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SURGICAL & MEDICAL NEWS

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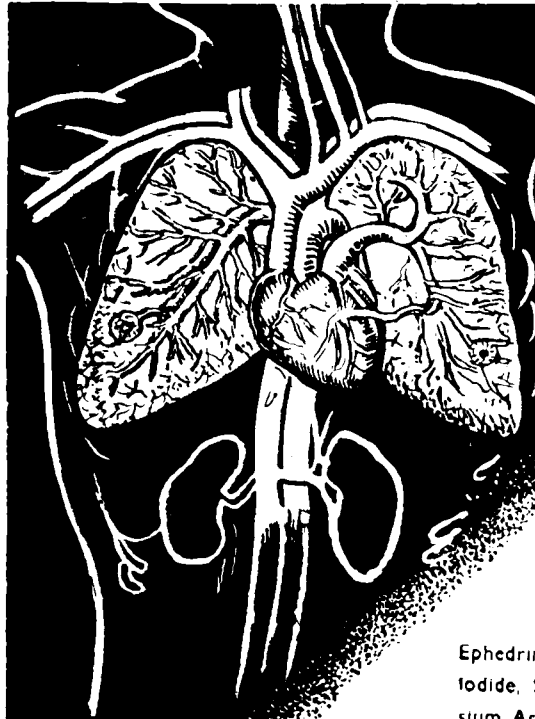
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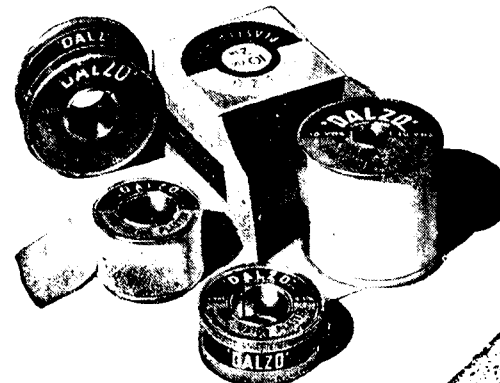
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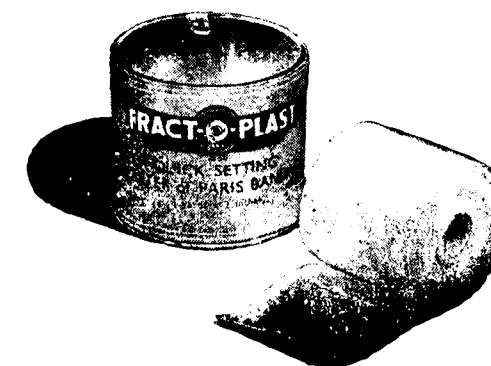
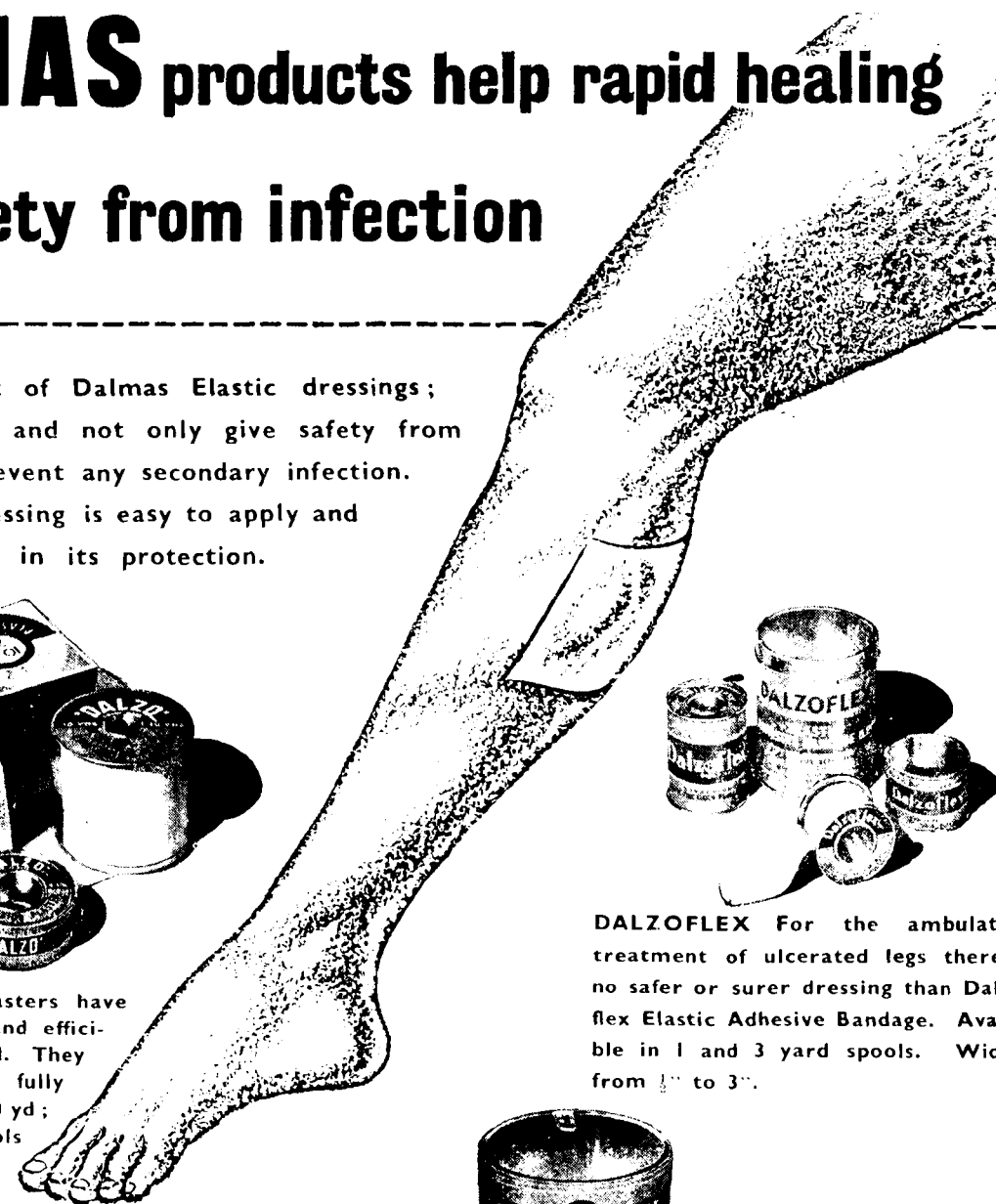
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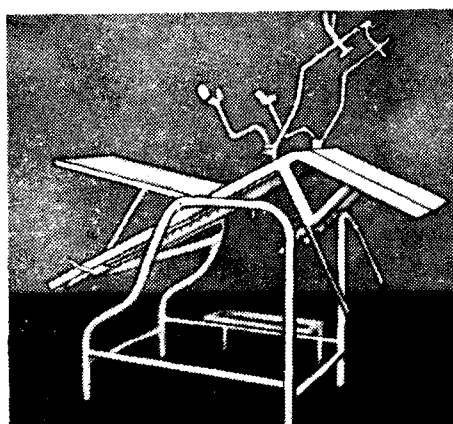
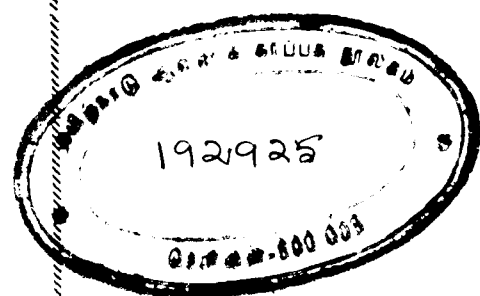


