

The deaths from diseases of the respiratory system numbered 10,056 being 954 more than in 1933 and 405 less than the average of the last ten years 1924 to 1933.

Tuberculosis accounted for 1,856 deaths as against 1,594 in 1933 and 1,576 the average for the preceding decennium 1924 to 1933.

One hundred and one deaths were due to malaria, being 30 more than in 1933 and 204 less than the average of the last decennium (1924 to 1933). There were 1,397 deaths from ague and remittent fever as against 1,192 in 1933. The average number of deaths for the last ten years (1924 to 1933) from malaria was 305 and from ague and remittent fever 1,697.

The deaths among infants under one year of age numbered 8,253 against 8,320 in 1933 and 7,564 the average for the last ten years (1924 to 1933). The rate of infant deaths per 1,000 births registered was 245.

Compared with the decennial averages (1924 to 1933) the total number of deaths shows a decrease of 1,322, the principal decrease in the mortality being 19 deaths under cholera, 96 under plague, 803 under smallpox, 204 under malaria, 300 under ague and remittent fever, 836 under diarrhoea, enteritis and dysentery and 405 under diseases of the respiratory system. On the other hand there was an increase of 46 deaths under measles, 30 under influenza, 68 under enteric fever, and 280 under tuberculosis.

[The above summary shows that the acute infectious diseases are being successfully controlled and to some extent overcome, but the increase in deaths from tuberculosis should be a matter of great concern to the municipal authorities.]

#### ANNUAL REPORT OF THE MALARIA ADVISORY BOARD, FEDERATED MALAY STATES, KUALA LUMPUR, FOR THE YEAR 1934. By A. NEAVE KINGSBURY, CHAIRMAN

THIS report does not lend itself to abstraction nor are the records of the work of this board likely to interest the majority of our readers, nevertheless it is of value as a demonstration of the importance of co-operation between all sections of a community in attacking the many problems of malaria control. It should be read in the original by all malaria control officers.

## Correspondence

### INTRA-UTERINE MALARIAL INFECTION

To the Editor, THE INDIAN MEDICAL GAZETTE

SIR,—With reference to our report on the use of atebirin in malaria sent to you for publication in the *Indian Medical Gazette*, we would like to report an interesting case recently treated, details of which we annex below.

A lady in an out-station in her seventh month of pregnancy had several attacks of malaria and was treated by the local doctor. She had about eighteen attacks of fever and in desperation was brought to this town for treatment by us with atebirin, as nothing seemed to do her good. She was promptly given two injections of atebirin dihydrochloride on two successive days. She had no fever after the second injection, but was given oral treatment of two atebirin tablets daily for five days. She remained free of fever even during her puerperium, which took place at term.

The child was a weakling and weighed five pounds at birth. When the infant was twelve days old she developed a temperature which recurred on the thirteenth and fourteenth days. One of us was then sent for and took a blood film in which we found a heavy malarial infection—mixed benign and malignant tertian; benign tertian gametocytes were present. While the film was being examined a message was

received that the child was sinking and that it would not be necessary for the doctor to go back to give the child an injection. On arrival there we found the child in a very low condition with bluish lips, and more or less unconscious and unable to swallow. The pulse was feeble and very rapid. After stimulation with camphor and ether, an injection of atebirin dihydrochloride—half tablet—was given. The next morning the child seemed much better, was taking the breast and was more lively. A second injection of the same strength was given and the temperature dropped to below normal and the improvement was maintained. This was followed by per-oral treatment with atebirin and equinine powders, and to-day the child is putting on weight and gaining strength, and is quite lively.

The infection in this case must have been through the maternal blood, while the child was *in utero*.

Yours, etc.,

A. E. SPAAR, F.R.C.S.E.

KANDY,  
15th October, 1935.

### EPIDEMIC DROPSY

To the Editor, THE INDIAN MEDICAL GAZETTE

SIR,—I shall be very much obliged if you will kindly enlighten me on the following points. The September issue of the *Indian Medical Gazette* contains a number of articles on 'Epidemic Dropsy'—the burning question of the day—even in the remotest villages.

The treatment indicated is tincture ephedra vulgaris for the heart, which is analogous to the action of adrenalin and so will accelerate the heart. What should be done in the following case of epidemic dropsy?

