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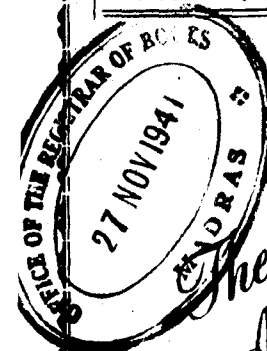
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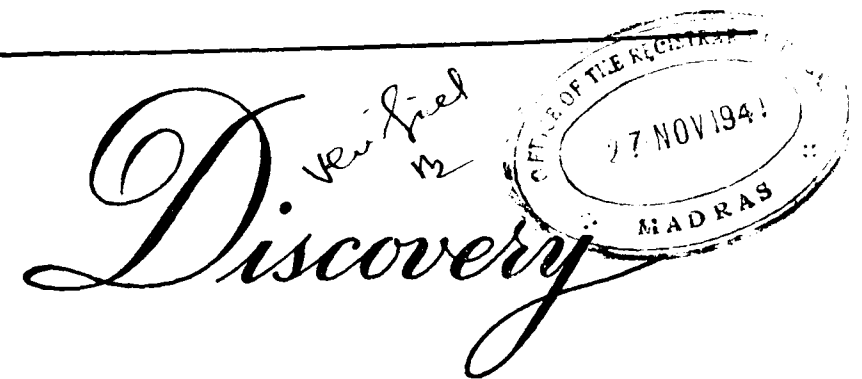
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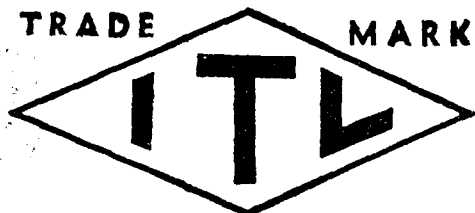
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VARICOSE VEIN TREATMENT.

EARL J. PERKINS, M.D.

Denver.

In this paper there has been no space given to history of treatment or theories of etiology. The paper is based on the premise that the proper treatment of varicose veins is sclerosis by injection, sometimes with ligation. The paper is chiefly concerned with contraindications, differentiation of cases, technic, and solutions.

Varicose veins produce definite symptoms, such as aching, easy fatigue, sense of heaviness, edema and ulceration. The involved extremity has a poor circulation and frequently the arches of the feet, the muscles of the leg, and the posture become the cause of complaint.

The injection treatment has few contraindications. The presence of an acute infection elsewhere in the body is one. An obliterative arterial disease is perhaps another, because the end result of a progressive obliteration of the arteries may be blamed, in the patient's mind, on the treatment of the veins. The presence of an acute spontaneous thrombosis has been considered a temporary contraindication, but it has been proved that at least some of these cases can be injected safely. To interpolate a warning in the care of cases of spontaneous thrombosis: They must have heat and a certain amount of rest, but they must not be totally confined to bed. These patients should be guarded especially against an attempt to perform elective surgery during the time of disability. We have seen fatal results in several such cases recently. Pregnancy is not a contraindication but rather the contrary, because the presence of pregnancy makes the veins progressively worse. It is only a contraindication to the use of quinine as a sclerosing agent. Diabetes is only a contraindication to the use of glucose solution. Some authors advise against injection in the presence of an ulcer, but we have never produced any serious complications

in treating all ulcer cases by this method. Also, the ulcer is very difficult to heal without injection and much easier after injection. Senility is not a contraindication. The treatment of the veins frequently improves the circulation of the legs enough to permit an almost bed-ridden oldster to move about with some degree of independence.

The cases must be individualized and the treatment modified accordingly. In making a broad classification, varicose veins may be designated as small, medium, and large. They may be confined below the knee, they may involve the whole leg and thigh, and even include the pubic area. Edema may be of any degree and may vary in character, being either hard and persistent (which usually indicates some focus of infection) or soft and easily pitted. Another possible confusion is an edema from some cause other than the veins.

Small veins may be treated by injection alone, even when they extend to the foramen ovale. Medium sized veins below the knee may be successfully treated in the same way. Large veins both above and below the knee are much better ligated at the foramen ovale, and then injected afterward. The cases which lie between these two extremes require judgment in choosing the best treatment. When there is doubt the patient should be given a few injections as a trial.

The younger patient has more tendency to form new varicosities after treatment, because the original cause continues to operate over a longer period of time. Therefore, more of the younger patients should be treated by ligation, followed by injection.

Any vein so large that its contents will dilute the injected solution as much as one-half can rarely be injected successfully. Ligation permits lessening of the volume of blood in these large "blowouts," making the injected solution more effective. The dilution factor determines the site of each injection. The more distal veins should be injected first, followed by those next above. This permits the solution to act on a small section in more concentrated form.

We do not inject solution into the distal portion of the vein at the time of ligation. This produces too much reaction and causes enough pain to make the patient take to his bed for several days. This is not desirable because the danger of emboli is increased very much by cessation of activity. For this same reason we prefer ligation in the office rather than the hospital, preferring the risks of sepsis to those of inactivity. The practitioner who has been well trained in surgical asepsis will be careful by nature of that training, but the patient who must be encouraged to get out of his hospital bed for exercise will not understand the need of hospitalization.

As to technic of ligation, there are a few simplifying points of value. It is helpful to mark the veins on the skin with a dye, using

some color other than that of the antiseptic paint. This marking is easier with the patient standing, and by palpation as well as by sight. In making the dissection the vein will be found deeper than expected, but not deep enough to uncover the muscle. It should lie directly over the muscle except when the tortuous course of the varicosity has bulged it toward the skin.

Usually we prefer to isolate the vein for about an inch, crush it, and tie above and below with No. 1 plain catgut, placing the upper tie as close as possible to the deep vein. In some cases it is best to isolate several inches in order to tie associated tributaries. We prefer to leave the vein in place rather than removing a portion, because if either tie breaks loose after removal, a large painful hematoma will result. Without removal one tie alone will hold. No hematoma will result even if both give way. Such an hematoma can be a grave source of danger if it should become infected, because of its proximity to the large vessels.

