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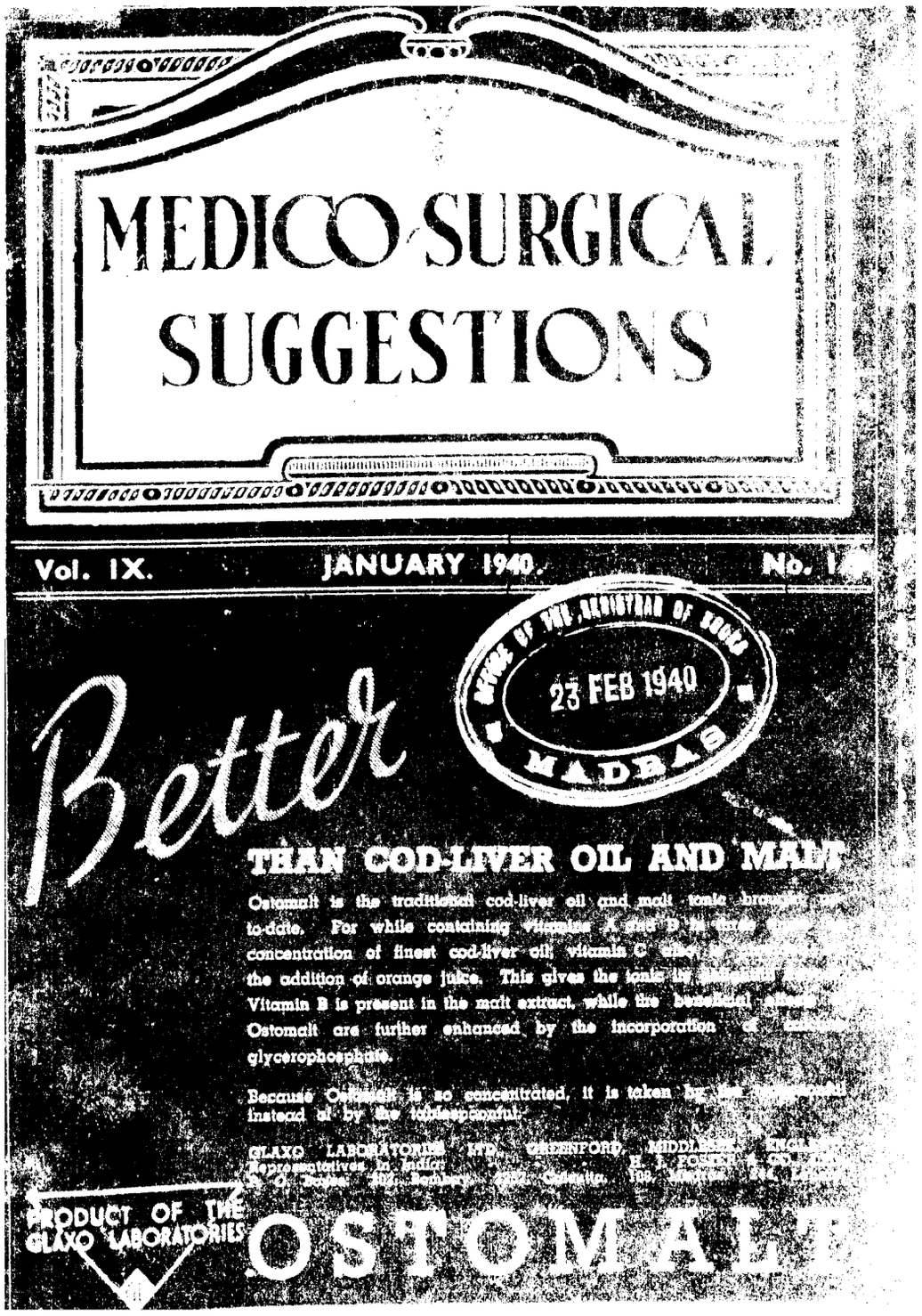
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MEDICO-SURGICAL SUGGESTIONS

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CONTENTS

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MEDICO-SURGICAL SUGGESTIONS

VOL. IX JANUARY 1940 NO. 1

Original Article.

IMMUNITY TO DENTAL CARIES

BY DR. S. K. GUPTA, B.D.SC., B.O. (PB).
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PASRUR, (Pb.)

The influence of heredity is not a factor in producing immunity to dental caries, but there appears to be some factor, as yet undiscovered, that tends to produce good teeth in the majority of children of some families.

There is no evidence that the chemical composition of the food plays any great part in producing this result, except in so far as a well-balanced diet provides an adequate supply of the mineral salts which is not depleted by an excess either of fat or protein.

The outstanding fact of the observation appears to be that 97 to 98 out of 100 of the children have good dental occlusion, that is to say, the teeth are well formed and well arranged in the jaws. It is probable that good dental occlusion renders the teeth almost self cleansing, because it facilitates the cleansing action of the tongue and the cheeks; it is thus the first essential in producing immunity to dental caries.

The observation appears to support in some ways each of the opposing theories on the production of dental caries, that which asserts that cleanliness of the teeth is the chief factor, and that which maintains that the structure of the tooth is its real protection. The truth is probably a combination of these theories.

In this connection it is interesting to note the result of observations made by me of the teeth of thirty children of 6 years of age—fifteen with perfectly sound teeth and fifteen with practically every tooth carious. The majority of the immune children had been breast-fed. The tendency of the teeth of these was to be well-spaced and set in a wide regular arch. In every case, too, the child was a nose-breather, all tonsils being normal. In the case of the children with carious teeth, two-thirds were bottle-fed, and the teeth set in narrow arches. In every case the tonsils were enlarged some were

exceptionally big. The standard of intelligence was higher for the immune children than for the ones with carious teeth.

The supperless child, too, seemed to have a big advantage over a child who went to bed "on a full stomach."

CONTRACEPTION

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Augusta

The average layman is much more familiar with the term contraception and its meaning than most medical students and physicians, so the aim of this paper is not so much to bring you a treatise on contraception as it is to prick your curiosity and professional pride. Contraception is the conscious control of the birth rate either by mechanical, chemical or operative means. Contraception is not new but until recently it has been unrecognized. It should be looked upon by the medical profession as one of the most progressive steps in the field of protective medicine; it is not a destructive thing but is a preventive worthy of as much notice as any vaccine used in the field of preventive medicine.

The principal medical factors involved in present day contraception are:

1. Sexual intercourse that is adjusted in frequency, duration and mutual response for the well-being of both partners.
2. Pregnancy to result only as often as it is feasible for the health and well-being of mother and child.
3. Control of conception when the above mentioned conditions cannot be met.

When selecting a contraceptive for a couple the physician should be as careful as he would be when preparing for a major operation, for it is just as important to those concerned. There are certain physiologic and psychologic factors that should be considered in the choice of the contraceptive. Frequency of intercourse, duration of the act, the amount of natural lubrication present and male and female rhythms have some bearing on the selection.

The amount of safety afforded is as varied as the types of contraceptives. The Consumers' Union of the United States has classified contraceptives as *unreliable*, *harmful* and *reliable*. The *unreliable* methods of control are: lactation, the safe period, foam tablets, powders, suppositories, douches, tampons and sponges, jellies and spermatoxins. The average woman is less fertile while lactating, but to prolong this period is neither wise nor safe. The calculation

of the safe period is not easily understood by most women and the fact that accurate records should be kept for long periods of time before applying the method make it more difficult. Two proponents of this method, Dr. Reiner and Dr. Latz state that the "safe period" should not be used for several months after confinement, miscarriage or abortion; nor after fever and debilitating diseases, or severe physical injuries; nor after a drastic alteration in the routine of life, such as prolonged travel in a strange climate; nor after strenuous exercise. The foam tablets are dependent upon moisture to liberate carbon dioxide, thus if the vaginal secretion is slight the male ejaulation may take place before the vaginal walls and cervix have been coated. The dry powders may not spread sufficiently to be effective. The suppositories carry the same objections as the powders. Douches, as a contraceptive method, are reliable only for those women who are less fertile. Tampons and sponges are too easily pushed aside during intercourse and even though they remain in place they are apt to be medicated with some irritating chemical. The spermicidal jelly is more effective than the suppositories, tablets and powders providing the woman has never been pregnant, but where there has been one or more pregnancies the jelly is very unreliable. The use of spermatoxins is still too much in the experimental stage to be a safe contraceptive; there are also the dangers of psychic shock and permanent sterility.

The *harmful* methods are: coitus interruptus, intrauterine stems and the Grafenberg Ring. The withdrawal of the penis before ejaculation gives rise to psychic disturbances as a result of the fear of pregnancy, and lack of satisfaction; and possible pelvic disease as a result of prolonged use of the technic. The intrauterine stems provide a ladder for infection, cause irritations and often perforate the uterus The Grafenberg Ring may induce marked uterine contractions, chronic inflammation and even excessive bleeding.