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THE ANÆSTHETIST'S PLACE IN MODERN SURGERY

EVERY surgeon, irrespective of the branch of surgery which he practices, should have the chastening effect of at least three months spent as an anæsthetist. This should be in a unit where a high standard of anæsthesia is practised, and where access is had to a wide range of modern equipment and anæsthetic reagents. It should not be in a place where any passer-by who can successfully aim ethyl chloride or æther at an open face mask, is considered a competent enough anæsthetist. This excellent training will enable the surgeon to see himself as the anæsthetist sees him. He will learn to appreciate also the difficulties which confront the anæsthetist and obtain an insight into what he may reasonably expect by way of good relaxation and sound anæsthesia from his colleague.

Although my interests are primarily devoted to Obstetrics and Gynæcology I am convinced that a preliminary training in general surgery is essential. This should include an appointment in Anæsthesia as well. Apart from its value to the general surgeon, anæsthesia is of great practical application not only in childbirth but also in the operative aspects of Obstetrics and Gynæcology. Prior to leaving the U.K. I served for a time as Resident Anæsthetic Registrar at Queen Mary's Hospital, Sidcup, Kent. Among other things I learnt the art of laryngeal intubation and the use of relaxants. Queen Mary's Hospital enjoys a great reputation, and figures in the more recent history of anæsthesia. It was here that the father of British Plastic Surgery, Sir Harold Gillies did his pioneering work on the treatment of Facio-maxillary injuries and other forms of reconstructive surgery after the last great war. Those who served with him then have spread out to different parts of the world and established names for themselves—men like Sir Archibald McIndoe, Pomfret Kilner, Rainsford Mowlem, Clarkson, Rank and Wallace. Two anæsthetists served on his team and they were Ian Magill and Rowbotham. It was at Queen Mary's Hospital that they perfected the art of endotracheal intubation.

When I told a medical friend of mine that I had once served as an anæsthetist he became worried on my account. "Don't raise your voice above a whisper. Even walls have ears. If this information gets around you will be ruined. You will find yourself in "anæsthesia

anæsthetist is someone upon whom they could vent their surgical fury in the theatre, particularly when things are not going as well as might be expected. It is on the broad and uncomplaining shoulders of his anæsthetist that the surgeon can place the responsibility for any irreversible misfortune on the operating table. Patience and quiet endurance developed over the years, helped partly no doubt by the vapours inhaled, has enabled the anæsthetist to act as a buffer to surgical wrath, and to offer a relative protection to the helpless nursing staff led by the theatre sister and to those at the lower rungs of the surgical ladder. "The surgeon has two great enemies. The first is sepsis. The second is the anæsthetist". So wrote Richard Gordon, (who in real life is a distinguished Oxford anæsthetist) author of "Doctor in the House"—a popular book which has been filmed—in one of his humorous contributions to "Punch".

