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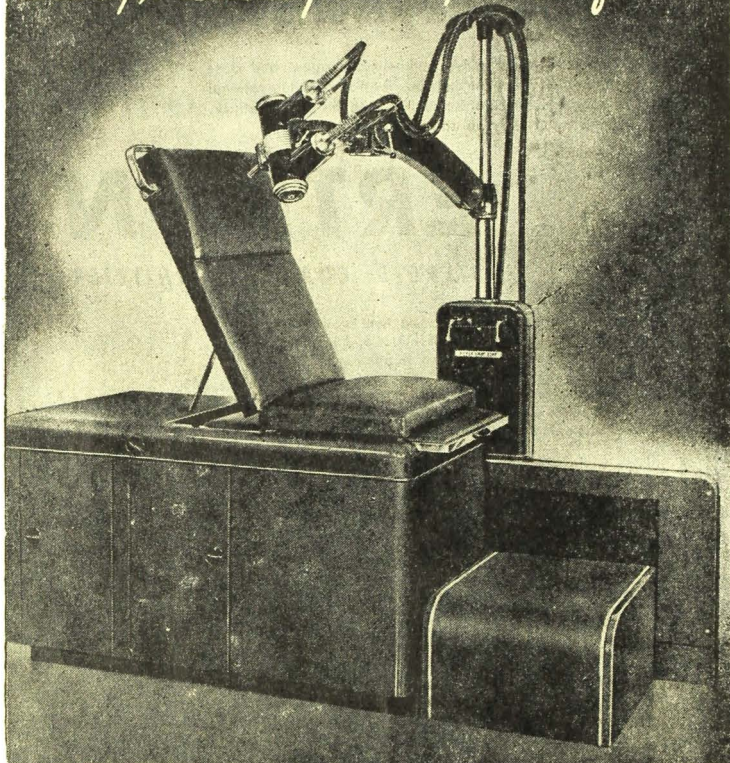
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*Anderson, J. and Steele, C.: *Use of Nitrofurazone Therapy in External Otitis*, *Laryngoscope* 58:1279, 1948. • Douglass, C.: *The Use of Furacin in the Treatment of Aural Infections*, *Laryngoscope* 58:1274, 1948. • Reardon, H.: *Unpublished results.*

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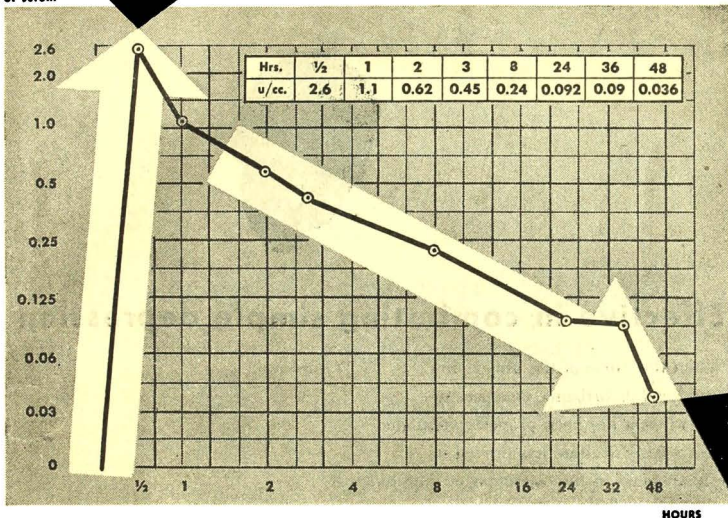
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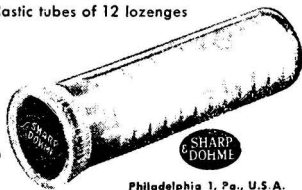


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Original Articles

**OBSERVATIONS NOTED IN THE PRACTICE OF E.E.N.T.
IN THE PROVINCE**

PABLO J. NAÑAGAS, M.D.
Lucena, Quezon

On the Location of Practice

The location of practice has much to do with its nature. The provinces of Quezon, Laguna, parts of Batangas, and of the Bicol Peninsula, from which come the greater number of patients here, are predominantly agricultural. The greater bulk of the patients, therefore, are farmers. However, because the clinic is located in the sea-side town of Lucena, there are also significant numbers of government and company employees, grade and high school students, small businessmen and proprietors, fishermen, and unskilled laborers. There is only a sprinkling of skilled laborers from the few machine shops in the town, and some from the Red V and the Peter-Paul dessicated coconut factories.

On the Economic Side of Practice

Since the patients come from the lower bracket of the large middle class, a paying but nevertheless poor group, practice has to be geared as much as possible to inexpensive and rapid methods of diagnosis and treatment without making these too routine or institutionalized. Thus repeated short appointments have made way to long sessions of examinations.

This, while impractical in city practice, fits in with the provincial, because office hours in the latter start at sunrise and only end with evening. There is little chance of conforming to strict schedules. Patients who come by trains and buses, or by "batels" and bancas at odd hours desire immediate relief and cannot stand much waiting. Furthermore, there is a certain tempo that prevents rigid adherence to scheduled work, quite the exact opposite the tempo in the city that requires strict adherence to pre-arranged schedules.

Ambulatory treatment and postoperative early ambulation are almost compulsory, despite very good hospital accommodations (the Que-

zon Memorial Hospital). X-rays and requests for laboratory examinations have to be cut down to a minimum, also as part of the economy measure. Tonsillectomies and polypectomies have become definitely ambulatory here; cataract cases leave the hospital as a rule on the third or fourth postoperative day.

Consultation, treatment, and operation fees, have no fixed standard; and they are generally much lower than in the city. Some patients pay in kind (chicken, eggs, fish, vegetable products, and one, even a daily bread ration for several months because he happened to be a baker). Provincial patients have a deep-rooted bargaining instinct, and a few (and fortunately, only a few) even haggle over the consultation fee.

The Clinic: Its Equipment

Since the patients in the province come at odd hours of the day for consultation, the clinic in the province must be located in the residence of the specialist. The waiting room and the examination and treatment room should be fairly large; patients seldom come alone, and it is the rule that they come with at least one or two companions. Some patients have come with the father and mother, brothers and sisters, and wife and children in tow, all anxious to be present at the examination and treatment of their relative. Luxurious furniture should be discarded for sturdy benches in the waiting room. A commodious garbage pail and several spittoons should be in conspicuous places. Patients who arrive just before lunch, anticipating a wait beyond that meal time, sometimes bring their lunches with them. Sanitation in the waiting room, not to say in the clinic itself, is a full-time janitor's job.