The *reliable* methods are: the condom, the diaphragm used with spermicidal jelly, the cervical cap and jellies used with the condom or diaphragm. The condom is a much better method of contraception than is commonly believed. It falls short of complete efficiency because of the poor quality of the commercial brands, about 60 per cent of the total sold are defective; and because the average man is apt to understand neither the technic of application and removal nor the art of testing and preparing one for use. Their satisfactory use demands care and foresight from an intelligent. unprejudiced user. The condom used with a contraceptive jelly should give a protection equal to that given by a diaphragm and jelly. The vaginal diaphragm is a much newer method than the condom and is harmless. It is physically acceptable except where there are conditions that hamper deep reach into the vagina, chiefly thick abdominal walls and shortness of fingers. Extreme relaxation of the

vagina, a much damaged pelvic floor or a marked cystocele hinder the use of the diaphgram. Not all women can be perfectly fitted but a questionable fit is often preferable to the use of other methods. Dullness of intelligence and absence of real willingness to take the trouble to secure protection are causes of many of the failures where this method is used. When properly fitted and properly inserted neither the man nor the woman is conscious of the vaginal diaphragm. The coiled-spring type is the most frequently prescribed vaginal diaphragm. The cervical cap differs from the vaginal diaphragm in that it fits snugly over the cervix instead of lying along the vaginal wall. It is held in place by suction. The cervical cap may be made of rubber, bakelite, celluloid or metal. This type of pessary is more difficult to insert than the vaginal type, but when prescribed by a physician who selects the correct size and carefully explains its use it is fairly safe. There are many contraceptive jellies on the market but there is perhaps no one jelly which is suitable for all women, since women react differently to the various formulas and may complain of irritation, excessive lubrication, or dryness. Some of the necessary specifications of a reliable jelly are: spreads readily, adheres well, keeps well, kills spermatoza instantly, be odorless or pleasant in odor, and non-staining and non-poisonous if absorbed. The Bir-con-jel, Lanteen Blue and Locorol should not be acceptable because they do not meet the above mentioned requirements.

The ideal contraceptive, according to Dr. Hannah Stone, one of the country's leading authorities on contraception, is "harmless, entirely reliable, simple, practical, universally applicable and esthetically satisfactory to both man and wife." Modern methods fulfill most of these qualifications but there is as yet no method which is infallible or universally applicable

"An increase in the number of successful marriages will depend in no small part on the increase in the kind of knowledge the physiologist and the physician can furnish. Protective medicine has a special function in the matter of sex instruction. For members of his own profession as well as for other teachers, the physician has a duty to attempt some clear formulation of the physics of the begetting of children and of love comradeship for life, set forth with dignity and directness. The present training in taboos and the present unpreparedness for the most important of our industries, home making, can be amended only by sound education."

The fact that the *American Medical Association* and the federal and state governments have frowned upon contraception until recently has caused the majority of physicians to shy at their duty to patients and society. Even now no federal law has been repealed or amended, but the status of the physician has been clarified by a series of legal interpretations culminating in the U. S. Circuit Court

of Appeals in which it was stated: "Its (the Comstock Act) designs in our opinion was not to prevent the importation, sale or carriage by mail of things which might intelligently be employed by conscientious and competent physicians for the purpose of saving life or promoting the well being of their patients." Some of the state laws are still ambigious, but it is fairly safe to assume that in view of the three decisions by the high courts a successful prosecution under these laws would be improbable. The physician is, therefore, free to give contraceptive advice to his patient in private, hospital or clinic practice. The recent action of the House of Delegates of the *American Medical Association* marks a very important milestone in medical contraception. The four specific recommendations are:

1. That the American Medical Association take such action as may be necessary to make clear to physicians their legal rights in relation to the use of contraceptives.

2. That the American Medical Association undertake the investigation of materials, devices and methods recommended or employed for the prevention of conception, with a view to determining physiologic, chemical and biologic properties and effects, and that the results of such investigations be published for the information of the medical profession.

3. That the Council on Medical Education and Hospitals of the American Medical Association be requested to promote thorough instruction in our medical schools with respect to the various factors pertaining to fertility and sterility, due attention being paid to their positive as well as to their negative aspects.

4. All dispensaries, clinics and similar establishments where information and advice concerning the prevention of conception are given to the public should be under legal licensure and supervision and under medical control.

(*The Journal of the Medical Association of Georgia, Feb. 1939.*)

ORAL LESIONS AS SOURCES OF INFECTION.

THEIR DIAGNOSIS AND TREATMENT

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Colorado Springs.

Three types of lesions involve the tissues of the oral cavity. First, those which are local manifestations of some constitutional disorder for which local therapy is of little value other than as a palliative measure. They rarely constitute true foci of infection and respond only to systemic treatment. The second type consists of neoplasms of both benign and malignant character which may or

may not be of dental origin. However, chronic irritation from defective dentition may be considered as the chief contributing factor. Some, such as the leukoplakia of syphilitic origin, are constitutional. The third type is the typical oral focus of strictly dental origin, but its ramifications extend beyond the commonly accepted focus of oral infection—the non-vital tooth. This discussion will treat only of those lesions that commonly involve the teeth and investing tissues.

A differential diagnosis of oral lesions requires a routine clinical, roentgenographic, and biopsy examination together with a co-operative medico-dental consultation. To evaluate the importance of a complete diagnostic routine for locating dental foci it is necessary to realize the indefinite nature of the potential symptoms either local or constitutional which may emanate from such a focus. As no differential interpretation can be made between oral and other body foci, and as the great majority of oral foci seldom manifest local symptoms; the process of diagnosis consists of the elimination of their possible presence by a positive survey of all areas.

It also becomes necessary to comprehend thoroughly the dental mechanism and its function in order to recognize any existing anatomic or physiologic deviation from the normal. Lesions of dental origin may involve not only the teeth and alveoli but the supporting jaws, the tongue and sublingual tissues, the structures of the lateral throat, and the maxillary sinuses.

From the inception of the foci theory of infection and the general recognition of the importance of oral foci in particular, a proper and emphatic protest has been voiced by many members of both the medical and dental groups against the indiscriminate removal of teeth. If only non-vital teeth had been removed the protest would not have been so well founded; but in many instances wholesale extractions were ordered by members of both groups, their condemnation of the teeth based only on clinical appearance or faulty x-ray diagnosis. In many cases all of the teeth were removed, leaving the actual foci undisturbed. Naturally, the entire theory of oral foci was promptly questioned.

The mere clinical aspect of a tooth should not condemn it to extraction, for many normal and healthy teeth, thinly overlaid with restorative dentistry, are needlessly lost while a tooth without visible defect may maintain a positive focus of infection. It becomes then a matter of a comprehensive survey of the oral cavity and related tissues, findings of which in many cases require a medico-dental consultation before radical surgical measures are instituted.

For instance, the prevalence of Vincent's Angina, classified as a superficial oral infection, demands closer co-operation between medicine and dentistry if we are to combat the rapid increase of this disease. Simple medication without dental instrumentation is useless. The anaerobic characteristics of the Spirochaete of Vincent and the

associated Bacillus fusiformis require and depend on subgingival irritation where suitable pockets and culture media are provided for its cultivation. In its acute stage a rapid deposition of serumal calculus increases the depth of these pockets, thereby assuring continuation of the subgingival irritation.

That a case of acute Vincent's Angina ever occurred in a perfectly normal mouth is doubtful; and it is equally doubtful that a cure was ever effected without dental instrumentation to remove the retentive pockets. It is believed that this failure to resort to dental instrumentation is responsible for the frequent recurrence of the disease and the many chronic cases presenting for treatment. Chronic Vincent's Angina results in ultimate loss of dentition through direct destruction or subsequent periodontoclasia. A negative smear is of little value.

Deep bacterial invasion of the investing and supporting tissues of the teeth may occur by way of defective gingiva, from non-vital teeth, as the result of retained residue from dental surgery or though the functionless developmental crypts of unerupted and partially submerged teeth. In any case a typical focus of dental infection develops.

Invasion by way of a break in the continuity of the gingival attachment is caused primarily by deposition of salivary calculus beneath the free margin of the gum. When augmented by rough and overhanging margins of dental restorations a rapid disintegration of the alveolar crest and an accompanying edema of the gingiva results in periodontoclasia—the modern terminology for pyorrhea alveolaris. As subgingival destruction advances the edematous constriction of the gingiva about the necks of the teeth prevents drainage of underlying areas. Thus the rapidity of bacterial invasion is greatly increased and a positive focus established.

Subgingival foci in the form of deep periodontoclasia may be a continuous horizontal destruction of the alveoli or individual pockets about a group of teeth. In either type the bacterial invasion may terminate in destruction of bone in the periapical region of the roots and result in devitalization of the teeth involved. Thus we have a combined peridental and periapical focus. The commonly recognized periapical foci are the direct result of non-vital teeth in which devitalization has occurred because of detnal caries, traumatic injury, or thermal shock.

