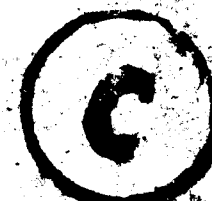


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MEDICO Surgical
Suggestions

VOL - XIV MAY 1945



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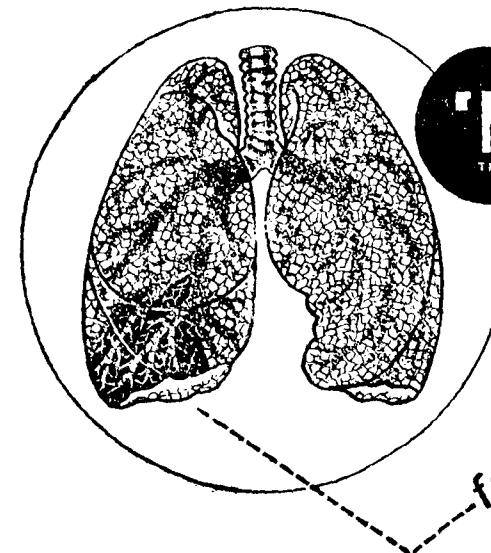
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MEDICO-SURGICAL SUGGESTIONS

Vol. XIV

MAY 1945.

No. 5.



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 Course of sulfathiazole (20 Gm.). If the patient failed to respond to one five day course of treatment he was instructed to take four liters of fluid daily in addition to liquids taken with his meals and to continue the same hygienic measures. During the five-day rest period (this has now been reduced to two days) no other treatment was given. From September, 1942, to January, 1943 the criteria of cure consisted of absence of symptoms and signs of gonorrhea, clear urine in both glasses of the two-glass test and negative smears of prostatic secretion obtained by gentle stripping of the prostate. Examination of prostatic secretion was thereafter eliminated as a test of cure as it was felt that in many instances even gentle prostatic massage precipitated a flare-up of infection in the posterior urethra and increased the recurrence rate. Patients discharged from the hospital were examined weekly for a period of two weeks at the Venereal Disease Clinic. This weekly follow-up consisted of checking for symptoms and signs of recurrence, the two-glass urine test and microscopic examination of urine or urethral material whenever indicated.

Of the 2,100 patients treated, 1,714 (81.6 per cent) recovered on one course of sulfathiazole (20 Gm.). One hundred and ninety-three (9.2 per cent) recovered on an additional course of sulfathiazole, giving a total recovery rate of 90.8 per cent.

DUTY STATUS TREATMENT OF ACUTE UNCOMPLICATED GONORRHEA

The patients on "duty status" treatment were divided into two groups. The first group consisted of soldiers treated at their own unit dispensaries. They received two weekly checkups consisting of examination for discharge and a two-glass test following completion of sulfathiazole therapy. These checkups were made one and two weeks following the first or second course of treatment, whichever was necessary to render the patient asymptomatic. The second group consisted of selectees treated at the Reception Center dispensary. Movement of troops through the Reception Center was so rapid that tests of cure were not made at this station but were made at the soldier's first assigned post. However, Reception Center patients were rendered asymptomatic before transfer to another Army post.

Eleven hundred and seventy cases were treated on "duty status." These men continued their regular military duties and training while under treatment. A change of duty assignment was made only in flying personnel and in a few selected individuals whose work required a high degree of muscular co-ordination. The "duty status" treatment saved a large number of days lost from military duties and released hospital beds for other patients.

Two hundred and eighteen soldiers in the first group were treated on duty status. One hundred and thirty-one (60.1 per cent)

recovered on one course of sulfathiazole (20 Gm.). Fifty-four (2.47 per cent) recovered on an additional course of sulfathiazole (total 40 Gm.) giving total recovery rate of 84.8 per cent.

Nine hundred and fifty-two selections in the second group were treated on "duty status." Seven hundred and forty-two (77.9 per cent) were asymptomatic after one course of sulfathiazole (20 Gm.). One hundred and sixty-two (17 per cent) were asymptomatic after a second course of sulfathiazole. A total of 94.9 per cent were rendered asymptomatic after two courses (40 Gm.).

HOSPITAL TREATMENT OF RECURRENT GONORRHEA.

