

replaced by the collapsed fibrous sac consisting of a prostatic sheath of pelvic fascia communicating with the neck of the bladder above and membranous urethra below. This passage is later on lined by mucous membrane growing above from the neck of the bladder and below from the membranous urethra.

The severe cases were those in which the temperature continued very high causing delirium and prostration or were complicated by an underlying lung condition, e.g., pleuro-pneumonia or broncho-pneumonia.

It is in these cases that the drug (iodine) used intravenously has proved so beneficial in our

No.	Name, nationality and age.	Occupation.	Prominent symptoms and duration.	Date of operation.	Special points about operation.	Course and treatment.	Date of taking out drainage tube.	Date of passing urine by urethra.	Date of discharge.
1	Mg. Po Thar, Burmese male, aged 60.	Cultivator.	Burning urine. One year.	13-3-25.	Phosphatic stone and enucleation prostate.	Severe Haemorrhage (20th-23rd), checked by calcium lactate injections and orally and careful washing.	20-3-25.	3-4-25.	16-4-25.
2	U. Thi Ka, Burmese male, aged 70.	"	Frequency of micturition. 22 days.	17-5-25.	Enucleation..	....	22-5-25.	12-6-25.	29-6-25.
3	Mg. Htaw, Burmese male, aged 73.	"	Retention of urine 3 days with dribbling. Two previous admissions into hospital. Had auto-toxæmia.	3-6-25.	Enucleation..	....	8-6-25.	25-6-25.	Still in hospital.
4	Mg. Po Han, Burmese male, aged 58.	"	Frequent micturition with straining and burning. Total 1 year. Bad 15 days.	11-6-25.	Enucleation. Comparatively small prostate, middle lobe very prominent, bigger than a marble.	....	16-6-25.	17-6-25.	"
5	Phongyi U. Thamingala, Burmese male, aged 75.	"	Retention of urine 5 days. Attended outpatient department 3 days. Drawn a lot of bloody, offensive urine.	20-6-25.	Very big indeed. Enucleation.	....	25-6-25.	..	"

A NOTE ON THE VALUE OF IODINE INTRAVENOUSLY IN THE TREATMENT OF INFLUENZA.

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DURING the month of June 1925, there occurred at this Jail an epidemic of influenza resulting in the admission of 66 cases to hospital within a short period. All the cases were of the typical acute catarrhal variety (respiratory type) of the disease. Twelve cases were complicated by lung conditions, pleuro-pneumonia or broncho-pneumonia. There were no deaths.

My attention having been drawn to the value of iodine intravenously in septic conditions, the method was given a trial in the very severe cases when the usual remedies, e.g., sodium salicylate, cinchona, etc., had little or no effect.

hands. In fact we have been struck by the marked improvement in the general condition of such patients. Within 24 hours of the injection most of the patients passed from a condition of anxiety and distress into one of comparative comfort.

There is no danger attached to the method if the usual precautions are taken. The formula used was that of Dr. Chaudhuri as advocated by him in the *Indian Medical Gazette* for February, 1925, but instead of 3 to 6 minims as a dose, 20 minims were given in 10 c.c. of saline as the initial injection. If the temperature and general condition do not improve a second injection of 40 minims diluted to 10 c.c. of saline is administered generally within 48 hours.

In our series most of the cases were greatly benefited by one injection. Some of the more serious cases required a second and even a third

injection, while one case—the most serious of all that we had—received five injections:

Formula:—

Iodum	.. 1 drm.
Pot. Iodide	.. 1 drm.
Aq. distillata	.. 5 ozs. 2 drms.

The iodine is dissolved in the solution of potassium iodide in distilled water, previously prepared.

Roughly, 20 minims of the above solution contains $\frac{1}{2}$ grain of iodine.

Initial dose. 20 minims ($\frac{1}{2}$ grain iodine).

Second and subsequent doses. 40 minims (1 grain iodine).

