

252

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Vol. IV

OCTOBER 1937

No. 10

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CONTENTS.

I. SPECIAL ARTICLE.

Cerebral Trauma (J. A. M. A.)

II. EXTRACTS.

Renal Calculi (J. A. M. A.)

Deafness

Skin Eruptions in Patients Receiving Sulfanilamide

A Comparison of Mandelic Acid and Sulfanilamide as
Urinary Antiseptics

Vitamin Therapy of Nervous Diseases

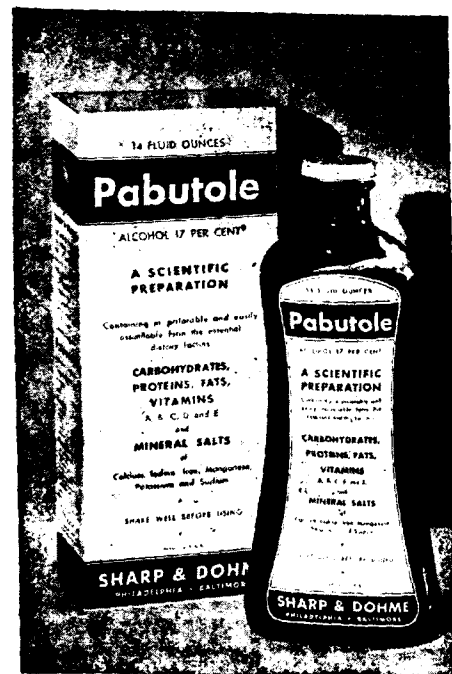
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III. PROCEEDINGS.

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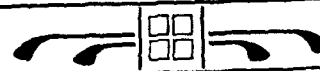
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MISCELLANY

OF

The Trichinopoly District Medical Association

(REGISTERED)

OCTOBER 1937

Cerebral Trauma (J. A. M. A.)

Classification:—

Linear and or comminuted fracture
Depressed fracture

SKULL:—Compound fracture.

Special fractures:—Involving paranasal sinuses.
Middle and external ear.
Pneumoencephalacole cribri-
form plate.
Bullet wounds.

Concussion

Oedema

Contusion and or laceration

Special:—Haemorrhage:—Sub or extradural

Rarer forms:—Subpial.

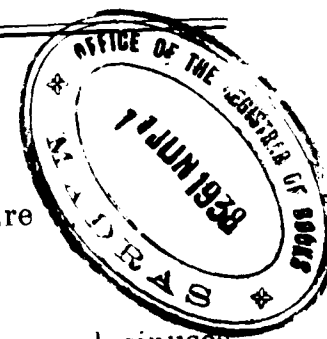
Subcortical

Intraventricular

Rupture of venous
sinuses. Multiple
peticheal.

Infection:—meningitis

Cortical abscess.



JL
1000, 135715
132.4.10-12

Normal pressure of C.S.F. is 100 to 150 mm of water.

General considerations Physiology and Pathology.

Blood—→ Choroid plexus —→ I & II Ventricles and
 through—→ Foramina of Munro to III „ and
 „ Aqueduct of Sylvius to IV „ and
 „ Foramina of Lusk and Majendi to „ and
 —→ Cisterna Basalis Subarachnoid Space to Blood
 through Arachnoidal villi.

Immediately after a blow the arterial side of the capillary loop dilates. There is a sudden hydrostatic pressure and a seepage into the perivascular spaces by blood serum. Osmotic changes step in and increase this seepage which in turn compress the venous side of the loop, thus producing back pressure in the loop. This produces anoxaemia of the involved part of the brain and probably due to the stasis, it leads to minute petichial haemorrhages. Due to the anoxaemia the medullary centres respond with a rise in the systemic blood pressure and a slowing of the pulse which counteracts the vicious circle for sometime and if it is not broken at this stage with a reduction of Intracranial pressure, it results in complete exhaustion of the centres and death.

According to the degree of deprivation there will be varying degrees of nerve cell affection; sometimes even to irreparable destruction. This may be responsible for the late effects of cerebral trauma like headache, convulsions, and post traumatic neuroses. This is also responsible for increase of cerebral tension.

There is another factor responsible for the rise of cerebral pressure due to the mechanical blockade to the absorption of C. S. F. in the arachnoidal villi thus leading to a rise of pressure in the entire subarachnoid and ventricular systems.

Examination of a case of cerebral injury needs a lumbar puncture and the pressure of C. S. F. as found by a manometer.

I. *Congestion and oedema* (about 25% of cases.)

i. Primary loss of consciousness followed by headache on return to conscious state.

- ii. May have disturbances of memory.
- iii. In serious cases convulsion and motor weakness.
- iv. C. S. F. does not contain R. B. C., and pressure is moderately raised as there is no mechanical blockade to the absorption of C. S. F.

II. *Contusion and Laceration* about 50%.

- i. All the symptoms of the previous ones are present in a greater degree.
- ii. C. S. F. pressure is raised and R. B. C. found in C. S. F. the amount proportional to damage and directs prognosis.

Treatment.

- i. All patients at first are actually or potentially shocked. This must first be treated. Patient is wrapped in warm blankets. Temperature, pulse, and B. P. are taken. 50 ccs of 50% dextrose is given intravenous to combat shock if temperature is subnormal.
- ii. No detailed repair of wound is attempted; but with a finger a skull fracture is detected if present.
- iii. If there had been loss of blood 250 to 500 ccs of normal saline is given.
- iv. Extreme restlessness is treated with an injection of Phenobarbital Sodium repeated if necessary. Morphine or its derivatives are contraindicated in view of the fact that respiratory centre is already depressed.
- v. Stimulants if necessary (Post Pituitary or ephedrine).
- iv. During unconscious period keep patient in lateral prone position with foot of bed raised to about 12" to prevent aspiration of mucus into lung. This is most important.
- vii. When patients temperature is about 98 degrees neurological examination must be done. Note

depth of stupor state of pupils, cranial nerves, muscle tone and reflexes.

Note also type and rate of respiration.

viii. Do a lumbar puncture to note

I. Pressure. II. R. B. C. and III amount.

If pressure is within normal limits only symptomatic treatment. If elevated withdraw C. S. F. to normal limit. Another method to bring down excessive pressure is therapeutic dehydration. Hypertonic solutions intravenous are good in oedema cases only since it reduces brain volume while repeated lumbar punctures are good in other types of Injury.

If after this, the patient is not improving extra and subdural haemorrhage should be suspected.

In these case sub-temporal decompression with a burr is to be done.

H. MOORE, M.D., J.A.M.A.

Renal Calculi (J. A. M. A.)

Causation—i. Obstruction like stricture.

ii. Infection.

iii. Precipitation from super saturated solutions (i. e.) colloids and crystalloids.

iv. Diet. Good feeding with vitamin A and an acid ash diet has been able to reduce the recurrence of calculi in humans. There was a low calcium content in diet as well.

Scalp:—Lacerated and or incised wounds.

Contusion.

Haemotoma.

General Bodily condition:—

Shock.

Exhaustion.

Dehydration.

Deafness

Prevention Versus Palliation

By

A. TUMARKIN, M. B. LIVERP. B.R.C.S. Edin., D.L.O.

(From the 'Lancet October 2nd 1937)

The disabilities and misfortunes of the deaf are at last beginning to receive reasonable attention.

It would, however, be singularly unfortunate if these excellent schemes should by their very importance and success overshadow other problems that are even more important and pressing—I refer to the prevention of deafness. A recent publication of the Medical Research Council (Kerridge 1937) shows that well over 30 per cent. of juvenile deafness is due to middle ear suppuration. These unfortunate children need educating by the most elaborate and expensive methods, and at best they will be sadly handicapped in the bustle of life. It is my present theory that most of them need never have lost their hearing at all. Chronic otorrhoea is a lasting reproach to the medical profession. Blame must be apportioned to general practitioners, otologists, and medical officers of health alike.