The question invariably arises as to whether a recurrence is a relapse of the original infection or a re-infection. Patients re-admitted to the hospital within a period of two months following their discharge to duty were considered recurrent gonorrhea as they invariably denied sexual exposure. Many cases were probably reinfections but this could not be proved. They were given the same as acute gonorrhea.

Two hundred and eighteen of these represent a 10.4 per cent recurrence rate in the original 2,000 cases analyzed. The remaining 35 patients had been treated recently for acute gonorrhea at another Army post. Their recurrences had taken place after transfer to this station.

SULFATHIAZOLE FAILURES

Patients who failed to respond to two courses of sulfathiazole treatment were carefully examined for factors contributing to chronicity. Each case was individualized. The chief cause of failure was infection with gonococci resistant to sulfathiazole. The second cause of failure was found to be some complication of gonorrhea in the genitourinary tract such as prostatitis, epididymitis or periurethral abscess. Foci of infection in other part of the body contributed to chronicity in very few instances. A third cause of failure was found to be an obstruction to a free flow of urine due to a small meatus, marked phimosis or urethral stricture. These three groups of sulfonamide failures were transferred to Army general hospitals for further treatment. Transfers were made because fever therapy was not locally available and because station hospitals must keep their beds free for acute disease. As beds were not always available at general hospitals, 70 per cent of the sulfonamide failures were treated at Fort Bragg. The sulfathiazole-resistant cases were treated conservatively and with the greatest gentleness, as it was felt that tissue damage and complications could in this way be avoided. Four to six cubic centimeters of 5 per cent argyrol or 0.5 per cent protargol were instilled into the anterior urethra two or three times daily. After the urethral discharge changed from purulent to mucoid, a third course of sulfonamide drugs (sulfathiazole or sulfadiazine) was given and gentle

prostatic examination (not massage) was done 24 to 48 hours after treatment was started. The object of this examination was to determine whether complications of gonorrhea had developed while the patient was receiving local treatment, as classical symptoms of complications are often absent in sulfonamide-treated patients. No treatment other than bed rest and hygienic measures was given to patients with a complication such as prostatitis until the acute phase of the infection had subsided. Even then only very gentle prostatic massage was employed as an aid to drainage. This was done after the third course of sulfonamide therapy was started. The obstructions to urinary flow were treated by the urologist and sulfonamide medication was always given before and after manipulative or surgical procedures. The following general principles were found to be especially important in cases failing to respond to one or two courses of sulfathiazole: always be gentle, avoid trauma to tissues, avoid strong chemicals, follow progress with the two-glass urine test, give sulfonamides before and after any manipulative or surgical procedure, and emphasize hygienic measures such as adequate fluid intake, rest and cleanliness.

DISCUSSION

No significant difference in results has been noted in the hospital treated and "duty status" treated cases receiving the same dosage of sulfonamide drugs. The percentage of cures in the hospital-treated group would have been higher if the patients with complications had been excluded. It is clear that the Negroes responded to treatment promptly and more satisfactorily than did the white patients. No attempt is made to explain the difference in the results in the two races.

Drug reactions encountered in this series were few and not significant. They were usually promptly controlled by discontinuance of sulfonamides, forcing fluids and alkalization of the urine with sodium bicarbonate. The small number of reactions is attributed to the low dosage of sulfonamides employed. Sulfonamide-sensitive cases were given the same local and general treatment as sulfathiazole-resistant cases but sulfonamides were omitted.

Sulfathiazole was used exclusively in cases treated on "duty status." Sulfathiazole or sulfadiazine was used in the further treatment of patients who failed to respond to the second course of sulfathiazole. No apparent advantage of one drug over the other was noted, if adequate fluid intake was maintained.

The small number of patients developing complications was attributed to the fact that no local treatment was given on "duty status" and that, in the rare case requiring local treatment in the hospital, only the gentlest of handling was given.

The patients who developed reactions to sulfonamide drugs and those who failed to respond to sulfonamides offered a real treatment

problem. Use of larger dosage of sulfonamides may reduce the number of the latter but will by no means eliminate the group. The results recently achieved with penicillin in sulfonamide-resistant gonorrhea have been so strikingly successful that it is believed this material will replace local treatment, instrumentation, and fever therapy with their concomitant hazards in this group of cases. Likewise, penicillin will undoubtedly occupy an important place in the management of the sulfonamide-sensitive patient.