What a contrast is there between our poor anæsthetists and some of their bretheren abroad! We have been left far behind in the science of anæsthesia. Except for a very few many have become experts by learning, with what meagre resources they have had available, in the hard school of experience. They have found themselves in the unenvied position of anæsthetist; and by dint of hard work and perseverance, learnt by trial and error—an expensive method in terms of human life!—but one which inspires confidence in the practice of his art, and made the best of a bad thing. Having little direct practical guidance they have kept in touch, at least in theory, about advances in other countries through the medical literature. Poorly paid, often not paid at all, overworked, and at the beck and call of every medical man who harbours surgical pretensions, they toil. Their work is bereft of glamour. Equipment is costly and not supplied. Drugs are difficult to come by. The scope of their practice is limited. There is little gratitude and even less of appreciation for the work they do. Possessed of a burning inferiority complex they silently watch the surgeon at his work, secretly envious of his high position. All admiring eyes are turned towards the wielder of the knife, while the anæsthetist has to try and keep his place because medical students and casual spectators in a desperate endeavour to obtain a glimpse of surgical technique try and elbow him out of the way. The surgeon cares little for the anæsthetist's clinical judgment or knowledge when he bellows out "The patient is blue this end" or "Start saline and get blood". He obeys meekly. It is more judicious to do that than to invite surgical displeasure. "What is there in anæsthesia after all" is a popular surgical saying because it is accepted that any medical man with a little skill can inject a standard volume of anæsthetic drug into the spinal canal or spray ethyl chloride until the patient is under, and then carry on with æther until the operation is over.

Compare him to his counterpart in some British Hospitals—The Physician—Anæsthetist. What a contrast! He is a powerful man who precedes the surgeon in any ceremonial procession, because he is first and foremost a physician. Often he tells the

surgeon what to do and when. He claims the whole province of preoperative assessment and post operative care as his own undisputed territory. He will permit the surgeon to enter, but reluctantly. He does not easily stomach empirical surgical pronouncements from his surgeon—be it on shock or fluid balance. He comes to know the patient more intimately than the surgeon himself. The surgeon begins to doubt at times whether he is not reduced to a technician performing an operation to suit the anæsthetic. Surrounded by his gleaming Boyle's machine, re-breathing apparatus and carbon-dioxide absorbers, a battery of syringes and even at times special recording apparatus, the anaesthetist steals the surgeon's thunder. The spectators stare awe-stricken at the skill with which he controls these complicated devices. He administers cocktails, mixtures of drugs in various proportions and given at various times. Sometimes he is whimsical and may postpone or cancel a case on his own authority without any reference to his surgeon. Those employed at the lower rungs of the surgical ladder are timid to approach him for anæsthesia and they make their petitions with humility and great trepidation.

Although his somewhat "overbearing" manner may be to compensate for the inferiority complex which all anæsthetists by virtue of their history and tradition nourish in their hearts—he takes a sincere pride in his work. He anticipates every move of the surgeon and does everything in his power to make surgery speedy and safe. The patient's welfare is constantly in his thoughts.

The patient should remain on the table for the surgical operation and should not suffer apprehension, distress or pain. Despite careful surgery, shock may follow aggravated sometimes by unavoidable blood loss. This is combated by timely resuscitation. A good exposure of the region which is being operated on is facilitated by sound relaxation. Contracting voluntary muscles are not permitted to obscure the surgeon's vision. The drugs employed for anæsthesia should not unnecessarily jeopardise the patient's life or result in delayed harm.

In a modern operative team the anæsthetist makes a vital contribution. The success for an operation is shared by all. The anæsthetist receives his due. His opinion is freely solicited on pre

The anaesthetist should have a more important part to play both in undergraduate education and post-graduate teaching. To undergraduates he can emphasize the physiological, anatomical and pharmacological principles, the sensible appreciation and interpretation of which alone can contribute to successful anaesthesia. He can educate post-graduates in the importance of his art not only to the success of major surgery but to minor surgery as well. It goes without saying that he can train post-graduates who have chosen "anaesthesia" for a career.

We in India, have already made a start by appointing experienced and well qualified anaesthetists in the largest of our city hospitals. We are endeavouring to give some sort of training, at least for a short period, for those who practise this craft in other hospitals both within and outside of the cities. To stint on money or materials to provide a higher standard of service in anaesthesia would be most unwise. A big hospital which lacks a modern Boyle's anaesthetic machine, facilities for intubation anaesthesia and the use of relaxants, and equipment for urgent resuscitation must be considered somewhat primitive from accepted modern standards.

Anaesthesia should be recognized as a speciality. A Resident Anaesthetist is an essential member of the staff and should not be looked upon as an added luxury. We all know how much time is wasted in getting hold of an anaesthetist, particularly for emergencies which occur at night. Often the hospital anaesthetist is inaccessible, lives far away, or the only available hospital ambulance has to be sent to fetch him. If it is a desperate emergency, which requires urgent surgery, and Obstetrics is full of such, one has to fall back on a surgical colleague to give anaesthesia at a time when the services of an expert is most needed. With a trained anaesthetist on the spot, who has easy and speedy access to communicate with his senior consultant, a great deal of time can be saved and better training made available to those who take up this branch of medicine.