Injection technic is easier with the patient sitting or standing. This allows the veins to swell and makes them easier to puncture. After the needle point is in the vein, aspirate blood to be certain of the location of the needle, and watch the tissue throughout the injection. Stop injecting at once if there is any swelling of the tissue, or any increase in the pressure needed on the plunger of the syringe. These solutions must be placed in the vein canal, and not in the surrounding tissue. They are all sufficiently irritating to produce a slough if placed outside the vein in any quantity. This danger is more than doubled in the presence of edema where there is less circulation to pick up the irritating solution.

Before injection, the tissue is cleansed with a pledget of cotton or gauze moistened with alcohol, and this same pledget is fastened over the site of injection afterward—using a definite pressure to avoid leaking of blood or solution. This dressing is removed a few hours later or at bedtime by the patient. During the treatment of extensive veins, a great deal of discomfort may be avoided by wearing an elastic bandage during the day. An elastic bandage snugly applied gives better support than an elastic stocking.

A 26 or 27 gauge needle with a 2 c.c. or 5 c.c. syringe makes an efficient combination. Any number of solutions are available. Each operator finally settles on one or two favorites. The most widely used at the present time are the soap solutions. These are usually 5 or 10 per cent and are represented by sodium morrhuate, sodium ricinolate, potassium oleate, and several others. These are used in doses of 1 to 3 c.c. depending on the size of the sacculi to be injected and the previously determined reaction of the patient. In starting with a new patient, the first injection should be not over 1 c.c., as an occasional individual will get a very extensive obliteration from

one dose. This is no cause for alarm, even if the vein is red and hardened from the ankle to the foramen ovale, but it is very disabling. The happiest result is the obliteration of from two to four inches of vein with each injection. This will allow the patient to continue regular duties, and may be repeated at intervals of from three to seven days, depending on the hardihood of the individual and the time at his disposal.

The hard lump produced by this irritation will lose its soreness and tenderness rather rapidly, but it will remain palpable for three to six months. If the soreness becomes a source of complaint, it may be alleviated by hot applications and by the elastic support mentioned above. After each effective injection there will be a temporary increase of edema.

The trouble with all of the soap solutions is the occasional patient who develops a sensitivity after several injections. The first warning of this condition is a complaint of generalized itching within a few minutes after the injection. If the same or a similar solution is used for the next injection, the patient will hardly get clothing adjusted and out of the office before returning with a well-developed attack of urticaria. This may respond very shortly to adrenalin, but it may progress rapidly into an alarming attack of anaphylactic shock which will require several hours for recovery. Once developed this reaction is extremely persistent, and it is only by use of a different type of solution that the treatment can be completed. Our practice in these cases is to continue treatment with a combination consisting of glucose 30 per cent and sodium chloride 15 per cent. This solution is slightly less efficient than the soap solutions, and also produces a cramp at the time of injection, but some operators use it almost exclusively. The best dose is 3 c.c., although 10 c.c. can be used in the larger veins.

Quinine hydrochloride with urethane was long popular, but too many patients developed a quinine rash. Sodium salicylate in 20 to 40 per cent solution is effective, but the cramp produced is almost unbearable.

It is essential that all varicosities be injected before the patient is discharged. It may be necessary to have the patient rest in bed for a day or two before injection to reduce the swelling that hides some veins, but because the swelling will recur within an hour after arising it is also necessary to make the injection at the home. In such cases, also, it is well to inspect each patient several months after treatment. There may be several veins that have been hidden by the swelling from a nearby injection. Any such veins should be injected at this time.

GENERAL PRINCIPLES OF BEHAVIOR PROBLEMS IN CHILDREN.

BERT I. BEVERLY, M. D.

Oak Park.

It may seem like a far cry from the scientific discussion of arthritis you have just heard to a consideration of the mental hygiene of childhood. Let me remind you that all of those symptoms which are not due to organic disease are signs of a psychological maladjustment. This pointless statement becomes important when we remember that outstanding and authoritative physicians tell us that up to 50 per cent. of the hospital beds in America are filled with patients who do not have organic disease but have psychological maladjustments ("nervous breakdowns"). Let me further remind you that it is generally agreed that these emotional difficulties have their origin in childhood. No one ever becomes "nervous" after growing up. If we are to get anywhere in the prevention of these conditions, it will be through working out different attitudes towards children and new principles of child guidance. A justification for trying out some new ideas and different conceptions of child management is emphasized by a consideration of the outlook for the children in this country who are 14 years of age and under. Over one million of them will develop mental illness so severe that they will have to be confined in a state institution for a part of their lives. Over one half million will develop behavior difficulties so in conflict with the law that they will be incarcerated in penitentiaries. Untold millions of them will have "nervous breakdowns" so serious that they will be incapacitated for months to years of their lives but will not have to go to state hospitals. The most of them will get married. It has been stated by many individuals, and denied by none, that 80 per cent. of marriages are not completely harmonious.

It is not difficult to understand the general principles of the growth and development of children. Let us briefly describe them. Children are born with potentialities for development which determine, in a general way, their growth patterns. The general stature (size), for instance, that a baby will have when he grows up is largely determined before birth. It depends primarily upon his race and immediate ancestors. In order to reach that maximum development with the minimum of danger, the child requires an adequate amount of the proper kind of food and good physical care. If these essentials are not received, rickets, anaemia, malnutrition and a lowered resistance to disease may result. These are signs of abnormal physical growth.

In an analogous manner potentialities for the development of intelligence are present at birth. The general intellectual capacity

and intelligence characteristics of a person are determined first of all by his heredity. The stimulation of the growth and development of intelligence is influenced by the way the child is reared. Attention, affection and good physical care, with opportunities for play alone and with other children, when he is old enough, followed later by educational advantages in school are the environmental factors which stimulate intellectual growth. If these conditions are not provided, the child's ability to think may not develop as rapidly or as well as it should; he may not be as bright as he should be.