Orthoptic apparatuses, except for the stereoscope or the amblyoscope, are bound to be out of place in the provincial clinic. For one thing, very rare cases or none at all will submit to the tedious and prolonged exercises connected with their use. For another, the specialist will not have the time to conduct the exercises, and he is not in a position to afford a trained technician to handle his cases either. The simplest apparatuses are best, for these will save too much explaining to the patients.

In the choice of apparatuses, it will also pay to bear in mind that they should not only meet satisfactorily the job required of them, but that they should also be as portable as possible. Thus, on occasions, I have had to treat a patient in bed in his home with the short-wave diathermy and the suction apparatus, merely because he could not afford hospitalization.

Operating instruments in any case should be complete, because the provincial hospital, though fully equipped otherwise, lack both diagnostic and operating instruments.

A trained assistant is essential. However, he should be given training for one or two months before he can be expected to become fully efficient—that is, in addition to being a registered nurse in the first place. He is, in turn, nurse, surgical assistant, receptionist, secretary, and book-keeper. He takes care of the instruments and apparatuses as well as the

books in the modest library, indexes the journals, repairs leaking faucets, traces a short circuit, etc. He is expected to be, and should be, a jack-of-all-trades.

On the Clinical Cases Met in Practice

There is a preponderance of cases of neglected infections. Outstanding among these is the number of hypopyon keratitis. Almost all of them give histories of injury sustained by the eye while the patient was at work in the fields — and often, from blades of grass. They present mixed infections, predominantly staphylococci and streptococci, and, at least in the few cases where bacteriological examination by smear was done, never in pure form.

Remarkable, however, is the abundance still of advanced cases of hypovitaminosis. Xerophthalmia and keratomalacia predominate among the young; retrobulbar neuritis, ocular ariboflavinosis associated with cheilosis and glossitis, and corneal dystrophy among the adults.

Absolute and far-advanced cases of glaucoma, in proportion to the early cases of either the congestive or the non-congestive forms, is unusually high. I have seen more cases of irremediable glaucomas than those still amenable to medical or surgical treatment (during the last year — 30 cases of the former to 24 cases of the latter).

We have the usual run of the different forms of acute and chronic conjunctivitis, but in 500 cases so far, I have had *only two cases of conjunctival folliculosis*.

There is a marked incidence of cases which I believe to be of allergic origin—not only from their symptoms but also from the improvements produced by the anti-histaminic drugs. Greatest in number, of course, is allergic rhinitis. I have found that nicotinic acid, although not an anti-histaminic drug in itself, causes a remission of symptoms, at times even better than *Benadryl*. Some of my cases of recurrent tubal catarrh respond to nasopharyngeal washings with mild alkaline solutions and anti-histaminic drugs. Some of the stubborn catarrhal otitis media in children, refusing to respond to any form of local treatment, dried up with the addition of *Elixir Benadryl* or *Syrup Histadyl* orally. I have seen few — or I might have missed many — cases of ocular allergy. An interesting case was one who developed episcleritis just prior to every menstrual flow, and who improved satisfactorily to desensitization with estrogens.

The suction and pressure apparatus has become indispensable to me in the diagnosis and treatment of sinusitis. For instance, I rely more on the results of suction applied to the nose for the diagnosis of sinusitis, than on the results of transillumination. The procedure is as follows: I wipe off all secretions (if there are any) in the meatuses with a cotton-tipped applicator, spray the meatuses with a fine mist of ephedrine solution, and apply mild blanket suction of not more than three inches vacuum with the patient's head tilted to almost horizontal towards the opposite side. The appearance or the reappearance of discharge in the meatuses is examined with the aid of the electric naso-

pharyngoscope, thereby determining the ostium of origin and the corresponding sinus involved.

I have used the Proetz displacement method of treatment very extensively and fairly successfully — modified, however, as to the extent of hyperextension or inclination of the head on the shoulder, depending on which sinus is to be treated. I have found no reason to fear that this method of treatment may transmit infection to uninfected sinuses or to the ear. I have never used antro-nasal perforation as a method of treatment per se — much less for diagnostic purposes — but only as part of an intra-nasal modified radical operation for the maxillary antrum.

Some of the chronic otitis media with catarrhal or purulent discharge, unless foul or associated with multiple or marginal perforation of the drum, have responded favorably to irrigation with penicillin, either through a cannula in a moderate to large-size perforation or through intermittent very mild suction-pressure applied under visual guidance with the aid of the Siegel otoscope. In some cases, passage of the solution is effected into the Eustachian tube, and the patient would claim a slight bitter taste in the throat. This has often presaged drying of the ear, and logically, I believe, because it means that the Eustachian tube is either free from mucous plugs or that the mucosa lining is no longer edematous. I have only had one case of otitis media chronica submitting to an endaural mastoidectomy; it ended in a dry ear. However, I have had two previous cases of chronic mastoiditis which dried up after endaural semi-radical mastoidectomy, and am gaining more confidence in the performance of this operation.

The diagnosis of nasopharyngitis is increasing in frequency. At least, in my practice, many previously diagnosed as cases of granular pharyngitis only, and which recurred despite electrocoagulation, have finally ended up as nasopharyngitis primarily and only pharyngitis secondarily — and recovered with treatment applied to the nasopharynx. There seems to be no reason now that I can see why the pharynx alone should be chronically infected, or why the pharyngeal lymphoid tissues should be hyperplastic without some reservoir infection in the many crypts of the nasopharynx or in the nasal sinuses being present. The results of routine nasopharyngeal examinations with the electric nasopharyngoscope and of nasopharyngeal washings seem to bear out this belief.

Almost all the cases involving the larynx that I have seen here are either a chronic simple laryngitis or a chronic tuberculous laryngitis. I have seen only one polyp of the vocal cord, no case of newgrowth, and only one case of foreign body — a fish bone at that. Two cases of acute laryngo-tracheo-bronchitis (tracheotomized and recovered), three cases of epiglottic abscess, and two cases of edema of the glottis (allergic and associated with cutaneous angioedema) make up the rest of the laryngeal cases I have seen. I have had no experience with direct laryngoscopy, bronchoscopy, or esophagoscopy since coming to the province, due to the absence of the necessary but expensive instruments.

Neuralgias involving different nerves of the head and neck make up a large group of cases. Many of these appear to be secondary to dental foci of infection. There were two cases of neuralgias associated with sinus infection; one was a supra-orbital neuralgia associated with a chronically discharging frontal sinus, and the other was of the sphenopalatine type associated with an ethmoid sinusitis. I have had two cases of tic doloreaux improved with alcohol injection at the oval window, and one case of mandibular neuralgia (3rd division of trigeminal) improved with transoral alcohol injection.

