

The physicians always direct the patients to take barley, sago, etc., which they are not accustomed to take. They never think whether the patients have any objection to take it; we find most of the patients rejects it and remains in starvation. Is there any food which can be replaced for them? This can be answered in the affirmative.

Sago, barley, and arrowroot which we find in the bazar are not fresh and they are mostly adulterated. They are always mixed with unwholesome substances. The artificial foods which are found in the market are very costly and not suitable for our poor country.

The rice is the staple food of the Indians—specially of the Bengalee. Rice gruel can be placed in spite of barley, sago, etc., and can be used without hesitation. Sago, barley, etc., are not wholesome and have no nutrient value. Rice is nourishing, cooling, and easily digestible than the sago, etc. The patients cannot object to take it but we force them to debar from it. This kind of practice will be remedied. The diet is the main medicine of the patients without which we cannot resort to medicines only. I always administer rice gruel in diarrhoea, dysentery, and fever patients but I find the result is very encouraging. The condition of the patients is found much improved and hankering for the diet is abolished. I request the medical authorities to introduce the rice gruel in place of sago and barley, etc., in the jail and other Government hospitals for an experiment. In Jail dysentery rice gruel will act as a medicine also. I can say if rice gruel is used in Jail dysentery the mortality of the jail patients will become less.

Rice gruel is to be prepared from the paddy of one or two years standing and can be used as sago or barley water flavoured with lemon juice and salt, sugar and milk.

In conclusion I beg to state that I am not the proper person to advertise the articles in the columns of your highly reputed *Indian Medical Gazette* and I request you to publish it if your honour think it proper.

BENI MADHAB DE, S.A.S.,

Phansidewah Dispensary,

Dl. Darjeeling.

ABDOMINAL WOUNDS ON THE BATTLEFIELD.

To the Editor of "THE INDIAN MEDICAL GAZETTE."

SIR,—Will you allow me space to protest in the strongest manner possible against the misleading article on the above subject quoted from the "Military Surgeon" in your August issue. At ordinary times the article might be passed over with silent contempt, but as the greatest war on record is now being waged, this must not be; lest some well meaning but impressionable subordinate may be led in to putting these pernicious principles into practice.

Put briefly the writer bases his conclusions on these premises.

(1). That the one danger of penetrating bullet wounds of the abdomen is due to general peritoneal infection from the escape of intestinal contents—"endogenic infection."

(2). That drainage effected with "a piece of bandage, clean linen handkerchief, shirt, etc., twisted into a wick of about 3 inches between the fingers" and pushed into the abdominal cavity after enlargement of this wound, if necessary, is an efficient preventative, "provided it be applied within an hour or two."

(3). That the asepsis of this drain, "desirable but impracticable" does not matter.

Premise No. 1, though partly true overlooks the following acts: (a). That in a considerable percentage of bullet wounds of the abdomen inflicted by high velocity bullets of small calibre, the intestines escape perforation entirely. (b) That if the intestine is perforated the contents do not necessarily escape in such quantity as to set up general peritonitis, and that small perforations may become shut off by adhesions, if the bowels are empty and kept at rest. (c) The danger of intra-abdominal hæmorrhage.

Premise (2) assumes that a twisted wick of cotton is an efficient drain, whereas any practical surgeon knows that it is more likely to act as a dam than a drain.

Premise (3) ignores the obvious fact that such a drain will inevitably act as a seton, and set up peritonitis, even in those cases in which perforation of the intestine has not occurred.

It is difficult to write with restraint of this cavalier regard of the bedrock principles of the aseptic treatment of bullet wounds, which put back the hands of the clock by decades. I do not think it is putting it too strongly in saying that the practice advocated by the writer is nothing short of *malpraxis* nowadays. Fortunately I am able to supply the antidote in the words of Inspector-General Delorme in a paper read before the Academy of Sciences at Paris recently. He summarizes the proper treatment as "absolute repose, refraining from prolonged transport, total abstinence

from food and drink for several days, nursing of the mouth, administration of opium and placing the patient in the half-sitting posture."