The third potentiality for development which is present at birth is represented in emotions. Just as a child grows physically and intellectually according to fixed patterns, he grows emotionally. From the moment of birth an individual responds to every situation in terms of feeling and action. In feelings and emotions we see the manifestation of instincts. As such they may be traced back to earliest mankind. Deeply buried in the unconscious mind, they give rise to the wishes and strivings of life. The fulfilment of those wishes and strivings gives rise to pleasures and satisfaction.

There is already present at birth a well developed and functioning mechanism for emotional response. Every sensation is pleasant or unpleasant to the baby and he responds accordingly. During the first weeks of life at least behavior is almost entirely automatic. The baby acts the way he feels. As the brain develops and experiences are encountered, this behavior is altered and we see the beginning of habit formation. In that advance appears one of the most remarkable characteristics of the human mind—the ability of the baby to adapt himself to his environment.

If one places a newly born child on a pillow and rapidly lowers it, so as to give a sensation of falling, the child thrusts his arms forward, all of his muscles become tense, and he cries. The same reaction is elicited by loud noises (after the first day or two, or as soon as the mucous is absorbed from the middle ear), sudden jarring of the bed, hunger and pain. Within the first few days, if not at the outset, the same response is evoked by restriction of movements. In other words, we see that the baby protests against unpleasant experience by crying. These responses may be considered as emanating from the instinct of self-preservation.

The response described above continues throughout life. This crying of the baby becomes the temper tantrum of the older child and a part of the life-long fight for independence. As such it represents some of the strongest impulses responsible for human behaviour. Each individual thinks more of himself than of anyone else in the world—with, however, certain exceptions to this general statement which will be described later. Sudden loud noises continue to disturb individuals throughout life. The same is true of the sense of falling and restriction of movements.

In a child's early infancy it is impossible to recognize all of the primary emotional responses, or to distinguish one from another. The cry caused by the sensation of falling, for instance, as has been pointed out by Mandel Sherman, cannot be distinguished from that occasioned by loud noises. As the baby grows and emotional patterns develop, however, it is possible to perceive different emotional responses and the conditions which stimulate them. We find that under certain conditions the child feels scared, resentful or hungry and cries accordingly. The demand for love and attention is evident from the beginning.

With exception of the fears occasioned by loud noises, sense of falling and restriction of movements, specific fears are not inherited. The mechanism for response present from birth, however, is accompanied with a feeling of fear. This response is stimulated by any threat to the preservation of the individual. If one sees an automobile coming toward him and there is danger that he cannot get out of the way, he feels scared. Uncertainty stimulates fear. It has caused part of the apprehension which most of us have felt because of economic conditions for many years. The seriousness of the depression has not frightened people nearly as much as its uncertainty. How long will it last and where will it end? Are we headed towards Communism, Fascism or some other "ism?" Until these questions are answered, apprehension will continue. Whenever children are surrounded by uncertainty they are scared. In an analogous manner, lack of security and confidence stimulate fear; uncertainty, lack of security and need for confidence are threats to self-preservation.

In growing up, children hate anybody or anything that interferes with their pleasures. Adults who do not like to use the word "hate" may substitute the term "resent." From earliest infancy the baby is disturbed (anxious, frightened and resentful) when he does not receive sufficient love and security. More concrete evidence of this is observed between the sixth and eighth months of life. The baby then protests when a stranger picks him up. He actually is remonstrating at any attempt to separate him from his mother or family. He cries for the same reason when examined by the physician rather than because of any inoculations administered at the time.

Under certain conditions the baby feels hungry. This feeling is caused by the need of the body for food and, like the emotional response described, is important from the standpoint of self-preservation. It is impossible to keep from becoming hungry. In the same way, feelings of fear and hate cannot be prevented when the conditions which stimulate them are present.

The emotional responses already discussed have to do with unpleasant feelings. If we return to the nursery and observe the baby

further, we find that under other conditions he has pleasant feelings; he derives pleasures from other experiences. He will stop crying when fondled, unless he is in pain. He derives pleasure from many sensations, especially from the normal functions of the gastrointestinal tract *i.e.*, sucking the satisfaction of hunger and elimination. Those who doubt the pleasure derived from eating and elimination can be readily convinced by observing babies. There is no more perfect picture of satisfaction and contentment than that of a baby with a full stomach, who has nursed as long as he likes, and is free of colic. A similar picture is seen following a bowel movement.

Since the emotional demands of the baby are supplied by his mother, we see him completely dependent upon her and becoming attached to her emotionally. This emotional reaction gradually changes with growth. As the baby's mind develops and he is able to grasp objects, sit up, walk, talk, etc., we see him change from a passive, dependent chap to a more independent, active individual. This behaviour is motivated by curiosity which is one of the most important characteristics of the mind. It is the basis for all learning and makes it possible for a child to slowly adapt himself to his environment. This curiosity is first of all about himself and then the world about him. It gives rise to play which is probably more important, from an educational standpoint. As the young child rapidly loses his complete dependence and becomes an aggressive youngster interested in play, his reactions make up what has been called the "almighty" stage of emotional growth. This period continues until the physiological changes incident to puberty manifest themselves. During this time, boys and girls are interested in themselves—their own problems, exploration, adventure and play. At this time they are not interested in such abstract norms as justice, honesty, truthfulness, personal appearance and consideration for others—the concepts which are so important to adults. They have neither developed sufficient intelligence to understand nor reached the level of emotional growth to appreciate these adult standards of behaviour. Let me pause to assure you they will accept those norms of things when they are old enough, especially if they are left alone. There is no sufficient time to describe the details of emotional growth.

Infants are born with potentialities for physical, intellectual and emotional growth and develop according to general patterns which cannot be changed. In spite of this fact, which has been known and accepted for centuries, adults proceed to try and change or radically alter all of the normal emotional reactions of children from the time they are born. Let's see if that is true. Even though a baby has been a part of mother for nine months, the first thing we do at birth is to completely remove the infant from her. The baby has been

fed continuously for nine months, but at birth he must eat every four hours (usually.) He must eat a certain number of minutes and if he dares suck beyond that period, he is placed in a straight jacket. The amount of food he should eat is commonly determined in an arbitrary manner. His bowels must move at 8-30 A. M. and if they do not move at that time there is great distress in the home. We often see young mothers, often under medical guidance, spending one-fourth of their time forcing food into one end of the gastrointestinal tract and painfully washing it out of the other. This programme of infant care is carried out without any consideration for the emotional reactions of the baby, and in spite of the fact that habits of emotional response are forming from birth.