Method of Treatment

It may not be out of place here to outline the methods I advocate.

Acute Otis. Keep the external auditory canal as dry as possible. This may necessitate swabbing away discharge as often as every four hours.

Protect the pinna from irritating discharge.—Smear it lightly with a mild mercurial ointment.

To mop an ear out

First swab all the pinna with spirit. Then tease out a long narrow pledget of wool. There must be no loose bits which might get lost in the depths of the meatus.

Never force a fat swab down the ear. It will act like the piston of a syringe and drive pus back into the tympanum and possibly even into the mastoid.

If you use a narrow pledget, the pus will exude out past it as you push it in.

Remember the auditory canal is not a straight tube.

Never push the forceps too far into the ear you may damage the drum. By altering your grip of the wool you can push it ahead of the forceps right down to the drum without the risk of damage.

After using a few dry pledgets use a few soaked in spirit. This: (a) washes away residual pus; (b) sterilises the meatus; (c) shrinks the swollen drum and promotes drainage.

Finally, dry out the ear again, and instil a few drops of the mercurochrome solution. Put a large blob of wool loosely into the concha. Never pack it in so firmly that discharge cannot get out, and never use a small blob of wool which might slip down the meatus unnoticed.

No more elaborate methods than these are necessary to cure the vast majority of cases within three weeks. *Zinc ionisation, which is so valuable in chronic otitis media, is absolutely contra-indicated in acute and subacute stages: It will infallibly precipitate mastoid suppuration.*

Simple Zinc ionisation is our standby in chronic otitis. Even as used "en masse" in the minor ailment clinics it has proved itself far superior to all other methods. Naturally however the best results can only be achieved by individual study of cases. Wherever this clinic treatment fails, the child is admitted to hospital for a continuation of his routine treatment. Even the dreaded aural polypus can be tackled with considerable hope of cure. It may be necessary to snare off the main mass, then at a later stage to finish off with the usual monopolar zinc electrolysis.

Let us now consider a type of deafness of which much less is known. I refer to that which is due to recurrent catarrhal otitis media. Pain being minimal, and discharge absent, the condition is liable to escape notice until parents or teacher realise the child is deaf (or more often suspect it of stupidity).

1. Repeated "colds" lead eventually to infection of the paranasal sinuses (mainly the antrum). The latter naturally produces an apparently constant cold with nasal obstruction due to boggy turbinates and mucosa.

2. Hypertrophy of tonsils and adenoids (and allied lymphoid tissue in Eustachian tube), aggravating the mouth-breathing.

3. Repeated inflammation ensue—possibly sometimes a true tonsillitis or suppurative otitis media, but in many cases a mild but generalised infection of the whole mucous lining of the nose, throat, and ears. The child is fretful, has mild sore throat, and goes deaf. I believe many cases of adult "progressive middle-ear deafness" are a late result of these infantile infections.

Skin Eruptions in Patients Receiving Sulfanilamide.

By

JOHN G. MENVILLE, M. D.,

and

JOHN J. ARCHINARD, M. D.,

(From Journal of the American Medical Assn., September 25th 1937)

Summary.

Relatively large doses of sulfanilamide were given to four patients, in whom a maculopapular eruption developed associated with severe itching and the formation of minute unerupted vesicles. In one case the rash was associated with severe chills, fever and a leukocytosis. In all the cases the rash and its associated symptoms disappeared within seven days after the drug was discontinued.

It is interesting to note that in all four cases the rash appeared only on the parts of the body exposed to the sun.

No saline cathartic and no other form of medication other than sulfanilamide were given the patients while under treatment.

We have had other patients to whom we have given smaller doses of sulfanilamide whose hands, face and neck have been exposed to the sun without the development of an eruption of the skin. It would seem to indicate, therefore, that cutaneous eruption are more likely to occur in patients receiving large doses of sulfanilamide when they are exposed to constant rays of the sun.

A Comparison of Mandelic Acid and Sulfanilamide as Urinary Antiseptics.

By

HENRY, F. HELMOHOLZ, M. D.,

Summary and conclusions.

The introduction of mandelic acid and sulfanilamide has greatly improved the chances of curing urinary infections. Mandelic acid is dependent for its action on a concentration greater than 0.5 per cent and a pH of the urine less than 5.5 so that it is not likely to be successful unless the function of the kidney is normal or nearly so. The inability to reduce the pH of the urine of patients with *Proteus* infections makes mandelic acid therapy almost useless in the treatment of such infection. Its action on *Streptococcus faecalis*, however, makes it the antiseptic of choice for this type of infection. Sulfanilamide, because of its ease of administration and tolerance by the stomach, is the drug of choice, however, in the average cases, and it has the added advantage that it can be used during the acute stage of the disease. Acting best in an alkaline urine, sulfanilamide should be extremely useful in treating infections of the *Proteus* group. Its striking ineffectiveness in the treatment of *Streptococcus faecalis* infections, however, is a definite handicap.

These two drugs, one acting only in an acid and the other best in an alkaline medium, supplement each other, and they should be used in the treatment of urinary infections according to the type or types of organisms causing them.

KLINISCHI WOCHENSCHRIFT, BERLIN

Vitamin Therapy of Nervous Diseases.

Heiman reports thirty cases in the treatment of which he resorted to a preparation of vitamin B₁. The clinical histories of fifteen of these cases are reported in detail. He thinks that the injection of the B₁ preparation is indicated in all disturbances of the peripheral nervous apparatus. On the basis of theoretical reasoning, he differentiates two groups of nervous diseases. The first group included those disorders in which a deficiency of vitamin B₁ is presumably involved. The other includes in this group, among others, polyneuritis caused by alcohol, lead, thallium, arsenic, diabetes, beriberi, pellagra, carcinoma, pregnancy, edema due to starvation, and inanition. Although it may not be possible to demonstrate an absolute or relative vitamin deficiency in all these conditions, there are nevertheless indications of a relationship. The second group of disorders includes those peripheral nervous disturbances in which pain predominates or plays a part. It has been found by experience that these disorders respond to vitamin B₁ favourably. Since vitamin B₁ shows a greater affinity for the centripetal than for the centrifugal nerves, its application is especially suited in disorders that involve chiefly the sensory nerves. Central nervous disturbances, such as myelitis, funicular myelitis, multiple sclerosis and heredo-degenerative diseases, do not respond to treatment with vitamin B₁, according to the author's experience. He suggests that, in the initial stage of multiple sclerosis, the preparation of vitamin B₁ be tried.

(From 'Journal of the American Medical Assn.
Journal September 25th 1937.)

Munchener Medizinische Wochenschrift, Munich

(From Journal of the 'American Medical Assn-Journal'
September 25th 1937)

Technic of swallowing in Painful Dysphagia :—Fleshb describes a method which makes it possible to swallow liquid food quickly and painlessly in such conditions as tonsillitis, peritonsillar abscess, after tonsillectomy, after lancing of abscesses in the region of the tongue or the larynx, during pharyngitis and so on. After describing the mechanism of swallowing under normal conditions and after showing the difference between the swallowing of solid and liquid foods, the author states that, if the patient with painful dysphagia takes into his mouth an amount of fluid that will puff out his cheeks, while he is in the sitting position and, after the quantity of fluid has passively filled the space up to the anterior palatine arch, swallows it on command all at once, the following takes place : The quantity of fluid fills the spherical space between soft palate, tonsils and pharyngeal wall; the pharyngeal constrictors act on a soft fluid cushion that gives no resistance, and, when the pharynx is opened, the fluid food streams without resistance, with only slight pressure, almost automatically into the esophagus. The author has used this method successfully for almost ten years.