The technical difficulty of the successful preservation of teeth by root canal therapy lies in the anatomical structure of the root. The canal in the apical region terminates in multiple foramina rather than in a single foramen. This precludes the assurance of complete mechanical enucleation of the nerve tissues and the substitution of sterile root canal filling.

The retention of but a small portion of putrescent nerve tissue within the canal will create first a gaseous pocket at the root apex which ultimately fills with pus. This is the primary abscess. With this acute stage past, a granulomatous mass fills the apical cavity and remains until, through tissue intolerance, acute disintegration occurs and the whole process is repeated with marked extension of the area involved.

Many technics have been in vogue for the treatment of non-vital teeth. From observation of the limited success of these treatments it would seem that the deciding factor still is the degree of resistance to infections naturally inherent in the host. However, in view of present day knowledge, teeth which appear roentgenographically negative and clinically sound in patients presenting negative medical histories may be retained provided the host is cognizant of the potentialities of such a tooth.

A positive non-vital tooth is one which displays any break in the periapical continuity of the peridental membrane. Thus periapical change, from the slightest break in the membrane to gross disintegration of apical bone, would indicate a focus of infection and warrant the removal of the teeth. To differentiate between those of high or low bacterial virulence is impossible by other than laboratory methods. This naturally requires the removal of the tooth first making the value of the findings purely statistical or a definite confirmation of systemic diagnosis.

Residual areas containing foreign materials, sections of roots or granulomatous debris are in nearly every instance foci of infection. Usually covered by gum tissue they present no clinical evidence of their existence other than at times a lack of normal dental ridge resorption in the immediate region.

A minute particle of retained residue may cause extensive disintegration of bone and remain unencapsulated indefinitely. Prolonged retention of sub-periosteal infection results in a marked increase of calcific deposits throughout the surrounding bone. This increases the difficulties of roentgenographic interpretation as the proportionate resistance of these areas of eburnation to the penetration of the x-ray will obscure the residue present. Areas of eburnation should be viewed with suspicion.

The retention of a slender root tip in the alveoli is as serious a matter as the retention of the entire root of a non-vital tooth which may by size alone maintain drainage through the gum tissue rather than by systemic absorption. Roentgenographic examination of so-called edentulous mouths discloses subperiosteal foci in 50 per cent of these cases. It is common to find unerupted teeth and numerous residual areas under dentures which have been worn for years.

Following the normal period of tooth development, the encapsulated developmental tissues of the dental crypt of unerupted and

impacted teeth will disintegrate and become positive foci of infection. Irrespective of location, these teeth, whether remotely impacted or in open communication with the flora of the mouth, should be removed. A tooth unable to assume its proper position in the dental ridge, whereby all encapsulating tissue may atrophy, should not be retained. Few impacted teeth fail to communicate with the oral cavity by way of the periodontal space of adjacent teeth. Once communication is established the dental crypt becomes an ideal culture bed with perfect media for the propagation of all species of organisms. Especially is this true for the perpetual production of the anaerobic species of Vincent's Angina. During an institutional epidemic of Vincent's Angina among twenty-nine student nurses the removal of all impactions having communications with the mouth eradicated all acute cases. This result was obtained after repeated failure of all other methods of treatment either local or systemic. Some forty unerupted teeth were found of which twenty-seven were impacted. Unerupted teeth which obviously cannot assume their proper positions should be located and removed at ages from eighteen to twenty-one.

Cystic odontomas are fairly common and, though not oral foci, often become infected from adjacent traumatic irritation or pathologic processes. They occur in equal numbers in both maxilla and mandible and are commonly referred to as simple, follicular, or dentigerous cysts. Usually encapsulated, they are easily distinguished from residual areas, but careful differential diagnosis is necessary to distinguish between them and the more rare adamantinoma.

Adamantinoma occurs in nearly all instances in the molar region of the mandible and involves the posterior body of the bone and the ascending ramus. Roentgenographically it appears as a multilocular cyst partially encapsulated and partially in the process of active bone disintegration.

A complete x-ray oral diagnosis requires fourteen or more intra-oral films for the teeth, at least two extra oral plates for the rami and, in cases of some dental anomalies, various views of the maxillary sinuses. With these at hand each tooth must be accounted for and, if erupted, tested for vitality to verify, clinically, the periapical condition of the roots. The degree of response of each tooth to the vitality test will be in ratio to age and extent of dental restorations. In many cases this test is of no value and diagnosis must depend on the roentgenographic findings. All edentulous spaces must be checked for residue and proper postoperative bone calcification. The clinical height of the gingiva should be compared to the roentgenographic height of the alveoli to determine the depth of any existing peridental pockets. All areas of rarefied bone must be noted and diagnosis must distinguish between bacterial invasion and traumatic occlusion.

(*Rocky Mountain Medical Journal Feb. 1939.*)

THE PROBLEM OF CHRONIC ALCOHOLISM AND ITS TREATMENT.

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The general medical attitude to patients with alcohol problems, together with my own feelings, have been expressed in a recent paper which stated, "For many years, American psychiatry, with few exceptions, has looked upon the alcoholic with more or less hopelessness. This notion has become so deep-rooted in most sections, that one finds the individuality of the patient unjustifiably lost in the condemnatory fatalistic 'hands off' attitude of some of our colleagues. I do not wish to imply that there is hope for all alcoholics, for one must concede that many are past correction. However, a carefully selected number can be guided and helped to attain the goal of all therapy (total abstinence) by an objective, dispassionate and individual approach."

Society has termed individuals with alcohol problems as alcoholics and chronic alcoholics. The terms alcoholic and chronic alcoholic as used here include only the pathologic drinker and definitely exclude the social drinker. The social drinker can "handle" his or her alcohol while the other is "handled" by alcohol. That is, social drinking does not interfere with the individual's important life activities in business, in the home, in the family and in the community. Problem drinkers, uncontrolled drinkers, dipsomaniacs and spree drinkers are all pathologic drinkers. Chronic alcoholism is a very complex social and medical problem. I do not feel that all chronic alcoholics necessarily are poorly integrated individuals. Henderson and Gillespie state that "chronic alcoholism develops in a wide varity of persons; in some because of opportunity (barmen) in others because of the social environment, and in others it begins as a reaction to difficulties or as an expression of a psychopathic disposition (manicdepressive, for example)."

Successful results measured by total abstinence have been obtained by many approaches both lay and medical. Occasionally chronic alcoholics have rehabilitated themselves, others have been helped by friends, some by religious conversion, and others by temperance pledges. In Switzerland remarkable results have been obtained by a more or less lay society, "The Blue Cross." Henderson and Gillespie state that "psychological treatment has proved of great value in isolated cases more often than is generally realized."

METHOD OF SELECTION

The handling of the alcoholic should always be based on the study of each individual as presenting a separate problem. All patients should not be treated alike, as one usually finds in many of the mass treatment "alcohol drink cures." Before therapy is decided upon, a complete investigation of the patient is made by obtaining all the available facts through a biographic history from birth to the present, including his place in the family, developmental data, presence or absence of disturbing behavior in childhood, adjustment in school, vocation and marriage, sexual life and its complications, religious habits and feeling, financial status, family situations and his emotional attitudes to them. The formal studies of the mental status include the general behavior, stream of activity, mood, special preoccupations, sensorium and intellectual resources and insight. A physical and especially a neurologic examination is made to determine the presence of any organic disease. A partial or more detailed personality study, summing up the patient's assets and liabilities, is then prepared. The family and other relatives are interviewed for additional helpful information. The material thus obtained and studied is then used as an aid in determining why this particular alcoholic drink and to what treatment approach the patient belongs.

What aids are used to fit the treatment to the individual? A very important one is the presence or absence of a definite desire to abstain. If this desire is present, is the patient honest, sincere, and genuine about it? What are his alcoholic contacts in business and social life? If the patient is associated with the alcohol industry one should not attempt to help and guide him at home but he should be placed in a rest home farm. The make-up of the individual is, of course, very important in deciding the course to follow. He should have average or better intelligence; but a high degree of intellectual endowment alone is not enough, for there must be some degree of maturity in his emotional make-up. The apparent reason for drinking also aids one in selecting the patient. After studying many patients one finds one or more of the following apparent reasons:

1. As an escape from situations of life which he cannot face.
2. As evidence of a maladjusted personality (including sexual maladjustment).
3. As a development from social drinking to pathologic drinking.
4. As a symptom of a major abnormal mental state, such as a depressive or schizophrenic reaction, etc.
5. As an escape from incurable physical pain.
6. As a symptom of a constitutional inferior—a psychopathic personality, i.e., an individual who drinks because he likes alcohol, knows he cannot handle it, but does not care.