In other words the only permissible treatment of the subject of an abdominal bullet wound on the field of battle is, (1) to place him in a semi-recumbent position, (2) to apply the first field dressing, (3) to abstain from giving him any fluid to drink and to warn him of the dangerous consequences of drinking even water, and (4) to administer $\frac{1}{4}$ grain of morphia hypodermically. If abstinence from fluid is maintained for 5 or 6 hours, peritoneal adhesions have time to form and close a small perforation.

I am, yours faithfully,

E. A. R. NEWMAN,

LIEUTENANT-COLONEL, I.M.S.

October 5th, 1914.

THE RADICAL CURE OF HYDROCELE.

To the Editor of "THE INDIAN MEDICAL GAZETTE."

SIR,—Briefly there are three special features in the performance of this operation:—

I. The first and the foremost being the incision in the median raphe;

II. The second is the bringing together of the cut ends of the everted tunica vaginalis near the upper end of the Epididymis by a catgut stitch; and

III. The third is the washing out of the cavity with ether.

(1) Perchloride of mercury lotion (1 in 1,000);

(2) Carbolic lotion (1 in 20); or

(3) Pure sulphuric ether 20 minims.

The chief advantages of—

I. are:—

(1) The manipulation of both sacs by this single incision in the case of a double Hydrocele. This means saving of time which is a great desideratum both in the interest of the patient and the surgeon. In the case of a single Hydrocele, the same incision does not entail any greater expenditure of time than the one in vogue.

(2) Less bleeding as the area operated upon lies in the middle line of the body and hence fewer and smaller blood vessels are cut.

(3) Less pain—as for the same reasons, fewer and smaller nerve filaments are divided.

(4) Cheaper, for obvious reasons.

II. The chances of the everted tunica vaginalis becoming reinverted are absolutely nil.

III.—(1.) Sepsis almost altogether obviated. I personally prefer the pouring in of 20 minims of pure sulphuric ether after washing out the sac with 1 in 1,000 perchloride solution. (2.) Adhesion of the endothelial layer of the visceral tunica vaginalis to the inner surface of the infundibuliform fascia thus aiding II.

My only plea for putting this small article in this paper of wide circulation is the possibility of my fellow brethren in profession being benefited by this change of procedure in this special operation which ranks next to cataract operations in number and importance at any rate in this Province. I might add that so far as I have read the literature on this special subject I have not found it mentioned anywhere nor have I seen any surgeon performing this special operation in this special way, although I have worked with many surgeons.

Yours, etc.,

GORAKHPUR.

E. MILLICAUS KHAN, M.B. (Pudj.).

RADICAL CURE OF HERNIA.

To the Editor of "THE INDIAN MEDICAL GAZETTE."

SIR,—I read with great interest the interesting paper of Lt. Col. Newman, under the above heading, read before the medical section of the Asiatic Society of Bengal and published in your valuable journal of August 1914. Perhaps it may be of interest to him to know that I have myself performed a similar operation which he describes as a new method, for the past 9 years both at the Colombo General Hospital and at the Victoria Hospital, Bangalore. The only difference in technique between his method and mine is that he fixes the neck of the sac to the abdominal wall but I simply drop it into the abdominal cavity as in Bassini's. But in the main, from the incision down to the final closing of the wound my procedure has been very much alike.

I too divide the aponeurosis of the external oblique to the full extent of the skin incision, as this gives ample space to work on, and also in the case of strangulated hernia, the reduction is rendered very easy. Besides if the

aponeurosis of the external oblique is not divided, it is impossible to unite the conjoined tendon to the Poupart's ligament I only use a scalpel for it.