By the time a child reaches three years of age, he is convinced that all of his normal emotions are wrong or bad. Let's see if that is true. Suppose a three-year-old shows that impulse of independence (liberty), which is one of the strongest impulses back of human behaviour, to the point of talking back. He is called impudent. "No child can talk back to me." Why shouldn't children talk back? What is a child told who says he is scared? Most commonly he is laughed at. "Shame on you; you should never be scared." Yet fear is one of the important primary emotions—instinctive in character and physiological in nature. Adults are scared every day, especially if they are driving automobiles. Next, what happens if the boy or girl shows that other normal emotion that distresses the human mind so much, namely, hate, and says he hates his brother (as all normal children do, at times). He receives a more severe admonition: "You must love your little brother." (I will not say what the boy or girl thinks or feels then). Appetite which is the physiological component of hunger has probably been ruined a long time before the age of three is reached. Finally, let us suppose this little boy or girl does or says something which is associated in the mind of the parent with that "terrible" subject, sex. The child is scared into believing that is bad and something he must never think about. In a similar manner, children are convinced they are bad before they are five years of age. Also many children are convinced they are dumb and an unbelievable percentage are made to feel they are not liked by that time. These are some of the reasons for the generally accepted statement that the conditions which give rise to psychological maladjustments ("nervousness") in adults have their origin during the first three to five years of life.

If the above observations are true, the logical question is: What is important in the rearing of children? I think we have gone a long way in answering that question. There are three essentials for normal or optimum mental growth: security, confidence and an opportunity to develop self-reliance.

Security is the feeling which is given a child from birth by parents who are entirely satisfied with their offspring. The child has security who is accepted as he is; no alteration being necessary. It has been described as a feeling of "all rightness" on the part of the baby. In older children it may be described in this way; no matter what my child does, he can come to us (his parents) and discuss it without the slightest fear of criticism, humiliation or betrayal of confidence. In addition, he is assured that he will receive any aid his parents can give, if necessary, to help him out of any difficult situation that may arise. As the child enters school, he should have security in that school and his teachers. As he grows up, he should find security in his community and nation. Finally, as an adult, he should have security in his own ability to meet new and difficult situations in life and make a satisfactory adjustment to them.

In an analogous manner, a child should have confidence. Confidence in whom? First of all, in his parents. Parents normally think their children are superior to all others and should convince them of that fact. Later confidence should be found in the school, community, church, nation and eventually in the individual's own ability.

Habits begin to develop at birth. As stated above, the baby responds to all situations in terms of feeling and action. The way he responds determines the kind of habits that are formed. The first habits that are formed have to do with eating, sleeping and elimination. In fact there is a sleep schedule already present at birth. The baby sleeps a few hours, then awakens and cries. He wants food for hunger and, in addition, sucks for emotional gratification. His nutritional and emotional needs having been satisfied, he goes back to sleep. This cycle of sleeping and waking forms the logical basis for the feeding schedule. It is usually 3, 3½, or 4 hour intervals. The baby develops food habits, then according to his individual needs, both physical and mental.

How do children develop the third essential to normal emotional growth—self-reliance? By self-reliance we mean the ability of an individual to meet situations—especially new and difficult ones—and make a successful adjustment to them. Since all behavior is in terms of habit formation. The habits formed during infancy are most important and have a great deal of influence upon the kind of a personality the baby will have when he grows up.

More security is given a baby from breast feeding than in any other way; both physical and mental growth are stimulated more by it than by any other food or method of feeding. The infant can be allowed to take as much food as he likes. (If he is artificially fed it is assumed that it is of the proper proportions.) He can suck as long as he likes; there is no danger or harm from thumb-sucking during the first 3 to 5 years of life. The habit disappears before 18 months of age if the baby receives adequate security and attention.

How much fondling should a baby receive? The answer is: as much as the individual infant needs. He should be held and fondled at the feeding period (a comfortable rocking chair for the mother is desirable) until signs of fatigue appear. He should then be placed in his bed and left alone. A baby should not be used as an emotional outlet for parents, relatives and friends.

Babies quickly learn to take liquid from a bottle and solid food from a teaspoon if these foodstuffs are given early in life—before 4 months of age. By the time they are six months of age, babies like to put things in their mouths. This is the best time to begin offering the child milk from a cup. If it is given every day and the infant is allowed to take as much as he likes, he will often voluntarily wean himself from the bottle at about one year of age; he will voluntarily give up sucking in favour of the mature habit of eating all his food from a cup or a teaspoon. If he desires to take the bottle for a longer period, there is no objection to it.

The development of toilet habits can begin at about nine months of age. The baby may be placed on a comfortable toilet at the time he usually has a bowel movement. The best toilet is one that rests on the floor, so built that the child can rest his feet on the floor or on a support. He cannot be expected to make an effort if he is scared by placing him on an insecure toilet with his legs outstretched. Mother should not try too hard to develop toilet habits in their children; babies will acquire the habit more quickly if force is not used.

Parents should be warned against the giving of enemas which are seldom necessary and often harmful, psychologically. Abnormal emotional disturbances commonly result from too much stimulation of the rectal region with painful enemas. The baby who is receiving the proper kind of food will not be constipated. Failure to have bowel movements every day is not the cause of illness, as formerly thought. It does not make any difference whether a baby has a bowel movement every day or every two or three days. Daily bowel movements are good habits for older children. In the case of older children, however, these habits can be developed by voluntary effort. Children develop them when they want to.

Children will take full responsibility for their food habits by the time they are 15 months of age. It is only necessary to offer them three meals per day, allow them to feed themselves and eat as much and as long as they like. Every child will eat a sufficient amount of food for health and gain if given the proper kind of food and left entirely alone.

