THE MISCELLANY

OF

THE TRICHINOPOLY DISTRCT MEDICAL ASSOCIATION
(REGISTERED)
Affiliated to the Indian Medical Association

Vol. IV | JANUARY 1938 | No. 12

CONTENTS

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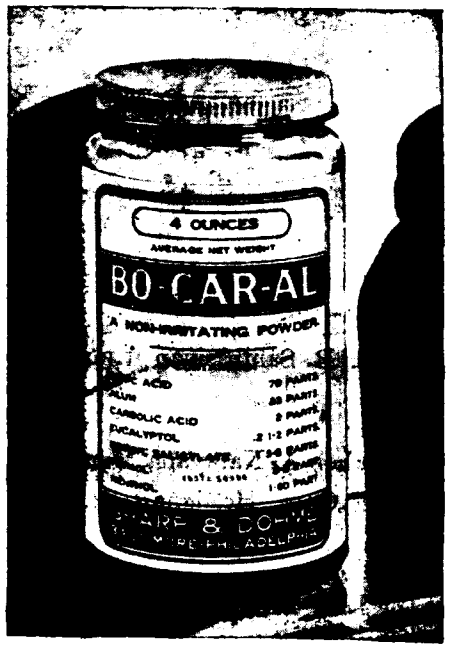

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MISCELLANY

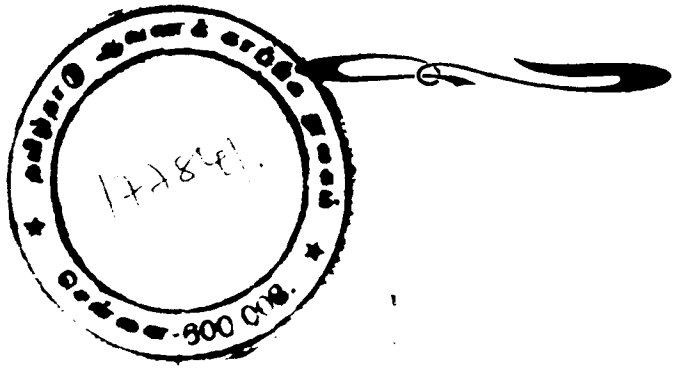
OF

The Trichinopoly District Medical Association

(REGISTERED)

JANUARY 1938

The Editor requests contribution on Medical, Topical and News Subjects from Members of the Association and other medical men. Contributions should be sent typed in duplicate and signed by the contributor. In case where it is desired to write under a non depiume the signature must be included for the information of the Editor as a token of good faith.



Editorial.

In penning these few lines I hope I am voicing unanimous hope and desire that this Association of ours grow stronger and stronger and the ideals we have placed before us are nearer fulfilment.

The office bearers and new Ideas have come in with the New Year but I am sure the same old sentiments will help us through.

It is high time this Miscellany of ours was more than a compilation—let it voice our original thoughts and mirror our peculiar problems. In a large membership like ours there should be no dearth of original and interesting material, medical, topical or otherwise. Let us make this Miscellany the link during the days till our next meeting. It means the interest and co-operation of every member who should feel the onus of a successful publication as much as do the editor.

Let us use the columns for discussion of and elucidation of our controversies so that we will have our meeting free to discuss more helpful things.

Will all our readers, members or otherwise take this invitation to contribute to the pages of the Miscellany? Will they also let it serve as a reminder to do their bit for our Association and our Journal.

The most interest bit of Medical News has been the abolition of the L. M. P. class. One wonders how other provinces have not moved as quickly in this direction. The results are obvious. This measure has not come a day too soon and will bring unity and self-respect among us.

The Honorary System is with us and is coming to stay with a vengeance. It is going to make a heavy call on the honoraries. But where is the honorary to turn for a living, for that security that helps him to carry out unfettered and wholeheartily the practice of his profession?

Ex-Students of Vienna that Mecca of every Post Graduate is passing through a crisis. One wonders how soon the change will come and those revered masters will be scattered to every corner of the globe and have to begin their life work again.

B

Food Problems in South India.

(DR. R. SAMBASIVAN M. B. B. S., TRICHINOPOLY.)

The Subject is so vast that we do not know really where to begin or where to end. We certainly cannot cover the whole field in any single lecture or paper. Under these limitations, we shall try to make a fair survey of the more important aspects of these problems.

The staple diet in South India is predominantly Rice. Rice is the biggest agricultural production in South Indian soil. It is axiomatic that the basal foodstuff of a community varies with the scope for agriculture in respective localities. Likewise, the quality of the stuff is dependent on the traditional activity of the Community. This explains how rice has come to be the staple diet in South India.

We shall now consider the value of rice from standpoints:

(*a*) Nutritive value.
(*b*) Vitamin value.

These two values are affected by various factors:—

(1) Soil conditions
(2) Irrigation methods
(3) Milling and polishing
(4) Parboiling
(5) Washing, soaking & boiling (cooking)

1. *Soil Conditions*:—Rice grown in the various districts of this Presidency varies greatly in its nutritive and vitamin values. These values are lowered in the 2nd crop grown in the same field, owing to the fact that fertility of the soil deteriorates after the 1st crop. Further cattle-manured soil gives better value than soil manured with complete chemical manures, other conditions being the same.

2. *Irrigation*:—Other factors remaining the same, wetlands deltaic areas (under channel irrigation) where water is allowed to stagnate through the Paddy-cultivation season, give a produce much lower in nutritive and vitamin values than dry lands under Rain-fed conditions. This has been experimentally investigated on rates (McGarrison). One group was put on Basal

Diet plus wet-crop rice (1 gm) Increase in weight on 70th day was 57.4%. A second group was put on basal diet plus dry crop rice (1 gm.). Increase in weight on 70th day was 92.6%. This is in favour of dry-crop Rice.

3. *Milling and Polishing*: Vitamin B is lost. Iron also is lost.

4. *Parboiling*: This reduces vitamin A. But vitamin B is preserved to a certain extent.

5. *Washing, soaking and boiling*: (*cooking*): Removes what little vitamin B is present. In an experimental test with Rangoon Rice, animals developed Polyneuritis more rapidly on washed, soaked and Boild Rice than on Raw, uncooked rice.

Nutritive value of rice: The protein content of rice is only half that of wheat. In proteins, it is the poorest of all cereals. Having recognised this fact, we shall now proceed to consider the Protein value of rice under certain practical conditions.

25% protein is lost in polishing, parboiling and washing. (Fat and corbo-hydrate values are unaffected by such processes). In this connection mention may be made of the value of cooking rice in the recently introduced Brass domestic cookers-which does not subject rice to washing and soaking processes.

To satisfy normal metabolism, rice-eaters have to take it in quantities quite out of proportion to the nutriment in contains. This bulky intake is bad. This bulk interferes with efficient Protein absorption. The following observations (M. C. Cay) will illustrate this point clearly:—

Protein absorption (in terms of nitrogen) for various quantities of rice intake.

Diets containing	30	oz. dry rice.	6.55	gm.	nitrogen absorbed
,,	26	,, ,,	7.55	,,	,,
,,	24	,, ,,	8.00	,,	,,
,,	23	,, ,,	8.09	,,	,,
,,	20	,, ,,	8.40	,,	,,
,,	19	,, ,,	8.47	,,	,,

From this it is clear that the degree of protein absorption from rice varies inversely with the total volume of any deit. In mixed diet, containing a large volume of rice, not even 50% of total protein present will be absorbed.

Vitamin value of Rice:—Vitamin A is found in traces in the bran and the germ. It is the poorest of all cereals, in vitamin B content. (further loss occurs in milling, polishing, soaking and washing)

Rice constains no vitamin C or D.

Comparison with wheat. Wheat contains 2½ times more protein than rice; there is less manganese in rice; wheat is considerably richer in vitamin B than rice. (Reference is to whole wheat made into flour and un-sifted and not the white flour of commerce).

Comparison with cholam and cambu: From exprimental investigation on rats, Mc Carrison has found these two cereals are much superior and in vitamin values, as a staple diet to even the best quality rice.

Though these have better protein value chemically than whole wheat, it has been found wheat contains proteins of higher biological value (resembling active proteins of animal tissue) easily convertible into body Proteins.

Dhal: For all practical purposes, experimental investigations established that dhals possess the same nutritive and vitamin values as whole wheat.

Dhal cannot be used as a staple diet. A rice eater can absorb and utilise only 5 oz. of dhal daily. Beyond this quantity it acts as an intestinal irritant often setting up diarrhoea.

On the other hand, whole wheat can be utilised by the body in twice this amount i.e. 10 oz. daily, with sufficient intake of vitamins A & D (in the form of butter or ghee)

5 oz. of dhal are equal to 500 calories.
10 oz. of dhal are equal to 1000 calories.

So, whole wheat is preferable to dhal as staple diet though both are approximately of the same nutritive and vitamin values.

In the South Indian mixed diet, dhal is a very useful accessory, supplying extra proteins and vitamins to balance the deficiency in rice.

Faulty nutrition in relation to incidence of disease in man:-

In this connection Mc Carrison has published results of over two years of large scale experiments on rats. He put up two communities of albino rats in two rooms. Both communities were made to live in an exactly similar environment in the matter of housing, cleanliness, and comfort.

The control group was fed on well-balanced diet composed of natural foodstuffs, *i. e.* whole wheat, pulses, raw milk, butter, fresh vegetables, and fresh meat, with fat and bones occasionally all these so combined as to provide in proper amounts and proportion all elements and complexes necessary for normal nutrition.

The experimental group, on the other hand, was fed on ill-balanced diet, composed mainly of cereals, vegetable fats, with little or no milk, and without butter or Fresh vegetables.

The contrast between the two communities was remarkable. The properly-fed animals were remarkably free from disease while the improperly fed animals were much subjected to disease.

Those faultily nourished showed a large proportion of the diseases incidental to humanity, whereas in the stock rates (control group), within the same period of over two years, no case of illness, and no infantile mortality occured.

Can these experiments help? Yes. This is as it should be even in man. "For, nutritional phenomena are basal phenomena. They differ in detail, but are fundamentally the same in all mammalia" (Hopkins)

The faulty nutrition of many of our communities creates only a too ready soil for everyday infections, lowers the resistance, and tends to produce an underdeveloped short-lived race.

Robert Mc.Carrison has pointed uot bymeans of an illustrative chart that leprosy (T. P.) is most common in provinces where the food is least nutritous, On this basis, and from other observations, he has classified the national diets of India in order of merit as follows :—

1. Sikh.
2. Pathan.
3. Mahratta.
4. Gurleha.
5. Canarese.
6. Bengali.
7. Madrasi (ranked last).

Tentative solution for nutritional Problems :— Various schemes have been suggested for urban areas among which may be mentioned allotment schemes, communal vegetable gardens, municipal Diary and Poultry Farms. These schemes relate solely to the so-called "Protective Foods"—milk vegetables, and fruits ; whereas, with regard to staple foods, such as cereals and pulses, practical difficulties of storage and distribution do not arise for they are easily marketable commodities, easily stored, free from risk of decomposition, for months. Their vitamin and nutritive values are practically unaffected by storage.