Refraction cases have shown me that the local incidence of myopia consulting, compared with that of hypermetropia, is very low; and that the ratio of one to the other is 1:5. I follow a certain routine in refraction cases, starting with the naked eye and loupe examination. Vision for far and near is taken, followed by ophthalmoscopy. Retinoscopy, combined with fogging, comes next. I try the objective finding on the patient and make the necessary changes in the sphere as the patient may subjectively think or feel better. (This is usually to *decrease* the spheres whether plus or minus.) I always take the astigmatic correction and its axis as found objectively at face value and make no more changes in this regard. I use the cyclopegeic less and less now, and find that in comparing the final results of static and dynamic refraction, with the ultimate satisfaction of the patient as guide, static refraction has no very great advantage over the other. There are always exceptions of course, and on such cases as those with spasm of accommodation, or in those whose astigmatic axis change with repeated retinoscopy, I still use the cyclopegeic — with a preference for atropine.

Several cases have interested me a great deal lately. These showed, on monocular retinoscopy and refraction, astigmatic axes of from 135 to 100° or from 45 to 50° but who, on binocular retinoscopy and refraction later, showed that the axes have changed to 90° in the first group and 180° in the second group. Atropinization did not abolish the difference in astigmatic angles between monocular and binocular retinoscopy. Are these cases of cyclophoria?

Some interesting cases that I have seen are: (1) possible ocular pemphigus in a woman with oral and vaginal lesions (pathological examination—lymphocytic filtrations—compatible with such diagnosis); (2) two cases of the limbus girdle of Vogt (corneal degeneration); (3) a case of coloboma iris with coloboma of the choroid and a cyst-like ectasia of the sclera posteriorly; (4) a massive retinal detachment ballooning out so as to be visible through the dilated pupil by naked-eye examination in a case of uremia, which resolved spontaneously just prior to the death of the patient; (5) three sisters of a well-to-do family, all suffering from corneal dystrophy, which responded favorably to high doses of vitamin B-complex; and (6) a family whose male members have pigmentary retinosis.

On the Relation of the Specialist to Patient

The specialist in the province is closer to his patient and to the pa-

tient's family than the specialist in the city. He is, therefore, in better position to know family predispositions and hereditary diseases, as well as home conditions of the patients. For this reason, he is also better able to cope with psychosomatic disturbances affecting eyes, ears, nose, and throat. Many times, the specialist is called upon to see on several occasions, several members of the same family—so that he becomes, in effect, also a family physician.

The patient in the province, however, is more prone to procrastinate in consulting for minor pains—hence the incidence of advanced cases in the province is higher in comparison to that in the city. He is less inclined to submit to operative interventions. At the same time, he is more impatient of improvement. He is probably a little more inquisitive and often embarrasses the specialist by questions on the nature and other details of his illness.

A severe handicap to the specialist is the inadequacy of medical terms in the vernacular. Something will have to be done about putting in order and standardizing medical nomenclature in the dialect. I have always wanted to know what Tagalog term could be used to designate *a nerve* without falling back on the word *nervios* and wrongly making the patient think that he was nervous.

The patient expects the observance of the social amenities in consultation, and it is many times evident that the patient is reluctant to leave even after the prescription has been given. Many times, however, this same informal attitude has helped in forming a diagnosis by the offer of unsolicited but highly important information regarding the illness or regarding home life relevant to the illness.

On the Relation of the Specialist to Colleagues in General Practice

At the start of practice, the specialist in the province is looked upon with suspicion. This is quite natural and to be expected. More ready to recognize the specialist's ability and thoroughness of training are physicians in the government service, particularly the staff of the provincial hospital. This is usually brought about by bedside discussions of hospital cases and by demonstrations, more specifically in the field of surgery. Private practitioners are less apt to be cognizant, or are slower to accept the merits, of a newcomer. This may in part be the reason for the dearth in referred cases, which are few and far between. I have come to consider it an unusual event, indeed, to receive a patient with hypertension, nephritis, or diabetes referred for examinations of the eye-grounds for diagnostic or prognostic reasons.

There is hardly any occasion other than social for the specialist and the private practitioners to get together in the province. Medical society meetings and conferences may take place, but no more than once in a year. Attempts to encourage informal medical conferences have met with no success so far, but I am still trying.

On Laboratory, X-Ray, and Physical Therapy Facilities

There is still much to be desired in the facilities offered by the lab-

oratories of the provincial hospital, and there are no other laboratories available. This is not so much due to lack of competent personnel—in fact, laboratory personnel now is excellent—as to the utter inadequacy of equipment. Aside from the routine cellular counts of the blood and spinal fluids, urinalysis, and feces examination, there used to be no other form of laboratory examination available.

Lately, however, bacteriological examination of stained smears, blood-typing, and cross-matching have been made available; and only quite recently, with the acquisition of an electric colorimeter, glucose determination in the blood and other quantitative examinations of blood constituents are now available. The laboratory man and myself are still praying for a microtome and staining equipment to be able to do histopathological examinations. We are also praying to be able to do bacteriological cultures.

The diagnostic X-ray apparatus, both government and private, are the best available. Further technical training, perhaps, is still to be desired to obtain meticulous exactness in the radiography of the skull—particularly the optic foraminae, internal auditory meatuses, etc.—but this should not be long in coming with the interest and potential abilities shown by local radiologists.

The therapeutic X-ray is not available; and for the treatment of tumors, postoperative or otherwise, the patient has to be referred to Manila. The use of the X-ray for the treatment of sclero-keratitis, vernal conjunctivitis, or pterygium, and as a preventive or cure for neo-vascularizations of the cornea is therefore out of the question.

The short-wave diathermy apparatus and the galvanofaradic machine are parts of the office equipment, and are also available in the provincial hospital.

On the Need for a Medical Library

This is a sore spot in the provincial specialist's extra-clinical activities, because aside from whatever books or journals which he himself may buy, there is no medical library in the province. He is insufferably handicapped, therefore, in the way of references for the study of some of his cases and more so in the preparation of scientific papers. Research in any form is bound to lag or stagnate from the difficulties encountered in obtaining information regarding research along similar or the same lines.

CONCLUSION

It is very evident that specialists are needed in the provinces. One way or another, they should be able to continue to practise their respective lines, although not as ideally or as lucratively as in the city. The specialist should be prepared for some amount of dissatisfaction—economic, social, clinical—and should steel himself to the handicaps which continually obtrude into his daily routine without losing his scientific attitude toward cases. He should be reasonably ambitious, so as never to lose his desire for continued improvement; otherwise, he is bound to regress and be left behind by his colleagues in the city.