THE MOSQUITO FACTOR IN THE MALARIA OF ASSAM TEA GARDENS..

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INTRODUCTION.

THE main object in here reproducing this paper which was read before the Assam Branch of the British Medical Association at its Jorhat Meeting on March 2nd, 1925, is to publish it with the illustrations which were given by lantern and to correct a few minor misapprehensions thereanent which have arisen.

The subject was the conclusions arrived at from a mosquito malaria survey of the tea gardens of Assam which the Endowment Fund of the School of Tropical Medicine was enabled to finance by the generous help of the Indian Tea Association. Further study of the detailed observations which have only recently been concluded may of course oblige us to modify the opinions expressed here, but in the meantime they are submitted for "necessary action."

I wish to repeat here that I owe a great deal to Lieutenant-Colonel J. W. D. Megaw, I.M.S., Director of the School of Tropical Medicine, for his sympathetic administration of the work undertaken, and to the officers and members of the Indian Tea Association for their help in every way. The work would have been impossible had it not been for the acceptance of the spirit of the scheme by the Medical Officers of the tea estates, for they placed all information at my disposal and every possible facility for collecting the data which I required.

THE ADVANTAGES OF A SURVEY.

While a malaria-prevention campaign without a previous survey can indeed be carried out by employing certain measures which are of general application, a survey has three advantages, enabling one to (1) find out if a healthy site be available; (2) localise the area in which prophylactic measures should be taken; and (3) choose the most appropriate measures to deal with the situation. The last item is very important because some anti-malarial methods not

being of general application might, if tried without knowing what situation is being dealt with, cause worse trouble. Take for instance, open earth-drainage; one drains a swamp and eradicates the species *umbrosus*, one drains another and introduces *maculatus* or *funestus*. In this connection Boyd says "all anopheline mosquitos are not carriers of the malaria parasites, and gross variations with regard to breeding habits are found among the different species of anophelines. Thus, it often happens that in a mosquito-infected district where malaria is occurring, only a small portion of the total mosquitos are of the carrier type, and these may have quite specialised breeding habits, so that general measures of mosquito destruction might miss them altogether. The first essential in any district is, therefore, to make a critical survey to ascertain what mosquitos are carrying the parasite and what their breeding habits are; after which, if feasible, steps specifically directed against the carrier species may be undertaken. To illustrate the diversity of breeding habits the following instances may be quoted:—*Anopheles maculipennis*, a well-known carrier, breeds chiefly in swamps and marshes and does not breed in running water, so that it can be attacked by draining the swamp. Conversely, *A. maculatus*, which gave rise to much trouble in the Federated Malay States, breeds in running water. Other things being equal, therefore, draining by open drains (the usual method) would not abolish but rather encourage the breeding of this species. Yet another, *A. stephensi*, is almost exclusively a well-breeder and can only be countered by screening or oiling the responsible wells. It can thus be seen that haphazard measures are almost bound to involve a waste of time and money, and may even render the last state of affairs worse than the first by taking away conditions under which harmless mosquitos were breeding and replacing them by others suitable to the propagation of carrier species" (1924).

On the same subject Sir Ronald Ross at a meeting of the Royal Society of Tropical Medicine (1924) stated how different species of mosquitos must be dealt with in different ways. He said "We must deal with each species on its merits"; to which dictum Major Austin agreed, and Dr. Balfour and Major Austin both were of the opinion that it was necessary to make careful biological investigations before starting upon any anti-malarial campaign. Watson (1924) in this connection said, "Let me candidly admit that for some years we cleaned up the ravines in our hill-land in Malaya making the malaria worse. We had to adopt an entirely different method. Let me remind you too that in 1901 when the Federated Malay States Government gave me the money to clean up Klang, Dr. Braddon applied for money to clean Seremban, a town on the main range. Presumably he would have felled jungle and "trained" streams, and would have caused a big outburst of malaria in, at that time, a healthy