the state are led to assume their responsibilities as regards the health and welfare of the child; for no public authority in the world can withhold the righteous demands made by enlightened parents on behalf of their children. This response from the public authorities is the very essence of all national progress.

As in other countries which have led the way, the administration of Maternity and Child Welfare was left in the past to voluntary workers. The work was thus naturally considered to be a charitable undertaking and suffered from limitations due to lack of finance, of continuity of service and effort, of expert advice, of constant change in personnel of membership of voluntary associations. Enthusiasm thus ebbed and flowed; work suffered; and as a result a satisfactory Maternity and Child Welfare Service could not be built up. Since the Government of Madras established a policy whereby local bodies were required to administer their own services under the guidance of the Director of Public Health and the control of their own Health Officers assisted by specially trained Home Medical Officers work has proceeded apace. Now we have the foundations of work rightly laid in all but three or four districts of this Presidency as regards rural areas and in several municipalities besides. How work proceeds and develops in all these places in the future depends on the patience and tact of workers, an intelligent response from the public guided by the medical profession, and most of all on the willingness of the local authority to shoulder its financial and administrative responsibilities in this respect.

There are other factors which have great influence in the development of Maternity and Child Welfare work. The Director of Public Health has not lost sight of these but has taken care to foster their growth and expansion. Such are the provision of residential treatment in Women's and Children's Hospitals, the establishment of a sufficient number of training schools for

mid-wives, nurses and health visitors, the provision of a post-graduate course in maternity and child welfare for medical women; satisfactory relationships with the voluntary services ensuring their co-operation and assistance; the improvement in the conditions of service for women medical officers, health visitors and midwives in the maternity and child welfare services, and improvement in the type of buildings for maternity and child welfare centres. A great deal has yet to be done but it could be achieved with the good will of such bodies as the Medical Association of Trichinopoly who have been the first Medical Association to think it worth while to devote one of their meetings to this subject.

The response from local bodies too was most encouraging, for, while they had spent only Rs. 1,25,281 in 1931-1932, in 1936-1937 they spent Rs. 2,29,928 and in the present year more. The sanctioned strength of Women Medical Officers in 1936-1937 was 31, of Health Visitors 24 and of midwives 303 in centres under local bodies alone. 35453 mothers were brought under care—of these 30058 received Ante-natal supervision, 14385 were attended at labour, 9480 infants, 6228 pre-school children were brought under the care of the official staff in 1935. Attendance at the mothercraft classes was 26400. At these classes village mothers realised increasingly their influence on the advancement of the community and on public health; the attendance at the health classes in girls' schools totalled 13359.

In the words of the Chief Medical Officer of the Ministry of Health, England and Wales.

"The Department of Public Health which deals with the Maternity and Child Welfare services is one of those directly appealing to public interest and sympathy and the provision made for these purposes is recognised as of primary importance for the future well being of the nation. It covers even a wider field than the problems of control of definite disease and touches on many points including not only various aspects of medical and midwifery practice, but also the social, hygienic and nutritional conditions of the people."

The medical profession can wield an enormous influence on the progress of the people. Our country needs to be freed from the shackles of disease and from needless suffering. There is no greater freedom than this.

Measures undertaken for the health of the child population are those that best help to establish health for the adult population and so may it truly be said "A little child shall lead them."

(Lecture delivered at the Monthly Meeting of the Trichinopoly District Medical Association on the 20th March '37 by Dr. Mrs. Chinnappa, Assistant Directress of Public Health.)

The Investigation and Treatment of Cases of Leucorrhoea.

By

NORMAN WHITE F. R. C. S.

(From the *Clinical Journal*, London, March 1937)

The Vagina normally contains a small amount of discharge which comes from various sources.

The Physiology of the Vagina.

At birth the vaginal epithelium is thick and well developed, and the squamous cells contain glycogen. In children one month old, the stratified epithelium is thin and inactive, and contains no glycogen. There is usually no discharge. Just before puberty the epithelium again proliferates and glycogen appears in the cells, which are again shed in large numbers. This condition is maintained till the menopause, when the epithelium again becomes thin and inactive, and smears show few epithelial cells.

It has been shown that oestrin is responsible for these changes in the vaginal wall. As the ovaries of the child do not produce oestrin, it is evident that this substance, which is present in large quantities in the blood of the pregnant woman, must reach the foetus through the placental circulation.

The Bacteriology of the Vagina.

The vaginal bacillus of Doderlein is the characteristic organism of the normal vagina between puberty and the menopause. In adult life Doderlein's bacillus is found in large numbers, and other organisms are very few or absent. After the menopause the flora is variable, and tends again to be coccoid in type; Doderlein's bacillus may be absent or present only in small numbers.

The Acidity of the vagina.

Lactic acid is found in small amount in the vagina of the new born child and in the sterile fluid of a haematocolpos. The vagina of the child after the first few weeks and of the woman after the menopause is only slightly acid.

The strongly acid reaction of the vaginal discharge between puberty and the menopause is due to the production of lactic acid from glycogen by Doderlein's bacilli and is an important protective mechanism, because it is unfavourable to pathogenic organisms. The vagina becomes more acid in the second half of pregnancy, and a woman who has a mixed culture of potentially pathogenic organisms in her vagina in early pregnancy is often found later on to have a pure culture of Doderlein's bacilli.

Uterine Discharge.

The cervical mucus is alkaline in reaction, but normally has not much influence on the vaginal acidity. The cavity of the uterus inside the internal os is normally sterile.

Increase of The Normal Vaginal Discharge.

Vaginal discharge may be merely an excess of the normal discharge. Hypertrophied endometrium and endometrial polypi may produce some excessive secretion. Excessive mucous secretion by the cervix is a more important cause of leucorrhoea. It is often associated with infection, but occasionally it occurs in the virgin where there is no evident infection. On examination a congenital cervical erosion is found.

Excessive vaginal desquamation is probably the commonest cause of non-infective vaginal leucorrhoea. This is often

noticeable in normal women just before menstruation, when the amount of oestrin in the blood is at its maximum, and in children just before the first period. Leucorrhoea of this type is often associated with irregular menstruation, and with periods of amenorrhoea due to ovarian dysfunction. A similar troublesome discharge may occur after total hysterectomy in a woman who is not of menopausal age, when both ovaries have not been removed.

Three other causes of non-infective leucorrhoea must also be mentioned. In pregnancy the patient often has a non-infective leucorrhoea, due partly to increased mucous secretion by the cervix, and partly to increased vaginal desquamation. Masturbation causes pelvic congestion, and is said to be responsible for excessive vaginal discharge, anaemia and debilitating diseases may have leucorrhoea as one of their symptoms.

Discharge due to new-growths.

Carcinoma of the body of the uterus, cervix and vagina usually cause a blood-stained discharge, but it is important to remember that this is not always so in the early stages of a growth. The first symptom of carcinoma of the body of the uterus is commonly a thin white serous discharge, and carcinomata of the cervix and vagina exceptionally begin in the same way.

Carcinoma and papilloma of the Fallopian tube usually produce a watery vaginal discharge, which may be very excessive. Fibroids of the uterus will cause a little discharge by increasing the area of the endometrium, especially if fibroid and endometrial polypi grow into the cavity.

Infective leucorrhoea

It is always useful to note the naked-eye characters of vaginal discharge, and to examine under the microscope a drop of fresh unstained discharge, diluted with normal saline. A non-infective cervical discharge consists of clear mucus which, when it passes into the vagina becomes coagulated and whitish. A non-infective discharge of vaginal origin is white and rather granular, and sometimes thick and caseous. Microscopically, both show epithelial cells and Doderlein's bacilli, with very few

pus-cells. An infective discharge is usually more fluid, and is often yellow. It consists mainly of pus-cells and small cocci and bacilli, epithelial cells and Doderlein's bacilli are few.

Cervical infections cause a purulent mucoid discharge, recognizable on inspection. The origin of the infection may be gonorrhoea, puerperal laceration of the cervix with ectropion of the mucosa, infection of a congenital erosion, or, rarely, tuberculosis. Mucous polypi may be found in cases of old non-specific infection.