SUMMARY OF EXPERIENCES WITH ADRENOCORTICOTROPIC HORMONE (ACTH) ON COLLAGEN AND ALLERGIC DISEASES *

FLORANTE C. BOCOBO, M.D.**

In 1855, Thomas Addison described the clinical syndrome bearing his name and characterized by abnormal pigmentation, asthenia, anorexia, and extreme inability of the patient to withstand stresses, such as infection, physical exertion, marked changes of temperature, etc. This was followed through the ensuing decades by a vast amount of laboratory work on animals which revealed that the changes caused by the removal of the adrenals in animals simulated to a large degree the Addisonian disease in man, and that it was the adrenals that endowed the animals the ability to resist environmental stresses. Twenty-five years ago, Evans reported that a pituitary extract prevented the atrophy of the adrenal glands, resulting from hypophysectomy in animals. Subsequent work on the relation of ACTH from the pituitary with the adrenals gave rise to the hypothesis that the ability of the individual to withstand acute environmental stresses is the result of an endogenous stimulation of the adrenals by ACTH, which is physiologically called the "alarm reaction." Selye further elaborated on the adrenal gland adaptation phenomenon and adaptation disease, concluding that certain experimental hypertension, nephritis, and joint diseases in animals are the result of the adaptation of the adrenals to chronic internal and external stress situations. Thorn, in 1947, first injected ACTH into human beings and confirmed that, in man, the hormone stimulated the adrenal glands to increase the secretion of adrenal steroid hormones, through which ACTH produces its therapeutic effectivity.

There are 30 different steroids so far isolated from adrenal gland tissue, eight of which are physiologically active. These active cortical hormones or corticoids fall under three general types: (1) compound F-like hormones or 17-hydroxy-cortico sterone-like steroids, (2) desoxycorticosterone-like hormones, and (3) adrenal androgens. Most of the physiologic effects observed during ACTH stimulation of the adrenals are due mainly to hormones of the first group. Cortisone (17-hydroxy-11-dehydrocorticosterone) or compound E of Kendall belongs to the first group and has very strikingly parallel clinical effects of ACTH and, consequently, used in the management of essentially the same groups of diseases.

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Most of the ACTH used in clinical studies was prepared by the Armour Laboratories from pork pituitary glands by an iso-electric precipitation method. It is available commercially as a sterile powder that may be dissolved in isotonic saline solutions for intramuscular injections. Cortisone is prepared by partial synthesis from bile acids and is available as crystalline suspensions of the acetate in saline solution (Cortone, Merck and Cortisone, Ciba).

In early clinical studies, the full implication of the role of ACTH in diseases in general was not realized, so that its use was largely limited to the study of individuals with obvious endocrine disturbances, although it was used effectively even at that time in varying degrees in myasthenia gravis, acute gouty arthritis, nephrosis, and rheumatoid arthritis. In the light of such divergence of these diseases, it was thought advantageous to screen disease syndromes in general.

The first logical group of diseases to be studied was the collagen diseases. This was found justified; for in all groups so far investigated, the use of ACTH was followed by striking clinical and laboratory improvement, not infrequently with complete remission, particularly in acute rheumatic fever in which the fever and the signs and symptoms of arthritis, pericarditis, myocarditis, and pleuritis rapidly disappeared. And the E.C.G. changes and sedimentation rate returned to normal even with small doses of the hormone (30-50 mg. daily).

The best results so far have been in acute first or second attacks of rheumatic fever, with no evidence of previous heart damage. The response in chronic active rheumatic fever with signs of real cardiac damage were not as encouraging, although marked improvement was also attained with ACTH therapy. Active disease returned with cessation of ACTH administration.

Similar striking improvements were obtained in rheumatoid arthritis, although the activity returned frequently whenever the administration of ACTH was stopped. Maximum results could not be expected in long-standing cases with severe crippling and deformity.

Favorable responses to a lesser degree have been elicited also with ACTH in other collagen diseases such as lupus erythematosus disseminatus, dermatomyositis, scleroderma and periarteritis nodosa. However, as in rheumatoid arthritis, relapses have been more common than not after stopping ACTH.

With the seeming correlation of collagen diseases with the mechanism of hypersensitivity, the effect of ACTH on allergic states was also studied. Excellent results were obtained in chronic intractable asthma and status asthmaticus with cessation of symptoms and recovery of satisfactory respiratory capacity in 24-48 hours of ACTH therapy. Marked relief was also afforded cases of allergic rhinitis, atopic dermatitis, drug sensitivities, urticaria and angioneurotic edema, Loeffler's syndrome and gastrointestinal allergies. The toxic symptoms of allergic origin as malaise, weakness, ease of fatigue, myalgia, headache, depression and dulled mental acuity were the first symptoms to be relieved, so that

a state of euphoria became apparent in the patients. However, upon withdrawal of ACTH, relapses occurred.

As in most any biological system, the response of the adrenal glands to ACTH stimulation varies. The effective dose of the hormone differs with each individual. As a general principle the hormone is given at a minimum effective therapeutic dose without causing any undesirable side-effects and metabolic changes. In most diseases, it is recommended that the patient be started on 10-12.5 mg. of ACTH four times a day for several days, and to increase the dose gradually by 5 mg. after every few days if no clinical effect is observed. The maximum dose seems to be 25 mg. every six hours, above which careful watch for metabolic disturbances must be observed. The daily dosage is to be divided into four injections given every six hours, inasmuch as the clinical and physiological effects of ACTH wear off within six hours.

After attaining a remission of the disease, the minimal effective maintenance dose must be determined. Thus, the dose is decreased and the interval between injections is lengthened to a point consistent with maintaining the achieved remission. This is particularly desirable in the more chronic affairs such as rheumatoid arthritis. Some cases have been in substantial clinical remission with a single small daily dose of 10 mg. of ACTH.

Thorn, in his original article, reported that the injection of large doses of ACTH caused a marked drop in the number of circulating eosinophils in the peripheral blood; an increase in the uric acid-creatinine ratio in the urine; an increased urinary excretion of 17-ketosteroids, 11-oxysteroids, potassium, and nitrogen; and a retention of sodium and chloride. Consequently these are used as laboratory criteria of ACTH stimulation of the adrenals. They necessitate the observance of certain precautions in its use, such as limitation of sodium chloride and fluid intake and the maintenance of high potassium and protein intake.

Undesirable side-effects that have been observed are transient hypertension, glycosuria, mental disturbances, salt and water retention, hypokalemia, a peculiar acneform skin eruption, hypertrichosis and a rounding of the facial contours and other features of Cushing's syndrome. The contraindications to its use are hypertension, diabetes mellitus, chronic nephritis, congestive heart failure, psychotic and psychopathic personalities, Cushing's syndrome and hirsutism.