The results achieved in these groups of patients treated chiefly by medical measures clearly show that acute gonorrhea from a therapeutic standpoint is a medical and not a urologic disease. The treatment of gonorrhea should remain in the hands of the internist because of his better training in the use of sulfonamides and because of his aversion to the use of instruments and local treatment. The urologist's place in the treatment of acute gonorrhea should be similar to that of the surgeon in the treatment of pneumonia. When an empyema must be drained, the surgeon's help is sought. In gonorrhea, when skilled, mechanical, local measures are needed in the treatment of failures, the help of the urologist is essential.

(*Indian Journal of Venereal Diseases and Dermatology, March 1945.*)



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PROGNOSIS OF THE CARDIAC PATIENT

BY Lt.-COL. KEELE, R.A.M.C.

PROGNOSIS AND THE PATIENT.

When a patient goes to see a doctor he wants one thing—a prognosis that is to say he wants to know his future. He does not consider that prognosis depends upon correct diagnosis and treatment. We, as doctors know this and must therefore refrain from giving a prognosis until we have built up correct diagnosis and assessed the response to treatment.

Often prognosis is disposed of in text-books by a few sentences relating to survival period of patients. Prognosis regarding life is obviously of first importance, but our task as doctors does not end there. If the patient will live—how will he live, bedridden, permanently invalid or will he be able to perform his functions as a money earner, enjoy sports and lead a full life of activity? These difficult questions are urgent in their need for satisfaction. They may be summarised as the physiological side of prognosis. Finally, the psychological aspect must be considered. Life may be secure, the diseased organ recovered, but the patient remains a useless individual to himself and society by virtue of the psychological trauma of his disease. This trauma is sometimes inflicted by the doctor in his management of the case.

Prognosis is reached by two methods—rational and empirical. Rational prognosis consists of a time picture of the patient's future, built up from the picture of his past, as related in his history. The importance of accurate history-taking cannot be over-emphasised therefore, with regard to making a prognosis. Combined with the full evidence of the patient's present state on examination it provides all the data (his "present state" including his response to the treatment instituted).

SPECIAL ASPECTS OF PROGNOSIS IN THE CARDIAC PATIENT:

(1) *Psychological*: The patient who thinks he has heart disease, whether he has or not, is very frightened. The heart, with its visible, palpable, and audible beat in health is one of the few viscera of which a man may be conscious. Heart-consciousness of exaggerated degree is therefore common in anxiety states. It is a morbid awareness. If the doctor too is frightened, the patient's fear is redoubled. Many cardiac neuroses are set up in this way in people with healthy hearts presenting some innocent irregularity such as sinus arrhythmia or a functional systolic murmur at the apex.

(2) *The toughness of the Heart*: From the organic point of view it is often surprising how much pathological change is present in a heart which performs its mechanical function reasonably well.

PROGNOSTIC CRITERIA IN HEART DISEASE:

The diagnosis of the nature of the infective agent carries with it a remarkably clear prognostic significance in heart disease. For example with Acute Ulcerative Endocarditis, where the valvular infection is merely an incident in a septicaemic process, the duration is about 6 weeks, that of a septicaemic course.

In subacute bacterial endocarditis, with strep. Viridans as the cause, 6-12 months usually sees the end. This one can forecast however mildly ill the patient appears, if one finds the triad of valvular damage, positive blood culture and evidence of embolism, usually first evident in the kidneys, where red blood cells appear in the urine.

In aortic regurgitation of syphilitic origin life averages 3-4 years from the time of diagnosis, in spite of treatment.

Rheumatic carditis may last anything from a few weeks to 20 or 30 years. Prognosis here depends upon activity.

In diphtheria the danger is in the acute toxic stage and convalescent period following. There is no danger after recovery. Chronic diphtheritic myocardial disease does not exist.

(b) *Activity*: This is assessed by progress of the heart lesion as measured by change in valvular signs and functional failure of heart muscle, including enlargement.

In rheumatic carditis the criteria taken are most often found outside the heart, temperature, sleeping pulse, sedimentation rate, white blood count, and presence of nodules providing, taken together, an accurate picture of activity.

(2) *Mechanical Failure*: (a) Left ventricular as evidence by (1) Dyspnoea, (2) Cardiac Pain.