Many times one cannot determine any great and glaring mechanisms as the basis of why the drinker drinks; but the outstanding fact may be elicited that alcohol is taken to relieve a certain

vague restlessness in the individual incident to friction between his biologic and emotional make-up and the ordinary strains of life.

The psychiatrist then determines to which of the following the individual belongs:

1. The individual who desires to abstain but who is unable to do so by himself. This paient has the desire to abstain and his life habits and contacts are not too bad; he has good intelligence and some maturity in his make-up. This patient is to be handled in outside office practice type of psychotherapy.

2 The individual who desires to abstain but is unable to do so by himself, who has poor habits and contacts, good intelligence and some maturity in his make-up. This patient should be placed in a rest-home farm where psychotherapy including help and guidance away from his contacts is started.

3. The individual with good intelligence, with rather immature make-up, who should abstain but does not desire to do so. Most of this group have poor habits and contacts, although some do not. This patient should be placed on an alcohol farm, sanitorium, or hospital under the Inebriate Act, for a definite length of time.

4. Korasakow's psychosis and alcoholic deteriorate patients are treated in mental hospitals permanently.

5. Individuals with delirium tremens should be placed in acute psychopathic hospitals and then studied in the above way for future handling.

6. Feeble-minded individuals with history of repeated commitment to the workhouse or house of correction, after careful examination, should be handled by the penal system.

THE TREATMENT

Henderson and Gillespie, in discussing the treatment of alcoholism, state: "The kind of treatment to be adopted, and the hope entertained for it, depends partly on the type of chronic alcoholic with whom one is dealing, and partly on the stage at which he comes (or is brought) for treatment Careful investigation from a physical and psychiatric viewpoint is an essential preliminary. Where alcohol is found to be a symptom of some disease, mental or physical, as general paralysis or a recurrent manic-depressive psychosis, the treatment is that of the underlying disease. When the alcoholic habit itself is in the forefront, the chief line of attack is a thorough investigation of the factors of the patient's life and personality. Usually the first step that should be insisted on is that the patient should place himself in a nursing home or in a hospital where he can be adequately supervised. This, of course, is usually what the patient refuses to do, but with the exercise of tact and patience it is often possible in the early stages to get the patient's co-operation. In our experience, the psychologic viewpoint is usually a revelation to the patient, and the physician who places

it before him is at once at an advantage; for always the patient has been taught by his friends that his condition is simply one of moral turpitude, and nearly always he has personally come to regard his alcoholism as mysterious and inevitable. The patient's good will having been gradually obtained in this way, it is usually possible to show him the factors, psychologic and circumstantial, which have contributed to his illness; and to show him how they can be more satisfactorily dealt with Advice also about the conduct of his life in future gives the patient back some of his self-confidence, which in the early stages of alcoholism has often been lost. Complete abstinence should be insisted on. The patient has usually to be taught that it is not unmanly to the abstinent. An avoidance of unnecessary opportunity for drinking is extremely important; for example, it is nearly hopeless to send him back to work as a bartender or an excise-man. The cultivation of hobbies and social recreation of a healthy kind to replace the discarded alcoholism is also important. When the immediate treatment is finished with and the patient returns to work, he should be encouraged to keep in touch with his medical adviser for a year or two."

Diethelm, in discussing the treatment of alcoholism, states: "The treatment of chronic alcoholism has usually been directed along three lines: That of personality analysis, in an endeavor to find strivings which drove the patient into alcoholism; reeducation under enforced abstinence; and the use of drugs to change hypothetical chemical processes in the body or to produce a lasting disgust to alcohol through chemical alterations. The attempt to treat with drugs can hardly be called scientific and is, therefore, usually administered by nonphysicians. The large number of persons who seek help in such institutions is an indication of the failure of medical science to outline well planned treatment.

"The only treatment which can be effective in all cases and which can be adjusted to the patient's individual needs is treatment which combines personality analysis and adjustment with training of healthier habits over a long period of time and under strict abstinence.

"The treatment can be divided into two phases. It should begin with immediate withdrawal from alcohol and be carried out under complete abstinence. Immediate withdrawal is psychologically important. It proves to the patient that there is no medical necessity for the use of alcohol in his case, and this realization is the beginning of his reeducation. The patient must break away from many of the ideas, attitudes and habits of his past life and learn that alcoholic drinks are not necessary for him to be cheerful and happy; that although they may help temporarily, in reality they increase his difficulties.

"During the second phase of treatment, which deals primarily with reeducation of his habits, our knowledge of his personality should permit us to utilize an individualized approach. It is desirable that this can be carried out in an open institution in which the patient can lead a healthy life with a well-balanced routine, which includes work and suitable recreation and a healthy physical regime."

AUTHOR'S TREATMENT.

Treatment should begin with the immediate withdrawal of alcohol. The patient should be instantly informed that the goal is total abstinence, and all concerned must recognize that an individual who has been a pathologic drinker can never be a social drinker. A person who has once been an excessive drinker can never be a moderate, controlled, or a one-or-two cocktails drinker. He must understand that there is a sacrifice of both time and money involved in the treatment and that the road to the goal is a long and hard one, requiring patience, determination and absolute honesty of relationship between patient and physician. He is given to understand that failures in the past under other types of treatment mean nothing and are not obstacles to his attaining the goal, and that "once an alcoholic, always an alcoholic" is a general misstatement. For months, in some patients, the only headway made is the teaching of the fact that he can live without alcohol and this realization plays a great part in his reeducation.

The patient reports to the psychiatrist's office at regular intervals, at first daily or three times a week and then less frequently.

He must be punctual, in spite of inclement weather, "previous engagements," or any other issues used so often for cancellations and postponements. Coming is his job!

Should he feel after a few weeks of abstinence that he can go along on his own and stop coming for his interviews, the physician will not call him or otherwise remind him of his negligence. The responsibility is his.

He must never test himself out to determine whether or not he has the problem "beat" by taking one drink. All drinking must be stopped instantly, without any tapering off.

When a large alcohol intake is abruptly stopped, sedatives are often necessary for a while to relieve the "shakes" and any jittery feeling which may follow the withdrawal. With this the sugar intake is definitely increased and the patient is also advised to take heavy doses of vitamin B.

Psychotherapy is continued throughout interviews. Other methods of handling the need for escape from situations are considered. Very frequently it is possible to modify poor vocational adjustment or irritating marital situations involving sexual incompatibilities, unwholesome living conditions with in-laws in the family life, parental conflict over the management of children, etc.

The patient himself may not be conscious of the strains of all these things upon him. When it is not possible to modify the situation, it is often possible to change the patient's attitude toward the difficulties he has to meet. Many a person becomes morbidly self-accusatory and fatalistic because of what he considers his failure to modify the unmodifiable. Such an individual may be greatly helped by mutual discussions, constructive criticism and wise guidance.

The interviews are further used to outline a recreational program and develop interest in new hobbies, diversions, club activities, etc. It is wise to have the patient at the beginning of the treatment give up his drinking friends and meeting places and replace them by non-drinking contacts. Later on he is allowed to visit friends and go to dinners where cocktails are served

During all this time stress is laid upon the point that total abstinence is the only possible road to, and goal of, therapy.

The mate of the patient is interviewed many times, because the attitude toward drinking of wife or husband is extremely important. The mate's tact and diplomacy in handling past and present situations and episodes together with his intelligent co-operation in the planning of new activities are major therapeutic aids. One cannot stress too much the significance of the mate's attitude and co-operation. Many a poor result of treatment is due to the absence of any insight whatever in wife or husband.

During the early months of treatment the patient uses as a splint the physician rather than the alcohol which he has previously utilized. Throughout the treatment there is established a close personal relationship between the patient and the doctor. In this way the latter develops a definite knowledge of how the patient "ticks" and the patient derives confidence and helpfulness in realizing the physician's understanding of his own particular problems.

The patient who comes with an honest desire for help should be approached with sympathy and kindness that eliminates ideas of punishment, fears of failure and attitudes of inferiority. Patient and physician should meet each other halfway with frankness and mutual expectation of confidence. The psychiatrist's tact and diplomacy in presenting to the patient the liabilities of his make-up is extremely important.

The interviews are used for many purposes, although one cannot put in words exactly what takes place during an interview. Aside from the above psychotherapy and obtaining all the available information necessary to complete the survey of the individual, the patient is indirectly forming new habits and breaking down old ones. The interviews are also used for the permanent development of proper attitude, and the patient learns to be guided by his judgment rather than his emotions. With many patients the interviews are used to discuss the individual alcohol sensitivity. A great deal of

the time is also spent on individual personality disciplining. The thought processes preceding the last alcoholic bout and other bouts are gone into also. While directing the attitude of the patient to the fact that total abstinence for life is the goal of therapy, therapy should indirectly divert the mind of the patient from the whole subject of drinking.