Medicine has found in ACTH an effective agent in its therapeutic armamentarium to combat a number of disease syndromes, particularly the collagen and allergic diseases. But medical men must not lose sight of the fact that to date no curative property has been attributed to it, and the efforts to determine the actual etiological factors of these diseases and their correction must not be slackened. The greatest clinical value of ACTH so far seems to be to tide the patient over the acute and more dangerous phases of the disease, so that the more definitive and established procedures of treatment can be applied effectively. Years of work are still needed to establish definitely the actual role played by the adrenals

and their stimulation by ACTH in the development and therapy of human diseases.

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THE PERENNIAL RHINITIS

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The underlying mechanism in an allergic reaction, according to the present theory, is based on a specific antigen-sensitized cell reaction resulting in the release of histamine or a histamine-like substance in a hypersensitive individual. This broad concept includes both the immediate or wheal type and the delayed or tuberculin type.

The seasonal type of coryza due to pollen sensitivity is known as hay fever. The perennial type, on the other hand, occurs throughout the year and has numerous names, including perennial allergic rhinitis, allergic rhinitis, non-seasonal vasomotor rhinitis, atopic coryza, or perennial coryza. It is difficult to state which is the proper term to be employed; but to the speaker, perennial rhinitis appears to be the most satisfactory.

The title of this paper is an underestimation; its latter half should also include the adjective "most neglected and worst treated." It occurs more frequently than any other allergic condition of the respiratory tract. It is often so mild and inoffensive that its victims do nothing about it in its early stages, when diagnosis and treatment are not only simple and curative, but can also prevent more serious complications. Not until secondary infection in paranasal sinuses has arisen, or nasal mucous polyps have developed, do the patients seek relief. Too much unwise surgical attention is paid to such complications while the underlying allergic process is ignored. Worst still, many patients are seen only after the onset of that most serious of all allergic status, asthma, which may have been prevented.

Respiratory allergy is relatively common, with an incidence of 1-3% of the general population. Approximately 20% of this will be seen with the chief complaint of perennial allergic rhinitis, 30% with hay fever, and the remainder with asthma. Thus asthma is the most common condition that brings patients to the allergist; but then figures fail to demonstrate the actual frequency of these conditions, as approximately 60% give a clear and prior history of perennial nasal symptoms and 30% give a prior history of hay fever. Of the patients who give a chief complaint of hay fever, 50% also have perennial nasal allergy. Thus perennial allergic rhinitis is clearly the most common of all allergic disorders of the respiratory tract.

Perennial allergic rhinitis is the most neglected of respiratory allergic conditions, as one half of the patients have symptoms over five (5) years prior to therapy. Many mild cases never come to the attention of the physician, but many more would be found if one routinely

questioned patients about excessive sneezing, nasal blocking, and profuse nasal discharge. It is a forerunner of asthma in at least a third, and probably a half, of the cases of asthma, which it may precede for as much as twenty (20) years. In my experience, the same etiologic agents are, in most instances, at the bottom of the bronchial as well as nasal symptoms, although there may be new allergies—and often infection. There is an etiological relationship to asthma, especially by neglect.

The neglect of perennial allergic rhinitis must be blamed largely on the patients themselves, or on their parents, chiefly because of the usual mildness of the symptoms and their unchanging persistence over long periods. A dozen sneezes and an itchy, watery nose during an hour or two each day are not sufficiently troublesome to inconvenience the patient. Some actually enjoy sneezing as our ancestors took snuff to make them sneeze. Children are especially likely to accept their affliction without complaint; and the parents become accustomed to the child's sniffles, especially when they realize that these symptoms do not mean the onset of a cold or some more serious illness.

But the physician also shares in the responsibility for this neglect on several counts. The first is his failure to inquire routinely about symptoms of a stuffy nose. He always asks his patients whether they belch or cough. If he asked whether they sneeze, he would strike oil oftener. When a patient casually mentions his nasal symptoms, the doctor either misses their allergic significance or fails to consider them worthy of further study. Instead of advising an allergic survey, he often dismisses the patient with a prescription for some tablets or a shrinking nasal spray of ephedrine; and so the era of mistreatment begins.

Months or years later, when complications have arisen in the form of sinus infection or nasal mucous polyps, the patient again seeks medical advice only too often to have his mistreatment continue along surgical lines with submucous resection, turbinectomy, drainage of sinuses, or the removal of mucous polyps, with little or no thought for allergy which is responsible for the origin and continuance of the complications. Not all such surgical procedures are unnecessary, but treatment along allergic lines might have resulted in a need for fewer operations. Fortunately, the rhinologists have shown an increasing appreciation of the basic importance of allergy in their patients; so that in the hands of such well trained specialists, these cases no longer merit the description "worst treated" among the respiratory allergic disorders.

Clinical Picture

The normal individual is entitled to two (2) or at the most three (3) consecutive sneezes, but he who sneezes six (6) or more times in a row in the absence of a cold is as surely allergic as the patient with typical asthma. If the contact is not too protracted or frequent and the allergen is fairly obvious, the patient will recognize the cause-effect sequence. For example, he sneezes "whenever he is around horses." Yet this same individual, who later develops mild symptoms that occur every night, may never suspect the new horse hair mattress on which he sleeps.

In children such intermittent and occasional contacts produce symptoms that mothers mistake for colds. The allergic nature of such attacks is suggested by their lack of fever and their short duration. A true cold does not run its course in two or three hours. In such cases there is a pallor of the mucosa, but not inflammatory congestion, and often a profuse watery discharge that usually contains eosinophiles.

When there are several allergens, or when exposure to allergen or allergens is frequent, the symptoms are correspondingly more frequent. They may still be limited to certain times of day. Thus they are most common in the early morning hours because of allergens in the nocturnal environment, or they may be more or less continuous if the exposure is constant. Nasal blockage tends to be more frequent and annoying than sneezing. It is commonly noted at night, but the majority of this group develop their symptoms so gradually that they can tolerate it without complaint. And in all these patients the nasal mucosa is more or less constantly pale and edematous.

The final stages of allergic changes in the nasal mucosa, and probably sinuses, are mucous polyps which may extend into the sinuses. Clinically, the polyps manifest themselves by a gradually increasing degree of nasal obstruction, with less and less reopening of nasal passages during the period of no exposure to allergens. But the process is so gradual that the patient, not only is unable to determine the approximate time of development of polyps, but may not be even aware of their presence.

