Correspondence.

"A TWENTY-ONE DAY FEVER."

To the Editor of THE INDIAN MEDICAL GAZETTE.

DEAR SIR,—More than twelve years since a peculiar sort of fever has been constantly noticed by me amongst Indian people, which almost exactly resembles the typhoid fever in its general symptoms, except certain peculiarities which I am going to mention here, with the ordinary course of the disease as is often seen by me.

I am obliged to send you an elaborate description of the fever because there is a wide tendency to regard this fever as malarial remittent, while quinine has not the least effect in cutting it short.

Onset.—Mostly gradual with typical rise of temperature, headache, tenderness all over the abdomen, and pain and gurgling on pressure on or about the right iliac fossa and particularly over the region of the cæcum.

In some cases the attack may be sudden with colic-like pain in the abdomen, shivering, a few thin burning motions and fever. Many patients would point out that the early motions were blackish in colour.

The abdomen is more or less tympanitic throughout the course of the disease.

TEMPERATURE.

First week.—Gradually rising daily while remaining above normal all the while until in

Second week.—Remaining constant about 102.5 degrees Fah. in the morning to 104 degrees Fah. in the evening.

Third week.—Getting remittent and even inter-mittent in the last 2 or 3 days, coming down to normal exactly after 21 days, in majority of uncomplicated cases.

There are two perceptible increases in the temperatures, *viz.*, at midday and midnight followed by sweating although the sweating in no way influences the course of fever in reducing it.

In mild cases the temperature has been noticed to come down on the 16th day, or even soon after the appearance of the rash, or otherwise prolonged beyond 21 days if complicated with diarrhœa or broncho-pneumonia.

Motions.—Diarrhœa occurs only in neglected cases or in adults. Otherwise constipation is the rule, especially in children, so much so, that the patient may not have passed a single motion for a week, and the hard masses of the fœcal matter may require to be removed by scooping.

In diarrhœa the stools are not so characteristic except that they are very foul smelling.

Eruption.—Diagnosis remaining uncertain between common malarial remittent and this type of fever, until the appearance of the rash. This is not that typical rose rash of our text-books, but it has the appearance of "Sudamina" minute, shining, distinct, uniform vesicles, quite pale in colour, that is, having not the slightest trace of redness around.

This rash invariably occurs between 9 and 13 days; and their favourite positions are lower part of the abdomen below the level of the umbilicus, upper part of the chest, and both sides of the neck. In extreme cases they have been occasionally seen on the back of hands and fingers.

They disappear in four to six days by indistinct desquamation. There is a "*ghee*" (clarified butter) like smell from the body during rash period in cases not complicated with diarrhœa.

As early as even the fifth day the practised eye can mark the change in colour of the hair roots (that is, they get whitish) at the lower abdomen, where the rash is to appear in future.

Again if the case is under treatment from the very beginning and if carefully observed, these minute vesicular rash appear earliest on the tongue between the 6th and 9th day, thus much before they are noticed on the skin.

Very often from the lower abdomen they spread down to the middle of the thighs. Females call this "descending," supposed to be a favourable hopeful sign.

Mental Condition.—In some cases of young children, delirium, unconsciousness and irritability of temper begin in the second week and may last for two weeks or even more. Diarrhœa is more common in cases attended with delirium.

Relapse.—This type of fever has relapses too. And if a relapse is likely to occur, the temperature again begins to rise after two or three days of normal condition. But the course of fever is this time much shorter, thus it may last 12—14 days only with, of course, appearance of the rash at the usual period, when usually the temperature falls.

In exceptional cases I have seen two relapses with twice re-appearance of rash.

One attack does not confer immunity, as the same individual may suffer from it next year too.

The spleen.—It is a noteworthy fact that in this fever spleen is quite an insignificant factor, as it is never seen enlarged or felt beyond the costal margin except in rare cases of relapses.

Age.—The disease is most common in boys and girls under 12 years; less common between 12 to 30; and rarely seen beyond 40 or under 1½ years of age.

Season.—Seen throughout the year, though much more numerous cases occurring in October November and March-April.

Complications and Sequelae.—Diarrhœa ; bronchitis in the second week in almost every case; broncho-pneumonia; synovitis of the knee joint during the course; otorrhœa; sloughing boils all over the body; deafness is often met with in severe cases.

Prognosis.—Always favourable thus bearing a marked contrast with the enteric fever of the text-books; in Indians it is least fatal, unless through exhaustion from diarrhœa or broncho-pneumonia.