I always make it a point to separate the sac as far as its neck. This is very important. I have never found it so easy as to separate the tissues of the cord off the sac with a gauze swab. I have to use a pair of dissecting forceps for the purpose. When the sac is separated, it is opened at its distal end and the contents examined. The distal end is then caught in a pair of Spencer Wells' forceps and twisted until it forms a thick cord. The neck of this cord is transfixed by an aneurysm needle, as close to the abdominal wall as possible, and ligatured with a stout silk ligature, in two halves, each half being made to interlock the other, to prevent slipping of the ligature, and the sac excised beyond the ligature.

With regard to the repair of the abdominal wall, I am of the same opinion as Newman, that no operation for the radical cure of an inguinal hernia is complete without it. I am fully aware that opinion is divided on this point. Some surgeons are of opinion that a hernia is always caused by the persistence of a peritoneal diverticulum, in this case the processus vaginalis. Whatever may be the original cause of a hernia, one cannot deny the abdominal wall in the region of the hernia is rendered weak by the disturbance of the normal relations of the structures joining the inguinal canal. If one should examine the bottom of the abdominal wound after excision of the sac, he would not fail to notice a large gap bounded above by the conjoined tendon and below by the Poupart's ligament and the floor by this space joined by the fascia transversalis, superperitoneal fatty tissue, and the peritoneum. Now if we leave this space unprotected what guarantee is there that this may not form a weak spot for a direct hernia in the near future. Therefore, I always make it a point to unite the conjoined tendon to the Poupart's ligament, with 3 or 4 meters silk sutures of medium thickness as this is the only possible way to close this gap in the abdominal wall. I prefer silk, as this material can be easily sterilized by boiling and as it is not quickly absorbed. Some surgeons think that a muscle and a tendon can hardly unite with each other, and, therefore, they omit this part of the technique. But my experience has convinced me that union does take place sufficient to prevent the formation of a hernia, if no septic injection of the wound takes place.

With regard to the spermatic cord, there is no special advantage, to my mind, in placing it over the conjoined tendon as in Bassini's operation. I find it easy to unite the conjoined tendon and the Poupart's ligament over the cord, leaving just enough space at the external ring to prevent any undue pressure on it. The thigh is always placed to rely the parts before the sutures are tied.

I have now performed more than 200 operations for the radical cure of inguinal hernia according to this method and the results have been very gratifying.

Yours, etc.,

H. H. MYLVAGANAM, F.R.C.S. (ENG.),
Surgeon to Victoria Hospital, Bangalore.

THERAPEUTIC NOTICES.

The Proprietors of HORLICK'S MALTED MILK (Messrs. D. J. Keymer & Co., London) ask us to draw attention to the fact that there is no increase, owing to the war, in the price of this excellent food-drink, which is much used in the tropics.

We have been asked to republish this letter, which appeared in *The Lancet* and in *B. M. J.*

"A SWISS FIRM.

To the Editor of "THE LANCET."

SIR,—An impression appears to prevail in some quarters that we are a German house, and as such are no longer able to supply Roche Products. Both impressions are quite erroneous, the first, no doubt, being due to the fact that we have laboratories and works in Grenzach (Baden). Our head offices and laboratories are, however, at Basle (Switzerland), where we have been established for many years.

With regard to the second point, we are taking steps to announce the fact that we have large reserve stocks, and not only anticipate no difficulty in filling orders, but, furthermore, do not propose to increase the prices.

We are, Sir, yours faithfully,

THE HOFFMANN-LA ROCHE CHEMICAL
WORKS, LTD."

10, LANE, E.C., Sept. 2nd, 1914.

Service Notes.

CIVIL DEPARTMENT, PUNJAB.

The following officers of the Civil Department of the Punjab have reverted to military duty:—

Lt.-Col. R. Heard, I.M.S., Professor of Midwifery, Medical College, Lahore.

Major D. H. F. Cowin, I.M.S., Medical Adviser, Patiala State.

