On the other hand there is a high insanity rate among Eurasians—due, as Surgeon-General Bannerman says, to the severe competition in their lives, and the fundamental fact that Europeans cannot colonise and perpetuate their race without degeneration in the tropics, and the further fact "that mixed races of European and Asiatic blood are not, as a rule, a biological success."

Correspondence.

VESICO-VAGINAL FISTULÆ.

To the Editor of "THE INDIAN MEDICAL GAZETTE."

SIR,—I have been greatly interested in the article recently published by Lt.-Col. Smith on the treatment of vesico-vaginal fistulæ. I should like to state my experience in a fair number of recent cases. The cases include those which resulted from sloughing of the tissues after labour, and rupture of the bladder during labour—those in which there was one fistula, those with more than one fistula—cases which came into hospital many months after injury had occurred, and those of more recent origin.

In my operation, I pull down the cervix, expose the edges of the fistula and pare them thoroughly. Formerly, I used to insert silver wire sutures to a depth just short of the vesical mucosa. Latterly, I have had much better results from the use of Michel's clips, several inserted close together which clip the edges into a ridge, approximating but not penetrating the vesical mucosa. These Michel's clips I leave *in situ* for 15 days. Thus I get over the difficulty of the pricking ends of the wire sutures, besides avoiding the possibility of sepsis being conveyed to the area of operation by careless nursing, in the event of the sutures being brought outside the vulva.

The after treatment I give is continuous drainage (soft rubber catheter No. 8)—boric acid and barley water by mouth—a boric bladder wash every third day when the catheter is changed or more often if necessary, and vaginal douching.

I have had success in all my cases by this method and in one case only was there a post-operative complication, *e.g.*, incontinence per urethra after the catheter had been removed owing to atony of the ureteral muscles. This incontinence has gradually yielded to drugs, and the patient has now completely recovered.

I think that by this method I avoid the pain which Col. Smith says the patients experience when gauze is removed from the urethra, and also minimise any ill-effects from dilatation of the urethra.

Yours, etc.,

JANNETT D. HENDRIE SIMONSEN.

MYLAPORE, MADRAS.

THE CAUSES OF FAILURE AFTER VISUAL IRIDECTOMY.

To the Editor of "THE INDIAN MEDICAL GAZETTE."

SIR,—There is no operation which more often causes disappointment to the patient than this.

During the early years of his career the eye-surgeon is also very disappointed with his results after this operation if he takes the trouble to find out how small the amount of improvement is and he feels inclined to abandon the operation.

The common causes of failure are :

(1) Iris adherent to cornea.
(2) Too small an iridectomy.
(3) Extensive opacity of cornea.
(4) Adhesions of iris to capsule of lens.
(5) Opacity of the lens.

Let us next consider the points in operating. In children full chloroform narcosis is essential.

Incision.—The text-books tell us that the site of election should be opposite a clear portion of cornea and by preference downwards and inwards, and in this the books are quite right. For the incision a Græfe's knife should be used and the incision made through sclera and if the patient is steady a conjunctival flap be made.

Adhesions.—Must be dealt with (*a*) by atropine, (*b*) by breaking with needle or spud, (*c*) inclusion in the iridectomy.

Opacity of Cornea.—If this is very large, it is no use attempting an iridectomy; if the periphery of the iris is clear no improvement of vision results.

Cataract.—When this is present it should be dealt with by a subsequent operation, but if the patient will only have one operation then extract in the following method.

Before beginning the operation instil adrenalin two or three times after cocainization.

Make a large corneal incision with a broad conjunctival flap downwards and inwards—perform the iridectomy, then the cataract which you have suspected becomes manifest. Proceed with the extraction as follows: lay the convex side of the spoon on the upper half of the cornea and press backwards when the lens bulges into the wound, harpoon it with V. Græfe's knife and deliver. As the lens comes out the capsule is divided by the edge of the knife. If the capsule were not divided there would be great probability of loss of vitreous in these cases.

Finish the operation by replacing iris and conjunctival flap with the greatest care.

Sight was restored by this method to an eye which had been blind for twenty-two years.

KASHMIR, *March*, 1916. } Yours, etc., SOMERTON CLARK, F.R.C.S. (Ed.).

THE WAR AND THE SUB-ASSISTANT SURGEONS IN BENGAL.

To the Editor of "THE INDIAN MEDICAL GAZETTE."

SIR,—It is now close upon two years since the great war broke out in Europe. Offers have in the meantime been more than once made to the medical profession in Bengal. Few have as yet embraced this opportunity of making their mark in life, while fewer still have volunteered their services in the military department. This slowness on their part is in no small degree due to the vagueness which prevails as to the actual situation. I feel sure many among us will try their chance as soon as this vagueness and uncertainty which stands in their way is dispelled.

I, for one, am of opinion that the prospect which the war has opened up before the medical profession in India is really rare and unique. It will afford us opportunities of displaying our fitness for the department to which we have so long been perfect strangers. The varied experience which one will gain while in military service, especially in active service, cannot be altogether lost upon him. While the risk which one runs is, I may assure my countrymen, almost nil, as the rumour of casualty among Sub-Assistant Surgeons is quite unfounded. If to this be added the prospect which awaits one, I am bound to pronounce this to be really a golden opportunity which should not be hastily thrown away.

The treatment that is accorded to those that are already there is all that can be desired. I believe, my testimony will not go in vain as I myself had been on active service for about six months and two of my relatives are still in active service in Mesopotamia. A compounder, of Sylhet district (Indian Christian), who accompanied me, has been rendering services with enthusiasm and speaks in unmistakable terms of the charms of life there. His name is P. Jones. It was ill health, heart troubles, that compelled me to return so soon, but nevertheless I cherish the hope of soon rejoining military service. The information which I have all along been getting from the circle of my friends also confirms the above testimony.

I am aware some of my friends went so far as to resign their posts with a view to avoid the call for service even in military base hospitals in India. I cannot regard this step on their part wise inasmuch as their panic was altogether unfounded. It is not too much to hope that their cases will also be favourably considered if properly placed before our kind-hearted Surgeon-General.

Before conclusion I should once more emphasise the sacredness of the call to which we are morally bound to respond.

Yours, etc.,

CHANDPUR, *23rd March* 1916. } UPENDRA CH. CHAKRABARTI, *Sub-Assistant Surgeon, Chandpur.*

POLICE CASES.

To the Editor of "THE INDIAN MEDICAL GAZETTE."

SIR,—Will you or any of your numerous readers kindly inform through the medium of your journal the procedures obtaining in Madras, Bombay, Calcutta, etc., with regard to the disposal of hurt cases which come to the hospital through the police for medico-legal purposes. In Burma each and every case reported to the police is sent to the hospital for treatment and evidence. The patient is admitted, the injuries are recorded, and the report is sent to the police. The medical man is called into court for evidence in almost all cases.