Recovery is generally very rapid.

Treatment.—Internally full doses of quinine, or injections of quinine for days even, have not the slightest effect in cutting short the course of the disease.

My routine plan of treatment is, of course, chlorine mixture (Burney Yeo) with quinine suplh. gr ii. in each ounce; acetozone gr. x, per pint of boiled water as free antiseptic drink; salol and bismuth carb. for diarrhœa; tepid sponging in children whenever temperature 103 degrees or more.

Children disliking the taste of chlorine mixture could progress satisfactorily on acetozone drink alone, it being almost tasteless.

The points that I want again to lay stress upon for the investigation of the nature of the fever :—

(1) Most common amongst children under 12 years.

(2) "Sudamina" like eruption chiefly constant and characteristic, invariably noticed between 9 and 13 days. This is prominently marked feature of the disease and certainly diagnostic.

(3) Least fatal.

(4) No influence of quinine on its course, however large and prolonged doses be given.

(5) No perceptible enlargement of the spleen.

(6) Abdominal tenderness and flatulence.

(7) Midday and midnight rises of temperature.

Blood examination did not help me much except occasional malarial parasites under the microscope.

Diazo reaction although positive in every case in the second week, it is not so positively reliable.

In United Provinces this fever is popularly known as "*Moti Jala*" or "*Moti Jara*" from the minute transparent pearl (moti) like appearance of the rash. There they include this fever under "*Chaichak*" or "*Mata*" (small-pox-like eruptive evers) and have the superstition of believing it to be due to the wrath of the goddess, and therefore they very often hesitate to take medicine even.

I had till now the impression that this disease—next to Rajputana—prevailed in the United Provinces only, where I constantly came across numerous cases during my official career. But recently during my residence at home in Cutch too, a thousand miles away from U. P., I see similar cases every now and then, and hear mothers, calling it "*Noor Bibi*" with the same popular belief and superstition.

Also patients coming here from Bombay have been seen suffering from the same type of fever, but treated there as malarial remittent, while the fever not yielding to quinine, came down exactly on 21st day.

Now the question is whether to call this enteric fever, or by some other name. In what light much abler expert physicians take it to be? Bacteriologist can decide it.

Yours, etc.,
KESHAVLAL J. DHOLAKIA, L.M.S.

BHUJ (CUTCH):
28th August, 1919.

THE VITAMINES OF DATES.

To the Editor of THE INDIAN MEDICAL GAZETTE.

SIR,—Would some one kindly inform me if the date is of high vitamine value? Does it contain the three food accessories, anti-neuritic, anti-rachitic and anti-scorbutic vitamines?

In this desert island of Henjam during the last year I have noticed there were no cases of scurvy, beri-beri or rickets amongst the Persian coolies and their children, who subsist mainly on dates, rice and fish (fresh or rotten). Of vegetables and fruit there are practically none grown on the island, except the radish and brinjal which is in season a very short while in November and December. Amongst the Indians employed on the island, I have had one case of beri-beri and three cases of scurvy. The rations for the Indians are on a liberal scale, but do not include dates. Persian children from a very early age are fed on dates and so far I have had no rickets here amongst them. If these vitamines exist in the date, the date being as cheap and plentiful as it is in the Gulf, it would be a most valuable addition to the rations of Indians employed in the Persian Gulf.

Yours, etc.,
WILL. E. MOODY,
Lieutenant, I.M.D.,
Medical Officer, Coal Depôt.

HENJAM, PERSIAN GULF:
22nd November, 1919.

Service Notes.

OBITUARY.