On the other hand, milk, vegetables and fruits are really practical problems. They cannot be stored for more than a few hours or some days. They cannot be handled without risk of deteriorating in quality. They are subject to decomposition in tropical climate. So, we shall now consider the various schemes mentioned above with regard to these "Protective Foods" (i. e. supplement to staple foodx)

Allotment scheme : Individual plot of ground in Municipal or suburban areas can be allotted to private citizens. Supply of food minimum quantity of milk fruits, or vegetables to the local Health centre should be guaranteed by the holders of these plots, as compensation for the freehold. The health centre should be the medium of distribution to the population, free to the indigent, and at cost to the well-to-do.

Communal vegetable gardens : Plots of ground in Municipal and suburban areas can be assigned to local co-operative societies municipal ward committees, private corporations, or other recognised private bodies. These various bodies should grow vegetables and fruits on these assignments, and distribute them among their own members in return for their paid memberships.

Municipal diary and poultry forms : Every municipality can run a separate dairy form and a poultry farm. Abundant and fresh milk supply can in this way be undertaken by the Municipal health authorities. Poultry and eggs of improved quality and bread can be maintained for sale. These activities can very easily be made self-supporting and further, they can grow to be a substantial source of revenue to the municipalities.

For all these schemes, the Municipal Health and Welfare centres can be the media of distribution. The Railway Peripatetic co-operative store wagon can also undertake distribution work. Private merchants and brokers cannot be entrusted with this work for obvious risks are involved in that, viz. profiteering and adulteration.

The cardinal factors to combat in the solution of these problems are (in the words of an eminent authority) "Prejudice, Penury, Ignorance, and Habit."

The Trichinopoly District Medical Association Trichinopoly.

Rules

1st January 1938.

1. The name of the Association shall be **The Trichinopoly District Medical Association.**
2. The association shall be located in Trichinopoly Town.
3. The objects of the Association are :—

(*a*) To promote scientific medical knowledge in all its branches,

(*b*) To promote unity and comradeship amongst members of the medical profession.

(*c*) To guard the interest of the medical profession.

(*d*) To subscribe, print and publish and distribute medical journals, books and pamphlets and other literature.

(*e*) To hold meetings, conferences, exibitions etc., for the promotion of public health and medical or surgical knowledge.

(*f*) To organise Library, Laboratory, Dispensary, Clinic, School, Hospital or other institutions for the promotion of public health or of medical and surgical knowledge.

(*g*) To acquire, erect, construct or purchase any buildings, works, property or machinery necessary or convenient for the association's business.

(*h*) To amalgamate or enter into working agreement with any other association, union or interest, carrying on or broposing ro carry on any business within the objects of this Association.

(*i*) To do all and such other things as are incidental or may be deemed by its Managing Committee conducive or expedient to the attainment of the above objects or any of them.

Constitution

4. The association shall consist of:—

(*a*) Ordinary Members.

(*b*) Honorary Members.

5. The Funds of the Association shall consist of subscription from the members, any donation from public bodies and private gentlemen, and money that is available from the proceeds of sale of periodicals and such other property of the Association, and such of the properties as may be acquired from time to time. Accounts shall be kept from 1st November to 31st October of each year.

Members

6. The Association shall consist of members whose names are found in the Register of Members of the Association.

7. Any one who possesses a Registerable medical qualification in alopathic medicine, is eligible to be an Ordinary Member.

8. *Honorary Members*: Persons of eminece, distinction and culture and such others as may have done valuable services to the Association may be elected by the General Body, and these shall be medical men.

9. Any person qualified to be a member may be enrolled as such on applying to the Secretary in writing and on the application being accepted by the Managing Committee.

10. Every Ordinary Member will pay a subscription of annas eight payable by the 25th of every month. Every Ordinary Member who is newly enrolled will also pay an entrance fee of Re. 1/-.

11. Only members who have paid their subscription till 31st October are eligible to vote in the Annual General Body Meeting.

12. Any Ordinary Member who is in arrears of subscribtion loses the right to vote at subsequent meetings. Members who are in arreas for more than six months may be removed from the rolls subject to the approval of the Managing Committee.

13. Such members may be readmitted on payment of arrears together with an entrance fee of Re. 1/-.

General Body

14. The General Body shall ordinarily meet once a year to adopt the Annual Report and Balance Sheet of the preceding year and elect new office bearers.

15. Each ordinary member only is entitled to a single vote, either in person or by proxy.

16. Proxy forms issued only with the seal of the Association under the authority of the Managing Committee are valid.

17. Subjects and agenda for a General Body Meeting shall be brought to the notice of the Secretary full fifteen days before the date of meeting.

18. The election of offlce-bearers shall be as follows:

The Honorary Secretary shall circularise all the members with a return slip one month before the meeting asking them whether they are willing to stand as office-bearers. On the members signifying their willingness within ten days from the

date of issuing the circular a list of such candidates will be circulated to all the members not less than ten days before the Meeting. At the meeting each member will be supplied with a list of candidates in which he will mark P. (President) V. P. (Vice President) S. (Secretary) T. (Treasurer) and C (Committe) against those names he considers suitable for such posts. He will then retain on the list the names of the remaining members whom he wishes to be on the Committee scoring off the rest. The list will not be signed or any mark put to identify the same. They will be put in a box kept in the room. The General Body shall appoint two tellers and two scrutinizers to count the votes and submit the result to it. Any member who wishes to attend the checking of votes can do so.

19. In case no application for the election of office-bearers is received within the stipulated time, the election will take place on the floor of the house on the day of the Annual Meeting. The manner of election whether by show of hands or by ballot shall be decided by the sense of the meeting.

20. *Extra-Ordinary Meetings:* An Extra-Ordinary General Body Meeting may be called at any time of the year on the requisition of the majority of the Managing Committee or on the requisition of 20% of the members of the General Body.

21. The General Body is authorised to amend the constitution at an Extra-Ordinary General Meeting only with a quoram of half the number of members on the rolls and a majority of two third on any resolution or amendment alone shall be binding.

22. Each ordinary member present at the extraordinary meeting is entitled to a single vote.

23. Ten days clear notice with the agenda shall be given to the members.

24. Subjects not included in the agenda of the notice of the meeting shall not be considered except in the extraordinary cases with approval of the house.

25. The decision of an Extraordinary meeting shall come into operation after one full month from the date of that decision.

26. Such decisions must be confirmed, rejected or modified by the next Annual General Body Meeting.

Managing Committee.

27. Any ordinary member shall be eligible for election to the Managing Committee.

28. The Managing Committee shall consist of the following nine members:

President
Vice-President
Secretary
Treasurer and
Five other members.

29. Any interim vacancy in the Managing Committee shall be filled by the Committee itself which shall include the Secretary.

30. The Managing Committee shall meet once a month or more often if necessary.

31. Five members shall from the quorum.

32. The Managing Committee shall conduct the business of the Association and all matters, acts and things which from time to time shall be expedient for attaining the objects of the Association.

33. The property of the Association shall be vested in the Committee in trust for the members.

34. The Committee shall have authority to frame Bye-Laws not inconsistent with these rules.

35. Any such bye-law shall come into force at a date not less than one month after it is passed by a two thirds majority of the Managing Committee. Members shall be notified immediately of the proposed bye-law and it shall continue to be in force until varied or removed by the General Body.

36. *President:* The President shall preside at all the meetings of the General Body. He shall have a casting vote in case of an equality of vote.

37. *Vice-President:* The Vice-President shall preside at all the meetings in the absence of the President.

In the absence of the Vice-President, the members shall elect one amongst themselves as Chairman to exercise all the powers of the President on that occasion.

38. *Secretary:* The Secretary shall be responsible for office work, correspondance and to organise and convene all meetings, conferences, lectures and demonstrations. He shall maintain a record of the minutes of such meetings. He shall prepare the annual report to be laid before the Annual General Body Meeting.

39. He shall keep a permanent advance of Rs. 10/- and shall recoup the amount spent from the Treasurer on production of vouchers Expenditure exceeding Rs. 10/- at a time shall be incurred with the permission of the Managing Committee.

40. He shall be responsible for such work as the Managing Committee shall fix for him from time to time.

41. *Treasurer*: The Treasurer shall be responsibe for collection of subscriptions and donations from members and well-wishers. He shall sign receipts and prepare statement of income and expenditure of the Association duly audited by a certified auditor by the 30th November and shall present the same at the Annual General Body Meeting. He shall submit a general statement of accounts at every monthly meeting.

42. The members of the Managing Committee, collectively and severally, the members and other office-bearers—(if any)—of the Association shall not be answerable for the acts. neglects, receipts or defaults of any other or others of them or for any other misfortune or damage which may happen in the execution of their respective offices except the same shall happen by or through their own wilful neglect or default respectively.

Syphilis and Heart Disease.

By

RAO SAHEB A. NARAYANA MENON, M. B., B. S.,

Hony. Venerealogist, Govt. Head Qr. Hospital, Madura.

(From the Antiseptic—February 1938.)

Although actual figures are not available, in South India, incidence of syphilis is rather high almost amounting to 10% of the cases a general practitioner comes across with and 10% of these cases of syphilis generally develop cardiovascular symptoms, if adequate treatment is not given to every case in the early stage. Moreover, cardiovascular syphilis, with the exception of neuro-syphilis, is the most frequent basic cause of death in the acquired variety of the disease. It is also worthwhile to remember that syphilis forms an aetiological factor in 10% of all definite cases of heart disease : it has also been found as a result of recent studies that 30% to 40% of all non-traumatic sudden deaths are the direct result of cardiovascular syphilis.

The picture of syphilistic heart disease is entirely different from that of rheumatic fever. The fundamental lesion in cardiovascular syphilis is "aorititis," while in rheumatic disease, it is mainly a "carditis." The main clinical types of cardiovascular syphilis are : (1) Subclinical aorititis, (2) Uncomplicated aorititis, (3) Aortic aneurysm, (4) Aortic regurgitation, and (5) Syphilitic myocarditis. The classification of clinical groups is based upon the extent and the degree of the anatomical lesion. I shall deal only with the first two clinical groups namely : (1) Subclinical aortitis in which, although anatomiol changes in the wall of the aorts have taken place, no detectable alteration in the physiology of the circulation has occurred : and (2) Uncomplicated aortitis where the lesion has progressed sufficiently to produce physical signs are subjective symptoms but where there is no valvular incompetency or aneurysmal sacculation.

For the diagnosis and detection of early cases of aortitis, every case of late syphilis and every patient with cardiovascular symptoms must be subjected to a careful history and a thorough physical axamination. In the history, presence of substernal

or praecordial pain occurring while at rest is extremely significant, and a paroxysmal nocturnal dyspnoea, without a history of breathlessness on effort, is almost pathognomonic of cardiovascular syphilis.

In physical examination, particular attention should be paid to the position of the impulse, presence or absence of any unusual pulsation, especially in the neck, the upper arm, the upper chest front and back, in the supra-sternal notch, and in the supra-clavicular fossae. By palpation, presence of praecordial thrills and shocks should be noted, and the character of the radial pulse should be carefully observed. A comparison of the equality and synchronousness of the two pulses should be made as well as a note of the form of the pulse wave. The quickness or collapsing quality of the radial pulse may be accentuated by holding the patient's arm up well over his head By percussion, the extent of cardiac dulness extends beyond the level of the third rib. This may be made out by careful percussion upwards and downwards over the sternum in the middle line. In auscultation, the tympanic tambour quality of the aortic second sound, in the absence of hypertension is characteristic ef uncomplicated syphilitic aortitis.