SUMMARY.

The results obtained with the approach described have been encouragingly satisfactory. The treatment (although individual) in general embodies personality analysis and adjustment, development of proper attitude to alcohol and psychogenic strains, and new habit formation which breaks down indirectly the old habit associations.

Medical Annals of the District of Columbia, Feb. 1939.

SOME GENERAL PRINCIPLES IN DERMATOLOGY

BY IVAN M. WARTZKI, M.B., B.S.

Clinical Assistant to Dermatologist, Royal Melbourne Hospital.

General principles as applied to both the diagnosis and the treatment of skin affections are of paramount importance, and the successful practitioner will be he who applies general principles, especially in treatment, rather than a hard and fast routine such as thinking in terms of a favourite prescription for each dermatological condition. Let me give an instance where routine prescribing would be very inimical to the patient. A universally recognized treatment for tinea (ringworm) is Whitfield's ointment, consisting of about 3 per cent each of salicylic acid and benzoic acid in an inert base ; but woe betide the doctor who values the goodwill of his patient if he prescribes this in the acute weeping eczematous stage of such an infection. On general principles the indication in such a case is to allay the acute inflammatory state by the application of a local sedative such as zinc cream, and only after the eczematous reaction subsides should the Whitefield's ointment be ordered, and even then very cautiously, starting with a weak dilution and gradually increasing the strength according to the tolerance of the patient's skin.

DIAGNOSIS.

In considering any dermatological case an intelligent history is just as necessary as in a medical or surgical case, and on examination special emphasis is placed on the distribution of the eruption and the nature of the individual lesions of which it is composed. Therefore we start, as in a medical case, by enquiring of what the patient complains and for how long it has been present. This in

the case of a recent eruption rules out the more chronic conditions and *vice versa*. For instance, an eruption on the face of one week's duration would rule out such a chronic condition as lupus erythematosus, and would suggest a more acute one such as impetigo contagiosa, both of which occur most frequently on the face.

Next the importance of distribution cannot be exaggerated, Many dermatoses have a predeliction for certain areas, and are rare on others.

Psoriasis is commonly found on the extensor surfaces, particularly the points of pressure such as the elbows and knees. Seborrhoeic dermatitis on the other hand usually affects the flexor surfaces and natural folds such as the axillae and groins, as well as the midline of the chest and the sweat furrow of the back. Therefore, on general principles, if the diagnosis lies between these two, an extensor and pressure point distribution would favour psoriasis, and a flexor surface and natural fold distribution would favour seborrhoeic dermatitis. There is a flexural form of psoriasis, but this is relatively uncommon.

Confirmatory evidence should be sought in other commonly involved sites, *e. g*, dandruff on the scalp in seborrhoeic dermatitis and silvery scaly lumpy areas on the scalp in psoriasis. Also, the nails should be examined for pitting or dystrophy so common in psoriasis.

Next we come to the individual lesions of which an eruption is composed, and the previous two diseases afford an excellent example of the value of this observation.

The individual and primary lesions in seborrhoeic dermatitis are small, red, scaly follicular papules, and by extension and fusion of these the typical lesion is formed. Therefore, on examining a case of seborrhoeic dermatitis there will nearly always be found some outlying follicular papules, whereas in psoriasis the typical plaques are originally such, and enlarge by extending peripherally, and so give a sharply demarcated edge to the lesion with no outlying follicular papules.

The typical text book example of each of these conditions would cause no difficulty in diagnosis ; but, as in any other branch of medicine, the various conditions do not always "run true to form" and sometimes present a real difficulty in differentiation, even without considering the intermediate forms known as psoriasiform seborroides, presenting characteristics of both conditions.

Another example of the significance of characteristic distribution and characteristic individual lesions are the predeliction of lichen planus for flexor surfaces and its composition of polygonal, flat-topped, shiny papules with whitish streaks known as Wickham's striae. If an eruption is seen to be made up of a conglomeration of

these typical papules distributed over the flexor surfaces, the diagnosis of lichen planus can be made with a fair degree of certainty, and often can be confirmed by looking for and finding milky white streaks and plaques on the buccal mucosa, lips, and tongue.

Circinate impetigo and tinea circinata (ringworm of the glabrous skin) could easily be confused unless the individual lesions of which the eruption is composed are carefully examined, when it would be found that circinate impetigo has a continuous blister (phlyctenular) edge, whereas the edge of a patch of tinea circinata is composed of a number of minute vesicles.

Scabies, that bugbear of the dermatologist as well as of the general practitioner, can often be diagnosed with certainty by its distribution alone, affecting as it does most frequently the flexor and ulnar surfaces of the wrists and forearms, the interdigital spaces of the hands, the anterior axillary folds, the buttocks, the genitals in males and the nipples in females.

Urticaria, with which it is frequently confused, has no typical distribution. Both conditions may co-exist and can be diagnosed separately or conjointly by a careful search for the typical primary lesion of each. In scabies it is the burrow which should be searched for in the above typical areas, and if found the female acarus can often be removed and demonstrated under the microscope, whereas in urticaria the primary lesion is the wheal. It is very important to recognize scabies in such a case, as the cure of that condition is speedy and certain if properly treated.

In acne vulgaris the distribution is also typical, affecting those sites where the sebaceous glands are most numerous and active. The face, chest, and back answer this description, and are the sites of predeliction for acne vulgaris. The comedones are the primary lesions, and although these may become pustular and small abscesses predominate, the finding of comedones is essential before a diagnosis of acne vulgaris can be made. An eruption with similar distribution consisting of pustules or abscesses, but with no comedones, is not acne vulgaris, and would make one think of the possibility of a dermatitis medicamentosa, such as a bromide or iodide eruption, or one due to irritation by such agents as tar, chlorine, oils, etc., with which the patient may come into contact at his work. As obviously the cure of such a case could only be brought about by eliminating and avoiding the offending cause, it can be seen how important it is to bear in mind the essential presence of the primary lesion, the comedo, in making the diagnosis of acne vulgaris.

In rosacea, the essential changes are reflex dilatation of the superficial vessels of the face especially affecting the midline, forehead, nose, cheeks, and chin, and the secondary but not essential formation of papules on the same areas.

Other but rarer dermatoses that can be diagnosed only by looking for and finding the characteristic primary lesions of which the eruption is composed are :—

Lupus vulgaris.. typical apple jelly nodules.

Lupus erythematosus—fixed erythema with adherent scale, removable with difficulty and pain, and beneath which can be seen the patulous pilo-sebaceous follicles.

TREATMENT.

As local treatment plays the major part in the cure of skin diseases, I will consider this aspect first. I have shown above how the different stages of tinea require different treatment. The same principle applies to all skin diseases.

One frequently has been asked what is the best local treatment for eczema, My answer is that there is no "best treatment" for eczema, but there are certain definite indications according to the stage it is in. In the early erythematous stage, dusting powders or sedative lotions, such as lead lotion with are without calamine are on general principles indicated. Later in the vesicular stages soothing creams such as zinc cream or calamine linament, in the weeping stages calamine lotion or linament, and when the weeping has practically ceased a protective and sedative paste such as pasta zinci (zinci oxide 3ii, pulv. amyli 3ii, adip lanae hyd. 3ii, paraffin molle ad ounce i).

In the squamous stage a stimulating and perhaps keratolytic preparation such as the zinc paste with picis carb prep. 3ss to 3i or ac. pyrogallic gr. i to each ounce; with or without salicylic acid gr x. If the skin is very hard and dry, the same two agents, but in a more greasy base such as an ointment with a plain vaseline base.

In the early stages of impetigo contagiosa, when there is much oozing of serum, it is best to apply an antiseptic lotion frequently, such as 1 in 4000 hydrag perchlor or eau d'alibour (zinc sulph gr. vi, copper sulphate gr. iv, aq. camph. ad ounce i) several times a day for a few days until the eruption is dry, and then apply an antiseptic paste (zinc paste plus 2 per cent. hyd. oxid. flav). Here I would mention that pastes are always preferable to ointments in impetigo contagiosa, as they have a large powder content, and so are more absorbent, whereas the high greasy content of ointments dams up the oozing serum.

Seborrhoeic eczema is another example of a condition requiring treatment on general principles varying according to its different stages. Sulphur is the time honoured treatment for seborrhoeic dermatitis, but here again the eruption must be brought to the non-eczematous stage by the judicious use of soothing remedies before applying sulphur, which is then prescribed in weak dilutions, gradually increasing the strength according to the tolerance of the patient's skin.

As to internal medication, there are certain general indications here also, varying according to the type of patient suffering from an eruption, as well as the nature of the particular eruption itself.

Allergic patients suffering from various skin diseases require, firstly, medication to de-sensitize the epidermis. Examples of this are alkalies in moderately large doses or calcium in some form, preferably the lactophosphate or the gluconate, sodium thiosulphate, each of which acts as a de-sensitizer.