Just as it is necessary to pass through various phases of seniority (House Surgeon, Senior House Officer, Junior Registrar, Senior Registrar) to become a consultant in surgery, so too must there be a graded pathway to become a consultant in anaesthesia. We have no diploma or degree courses in anaesthesia. It would be premature to establish such until we have a cadre of anaesthetists fully trained in modern methods of anaesthesia by established experts in the field, not ones who have "just picked it up as they went along by a process of trial and error"! Teaching units in Anaesthesia should be fully equipped with modern anaesthetic apparatus and have access to all the requisite drugs that are employed.

Unless we are willing to alter our attitude towards anaesthesia and to those who

administer it, the progress we make in surgery, more particularly in specialised forms of abdominal and thoracic surgery, will be very slow indeed. We have already been left far behind and unless we act now we shall be left still further behind in this branch of Medicine. Let us accept without reserve that successful surgery depends almost wholly on good anaesthesia.

Those surgeons who believe that they cannot "afford" to engage the services of an anaesthetist, particularly for their private cases, or adopt the attitude that they can manage "somehow", perhaps single handed, not only do a real dis-service to this branch of medicine which is still in its infancy, but strike a mighty blow at the very roots of progress of surgery in our land. (Dr. Vishnu Sarma.)

This Doctor recognized a similar condition the night he asked a patient "Where did you get that ecchymosis, that black and blue eye, Charlie?"

"In the War Doctor."

"What war?"

"The boudoir."

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and weary hours in the wards of a fully equipped Hospital of over 500 beds, seeing and learning different diseases at the bed side besides the hours spent in the laboratory and dissecting rooms, has to pass through the hands of different sets of examiners before he gets qualified to practice the art of Medicine. Long before he leaves his tutors and teachers, he has occasion to see the various diseases and their treatment, he himself handles many of them, gains practical knowledge and confidence in dealing with most of the cases and comes out of the institution experienced and prepared. In spite of these a fresh graduate is considered a raw hand but according to ability, knowledge and tact he plods his way through. During the period under training he has to learn systematically Biology, Bio-chemistry, Anatomy, Physiology, Embryology, Pharmacology and Therapeutics, Hygiene, Medical Jurisprudence and Toxicology, Pathology, Medicine, Surgery and Mid-wifery with sufficient of the diseases of the Eye, Ear, Nose and Throat. He has to pass many examinations in all these subjects and has to satisfy his examiners of his ability to do the job he is undertaking. It is only then he is allowed to practise these. In no other system is such elaborate preparations required or compulsory

and no other system gives anything so thorough and complete to persons aspiring to learn those arts.

Now-a-days in Ayurvedic schools and colleges many of the subjects of Modern Medicine are taught in their elementary forms. In a sense this is a good practice, but to manufacture Medical graduates with insufficient knowledge of either systems and a mixture of incomplete knowledge of many systems is a dangerous practice. The innocent masses of people will have to bear the evils unawares.

There are also fundamental differences in the treatment of a disease or on the use of a particular remedy in the different systems of Medicine. Modern Medicine on the basis of signs, symptoms and experimental proofs advocates a particular line of treatment. There are only very few occasions where a line of treatment is carried out on an empirical basis. The other systems mostly depend on symptoms for their treatment and most of the treatments are carried out on an empirical basis and are mostly symptomatic treatments with no experimental proofs to substantiate the line of action taken. I do not deny the fact that there are some good remedies and effective line of treatment in the other systems, but they

are very limited. In Modern Medicine as opposed to the other systems it is not only the disease and treatment that are understood, but the cause, signs, Symptoms, Pathology, Complications, treatment both prophylactic and curative are all studied systematically. Of course there is quite a lot to be understood yet, but what is known is thoroughly understood and sincere efforts on scientific lines are made to comprehend what is not known. Take for example the development of a human foetus inside the mothers womb. Every stage of its development from the single microscopic cell to the fully developed baby is understood. The complicated processes involved in the development, how the eyes are formed, how the brain develops, how the limbs are formed, how the internal organs develop and arrange themselves in their respective places and every other such detail is understood. So also what defects are likely to happen during the development, their remedies and all the connected matters are known. Similarly the life cycle of the Malarial Parasite, the causative organism of Cholera and Typhoid, the composition of human blood and the changes taking place in blood in the course of various diseases, how the intestinal worms get into the human body and develop etc., are all known to Modern Medical Science. Even the changes taking place in the human body after a person dies is not neglected but minutely studied. Above all proper records of things are kept for future reference. Nothing is kept as a secret but wide publicity is given to everything useful. In short Modern Medicine is no proper scientific basis. Do we get such details in any other systems on such scientific basis?