Blood pressure, both systolic and diastolic, should be made in both arms and at least in one leg. The normal blood pressure in the brachial artery has approximately a 1 : 2 : 3 ratio between pulse pressure, diastolic pressure and systolic pressure: any significant deviation from this relationship, in the direction of increase of pulse pressure, should lead to a suspicion of aortic incompetency. Normally, with the patient lying down, the systolic pressure in the leg is about 10% higher than that in the arm. In aortic insufficiency, even in its earliest stages, the systolic pressure in the leg will be considerably higher than this.

Radiological examination is invaluable, especially a fluoroscopic examination of the cardiovascular stripe in every case of the suspected group. Lastly, every patient presenting with cardiovascular symptoms should have the benefit of a routine Kahn of Wasserman test.

Subclinical aortitis according to the definition is not diagnosable: but it is worthwhile to remember that every late syphilitic, who has been allowed to go on without adequate treatment, is a potential cardiac, and that the difference between the subclinical aortitis and uncomplicated aortitis is merely one of degree.

The following seven diagnostic criteria, prepared by Carter and Baker after a review of a series of clinical histories of patients, who were found to have uncomplicated aortitis in autopsy, are very useful in the diagnosis of this condition :—

(1) Fluroscopic evidence of aortic dilatation or a visible and palpable pulsation in the suprasternal notch in the absence of hypertension.
(2) Increased retro-manubrial dulness.
(3) A history of circulatory embarrassment, chiefiy exertional dyspnoea with or without progressive cardiac failure.
(4) A tympanic tambour, bell-like quality in the aortic second sound, with or without marked accentuation.
(5) A rough systolic murmur heard best in the aortic area which may be transmitted upward or downward or in both directions.
(6) A substernal or less frequently praecordial pain occurring without relation to exercise and usually without radiation, A dull aching substernal pain which occurs even at rest is pathognomonic of the condition.
(7) Paroxysmal dyspnoea, occurring without effort and most characteristically nocturnal.

All these phenomena may also occur in other types of cardiovascular disease, as in extremes of arterial hypertension ; and hence the determination of blood-pressure should put the examiner on the guard. In hypertension, although dilatation of the aorta and accentuation of the second sound are present the tympanic tambour-like quality is absent. Circulatory embarrassment and progressive cardiac failure may occur in

any form of heart disease and are not definitive. An aortic systolic murmur may be present in sclerosis of the aorta and disease of the coronary vessels may be the cause of substernal pain. True paroxysmal dysponea, occuring without exertion or emotional strain is seldom seen except in cardiovascular syphilis or in hypertensive heart disease with left ventricular failure.

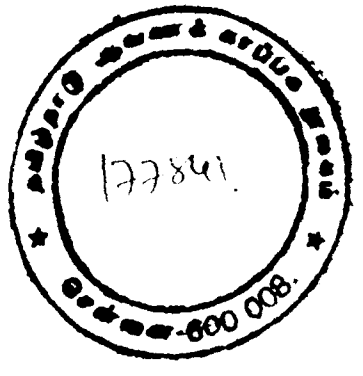
The presence of any five of the abovementioned criteria justifies the diagnosis of cardiovascular syphilis. In a patient with a positive Wassermann or a definite history of syphilis, the presence of any three criteria shown in the list, makes almost certain the diagnosis of uncomplicated aortitis. In a patient with no definite history of syphilis or other physical evidence of the disease, and a negative serological test, the diagnosis of uncomplicated aortitis may be made with a certain amount of assurance, if circulatory embarrassment and three of these criteria are present, in the absence of hypertension.

The presence of hypertension (systolic pressure over 150 mm hg. or a diastolic pressure over 100 mm. hg.) render the diagnosis of the condition much more difficult. But if a late syphilitic suffers also from hypertension, it is wise to consider him as a potential victim of cardiovascular syphilis and to manage his subsequent care occordingly. Uncomplicated aortitis may be associated with other non-syphilitic conditions which influence its prognosis and the applicability of the methods of treatment.

Irrespective of treatment, the mortality rate in patients whose aortitis is complicated by hypertension is twice as great as those in whom it is not. The prognosis of uncomplicated aortitis depends upon the stage of development the lesion has reached before being recognised. Without treatment, the disease terminates in disabling cardiovascular disease with eventual death in 5 to 20 years: if properly treated, in early cases there is no appreciable shortening of the life-span and the more fully developed cases will have an expectancy of ten to twenty years or more.

Treatment:—In these cases, careful examination and individualisation of treatment are very essential. We must

carefully avoid untoward reaction of any sort to the drugs employed *e. g.* nausea and vomiting, which might throw an additional strain on an already damaged heart. Herxheimer reaction, also known as therapeutic shock, which may cause sudden death from coronary occlusion or rupture of an aneurysm, must also be avoided. We must also avoid therapeutic paradox by which is meant the rapid healing of the syphilitic inflammatory tissue in the aortic leaflet or wall or in the myocardium. Thus, in spite of the improvement of the lesion of syphilis, the patient is functionally worse off than before and may be precipitated into congestive cardiac failure Hence there is a definite risk in the use of arsenic in cardiovascular syphilis, for the reasons stated above. The patient should be given bismuth or mercury in combination with potassium iodide as a preparatory treatment before arsenic is exhibited. If the cardiac reserve is very low, arsenobenzene should be carefully avoided. The patient should be carefully examined periodically, and it is desirable to give an yearly course of treatment. For the associated neurosyphilis, tryparsamide which exercises no deleterious effects of the arsenophenamines on the cardiovascular apparatus, may be freely employed.



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எழும்பூர், சென்னை-600 008.

தவணைத்தாள்.

தே. எண் : ப. எண் :

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THE MISCELLANY

OF

TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION

(REGISTERED)

Editor : DR. M. C. CONDILLAC, M.R.C.S., L.R.C.P., M.M.

FEBRUARY 1938

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BO-CAR-AL

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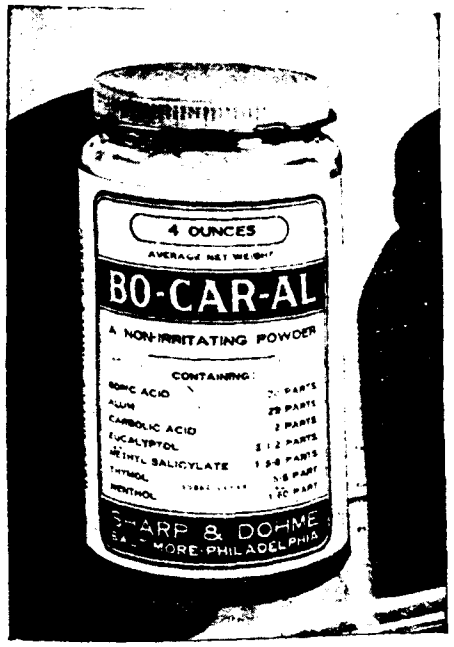

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Vol. [illegible]V] FEBRUARY 1938 [No. ~~152~~

THE rush in producing the much-delayed back numbers of our Miscellany has limited the amount of matter, both medical and general.

There seems however an awakened interest from all directions and with the promised and practical co-operation our Association and Journal should have a new lease.

Our finances form a disturbing factor. The arrears of subscription are heavy and there seems no solution but the ready payment by members concerned. This financial embarrassment makes one feel that we should reconsider the question of our joining the Indian Medical Association or rather delaying the question.

The question of becoming a branch of the Indian Medical Association cannot be delayed too long and yet with the halving of our income as a result of our quota of contribution to the main body, we are going to be precariously placed.

Our monthly meetings are becoming so filled with discussion on points affecting the running of the Association that little time is left for the truly medical and clinical side of our gatherings. There is promise of a clinical meeting every month in the future; and members working in hospitals and in practice could not do better than produce half a dozen cases at each meeting.

Facts and Fallacies in Clinical Endocrinology.

BY

P. M. F. BISHOP, B.M., B.Ch.,

CLINICAL ENDOCRINOLOGIST, GUY'S HOSPITAL.

(*From the Clinical Journal, January '38*).

THE pendulum of credulity has swung during the last two or three years from the right of obstructive scepticism to the left of unmanageable gullibility, and it is now the aim of all who are seriously interested in clinical endocrinology to manoeuvre it back to the meridian of sanity.

We have at our disposal three potent hormone preparations. (As I am particularly concerned with the more recent developments of endocrinology I am excluding from consideration thyroid extract, parathormone, posterior pituitary extracts, insulin, adrenalin and suprarenal cortical extract.) These three hormone preparations are: (Estrin, the hormone secreted by the ovarian follicle; progestin, the hormone secreted in by the corpus luteum; and the luteinizing gonadotropic harmone, which is excreted in urine of pregnancy. We find ourselves concerned, therefore, with the indications for the use of the three hormone extracts first mentioned.

First with regard to oestrin, its function is to stimulate and maintain the normal growth and development of all the secondary sexual characteristics of the female. Its most successful use is in menopausal conditions. It is not completely destroyed by the digestive juices and is to some extent absorbed from the small intestine. In the milder form of the menopausal syndrome quite small doses of oestrin are effective in 100 per cent of cases, even when given by mouth. By such treatment it is possible to control the hot flushes and to give the patient a new lease of life psychologically. Some of the sequelae of the menopause, such as pruritus, kraurosis vulvae, senile vaginitis and vaginal ulceration are due to an inefficient blood-supply to the genitalia owing to the relative lack of ovarian secretion, and may be cured by the administration of larger doses of oestrin, preferably by injection.

Many cases of dysmenorrhoea, particularly of the spasmodic type, are due to a minor degree of ovarian deficiency and are frequently associated with uterine hypoplasia and scanty and infrequent menstruation. A high proportion of such cases are relieved by administration of oestrin, sometimes by mouth, though at times, in the more resistant cases, injection is necessary.

In certain cases of amenorrhoea, hypomenorrhoea or oligomenorrhoea there has been a relative lack of ovarian stimulation by the uterine endometrium. A course of oestrin at such a time may sufficiently supplement the patient's ovarian secretion to overcome this resistance and to restore the normal sensitiveness of the endometrium, so that it will in future respond to the available secretions of the patient's own ovaries. This fact probably accounts for the small percentage of successes claimed for endocrine therapy in amenorrhoea.

The corpus luteum hormone, progestin, is responsible for the development of the progestational, premenstrual or secretory phase of the menstrual cycle, and for the decidual changes which are essential for the implantation of the ovum, and the maintenance of early pregnancy. Its use is effective, therefore, in cases of habitual abortion, particularly when these occur during the first three or four months of pregnancy. Progestin has also been shown to be antagonistic to oestrin in that it lowers its effectiveness. Certain cases of menorrhagia are associated with a failure to ovulate and therefore to form a corpus luteum, the prolonged and excessive uterine haemorrhage being due to the unopposed action of oestrin. In these cases the administration of progestin lowers the level of the oestrin effect and quickly controls the haemorrhage. The use of luteinizing gonadotropic extracts, such as pregnyl, prolan and antuitrin-S appears to be almost as effective as progestin itself in both this condition and habitual abortion.