Gonorrhoea.

In acute gonorrhoea the discharge is mainly pus, but after a few weeks this is succeeded by a mucoid discharge. It may be necessary to exclude gonorrhoea in a case of cervical infection if the history is suggestive, or if there is pus in the urethra, or in Bartholin's glands. The investigations should include microscopic examination of films, cultures, and the complement-fixation test. Too much reliance on smears has in the past caused many cases of trichomonas vaginitis to be diagnosed as gonorrhoea. Pairs of dead staphylococci or *Streptococcus neocalis*, may appear to be Gram negative. An associated urethritis or Bartholinitis is very suggestive, but pus may be found in the urethra in many cases of profuse discharge, especially in trichomonas infections, and Bartholin infection is not always gonorrhoeal. When smears are made for microscopic examination the external discharge on the meatus and cervix must always be mopped away first, and only the endocervical and endo-urethral material taken. Smears contaminated with vaginal discharge will show many micro-organisms, and will be quite valueless for diagnostic purposes.

Vaginitis.

Vaginitis may be primary, or secondary to a purulent uterine discharge. In the primary cases the vaginal wall is usually uniformly red, and the discharge is more fluid than a cervical discharge. Many organisms are credited with the power of causing vaginitis, but it is difficult to say that one organism is the original cause and the others secondary invaders.

The patient complains of profuse discharges with soreness and sometimes excoriation of the neighbouring skin. There may be frequency, and burning pain on micturition. The discharge is typically fluid, yellow, frothy, and offensive, but a white, non-frothy discharge is found in some cases. The diagnosis is established by finding the organisms in a drop of fresh discharge mixed with normal saline and examined under the $\frac{1}{6}$ in objective. *Trichomonas*, when examined at once, is usually very active, irregular pyriform in shape, and a little larger than a leucocyte. Numerous bacteria are usually also present. Most writers consider *trichomonas* the responsible pathogenic organism.

Senile and other forms of Vaginitis.

Senile vaginitis is a catarrhal condition due to the loss of glycogen in the atrophic epithelium, and the consequent absence of Doderlein's bacilli, which renders the vagina liable to bacterial infection. Chemical vaginitis is sometimes found in women who use strong antiseptic solutions for douching.

Yeast vaginitis is rare. It is said to be commoner in diabetics, and a diabetic husband may infect his wife. The discharge is rather cheesy, or forms a kind of false membrane clinging to the vaginal walls, and on microscopic examination the mycelium and yeast cells may be seen in a fresh drop of secretion.

Pyometra.

Pyometra should be mentioned as a rare cause of purulent discharge, which is usually blood-stained. It is due to infection of the uterine cavity, plus cervical scarring, or senile atrophy of the cervix. It may be suspected when one of these latter conditions is present, and the diagnosis made by dilatation of the cervix.

Vaginal Discharge in Children.

Foreign body is a cause of discharge which must be kept in mind; Thread-worms sometimes migrate from the anal canal to the vagina, and uncleanness may allow bacteria from the bowel to invade the vulva and vagina. It is necessary to be especially careful not to diagnose gonorrhoea without good evidence. It is desirable to try to obtain a positive culture, and

it may be necessary to establish the identity of the organisms by fermentation reactions.

Treatment of Leucorrhoea.

Non-infective leucorrhoea of vaginal origin, where the discharge consists of epithelial cells and Doderlein's bacilli only is difficult to treat. The rational method would be to decrease the amount of oestrin present. This can be done only by X-ray irradiation of the ovaries, a suitable method after 40, but unjustifiable in young women. I have found pessaries of 5 per cent lactic acid in glyogelatin useful; they cause the epithelial cells to cling together in caseous masses, and relieve the patient of the continuous more fluid discharge, though much caseous material can be seen when a speculum is passed. I usually prescribe also douche of $\frac{1}{2}$ to 1 per cent lactic acid to be used occasionally. The amount of leucorrhoea varies spontaneously from time to time, and may decrease without treatment. Attention to the general health and treatment of such conditions as anaemia may assist.

Treatment.

Mucoid discharges due to congenital erosions or ectropion of the cervix, are best treated with the ordinary electric cautery or the diathermy cautery. The cauterization may have to be repeated more than once. The results are much better than those of amputation of the cervix. An anaesthetic is usually not required.

If palliative treatment is preferred, the lactic acid and glyogelatin pessaries may be used. The lactic acid acts as an antiseptic, and the glycerine assists in draining the mucous glands. A daily douche should also be given. Medical diathermy, applied to the cervical canal, has been strongly advocated for these conditions by Robinson (1931), especially when the cervicitis is causing backache or abdominal pain. I have found the ultimate results disappointing, because the mucous glands remain, and the discharge tends to recur.

Trichomonas vaginitis requires prolonged treatment. Any mild antiseptic will kill the delicate organisms, but continuous

action of the antiseptic is essential if any difference is to be made to the vaginal condition. Treatment with pessaries or tablets is therefore the method of choice. I have tried 1 per cent picric acid pessaries, and found them ineffective, possibly because the patients will not continue to use a substance which stains their clothes. Lactic acid pessaries are better, but Bayer's Devegan tablets are much more effective. One or two are introduced high into the vagina once or twice daily for a month. The symptoms are rapidly relieved, but recurrence is common and requires further treatment. Douching is usually necessary to remove the masses of Devegan and epithelial cells

In the treatment of senile vaginitis, strong antiseptics must be avoided; lactic acid pessaries and douches are usually the best. Oestrin may be given to stimulate the epithelium to resist infection. It has been found useful in the senile atrophic condition of the vulva and vagina known as kraurosis. Yeast vaginitis may also be cured by lactic acid. Zinc chloride and other antiseptics are commonly given as douches in all kinds of infective vaginal discharge, but I think they are more irritant and less efficient than the natural vaginal antiseptic.

Gonorrhoea is treated by cleansing the vagina through a speculum, and then mopping out the cervical canal and urethra with a piece of cotton-wool fixed on the end of a probe, and soaked in an antiseptic. Ten per cent. mercurochrome, protargol, or neoreargon, 2 per cent flavine and 1 per cent picric acid are some of the most suitable solutions. The treatment should be carried out daily, or at least five times a week, by a doctor or nurse. Vaginal douches are useless, especially if the patient has to give them to herself. Treatment is stopped during the period, and regular monthly post-menstrual smears are made. An alternative method is to irrigate the urethra and cervical canal with weaker solutions of antiseptics, but this requires a special cannula. In order to avoid injection of fluid into the uterus. When the cervical discharge becomes mucoid the antiseptic is usually dissolved in glycerine, in order to promote drainage of the cervical glands. If there is an erosion, a light

vaginal pack, with its upper end soaked in glycerine, may be inserted against the cervix for twelve hours each day.

If after a month there is no marked improvement and the complement-fixation test remains negative, Vaccine therapy will be needed to stimulate the formation of antibodies. A chronic infective discharge from Bartholin's duct, or from Skene's tubules, is another cause of persistent ureteral and cervical infection. It may be necessary to excise Bartholin's gland or cauterize Skene's tubules.

In children with vaginitis I generally use mercurochrome in 2 to 10 per cent solution of vaginal swabbing. Oestrin has an important field here, and has been found to cure gonorrhoeal vulvo-vaginitis. I have used doses of 4000 international units daily by the mouth for a month. TeLinde and Brawner (1935) found oral and hypodermic administration of oestrin useless but were successful when they gave it in vaginal pessaries. This method is still in the experimental stage.

Application of Calomel in Pruritus Ani

(From the Clinical Journal London March 1937)

The late Dr. Thaysen, obtained excellent results in cases of pruritus ani, of which some were severe and refractory, from application of calomel.