In spite of all these, it must be remembered that some of the remedial measures employed in these different systems and certain principles followed in the treatment of a number of diseases are more or less the same but in different forms. Some systems utilise the crude forms and the principles followed are not modern, while other systems make use of the refined products and the methods employed are modern and up-to-date. Moreover people practising the other systems like Ayurveda and Homeopathy often utilise the drugs and principles of Modern Medicines to supplement theirs. Modern antibiotics, the Sulpha drugs, a good number of the tinctures of the B. P., and vitamin preparations etc., are very liberally used by them. As opposed to this the

occasion to resort to the use of an Ayurvedic preparation or a Homeopathy drug by a Modern Medical man are few and far between. In other parts of the world where Ayurveda is not known and practiced Modern Medicine is found sufficient to cater to the needs of the people in health and in sickness. Modern Medicine has nothing much to borrow from other systems but the other systems have quite a lot to gain from Modern Medicine, as it is a scientific system, elastic and dynamic with very great potentialities and capable of achieving better and better standards in time to come.

It is often told that people resort to Ayurveda and Homeopathy because they are cheap and available everywhere. It is an established fact that the supply and demand of a particular commodity has a definite relation to the cost of it. The Medicinal plants used in Ayurveda grow almost everywhere and are easily got. No elaborate manufacturing processes are involved in the making of the preparations and many of them are used

TREATMENT OF HYPO-CHRONIC ANÆMIA

BY MAJOR A. KRISHNAN, M. B., B. S.
MADRAS

THIS Group of anæmias comprise a large number of common micro-cytic hypo-chronic anæmias such as secondary to hæmorrhage, both acute and chronic, anæmia of infancy and childhood, Patterson's œsophageal syndrome etc. Amongst this group also comes iron deficiency anæmia due to deficient intake or absorption of iron and excess demands of menstrual disorders and pregnancy.

This group of anæmias is common in India and a general practitioner is called upon to treat these cases either as a main condition or often associated with other diseases. Failure of adequate response to treatment is often due to the neglect of complete eradication of the causative factor or any other contributory factor. Such cases need a thorough investigation into the ætiology and pathology before one can get a satisfactory result.

Treatment can be divided into the following headings :—

- (1) Removal of cause
- (2) Rest
- (3) Attention to Sepsis
- (4) Diet
- (5) Medical Treatment

ÆTIOLOGICAL FACTORS

Must be detected and the cause of anæmia should be removed. As for instance hæmorrhage from peptic ulcers, hæmorrhoids etc., should be stopped and treated adequately.

FOCAL SEPSIS

Focal sepsis acts as a contributory factor in chronic anæmias. Chronic infection wherever they may be should be eradicated. Oral sepsis such as pyorrhoea, bad tooth should be attended to.

REST

In severe cases rest in bed should be instituted. If the hæmoglobin is less than 60% it is advisable to confine the patient to bed, till such a time the hæmoglobin level goes up. For moderate or mild cases rest in bed is not necessary, but hardwork should be prohibited.

DIET

Diet should be nourishing and easily digestible. It must contain less of roughage. It should contain liberal quantities of protein and vitamins. Meat, eggs, liver, green vegetables, oatmeal, Milk and fruits should be given. Fresh air and adequate sunlight are valuable therapeutic aids.

MEDICAL

The main need in this group of anæmias is iron in some form. This may be given in one of two ways.

- (a) Oral
- (b) Parentral

ORAL IRON

It is essential to give adequate dosage orally, till such a time the blood picture shows satisfactory improvement. The dosage can be reduced there-after and it should be continued for some time more. Oral iron can be given once a week every month.

Iron can be given in one of the following forms :—

- (1) Ferri-et-amm-citrus
- (2) Pillula Ferri Carb. (Blands Pill)
- (3) Ferri Sulph
- (4) Ferrous Gluconate

It should be given anywhere up to 90 mgrs. a day. Enteric coated tablets are available which cause less gastric irritation and preferred by many patients. Patients who are not able to swallow tablets may be given liquid preparations. For some who are really intolerant to inorganic iron salts a colloidal suspension may be given.

The normal daily requirement of iron is only 1.2 mgrs. A well balanced diet is sufficient to give this amount of iron for a normal man but in cases of iron deficiency the requirement of iron would be more and the iron in the food will not be adequate. The utilisation of 25 mgr

The Eleventh International Congress on Industrial Medicine at Naples

BY DR. P. K. GHOSH, F.R.C.P., (Edin), F.C.C.P. (U.S.A.)
CALCUTTA.

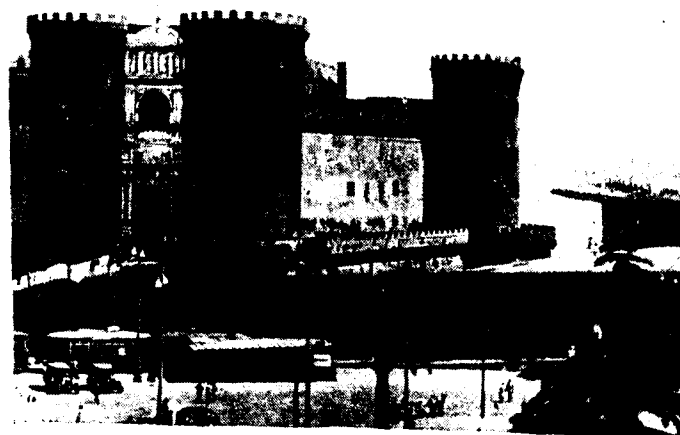
Exclusive to "Surgical & Medical News"

IN the thirteenth century rock-built majestic castle of the Anjous, projecting into the blue waters of the Mediterranean and guarding the harbour of Naples, was held the eleventh session of the International Congress on Industrial Medicine. Near the entrance to the castle, at the mouth of the drawbridge proudly fluttered the gay flags of the thirty-two participating nations, including the saffron, white and green of India.