Apart from these indications the luteinizing gonadotropic hormone has one very important clinical use in cases of im-

perfectly migrated testes. In cases carefully selected from the point of view of age and absence of mechanical hindrance to descent, such as an old hernia scar, the administration of gonadotropic hormone completes the descent into the scrotum in about 70 per cent.

Now I want to pass on to consider certain fancies of endocrinology which, though having no scientific basis, have made their appeal to many up-to-date and fashionable consultants. The first is the practice of administering pituitary preparations by mouth. Although we do not as yet know the chemical structure of the pituitary hormones there is considerable evidence that they are complex substances of a protein nature, and that their activity is almost completely destroyed by passage through the alimentary canal. I am aware that certain quite reputable firms put pituitary tablets on the market, and I have, indeed, remonstrated with them. I can honestly assure you that, apart from the psychological effect, which varies in direct proportion with your ability to impress your personality on your patient, you might just as well prescribe black currant lozenges as pituitary tablets, except that the latter are much more difficult to swallow and considerably more expensive. This condemnation of oral administration applies also to progestin, because it is not at present available in sufficient concentration to be effective by mouth, but not to oestrin, the oral administration of which has already been shown to be highly successful in the menopausal syndrome.

Not only do consultants make the one mistake of prescribing pituitary preparations by mouth, but they follow it up with a second and almost equally criminal mistake of ordering pituitary by mouth in cases of obesity. It would appear that there is a neutro-endocrine mechanism controlling fat metabolism, by which impulses pass between the nuclei lying in the region of the tuber cinereum and the various parts of the pituitary gland by way of nerve-fibres running through the stalk of the pituitary. It is therefore obvious that administration of pituitary extract is unlikely to be of benefit in cases of obesity.

A subject which has been lately brought into considerable prominence is the endocrine treatment of prostatic enlargement

could be experimentally produced in dogs by administration of oestrin. It was thought that prostatic enlargement in man was due to an imbalance between the secretion of testosterone and oestrin in the male organism, the former diminishing in amount at the time of the male climacteric. On this theory was based the treatment of prostatic hypertrophy with male hormone extracts. During the past two or three years clinical experiments have been conducted along these lines.

In more than half my series of cases I have been able to reduce the nocturnal frequency appreciably with sterile olive oil alone. This shows the importance of choosing reliable objective signs rather than subjective symptoms in making a critical assessment of results. It has further appeared that many of the cases of prostatic enlargement are not due to a hypertrophy of the fibrous tissue of the prostate, which is the type experimentally produced by administration of oestrin, but are due to an adenomatous enlargement, and that administration of testosterone is likely to encourage rather than inhibit glandular development.

Finally, a word about hormone estimations. One is constantly being asked to estimate the amount of oestrin or of gonadotropic substance in the urine or blood of patients. The technical difficulties of such a procedure are at present so great that no accurate quantitative determination can be made, and such tests are at present completely valueless as aids to diagnosis. This very important and very difficult subject is being carefully investigated by some of the most brilliant research chemists in the country, and it is expedient to wait patiently for their report. The only conditions in which a quantitative analysis of urinary hormones is of diagnostic value are hydatidiform mole, chorionepithelioma and testicular tumour, in all of which the urine contains an abnormally high amount of gonadotropic substance. The quantitative analysis of gonadotropic hormone in the urine in cases of pregnancy forms the basis of the well-known Aschcim-Zondek and Friedman tests. These tests, when conducted by skilled and experienced workers, are extremely reliable, showing a percentage error of less than 2.

Some Surgical Emergencies

BY

N. S. NARSIMHA AYYAR, L.R.C.P., F.R.C.S., (ENG. & IRE.)

THE energetic secretary of the Trichy District Medical Association asks me to write to the Miscellany on some topics.

The following few points are written with the belief that the co-operation of the practitioner in the outlying areas is essential in every case.

The problem of early diagnosis is important in many surgical emergencies and delay is fatal.

Of the many such problems, the diagnosis **of acute intestinal obstruction** is one such. A patient of any age comes to the doctor for absolute constipation i.e., inability to pass flatus and faeces. There is only one treatment (for that condition of acute intestinal obstruction) and that is by operation. Therefore it has been agreed that the diagnosis must be made early, with promptitude and the patient must be sent to the nearest, available surgeon. These cases, excepting Strangulated Hernia which form a good proportion of these types, cannot be dealt with by a Practitioner who is all alone in an out-of-the-way place. A diagnostic enema of a pint is given by the doctor himself taking care to exclude all air from the Rubber tube. This enema may act and the evacuation may consist of fæcal matter below the point of obstruction. It is the expulsion of gas that matters and this must be watched by the doctor. If this is negative another enema may be tried after an hour's interval. If there is no expulsion of gas after both the enemas and if there is no relief felt by the patient, the case must be diagnosed as acute intestinal obstruction. Mistakes do occur even in the diagnosis of strangulated external hernia both in the inquinal and femoral region. An irreducible swelling in the inquinal and femoral region must be operated on if symptoms of intestinal obstruction are present.

When there is strangulation of the portion of the wall of the gut, there will not be an irreducible swelling but a tender thickening will be palpable at the site of internal abdominal ring. These are the cases which are often liable to mislead one especially symptoms of obstruction may not be present in the beginning.

Empyema Thoracis :—

It is not uncommon to meet with in the post-mortem room and in dissection rooms; bodies which prove that cases of huge empyemas go undiagnosed.

It is no exaggeration to say that these cases are not diagnosed easily enough ordinarily in general practice.

The post-pneumonic type of empyema is easy to appreciate. Typically it follows a pneumonia of pneumococal origin, and everyone is familiar with the reappearance of pyrexia after the crisis or the failure of complete subsidence of fever and gradual assumption of the swinging or septic type of temperature. This fever is associated with general signs of septic absorption and local signs of fluid in the pleura.

It is well to remember that there is no such thing as a recurrent pneumonia. In examining a chest, one is always struck by the fact that a Silent Chest is always more dangerous, than a chest where one hears roaring sounds; Empyemata are often mixed in children.

Aspiration with a syringe under local anæsthetic is a safe diagnostic procedure and drawing out thick pus, which gives the diagnosis of Pneumococial empyema.

There is a type of empyema which follows influenza in adults and respiratory infections of childhood as measles.

The clinical history is that the patient has been ill for 2 or 3 days with high temperature and when the doctor sees the patient, the patient is extremely ill with dyspnoea.

Systematic Examination of the chest will reveal a large collection of fluid and aspiration of the chest shows fluid, the character of which must be studied carefully.

In the earliest stages it is clear or very faintly turbid, slightly straw-coloured or even tinged with blood; this fresh Exudate usually clots spontaneously. If left in a test-tube overnight there sediments out a very small amount of cellular material, either red cells or Leucocytes. As each day passes the aspirated fluid becomes turbid, and then definitely purulent. Finally the stage is reached when over 90 of the aspirated material sediments as pus and only 10 or less is clear fluid. The time taken for this is two to three weeks.

This information is important and naturally requires repeated aspirations. In the earlier stages, the patient is suffering from a septicaemia and coincident pneumonic process with a diffuse suppurative pleurisy and ought not to be operated; the fluid collection in the pleura is only an incidence and drainage ought not to be done. During this period of waiting only aspiration ought to be done and the fluid removed till the diffuse suppuration becomes localised.

The practitioner is often asked to decide whether an open drainage operation has to be done at once. An empyema is rarely fully formed and ready for external drainage, before the third week of the illness.

A fourth hourly chart must be studied. A high fever, intermittent, but not falling below 102 degrees but very often in children from 103 to 105° shows that the pneumonic process is still active.

When the pneumonia has subsided and a localised abscess in the pneural cavity remains in the pleura the temperature has a characteristic swinging type of retained pus ranging from normal to 102° or 103° every evening.

After aspiration in a localised case the temperature goes only to 100° that evening; but if an active pneumonic process still exists, aspiration of fluid makes no difference to the temperature chart; there is no fall in temperature after the aspiration. These simple facts will help in enabling the practitioner in arriving at the correct time to advise an open drainage. The early diagnosis by aspiration entirely depends on the attendant doctor.

Diagnosis of acute osteomyelitis:—

Most doctors have experience of chronic osteomyelitis cases. These are patients for a long time, require many operations, and travel from hospital to hospital.

If they had been diagnosed during the very early stages, and correctly treated, they, in the majority of instances will heal early.

Young children usually suffer. The seat of commencement of the disease is usually at the junction of the diaphysis and epiphysis of long bones; (other types of bone are also affected as the mastoid process and other skull bones). The child is brought with fever, and pain over the part which is usually near a joint.

Many mistakes occur because of the proximity of the disease to the joint. Rheumatism is diagnosed. There may be redness of skin which leads to the error of lymphangitis, erysipelas. The child has some boils or sores. The infection comes into the bone from these boils.

The important diagnostic feature is that there is *localised tenderness over the bone*; when you wait with the patient and the child begins not to be alarmed with your presence, the joint can be moved without pain.

If there is a localised tenderness, the child requires an operation which consists in making an incision down to the bone; if there is pus in the subperiosteal space this is enough; if there is no pus a hole must be drilled into the bone. This relieves the tension in the bone, the pain is eased, temperature becomes normal; because of the ease of tension in the bone, death of the bone can be prevented.

The joint requires to be supported in a splint or plaster-of-paris cast. This is a procedure which has to be undertaken by every doctor.

The Trichinopoly District Medical Association
(Regd.)

THE 8th annual General Body Meeting of the above Association was held on 23rd January 1938 at the premises of the National College, Trichinopoly, when Dr. C. E. R. Norman, the President of the Association, presided. The meeting commenced at 11 A.M. About 60 members were present.

After the reading of the annual report it was discussed by the General Body and the passing of the report was proposed by Dr. T. N. Subramanyam and seconded by Dr. T. V. Srinivasan and was carried, one member dissenting.

The following Ruling from the Chair was accepted *Nem. con.* by the General Body.

I. Resolved that the General Body meeting decide to overrule the previous bye-laws and to formulate a new set of rules at this meeting.

II. It was proposed from the chair that "This meeting be changed into an extraordinary General Body meeting for the purpose of enacting the Bye-Laws" and was seconded by Dr. Sambasivan. This was passed *Nem. con.*

Then the members present formed into an extraordinary General Body and the new set of Bye-Laws were passed.

The Extraordinary General Body meeting was adjourned *sine die.*

The new set of Bye-Laws passed at the Extraordinary General Body Meeting was confirmed at the Annual General Body Meeting on the proposal of Dr. Norman and seconded by Dr. Kalamegham.

The next Item was the election of Office-Bearers for the new year.

It was proposed by Dr. P. A. S. Raghavan that Dr. C. E. R. Norman be elected President and was seconded by Dr. O. R. Balu and was carried unanimously.