Etiology

Although allergic perennial rhinitis may occur at any age, it is more frequent in the second and third decades of life. It is undoubtedly more prevalent in children than is generally believed and is often overlooked as a common cold. Sex is not an important etiological factor, although females are somewhat more commonly affected than males.

Heredity is an important factor, although a history of this is not obtained as frequently as in asthma or hay fever. Commonly, however, a positive family history makes the condition more likely, due to allergic factors. In the immediate or wheal type reaction, there is definite familial relationship. When allergy exists in both mother and father, the age of onset is earlier and approximately 75% of all offspring will have allergy.

The exciting factors or allergens which produce attacks of rhinitis form a heterogenic group which may be divided into three major groups and two minor groups.

- (1) Air-borne substances or inhalants
- (2) Food and drugs
- (3) Infectious agents
- (4) Injections (penicillin)
- (5) Unbroken skin (mustard plaster)

Among the specific causes, the inhaled allergens are by far the most important; and they can be divided into two groups: seasonal and non-

seasonal. Seasonal antigens usually cause hay fever produced by pollens from trees, grasses or weeds. Molds play very little part in respiratory allergy in the United States but may have a significant part in the Philippines. It is more prevalent during the rainy season. Insects also have a seasonal occurrence, such as the caddis fly in August in the region of the Great Lakes.

Among the specific causes, non-seasonal inhaled allergen is by far the most significant. House dust, bedding materials, wool and domestic danders, cosmetic, pyrethrum, and various organic dusts incident to occupation are the commonest. Their frequency decrease in the order mentioned. House dust contains such materials as lint from wool, silk, kapok, cotton, and linen; hair from cows and horses, feathers from bedding and upholstery and pets in the house.

Food has a greater significance in the early years of life. From one to five years of age asthma, but not rhinitis, is frequently due to food allergy. As the child grows older this gastrointestinal mucosal sensitivity disappears, but the skin sensitivity is still present. Ingested substances are occasionally involved, notably cereals, nuts, chocolates, sea foods eaten raw, milk, and eggs. Rarely, the drugs are causes, sometimes as inhalants when in powder form and sometimes after ingestion, as for example phenolphthalein.

Bacterial infection agents are of less importance in the production of rhinitis than asthma. The existence of bacterial sensitization is so hard to prove as to be diagnosed by a process of exclusion.

Exciting causes are often mentioned by the patient: smoke, especially the sulphur dioxide of coal smoke; sharp odors; fumes of paint, and lacquers. In some, these odors may have the possibility of toxic sensitivity existing, but as a rule these causes are inactive in the absence of the effect of specific allergens.

Other non-specific factors in the aggravation of symptoms are sharp drops in temperature, and to a lesser degree barometric pressure. The presence of marked septal deflection or nasal spurs is at times responsible for discomfort and headache.

There is little doubt that nervous and psychic factors may aggravate an already established rhinitis, but it is doubtful whether it acts as an initiating cause.

Diagnosis

It must again be emphasized that even the mildest case of perennial allergic rhinitis is worthy of an accurate and complete etiologic diagnosis. The milder and earlier the condition, the more easily will treatment be effective and complications avoided. The diagnosis of this disease in many instances is not a one-man job; it may require the special services of the allergist, the rhinologist, and the roentgenologist.

The value of the history is directly proportional to the historian's knowledge and experience in clinical allergy. The more he knows about possible causes of trouble and the more carefully he traces the relationship of the patient's symptoms to contacts with such causes, the fewer skin tests will be needed and more likely the tests will be helpful. We

must, therefore, go into minute detail as to environment and occupation. We must inquire into the timing of symptoms with relation to season, weather, wind, temperature, day of week, time of day, menses, geographic location, place of residence, indoors or outdoors specific activity, work, vocation, foods, meals, medicines, companions, animals, insects, and insecticides.

The physical examination, in addition to the usual routine one, must include special studies of the nose and sinuses, both clinically and by X-ray. Of course, no clinical examination is complete without transillumination of sinuses and the use of nasopharyngoscope. Nasal polyps are not diagnosable with certainty by inspection alone. Biopsy and microscopic section are necessary to rule out other polypoid growths. The finding of mucous polyps in the nose is positive proof of the allergic etiology of the patient's trouble.

Skin tests for sensitivity are an essential part of the diagnostic procedure. Their value, however, depends upon the ability of the one who selects the substances to be tested and how interpreted. A detailed history prior to skin test will often give a definite clue concerning who would have a general reaction. By the same test, there must be a close correlation between the history and skin test; and treatment must be based on history. If symptoms persist or recur, new tests and reevaluation are in order.

The range of substances to be tested will vary from case to case, but certain general rules apply. In each instance the common inhalants must be included: chicken feather, duck feather, goose feather, cat hair, dog hair, sheep wool, cotton-seed, kapok, silk, flaxseed, orris root, glue, and corn. Additional inhalants to be added depend on the history of exposure. Because of the frequency in these cases of a secondary diagnosis of hay fever, the pollens occurring in the patient's part of the country is essential. Foods may or may not be tested, but one must be able to reproduce the symptoms with the foods. One substance that should not be omitted is the patient's own house dust.

Treatment

Treatment of perennial allergic rhinitis will be discussed from the standpoints of:

- (1) Allergic factors
- (2) Complications
- (3) Measures for symptomatic relief

Allergic Factors

(1) Complete avoidance of offending allergens to which the patient is sensitive gives by far the best therapeutic results. The avoidance of inhaled factors is always possible but often difficult or impracticable. Because of this a compromise is too often made.

Animal danders are among the most common and most important antigens in our home, particularly so in our bedroom where we spend at least a third of our lives. There must, therefore, be no compromise

in the matter of complete avoidance of these substances in our bedroom. Yet, time and again, the patient's roommate continues to sleep on a feather pillow or a horse hair mattress. Covering the pillow or mattress with so-called allergen proof casing does not establish complete avoidance of the contact. Such covers reduce the intensity of exposure and are therefore helpful. There is now commonly available air foam and fiber glass bedding. Every trace of an inhalant allergen must be removed from the bedroom.

Pollens and mold spores can be completely avoided only in an oven where these substances do not exist, or at sea, or in a room supplied with filtered air, with which every hospital should be equipped.

Specific organic dusts of many kinds present similar problems. Pyrethrum insecticides should never be used in the homes of patients. Occupational dust can be completely avoided as a rule only by a change of occupation.

Avoidance of house dust presents a common and important problem. Complete permanent avoidance may be achieved by a change of residence, but often such change fails to bring relief because the source of trouble lies in the old furnishings which were moved to a new residence. Complete temporary residence is often possible by a visit elsewhere or even a stay in the hospital.