A child can dress himself at two years of age. He cannot be expected to tie a bow knot or put on very complicated clothing in a manner that will always meet the approval of mother.

Children will usually take full responsibility for their toilet habits when they are about 2½ years of age. Boys and girls will

stop wetting their beds as soon as they want to. They succeed as soon as they wish to please their parents and make an effort to do so. Restriction of fluids and getting children up at night do little good. The best results are obtained when the child is reminded occasionally that he does not have to wet the bed any more, given praise for any success, and ignoring his failures.

During the third year children begin to desire playmates. They should be allowed this young companionship for the discipline as well as the pleasure it affords. In this way they develop the habit of getting along with one another. In play they develop habits of caution and learn to do things for themselves.

There is no time to continue this important discussion of the ways and means of helping children develop habits for self-reliance. We have, however, covered the most important period and indicated the general principles to be followed. Give a child security, confidence and allow him to develop habits of self-reliance and he has the best chance of normal mental growth and success in life.

(*Illinois Medical Journal*, August 1941).

RECENT PROGRESS IN ESTROGEN THERAPY

S. Charles Freed, M. D.

CHICAGO

With the rapid progress made in endocrinology during the past decade, numerous pure, potent endocrine principles have been made available for therapeutic use. Of these, none has been more useful to both the specialist and general practitioner than the estrogenic substances.

The availability of crystalline highly active estrogens has been of great benefit to large numbers of patients, particularly those suffering from the menopause, either artificial or spontaneous. Active investigation on improving estrogenic therapy is constantly going on. Progress has been definitely made in two respects; in (1) improving on the natural estrogens by various procedures and (2) devising synthetic preparations. In the first method, there is considered a factor which plays a most important role in improving the efficiency of a known estrogen, that is, delaying absorption from the site of injection. In doing this, the estrogens enter the blood stream at a slow, constant rate, thereby avoiding the rapid excretion and destruction which occur when they enter into the blood stream over a short period of time. It is well known in this respect that other therapeutic agents have an increased efficiency when their

absorption is retarded, such as with protamine insulin, adrenalin in oil and numerous others. The method of retarding the absorption of estrogens consists of altering them chemically by combining them with fatty acids to form, for example such compounds as estradiol benzoate and estradiol dipropionate. These substances will induce a more protracted estrus in laboratory animals than the simple estradiol. Of these two esters, the dipropionate will induce a far more persistent estrus response than the benzoate which, in turn, will induce a longer estrus period than estradiol. In the human there is little information available about the rates of absorption of these compounds. There is, however, some evidence that estradiol dipropionate after a single injection is excreted over twice as long a period of time as the benzoate. The advantages of using such preparations are obvious. In the first place, the therapeutic effect is undoubtedly increased and, secondly, the beneficial effects will be obtained over a greater period of time, thus necessitating less frequent injections.

A compound of estradiol, namely ethynil estradiol has been made available to investigators for some time. This compound retains much of its estrogenic activity when administered by mouth in contrast to the loss of 90 to 95 per cent of the activity of estradiol administered orally. As yet, however, no extensive reports have appeared regarding the use of this compound in therapeutic practices. In regard to estrone, the first crystallized estrogenic substance, esters of this compound have not been found whose efficiency is increased to any appreciable extent over that of estrone.

The absorption of estrogens may be delayed without altering the chemical state of the estrogens but by placing them in a media which is absorbed slowly; thus oil solutions of estrogens are much more efficacious than water solutions when both are administered in single injections. More recently it has been found that placing tablets or crystals of estrogens directly into the tissues of the patient gives rise to slow, constant absorption into the blood stream inasmuch as these dried materials are only slightly soluble in tissue fluids and, for this reason, they are absorbed slowly. Thus, implants of crystals or pellets of 20 to 40 mg. of either estrone or estradiol will induce a therapeutic effect for up to six months or more. It might be stated that other hormone preparations such as testosterone and desoxycorticosterone implanted directly into the tissues are at least four times as efficient as oil solutions. This, then, would be an ideal method of administering estrogens. Tablets or crystals for implantation are not available for purchase at the present time. One of the disadvantages of this form of therapy is the lack of control of the patient, but this is perhaps not so important for the estrogens as it is for such a substance as desoxycorticosterone where overdosage may be fatal. The technic of implantation is not complicated; a

small incision is made in the skin followed by blunt dissection of the subcutaneous tissues and the pellets or crystals deposited. Sterility precautions must be strict. Some investigators have used a trocar for the insertion of pellets of the crystalline material directly under the skin.

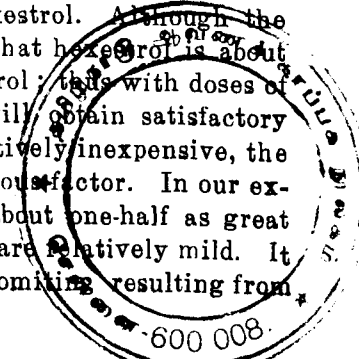
Recently at the Mercy Hospital Dispensary we have experimented with a new type of estrone preparation. We have administered to patients by injection estrone crystals suspended in an aqueous media. In this instance we were interested in having the crystals suspended in a vehicle which would be rapidly absorbed by the tissues, leaving behind a deposit of crystals. The absorption of estrone in this way would be similar to that from small implants of estrone crystals. In this study we have found that the administration of suspensions of estrone containing 5 mg. per cc. injected at weekly intervals for three weeks results in relief of menopausal symptoms for a period of many weeks after the last injection. The average period of relief was about five weeks, but at least one-fourth of our patients had relief for ten or more weeks after the last injection. We have found that aqueous suspensions are much more efficient than suspensions of estrone in oil. Laboratory work which preceded our clinical trials with these suspensions indicated that the estrus in rats induced by aqueous suspensions of estrone was twice as persistent as with the oil suspension which, in turn, was more protracted than with similar quantities of estrone in oil solution. We have concluded on the basis of clinical and laboratory work that aqueous suspensions of estrone are more efficient than oil solutions of estrone. An additional advantage of aqueous suspension is the absence of possible sensitivity reactions to oil vehicles.