The Trichinopoly District Medical Association

(REGISTERED)

(Affiliated to the Indian Medical Association)

A monthly meeting of the above Association was held on Sunday the 31st October 1937, at 5-30 p.m., at the Clinical Laboratory, Palakarai, Trichinopoly.

Dr. V. IRAVATHAM was At 'Home' to the members. About 35 members were present and Lt. Col. N. K. BAL, M.C., I.M.S., District Medical Officer, Trichinopoly presided.

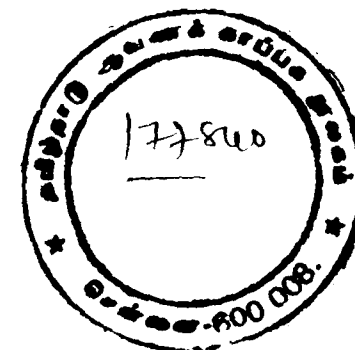
Dr. F. YSANDER, M.D., of the Swedish Mission Hospital, Thirupathur delivered an interesting lecture on 'DIAGNOSIS AND DIAGNOSTICS'. After the lecture there was interesting discussion in which many members took part.

Then the Secretary informed the Members to become members of the ensuing All India Medical Conference to be held at Madras during Christmas Holidays.

Afterwards the meeting terminated.

TRICHINOPOLY, }
29-11-1937.

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



30-11-1937
10-12-1937

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Infants and children in proportion according to age.

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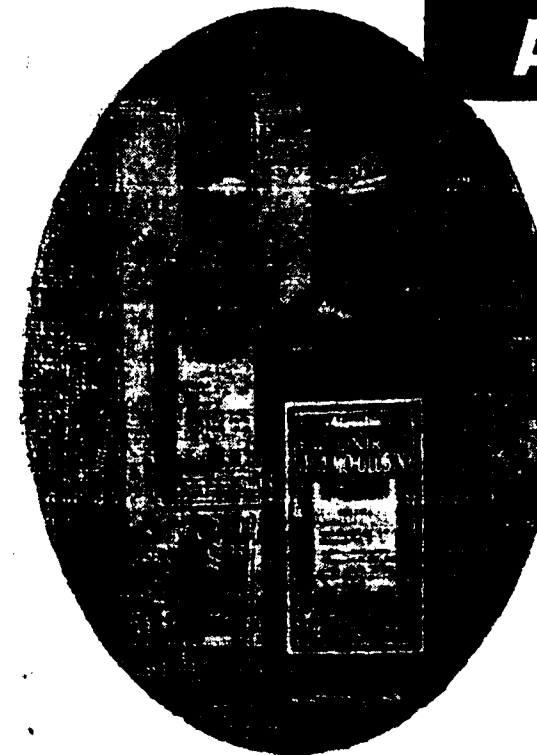
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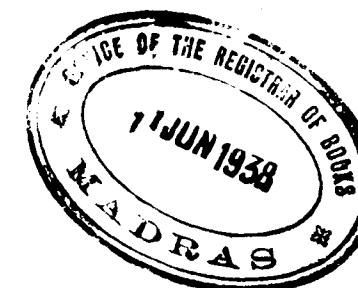
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CONTENTS.

I. SPECIAL ARTICLE.

Endocrine in theory and practice

II. EXTRACTS.

Local Anaesthesia in the Repair of Torn Perineum.

Histidine Therapy in Cases of Peptic Ulcer

Use of Insulin in Nondiabetic Malnutrition

The treatment of Eclampsia

The use of Adsorbents in Gastro-Intestinal Diseases.

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NOVEMBER 1937

Endocrine in theory and practice

Hormones in the treatment of menstrual disturbances

By

P. M. F. BISHOP, B.M.B.CH.

(From the 'British Medical Journal' April 10th 1937)

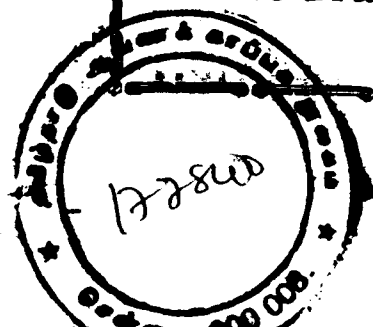
The causes of menstrual disturbances may be organic, nervous, or endocrine. Organic causes should be excluded before endocrine therapy is considered.

The menstrual cycle is disturbed in such glandular syndromes as Graves' disease and myxoedema, Simmonds' disease, acromegaly, pituitary basophilism, and the adreno-genital syndrome; but treatment of the general endocrine disorder rather than of the menstrual derangement is indicated.

The alteration of menstrual function may be the only sign of hormone deficiency, and it is with the treatment of such cases that this article is concerned.

Uterine bleeding in menstrual disorders

If a course of large doses of oestrin, the ovarian follicular hormone, is administered to a castrated woman uterine haemorrhage will take place from one to two weeks after the last injection." If smaller doses are given intermittent haemorrhage may arise during the course of treatment. Such haemorrhage is due to the effect of oestrin on the endometrium being maintained at a level. This may be described as "threshold bleeding." Oestrin-withdrawal bleeding therefore supervenes when the oestrin effect on the endometrium is withdrawn from a super-threshold level.



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Whether menstruation occurs regularly, not at all, or irregularly and excessively, depends, therefore, on the effect of oestrin on the uterus and the subsequent presence or absence of progestin. Amenorrhoea is usually due to a sub-threshold effect of oestrin on the uterus. The endometrium fails to reach that stage of development which must be attained before bleeding can be induced. Menorrhagia and metrorrhagia supervene when oestrin reaches and is maintained at the threshold or bleeding level. Since ovulation fails to take place and no corpus luteum is formed this constant effect of oestrin continues unopposed owing to the absence of progestin.

Amenorrhoea, Hypomenorrhoea, Oligomenorrhoea

Ovarian Replacement Therapy

The sub-threshold effect on the uterus in amenorrhoea (prolongation of interval), may be due to inadequate secretion of oestrin (ovarian deficiency), to failure of the uterus to react to normal quantities of oestrin (uterine deficiency) or to a combination of the two. The uterus is usually small and the endometrium atrophied.

The first stage of treatment, is to build up the uterus to adult size, which in itself, is rendering the endometrium more sensitive to ovarian stimulation. This may be accompanied by the administration of some compound of oestrin (ovarian replacement therapy): 50,000 I. B. U. * of a reliable preparation of oestradiol (the hormone actually secreted by the ovarian follicle) are injected intramuscularly at intervals of three to four days until five doses have been given. This course of 250,000 I. B. U., which probably represents an unnecessarily high dose, should induce an oestrin withdrawal haemorrhage ten to fifteen days after the last injection. A second course of injections should begin immediately bleeding occurs. In the absence of a haemorrhagic response an interval of three weeks should separate the two courses.

* (I. B. U. (international benzoate unit) is equal to 0.1 oestradiol benzoate—that is, 1 gramme oestradiol benzoate is equal to 10,000,000 I. B. U.)

* Di-menformon (Organon), Progynon B Oleosum Forts (Schering), Oestroform B (British Drug Houses).

Ovarian Stimulation Therapy

If the uterine hypoplasia results not from a primary failure of uterine development but from defective ovarian activity this must now be dealt with. It may be due to an inadequate pituitary stimulus or to a failure of the ovary to respond to normal amounts of pituitary secretion.

The second stage of treatment consists, therefore, in prescribing gonadotropic extracts (ovarian stimulation therapy): 100 to 500 R. U. of a gonadotropic extract of pregnancy urine are injected intramuscularly three times a week for four weeks. This course may be repeated. Treatment should then be discontinued for a month, after which it may be resumed if there is no re-establishment of spontaneous menstrual rhythm.