The method is as follows: In the morning and evening the anal region is washed with tepid water and a bland soap, and wiped with a soft towel. The area is then powdered with finely pulverized calomel. It is essential that the bowels move freely, if necessary helped by some mild laxative. Thaysen always advised patients to try to have their bowels opened shortly before they go to bed, as he thought the hard faeces in rectum might aggravate the itching. Apart from this he did not give any form of treatment; in particular he did not forbid tobacco, alcohol or spices. After a few days, at most 10 to 12, the itching decreased—and within a week or so disappeared. Not infrequently a relapse occurred, but soon yielded to the Calomel treatment. In diabetic pruritus or in combined pruritus of the anus and vulva the treatment was not effective.

The Knee-Jerk in health and Disease.

By

ADOLPHE ABRAHAMS, O. B. E., M. D., F. R. C. P.

(*Practitioner, March 1937*)

The knee-jerk—response elicited by a tap on the patellar tendon when contraction of the quadriceps extensor muscle is expected—is the most convenient to test and most familiar of all the tendonreflex phenomena. It is open to the objection that it is not a true reflex since the muscular contraction occurs too soon after the tap for the nerve impulse to have had sufficient time to travel. But, after all, the response depends upon the reflex tonus in the vastus internus, and the state of this response is an index of the integrity of the reflex arc upon which this tonus depends.

The contraction of the muscle may be seen or felt even if the actual extension of the leg on the thigh is not evident.

The tap on the tendon should be smartly given with a proper percussion hammer. The old-fashioned method of employing the tips of the fingers or the edge of the hand is most unsatisfactory.

Relaxation of the muscles is a *sine qua non* and spasticity may conceal a contraction which is interpreted as "absent." It is desirable therefore on occasion to employ one or other of the methods adopted for reinforcement, all of which methods have as their object distraction of the patient's attention by giving him some voluntary movement to perform. The best known is the method of Jendrassik in which the patient is instructed to hook his hands together and pull them apart whilst looking upwards. In Laufenaue's method the observer grasps the patient's thigh whilst the patient grasps the observer's upper arm which he is instructed to squeeze at the moment when the patellar tendon is struck.

Various adjectives are applied to description of the knee jerk, e. g. absent, present, normal, active etc. It can only be said that the absence of a jerk is in the vast majority of cases an abnormality, and it is of the greatest importance, therefore,

to ensure that the proper method of examination and, if necessary reinforcement is employed to establish as a certainty that no response is elicited. To differentiate various degrees of briskness is in general valueless. Any inequality of the two sides is always a valuable index.

Two other terms are occasionally used in regard to the knee jerk. In cerebellar disease the leg instead of falling back to its normal position of rest may continue to swing to and fro like a pendulum. A somewhat similar phenomenon is encountered in chorea, in consequence of muscular hypotonia; the knee-jerk is then described as "Sustained."

Absent Knee-Jerks

As in the majority of cases an absent knee-jerk is evidence of disease it will be best to deal at once with the various causes which may be responsible.

In the first place, certain *Myopathies* which affect the quadriceps may be responsible and the diagnosis will be assisted by the condition of other muscles in the body.

Implication of the *afferent* path is most typically seen in tabes: not that in tabes the knee-jerk is necessarily lost since for this to occur the lumbar cord must be involved, and, indeed, early in the disease the reflex may be exaggerated. In the same category will be included some examples of dementia paralytica.

In *myelitis* in the region of the third and fourth lumbar segments with affection of the anterior horn cells, the knee-jerk is necessarily lost. This is exemplified in acute poliomyelitis, progressive muscular atrophy, syringomyelia and Landry's paralysis. In such lesions muscular paralysis and atrophy are to be expected.

On the *efferent* side first come some forms of peripheral neuritis which involve the anterior crural nerve. The most common poisons responsible are alcohol, arsenic, lead, and those of diphtheria, beri-beri and diabetes mellitus. In any severe toxæmia, especially typhoid and pneumonia in the early stages, the knee-jerk may be in abeyance.

In complete transverse section of the cord all reflexes below the level of the lesion are lost for a time. Inhibition of the knee-jerk may also be due to irritation of the pyramidal tract in increased intracranial pressure, especially with tumours in the posterior fossa, in coma from whatever cause arising. For a short time after an epileptic fit during the stage of coma and flaccidity its absence may be detected.

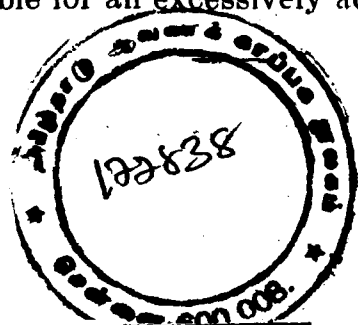
Notwithstanding these various causes it is on rare occasions impossible to explain an absent knee-jerk. In old people little regard to its absence need be paid. It must be remembered, too, that an absent knee-jerk may be the only evidence of a peripheral neuritis and that in some instances its persistent absence is the legacy of diphtheria in the remote past.

Exaggerated Knee-Jerks.

Less importance is of necessity attached to an exaggerated knee-jerk since loss of control from the higher centres from whatever causes arising will lead to a brisk response and such loss of control may be of functional or organic origin. An exaggerated response is expected, therefore in the highly nervous emotional subject and also in anyone whose control may temporarily be disturbed by ill-health. When a very brisk "exaggerated" reflex is accompanied by a flexor plantar response and normal abdominal reflex it is accepted as functional. But any other abnormality indicates organic affection of the cells of the motor area or pyramidal tract with interruption of conductivity. As intracranial causes we think of disseminated sclerosis and amyotrophic lateral sclerosis. Frequently, but not invariably, there will be spasticity of the legs. In this connection any asymmetry is of great significance.

In hemiplegia there will necessarily be inequality of the knee-jerks, that on the paralyzed side will be the brisker.

Certain poisons, especially strychnine and that of tetanus, may be responsible for an excessively active knee-jerk.