LIEUTENANT-COLONEL CECIL ROBERT STEVENS, Bengal Medical Service, died at Paignton, Devon, on November 18th, aged 52. He was the eldest surviving son of the late Sir Charles Stevens, K.C.S.I., Lieutenant-Governor of Bengal; was born on March 14th, 1867, and was educated at St. Bartholomew's Hospital and at Zurich, taking the diplomas of M.R.C.S. and L.R.C.P.(Lond.) in 1890. He graduated M.B. and B.S.(Lond.), with honours in medicine and midwifery, in 1891, and M.D. in 1892, and took the F.R.C.S.(Eng.) in 1892. He won an exhibition in zoology at the preliminary scientific examination of the University of London, an open scholarship at St. Bartholomew's in 1885, and the Martin gold medal and Fayrer prize in pathology at Netley. After filling the posts of house-surgeon and midwifery assistant at St. Bartholomew's he entered the I.M.S. in 1893, and attained the rank of lieutenant-colonel on January 30th, 1913. After three years' military duty he took civil employment in Bengal in January, 1896, served as resident surgeon of the Medical College Hospital, Calcutta, from 1896 to 1899, as a civil surgeon in various districts, including Bhagalpur and Darjeeling, from 1899 to 1907, and in June, 1907, was appointed professor of anatomy in the Calcutta Medical College and second surgeon to the College Hospital. In November, 1914, he reverted to military duty, and came to Europe, and through 1915 served in the Indian hospital at Bournemouth. He had previously served on the North-West Frontier of India in the Chitral campaign of 1895, receiving the medal and clasp, and in the Tirah campaign of 1897-98, gaining two more clasps to the Frontier medal. —*British Medical Journal.*

INDIAN MEDICAL SERVICE.

A WHITE PAPER (Cmd. 398) contains further correspondence regarding the medical arrangements and comforts for the troops on the North-West Frontier. In an introductory note the Secretary of State for India deals seriatim with the recommendations of the Mesopotamian Commission and with the criticism that the lessons of the Mesopotamian operations in regard to medical administration had been neglected by the Government of India. He gives a summary of the action taken on the recommendations of the Mesopotamian Commission :—

(*a*) As to the recommendation of the Commission that the D.M.S. India should have far greater powers to authorize expenditure, medical purchases, and delegate such power to his subordinates, it is stated that the sanction of the Government could be obtained within a few hours, and that general officers commanding divisions, divisional areas, and independent brigades possessed the power before the Commission reported to sanction expenditure up to a limit of Rs. 25,000 in each case on hospital and convalescent accommodation, furniture, clothing, and medical and other stores required for sick and wounded men returning from field service to India.

(*b*) The recommendation that improvements should be made in the standard of comfort and accommodation in the hospitals for British troops in India had been met by providing electrical installations, by the extended provision of operating rooms, recreation rooms, facilities for X-ray and laboratory work, and superior hospital equipment generally. The position had been examined by a committee under the presidency of Sir George Makins, which made recommendations with a view to bringing station hospitals up to the level of war hospitals and of civil hospitals in India. The Government of India has accepted the principles, and effect is being given to them so far as funds and other circumstances permit.

(*c*) The principle of the substitution of station hospitals for Indian troops for the regimental system has been accepted, and station hospitals have been instituted on a provisional basis, the most suitable of the regimental hospitals being adapted for this purpose; the remainder are used as ancillary section hospitals. Improved scales of accommodation and diet, the latter being now free to both troops and followers when in hospital, have been issued, the aim being to bring the Indian hospitals as nearly as possible up to the same standard as the hospitals for British troops. The India Office has under consideration a scheme for the formation of an Indian Hospital Corps, which would be an essential feature of the station hospital scheme in its complete form. The Government of India appointed a travelling committee to inspect some of the station hospitals, both British and Indian, and to prepare plans for extensive structural improvements; but for the time being action is suspended, as other measures were held to have the first claim on such funds as were available.

(*d*) As to the recommendation that the mobilization equipment of general hospitals should be stored, kept in readiness, and inspected, it is stated that twenty-one general hospitals were available on mobilization for the frontier operations in May, and that fifteen were mobilized and opened in time to meet the requirements of troops as they were evacuated.

(*e*) A scheme for the reintroduction of base depôts of medical stores has been sanctioned.

(*f*) The Commission recommended that a separate superior sanitary organization and staff, responsible to the P.M.O. of the force, but otherwise independent of organization for the care of sick and wounded, should be formed. On this head it is stated that the divisional headquarters of all forces include sanitary officers who form the staff responsible to the D.M.S. or A.D.M.S., and that during recent operations additional sanitary officers were appointed to the lines of communication and areas. During the war motor ambulance convoys were organized and the hospital train service considerably expanded.

(*g*) The field service ration, as the Commission advised, had received very careful consideration. The Commander-in-Chief in India was of opinion that while quality, especially in regard to meat, was not up to the home standard, which could not be expected in India, yet it compared favourably with the average standard procurable in that country. The peace ration of British troops in India was larger and more varied than the sanctioned scale at home. At the request of the Government of India two expert officers are being sent out by the War Office with a view to improving the methods of preparing the ration.