- (1) Patient, aged 7 years; history of beri-beri—three months.
- (2) Sudden dilatation of the heart—apex beat diffuse and 1 inch lateral to the nipple line.
- (3) Pulse 170 and respiration 70 per minute.
- (4) Hæmoglobin—45 per cent. The patient suffering extremely from dyspnoea—apparently cardiac in origin.
- (5) Temperature—101° F.

#### Questions

- (1) Whether tincture ephedra should be given or not—if so in what dose?
- (2) Whether digitalin, cardiazol, adrenalin (accelerator) should be given in such cases?
- (3) What about giving 'coramine'?
- (4) If digitalin, digifortis, digistan (B. C. P. W.) produce no action, what is to be done?
- (5) Whether blood letting should be done in anæmic cases like this?
- (6) Is Vity's (B. C. P. W.) to be given?

I shall be very much obliged if you will kindly give me detailed advice on these points.

Yours, etc.,

S. P. ROY CHAUDHURY, M.B. (Cal.).

PALANG,  
24th September, 1935.

[Note.—Sudden dilatation of the heart after an attack of epidemic dropsy for three months is obviously a grave condition. Such an advanced case with organic cardiac changes should be treated as one of acute cardiac failure. Blood letting should be done when there are indications of great distension of the right chambers of the heart—as, for example, severe dyspnoea, cyanosis, engorgement of the veins of the neck and weak pulse. If venesection be not possible, application of leeches in the liver region is a good substitute. With a pulse rate of 170 it is advisable to give strophanthin gr. 1/500 intravenously followed by oral administration of digitalis or pandigal, although they are not so effective in these cases as in acute failure due to mitral valvular disease, e.g., auricular fibrillation. Cardiazol or camphor in ether and glucose are given also. Coramine can be tried, but it is more useful in cardio-respiratory

failure due to anaesthesia or poisoning. If the blood pressure be low—tincture ephedra ( $m\frac{v}{v}$  to  $m\frac{x}{x}$ , t.d.s., in a boy of 7 years) will help the process of circulation by counteracting the dilatation of capillaries that occurs even in the heart of epidemic dropsy cases.—EDITOR, I. M. G.]

## Service Notes

### APPOINTMENTS AND TRANSFERS

LIEUTENANT-COLONEL R. N. CHOPRA, C.I.E., Professor of Pharmacology and Officiating Director, School of Tropical Medicine, Calcutta, is appointed to officiate as Surgeon-General with the Government of Bengal, with effect from the 13th September, 1935, *vice* Major-General D. P. Goil, granted leave.

Lieutenant-Colonel J. Rodger, M.C., Civil Surgeon, Sibi and Loralai, is appointed to officiate as Residency Surgeon and Chief Medical Officer in Baluchistan, in addition to his own duties, with effect from the forenoon of the 14th September, 1935, and until further orders.

The services of Lieutenant-Colonel F. A. Barker, O.B.E., Officer on special duty in the Home Department, are replaced at the disposal of the Government of the Punjab, with effect from the 16th September, 1935.

Lieutenant-Colonel T. C. Boyd, on return from leave, is reappointed as Principal, Medical College, and Superintendent, Medical College Hospitals, Calcutta.

Lieutenant-Colonel B. H. Singh, Officiating Principal, Medical College, and Superintendent, Medical College Hospitals, Calcutta, on relief, is posted to Burdwan as Civil Surgeon, *vice* Rai Dr. J. N. Chatterji Bahadur.

Lieutenant-Colonel F. J. Anderson, on return from leave, is reappointed as Professor of Clinical Surgery, Medical College, Calcutta.

Lieutenant-Colonel P. F. Gow, on return from leave, is reappointed as Professor of Midwifery, Medical College, Calcutta.

Major A. D. Loganadan is appointed as Officer on special duty in the office of the Public Health Commissioner with the Government of India, with effect from the 9th September, 1935.

Major J. C. Drummond, Officiating Professor of Clinical Surgery, Medical College, Calcutta, on relief, is appointed as Civil Surgeon, Hooghly, *vice* Lieutenant-Colonel C. A. Godson.