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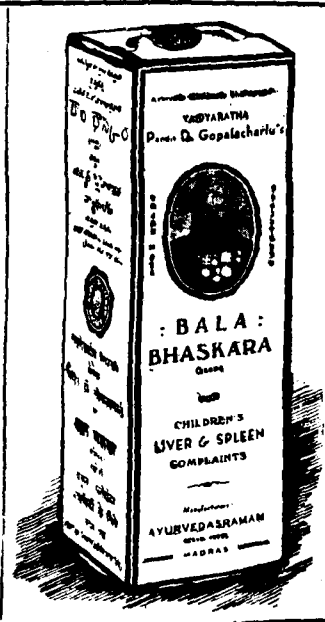
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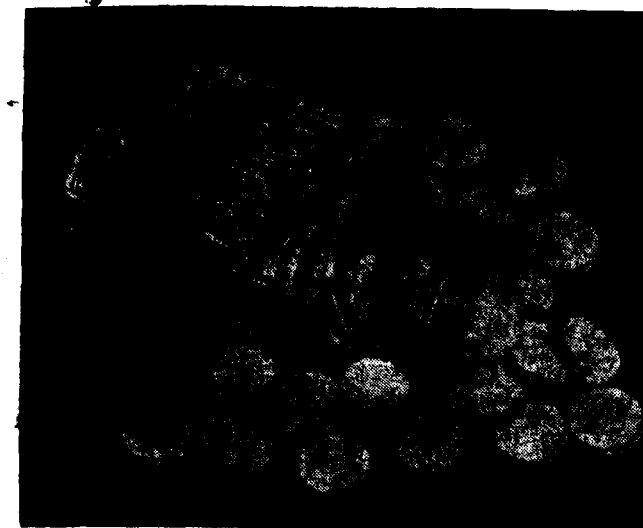
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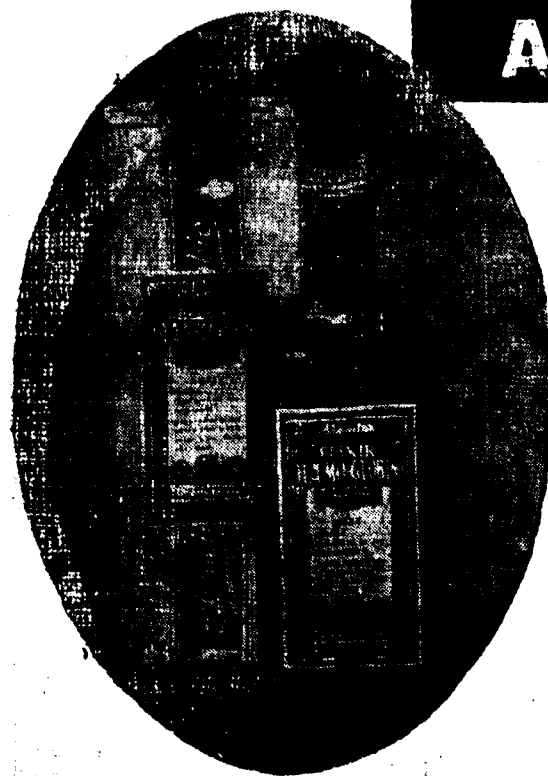
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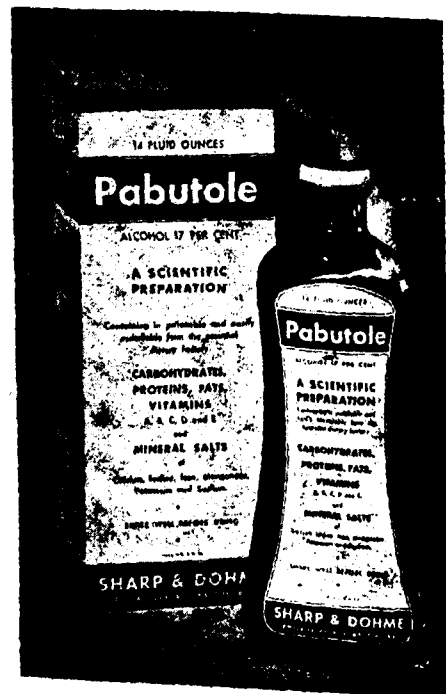
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- III. ASSOCIATION NOTES.
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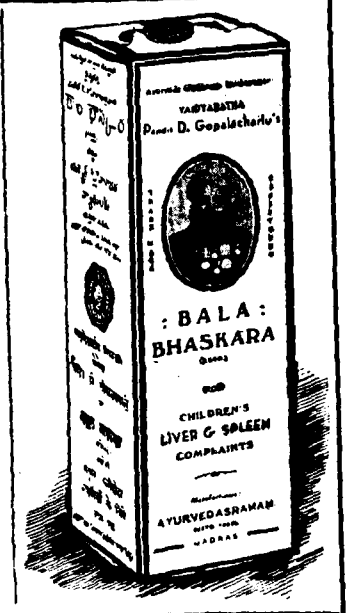
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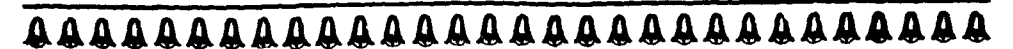
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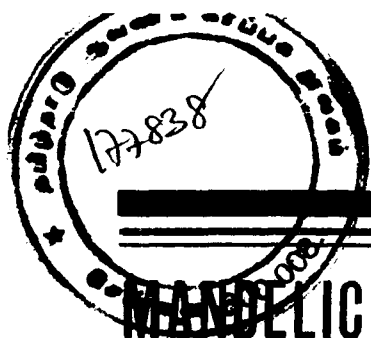
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Cough in Children.

By

DR. ALAN MONCRIEFF.

(From the Lancet, Vol. II, 10th October, 1936, p. 871)

(Adapted from the Indian Medical Gazette February 1937).

The commonest symptom in outpatient work in a children's department is undoubtedly 'cough' and I have thought it preferable to deal with this complaint rather than with any of the diseases in which it specially occurs. Not only is it the commonest presenting symptom in childhood taken as a whole, but as a rule it is not associated with disease in the chest, so that the average textbook dealing more particularly with disease syndromes does not adequately cover its more usual causes.

Viewed as a modified reflex act, cough can be regarded as always having somewhere a site of origin, I do not propose to deal in detail with the very interesting work which has been done in recent years on the relative sensibility of the various areas, but I must mention that the origin of the cough reflex is much more likely to be in the upper part of the respiratory tract—i. e., above rather than below the bifurcation of the trachea. The simplest way to consider the subject is to follow the respiratory tract down from its upper reaches and thus enumerate the different areas from which a cough may arise. Acute inflammation of the nose and nasopharynx comes first, and it is here that adenoids and infections of the nasal sinuses are of great importance. Pharyngeal coughs and tonsillar coughs are probably the commonest you find in childhood, and it is well to realize that a cough rather than the complaint of a

JL
1. 11. 1937, 11. 35 MS.

sore-throat is the presenting symptom in most cases of tonsillitis in the young child. It is just this type of cough which is diagnosed as bronchitis by advice; which, in the case of diphtheritic tonsillitis for example may be a disastrous course.

The middle ear may strictly be regarded as a branch of the respiratory tract, but I doubt whether a cough ever arises as a result of ear disease alone although, I have been told of an instance where a foreign body in the external auditory meatus did appear to be the cause of cough. Next on the way down comes the larynx, and here the characteristic 'croupy' element generally makes diagnosis easy. In the child most laryngeal coughs are due to a combination of inflammation and spasm, and quite apart from the strict groups of laryngitis and laryngismus there are two conditions to be remembered of importance with a croupy cough. One is the early stage of measles in which the cough is probably due to Koplic's spots on the laryngeal mucosa and the other is retropharyngeal abscess. Arising from the trachea are a group of coughs—harsh, painful, ineffective—which are the end-results of an infection of the nose spreading downwards. Coughs of tracheal origin may also occur with an enlarged thymus or enlarged mediastinal glands. Inflammation of the bronchi may be associated with extraordinarily little cough; usually there is a certain amount of coughing, but it is noticeable that this diminishes as the finer tubes become affected and even more if the inflammatory process reaches the alveoli. Pneumonia, for instance, may be an almost silent disease, and such a serious malady as acute military tuberculosis gives rise to little or no cough. In speaking of tuberculosis I would emphasize that this disease as a cause of cough in childhood is comparatively rare.

Still further down, so to speak, comes the pleura, and a short period of irritating cough is a feature of the early dry phase of pleurisy. Of the other forms of cough, which do not appear in this list, whooping-cough is the most important. The diagnosis of this malady by means of the cough plate is becoming perfected, and I have found the sublingual ulcer of very great value, particularly in the early stages. The possibility of

a 'stomach cough' is supported by certain experiments, but I think more often the cough and the gastric upsets have a common origin in the catarrhal state of the pharynx. Finally cough may sometimes be habit spasm.

When the origin of a cough has been correctly diagnosed treatment becomes relatively simple. Clearly for coughs affecting the upper respiratory tract a sedative linctus is indicated in addition to measures dealing with local infection. A useful prescription is (for a child of one year): tinct. opii camph., oxymel scillae, and glycerin., aa 10 minims; water to 60 minims; one teaspoonful as required. If there is evidence of bronchitis some expectorant mixture is usually employed, but I am coming to believe less and less in the value of these drugs. The commonly used tincture of ipecacuanha in doses of 5 to 10 minims is probably largely ineffective, while larger doses may seriously upset a child's digestion. Probably the best clinical measure in bronchitis is to give a copious supply of fluid to keep the bronchial secretion from becoming thick and retained. For the same reason a moist atmosphere is also beneficial, provided it is not allowed to get too warm; it is best obtained by steaming a kettle in the room at intervals while the temperature is not allowed to rise higher than about 65 degree F to 70 degree F. Liniments applied to the chest are probably mostly of value because they lead to the child inhaling a certain amount of the medication vaporized by the warm body.

With recurrent bronchitis in the young child two points should be kept in mind as regards treatment. The first is that asthma often masquerades in this guise; the second, that the atmosphere of many houses is dry and dusty and may predispose to inflammation of the delicate mucous lining of the respiratory passages.

The use and Abuse of Morphine in Therapeutics.

BY

DR. G. V. SUBBA RAO, L.M.S.

(Hon-Asst. Surgeon, Tenali.)