(1) *Dyspnoea*: This symptom is of utmost prognostic importance if progressive and unaccompanied by other symptoms. By "progressive" it is meant that the symptom of consciousness of difficulty in breathing, appears on an ever diminishing amount of exertion, until it may be present at rest, in which case it is worse on lying flat on the back—orthopnoea.

Paroxysmal dyspnoea at night occurs, simulating asthma, and indicates failure of the left ventricle with congestion of the hilar vessels. It is of bad omen.

Dyspnoea combined with many other symptoms occurs as part of cardiac neurosis. It is then not quantitatively related to exertion.

(2) *Cardiac Pain*:

(a) The pain of *angina of effort* often replaces dyspnoea. This pain is substernal, it may radiate to both arms or jaw, or through to the back. It is quantitatively related to effort, its duration is short, and it is progressive in the same way as cardiac dyspnoea. It is relieved by rest and nitrites. The severity of the pain is no guide to its prognostic importance in terms of degree of myocardial

(b) *Coronary Thrombosis*:

Distribution of this pain is similar to that of angina of effort, but it occurs usually at rest. The extent of infarction is suggested by (1) degree of shock, as shown by collapse, low blood pressure, cold extremities with peripheral cyanosis; and (2) the degree of reaction, as shown by pyrexia, white cell count, sedimentation rate, and possibly, extent of pericardial rub. Electrocardiograms also add invaluable information as to site and extent of the lesion.

(c) *Cardiac Enlargement*:

Diagnosed by hearing apex-beat, more than 4" from the mid line this finding means diminution of cardiac reserve in proportion to the size of the heart. The larger the heart, the shorter the life. X-Ray evidence precedes clinical evidence of enlargement since the first direction of enlargement is posteriorly, then laterally. Enlargement due to acute dilatation is less common than is usually supposed. It is rare in acute infections and marked only in beri-beri of wet type and myoedema.

PSYCHOLOGICAL EFFECT:

The organic criteria above mentioned all assume psychological overlay of varying degree, which may be of worst prognostic invalidating power than the organic lesion itself. This factor can be greatly influenced for good or ill by the doctor himself who manages the case.

REMARKS ON AORTIC REGURGITATION

Some of the unusual features of the cardiac pain in aortic regurgitation may be accounted for by oedema in the region of the coronary orifices. Such an aetiology was suggested in the case of a woman of 37 who complained of angina of effort. There were minimal signs of aortic valve disease and no cardiac enlargement. Response to iodides was satisfactory and the pain did not recur for some months at least. This risk of oedema is presumably the reason why it is dangerous to give arsenicals in syphilitic aortic lesions.

Variable sensitivity to pain is possibly one reason why angina pectoris is so difficult a problem. In a series of 25 angina cases tested for pressure pain sensitivity, similar results were obtained for all.

Many of the unusual types of chest pain described are, in my opinion, the result of functional overlay and it is unlikely that they correspond with particular anatomical or pathological changes.

(The Medical Bulletin, June 1944).

Extract.

DRUG CONTROL OF MALARIA.

There are certain points to be considered before starting the treatment of malaria :

1. Poverty of patients residing in malarial districts.
2. Heavy cost of antimalarial drugs.
3. The unpleasant and toxic effects of antimalarial drugs.

At present there are two drugs mostly used: (1) quinine and (2) mepacrine.

None of the above is satisfactory for prophylactic treatment.

In vivat infections relapses tend to occur about the second and eighth month after the primary attack and in falciparum infections mostly within two months of the primary attack.

It is believed that final eradication of malarial infection is brought about by immunological process. Experimentally Boyd has shown that premature termination of primary attacks by means of intense doses of drugs results in recurrences and development of immunity against infection.

Treatment of clinical attack:—There are two schools of thought, one of which advocates intensive treatment with large doses of antimalarial drugs and the other advocates small doses of a long time.

Treatment with small doses:—15 grains of quinine for 7 days in acute attack with large doses in severe cases is sufficient, to relieve the attack. Then anti-relapse treatment should be given which consists in giving 10 grains of quinine or 0.1 g. mepacrine, twice or thrice daily on two consecutive days of each week for two months, after the treatment of primary attack. A recent recommendation for patients not resuming continuous treatment is 0.1 g. of mepacrine thrice daily for 5 days beginning 10 days after treatment of acute attack was ended. In acute attack some prefer to combine all three drugs giving for example quinine for first two or three days, then a five-day course of mepacrine, and finally after an interval of a couple of days, a course of pamaquin.

to 0.4 g. which is given for 4 days followed by pamaquin for 2 days and quinine sometimes.