In acne vulgaris there are two distinct types of sufferers—the sallow type who usually has indican in the urine, and the flushed type. The former requires a general tonic containing iron, etc., and the latter requires alkalies, and both require restriction of the carbohydrates and fats in their diets, to which I shall refer later. In psoriasis there are also two distinct types. The small patch more or less generalized type, which frequently follows sore throats, requires removal of the focus of infection, and measures directed against infection such as tonics; and vitamin A as in the various cod liver oil preparations The other ordinary type appears to have a metabolic basis, probably associated with impaired liver function, as sufferers have a high blood uric acid content. In this type an alkaline mixture containing mag sulph., sodii sulph., sodii bicarb, and pot. cit. sufficient to keep the urine alkaline is indicated.

In rosacea, those patients with an absent or low hydrochloric acid content of their gastric secretion require the administration of acid, whilst others seem to do better on an alkaline mixture given before meals.

Diet along certain general lines has an influence in certain skin diseases, *e. g.*, the heavy obese female patient with varicose veins and dermatitis of the legs, besides local and supportive treatment, requires to be ordered a lower calorie diet to effect a reduction in weight, which is brought about by the intake of about 1200 calories per day. Allergic patients with skin diseses tend to retain fluids and mobilize them, therefore an anti-retentional diet is indicated, *i. e.*, one rich in proteins and especially nucleoproteids such as meat, liver, kidneys, etc., and a corresponding reduction in the carbohydrates and fats. Some foods seem to be particularly deleterious in certain dermatoses apart from individual idiosyncracies, the most noticeable being the adverse effect on acne vulgaris, particularly of chocolates (the offending ingredient being coco butter); but also of cheese and pig fat. It has also been proved experimentally and clinically that a large carbohydrate intake adversely affects staphylococcal infections such as boils and carbuncles, apart even from those cases occurring in proved diabetics. The skin of these subjects (even the non-diabetic) has been shown to have a higher than normal sugar content, and so a reduction of the carbohydrate contents of the diet is indicated in these infections.

No paper dealing with dermatology would be complete without some reference to X-rays, the greatest single agent in the treatment of most skin disorders.

It may puzzle the general practitioner to understand why a single modality is used so frequently as this is, and with such astoundingly successful results in such a variety of different skin diseases. The explanation is that X-ray treatment has different effects according to the different doses in which they are used, and so varying doses are used to bring about a definite result. In minute or sub-fractional doses (⅛ to ⅙ of a Sabarond pastille B dose, called ⅛ B to ⅙ B) cell function, particularly that of reproduction is stimulated. Therefore. X-rays are indicated in such doses to stimulate hair growth in alopecia, and tissue repair in ulceration, etc.

In slightly larger doses, called fractional doses (¼ B to ⅓ B) they exert a sedative and desensitizing action, and are used to modify tissue reaction to infection and also to allay irritation and so prevent the patient from perpetuating the eruption by conscious or subconscious rubbing or scratching.

In slightly larger doses still (½ B to ¾ B) they inhibit cell function, especially the rate of reproduction, and so in these doses are useful in inflammatory states where the epidermal cells are in a state of active mitosis, with the production of a thickened malpighian layer and incomplete keratinization leading to sticky adherent scales (a condition known to dermatologists as parakeratosis), and manifested clinically by the formation of scales as seen in the squamous stages of dermatitis and eczema, and in psoriasis, etc.

In larger doses still (4/5 B to 1 B) they cause a temporary cessation of cell function secretion of secreting cells and subdivision of epidermal cells, *e. g.*, they lessen the secretion of sebum by the cells of the sebaceous glands, sweat by the cells of the coil glands, and the production of hair by the papillae of the hair follicles, and on account of these properties are used in acne, seborrhoea, hyperhidrosis (increased sweating), and to cause temporary epilation of the hair of the beard in tinea barbae (ringworm of the beard), and in tinea tonsurans in children (ringworm of the scalp).

In larger doses still they cause death of the cells and for this purpose are used infrequently to cause permanent epilation of the beard, in refractory cases of cocogenic sycosis, and more frequently in rodent ulcers and epitheliomata. In the latter condition they have the added fortunate advantage of exhibiting a predeliction for the actively mitotic cells causing destruction of them with less effect on the surrounding normal epidermal cells.

A further interesting feature of X-rays is that they have neither bacteriacidal nor fungicidal properties, and when used in infections caused by either bacteria or fungi, exert their beneficial action not by destruction of the offending organism, but by altering tissue

reaction in some subtle way and allaying the resulting inflammation. In tinea of the beard or scalp they bring about a cure by causing the infected hairs to fall, and with them the fungus is got rid of, epilation doses being used to bring this about.

It will be seen from these remarks that the dermatologist must have an exact knowledge of the diagnosis and histopathology of the particular disease he is dealing with. He must have a definite object in view to be brought about by a definite and carefully measured dosage of X-rays varying with the indications and the effects desired, and so with varying doses according to the specific indications. Remarkable cures result from superficial X ray therapy with the appropriate local and general treatment in such varied conditions as eczema and dermatitis lichenification, acne vulgaris, pityriasis capitis (dandruff), seborrhoeic dermatitis, psoriasis, hypertrophic lichen-planus, warts, rodent ulcers, squamous epitheliomata, abscesses, boils and carbuncles, ringworm of the skin, scalp, beard, groins, epidermophytosis of the feet (athlete's foot or surfer's itch), granuloma pyogenicum, granuloma annulare, paronychia, and a host of other dermatological conditions

The General Practitioner, Feb. 1939.

Extracts.

RADIUM TREATMENT OF CARCINOMA OF THE CERVICAL STUMP.

R. E. Fricke, M. D., Section on Therapeutic Radiology: In 1896 Chrobak first described as a clinical entity carcinoma occurring in the retained stump of the cervix following subtotal hysterectomy that had been performed, usually, for some benign condition. This description aroused much interest and, since the treatment of carcinoma in a retained cervix is so tedious and cure of this condition so infrequent, there has been great emphasis on prevention of this condition. Many prominent surgeons advocate discarding subtotal hysterectomy and performing panhysterectomy, even for benign conditions. In addition, C. H. Mayo and C. F. Dixon have pointed out that a retained cervix may also act as a focus of infection. J. C. Masson and Herbert Spencer have stated that the total operation in skilled hands has very little added risk over that of subtotal hysterectomy. On the other hand, many other prominent surgeons believe the incidence of carcinoma of the cervical stump to be too low to abandon the subtotal operation. They regard panhysterectomy as having a much higher risk and also as entailing a loss of

support to the pelvic floor. Hence, the question of incidence of this condition is important, but the incidence is very difficult to ascertain precisely.

In the German literature, surgical statistics from the follow-up of results of several thousand supravaginal hysterectomies give an incidence for carcinoma of the cervix of 00.3 per cent, and the figures vary up to an incidence of 4.1 per cent, as quoted from radiologic literature. Of course, it must be remembered that different things are being compared. A surgeon may have to trace his patients for a quarter of a century to see if carcinoma has developed At radium centers or other radiologic institutes, a greater number of carcinomas of the cervix are seen and a fairly high incidence of carcinoma of the cervical stump appears as a natural result.

Another point of interest is that some prominent surgeons consider that the conservative operation, followed by cupping or coning-out of cervical mucosa, will obviate later malignant changes in the cervical stump. However, Polak disputes the value of such a procedure stating that nearly all cases involve squamous-cell epithelioma and arise from the mucous membrane of the vaginal portion of the cervix.

I am not qualified to take sides in the surgical dispute, but I am interested in the clinical aspects of these cases and the results of treatment that have been recorded at the Clinic.

I have collected cases of carcinoma of the cervix in which the patients were treated with radium at the Clinic from 1915 to 1930, inclusive, a series which Dr. Bowing and I collected for the Fifth International Congress of Radiology. The total number of carcinomas of the cervix treated during these years was 1,676. Of this group there were 108 cases in which the diagnosis was carcinoma of the cervical stump. However, omission of patients not treated at the Clinic or those having obvious metastatic processes extending from primary conditions of the ovary or uterine fundus, left ninety-nine possible cases of the disease.

Moreover, to these ninety-nine cases I have applied the differentiation recommended by Nuttal and Todd of England and by Sharples—that two years or more should have elapsed between subtotal hysterectomy and the diagnosis of carcinoma of the stump for the lesion to be a genuine one. Nuttal and Todd have called cases in which diagnosis was made earlier than two years from the primary operation "coincidental cases." In other words, they probably involve patients in whom malignancy of the cervical stump was overlooked at the time of the original operation. This criterion reduced the number of genuine cases in the present series to fifty-seven, an incidence of 3.4 per cent of the entire number of 1,676 patients having carcinoma of the cervix treated during this period.