(From the *Andhra Medical Journal* January 1937.)

"Opium is one of the most important and most extensively used drugs in the Pharmacopeas of the present day"; "In almost any disease, conditions that are favourably influenced by Morphine may present themselves". The danger of its abuse is as great if not greater than its normal use. We miss the diagnosis of the disease since we are masking up the symptoms. We innocently land the patient into the habit. It is perhaps only in the province of surgery that the drug is aptly and correctly used without the odium of abuse. It happens to be an excellent adjuvant to Criles' Anoci-Association and in Regional anaesthesia. It prevents operative and post operative shock and can be combined with scopolamine which seems to enhance its value. Writes Sajous "Opium or morphine inebriety is the result of careless administration of the opiates to patients for the relief of pain or insomnia and in physicians to their heedless use on themselves. Indeed the medical profession seems to afford the greatest number of victims: of 545 morphomaniacs 289 were doctors and nearly every case of morphine addiction is traceable to medical advice in some chronic condition". Also it is to be remembered that it is far easier to cure alcoholism than morphinism.

The official preparations of opium and morphine are a legion and as already pointed out any disease might present at least one indication for its use in practice. If one had seen the disasters after the use of drug, and correctly traced them to their cause one would find only few occasions for its use or abandon its use altogether, in preference to less harmful drugs. Unless we feel strongly that a want of rest lands the case in complications as in acutely high strung maniacal state or that of a constant pain causing slow exhaustion as in cancer or osteogenetic pain we would not be justified in administering opium or morphine. Also we have to take into

consideration the initial state principle recently proposed. It shall be an eye-opener for us both in the matter of choice of drugs and their dosage. There would be no use of morphia or ordinary doses of Luminal in a full-fledged case of status epilepticus for already the cells are exhausted and react very easily even to small doses. Perhaps a few grains of bromide are enough to check the small fits you might notice in the case. A case of eclampsia that had already had about 40 fits with twins inside, required only $\frac{1}{4}$ grain of morphia to check the fits preliminary to a forceps where no chloroform was necessary.

Probable causes of convulsive states and their pathology, reveal the fact that a hypomagnesemia, a hypocalcemia and lessening of the Brom Ion concentration in the system are being recognised as some of the vital causes. Thus it is better to exhibit calcium and magnesium in more effective and higher dosage in these cases than resort to the unsound method of doping the patient as best as we can.

Pyrexial States. It is quite well and good to use it in the initial stages of these fevers and in the yet unexhausted conditions of the brain cell. (1) But if the temperature is very high and continuing for a good length of time (2) if already there had been intense restlessness and delirium. (3) If a number of convulsions had already occurred (4) if there are suggestive signs of coma vigil (5) or if signs of a respiratory failure are imminent, it is positively dangerous to administer morphine. It is a clinical truth that it is far easier to dullen or depress a brain-cell than revivify or resuscitate one depressed either by disease or drugs like morphine.

Symptoms that should put us on the guard and desist us from the use of morphine in pyrexial states are (1) a pinched and fatigued expression (2) a slightly rapid and low tension pulse (3) an evanescent cyanotic tinge in the face that disappears on waking (4) a pronounced disparity between the range of temperature and the depth of the clinical signs (5) and lastly cold extremities.

Respiratory Disorders

Morphine or opium is an active ingredient of a number of proprietary remedies for the relief of cough and other pulmonary troubles. Due to its depressant action on the respiratory centre greater relief is afforded. Thus it is useful in checking the hacking cough of acute bronchitis and tuberculosis. It can also be used to abort an impending coryza or bronchitis or a pneumonia, provided you give a few preliminary doses of aconite. It can also be used with great benefit in pleurisy and pleurodynia. In pulmonary haemorrhage it is the drug of choice to allay the restlessness and shock. Still its use in the various forms of asthma is a trite question and sometimes is fraught with the gravest consequences to the life of a patient. Adams, another authority is more definite on the point and says that the asthmatic seizure does not by itself kill an individual, and that the deaths he knew of, were cases where morphine had been used for the relief. The respiratory centre is making violent efforts to break through a vicious cycle. The asphyxia in question is due to lessened intake of air, and insufficient expiration, due to lessening of the calibre of the bronchioles. The relief of a spasm is heralded invariably by the onset of audible cough, vomiting or some times aerophagia. Whatever interferes with nature's efforts in its struggle surely brings on fatal ending. The mechanism is probably a depression of the respiratory centre causing shallower respiration with abolition of the cough reflex. The above authors state: "that opiates are contraindicated in asthma cannot be doubted by anyone with sufficient experience of the disease."

Cardiac and Renal Diseases.

Morphine is an excellent drug in coronary thrombosis and anginal pain. As a rest-inducing agent in cardiac decompensation it is wonderful.

Obstetrics and Gynaecology.

Morphine finds high place in the above two branches of medicine. The induction of painless labour "Twilight sleep" is a case in point. Its use in post-partum eclampsia will be most useful.

Alimentary Disease

It is most useful in a number of alimentary diseases. It is perhaps the best agent to allay the pain and tenesmus of dysentery. Somewhere in surgery I remember having read that in peritonitis it is the only remedy available and the last demands of humanity have to be respected. "That a condition most painful to see is not often painful to experience". Other drugs are so flooding the market, that very soon perhaps the good old morphine might become a back number. The fewer number of drugs we use, the more harmless they are, the greater is the value of therapeutics and the lesser the danger to the patients.

Turmeric (Curcumin) in Biliary Diseases.

BY

ALBERT OPPENHEIMER, M. D.

*(From The 'Lancet' March 13th 1937'.)***Summary.**

Intravenous injection of curcumin, the pigment contained in turmeric, produces considerable increase of the flow of bile and - but not constantly - rapid emptying of the gall - bladder. Curcumin passes through the liver into the intestines and is eliminated by the kidneys, after either intravenous or oral administration. Clinically, oral administration of preparations containing curcumin shows remarkably good results in chronic cholecystitis. In this series of observations, these results were obtained by oral administration of curcumat under very slight dietary restrictions, without any other therapy, and in ambulant patients. The clinical observations have been confirmed, in 18 cases by radiography before and after treatment. Ill effects have not been seen. It seems justifiable, therefore, to conclude that the treatment with curcumat is a valuable contribution to the therapy of chronic cholecystitis and allied diseases.

Sulphaemoglobinaemia Following Sulphanil Amide Treatment.

BY

GEORGE DISCOMBE, B. SC. (Lond)
(From the Lancet March 13th 1937.)

Summary.

- (1) Sulphaemoglobinaemia is a commoner consequence of sulphanilamide treatment than has hitherto been recognised.
- (2) Sulphamoglobinaemia is dangerous to anaemic patients.
- (3) Regular spectroscopic examination of the blood of all patients receiving sulphanilamide is therefore advocated.

The Trichinopoly District Medical Association. (REGISTERED)

(Affiliated to the Indian Medical Association.)

A meeting of the Executive Committee of the Trichinopoly District Medical Association was held on 17-4-37 in Dr. C.E.R. Norman's Bungalow. The following members were present.

Dr. C. E. R. Norman,	<i>President.</i>
" V. Subramanyan	<i>Treasurer.</i>
" R. Kalamegham,	<i>Secretary.</i>
" M. R. Bhat,	<i>Member.</i>
" David of Srirangam	<i>Do.</i>

The following resolutions were passed unanimously :

1. Passed the accounts of the month.
2. Resolved to accept the resignation of Dr. N. S. Many, Musiry.
3. Resolved the amount of Rs. 75—10—6 be put before the general body and its views taken before payment to Dr. P. A. S. Raghavan.
4. Drs. Mrs. M. Monsingh and Col. Bal were elected to the Managing Committee to the vacancies present.

R. KALAMEGHAM, B.A.M.B.B.S.,
Secretary.

A meeting of the general body of the above Association was called for by the Managing Committee on the 24th April 1937. Since there was no quorum available no meeting could take place.