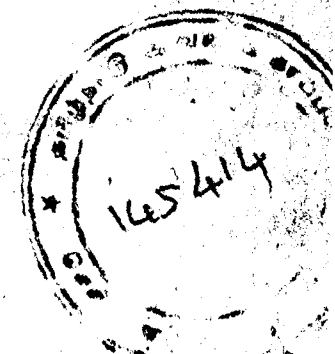
It is said that there are drug fast strains of parasites which are very resistant to treatment. This is wrong. There are other factors such as (1) inadequate supervision with evasion of drug; (2) careless administration; (3) adulteration of drug and (4) failure of absorption due to vomiting or other cause are responsible for non-response of drug. In such cases parenteral administration of drug should be done.

Suppressive Treatment:—Mepacrine is considered as a good drug due to shortage of quinine. 0.3 gm. mepacrine weekly for 3 months is the best way from points of view of efficacy, safety, and convenience of administration.

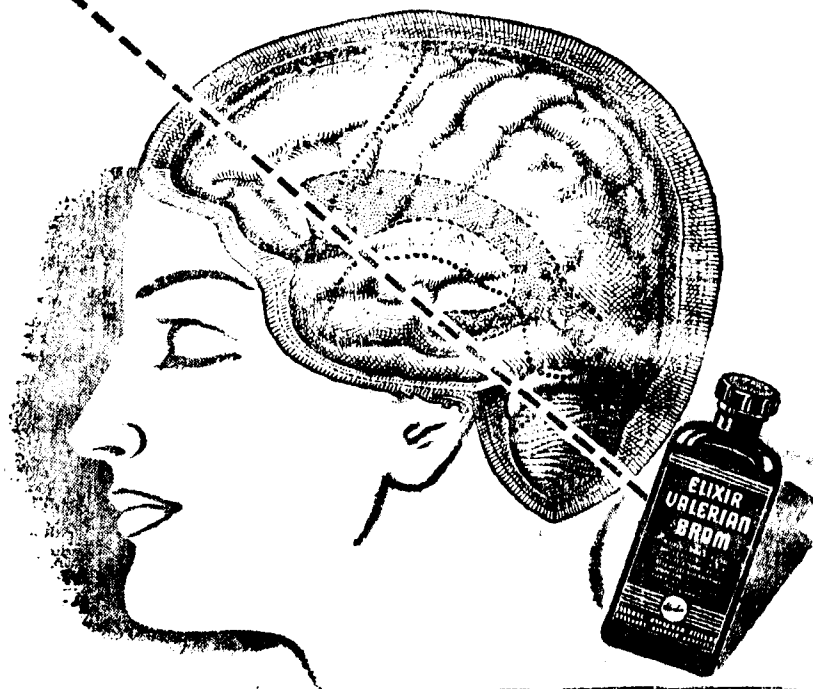
Diagnosis:—It is sometimes difficult to distinguish between relapse and reinfection. This may cause confusion in treatment. In malarial districts in every case of fever, malaria should be excluded. If malarial parasites are found in peripheral blood diagnosis is certain; blood must be examined, 24 hours before attack, and 2 or 3 days after attack. M. P. can be found in peripheral blood even if the patient has taken quinine for 2 to 4 days after the attack.

There are other acute infections which may be mistaken for malaria, such as (1) amoebic hepatitis, (2) pyelitis, (3) pneumonia, (4) typhoid, (5) meningococcal septicæmia, (6) typhus, (7) leptospirosis and (8) acute lymphocytic chorio-meningitis. True cases of malaria in absence of adequate examinations may be mistaken for other disease. Clinically malaria often fails to conform to any classical picture of intermittent fever especially the malignant tertian infection. A group of cases of chronic malaria often give difficulty in diagnosis as M. P. are not found in peripheral blood but patients get fever if they stop quinine for 5 or 7 days parasites may be found in peripheral blood as the patient gets fever. Patient with chronic malaria has classical picture of splenomegaly anæmia and emaciation. These patients are also subject to ankylostomiasis or malnutrition along with malaria.

Lancet (1943) June 5, p. 699.



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