It is interesting, in view of the fact that carcinoma often arises in old lacerations following childbirth, to find on analyzing these cases that 21 per cent of the patients had never been pregnant. This seems a rather large percentage of nonpregnancies but agrees well with statistics quoted in the literature of other large groups of similar cases.

The antecedent operation in cases involving the cervical stump was performed mainly for uterine myoma or for menorrhagia. In nine cases it was performed for a questionably benign tumor of some sort. In only nine cases, or 15.8 per cent, had the patients had their operation at the Clinic.

The anatomic extent of the carcinoma before treatment was instituted (the anatomic extent of a lesion being the basis on which we of the Section on Therapeutic Radiology classify the stage of the lesion) is interesting. In our cases there were no stage 1 lesions; 20 per cent were stage 2, and 80 per cent were either stage 3 or stage 4, the last stage implying a far advanced lesion. Biopsy was not performed in about 22 per cent of the cases; these cases involved mainly patients that had been seen in the early years included in this study, at a time when very little material was taken for biopsy from these evidently malignant lesions. All but two of these patients from whom specimens for biopsy were not taken died later of malignancy. Of the lesions that were identified by biopsy, 82 per cent were squamous-cell epithelioma, and of these the majority (75 per cent) were grade 3 or 4 (Broders' index).

Radium treatment at the Clinic has been altered in the course of the years. In the very early years, vaginal and rectal applications were given in cases involving carcinoma of the cervical stump. In later years, radium treatment has been administered in the cervical canal and in the vaginal cavity by the divided-dose method. Three or four applications are given in the cervical canal and two or three applications in the vaginal cavity for an averge total of 400 mc. hours, administered over a period of about to weeks. This procédure is followed by roentgen-ray therapy in the region of the pelvis. In the early years this was done with rays generated at moderate voltage, but since 1923 high-voltage therapy has been used.

The results of treatment have compared favorably with those quoted elsewhere. The largest series reported is probably that by Von Graff, who in 1934 reviewed all cases reported in the world literature - 428 in all—and who found five-year cures obtained by any method of treatment to be 9.3 per cent. Other authors, reporting groups of cases involving from ten to thirty-six patients, quoted five-year cures ranging from 7.6 per cent to 50 per cent.

The series of fifty-seven cases contained in the present study show five-year cures in 26.3 per cent of the cases, including patients

now living and well nineteen, seventeen and sixteen years after administration of the last treatment.

To consider briefly the so-called coincidental cases, forty-two patients had a diagnosis or cancer of the cervix made from one month to two years following subtotal hysterectomy. Within this brief interval between operation and diagnosis, carcinoma was probably already present in the cervix, or, in many instances, the growth in the cervix was a metastasis from an ablated cancer of the fundus or ovaries. In those cases in which biopsies had been made, 87 per cent of the lesions were squamous-cell epithelioma, and 79 per cent were graded 3 and 4. Besides occurring within a slightly younger group than those patients having true carcinoma of the cervical stump, the stage of the disease was further advanced than was the case among the genuine instances of carcinoma of the cervical stump--in 93 per cent it was stage 3 or 4. The results of treatment have not been so good as those obtained among patients having true carcinoma of the cervical stump A poor result might be expected in these coincidental cases, a result to be expected from the incomplete surgical excision of cancer anywhere in the body. Five-year cures in the coincidental cases were 21.4 per cent. about 5 per cent less than those obtained in the true cases, but the greatest difference was in the almost immediate mortality among those patients in the coincidental series. In the genuine cases, only 22.8 per cent of the patients died within a year following the treatment, whereas in the coincidental cases 54.8 per cent of patients died within the first year following treatment.

Further study, dividing the cases into five-year groups, would show improved results in latter years, but for lack of space additional figures will not be included herein.

SUMMARY AND CONCLUSIONS

Carcinoma of the retained cervix following subtotal hysterectomy is a very serious condition. When discovered, most of the lesions are advanced and the prognosis is poor. The condition is musually found following subtotal hysterectomy for uterine fibroyoma. As Branscomb has suggested, in the presence of vaginal bleeding and uterine myoma, no further source for the bleeding may be considered and the coincidence of cancer of the cervix is easily overlooked. I think that to constitute a true case of carcinoma of the cervical stump two years or longer should have elapsed between the operation and the diagnosis of malignancy in the retained cervix. Among 1,676 patients who had carcinoma of the cervix treated with radium at the Clinic from 1915 to 1930, inclusive, fifty-seven true cases were found, a percentage of 3.4 of the total series. The interval between operation and the time diagnosis was made was from two to twenty-nine years. It was more than twenty years in five cases, and between ten and twenty years in fifteen additional cases.

Analysis of these fifty-seven cases showed that careful radium and roentgen-ray treatment does yield worth-while results and these results have been improving in later years with changes in technic. Cure for five years or longer was obtained in 26.3 per cent. of cases. Results in the coincidental cases were not so good as might be expected following subtotal operation of cancer anywhere else in the body. Five-year cures amounted to 21.4 per cent, but more than half of the total number of patients in this series died within the first year following treatment. Hence, although careful radium treatment for carcinoma of the cervical stump can accomplish much and although the prognosis is not hopeless, much remains to be accomplished in the way of prevention. The seriousness of the condition must be re-emphasized. Whenever subtotal hysterectomy is performed, carful examination, of the cervix should be done. Following subtotal operation, the patient should undergo pelvic examination at stated intervals and should be instructed to return voluntarily for examination if at any time vaginal bleeding should occur.

PAINLESS CHILDBIRTH.

According to *L H. Dongen*, *F. W. Peyton* and *J. R. S. Sian*, paraldehyde, given per os, is an entirely harmless and safe anæsthetic in childbirth. Paraldehyde causes a definite lowering of the blood pressure in hypertonia. The remedy is, therefore, also to be recommended in eclampsia and pre-eclamptic conditions. On the other hand, paraldehyde must not be given to patients with weak hearts or hypotonia.

The labour pains are not influenced by this hypnotic, and it has proved to be entirely harmless for mother and child.

The dosage is 24 c c. paraldehyde, mixed with water, orange juice or aromatic elixir (U. S. Pharmacopœia). *Colvin* and *Bartholomew* give the medicament chilled on ice and by mouthfuls, so that the whole quantity is taken in about a quarter of an hour. If the woman is inclined to be sick, her nose must be plugged with cotton wool, and she must finish the whole dose at once. The anæsthesia begins after 10 or 15 minutes and is complete after 20 to 30 minutes.

The birth of the child usually takes place about 3½ hours after the medicine has been taken if the mother is a primipara; if she is multipara, then after 2½ hours. After the birth, the women usually sleep for a few more hours. *Colvin* and *Bartholomew* do not give the drug until the entrance of the womb is four to five centimeters wide (two or three centimeters for a multipara). If necessary, the

pains are stimulated by intra-nasal instillation of a few drops of pituitrin. These authors, too, have always found the paraldehyde medication completely harmless. Amnesia was complete in 92.5 per cent of all cases, and 98.8 per cent of the births caused no suffering at all. There are no objections to this method in general practice.

(*Americ. Journ. Obst. & Gyna., 1938, No. 4.*)

Medical News and Notes.

I

THE KRISHNA DISTRICT MEDICAL ASSOCIATION, MASULIPATAM.

(*The Krishna District Branch of the Indian Medical Association*).

The Minutes of the 9th Monthly meeting of the Krishna District Medical Association, Masulipatam, held in the Head Quarters Hospital, Masulipatam, on the 19th January 1940.

Lt-Col. T.S. Shastry, I.M.S., the President, presided. 40 members including 3 lady members attended the meeting. After delightful tea and music, the clinical meeting began at 5-30 p. m.

The following case-notes were read and cases exhibited :—

1. A case of Double Pyosalpinx by Dr. Seethammal, L. M. P., of Gudivada. The Patient was also shown.
2. Tumour of the female breast was discussed by the President.
3. A case of Injury to the Cervico-thoracic spine by Dr. M. V. Subbarao, L. M. P., Resident Medical Officer.
4. Myeloma of right femur, for which disarticulation of the hip was done, by Cap. K. Venugopalarao Naidu, L.M.&S., Assistant District Medical Officer.

Molar Pregnancy—Caesarian section.

There was ample discussion on these cases. A short account of the Annual meeting of the Association of Surgeons of India, and of the subjects discussed there in, which was held at Madras during last Christmas, was given by the President.

Likewise, a reference was made to the prospect of Vizagapatam being the next meeting place for the All-India Medical Conference of the Indian Medical Association in December 1940.

An appeal was made that all the members of the Medical Profession in the District should work hard train up as many men and women of their area as possible for Red Cross work, in Home Nursing and First Aid, and General Sanitation.

A delightful dinner was arranged and got up by Dr. M V. Subbarao, L. M. P., the Resident Medical Officer.

II

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION, PALAMCOTTAH.