R. KALAMEGHAM, B.A.M.B.B.S.,
Secretary.

An ordinary monthly meeting of the above Association was held on Saturday the 24th April 1937 in the E. R. High School, premisses. Dr. C. E. R. Norman F.R.F.P. & S.D.P.H. Etc., presided. A committee of hosts stood 'Tea' and 'Dinner' on the occasion in honour of two members of the Medical profession who were

recipients of honours from the Government recently:—
Dr. A. Mathuram who was made a Rao Sahib and Dr. Mrs. D'Costa who was given the Kaiser Hind second class medal. About 35 members attended, the function.

After felicitations from the President to the Chief Guests of the evening Dr. P. Rama Rao, D.M.R. (Vienna) delivered an interesting lecture on the "Radiotherapy of Tumours". After the lecture an interesting discussion followed in which many members took part. The members adjourned for Dinner in the same premises. With a vote of thanks and a farewell to Dr. Norman who is proceeding on leave and to the Chief Guests and with other usual vote of thanks the meeting terminated at a late hour.

Trichinopoly, }
20-5-1937. }

R. KALAMEGHAM, B.A.M.B.S.,
Secretary.

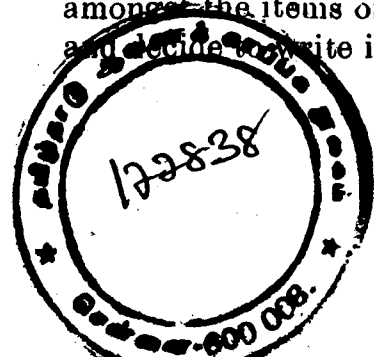
A meeting of the managing Committee of the above Association was held in Dr. C. E. R. Norman's Bungalow on Monday the 26th April 1937 with Dr. Norman in the chair.

The following were present.

Dr. C. E. R. Norman,	President.
„ R. Kalamegham,	Secretary.
„ V. Subramanyam,	Treasurer.
„ David of Srirangam	Member.
„ Mrs. M. Monsingh	Do.

The committee discussed the question of Rs. 75-10-6 with Dr. Raghavan. From the evidence at their disposal it is clear that there had been a mistake in the accountancy with an expenditure on stamps being actually heavier than the amounts shown to have been expended; and it is therefore most likely that the total amount must be considered as having been distributed amongst the items of expenditure for the association as a whole and decide to write it off.

R. KALAMEGHAM,
B.A.M.B.S.,
Secretary.



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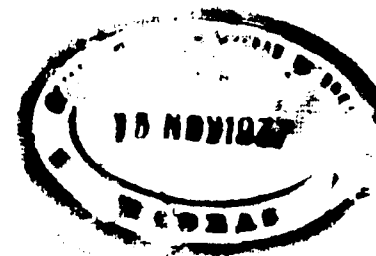
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Vol. IV

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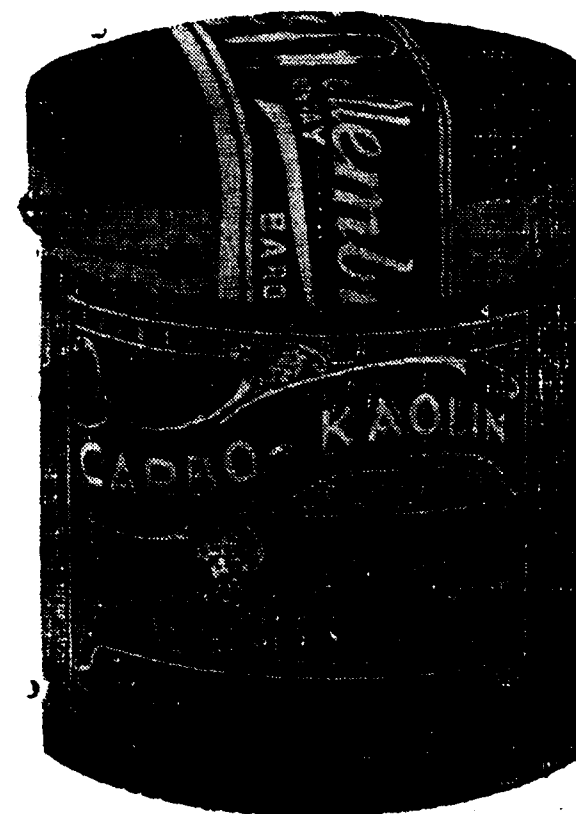
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salicyl esters.

Vitamin C in Treatment of Pneumonia.

III. ASSOCIATION NOTES.

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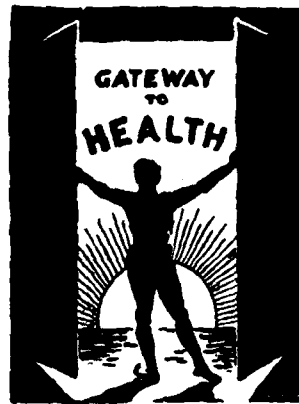
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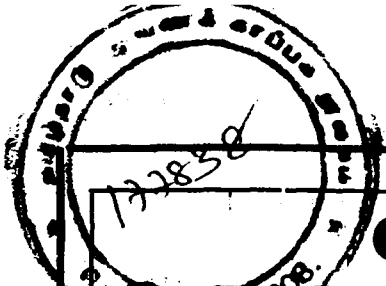
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OF

The Trichinopoly District Medical Association

(REGISTERED)

JUNE 1937

The use and Abuse of Sedatives.

By

W. RITCHIE RUSSELL, M.D., F.R.C.P.

(Assistant Physician, Royal Infirmary, Edinburgh)

(Adapted from the 'Practitioner' April 1937.)

SEDATIVES exert a depressing influence on the organs to which they are directed. They are of value therefore in the treatment of many diseases in which physiological rest for the affected organ is desired. Cerebral sedatives, for example, are used frequently, and are of great value in both functional and organic disease for the relief of nervous symptoms and insomnia. Visceral activity is often greatly influenced by emotional disturbances, hence a brain sedative may also act as a visceral sedative.

Cerebral Sedatives.

The bromides, alcohol and paraldehyde have a direct depressing effect on the cerebral cortex. The derivatives of barbituric acid act also on the cortex but, in addition, probably have a further depressing effect on the thalamic region. Morphine depresses most regions of the brain, particularly that part which appreciates pain: in addition it has a strong sedative effect on the respiratory and the cough centres. It tends to stimulate the vagus centre and thus causes slowing of the pulse, and some times vomiting.

Those people who tend to be neurotic or neurasthenic often derive great relief from cortical depressants such as the bromides.

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Sedatives are not of much value in true hysterical states, for the sufferers from this type of disorder are usually quite placid and are subconsciously well content with their disability.

Sedatives for Epilepsy

Unfortunately the use of sedatives remains the most powerful means available for treating epilepsy in the absence of organic disease of the brain which can be relieved surgically, as Sodium Bromide or Luminal, which is taken regularly every day for a period of many months or years, provided drowsiness does not result.

In cases of status epilepticus, paraldehyde, if given freely, seldom, if ever, fails to arrest the convulsions: 240 minims in four ounces of water are given by the rectum and, there after 120 minims of paraldehyde diluted are given every half hour by the rectum until the fits cease.

Choice of a Sedative-Dangers.

The bromides are mostly employed and are of great value. They have a pure depressor effect on the cerebral cortex, and many patients take ten or more grains of a bromide salt three times daily for a period of many months. Bromide skin eruptions sometimes develop but can usually be prevented by adding a few drops of liquor arsenicalis to each dose. They also may be dangerous, for bromide tends to accumulate in the body, and serious, and even fatal poisoning may occur. In such a case all drugs should be stopped, and sodium chloride and water should be given freely to displace the bromide accumulated in the body tissues.

In states of toxic delirium such as delirium tremens when sedative treatment is urgently required, sodium bromide (30 grains) with chloral hydrate (20 grains) remains a most valuable method of treatment. The full dose may be repeated in an hour if necessary. The subcutaneous administration of morphine ($\frac{1}{4}$ grain) with hyoscine hydrobromide ($\frac{1}{100}$ grain) is also effective in quietening delirious states. The injection may sometimes cause excitement. Paraldehyde is safe and has a strong sedative and hypnotic action if given in adequate amounts: 120 minims (diluted) may be given by the mouth and

thereafter 60 minims may be given every half hour until the desired degree of depression is obtained.