Proposed by Dr. P. A. S. Raghavan and seconded Dr. V. Subramanyam, Lt. Col. N. K. Bal was unanimou elected Vice-President.

Proposed by Dr P. A. S. Raghavan and seconded by D V. Subramanyam, Dr. O. R. Balu was unanimously electec Secretary.

For the Treasurer two names were proposed and seconded as under:

I. Dr. T. V. Srinivasan – Proposed by Dr. Kalamegham and seconded by Dr. V. Subramanyam.

II. Dr. P. A. S. Raghavan –Proposed by Dr. R. Sambasivam and seconded by Dr. K. R. N. Chary.

On the withdrawal of Dr. T. V. Srinivasan, Dr. P. A. S. Raghavan was declared elected.

For the Managing Committee the following names were proposed and seconded as shown below: –

Dr. T. V. Srinivasan
„ R. Sambasivan
„ Balambal
„ Venkatachalapathy
„ Swaminatha Sastri
„ Condillac

} Proposed by Dr. P. A. S. Raghavan and seconded by Dr. O. R. Balu.

Dr. M. R. Bhat.
„ D. Srinivasan

} Proposed by Dr. Sethuram Rao and seconded by Dr. Viswanathan of Vallianai.

Dr. Bhat and Dr. D. Srinivasan withdrew.

Dr. Visvanathan, Vallianai...Proposed by Dr. Kasturi Rangan and seconded by Dr. N. S. Krishnamurthi.

Dr. Visvanathan withdrew.

Dr. Sethuram Rao...Proposed by Dr. D. Srinivasan and seconded by Dr. O. R. Balu.

Dr. Venkatachalapathy and Dr. Swaminatha Sastri withdrew. So the following members were elected to the committee.

I. Dr. T. V. Srinivasan.
II. „ R. Sambasivan.

III. Dr. Balambal,
IV. „ Sethuram Rao,
V. „ Condillac.

After this a few resolutions were proposed, seconded and carried as shown below:—

I. Resolved that the Trichinopoly District Medical Association become a Branch of the Indian Medical Association.

Proposed by Dr. C. E. R. Norman,
Seconded by Dr. Kalamegham.
(Carried Unanimously.)

II. Resolved that Members of the Association pledge themselves not to undertake Medical Examination for Life Assurance or similar work unless they are paid the full fee to which they are entitled without any deduction whatsoever, whether by commission to the Insurance Agent, or otherwise.

Proposed by Dr. Johnson,
Seconded by Dr. Norman.
(Carried Unanimously.)

III. Resolved that the above Resolution be circulated to the press, every medical men, and to the Association of Insurance Companies.

Proposed by Dr. Kasthuri Rangan,
Seconded by Dr. Visvanathan.
(Carried unanimously.)

IV. Resolved that this conference is of opinion that in any future scheme of Rural Reconstruction the Government will be pleased to recognise the Status of the Rural Medical Practitioner as an integral part of the Scheme.

Proposed by Dr. Sethurama Rao,
Seconded by Dr. Kalamegham.
(Carried Unanimously.)

V. Resolved to send a copy of the above resolution to the Hon. Minister for Public Health.

Proposed by Dr. Sethurama Rao,
Seconded by Dr. Kalamegham.
(Carried Unanimously.)

After the passing of the Resolutions the members adjourned for Lunch.

After Lunch, Dr. M. C. Condillac, M.R.C.S., L.R.C.P., M.M., delivered a Lecture on "MODERN METHODS IN SURGICAL TREATMENT".

He stated that modern methods in surgery were based upon Good Anatomy, Physiology and Pathology and gave us useful hints on the treatment of some common surgical conditions that are met with by the general practitioner.

Then Dr. Sanjeevi, M.D., from Madura, gave us a very interesting lecture on Tuberculosis and showed a set of interesting skiagram on every phase of the disease. The lecture was far from what he chose to style it viz. "THE RAVINGS OF A PHTHISIO MANIAC" as it contained some very valuable and helpful information. A good discussion followed.

Then Dr. Ranganathan from Tanjore gave us a very interesting lecture on 'Blood Transfusion.' He gave us a glimpse of the working of the BLOOD TRANSFUSION Service that is conducted in England, and emphasised the usefulness of Blood Transfusion in Surgical, Medical and Midwifery cases.

After that Dr. Rathanaswamy, M.D., from Tanjore, gave an interesting lecture on PUERPERAL SEPSIS which was followed by a very good discussion.

Dr. P. A. S. Raghavan then demonstrated a case of Dextro Cordia by means of a series of skiagrams.

Then Tea was served. After Tea Dr. T. S. Tirumurthi gave us a lucid and instructive lecture on Modern Concepts about Renal Disease, and Bright's Disease in particular, which was attended to by members with rapt attention. He gave us the concept of a Nephron and about the structure of the Kidney and he explained how the pathology could explain the signs and symptoms in the different types of Renal disease. He explained in his own unimitable way the clinical applications of these modern pathalogical concepts. A very good discussion followed.

After the Lecture Vote of Thanks were proposed by Dr. Condillac to the following Gentlemen :—

I. To the outgoing office-bearers.
II. To the President.
III. To the Lecturers.
IV. To the Visitors.
V. To the Hosts.
VI. To the authorities of the National College who were kind enough to lend us the use of the building for the occasion.

After a hearty dinner the members dispersed very late at night.

The Refreshments and Boarding arrangements were made possible by the kind co-operation of the following firms who contributed liberally towards the same.

I. The French Medicines Agency.
II. Messrs. Raja D. Mawnay Ltd.
III. Messrs. T. M. Thakore & Co.
IV. Messrs. Raptakos Bret & Co.

The Dangers of Treating "Indigestion" by Advertised Nostrums

A. B. Rivers, M.D, Division of Medicine: Physicians need no statistical evidence to convince them of the importance of symptoms of dyspepsia. Scarcely a day passes in which it is not necessary for them to give an opinion regarding the cause of some patient's gastronomic indisposition. The importance of dyspepsia to the laity can readily be appreciated by considering the various advertising mediums which are utilized to bring to their attention various means of achieving gastro-intestinal comfort. Almost any evening, during the height of the radio programs, it is possible to hear four or five smooth-tongued announcers advising rapid and inexpensive methods of curing gastro-intestinal difficulties. Drugstore shelves are filled with attractively displayed means of curing indigestion. The highways are bordered by signs indicating how the passers-by can quickly return to the happy state wherein they can again enjoy their food. Magazines and newspapers daily carry therapeutic advice regarding gastronomic disturbances for the benefit of their dyspeptic readers.

Recently, at the Clinic, we have completed a survey relative to the incidence of dyspepsia among a large number of patients presenting themselves for examination at the Clinic. We have found that almost half of the patients between the ages of thirty and sixty years included among their complaints that of dyspepsia. Although we found that in youth the cause of these symptoms frequently was not serious, we were impressed with the potential gravity of the symptoms of dyspepsia beyond the age of forty years. We were impressed by the fact that about half of the men forty years of age and older, who come to us primarily because of dyspepsia, are found to have peptic ulcer, cholecystic disease or carcinoma of the gastro-intestinal or accessory gastro-intestinal tract. Two of five women of that age group are found to be suffering from gallbladder disease, peptic ulcer or cancer of the stomach, pancreas or intestine. One of six men of this group is found to have carcinoma of the stomach, pancreas or intestine. One of eight actually has carcinoma of the stomach.

It is startling to think of the harm that might be done to dyspeptic people who reach the age of forty years but who seek aid in the advice given by the venders of therapeutic nostrums. It would seem to us that there falls on the medical profession the serious responsibility of educating laymen concerning the dangers of heeding nonprofessional advice that they cure themselves of dyspeptic unhappiness, particularly if they have reached middle age. Patients of that age should be made to realize that it may be very dangerous to procrastinate in seeking the advice of their physicians and, instead, trying to cure their indigestion by utilization of methods of treatment suggested by advertisers. They should understand that by taking these short cuts in treatment they may delay their cure or actually jeopardize their chances of survival if their symptoms, which they may have masked temporarily by their inadequate measures, should be caused by some malignant process. Physicians, too, should realize their responsibilities in making an accurate diagnosis when called on to evaluate the symptoms of dyspepsia of patients who have reached middle age (table 1).

Table 1

The most frequent causes of dyspepsia among men and women aged 40 and over.

Males

Peptic ulcer 23%

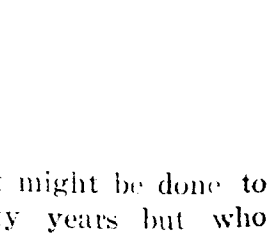
Functional 20%

Cancer gastro-intestinal and accessory tract 17+%; ratio 1 : 6

Cancer stomach 12·2+% Ratio 1 : 8

Cholecystitic disease 9+%

Cardiovascular disease 5%



49+% of men in this age group with primary complaint of indigestion had ulcer, gall bladder disease or cancer of G. I. or accessory G. I. tract.

Females

Cholecystic disease 24·5% Ratio 1 : 4

Functional 19·8%

Peptic ulcer 9·5% (D. U. 43, G. U. 3, G. J. U. 1)

Cancer, G. I. or accessory G. I. tract 5·8%

Cardiovascular disease 4·8%

Cancer stomach 4·2%

38% of women included in this group had gall bladder disease, peptic ulcer or cancer of G. I. or accessory G. I. tract.

Treatment of Tennis Elbow*

BY

G. PERCIVAL MILLS, F.R.C.S.

Surgeon, General Hospital, Birmingham: Surgeon, Royal Cripples Hospital, Birmingham: Orthopaedic Surgeon, Birmingham Children's Hospital.

"TENNIS elbow" occurs mainly in tennis players, but occasionally in golfers, and more rarely in metal workers and amateur gardeners who use respectively the hammer and the trowel. There is practically never a history of injury the pain comes on gradually during or after the favourite pastime. The most prominent symptom is pain on the outer side of the elbow when gripping, and this pain is usually much worse on gripping with the forearm pronated; indeed, the grip in the supine position is often painless. The pain may come on while grasping some trifling object like a tea-cup, which may even be dropped, but most characteristically it occurs only during indulgence in the favourite game. It may be merely a nuisance and noticed only on mishitting a back-hand shot, but in some cases the patient cannot even hold a racket. On examination there is nothing to see, but there is always a tender point, either exactly over the radio-humeral joint, on the epicondyle just above, or in the extensor group of forearm muscles. It may be difficult to locate the exact spot, but the patient can nearly always find it, and pressure on it will make him wince.

Physical Signs and Treatment

Of fifty-eight cases of which I have full notes the tender point was over the joint front, back, or side in thirty-two, the epicondyle in twelve, and somewhere in the muscles in fourteen; but the respective points are so close together that certainty as to the exact position is not always possible. As an example of this I would quote a case which I classified as

* Read in opening a discussion in the Section of Orthopaedics, including Treatment of Fractures, at the Annual Meeting of the British Medical Association, Belfast, 1937.

of the muscular type and thought I could feel a bursa. At a subsequent operation the bursa was found to be a protrusion of synovial membrane from the radio-humeral joint. Clearly this should have been classified as the joint type. The only other physical sign is a slight limitation of extension at the elbow-joint, more evident and often only evident with the forearm pronated; this occurred in approximately two-thirds of my cases, and is, I believe, the essential indication for manipulation. It may be very slight and no more than a springy resistance to complete extension, which is not felt in the opposite limb. It may be so slight, in fact, that it can be overlooked. On two occasions I have noted no limitation of extension, but against my general rule have for some special reason tried manipulation. In each case I obtained further extension with a definite click, and in each case there was a quick cure. Any gross limitation of extension, such as could be measured with an arthrometer, would suggest a much more serious lesion than the condition we are considering. In cases which present this typical limitation of movement the tender point is usually over the radio-humeral joint (74 per cent.), less frequently over the epicondyle (26 per cent.), and never in the muscles themselves.