Attempts to prepare synthetic materials with a high degree of estrogenicity have been quite successful. Of the numerous compounds prepared, the most promising up to the present time is diethylstilbestrol. This substance is a stilbene, not a steroid like the natural estrogens, and is completely synthesized by laboratory procedures. This compound when tested in rats by injection was shown to be 1 to 3 times as potent as estrone. A remarkable property of this substance, however, allows for relatively little loss of activity when it is administered orally. By the oral route, its activity in the rat is about equal to that of estrone injected, in contrast to the activity of estrone by mouth which is only about 5 to 10 per cent. of that by injection. The convenience and economy of such an orally active estrogen in therapy is obvious. Numerous reports have indicated that stilbestrol is an effective estrogenic substance and possesses all of the properties of the natural estrogens. The disadvantage of stilbestrol is the incidence of toxic effects. The percentage of patients reported to develop such toxic effects varies considerably amongst the investigators who have used stilbestrol. On

the average, however, it may be stated that about 15 per cent. of the patients develop unpleasant reactions, chiefly nausea with vomiting, dizziness and headaches. It has been indicated on the basis of animal investigation that stilbestrol produces damage to various organs such as the liver and bone marrow, but in the human there has been no adequate demonstration by objective evidence that this substance actually produces injury to the tissues in doses which are far larger than those used for therapeutic purposes. It is noteworthy that many of the patients who complain of nausea and vomiting after stilbestrol administration state that they feel as if they were pregnant. For this reason, it might be suggested that the sudden introduction of potent estrogens into the body fluids of the patient induces a reaction similar to that of morning sickness and that no actual pathological changes have taken place. In this connection, it has been observed that post partum women who receive large doses of stilbestrol rarely, if ever, complain of nausea and vomiting. It is therefore possible that these women have been adjusted to large amounts of estrogens and therefore do not react like normal women to the stilbestrol administration. Additional investigations are required, however, before stilbestrol can be pronounced safe for routine use. When and if this substance becomes available, physicians will have a potent estrogen effective by mouth which will be convenient and economical to administer. Its ease of administration may, however, result in promiscuous therapy and harm may arise from this. If the doses in conditions such as the menopause are restricted to about $\frac{1}{2}$ to 1 mg. daily, there appears to be little possibility that toxic manifestations would arise providing the period of administration is not unnecessarily extended. In this regard, estrogens should be administered for several months, after which there is a rest period until the symptoms return. Therapy should be then repeated with a similar course.

We have recently been investigating the therapeutic efficacy of hexestrol which is a modification of stilbestrol. Several reports in the English literature indicate that its properties are similar to stilbestrol but that the incidence of toxic results is fewer. There are no reports available in the American literature up to the present time. As far as I know present paper is the first in this country to deal with the therapeutic efficiency of hexestrol. Although the study is not completed, I feel safe in stating that hexestrol is about one-fifth as active in the human as stilbestrol. With doses of 3 to 5 mg. daily most menopausal patients will obtain satisfactory relief. Inasmuch as this compound is relatively inexpensive, the necessity of giving these dosages is no serious factor. In our experience, the incidence of toxic reactions is about one-half as great as that with stilbestrol and these reactions are relatively mild. It is only occasionally that the nausea and vomiting resulting from

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hexestrol necessitates cessation of therapy. It appears, therefore, that hexestrol is promising as an efficient economical estrogen. Before definite conclusions should be drawn, however, a considerable amount of evidence concerning the activity, toxicity and therapeutic efficiency of hexestrol is required.

In conclusion it may be stated that scientists have improved upon nature in regard to the estrogenic hormones. By chemical procedures they have devised more potent substances which are more efficient for therapeutic purposes. It is anticipated that within a short time these products will become available for routine use in the practice of medicine.

(*Illinois Medical Journal*, August 1941.)

Extracts.

TOXAEMIA OF PREGNANCY.

Subodh Mitra, M.B. (CAL.) M.D. (Berlin), F.R.C.S. (Edin), F.R.C.O.G.,
Associate Professor of Obstetrics and Gynaecology.
Carmichael Medical College, Calcutta.

ETIOLOGY. Etiology is obscure.

Classification. In the early pregnancy (1) hyperemesis gravidarum; in late pregnancy (2) essential hypertension in pregnancy (3) nephritic toxæmia (4) pre-eclamptic toxæmia (5) eclampsia and (6) acute yellow atrophy of the liver.

Hyperemesis gravidarum. The death rate in some places is about 6.8 per cent. of the whole maternal death rate of the hospital (Glasgow Royal Maternity Hospital). The toxic effects are the result of vomiting, dehydration and starvation and are not peculiar to the condition.

The management of a case of hyperemesis gravidarum should from the beginning be energetic, systematic, and adequate.

Treatment. 1. Isolation. The patient must be isolated to give her physical and mental rest.

2 No solid food to be given by mouth for the first 24-48 hours. She may have occasional sips of water, fruit juice, and lemonade.

3. A saline enema is to be given to wash out the lower bowel.

4. Normal saline with 10 per cent. glucose to be administered per rectum by drip method.

5. About 50 c. cm. of 25 per cent. glucose solution is given twice daily intravenously. In more severe cases the quantity may be

increased to 100 c. cm. each time. It is better to give glucose by drip method. 5 units of insulin may be given to prevent the loss of sugar in the urine from the second day.

6. Sedatives may be given in the form of bromides or barbiturates; about 40-60 grs. of bromides can be added to the night enema. Occasionally morphine gr. $\frac{1}{4}$ can also be given.

7. Intravenous administration of calcium is recommended by some (5-10 c. cm. of 10 per cent. solution) every other day to protect the liver against necrosis.

If the patient deteriorates in spite of the above treatment the pregnancy should be terminated.

Essential hypertension in pregnancy, nephritic toxæmia and pre-eclamptic toxæmia may be taken together as it is well nigh impossible to make a sharp line of demarcation between these groups during pregnancy.