The derivatives of barbituric acid

Though the drugs of this group are for the most part rapidly excreted, over dosage may result from a cumulative action. They are all dangerous poisons in large doses, and not only is the margin between the medicinal and the toxic dose small, but the individual tolerance varies greatly. Mental confusion, excitement, ataxia, or varying degrees of coma may indicate that poisoning has occurred. Habit formation is also a danger common to all the drugs of this group. When a pure sedative effect is desired, a simple prescription such as the following will bring relief to many neurotic patients:—

R/Sod. Brom.	...	...	10 grains
Tinct. nuc. vom.	...	...	10 minims
Liq. arsen.	...	...	5 minims
Inf. gent. co. rec.	...	...	to 2 ounce

Three times daily after food

A small amount of a barbituric acid derivatives taken at night is often a useful addition.

The use and Abuse of Serums and Vaccines.

By

LIONEL E. H. WHITBY, C.V.O., M.D.F.R.C.P.

(From the 'Practitioner' April 1937.)

General Principles.

It is an abuse to use a specific remedy when there is no bacteriological proof or sound clinical evidence as to the nature of the infecting organism, or, no reasonable grounds for believing that bacteria cultivated from various sites or various excretions have any relations to the clinical condition. It is an abuse, and indeed a crime, to apply the active method to patients who are acutely ill, who are already overloaded with their own antigen and who are ill because they lack the antibody which they themselves cannot produce. It is an abuse to subject a patient to a long, perhaps painful, course of vaccine therapy

when the infection itself is but a secondary event; say, the result of some anatomical abnormality, such as a kinked ureter or a badly deflected nasal septum. Minor abuses arises largely from lack of experience; a failure to recognize the great variation in individual requirements and a tendency to follow slavishly a schedule of dosage supplied by a manufacturer or a bacteriologist, which schedule is necessarily designed for the *average* person, not the individual.

Passive Immunization (Serum Therapy).

General Principles. Such treatment is designed to overcome a crisis; it confers an immunity which lasts at most a few weeks; but this, in an acute infection, is all that is desired. Serum has also a limited but valuable use for prophylactic purposes. A dose of 20 to 40 c. cm. per day of most of the *antitoxic* sera is ample; if effective there should be a favourable change in the patient's condition within a few days; if such a favourable change occurs, then persistence with the serum is usually rewarded. With highly toxic conditions, such as grave diphtheria infections, much higher doses may be required.

USES:—The value of diphtheria antitoxin, and of scarlatinal antitoxin for erysipelas, is unquestioned. Staphylococcal antitoxin is useful in the same way in severe or in generalized infections.

For the toxæmia of bacillary dysentery caused by Shiga's bacillus the antitoxin is invaluable. Botulinus antitoxin provides the only hope of treating a highly fatal disease, and the other anaerobic bacillary antitoxins, Tetanus, and *B. welchi*, are invariably used in their corresponding diseases.

Of antibacterial serums the specific pneumococcal types I and II are of proved value. Anti-meningococcal serum has recently been improved, but the value of administering the serum by the intrathecal rather than the intramuscular or intravenous route is doubted by many experienced immunologists. Human serum from convalescent cases of measles, poliomyelitis, and true epidemic influenza are valuable for the *early* treatment of these virus diseases; but supplies are difficult to obtain.

Normal human serum, in the form of a blood transfusion, is valuable in the treatment of septicaemia and other highly toxic conditions and also for effecting haemostasis in certain haemorrhagic disorders.

For prophylactic purposes tetanus and gasgangrene antitoxins are indispensable: the earlier they are administered the more consistent is the result.

ABUSES:—Admittedly no real harm is often done by administering a therapeutic serum simply on empirical evidence in many acute bacterial infections ; this point is sometimes used as an argument for employing pneumococcal serum in every case of pneumonia.

Active Immunization (Vaccines and other Antigens).

Vaccines may be used prophylactically or therapeutically. With active immunization the subject must be in a sufficiently good state of health to respond to stimulation without danger. A person who is toxic and ill is, as a rule, unfit for vaccine treatment. For the purposes of treatment individuals may be described as either *allergic* or *indolent*. The indolent type is the more easy to deal with; and will tolerate extremely large doses. The allergic type is highly sensitive to minute doses. Such persons require desensitization rather than immunization.

An obvious example is bacterial asthma but many minor grades of mild chronic illness belong to the same category. The difficulty is always in experiment. Subsequent doses are gauged by the reaction to the first. It is therefore a sound rule to make the first dose extremely small, even homeopathic; by so doing the sensitive subject is identified and the future course of treatment defined.

Prophylatic vaccines are usually given in two or three doses. First dose given may be about one-tenth of that which is recommended; subsequent doses are then gauged by the reaction to the first dose.

A point frequently raised is the relative merits of stock and autogenous preparations. Sometimes there is no choice as for example with prophylactic vaccines or when the infecting

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organism cannot be obtained in pure culture. As a general rule an autogenous preparation is better tolerated than a stock one, but it may not necessarily be as efficient an antigen.

Uses:—The prophylactic value of typhoid, paratyphoid, cholera and plague vaccines is unquestioned. Pertussis vaccine is considered a useful prophylactic but valueless in treatment. Of other methods for prophylactic active immunization the value of diphtheria alum toxoid and diphtheria toxoid antitoxin flocculus is proved beyond doubt.

For therapeutic purposes vaccines have a value, variable from patient to patient, in furunculosis, acne, bronchitis, asthma, gonorrhoea (especially the metastatic manifestations) colitis, rheumatoid arthritis, urinary infections, and a number of other chronic infective diseases.

Vaccines may be used for their non-specific effect in diseases in which fever and stimulation have been found to have a valuable action. Thus typhoid vaccine may be given intravenously in chronic rheumatoid arthritis.

Abuses:—The worst abuse is to over-stimulate the patient, hence as a general rule it is risky to use a vaccine in acute toxic diseases. Great harm may also be done by overdosage, even in healthy subjects. Any general reaction in the form of depression fatigue, urticaria or especially a rise in temperature is an indication of overdosage.

Birth Control Practices in England and America

BY

Mrs. HOW MARTYN.

(From the 'Medical Digest' Bombay, May 1937.)

The first thing we did was to open Birth Control clinics, we discussed very carefully what we could do with the Clinics and the first rule laid down was this, that every patient must be seen by a Doctor because we wished to distinguish this from all commercial exploitations. We regard Birth-Control as a part of preventive medicine which every doctor should know.

The patient who comes in is at first very nervous and very shy, so that we try to make her feel as comfortable as possible and try to understand her trouble and help her. One of the lay workers would see her, talk to her and ask her a few particulars and then gradually get out of her all the information.

All the information given by the said patient is taken down on a card which is reserved for the Doctor. A general examination of the patient is made as they will have to give birth-control advice only to those who are not fit to bear children, now the next thing after the particulars have been taken, is that they are sent in to the doctor. We used to find a great series of failures as they did not understand what the doctor was explaining.

We began to explain to her what happens when intercourse takes place. They are shown the pessary and are instructed how to keep it in position so that the semen may not enter the cervix. They gasp when they see the size of it, but when we say to the women "you know your babies head comes out of the same passage," they are quite relieved. We have to explain to them that it cannot get lost or get inside so as to require a surgical operation. Then we get them to practise them with a model and then we show them how it fits. You cannot reach the cervix with out the rubber Diaphragm. That does not move and is quite comfortable. The doctors will give them a size which will not be uncomfortable, for some of them require small sizes while others who are mothers of four or five

children require larger sizes. The constant use of it will tend to cause constipation, and women are warned against it. This lesson will take twenty minutes. The doctors to whom she goes afterwards finds his task more easy.