Major J. G. G. Swan, I.M.S., offg. Civil Surgeon, Rawalpindi.

Major S. H. Lee Abbott, I.M.S., offg. Civil Surgeon, Multan.

Major H. Hallilay, I.M.S., Civil Surgeon, Lyallpur.

Major R. A. Needham, I.M.S., Health Officer, Simla.

Captain A. K. Laudie, Civil Surgeon, Dera Gazi Khan.

Major W. W. Jeurwine, offg. Civil Surgeon, Ferozepur.

Major H. C. Keates, I.M.S., offg. Civil Surgeon, Multan.

Captain R. T. Wells, offg. Civil Surgeon, Jhelum.

Captain N. M. Wilson, offg. Civil Surgeon in the Punjab.

Captain G. S. Husband, I.M.S., offg. Superintendent, Central Jail, Multan.

On recall from leave the following officers were posted as follows:—

1. Lt.-Col. A. Coleman, I.M.S., to be Civil Surgeon of Rawalpindi.

2. Lt.-Col. E. V. Hugo, I.M.S., to his substantive appointment as Professor of Surgery, Lahore Medical College.

3. Lt.-Col. S. Browning Smith, I.M.S., to be officiating Sanitary Commissioner, Punjab.

4. Lt.-Col. R. Heard, I.M.S., to his substantive appointment as Professor of Midwifery, Lahore Medical College.

5. Major W. C. H. Forster, I.M.S., to his substantive appointment as Professor of Pathology, Lahore Medical College.

6. Major S. H. Lee Abbott, I.M.S., to be Civil Surgeon, Multan.

7. Major R. M. Dalziel, I.M.S., to his substantive appointment as Superintendent, Central Jail, Multan.

8. Captain W. T. Finlayson, I.M.S., to his substantive appointment as Superintendent, Borstal Central and Female Jails, Lahore.

The following officers of the Plague Department in the Punjab have reverted to military duty in connexion with the war:—

Major C. E. Southon, I.M.S.

Major J. Woods, I.M.S.

Captain K. Shumsher Singh, I.M.S.

Captain P. S. Mills, I.M.S.

SANITARY DEPARTMENT.

Lt.-Col. S. Browning Smith, I.M.S., on recall from leave, was appointed officiating Sanitary Commissioner, Punjab, vice Major E. L. Perry, I.M.S., who has reverted to military duty.

Major H. M. H. Melhuish, I.M.S., on transfer to military duty, was relieved by Major H. M. Mackenzie, I.M.S.

SURGEON-GENERAL TOM GRAINGER, C.B., I.M.S., gets the good service pension of £100 per annum, vacated by Col. Neil Campbell, C.B., C.I.E., retired; and Surgeon-General G. F. A. Harris, C.S.I., F.R.C.P., gets the good service pension vacated by Surgeon-General A. M. Crofts, C.I.E., retired in May last. Both these good service pensions will cease on the holder's retirement, as both officers will then have earned the extra pension of a Surgeon-General (v. Seton and Gould's Manual, I.M.G., page 120).

DR. WALTER ACTON, of West End, near Southampton, a Crimean Veteran, died there on 8th August 1914. He was born at Ludlow in 1826, educated at University College, London, and took the M. R. C. S. and L. S. A. in 1850. He served as a temporary Assistant Surgeon during the Crimean war, holding the post of Staff Surgeon to the Osmanli Cavalry for two years. After the war was over he practised for a short time at Stilton, and afterwards at Newcastle-under-Tyne. He retired from practice in 1887, and since 1893 had lived at West End.

LIEUTENANT-COLONEL DANIEL FRANCIS BARRY, Bengal Medical Service, retired, died on 13th July 1914. He was born on 27th January 1855, educated at Queen's College, Cork, took the M.D., M.Ch., and L.M. of the long defunct Queen's University in Ireland in 1877, and entered the I.M.S. as Surgeon on 30th September 1878. He became Sur-