The nations of the world had gathered at Naples on that memorable occasion at the invitation of the Italians in a spirit of friendship and fraternity, to discuss mutual problems of the welfare of the working class, particularly of those that work in various industries. This Congress is held every three years—the last one was held at Lisbon in 1951—and the next one will be held in Helsinki, Finland in 1957.

To many of my readers who do not know the origin of this Congress, the history of its growth will be interesting. In June 1906 renowned experts in industrial medicine from various countries had assembled at a meeting in Milan. At this meeting it was decided to found a Permanent International Commission on Industrial Medicine to promote and disseminate study and research in the field of occupational diseases. Thirty-two nations with 162 titular members belong to this International Commission. In addition the International Industrial Nurses' Committee and the Association Nationale des Assistantes Sociales (France) have been admitted to its auxiliary membership. The first meeting of this Commission was called the first International Congress.

The Eleventh Congress on Industrial Medicine was held between the 13th and 18th September 1954. The entire charge of organising the Congress was entrusted to a committee, headed by Prof. Scipione Caccuri, the President-elect, who was ably assisted by Prof. Giuseppe Graziani, the Secretary-General, and Prof. Luigi Pecora, the Treasurer. The organising committee had left no stone unturned to make the session brilliant, attractive

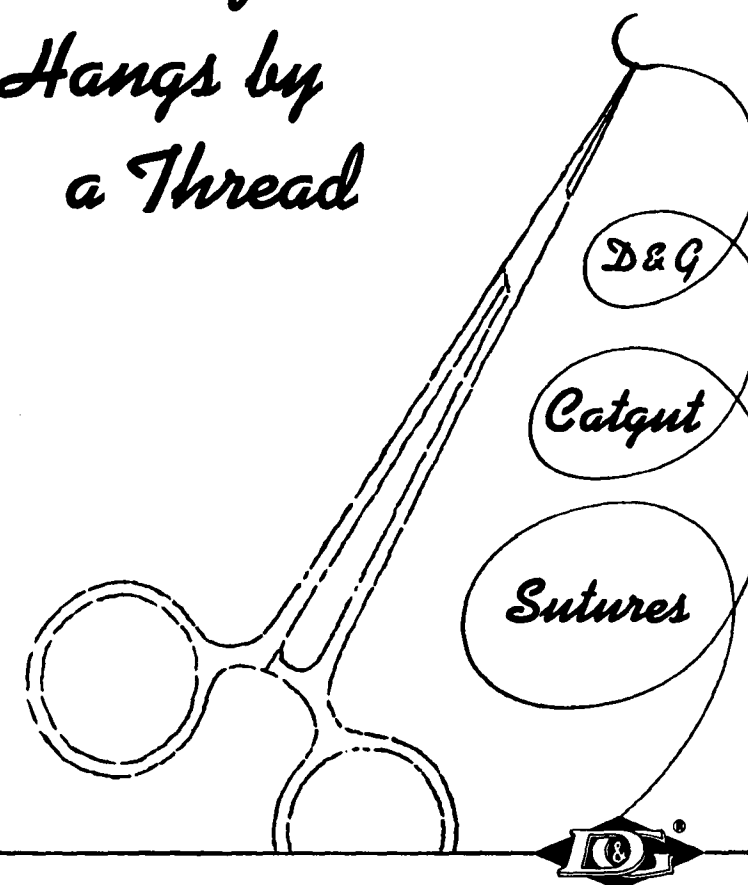


Maschio Angioino.

and pleasant. The delegates were accommodated in comfortable hotels—the wives of the delegates were offered dainty presents. The delegates and their wives were given free tickets for the full week to travel in the city buses and trams as often as they liked. It clearly showed the forethought of the organising committee, down to the minutest detail, which was greatly appreciated by all. It also demonstrated the kind and sympathetic attitude of the City Fathers in granting this civic amenity to their foreign guests. The people in Naples were not only sympathetic but enthusiastic, and greeted us in trams and buses, and in the streets with a smile, "Oh you are a doctor and come to the Medical Congress"!

The Congress was arranged in that great mediaeval castle of the Anjous, "Maschio Angioino". The main conference was held at the historic hall of the barons, "Sala dei Baroni". A number of scientific meetings was held in a different wing of the castle which now houses the University Naval Institute. The Mayor of Naples entertained the delegates and their wives at a

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MICROSCOPIC EXAMINATION

The Lungs : Section taken through the sub pleural yellowish nodule shows acute catarrh or a terminal bronchiole containing fibrin and leucocytes. Near and partially surrounding is a consolidated patch infiltrated essentially with polymorphonuclears and macrophages. The surrounding alveoli are huddled together in a state of collapse while there is moderate emphysema around. There is uniform congestion of the alveolar walls.

The Umbilicus : Shows large stellate fibro-blasts whose processes fuse with those of neighbouring cells. Chronic suppurative inflammatory cell are seen in the deeper dermis. The umbilical artery shows a recent thrombus consisting of fibrin, R. B. C., and leucocytes obliterating the lumen.