Cases with muscular tenderness are of an entirely different character. My practice has been to advise manipulation only in cases in which I found limitation of movement. The technique, which I described some years ago, is very simple. Under nitrous oxide anaesthesia the elbow is forced into full extension with the wrist and fingers flexed and the forearm pronated. At the same time, in epicondylar cases firm pressure is made over the tender point with the thumb of the hand which is controlling the elbow. When this movement is carried out one of five things is observed.

1. The elbow comes straight with a click, which gives one the impression of something slipping in the joint (thirteen cases).

2. It comes straight gradually, with a feeling as if adhesions were giving way (seven cases).

3. It gradually comes straight with continued effort, but neither click nor adhesions are felt (seven cases).

4. As soon as the patient is under the anaesthetic the elbow comes straight without the slightest resistance (three cases).

5. The elbow cannot be got straight (one case). This, of course, was a failure, and will be referred to later.

The routine after-treatment is simply two weeks' rest from tennis or golf, during which time the patient is instructed to maintain by daily exercises the extension that has been secured.

Results

Of thirty-three cases so treated twenty-two were cured within a fortnight; one was improved and could play tennis at once, but was not perfectly right for six months; three others took two, three, and four months respectively. Some of the cases were dramatic. One patient, for example, could not write, and on coming round from the anaesthetic he sat down and wrote me out a cheque, and naturally we were both impressed. A large number of the cases occurred in doctors and personal friends who would not hesitate to let me know if I had failed; in fact, the frequency of the condition among doctors has been a little disconcerting from the purely financial point of view. So much for the good side of the picture. Of the remaining seven cases three were apparently cured but subsequently relapsed, and these must be considered individually. One neglected his fortnight's rest and relapsed suddenly within that period; he was a medical man and insisted on a second manipulation, which cured him. One relapsed in five weeks, and the opposite elbow also became affected; this was probably an early general arthritis which I had overlooked. One relapsed in three months: he was 51 years of age, and gave up tennis.

Of the remaining four cases one has not been traced, and though the immediate result was satisfactory I should not like to call it a cure; the other three were utter and complete failures. One of these was an abnormal case, for, though there was pain in the elbow and limitation of extension, there was absolutely no pain on gripping. The diagnosis in this case was probably incorrect, but the patient came from a far Northern town and I have had no opportunity of seeing him again. The

second case should have been a cure: there was limitation of extension, which corrected with a click, and when I saw the patient a month later movement was complete. However, he still had his pain, and this case I cannot explain. The third case in which I failed is more interesting; this was the one referred to above in which I did not succeed in forcing complete extension. This patient went to Blake in London, who also failed. A year later he was cured by manipulation by the trainer to one of our local football clubs. He very kindly told me all about it, and it is clear that the trainer succeeded in securing full extension, which both Blake and I had failed to do.

It appears, therefore, that, taking limitation of extension as an indication for manipulation, twenty-seven cases out of thirty-three were cured, and one other was subsequently cured by manipulation elsewhere. During the same period six cases were seen in which manipulation was advised but for some reason was not carried out by me. The ultimate fate of these cases is interesting in view of the possibility of spontaneous recovery. I have succeeded in tracing five. Three when last heard of were still unrelieved; one had the manipulation done by an osteopath and was cured, and one recovered after a few weeks' rest and massage.

Conclusions

We are justified in saying, therefore, that when the typical syndrome is present spontaneous cure is unlikely, and that manipulation gives an immediate cure in two-thirds of the cases and a slightly delayed cure in another one-sixth, making five-sixths in all.

Cases with muscular or epicondylar tenderness and no limitation of movement are in quite a different category. Some of them are suffering from what, to conceal our ignorance, we call muscular rheumatism or fibrositis, and the part which is over-used is naturally affected first. They soon show lesions in other parts of the body. I have seen three cases which started as apparent tennis elbow and subsequently developed a generalized fibrositis. Most of the muscular cases, however, are simply the result of overstrain, and a prolonged rest is the best, though far from welcome, treatment.

Pathology

I have left this to the end because it has to be deduced from the results of treatment. I believe that the common type of case with joint tenderness and limitation of extension is due to a fraying of the thin edge of the coronary ligament and the nipping of a semi-detached portion between the bones. My reasons are as follows:

1. The condition is frequently cured dramatically by a manipulation which produces a click.

2. It may relapse suddenly and be cured by a further manipulation. This happened to a medical man, referred to above.

3. In a case treated without anaesthesia the patient was certain that something had slipped back into place. He came to me in the middle of an important tournament and said he could not even hold a racket. A few hours after manipulation I watched him play a fine game.

4. On one occasion I opened the radio-humeral joint and found the thin edge of the coronary ligament frayed out as I have suggested.

5. The similarity to a displaced internal semi-lunar cartilage is very striking. Curiously enough, my manipulation for tennis elbow is exactly analogous to Sir Robert Jones's manipulation for reducing a knee cartilage.

I believe, therefore, that the dramatic cure that occurs in some cases is due to the freeing of a frayed edge of the coronary ligament which has got displaced between the bones. Cases with epicondylar tenderness are also often cured by manipulation, always provided there is limitation of movement, but I have noticed that it is seldom so dramatic as in the joint type. Patients often say that the elbow felt better from the first, but that it was a few weeks or months before it became quite right. I can only suppose that some tense bands, which were painful on being stretched, are ruptured completely by the manipulation.

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(REGISTERED)

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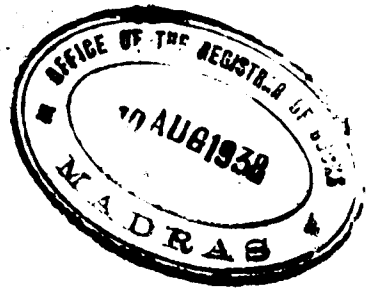

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(REGISTERED)

Editor : DR. M. C. CONDILLAC, M.R.C.S., L.R.C.P., M.M.

MARCH 1938

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ENDOCRINE therapy needs comment. There are so many products now on the market of varying strengths and potencies not to mention the therapeutic values claimed for each. The day of the gunshot polyglandular treatment has gone; it is interesting to note however that the idea of an inter-glandular co-ordination was not so new.

Modern hormone therapy resolves itself into substitutional and stimulative therapy. It calls for treatment over a prolonged period and in sufficient dosage to produce an optimum concentration. The bugbear however is whether the method of introducing the drug into the system is satisfactory. Oral administration except in the case of thyroid and oestrin is precarious, if not useless. Pituitary extracts are entirely valueless by mouth. Intravenous injections produce a transient concentration ineffective in treating chronic states.

Much work has been done recently to show the value of intramuscular injections with the hormone combined with substances sufficient to produce slow absorption and even concentration. The latest advance is the subcutaneous implantation of concentrated crystalline tablets—a method which has been found rather satisfactory.

Gunshot Wounds

BY

M. C. CONDILLAC, M.R.C.S., L.R.C.P., M.M.

District Medical Officer, South Indian Railway
Lieut., Auxiliary Force Medical Corps

THIS article is published in an unofficial paper as the outcome of the peculiar problems gunshot wounds present both in their pathology and in the unusual circumstances one is called upon to treat them. Circumstances, which in these days, may be the lot of even the private practitioner.

Working with a Field Ambulance, and at the base hospital during the last Operations on the North-West Frontier, I had the rare opportunity of studying these cases both in the field and in the wards.

Normally, one would not be justified in offering conclusive comment on such a limited number of cases. This paucity, however, has permitted a closer and more detailed study than is usually possible. Unlike most gunshot wound cases which are passed down the 'line' through varied treatment centres; local conditions limited the treatment of 90 of these cases to first aid in the field, and to treatment in a hospital functioning as main dressing station, casualty clearing station, and base hospital, all in one. This permitted continuity in treatment and that close 'follow up' so necessary in correctly assessing a case. Nay, 8 of these cases were followed up from the moment of sustaining the injury. Routine post-operative dressing of these cases, was not left to the nursing staff. Cases were dressed at first twice a day, and later once a day.

The 42 cases reviewed are as follows:

Penetrating wounds of the head	2
" " abdomen	3
" " chest	1
Wounds involving structures other than bone	26
Wounds involving bone	10

Pathologically, these cases can be grouped under one or the other of the three types described below:—

1. A clean-cut, small, and often valvular entry leads to a tubular track. This track has a wall of charred, matted and necrosed tissue. It is clogged with clot and bits of skin, and sometimes, shreds of clothing. At one stage this tubular track can be rolled under one's finger, if not too deeply placed. The exit is irregular, larger than the entry, fissured; and often gapes. This type results from the standard, hard-nosed bullet, fired at effective or closer range.

2. A small entry wound leads to a single or a branching track, with no exit wound. The bullet remains in the tissues, either whole or splintered. The track at first tubular, becomes larger and irregular and may end in a ragged cavity, with much damage to muscle and bone. Lesions of this class are caused by nearly spent missiles, fired from long range, and ricochetting hits. Resistance of thick muscle and bone to the normally travelling hard-nosed bullet may also produce such a type.

3. In this last type, a variable-sized entry, usually small, leads to an irregular track and a large, rugged exit. There is much loss of tissue and skin. Wounds of the third type result from soft-nosed and, dum-dumised, bullets. Disintegration of a hard-nosed bullet before exit would also cause such a lesion if bone resistance were sufficient.

Shrapnel wounds are not considered, no casualties among the number reviewed being caused by them. The types of these wounds, one would assume, are varied. Grouped thus the cases reviewed are 7 in the first class, 18 in the second, and the remainder, 17, in the last.

Summarising pathology, we have much devitalisation of tissue, deep embedding of skin, dirt and clothing which are carried before the bullet; demarcated tubes and isolated nests of necrotic tissue. In gunshot wounds with much loss of muscle and skin, subsequent sloughing seems more extensive than in other wounds. The skin sloughs over a much larger area than the underlying muscle. The area of necrosis radiates

in fanwise planes, spreading out from within outwards; thus suggesting a process not unlike infraction; and perhaps the result of emboli (coagulatad tissue proteins and disintegrated tissues) in the vessels of the injured area.

Comments on treatment are limited to those methods that were found to give the best results; and are divided up into methods of treatment in the field and treatment where operative measures and post-operative treatment can be carried out.

Having satisfied oneself that there is no further free bleeding, a first Field Dressing once put on, if correctly applied, should be left alone. Should further pressure be necessary, a bandage can be applied on top of the dressing. Haemorrhage calls for immediate treatment by local pressure, torniquet, ligature, and sometimes packing. This last is often the only satisfactory method especially in large, oozing, ragged cavities. It is however responsible for sepsis and delayed healing.