Pre-eclamptic toxæmia is characterized by high blood pressure, oedema, albuminuria with subsequent development of oliguria, headache, giddiness and dimness of vision. Abnormal increase in weight is an early sign of pre-eclamptic toxæmia. The blood pressure is high in all these conditions but much higher in essential hypertension than in either pre-eclamptic toxæmia or nephritic toxæmia. In nephritic toxæmia a previous history of nephritis is also present as well as cardiovascular changes. There is retention of urea-nitrogen in blood.

Treatment. Rest, carbohydrate diet, vegetables, fruits and milk, saline purgatives and sedatives. If oedema is marked, restrict fluid and give salt free diet, venesection may be needed if the blood pressure is persistently above 180 mm. Hg. In more serious cases pregnancy may be terminated.

Eclampsia is the most frequent form of toxæmia of pregnancy carrying a high mortality. Its incidence is reported to be 1 in 33 or 1 in 58 in India to 1 in 318 to 1 in 842 in European Countries. Mortality rate is reported to be 8 per cent. in mild cases to 42 per cent. in severe cases. An eclampsia case is called a severe one when any two of the following symptoms are present: (a) Coma (b) pulse over 120, (c) temperature above 103 F (d) fits more than 10, (e) albumin in urine plus and (f) blood pressure over 200.

Treatment. It should be on conservative lines. Avoid all irritation to prevent the occurrence of fits. The patient must be isolated in a quiet, warm and well-ventilated room. Chloroform is given occasionally whenever external or internal manipulations are done. Immediately the patient has dozed off from the effects of chloroform a quarter of a grain of morphine and $\frac{1}{200}$ gr. of atropine are injected subcutaneously.

The clothes are loosened, a catheter specimen of urine is taken, and a mixture containing 30 grs. of chloral hydrate, 2 drachms of

infusion of digitalis and 4 ounces of normal saline in each dose is ordered. After exactly one hour, one dose of the above mixture is given per rectum slowly, if the patient is restless under chloroform. This is repeated at the 7th hour after the onset of treatment. By the time the patient is fairly under the narcotic, a careful vaginal examination is done and membranes ruptured, even if the os is not open. But when the patient is not at term and labour not likely to start, membranes are not ruptured. At the 3rd hour from the onset of treatment another injection of morphine is given, either gr. $1\frac{1}{4}$ or gr. $\frac{1}{6}$, depending on the irritability of the patient. The patient is kept on her side and changed to the other side every 2 hours. Chloroform is given at the return of fit but discontinued during the tetanic stage. Oxygen inhalation is given liberally after each fit. If there are more than 3 fits after the treatment, venesection should be done immediately. About 7-10 oz. of blood are to be let out. If fits continue, venesection is to be repeated. In anemic cases the quantity of blood drawn should be less and if there is low blood pressure glucose solution is injected intravenously.

The patient should be covered with light warm clothing, and to stimulate kidney function, warmth by way of poultices may be applied over the kidney region.

THERAPEUTIC USES OF SNAKE VENOMS.

Dr. B. N. Ghosh, D. Sc. (Lond.) Department of Applied Chemistry, University College of Science and Technology, Calcutta.

Complex nature of Snake Venoms. A comparison of the physiological action of the venoms of the colubridæ with that of the viperinæ group of snakes shows many striking differences. The colubridæ venoms exert a powerful paralysing action on the nervous system, do not produce marked hæmorrhagic lesions, nor do they coagulate blood. They have, rather, an anticoagulant action on blood similar to that of peptone or extract from leeches head. In poisoning by the viperinæ venom on the other hand, it is the coagulation of blood and severe hæmorrhagic lesions, which constitute the prominent feature, the suppression of the functions of the nervous system being only of secondary importance. These different physiological properties have been found to belong to the different constituents present in the venoms. These constituents are called active principles. Cobra venom, for example, contains about a dozen active principles, the two most important ones among them being

Snake venoms in epilepsy. The use of viperine venom has been recommended for the treatment of epilepsy. It has been reported that epileptic patients who have been bitten by vipers, subsequently remained free from fits for long periods. Spangler (1927) and later Finkleman (1937) have successfully utilized crotalus venom in the treatment of patients suffering from epileptiform fits. Chowhan (1940), however, advocates the use of a mixture of the venoms of cobra and *vipera russellii* for this purpose and reports to have obtained such encouraging results as to adopt it as a part of the routine method of treatment in the school of Tropical Medicine.

(*Indian and Eastern Chemist*, May, 1941).

FEIGNED EPILEPSY IN WARTIME

By Redvers Ironside, London.

The author states that simulation of epilepsy may be attempted in wartime and that the medical profession, particularly on medical boards, should be alive to the possibility of fraud when epilepsy is alleged as a bar to military service in those of conscript age.

Postepileptic stupor may be simulated by a full dose of a hypnotic drug by mouth, the clothing and floor on which the person is found lying having been wetted previously with water or urine. An incision made by a confederate on the tongue or lip will heighten the illusion that the patient has had a genuine convulsion. To complete picture, an accomplice may supply in considerable detail the entirely fictitious but convincing history of chronic epilepsy in the subject of the alleged fit. Complex simulation may require the co-operation of several persons. Sham fits are not commonly simulated before the patient's regular doctor but before a practitioner who is hurriedly called to see the patient for the first time.

In taking the history, stress will rightly be laid on the story of a lacerated or swollen tongue after the fit, blood on the pillow, incontinence of urine or subconjunctival haemorrhages. But one should be alive to the possibility that such "unequivocal" signs of an epileptic fit may be simulated or invented by the patient. About 30 per cent of epileptics show scars on the head, tongue or limbs. Burns are commoner in female epileptics; in males, they are usually insignificant cigaret burns. Electro-encephalography shows abnormal tracings in all cases of epilepsy during the fit and immediately afterward.