Theoretical considerations would indicate that the ideal form of treatment is the administration of a follicle stimulating hormone (prolan A) for a fortnight, followed by the luteinizing hormone (prolan B) during the second fortnight. Unfortunately clinically effective follicle stimulating extracts are not yet obtainable commercially, and consequently only luteinizing extracts are used. Available experimental evidence would indicate that the adequate dose for the human female is probably higher than now employed.

Pregnyl (Organon), Antuitin S (Parke, Davis), Prolan (Bayer), Gonan (British Drug Houses). Such extracts contain mainly prolan B, the luteinizing hormone.)

Menorrhagia and Metrorrhagia

This type of menstrual disturbance will be considered under three heading: menopausal, maturity, and puberty bleeding, for the treatment differs according to the age of the patient.

It is becoming insensitive to the gonadotropic stimuli of the pituitary, even though these are now relatively excessive. Oestrin is reaching no longer super-threshold but threshold or bleeding levels. Progestin, if secreted at all, is ineffective in lowering such levels. Attempts to prolong the life extracts are illogical. Treatment should be designed to deep X-Rays or of radium, or to remove the source of the haemorrhage by hysterectomy.

Maturity Bleeding (Metropathia Haemorrhagica)

Ovulation fails to take place, and the ovaries may be palpably enlarged and are studded with small cystic follicles which have not ruptured. The endometrium is submitted to continuous stimulation by oestrin, an exaggeration of the proliferative phase ("Swiss cheese" or glandular hyperplasia) results in thickening and some periods of profuse flooding or mild but continuous haemorrhage alternate with amenorrhoea. During the bleeding phase oestrin is presumably being maintained at threshold levels in the absence of progestin. During the phases of amenorrhoea oestrin has either failed to reach the threshold level or continues to be above it.

The treatment during a bleeding phase is to administer progestin or a luteinizing gonadotropic extract: 1 Rab. U; both, given by intramuscular injection daily succeed in arresting the flow within three or four days. The re-establishment of normal rhythm is more difficult, but an attempt may be made to do so by applying a continuous luteinizing stimulus, such as 100 R. U. of a pregnancy urine extract three times a week for a month. Such a course may be repeated as indicated in the section on amenorrhoea.

Puberty Bleeding

The cause of this type of bleeding is not completely understood, but it is probably due to defective function of the corpus luteum. The menstrual rhythm is usually undisturbed and the condition is one of pure menorrhagia, though sometimes the menstrual cycle is shortened to three weeks.

Treatment consists in increasing the luteinizing stimulus 100 R. U. of a gonatropic extract are injected intramuscularly three times a week for four weeks. The course may be repeated as indicated in the section on amenorrhoea. The results of treatment are highly satisfactory and normal flow is usually established within three or four months. It is important to deal with this condition early, as it frequently leads to amenorrhoea or maturity bleeding if left untreated.

Dysmenorrhoea

When extrinsic causes of dysmenorrhoea, have been excluded, there remain three factors—nervous, psychological, and endocrine—the relative responsibility of which it is difficult to assess.

The cases of endocrine origin fall into two groups: those due to deficiency of oestrin, and those due to lack of progestin. Dysmenorrhoea often accompanies uterine hypoplasia. Menstruation, which is usually scanty, is taking place in an organ inadequately developed for such a function. There may be lack of co-ordination between the contraction of the uterine muscle and the evacuation of the blood from the narrow os. The dysmenorrhoea may disappear if the uterine hypoplasia is corrected. This may be accomplished by the oral administration of a compound of oestrin: 1 tablet of oestrone, "the strength of which varies from 1,000 to 50,000 I. U. according to the requirements of the case. They may be given continuously throughout the cycle without fear of inhibiting menstruation. If higher doses are required they may be injected intramuscularly, as in the course out-lined in the section on amenorrhoea.

The administration of progestin therefore alleviates the symptom in some cases of dysmenorrhoea, particularly when the pain begins a day or two before the onset of the menstrual flow, and is most intense on the first day of menstruation: 1 Rab. U of progestin is administered daily, commencing one or two days before the expected onset of the menstrual flow, and continuing up to the third day of the period.

Conclusions

During the past four or five years the pendulum of opinion has swung from unreasonable scepticism to unscientific optimism, and it is important to consider critically the present possibilities and limitation of endocrine therapy in menstrual disorders. The subject is still in its infancy, and it will probably take another five years for sufficient data to be collected to enable sound principles of treatment to be laid down and clinical results to be evaluated.

Local Anaesthesia in the Repair of Torn Perineum.

(From the Medical Journal April 10th 1937)

Technique

The patient having been placed in the lithotomy position with sterile towels in place and the vulva thoroughly cleansed and painted with such antiseptic solution as the operator is in the habit of using, Bonney's blue, flavine, etc., a 5 c.-cm syringe is filled with 4 per cent novocain solution. The skin edges of the tear are infiltrated throughout their entire length. The infiltration should be done internally, and the skin not punctured at all. This is usually all the infiltrating that is necessary, since the torn deeper structures are as a rule insensitive to pain. In tears involving the levators, however, I have found that the muscles are sensitive, and I recommend their infiltration. About 4 c. cm of 4 per cent novocain solution is sufficient for the average repair. The largest amount that I have used was 10 c. cm. for a complete tear involving the whole of the posterior vaginal wall, the rectum, and external sphincter. I recommend the repair being done within two hours of delivery, as at the end of this time sensation begins to return to the deep structures.

The healing has in all cases been most successful, and I have had none which have broken down or gone septic.

Conclusions

1. Suture of perineal lacerations is essential, and unless done thoroughly is useless.
2. The anaesthetic of choice is local infiltration.
3. Infiltration of the skin edges is usually all that is necessary, and should be done internally and the skin not punctured.
4. It is an extremely practical method for general practitioners.
5. It is very much pleasanter for the patient.
6. The use of general anaesthesia for the repair of even large tears is both undesirable and unjustifiable.

STANLEY WAY, M. R. C. S., L. R. C. P.

Histidine Therapy in Cases of Peptic Ulcer.

(From 'Journal of the American Medical Assn. Journal August 7th 1937.)

Summary

A brief survey of the literature on the use of histidine in the treatment of peptic ulcer revealed the interesting fact that the extremely favourable results reported by early investigators have not been borne out by more recent experimental and clinical research.

With the use of a graduated form of therapy, it was found that the majority of the patients studied obtained definite relief only when a modified Sippy treatment was instituted.

It was found that the injection of sterile water resulted in slightly more so-called cures than the histidine form of therapy. It must therefore be concluded that histidine not only lacks specificity but is no more beneficial than the injection of sterile water in the therapy of peptic ulcer.

An interesting phenomenon observed was that four of the patients (three of whom received sterile water and the other histidine) responded remarkably well solely to the parenteral method of therapy. Thus, one must seriously consider the value of psychotherapy in some of the uncomplicated cases.

The ease and rapidity with which a patient responds to therapy depends not alone on the remedy used but also and to an even greater degree on the etiologic and pathologic factors involved. Therefore, individualization of therapy is most essential.