Captain C. L. Pasricha, who was provisionally appointed Professor of Pathology and Bacteriology, School of Tropical Medicine, Calcutta, is confirmed in the appointment, with effect from 15th July, 1933.

Captain A. M. Sheridan is confirmed in civil employment under the Government of India, Department of Education, Health and Lands, with effect from the 1st September, 1935.

The probationary appointment of the undermentioned officer is confirmed:—

Captain G. P. Charlewood. Dated 28th September, 1935.

Captain F. H. A. L. Davidson made over executive charge of the Rajshahi Central Jail to Mr. Chas. A. W. Luke on the forenoon of the 1st October, 1935.

The services of Captain H. S. Waters are placed at the disposal of the Chief Commissioner, Delhi, for appointment as Civil Surgeon, New Delhi, with effect from the 16th October, 1935.

### TEMPORARY COMMISSIONS

#### To be Lieutenants

Bashier Hussain Sayed. Dated 17th June, 1935.

V. Sivasankaran. Dated 22nd June, 1935.

Jagdish Ram Vaid. Dated 24th June, 1935.

Kamarasu Narasimha Rao. Dated 1st July, 1935.

Bhagwan Singh Khurana. Dated 1st July, 1935.

### PROMOTIONS

#### Colonel to be Major-General

E. W. C. Bradfield, C.I.E., O.B.E., V.H.S. Dated 14th August, 1935.

#### Lieutenant-Colonel to be Colonel

N. S. Sodhi, M.C. Dated 12th August, 1935.

#### Majors to be Lieutenant-Colonels

S. Nag. Dated 10th September, 1935.

J. Rodger, M.C. Dated 18th September, 1935.

G. B. Hanna. Dated 30th September, 1935.

### RETIREMENTS

Major-General Sir R. McCarrison, Kt., C.I.E., K.H.F. Dated 19th August, 1935.

Major-General H. R. Nutt, K.H.S. Dated 14th August, 1935.

Colonel A. H. Proctor, D.S.O. Dated 21st August, 1935.

### RELINQUISHMENTS

#### Temporary Commissions

Dated 31st August, 1935

Captain A. M. Khan.

Captain P. P. Chowdry.

Dated 1st September, 1935

Captain H. K. Handoo.

Captain P. N. Sathe.

Dated 5th September, 1935

Captain D. N. Basu.

Dated 8th September, 1935

Captain H. S. Ahluwalia.

### RESIGNATION

Captain J. M. Mathew resigns his commission, 5th September, 1935.

## Notes

### INTRATRACHEAL INSUFFLATION APPARATUS

MESSRS. DOWN BROTHERS of London have made for us the apparatus necessary for intratracheal insufflation of an oxygen-carbon-dioxide mixture in the treatment of asphyxia neonatorum, as described in the *Lancet* of 30th March, 1935.

The direct vision pharyngoscope illustrated is a modification of Howarth's Chevalier Jackson's instrument which has been designed for use in the new-born infant. The speculum is 10 cm. long and its greatest outside diameter is 1.6 cm. The spatula is very short so that the soft palate does not obstruct the line of vision. The handle of the instrument is parallel to the speculum and joined to it by a shank 11 cm. long. This parallel handle gives better control than one set at a right angle to the speculum, and a shank of this length gives sufficient clearance between the handle and the chest wall during use. A wide infra-lateral slot runs the entire length of the speculum so that the pharyngoscope can easily be withdrawn without displacing the catheter when the latter has been introduced into the trachea. The illumination is by a lamp situated at the distal end, and the current is supplied by a battery enclosed in a separate wooden box with a variable resistance. In practice this arrangement of having a large separate battery has been found to be very satisfactory, since a dry cell purchased eighteen months ago is still in use.

The catheter used is a Magill's silk-web endo-tracheal catheter with a funnel-shaped end. Sizes 3, 4 and 5 give a suitable range. The choice between these sizes is determined by the size of the infant.

The apparatus for delivering the oxygen-carbon-dioxide mixture (90 to 95 per cent oxygen and 5 to 10 per cent carbon dioxide) consists of a rubber bag of 3,000 c.c. capacity, fitted at one pole with an inlet tube