The Liver : Shows intense engorgement with blood with marked degree of necrosis and atrophy of the liver parenchyma. The hepatic artery shows a thrombus almost occluding the lumen but with slight retraction. (Fig. 2).

Comment : In the case noted here, the primary cause was neonatal omphalitis, leading to arteritis and thrombosis of the vessels mentioned above with the various embolic phenomena.

In the days bygone one was familiar with umbilical sepsis occurring in the new born giving rise to septicæmia, bacteræmia with distinct pyogenic inflammation or thrombophlebitis of the portal vein, liver suppuration and a fatal jaundice.

Peripheral gangrene occurring as a result of arterial thrombosis has no doubt given rise to an opportunity to revise the foetal circulation. Following the ligation of the umbilical cord the umbilical or the hypogastric arteries become thrombosed usually from the point at which they give off their last branches, namely the superior vesical arteries to the umbilicus and later converted into lateral umbilical folds of the peritoneum.

When a baby is born, the stump of the cord is the only part of the body that is not covered by the epithelium and therefore it is a site readily accessible to infection. The polysaccharide, hyaluronic acid

has been known to be found in the umbilical cord. What part the hyaluronic acid (in the cord) could have played in resisting the infection is perhaps the resultant apparently healed umbilicus.

The umbilical artery has a quite a typical special structure being lined with a single endothelial lining devoid of an internal elastic layer. It is only after birth even in the aorta the number and thickness of the elastic fibres increase. With these data in mind, it is reasonable to assume that at the dawn of life, the movement of the blood in the feebly elastic arteries caused by the beating of the heart is rhythmically interrupted—with regular flow through the branches.

A Sub-clinical neonatal omphalitis may pass unnoticed locally (because of the protection afforded by hyaluronic acid). The infection causes arteritis damaging the endothelial lining and thus initiating septic arterial thrombosis. At the beginning of life, as the heart beats, the irregular waves through the arterial system facilitates spread of thrombosis and infection, the embolic phenomena being secondary effects. The antibiotics have played their role in preventing suppuration of the lesions. It is wondered whether the above inferences would be acceptable.

It is not out of place to remark that the care of the umbilical cord is important to the well being of the child and mild local infection may pass unnoticed as in the above instance. Pyogenic infection may come to light clinically in the distal organs in a variety of ways.

References :

(1) Learmouth et al (1944): Edinburgh Medical Journal. 51:1.
(2) Levin and Mc. Elroy (1944): British Journal of Surgery. 31:340.

Of course no mention could be made of the liver without recalling Neal O'Hara's famous health column of other years. When one inquiry came in to Neal, "Where is the liver located?" O'Hara gave the classic answer: "Usually in the center of the platter between the mashed potatoes and the onions."

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A CASE REPORT

ABNORMAL LABOUR - SERIOUSLY COMPLICATED

By Dr. S. RAMANATHAN, L. M. P.,

Kalyani Clinic, Vadugapalayam, Palladam. (P.O.) (South India).

I was requested to attend upon a tenth para of about 35 years, at 9-30 A.M. on 25-4-'55 with a story, that she delivered a child at 5 A.M., that the placenta remained undelivered till then, that the size of her Abdomen appeared the same as before, and that they suspected the presence of another child. The patient, 5 miles away, was reached by 10 A.M.

Examination:—Her pulse was weak and rapid with increased frequency of respiration. Uterine contractions were absent, but the patient complained of extreme abdominal pain. No foetal heart could be heard. External hæmorrhage per Vaginam did not appear abnormal than could be considered usual, as a result of the delivery of one child.

On Vaginal examination membranes were found ruptured and the presenting part was fixed. It was a compound presentation of a hand with the head (It was possible to feel only the tips of the fingers). Hence, the general picture on the whole, was rather not very satisfactory, appearing as one of shock or hæmorrhage or a combination of either.

One thing appeared certain, that it was a case of obstructed and arrested delivery and that labour had come to a stand still. The conditions present therefore, were peculiar and complicated, namely, that it was a case of twins, that the second foetus remained undelivered with a compound presentation of a hand and head and devoid of Uterine contractions, that the condition of the

patient, a tenth para, long in labour, exhibiting signs and symptoms of a severe shock or hæmorrhage or both, and her unfortunate presence in a remote village, where, assistance of a co-practitioner or blood transfusion facilities could not be had.

The decision of adopting the correct line of treatment under the conditions was really a complex one. I, however, decided in favour of an immediate delivery by the application of Forceps for the fulfilment of which necessary indications also existed.

The patient was got ready for the operation after effecting necessary precautions regarding sterilisation etc. Extreme care was taken to apply the Forceps that the prolapsed hand was not included between the blade and the foetal head. A dead male child was delivered.

This was not the end of the troubles, as the third stage gave more anxieties. A reasonable time was allowed for the Urtrus to expel the Placenta, but it failed. In the mean-while, and as a precaution against P. P. H. injections Methergen, Ergometrine and Cal. Gluconate



Child in front—deceased.
Child behind—living.

were given. Compression and gentle massage having failed, manual removal of Placenta was resorted to and during this procedure it was possible to detect a rupture of the lower uterine segment.