Use of Insulin in Nondiabetic Malnutrition

(In pulmonary tuterintion)

(From 'Practitioner' London, May, 1937)

There are some who claim that insulin can be used in all cases of pulmonary tuberculosis. His (Ellman) own experience has failed to show any appreciable results in advanced active disease, although good results have been claimed in such cases. A patient whose appetite is poor, who falls to put on weight, who is afebrile, whose disease shows no gross evidence of activity and with whom the usual medicinal measures have failed to correct these symptoms is eminently suitable for insulin therapy. The author has avoided using insulin when there is fever, active pulmonary disease, hemoptysis or marked hypotension or when severe reactions follow the injections. It has been his practice to begin the course of treatment with a hypodermic injection of 5 units of insulin. This is given twenty minutes before the principal meal and is followed three hours later by a glass of milk or a table spoonful of dextrose to avoid any risk of hypoglycemia. The injection of 5 units is continued daily for the first week. This dose is increased by 5 units weekly, so that in the sixth week 30 units daily is given (15 before lunch and 15 before dinner). The course of insulin treatments is from two to three months. It can be repeated at intervals and the author has sometimes given two or three courses, although in many cases the effects of insulin have been maintained after the first course has been discontinued.

The treatment of Eclampsia

By

PIERCE RUCKER, M.D.,

Treatment

My initial dose is 20 c. c. of 10 percent solution, of magnesium sulphate. Frequently I have given a second dose of 15 c.c. and occasionally a third dose of 15 c. c. In a few cases I have used $7\frac{1}{2}$ grains (0.5 Gm.) of sodium amytal intravenously. I prefer the magnesium sulphate to the sodium amytal, because the former wakes the patient up when it stops the convulsions and the latter puts her to sleep. In such an event it is hard to know whether the patient is comatose or simply drugged. Nevertheless, sodium amytal is a drug to have around, because occasionally one drug will control the convulsions when the other will not.

2. Under the head of good nursing care, comes the avoidance of external stimuli, such as bright light, noises and jarring the bed. The patient should be kept on her side to lessen the chance of aspirating vomitus and other fluids in the mouth. The tongue should be protected during the clonic stage of a convulsion, and the nurse should be prepared to give artificial respiration if it should be necessary. Too much emphasis cannot be placed on rest. For this reason I am opposed to colonic irrigation, gastric lavage and purgatives. These patients are desperately ill and need all the rest they can get.

3. I feel very much better when the patient is putting out a good quantity of urine. Usually I rely on water or cream of tartar lemonade to promote kidney activity. The best way to give fluids to an eclamptic patient is by the stomach. If the patient is not awake enough to drink, one can slip a nasal tube into the stomach and pour in a pint of fluid every eight hours. When there is anuria or marked oliguria I resort to dextrose intravenously, varying the strength according to whether there is much or little edema present.

4. Digitalis has a definite place in the treatment of eclampsia. I give half a cat unit dose as soon as possible after I have

given the magnesium sulfate or sodium amytal. I have never seen edema of lungs when digitalis has been given. In the Medical College of Virginia Hospitals I was treating eclampsia with magnesium sulfate, rest and digitalis, with a maternal mortality of 5 per cent. The treatment was then changed to morphine, bromides and chloral and colonic irrigations and the mortality dropped to practically the same figure.

I have said nothing about delivery or terminating pregnancy, for the reason that I believe it has no place in the treatment of eclampsia. The patients who go into labor should be treated as conservatively as possible, which means in most cases episiotomy and low forceps under local anesthesia. When antepartum eclampsia is relieved and the patient is putting out a good quantity of urine, then comes up the question of terminating pregnancy. Unless one has exceptionally good control of the patient, it is unwise to let the patient leave the hospital undelivered. No eclamptic or recent eclamptic patient should have a general.

Summary

A series of 129 consecutive cases of eclampsia have been treated with an uncorrected maternal mortality of 4.65 per cent. The guiding principles in the treatment of these patients have been (1) stopping the convulsions with intravenous magnesium sulfate or sodium amytal, (2) the greatest possible amount of rest, (3) promoting kidney activity with fluids by mouth or dextrose solution intravenously, and (4) adequate dosage of digitalis.

The use of Adsorbents in Gastro-Intestinal Diseases.

By

EDWARD S. EMERY JR. M. D.

(From the Journal of the American Medical Association Journal)

January 16th 1937.)

Protoplasm is a colloidal substance, and therefore the behavior of biologic processes cannot be separated from the property of adsorption.

Adsorption is influenced by electrolytes such as the acids and their salts. Kaolin shows a high degree of adsorption in an acid medium and will release the same substances in an alkaline medium.

Hence the therapeutic use of adsorbents in the gastrointestinal tract involves a complicated interaction of compounds the results of which often cannot be fully predicated on test tube experiments.

Although the physician may desire to remove or render harmless the toxic substances, one cannot be sure that the object of medication will be fulfilled or that only desirable effects will be obtained. Therefore the physician who uses adsorbents is entering a field of therapeutics in which the pitfalls are not clearly indicated and the usefulness of which has not been definitely defined.

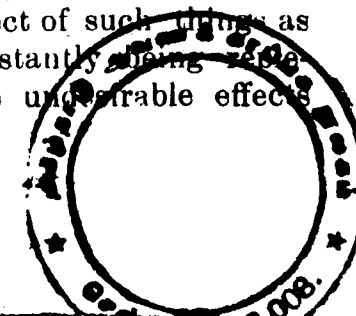
Adsorbents in Clinical use

Although many substance exhibit some qualities of adsorption, only charcoal and kaolin have been utilized in medicine to any extent, because of their adsorptive characteristics.

Limitations and possible dangers in the use of Adsorbents

Before prescribing adsorbents, one should keep in mind certain facts that limit their usefulness.

Because adsorbents are porous and are supposed to act by the removal of undesirable products, large quantities are necessary if one is attempting to nullify the effect of such things as toxins, bacteria, or gases which are constantly being replenished. However, large doses may cause undesirable effects.



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by removing elements such as vitamins, enzymes or essential minerals.

Because many therapeutic adsorbents are products of clay they have a tendency to settle and plug small openings, with resulting danger to the patient with a partial intestinal obstruction may be converted quickly to a complete one by the injudicious use of these substances, because of completeness with which these preparations lose water, hard concretions may form, causing serious trauma to the colon or even perforation.

The Therapeutic use of Adsorbents

The diarrhoeas.—Adsorbents have been advocated for diarrhoea and, as previously pointed out, kaolin was used in China for this purpose long before it was recognised in the Western world. Its apparent success in the treatment of cholera suggests its possible usefulness in the treatment of other diarrhoeas. Unquestionably it seems to have a beneficial effect in certain cases, but there are no exact indications for its trial. A judicious macologic action, which we do not possess about kaolin. Moreover, there are many incidence of diarrhoea in which the exact cause cannot be determined.

There seems no reason to expect results on patients whose diarrhoea is occasioned by nervousness, exophthalmic goiter or fat intolerance. Conditions like pernicious anemia and amoebic dysentery must be suitably treated with such preparations as liver and the anti amoebic drugs. The adsorbents are contraindicated in cancer and deficiency diseases. For the ordinary acute attacks of diarrhea the usual treatment with bismuth preparations and opium prove satisfactory, and for diarrhoeas due to specific agents such as worms the appropriate treatment can be instituted.

However, substances such as kaolin are worthy of a trial in patients suffering from severe food poisoning or from an infection with a dysenteric organism. The loss of fluids must be made up by the use of salt solution either intravenously or, by hypodermoclysis. All food should be stopped for a period of one to two days, during which time kaolin is given. To be

effective, large doses are required, and from 50 to 100 gm. of kaolin should be administered in water every three hours until the number of movements has begun to lessen; then the amount at one dose may be decreased, and the interval increased between doses, according to the judgement of the physician in charge.