(*Tinnevelly Branch of the Indian Medical Association.*)

The Monthly meeting of the Tinnevelly District Medical Association was held at Subramania Karayarur Public Library, Palamcottah, on the 24th of December 1939. Members numbering 25 were present.

After tea, the meeting began under the Presidentship of Dr. T. N. Govinda Aiyyar, M.B., & C.M., Vice-President of the Association.

The Secretary and Treasurer read out the minutes of the Annual Re-union which was celebrated on the 26th of November 1939, which were passed.

A resolution was unanimously passed congratulating Dr. L. Mahadevan, M.B.B.S., D.O.M.S., for his elevation to Ophthalmic Surgeon.

Dr. K. Rama Ayyar, M.B.B.S., Hony. Assistant Medical Officer, Government Headquarters Hospital, Palamcottah read a paper on Kalazar.

Dr. K Rama Ayyar, M.B.B.S, offered his thanks to Dr. T. N. Govinda Aiyar, M.B. & C.M., for presiding over the meeting and also thanked the Secretary, Public Library, Palamcottah for placing the Library Hall at the disposal of the Association to hold the meeting.

After Dinner the meeting came to a close.

III

DISPUTE OVER "GLAXO" NAME.

Perpetual Injunction Granted.

(BEFORE THE HON. MR JUSTICE SOMJI.)

Glaxo Laboratories, Ltd. ... *Plaintiffs.*

Vs.

Glaxo Surgical Co. ... *Defendants.*

In a suit filed by *Glaxo Laboratories Ltd.*, of Greenford, the well-known manufacturers of *Glaxo* products against *Glaxo Surgical Co.*, of Sialkot City in the High Court, Bombay, the plaintiffs' case was that they had for several years imported into and sold in India pharmaceutical and medical preparations through H. J. Foster & Co., of Bombay; that on almost all such products the name "*Glaxo*" appears prominently; that one of such products, a baby food by the name of "*Glaxo*," which contains the word "*Glaxo*" printed in a distinctive style, has become very popular all over India; that the word "*Glaxo*" on any product has come to connote to the public that it is a product of the plaintiffs; and that the word "*Glaxo*" appearing as part of the name of any concern has come to cannote that such concern is connected with the plaintiffs. They complained that the name of the defendants was so similar to their name as to

deceive and that the defendants had by circulars and otherwise advertised and sold surgical products such as hypodermic syringes and stethoscopes under the name "*Glaxo*" printed in the distinctive style in which it is used by the plaintiffs, and that such products had been purchased by certain members of the medical profession under the belief that they were the products of the plaintiffs, which they were not.

At the hearing of the suit on the 22nd December 1939, a decree was passed granting the plaintiffs a perpetual injunction restraining the defendants, their servants and agents from carrying on business under the name of "*Glaxo Surgical Co.*" or under any name which contains the word "*Glaxo*" or under a name which is calculated to deceive the public into believing that it is connected with or associated with the business of the plaintiffs, and from selling or from advertising for sale their products under the name "*Glaxo*" or a colourable imitation thereof or in a manner likely to mislead the public into believing that they are products of the plaintiffs. The court further ordered the defendants to deliver up for destruction before the 15th January 1940, all stocks in their possession of letter paper, bills, circulars, leaflets, stationery and goods bearing the name "*Glaxo Surgical Co.*," and the word '*Glaxo.*'

Book Review.

The Rise and Growth of the Alembic Chemical Works—A History.

BY RAJA MITRA, B.D., AMIN, B.A., M S.C.I, (LOND.), *Managing Director.*

The Alembic Chemical Works Co., Ltd., have been the pioneers of the Spirit and Pharmaceutical Industry in India, and during their existence of 32 years, their primary task has been to make available to the medical profession, indigenous medicines of a quality equal to those imported from outside India, and at cheaper prices. Various difficulties and problems that confronted them in this attempt on account of the unsympathetic policies of Governments in India, and the extent to which these difficulties have been partially solved after voluminous correspondence, extending over many years, are discussed in the above publication in detail and in this and other respects, the book is a 'history' of the Company.

NOTICE

Warning to Registered Medical Practitioners.

Dr. Henry S. Hensman, O.B E., M.R.C.S., L R C.P., Registrar, Madras Medical Council, writes : –

Instances have been brought to the notice of the Madras Medical Council where registered medical practitioners have issued certificates in favour of certain proprietary and other medical preparations. Such certificates have been utilised as a means of advertisement for the products, thereby indirectly advertising the practitioners themselves, with or without their knowledge and consent.

The Madras Medical Council warns the registered medical practitioners that the issue of such certificates or association in any other manner, with proprietary or other medical preparations comes under the provisions of sections 21 and 23 of Part II of the Code of Medical Ethics recognized by this Council, and will be dealt with seriously.

IMPORTANT

The Journal is published on the last day of every month.

First advertising formes go to press **three weeks in advance** of the date of issue.

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Unless distinctly instructed to the contrary the same advertisements of an advertiser will be continued from month to month till the contract is over.

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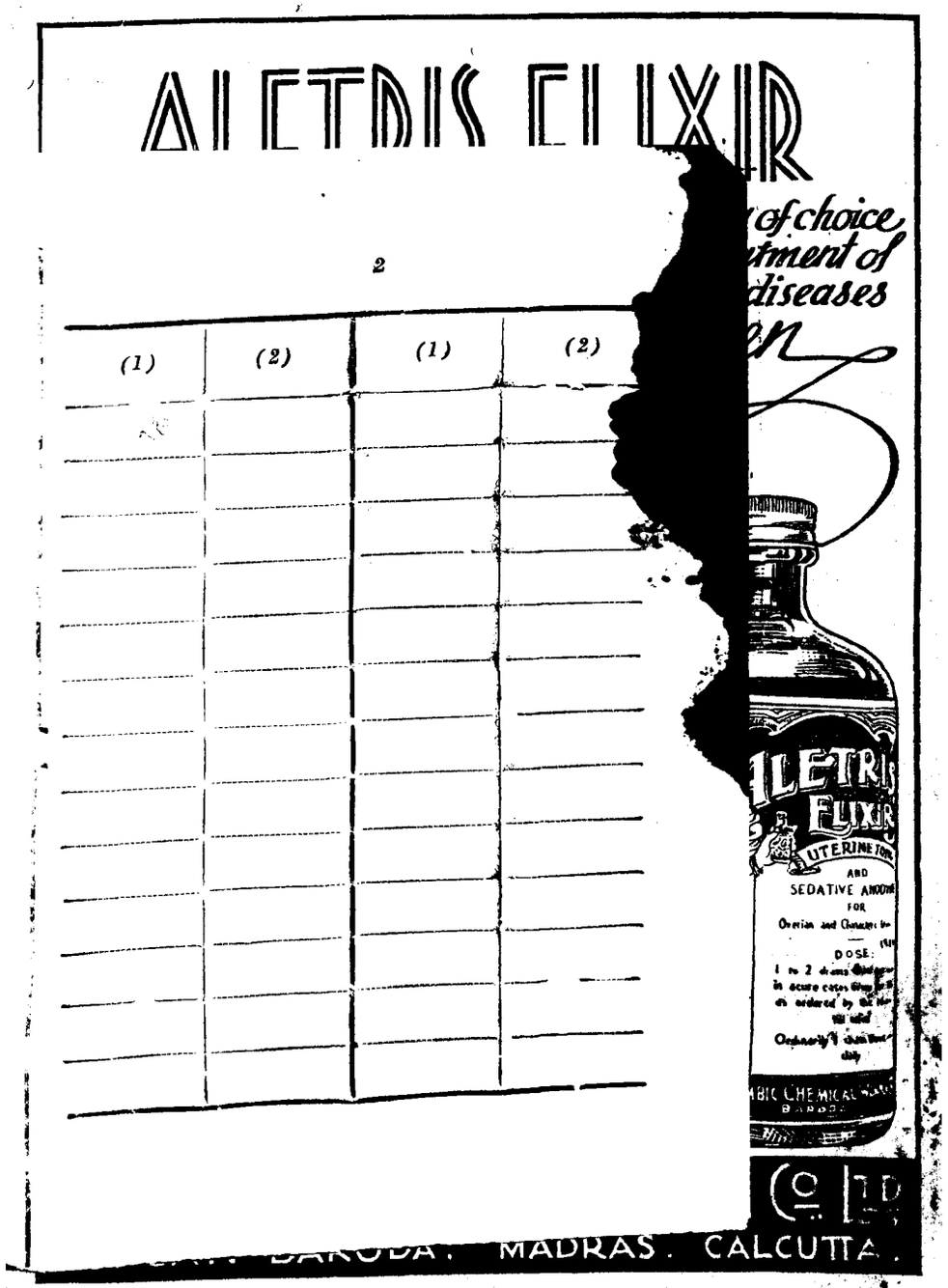

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