The next important treatment is that of shock. It can be carried out by non-medical men; and considering the case is in the hands of the stretcher-bearers, in the early stages; its importance and methods of treatment should be impressed on these men. The appreciation and the treatment of shock should be a stressed subject in First Aid classes. Keeping a patient warm, postural treatment, and all possible handling being done as gently as possible, cannot be overstressed. Fluid replacement is apt to be neglected. Frequent small sips of water to an abdominal case, when injury to the stomach seems remote or is limited to the pelvis, is not contraindicated. Even in other cases, frequently and regularly moistening the mouth is gratifying to the patient and also helpful. In dehydrated cases, it is stated, that water absorption does occur through the bucco-pharyngeal mucosa.

The major factor in the causation of and complication in shock, more especially in the field, is pain. The mental state of the average man in the field favours shock. Continued tension, attack, injury, helplessness in the face of the enemy, fear of loss of limb or life, are potent factors producing a lowered threshold to pain. Pain should be relieved early. Morphia should

be given in a generous dose. Morphia given hypodermically in a hypertonic solution acts within minutes. Solutions of magnesium sulphate or hypertonic saline may be used as solvents for tablets. A third of a grain is a useful dose.

Infiltration anaesthesia, little used so far has, I feel, a definite value in the relief of pain. From its gratifying results in fracture work, and from results obtained in other injuries and some gunshot cases, I am convinced that Novocaine infiltration has a definite place in field surgery. Infiltration with novocaine relieves pain, reduces muscle spasm and facilitates carriage of the patient—a once helpless patient can now fairly look after himself. A valuable advantage of novocaine used early in treatment is that it overcomes that spasm which originally developing as a result of pain is soon established and prolonged as the result of fear or more pain, thus considerably delaying the functional recovery. This is most noticeable in injuries about joints. Healing of the wound is relatively early compared to the restoration of function which is now long delayed as a result of what one may term a developing 'injury neurosis'. This neurosis being peculiar to war wounds and compensation cases.

Novocaine infiltration can be carried out easily and aseptically. Near 150 c. c. of a 1 solution can be safely injected. It does not increase shock. Anaesthesia lasts from 3-4 hours and an ordinary gunshot wound should not need more than 15-20 c.c. It facilitates wound toilet; can be used in cases where shock makes inhalation anaesthesia impossible; and can be repeated safely if a second operation or readjustment of the wound is imperative.

One case had a wound skin-deep, tracking superficial to tendon and bone, in front of his ankle. The entry and exit were clean and small. The patient had morphia and was carried on a stretcher for nearly 16 hours, over very difficult country. He complained of much pain and was anxious. His ankle was fixed in spasm; and though healing by first intention did not have normal movements restored till weeks after. Had the pain been relieved and spasm relaxed, he could have been carried on a pony; and thus saved a stretcher and a tedious

through the heel, and nursed on a Braun's splint. Another case I quote at length because, his wound was fairly severe: the various methods of treatment found satisfactory among the cases reviewed, were tried on him with success; he illustrates many of my comments; and lastly, was an intelligent and 'good' patient.

The wound, septic and ragged, tracked for nearly six inches across the back, with much loss of muscle and comminution of the spinous processes of the twelfth dorsal and first lumbar vertebrae. The spinal cord showed no signs of injury. The canal was intact. The only symptoms of indirect injury to the cord, the result of concussion, and later oedema were almost continuous shooting pains in both legs and feet. The wound had been plugged extensively which probably accounts for the greater sepsis. After trimming the sloughs and removing the comminuted spinous processes, the wound was swabbed out with eusol, then washed out with warm saline and sutured. A drainage tube and gauze dipped in hypertonic saline, completed the dressings. Bandages were found awkward to tie on, and later to remove; a padded jacket with shoulder and chest tapes was improvised; and found most satisfactory. Hypertonic dressings apart from their direct action in draining the wound, seemed to reduce the oedema pressing on the cord; for there was a marked relief of pain in the legs, within half an hour of dressing. The freedom from pain lasting for near two hours. In a few days large areas of skin sloughed; there was little sepsis; all stitches except those a good half-inch from the skin margin, cut through. Eusol swabbing followed by hypertonic saline dressings soon produced a granulating muscle surface. Two or three secondary anchoring sutures were put in. No iodine was used to clean the proximal skin, during the daily dressing and it was noticed that the skin irritation was negligible for a wound of such size. The recovery was prolonged but uneventful. The scar was complete but not too firm and suggested the need for a skin-graft later on.

Dressings and after treatment were carried out twice a day in most cases. Some secondary suturing was done, where primary sutures had given way. Where there were signs or suspicion of retained lead, further removal was carried out.

The case of compound comminution of the middle third of the tibia and fibula called for fine judgment as to early amputation or conservative treatment. A week later, secondary haemmorrhage clinched the issue. A satisfactory amputation was done, but the general condition of the patient gave us some anxious moments. In such cases it seems the alternates lie between early operation and loss of limb, and later operation with loss of limb and grave risk to life because of a deteriorating general condition. The correct verdict is for the experienced to express. I would suggest that delayed skin healing and much breaking down of the skin, point to poor local reaction and favour amputation. In this particular case it was marked.

No mention has been made so far of the prevailing organisms in the wounds. Smears of near a dozen cases showed a predominance of Staphylococcus luraus, a few Streptococci fasealis, and no haemolytic streptococci.

In reviewing the various surgical procedures adopted, one was impressed with the fact that cases in which total excision of the track and delayed primary suture had been carried out, gave the quickest and best healing results. Too much skin trimming was a handicap in healing. In suturing it was found that not enough allowance was made for the fan-shaped areas of sloughing. This resulted in most sutures cutting through. Sutures should be applied a fair distance from the skin margins.

Suturing of muscle was most successful where loose, bridging sutures were used. Dependant drainage was useful.

Insertion of drains through fresh stab wound was superior to placing them in the wounds. No attempt was made to remove comminuted bone lying in position. This gave surprisingly early union in a case of a fractured mandible and fibula, both of which were fairly infected.

The antiseptics used were iodine at the first dressing, then spirits, ether and weak flavine. Weak aqueous flavine was used in light gauze packing. Irrigations were done with eusol.

Swabbing out with hypertonic salines; swabs and packs of isotonic saline; and in the granulating stages, dressings with cod-liver oil, gave the most gratifying results.

Non-irritating dressings of physiological salines which encourage diapedesis and phagocytosis, are superior to chemical antiseptics; and certainly reduce skin irritation.

The procedure follows was as followed. Having cleared the sloughs with swabbing or irrigation with eusol (a procedure which eusol certainly facilitates). The wound was swabbed with hypertonic saline or irrigated with it. If free drainage was considered necessary, hypertonic saline dressings were left on; if not, normal saline was used in fomentation or wet dressings. Sinuses and deeper wounds, exuding much pus, were lightly plugged with gauze soaked in weak aqueous flavine.

To turn to dressings and appliances. Wherever it could be used, rubber tubing was found superior to gauze drainage. Large rolls of bandage make dressing tedious to both patient and dresser: and often do not remain in position. A satisfactory substitute, is a convenient-sized strip of bandage cloth sufficient to go round the part once, and kept in position by tapes sewn on the outside. Various sizes can be made, to suit various parts and various sizes of wounds. They are easily put on and taken off: keep well in place; are washable, hence economical; and can replace the ordinary roller bandage on every occasion except when pressure on a wound is necessary. Similar padded or broad-tailed bandages, are more useful in abdominal and chest cases.

Amputation stumps are best dressed with tubular bags, fairly fitting, drawn over the dressings, and hitched to a girdle round the neck or waist, by tapes sewn on to the open end of the bag. Three bags per case, would cater for all routine and emergent changes. A roll of cotton wool, heated before a fire, after unrolling, swells to twice its size. It can be split to from two new rolls; and is just as efficient, whether used as a padding or mop.

Elastoplast makes a quick, useful dressing. Cases for Elastoplast dressings, should be selected ones. Where free

discharges are present, it should not be used. In the field, it is a good seal for entry and exit wounds. In the wards, cases with mild sepsis and little discharge do well, if a small pad of gauze soaked in weak antiseptic, preferably flavine is first put on; and the wound then covered with a patch of Elastoplast. Dressings that have to be changed earlier than the third or fourth day, call for other treatment.

Small pieces of waterproof sheeting should be used in all types of closed dressings. Their value is obvious.

Most excellent is Braun's splint, in the treatment and nursing of fractures and large wounds of the lower extremity.

Three points in treatment need concluding comment. Care of the skin calls for particular attention. Infection and breaking down of the skin in the vicinity of these wounds, seem common. This perhaps because of the larger area that is deprived of its blood supply. The type of scar produced, suggests a strongly irritative factor; and this 'keloid'scar suggests an etiology other than inherent, in the pathology of keloids!

Early and close attention to restoring joint function, cannot be overestimated in these cases where the circumstances are such as to favour a 'compensation complex' or establish a troublesome traumatic neuroses. Early relief of pain, cutting down the time in bed, earlier removal of splints etc. than in other injuries, early passive movements and sustained encouragement to use the part, will avoid these troublesome and costly complications, and aid early discharge from hospital.

General constitutional treatment has an important place in the treatment of even the less severe cases. Cod-liver oil, Calcium and fresh vegetables and fruit should be included in the diet and treatment charts of all cases. One is struck with the unusual delay in healing and convalescence of even ordinary cases among Indian soldiers. Their marked reaction when placed on a balanced hospital diet, relegates this handicap to their ill-balanced, everyday dietary.

Abdominal Allergy: A Diagnostic Problem*

L. E. Prickman, M. D., Division of Medicine: Nowhere in medical diagnosis is a sound knowledge of general medicine more important than in evaluating allergic problems. This is especially true in studying abdominal allergy and the question of sensitivity to food.

Theoretically the entire abdomen from the outermost tissues of its wall to practically all of its contents, presents many potential sites of countless allergic reactions, with a resulting infinite variety of symptoms, depending on the situation, extent and severity of the reaction. Some idea of the possibilities involved can be obtained from a few simple illustrations.

A large urticarial lesion in the skin of the abdominal wall may cause simple itching; a reaction of the same size, however, involving the parietal peritoneum, may cause localized pain, tenderness and possible extravasation of peritoneal fluid. A similar reaction, this time involving the gastric wall in the region of the pylorus, may cause pain, tenderness, nausea, vomiting and other symptoms; involving the bowel in the region of the cecum, there may result symptoms and physical findings simulating appendicitis; or involving the urinary tract, the wall of the bladder as an example, it might produce frequency, urgency, dysuria and other symptoms suggesting possible cystitis, and so on. There are, of course, numerous reports in the literature of allergy and of gastro-intestinal and genito-urinary disease, on the occurrence of just such lesions which have been attributed, correctly or incorrectly, to allergy.