Treatment of Idiopathic Ulcerative Colitis. Kaolin has been used in the treatment of idiopathic ulcerative colitis to the satisfaction of some clinicians. However, the results do not appear as striking as in the type of case already described. In the ordinary food poisonings, for example, the infection is found throughout the small intestine as contrasted with ulcerative colitis, in which most of the lesions are in the colon. In the former group the adsorbents has a chance to act shortly after ingestion, whereas in ulcerative colitis the material must traverse the length of the small intestine before reaching the troubled area. One would not expect to obtain results unless a large enough excess is administered to permit kaolin to reach the colon in a state capable of exerting an adsorbent influence. Such an excess over any length of time involves the danger of removing vitamins and other substances essential to the individual. Hence it seems probable that the potential dangers offset the potential value of this medication in ulcerative colitis.

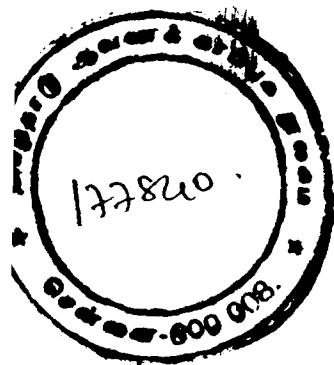
Diverticulosis of the Colon.—Kaolin and barium sulfate have been used in diverticulosis of the colon with some reported benefit. There is another group of patients with diverticulosis who have transient attacks of diarrhoea, and it is possible that that this is the type of case of diverticulosis in which the adsorbents are said to give good results. One should avoid prescribing these inert substances in the presence of a diverticulitis, because the danger of a perforation or obstruction is a real one.

The Dyspepsias.—So little is known about the cause of dyspeptic symptoms that a rational approach to the subject is difficult. However, a word of caution should be spoken of them because adsorbent drugs, particularly charcoal, have been administered for dyspeptic symptoms in the past. All patients suffering from

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these symptoms should have thorough examinations. After the presence of organic disease has been ruled out, the commonest cause is nervousness. Its recognition and treatment are essential if one is to obtain satisfactory results. Palliative medication may be of value during the course of treatment and all physicians see a certain number of individuals complaining of gastrointestinal symptoms for which no adequate explanation can be given.

Autointoxication.—Several observers have reported that the continued use of kaolin will result in a change of the intestinal flora from a proteolytic to an aciduric one. The suggestion is made occasionally that adsorbents are indicated in the treatment of so-called autointoxication. But, the use of adsorbents for this purpose is not warranted in our present state of knowledge.



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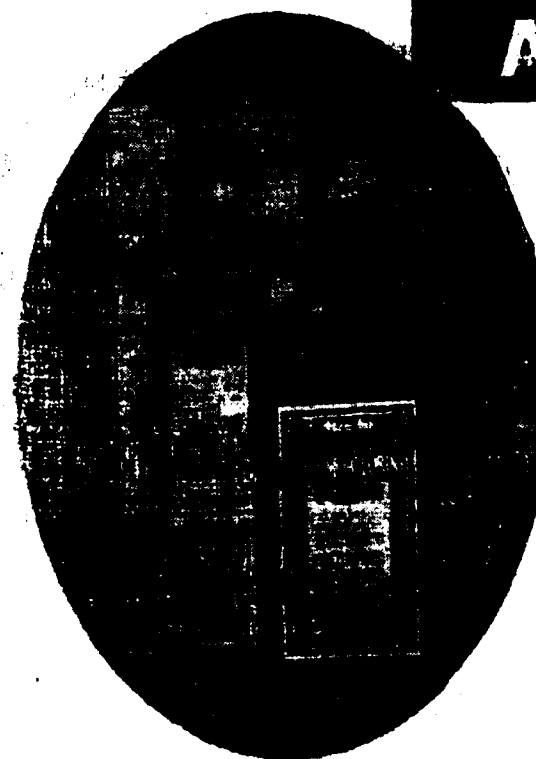
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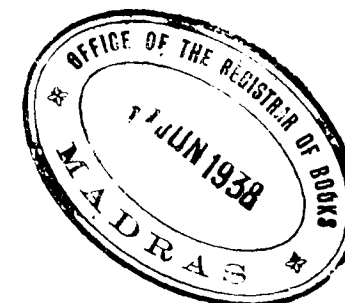
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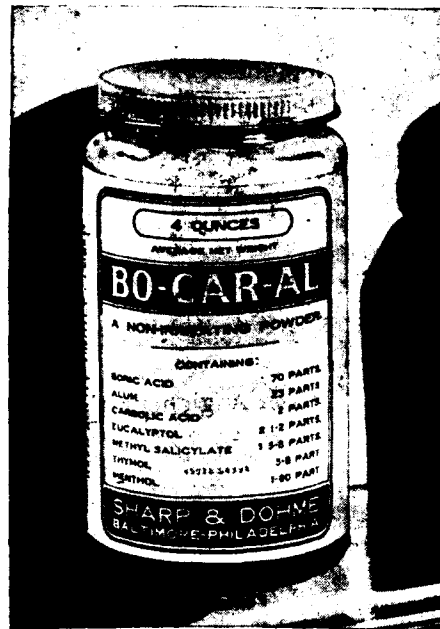
CONTENTS.

- I. Pulmonary Tuberculosis. (Methods of detection).
- II. Bed Sores & their treatment.
- III. Effective use of Epinephrine inhalations in Angioneurotic Edema.
- IV. Vaccine against the common cold.
- V. Treatment of Phthisic Night Sweats.
- VI. The effects of toxic doses of Benzyl Methyl Carbinamine in man.
- VII. Radiologic Treatment of Menopausal Hemorrhages.
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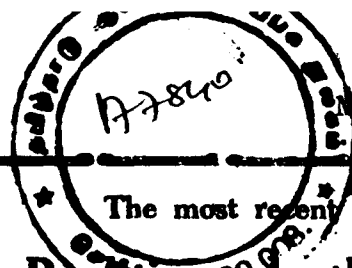
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Pulmonary Tuberculosis

Methods of detection

By

ANDREW MORLAND, M.D., M.R.C.P.

(From the Practitioner, November 1937.—Page 521.)

When the patient presents himself for examination in the early stage his chest must be carefully examined, differences in the percussion note between the two sides, especially the apices, duly noted, and in the stethoscopic examination local differences in air entry looked for in addition to the search for rales, which are most easily picked up during the sharp intake of breath which follows a cough at the end of expiration. A small proportion of early lesions, superficially situated, produce physical signs which may be elicited in this way, but the great majority do not give rise to any abnormal physical signs. The stethoscope rightly occupies a place of honour in clinical medicine, but its uses do not include the elimination of pulmonary tuberculosis, and if applied to this purpose it becomes a public danger, as most cases are no longer early by the time physical signs appear.

The detection of tubercle bacilli in the sputum is, of course, the only absolutely certain method of diagnosis and at least three sputum examinations should be made whenever there is the slightest suspicion that these disease is present. Should there be no sputum an expectorant mixture containing potassium iodide may be successful in producing a specimen for examination. Although most early cases have little or no cough and no

sputum an appreciable number pass through a stage early in the course of the disease during which a positive sputum may be obtained. In the early tuberculous infiltrations described by Assmann the typical history is that of a febrile attack, of only a few days' duration, towards the end of which there is a cough and frequently a little positive sputum; the symptoms usually disappear quickly but within a few months the patient develops signs of phthisis which is often of a severe type. The initial attack is usually taken for influenza, although the absence of any other cases in the neighbourhood may arouse suspicions. The belief that tuberculosis frequently follows influenza has been proved to be erroneous by the absence of any increase in notifications following widespread of the former disease.

Radiology has made a revolutionary change in the diagnosis of pulmonary disease, and controversy has arisen concerning the relative merits of film and stethoscope. Defenders of Laennec's tube have dwelt at length on the difficulties of radiological interpretation. Difficulties there undoubtedly are, although these are becoming less with improving knowledge and technique; but the subject is not one for controversy of this kind, early diagnosis being so difficult that every method must be made full use of and given due weight in the final decision.