There are a great many of these kinds of rubber caps among which the Koromex is considered to be one of the best. She must wear it eight to ten hours after intercourse; the best thing is to leave it out before that time, then she must use the syringe or soap water douche.

When she takes it out she washes it, puts it back into the box when it is ready for use again. All these things depend upon how many times they are used. If once or twice a week then it will last a year. She must come back to the Doctor every six months. They pay if then can afford it Rs. 1—10—0 for one of these. If then cannot do so at any rate they are asked to come back to the clinics. If the woman gets tired of this then she is asked to send her husband to the clinic. We then tell him to get a Condom Sheath.

We have also been using a powder called Duo-Foam Powder which is very simple to use. What happens is inside the box there is a Sponge. She is instructed to wet the Sponge in just ordinary water and then the powder is to be shaken and turned over and shaken on the other side. She then takes it in her fingers and rubs it and as she rubs it the more it foams, She then pushes that into the Vagina. Doctors and Clinics get it at a discount. As far as I know it gives very good results. It has now been only two years since we have been making use of it and there is not much clinical experience of it.

We have no experience of this powder. The results in America and India are quite good and I think the powder will replace the pessary since it is cheaper. There are of course many attempts being made to find better contraceptive methods.

I may conclude by saying that none of these methods have led to any bad results.

Prontosil album in puerperal sepsis.

BY

M. A. FOULIS, M.D. AND JOHN B. BARR, M.B.Ch., B.
(From the *British Medical Journal* February 27th 1937.)

Summary.

1. Out of a series of seventy cases of puerperal sepsis twenty-two were treated with the "sulphonamide" preparation prontosil album. Four of these had, in addition, occasional doses of prontosil soluble by injection. The other forty-eight cases were not considered sufficiently serious for chemotherapy.

2. Eleven of the twenty-two cases treated with prontosil album had septicaemia, eight proved by blood culture to be due to haemolytic streptococci, and a further three cases of peritonitis without septicaemia all yielded haemolytic streptococcal colonies on culture of the peritoneal fluid. The balance—seven cases—showed a haemolytic streptococcus on bacteriological examination of the vaginal discharge.

3. The dosage of prontosil album was high, ranging from 3 grammes (ten tablets 14·4 grammes over twenty-four hours, but the preparation was well tolerated and toxic effects were minimal.

4. The fall in temperature and the general improvement were rapid and striking.

5. The success of the treatment is evidenced in the mortality rate of 1·4 per cent. in a five year period in the same hospital.

Treatment of minor burns by amyl salicylate. and other salicyl esters.

BY

R. LESLIE STEWART, M.B.F.R.C.S., ED.

(From the *British Medical Journal* February, 20th 1937)

Summary.

1. Clinical tests in a hospital out-patient department have indicated that amyl salicylate possesses analgesic properties, and can be satisfactorily employed in the treatment of minor burns.

2. It lacks the coagulant effect of tannic acid on the tissues, and is therefore unsuited for the treatment of severe and extensive burns where there is a danger of toxæmia and shock.

3. The ester has little if any bactericidal power, and it therefore requires the addition of an antiseptic. In this series a mixture of isomeric substituted phenols, known by the trade name "abracide", has proved suitable.

4. The method is applicable to the treatment of infected as well as non-infected burns and scalds, provided the initial infection is not too severe.

5. Standardization of technique is very necessary if the best results are to be obtained.

6. Amyl salicylate has an extremely penetrating smell, but the results obtained with other less pungent salicyl esters have been inferior.

Vitamin C in Treatment of Pneumonia.

BY

J. GAUDER AND W. NIEDERBUGER,

(From *Munich Med. Journal*.)

Investigating Vit. C. metabolism in old people the favourable action of Citric acid in a case of Pneumonia led the authors to enquire whether Vit. C. metabolism may be deranged in Pneumonia and whether exhibition of Vit. C. may favourably influence the progress of the case.

The good results from a liberal use of fruit juices with a high C content in all febrile conditions; the Vitamin C. deficiency usually found in cases recovering from Pneumonia; animal experiments where Vit. C. deficiency led more to pneumonia rather than to scurvy; a remarkable correlation between incidence of mortality from pneumonia and frequency of Vit. C. deficiency; all these gave the impetus for looking into the condition.

With an experimental evidence from 15 cases the authors come to the conclusion that Vitamin C is a very valuable therapeutic measure in the treatment of pneumonia and that exhibition of calcium further enhances the therapeutic effect and helps to hasten absorption.

Looking closely at this form of therapeutics for Pneumonia it is after all nothing else but the establishment of a physiological state rendered abnormal through the illness. So the administration of Vit. C. therapy means no medicinal interference and hence no untoward results need be expected as any excess of the vitamin is immediately excreted in the urine.

From their observations the authors express that exhibition of vitamin C. hypodermically and then orally in the first stage of pneumonia brings about strikingly favourable results.

The detection of Vitamin C. deficiency is done by a very simple test of the urine and is to be done as a rule even as we do urine testing for sugar acetone and albumen; a test which any one can do.

The research laboratories of Hoffman-La-Roche have developed this simple test.

Simple diagnostic test for Vitamin C deficiency. Infants and young children are given 2 Redoxon tablets (= 100 mg. Vitamin C), older children and adults 6 Redoxon tablets (= 300 mg. Vitamin C).—20 c. c. of the urine passed from 3 to 6 hours after intake are collected and added to the blue indicator solution prepared with one tablet of Dichlorophenolindophenol 'Roche' in 30—50 c. c. of water.

No deficiency (a) If the colour is discharged within $\frac{1}{2}$ minute, the urine tested contains 5 mg. % or more of Vitamin C and a deficiency is improbable.

Deficiency (b) If the colour is not discharged within $\frac{1}{2}$ minute, the urine tested contains less than 5 mg. % of Vitamin C. In this case repeat the administration of Redoxon as above (once or twice daily) until the point of saturation is reached as under (a). Estimate the original deficiency by adding the doses of Vitamin C given and retained (1 Redoxon tablet = 50 mg. Vitamin C.)

The Trichinopoly District Medical Association.

(REGISTERED)

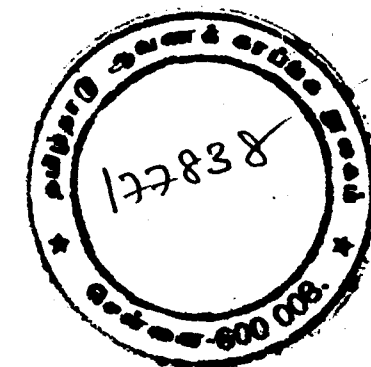
(Affiliated to the Indian Medical Association.)

An ordinary monthly meeting of the above Association was held on the 22nd May 1937 in the E. R. High School, premises at 5 p.m. After 'Tea' kindly provided for by Dr. M. R. Bhat of Pulivalam Dr. T. S. Balasubramanyam, was voted to the chair and Dr. A. P. Pillay O B E., M.B.B.S., (Madras) of Bombay delivered a lecture on 'Birth Control'. About 50 members were present. Without going into the Eugenic and other aspects of Birth control, Dr. Pillay gave us the various methods of Birth control with their comparative efficacy. After the lecture a movie show was arranged by Dr. Pillay where the technique of Birth control was shown. After the Cinema show which was made possible by Mr. Ponniah the local photographic artist giving us the loan of his projector the meeting adjourned late at night after the usual votes of thanks.

TRICHINOPOLY, }
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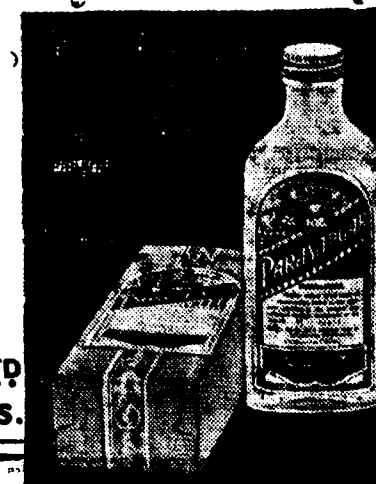
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