The rent was small and uncomplicated and probably of gradual occurrence as a result of the strain of an

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unduly prolonged and obstructed second labour on an exhausted uterus. It took one hour to accomplish these delivery of the second foetus by Forceps and manual removal of the Placenta.

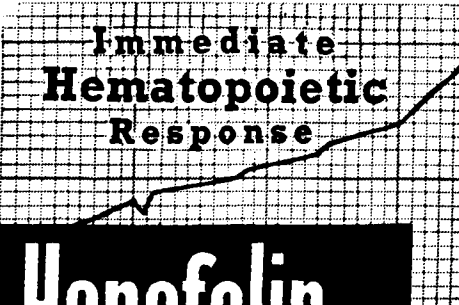
By now, the symptoms of a marked collapse due excessive loss of blood became very characteristic. Pulse was feeble and the respirations got hurried. The temperature became sub-normal with profuse sweating. She was given plentiful Saline and Glucose intravenously (the only available items with me then). In spite of these the patient gradually became more and more restless and dyspnoeac, the pulse was imperceptible and finally she became comotose. After a short while, she passed away, leaving her first born male as her only survivor.

The abnormalities and complications present could be summed up as follows :—

1. Twins (Multiple pregnancy).
2. Multiple presentation (Head and hand).
3. Prolonged and obstructed labour.
4. Absence of uterine contractions.
5. Delivery by Forceps (Second foetus).
6. Retention of Placenta and it's manual removal.
7. Rupture of Uterus (A gravest and most dreadful accident in the whole range of obstetrics).

The case is presented not because the abnormalities and complications are either new or unfamiliar. But a combination of the multiple abnormalities and complications enumerated above, occurring in an unfortunate tenth para, at a private residence, under such extraordinary circumstances, should certainly be considered very uncommon and extremely rare. It will add to the interest of our readers to know that this is the only living child of this tenth para.

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"B. C. G." as a Method of Immunisation against Tuberculosis

By DR. J. P. KARAN, M.B., B.S. (Patna), D.T.D.

Epidemiologist, Tuberculosis Demonstration & Training Centre, Patna.

EVOLUTION OF B. C. G.

ATTEMPTS to produce an ideal and successful method of immunisation against Tuberculosis have long been unsuccessful. Vaccine with dead tubercle bacilli or their products, unlike many others, proved of no avail. In the first year of the twentieth century, Calmette began the study with the bovine strain of the bacilli and in 1908 Calmette & Guérin announced that a particular virulent bovine strain grown on potato and ox bile had gradually decreased in virulence and in 1920 after some 213 subcultures the phenomenal observation was made that the organisms attained a stage known as '*virus fixe*' when it was incapable of producing progressive lesion of Tuberculosis and reversal to virulent form was considered almost remote. After much experimentation on animals, the vaccine was given to man, at first orally to infants by Wiel-Halle in 1922. In 1924 it was administered subcutaneously to infants by the same worker. In 1928 Hiembeck started immunisation of nurses in Norway by subcutaneous injections of B. C. G. But in its very infancy B. C. G. programme received a vehement opposition from Petroff in 1928 who believed in reversal phenomena. It received a death blow from the Lubeck Catastrophe in 1930 when 70 children died after B. C. G. inoculation. Later, however, it was proved beyond doubt that the disaster was due to contamination of the B. C. G. vaccine with virulent human type of organism through the carelessness in its manufacture. The Scandinavian workers, however pursued with B. C. G. and conclusively proved its harmlessness on the one hand and usefulness on the other. Later on, Americans took up B. C. G. for its critical analysis and the work of Aronson & Palmer (1946) is monumental which substantiates the Scandinavian claim.

The United Kingdom and many other European countries adopted the procedure, some

FROM its inception Sandoz has concentrated on the development of drugs from medicinal vegetable sources, making available their active principles in pure chemical and therapeutically standardised form. However, synthetic studies have not been neglected. The Sandoz Pharmaceutical Laboratories have contributed extensively to the knowledge of the autonomic nervous system, medicinal vegetable plants (ergot alkaloids, cardioactive glycosides, senna glycosides, etc.) and synthetic preparations (anti-convulsants, hypnotics, etc.).

ERGOT ALKALOIDS	Sandoz, a pioneer in the study of ergot of rye, first isolated ergotamine (Gynergen). Work in their Pharmacological Laboratories made possible its use not only in obstetrics and gynaecology, but also in disturbances of the sympathetic nervous system. Further important progress was made by partial synthesis of known and new ergot alkaloids.
CARDIAC GLYCOSIDES	Sandoz clarified the structure and relationship of various cardioactive glycosides and made available their pure, unaltered forms. Thus from Squill, Digitalis lanata and purpurea, and Strophanthus kombe, such important drugs as Scillaren, Cedilanid, Digilanid and Strophosid were obtained.
CALCIUM-SANDOZ	The exceptional tolerance of human tissue to calcium-gluconate was discovered in the Sandoz laboratories in 1926, thereby revolutionizing calcium therapy. Later a much more soluble double salt, calcium-glucono-galacto-gluconate was synthesised, making possible the production of highly concentrated ampoule solutions without the addition of stabilisers.

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