There is reason to believe that in the majority of cases radiological signs precede symptoms and the logical conclusion from this has been drawn by D'Arcy Hart in his recent Milroy Lecture in which he maintained that the mass examination by X Rays of groups of apparently healthy people was the only way of effectively increasing the proportion of cases diagnosed in the early stage of the disease.

Suggestive Symptoms.

Pulmonary tuberculosis is not a difficult disease to diagnose when once suspected; it is true that in rare cases the disease may exist (as shown by a positive sputum) without radiological signs, but in the great majority of cases a normal film properly taken and interpreted will be sufficient to exclude the disease with only a small margin of error. A doubtful infiltration,

coupled with suggestive symptoms, should lead to a presumptive diagnosis and suitable treatment, but not necessarily notification.

Among the symptoms for which X ray examination is essential the most obvious is hamoptysis; no chest has been thoroughly examined that has not been X-rayed and this symptom is so strongly suggestive of tuberculosis that it is inexcusable to dismiss the patient on the strength of a negative physical examination and sputum test even if he has a sore throat from which the blood might have come. Pleurisy is also presumptive evidence of tuberculosis and requires radiological examination as soon as the patient is fit enough; even if this shows the lung parenchyma clear on both sides the patient remains a suspect and, after a period of treatment on sanatorium lines, not necessarily in a sanatorium, he should be kept under observation for several years, the weight carefully controlled and the slightest departure from normal health should be the excuse for further X-ray examination. Cases of anal fistula should be treated in much the same way.

Cough is usual in smokers and common in others; it is often absent in early disease; when it persists after a febrile attack, usually referred to as "influenza" it should excite suspicion. Chronic bronchitis with cough and sputum is typical of fibroid phthisis in elderly people; such persons are dangerous carriers of the disease although repeated sputum examinations may be negative; a timely X-ray may save the lives of children and others living in close contact with such cases.

A slight evening rise in temperature is often absent in early cases but when present it is important. Small temperature variations can only be established by careful technique; as gentle exercise habitually causes an appreciable rise in the temperature of normal subjects, it is important that the suspect of tuberculosis should have been at rest for at least half an hour before temperature taking. Axillary temperatures are useless, and mouth readings, although less accurate than rectal, will be the usual method used; the best times for temperature taking

are (1) awakening, (2) 6 p. m., (3) 9-30 p. m. The end of the thermometer must be placed well under the tongue and the mouth kept closed for at least five minutes. A rectal temperature of 99° F taken in this way is definitely above normal.

Loss of weight, important when it does occur, is often absent in early cases. The association of consumption with wasting has caused the disease to be overlooked, with disastrous results, in many well-nourished people.

The phthisical chest occurs in normal as well as in tuberculosis subjects, and most patients with early phthisis have chests of normal shape.

Amenorrhoea is unusual but may occur, especially in cases in which the onset of the disease has been preceded by a long period of overwork and worry.

The most constant and typical symptom of early pulmonary tuberculosis is lassitude which is often associated with anorexia and vague digestive disturbances.

Radiological examination is certainly not frequent enough and those who fear to waste their patients' or the public's money may be reminded that one positive early case in a hundred means a great saving of money as well as the probable saving of a life and further dissemination of the disease.

Summary.

(1) Early pulmonary tuberculosis has no physical signs and often no symptoms.

(2) When suggestive symptoms are present or when the history give rise to suspicion X-ray examination of the chest is essential.

(3) Physical signs in the chest and the detection of tubercle bacilli in the sputum have great positive value in the diagnosis of pulmonary tuberculosis, but should never be relied on in eliminating the presence of the disease.

Bed Sores and their treatment.

(From the Practitioner—March 1937.)

Mc. Neil Love divides bed sores into acute or trophic and chronic or postural. The former are less common and are associated with injury to or disease of the nervous system. These commonly fail to respond to any form of treatment. The causes of the latter, he divides into those due to pressure, trauma, maceration, malnutrition of the skin. Pressure sores mostly occur on the bony prominences and are due to prolonged pressure causing malnutrition of the tissues. Prevention is more important in the treatment of these postural sores so that the nurse in charge of the patient should arrange to change the position on alternate sides every hour or so at the same time keeping watch on the skin over the pressure area.

Those sores which are due to trauma are preventable. And the prevention consists in avoiding wrinkling of the draw-sheet, which must be kept taut, meladjustments or rings and pads which are utilised to distribute pressure. Abrasion due to over-lain biscuit crumbs is the traditional cause of the bed sore of this nature. Linen sheet should be soft, pliable and non-irritating. Dusting powder should be of an impalpable nature not containing small pieces of grit which may cause abrasion of the skin. Vigorous rubbing with the powder will bring about a breach in the surface of the skin which may result in a sore.

Those due to malnutrition of the skin are to be avoided by careful nursing, by attending to the back which is sponged, dried and rubbed with an astringent and finally powdered. The skin is washed and gently dried with a soft towel and massage is applied in the form of gentle kneading and effleurage. A stimulating astringent preparation is rubbed into the skin. Mc. Neil Love is against using methylated spirit which is definitely harmful as it contains substances which are liable to irritate the skin. The skin is dusted with some powder such as Dermatol (Bismuth subgallate), Talcum Powder, or equal parts of boric acid, zinc oxide and starch, taking care to see that it contains no grit. The treatment is carried out several times a day.

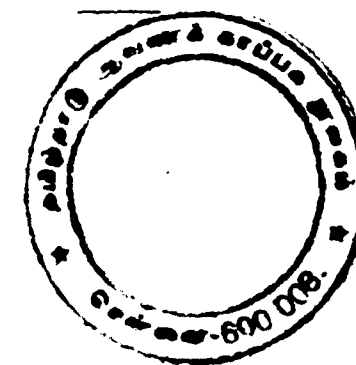
Those bed sores due to maceration are caused as a result of soddening of the skin due to sweat, urine, faeces pus. In the general treatment of these sores, he draws attention to general nutrition and the well-being of the patient which are to be attended to. He quotes Hare who recommends exhibition of iron in the form of Tr. ferri perchloride in full doses of 20 minims four-hourly. Insulin is also recommended even in non-diabetic patients and acts remarkably in some indolent sores. Healing commences two or three days after the initial injection. The injection given is 10 units once a day or five units twice daily.

In the treatment of threatened bed sore, he deprecates the use of moist dressings and ointments. The aim should be to harden the skin if it is unduly soft. For this purpose he recommends application of.

If the skin is already dry and harsh he strongly recommends the use of Elastoplast which he considers excellent, provided it is not stretched before application and that it is applied smoothly. Over smaller areas he recommends the application of several layers of Collodion Flexille which may prevent the skin from cracking. For inevitable bed sores, the aim of the treatment should be to minimise the amount of destruction to the tissues. For this the best local treatment is a spray of freshly prepared 5% solution of tannic acid in water at hourly interval and drying the area with electric hair drier or dry heat of the electric light. The adherent coagulum forms after about 20 applications. If pus collects under the coagulum, it is wither partly snipped away or removed entirely after softening by application of gauze soaked in liquid paraffin. In uncomplicated cases, the coagulum remains until healing is well advanced when it may be trimmed until finally the portion detaches itself. Those bed sores where ulceration has already taken place cause anxious time to the attendants as these sores in an alarming manner and cause toxic absorption. Greasy and oily preparations are unsuitable. He recommends the use of Elastoplast which gives very satisfactory results. Two pieces of elastoplast

are applied so as to cover the ulcer and the surrounding skin. If the sore is of great diameter than the width of the bandage two pieces are applied side by side and kept together with a third piece at right angles. It is important that Elastoplast should not be stretched before it is applied and is left in position until it is loosened by the discharge which may be at any time from one to seven days. The loose plaster is removed, the ulcer is cleansed with sterile gauze and the plaster is applied. This process is repeated as often as necessary. The advantage of this method of treatment is that the granulations are unimpaired by frequent dressings, and possibly that the retained discharge possesses a proteolytic power which liquefies the dead tissue. The advantage of the elastoplast treatment is its simplicity and that no skilled nursing is needed. When the stage of healing is reached and the discharge becomes serious he recommends 10% Ichthyol in glycerin which usually expedites healing in a very satisfactory manner. In later stages he recommends more stimulating dressings to encourage growth of epithelium such as Red Lotion or equal parts of zinc oxide and Resin ointment.