Avoidance of specific foods, which is always possible, is beset by many difficulties. In this, regardless of skin test, no food should be eaten which experience has shown to cause symptoms. Complete avoidance is difficult because the forbidden substance can be hidden ingredients in food mixtures. If you don't know what's in it, don't eat it.

(2) Partial avoidance of offending allergens and desensitization or hyposensitization becomes necessary when complete avoidance is impossible or impracticable.

Partial avoidance of allergens is a very important, but much neglected, therapeutic procedure. By this procedure, the production of symptoms may be lessened, as very little antigen may produce no symptoms or mild symptoms. Hyposensitization of a patient is rarely complete, usually affording only limited protection adequate to prevent symptoms on moderate exposure. Partial avoidance, therefore, is vital to the senses of hyposensitizing treatment. Occupational dusts may be partly avoided by the use of masks and by means of dust-removing suction devices in workrooms.

The amount of house dust productive of symptoms may be lessened greatly by the following measures: have walls painted instead of papered; leave bedroom floor uncovered, or at most with a washable rug; have few or no drapes, no pictures, no hot air heating, no ventilating circuits unless the air is filtered, no animal pets, and no pyrethrum containing insecticides. The bedroom door should always be closed to keep out dust from the rest of the house.

Pollens may be partly avoided by the use of an air filter in the bedroom and workroom, by keeping the bedroom windows closed and by spending the holidays at the seashore or in the woods.

(3) Desensitization becomes necessary when complete avoidance and partial avoidance fail to give complete relief. This is done by the subcutaneous injection of increasing amounts of an extract of the specific allergen.

In perennial rhinitis the most common substance in such treatment is house dust and mixed pollens. In a small percentage of cases, one uses orris root, feathers, animal danders, or occupational dust. Eggs, milk, and wheat are the only foods for which desensitization need be attempted.

In performance of hyposensitization, certain precautions as to procedure are worth mentioning. Use the proper extract. Begin with a small enough dose. Do not give the injections too frequently. If the reactions are mild, use the same dosage. When the patient has obtained symptomatic relief, level off the dosage; and after a few dosage, prolong the interval up to a month if the patient does well.

So-called non-specific desensitization with histamine and peptide are completely worthless procedures.

From the practical point of view, certainly, the most effective method at the present time for dealing with nasal polyps and polyposis in intrinsic cases is simple excision or coagulation and cauterization of polypoid degenerative tissue as it appears. But it must be remembered that surgery usually fails to control the nasal obstruction resulting from perennial allergic rhinitis, although it will in many instances result in certain benefits to the patients. It is impossible at the present time to select in advance patients who are certain to receive such improvement or cure.

Surgery directed toward improvement of the nasal cavities, mechanically and physiologically, and toward lessening sinusitis in the antrum, ethmoid and sphenoid sinuses, offer less risk of a poor local result in the nose and sinuses, and probably a better chance for improvement in allergic rhinitis than more radical procedures.

The treatment of infection calls for particular care. Bacterial allergy is a common factor in these cases. Its behavior differs from that of other types of allergy, its local manifestation of edema and hyperplasia of mucosa are more chronic and are intermingled with ordinary process of infection, and the skin tests are negative. A small injection of autogenous vaccine may result in dramatic and serious constitutional symptoms.

Cooke and his associates showed improvement in this group treated with autogenous vaccine and surgical removal of sinus infection. The initial dose should not exceed five million organisms subcutaneously (0.5 c.c.—100 million organisms). Given once weekly, this should be increased by five to 10 million organisms up to a dose of 100 million organisms. Reactions call for a modification of dosage even to the point of discontinuing the vaccine.

Symptomatic Measures

Measures to bring symptomatic relief are of less importance in the treatment of rhinitis. These drugs have no effect on underlying sen-

sitivities which may actually increase in number and degree during the use of drugs. In addition, their excessive use in the hands of patients may result in a diminished effectiveness, so that the patients are deprived of what could at times be a very useful contact. Finally, there are recorded instances of development of sensitivity to the drugs themselves.

Symptomatic measures nevertheless play a very helpful, though secondary, role in the management of this disease. They add greatly to the comfort of the patient when used at judicious intervals.

Since this is a rhinologist meeting, I shall only mention in passing the usually sympathicomimetic drugs. Atropine lessens the local edema and sharply diminishes the nasal secretions. This drying effect greatly restricts its usefulness but is less troublesome when small dosage is used, 1/150 or 0.13 mgm. in connection with other drugs, especially ephedrine.

The drugs, including epinephrine, ephedrine, propadrine, and adrenalin, used locally have a marked shrinking effect on the edematous nasal mucous. Benzedrine, by inhalation, likewise has a strong local action. All these drugs, when used too frequently, are followed by a nasoparalysis and a consequent increase of mucosal edema, so that the patient is made actually worse.

Based on the theory that the allergic reaction is due to the local liberation of histamine, there have been developed a number of anti-histamine drugs. Extensive clinical trials have shown that they are effective in varying degrees in producing amelioration of symptoms in several allergic diseases. Their greater usefulness has proved to be in the cutaneous manifestation of allergy, especially urticaria and itching. The least effect has been noted in asthma. The second best result has been in seasonal and perennial allergic rhinitis, with a high degree of effectiveness in about 60% of all cases.

These drugs, of course, are only temporary, lasting a matter of a few hours and have no influence on the underlying allergic state. The Forneau series of chemical compounds, phenolin ethers, were found to be anti-histamine in 1933. The first of a long series was antigen, followed by a host of others, such as benadryl, pyribenzamine, neoantigen, trimetren, and others.

The ill effects are somewhat more marked with benadryl than with neoantigen. Drowsiness, up to the point of actual stupor, is the most common—others being irritability, nausea, vomiting, and insomnia. To some extent these can be controlled or modified by lowering the dosage, and drowsiness is no drawback at night. Unfortunately, protracted use has at times resulted in development of sensitivity to the drugs, necessitating their withdrawal.

It is highly probable that even more effective anti-histamine substances will soon become available. These drugs tend to lessen the local reaction at site of a skin test. Patients should, therefore, be warned not to use these drugs less than eight hours before a skin test.

Conclusion

It deserves to be reemphasized that every case of perennial allergic

rhinitis, however mild, if allowed to continue, is in danger of secondary complications by infection of the sinuses and by the development of mucous polyps. The record of therapeutic results just stated showed that such complication definitely lessen the patients's hope for cure. What is even more serious, every patient untreated for allergic rhinitis is a potential asthmatic; for a majority of cases of asthma are found to have been preceded by such nasal allergy. Consequently, it is the duty of the physician to regard even the mildest case of allergic rhinitis as worthy of diagnostic study and treatment.