A simulated postepileptic stupor must be differentiated from status epilepticus, head injury and hysteria. Whenever doubt or

suspicion exists, the patient should be kept under isolated observation in the hospital, roentgenogram should be made of the skull for fracture and spinal fluid should be withdrawn for analysis after estimating its pressure. If produced by hypnotics, a simulated postepileptic stupor may last for days or weeks. True postepileptic stupor may last minutes or hours only. Drug stupors differ from status epilepticus in that they are unheralded and unaccompanied by any convulsion or clonic twitchings of the muscles. A visible external injury on the head or the presence of any unilateral neurologic sign should lead to the suspicion of intracranial trauma. Catatonic stupor and cerebral cysticercosis may have to be excluded. Between their attacks, malingerers may simulate a state of imbecility and "dress the part" by omitting to shave or sleep for some days. The apparent imbecility of the malingerer may be revealed by some discrepancy or incompatibility apparent to the trained observer. For example, a patient with a seemingly idiot mentality will find his way to the doctor alone and assert that he dressed himself unaided that morning.

Differentiation from hysteria may be exceedingly difficult. Hysterical symptoms may occur in epilepsy. The suspicion of malingering is aroused in the case of soldiers: (1) if the patient was not certainly known to be epileptic in prewar days: (2) if a man with a previously healthy record of service develops a fit on leave, or (3) in the case of civilian males of conscriptive age, if the patient has temporarily changed his address to be near a doctor he has not seen before.

The suspect must be examined apart from his relatives and friends and the separate stories compared for contradictions and discrepancies. Especial care must be taken to avoid putting leading questions during case taking. In case taking the following points may suggest the possibility of simulation: (1) the same history occurring in an epidemic of similar cases: (2) contradictions in the patient's own story if he can give one, or discrepancies between the patient's story and that of a relative or eyewitness: (3) overelaboration of the history; (4) suppression (through amnesia or some other irrelevant reason) of details of previous medical treatment, and (5) a history of constant, steady employment by a patient who is alleged to have frequent severe attacks. One of the characteristics of the epileptic is that he is constantly losing his job because of the fits.

(*B. M. J.* April, 1940).

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Medical News and Notes

THE XVIII ALL-INDIA MEDICAL CONFERENCE.

The 18th All-India Medical Conference is to be held at Hyderabad Deccan in the last week of December, 1941—the dates provisionally fixed are the 26th, 27th & 28th of December, 1941.

There will be three sections—(1) Medicine, (2) Surgery and (3) Midwifery and Gynaecology.

There will also be an Exhibition in two sections (1) Scientific and (2) Medical and Surgical appliances, Pharmaceutical Preparations, etc. Visits to places of interest and socials are also being arranged.

Members of the Medical profession are invited to contribute to the success of the Conference by taking part in its deliberations.

The terms of membership and the conditions for acceptance of papers to be read in the Scientific Sections are as given below.

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Secretary.

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(1) Papers published or submitted for publication elsewhere will not be accepted.

(2) Owing to the limited time available not more than 15 minutes will ordinarily be given for reading a paper. It is therefore suggested that the material be presented as briefly as possible. Facilities will be available for projecting diagrams, tabular statements or slides to explain the text of the paper.

(3) Preference will be given to papers embodying results of original observations of interest to the General Practitioners.

(4) The full paper, together with a short summary, not exceeding 200 words, should reach the under signed by the end of October, 1941, at the latest. Copies of the paper and abstract should be retained by the writer; though all care will be exercised and effort made to return to the writer any papers not accepted. The Conference cannot accept responsibility for accidental loss.

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MEDICAL ASPECT OF A. R. P. WORK.

Under the auspices of the British Medical Association, Madras, Major F. M. Collins spoke on "Some Medical Aspects of A. R. P.", at the North East Lecture Theatre, Medical College, Major-General H. Stott, Surgeon-General presided. The lecturer said that bombing in the City, situated as it was, likely to be indiscriminate. It was therefore necessary that proper precautions should be taken. While the manner in which the various shelters should be constructed, was a question for the engineering department, they, the medical men, must look to proper sanitation of the shelters.

Proceeding, the lecturer said that different types of injuries from bombing should be anticipated and should be provided for, so that treatment might be given with the least possible delay. The A. R. P. Wardens should be given instructions with regard to first aid that could be rendered to the injured. He urged that a mobile medical unit should attend to more severe cases at the spot. The unit should be fully equipped with expert medical staff. Even in hospitals, the lecturer suggested, first aid posts might be kept, so that the less serious injuries might be attended to by them.

Major Collins deplored that A. R. P. was not having the measure of response which it should have from the public in the City. There were people who, for various reasons, were apathetic. He urged the co-operation from the public themselves was greatly essential for affording proper protection against air raids, besides what the government could do in the matter. Enough men had not volunteered their services to the A. R. P. considering the City's population.

The Surgeon-General expressed his gratefulness to the St. John Ambulance Brigade and the medical men and the public, who had volunteered their services for A. R. P. work, at the sacrifice of their own time and leisure. He appealed to the public for greater co-operation in the matter of enlistment of volunteers for giving medical relief. Dr. A. S. Mannadi Nair proposed a vote of thanks.

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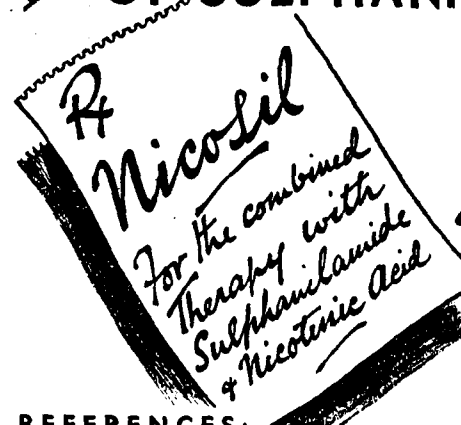
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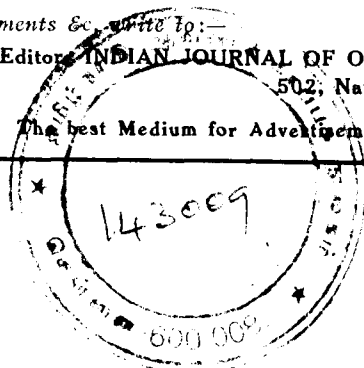
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