(Practitioner, March, 1937. p. 277.)



Effective use of Epinephrine inhalations in Angioneurotic Edema.

By

EDMUND W. KLINFELTER, M.D., YORK, PA.
(From the Journal of the American Medical Association,
November 27th, 1937.)

Summary.

1. Oral inhalations of epinephrine 1:100 solution have been found effective in preventing the development of angioneurotic swellings.
2. The necessity has been stressed of the early use of epinephrine inhalations before or shortly after the swellings have started.
3. Epinephrine in the fully developed acute case has been found of little benefit in reducing the swellings.
4. Continued use of inhalation of epinephrine in angioneurotic edema appears to exert a curative influence.

Vaccines Against the Common Cold.

(From the Journal of the American Journal of Public Health, New York.)

Bristol gives the results of treatment with standard stock vaccines or serobacterins from cultures of the common pathogenic micro-organisms of the respiratory tract in six separate groups of industrial subjects (totaling more than 19,000). The time over which this treatment against the common cold was available to the different groups varied from seventeen to five years. On the whole the study indicates an apparent reduction in the severity, duration and complications of acute respiratory diseases. There is little evidence that such vaccines have materially reduced the incidence of the common cold. To the extent that such vaccines reduce the length of disability and absence from work, they apparently may be of some value in the industrial health program. While no one procedure alone, such as the use of vaccines, should be relied on entirely to build resistance against colds, a broad program of preventive treatment should be encouraged particularly among cold-prone employees, in co-operation with their family physicians.

Treatment of Pythysic Night Sweats.

(From the Journal of the American Medical Association
dated 27th November, 1937.)

Hofmann cites factors and investigations which prove that the secretion of sweat is influenced by the cerebral cortex. In the treatment, however, this influence is usually disregarded. The author decided to try a central modification of sweats, particularly the central suppression of the sweats, generally say that their sleep is restless and superficial. If they are given an ordinary hypnotic (barbital), that is, one which influences the brain stem, the results are quite favorable. However it should be understood that the patient is not merely prevented from noticing the sweating by his deeper sleep; he actually does perspire less. The results are even better if the hypnotic influencing the brain stem is combined with one which influences the cerebral cortex (sodium bromide). The author recommends the combined administration of these two types of hypnotics.

The effects of toxic doses of Benzys Methyl Carbinamine (Benedrine) in Man

By

SYDNEY P. WAUD, M.D., CHICAGO.
(from the Journal of the American Medical Association
November 27th 1937)

Conclusions

1. Continuous inhalation of benzedrine can produce, definite toxic effects characteristic of sympathomimetic, excitation, stimulation of the central nervous system and depression of the cardiac muscle.
2. Ephedrine and benzedrine are pharmacologically very similar in toxic doses.
3. Benzedrine in toxic doses reduces libido moderately after sympathetic stimulation subsides.

4. The effect of benzedrine is marked but relatively temporary.
5. Benzedrine in toxic doses is a diuretic in normal individuals.
6. The stimulation of the central nervous system is marked but relatively temporary and is always followed by marked fatigue and mental depression when toxic doses of benzedrine are absorbed.
7. Permanent organic changes are probably negligible with normal doses of benzedrine over long periods of time.
8. The margin of safety of benzedrine is great in normal persons.
9. The likelihood of addiction is quite possible.
10. The indiscriminate use of benzedrine is very unwise.

Radiologic Treatment of Menopausal Hemorrhages.

*(From the Journal of the American Medical Association
dated 27th November, 1937.)*

Von Massenbach reports experiences with roentgen and radium irradiations on women of the menopausal age who were admitted to the clinic on account of hypermenorrhea. He discusses principles according to which the method of treatment was decided, the dosage of the radium and roentgen irradiations and the results of the treatment. He says that, if curettage revealed a cystic glandular hyperplasia of the uterine mucosa, irradiation was done, provided the woman was past the age of 40. However, if there was only hypermenorrhea and slight or no cystic hyperplasia, irradiation was resorted to only if the woman was more than 45 years. Regarding the dosage, the author says that amenorrhea is produced by applying to the ovary from 1,800 to 2,000 mg. radium element hours, or 290 roentgens. Treatment with radium is given the preference in patients who have suffered severe loss of blood, because it is

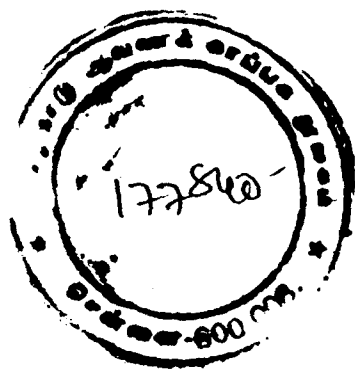
most reliable in effecting arrest of the hemorrhage. Roentgen treatment was employed in women in whom an inflammatory process could not be definitely excluded or in whom there existed deformities of the uterine cavity. In comparing roentgen and radium treatment as regards the after-effects, it was found that the former working capacity was re-established in more than two thirds of the women who had undergone radium treatment but in only about half of the women who had received roentgen treatment. In view of the superiority of the radium treatment in this respect, it was used chiefly in women of the constitutional type that is subject to symptoms of abolished function, provided of course that inflammatory processes of the adnexa and deformities of the internal surface of the uterus could be excluded.

Diabetis and Vitamin C.

*(From the Journal of the American Medical Association
dated 27th November 1937.)*

Pffeger and Scholl decided to determine how saturation with vitamin C affects the vitamin C metabolism of the carbohydrate metabolism of patients with diabetes mellitus. They accepted elimination in the urine as a measure of complete saturation. They determined the vitamin C deficit by means of the saturation method of Harris. They detected a hypovitaminosis in most diabetic patients; in some the deficit was as high as 2,500 mg. After the normal biologic status had been attained, attempts were made to influence the carbohydrate metabolism. In diabetic patients who were not treated with insulin the civitamic acid exerted no influence on the sugar content of the blood and urine, but the combustion of the acetone bodies was favourably influenced. After saturation with Vitamin C, the action of insulin was noticeably intensified by

cevitamic acid, so that the carbohydrate metabolism of the diabetic patients could be regulated with smaller amounts of insulin. In persons without diabetes, saturation with vitamin C did not influence the fasting blood sugar or the blood sugar after tolerance tests. The sugar curves that were obtained after the administration of insulin revealed a noticeable intensification of the insulin effect following saturation with vitamin C. The same effect, although in a milder degree, could be determined in diabetic patients. As explanation of the increased responsiveness to insulin on the part of the organism that is saturated with vitamin C, the authors assume that the civitamic acid produces an increase in the capacity of liver to assimilate glycogen, or an increase in the tissue metabolism either directly or by activating the insulin. In all diabetic patients irrespective of the modification of the sugar metabolism, civitamic acid improves the general condition: the fatigue disappears, the patient feels fresher and the vitality is increased. The authors direct attention to the vitamin C deficiency of the customary diabetic diets and stress the value of the medicinal administration of civitamic acid.



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