A familiar example of acute abdominal allergy is the young man who, within a few minutes after eating shrimp, experiences urticaria and swelling of the face and throat, increased peristalsis, severe abdominal pain and cramps, and vomiting and diarrhoea, all of which promptly subside after subcutaneous injection of epinephrine. It is common knowledge that many different foods, such as chocolate, milk, eggs, fish, nuts, cotton seed oil, and others, are capable of producing similar severe abdominal and generalized reactions in susceptible individuals. It is possibly less well known that individuals who are hypersensitive to drugs may react with similar severe allergic storms, with abdominal pain and vomiting as prominent symptoms.*

Such clear-cut instances of acute abdominal allergy as that just mentioned are comparatively uncommon, and in themselves do not present any diagnostic problem. The reaction is sudden, severe and definite; the condition usually responds promptly to administration of epinephrine, and the food or drug responsible for the attack is usually well known to the patient.

The transition from abdominal conditions of known cause, as represented by the shrimp-sensitive person previously referred to, to those of unknown causes, some of which conditions may be attributable to allergy, is very sudden. A host of symptoms and conditions is referable to the abdomen and its contents, conditions which usually are not associated with demonstrable organic disease and which have been loosely grouped as "functional." These present real diagnostic problems; it is especially difficult, in fact frequently impossible, to determine whether a given set of symptoms is caused by disturbances of physiology attributable to organic or functional causes, or whether they are defensive in nature or of allergic etiology.

In the large "functional" group from time to time are found individuals whose symptoms are attributable to allergy. As a result it is now customary, and rightly so, to consider carefully the possibility that allergy may be the basis of many complaints referable to the abdomen. The degree of the allergic reaction varies so tremendously, from mild to severe, in different cases and the situation and extent of the disturbances vary so greatly that the possibility of allergy must not be overlooked in the differential diagnosis of practically all abdominal conditions.

* Abstract of paper published elsewhere.

* Prickman, L. E. and Buchstein, H. F.: Hypersensitivity to acetylsalicylic acid (aspirin). Jour. Am. Med. Assn. 108: 445-451 (Feb. 6) 1938.

Although many instances of vague abdominal distress have been shown in certain cases, to be attributable to eating specific foods to which the patient is allergically sensitive, and with avoidance of the food the symptoms have been relieved; not all such symptoms, of course, are attributable to allergy. They may also represent early evidence of organic disease, too early to be demonstrated roentgenologically or by other diagnostic means; they may represent referred symptoms from some distant organic condition, or still more likely they may be the result of overeating, of fast eating, or eating when nervously upset, or they may be the effect of so-called nervous dyspepsia. Eusterman* has expressed the belief that nervous factors are responsible for the symptoms in many suspected cases of abdominal allergy.

The problem is further complicated by the possibility of organic disease being associated with allergic manifestations, or of organic disease afflicting an allergic individual. For instance, an allergic patient, a physician was found to have gallstones. He had the typical colic and the qualitative type of dyspepsia so characteristic of cholecystic disease. Replying to an inquiry as to how long he had had trouble, he replied, "I've had the colic for about three months, but I've had food allergy for years." What is the correct interpretation of his history? Are this man's symptoms excepting or including the colic, attributable to actual organic cholecystic disease, of infectious, metabolic or mechanical etiology, or are they attributable to allergic intolerance to foods (abdominal allergy) as he concluded? Assume that the next individual seen gave exactly the same history and findings except that he was not an "allergic" individual as well; should one place the same or a different value on the possibility that food allergy is responsible for the qualitative dyspepsia?

Many problems in the diagnosis of abdominal complaints are solved by thoroughly considering the allergic possibilities involved. The typical symptoms of duodenal ulcer are usually attributable to duodenal ulcer, but at rare intervals, one may encounter an individual who has typical symptoms of ulcer,

* Eusterman, G. B.: Personal communication to the author.

but no ulcer is found and the patient is later shown to be sensitive to milk or some other food. When the specific food is omitted from his diet, the patient's symptoms are relieved. It is important, therefore, to consider the allergic possibilities in any such case in which ordinarily satisfactory medical or surgical treatment fails to produce results.

How often abdominal symptoms are attributable to allergy is unknown. One of the chief hindrances to better knowledge of abdominal allergy is our inability to determine accurately which individual, or which condition, is or is not allergic. Only too frequently the diagnosis of allergy in an individual case is a matter of opinion. As has been pointed out by Alvarez and Hinshaw,* sensitiveness to food is not all allergic in nature. They stated, "actually, there is no reason for assuming that even a large number of the patients with whom foods disagree suffer in an allergic way. The trouble does not have to have an allergic mechanism back of it, even when it occurs in persons who suffer with allergic types of disease. Substances such as pepper and mustard and alcohol may well alter peristalsis by direct irritation of nerve endings in the mucosa of the stomach and the intestine. There are reasons for suspecting that cucumbers, melons, and tomatoes contain an emetic substance that in small doses produces only regurgitation and belching. Fats can produce of their tendency to delay the emptying of the stomach, and flatulence and colicky distress can be due to the presence in some foods of laxative substances which in small doses produce only peristaltic unrest."

To determine whether a suspected food is actually responsible for a patient's symptoms, the patient should avoid the food for about ten days; if relieved of his symptoms, he then should eat the food in sufficient quantity to provoke the symptoms about which he complains. No individual should be advised permanently to exclude a certain food from his diet until the above test has been carefully carried out, not once, but several times, so that the patient and the physician alike are absolutely certain of their ground. Many patients are

* Alvarez, W. C. and Hinshaw, H. C.: Foods that commonly disagree with people. Jour. Am. Med. Assn. 104: 2053-2058 (June 8) 1935.

susceptible to slight suggestion, so that advice as to their sensitivity to foods, based only on skin tests with foods for instance, has led many an individual to eat a totally inadequate diet, sometimes with serious results.

The problem of abdominal allergy is a diagnostic rather than a therapeutic one. When hypersensitivity to a food is known to be the cause of abdominal symptoms, complete avoidance of that food is indicated. Certain allergists advocate feeding gradually increasing amounts of the food in question, and this also may be attempted cautiously, although when possible complete avoidance is preferable.

In conclusion, four points seem worthy of special emphasis: 1. In the differential diagnosis of abdominal conditions, the possibility that allergy may be responsible for some or all of the symptoms must not be overlooked. 2. The attempt should not be made to explain as allergic, all diseases or symptoms of an allergic individual. The allergic patient may have bunions, gallstones, hypertension, nervous dyspepsia or psychoneurosis just as the nonallergic individual may have them. 3. With the exception of cases of drug allergy, the accepted indications for medical or surgical treatment in a given case are rarely changed by the mere fact that the patient is allergic; on the other hand, if any question of diagnosis is involved, careful consideration of the allergic possibilities is indicated before carrying out any but emergency medical and surgical treatment. 4. When a choice must be made between surgical intervention and allergic treatment in a doubtful case, as might occur when there is pain in the right lower abdominal quadrant, simulating either appendicitis or abdominal allergy, it is safer to adhere to accepted surgical principles of diagnosis and treatment.

Minutes of the General Body Meeting

Dated 28-2-1938 at 5 p.m., in E. R. High School, Trichy.

A monthly meeting of the above Association was held at 5 p.m., on Monday the 28th inst. in the E. R. High School, Trichinopoly, when 56 members were present. Dr. C. E. R. Norman, the President of the Association, presided and was at home to the members. Before the commencement of the meeting the Secretary appealed to the members to take some interest in the publication of the Miscellany by contributing extracts, articles and case-notes. The Treasurer made a statement of the financial aspect during the month and appealed for brisk payment of arrears of subscription. After the President's preliminary remarks, Dr. K. Rama Menon, M.B., F.R.C.S., Assistant District Medical Officer, Trichinopoly, delivered an interesting and constructive lecture on "Some Surgical Emergencies", laying particular stress upon early diagnosis and prompt treatment. After the lecture there was an interesting discussion, in which Col. Bal. Dr. Shastri and others participated. With a vote of thanks to the Chair and the Lecturer the meeting terminated at a late hour.

TO

THE EDITOR,

THE MISCELLANY,

Trichinopoly.

SIR,

I wish to bring to the notice of the Profession through your valuable Journal the following two interesting experiences.

About the middle of last year I was consulted about a curious case. A lady aged about twenty, healthy but rather thin, was shown to me with ulceration of the cutaneous and mucous sides of the lower lip. She had not conceived previously. She

had her menses 4 days back. For the last three menses she had acute pain during the periods at the beginning. The local doctor of her place gave her some medicine and the pain subsided on the second day. But on that day her lower lip began to itch intensely, swelled up and on the third day small papular eruptions appeared which went on to ulceration and eventually healed up in three or four days. This happened every time during the last three periods. I thought it might be due to some irritation of the sensory nerves of the lower lip as in herpes brought on by some defect in the ovarian function, which also is evidently the cause of the dysmenorrhoea. I prescribed her Harmotone and treated her lip. It got well in three days as usual. 25 days later I saw the lady; it was the first day of menses and she had acute pain. I gave her a sedative mixture. Next day I was told that the pain had not subsided but that she had no trouble with her lip, and that the doctor in her place had given her last time a tablet which relieved her of the pain. I thought that it might be Veramon (Schering) and gave her a tablet. Next morning I was surprised to see her with a swollen itching under lip. She told me that within an hour of taking the tablet her lip had begun to itch though her pain had begun to subside. She did not feel any itching anywhere else. I gave her adrenalin and a mixture with calcium and she was well the next day without any further trouble. She told me that the other doctor gave her a similar yellowish tablet during the last three periods when she had menstrual pain.

One night, last week, Mr. V. came to me with abdominal colic not confined to particular region. He said he used to have it often when he was not discreet in his eating, but that, this time it being more severe he had come to me. I gave him a dose of carminative and a tablet of Veramon. Next morning he came to me and I was surprised to find both his lips enormously swollen up. He said that within about an hour of his taking the tablet in the night, his colic had subsided, but his whole body began to itch specially both his lips which swelled up as soon as he rubbed them. The itching was much less in the morning I gave him adrenalin and a mixture containing plenty of calcium. By next morning he was well.

These look like anaphylactic reaction. I would like to know if my brothers in the Profession have had similar experience with this drug.

T. S. B.

[One wonders if it could not be put down to that particular batch of tablets. In our experience where Veramon has been continuously used over two years, no anaphylactic reactions have been noted, fortunately. *Editor.*]

THE EDITOR,

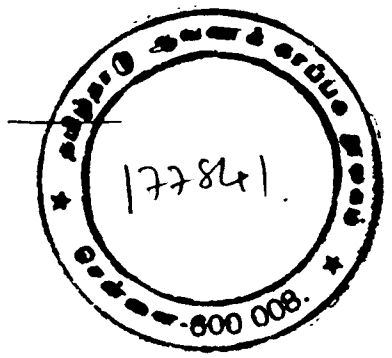
Miscellany.

SIR,

Could any of your readers suggest a line of treatment. A young man of 30 in general good health with a 'rash' on both hands limited to the fingers, dorsum and wrist. The rash comes up in a small papule, grows vesicular and ulcerates; heals; spreads forwards and after throwing up a flaky scab commences again. It is painless, non-irritating except when sweating and very persistent (2 months). There is no history of chemical irritants or syphilis.

Yours etc.,

DERMATOSES.



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