COMPLETE INVERSION OF THE UTERUS: A CASE REPORT*

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Inversion of the uterus, or its turning inside out, is said to be one of the rarest and most serious of obstetric complications. C. O. McCormick gives an incidence of one in 23,127 cases in American hospitals and one in 8,357 cases in India. We have not come across a published report on this subject in the Philippines.

History

R.T.A., a 35-year old Filipino housewife, Para VII, was admitted to the Cagayan Provincial Hospital in the afternoon of October 21, 1948, with the chief complaints of a round, reddish mass protruding from her vagina. Five and a half hours before admission, she had delivered spontaneously to a full-term child with the placenta, under the care of an unlicensed midwife. About 3-1/2 hours after delivery, she had sat down on a chamber basin due to an urge to move her bowels; but while thus sitting, she suddenly felt a mass come out through her vagina. There was moderate hemorrhage and slight pains but no signs of shock. A physician was called in, and he advised that she be confined in the hospital.

The patient had five children by her first husband and two by the present, but all her deliveries had been normal except this last one. Had her menarche at age 17, and menstruation has been normal since then. The physical and laboratory examinations showed nothing of importance except the finding in the vagina: a round, reddish mass, the size of a ball used in softball, oozing blood, visible externally. This was found to be the inverted fundus of the uterus.

Treatment and Observations

Condition on admission: A fairly developed and nourished, slightly pale, bed patient. Conscious and rational. Unable to urinate freely. Catheterized urine amounting to 600 c.c. was examined and found normal. Temperature — 37.7° C, Pulse — 90, Respiration — 22.

Manual reposition was soon tried after admission but was unsuccessful. Sulfadiazine, pituitrin, ergotrate, and Beclysyl 10% intravenously were given. The following morning after catheterization, reduction was again tried under pentothal anesthesia. With the closed fist of the right hand, the inverted fundus was pressed hard, gradually and firmly in the direction of the superior straight. At the same time, the stretched fingers of the left hand were dipped down to the abdomen just above the symphysis pubis for counterpressure. Sixteen minutes of maintained pressure and around 0.30 gm. of pentothal were used to return the uterus to its normal position. One big gauze pack was left in the vagina and an ab-

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dominal binder was properly applied to keep the uterus in place. Penicillin injections were started and sulfadiazine continued.

By that afternoon, the patient was already able to urinate voluntarily. She complained of slight headache and pain at the lower abdomen. No signs of bleeding. Temperature was 38.1° C., Pulse — 98, Respiration — 22. On the second and third days, the patient felt all right except for the slight headache which was relieved by aspirin. Highest temperature during these two days was 37.8° C. The vaginal pack was removed on the morning of the 3rd day. No signs of fresh hemorrhage. Beginning on the 4th day she had no more headache. Placed on back rest. Ferrous sulfate, parenteral Combex and Abbotoniq started. Up and about on the 7th day. Discharged on the 11th day.

Remarks

Our interest in reporting this case lies in the following: (1) its rarity and its importance as a complication and cause of hemorrhage during the 3rd stage of labor and immediately after delivery; (2) it is an acute and complete inversion; (3) the absence of shock in this case which is a prominent symptom in cases of inversions; (4) its spontaneous occurrence in a Para VII following voluntary expulsion of child and placenta; (5) its reduction by manual reposition under pentothal anesthesia nineteen hours after its occurrence; and (6) the patient's uneventful recovery with the aid of, among others, penicillin and sulfadiazine.

At the time of this report, the patient is living and well. She had, however, an abortion of a 3-month fetus on June 24, 1950.

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UROLOGY IN GENERAL PRACTICE *

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The blood that passes through the kidneys at any single moment comprises about one-fifth of the circulating blood volume. Thus the entire urinary tract is most accessible to medication. Unfortunately too, the kidneys are also exposed to any circulating toxins, poisons, or microorganisms.

The kidneys are suspended from the midline of the body by a bundle of blood vessels around which are entwined nerve filaments of the autonomic nervous system.

The ureter, that efficient long hollow muscular tube, seldom comes into clinical prominence. But the impaction of a stone within its lumen interferes with its function as a urinary conduit with ensuing alarming symptoms.

The urinary bladder, due to its inherent ability to accommodate increasing amounts of urine without substantial increase in pressure, will comfortably accommodate up to about 400 c.c. of urine. But in the presence of a foreign body, inflammatory or neoplastic disease of its walls, frequency of urination, oftentimes excruciatingly painful and intolerable, sets in. An obstruction at the bladder outlet or in the urethral canal may produce the opposite. Frequency of micturition and urinary retention are symptoms of the most distressing nature.

The prostate with its sieve-like structure of glands and rich blood supply is second only to the kidney in frequency of metastatic infections. Being at the cross-roads of the urinary and genital tracts, the prostate may produce a confusing symptomatology.

Such random observations on the anatomy and physiology of the genito-urinary tract will form the basis for the clinical notes that follow.

Renal Infections

The most important avenue of infection to the kidneys is the blood stream. A transient bacteremia ushers in the well known chills of acute renal infection. The fever could be mistaken for fever of non-renal origin but a catheterized specimen of bladder urine will show pus cells if the case is one of pyelitis. Pain in the lumbar area and tenderness at the costo-vertebral angle will clinch the diagnosis. Many times such renal pain is more important than pyuria, for the urine may remain free from pus cells if the renal infection is cortical and has not yet broken

* A clinical lecture read at the 28th Scientific Meeting of the Pangasinan Medical Society held in Dagupan City on October 29, 1950.

into the uriniferous tubules. Closed pockets of pus within the renal substance produce more renal pain and tenderness, more chills and fever. Pyuria makes the diagnosis of renal infection, but its absence cannot deny it. Typical instances have been seen of chills, fever and loin pain with clear urine to be followed in a few days by lowering of the fever, disappearance of the pain and a clouding of the urine. Occasionally the renal tenderness rapidly leads to increasing bogginess in the loin. The skin becomes slightly edematous, superficial veins more prominent, the ill-defined swelling thus palpated leading to the diagnosis of perirenal abscess. A limited incision and drainage is mandatory over the most prominent part of the swelling in the loin. The cut must be made deliberately layer by layer, not by the usual stab method employed for a furuncle. In this manner one will feel when he has opened up the deep lumbar fascia under which the pus is pressing. The peritoneum is far from the site of the incision having been pushed forward by the perirenal abscess. Only after the pus has been drained may antibiotics be given. Evacuation of an abscess is still more important than any antibiotics thus far known.

Urinary infection and obstruction constitute a vicious cycle with clear cause and effect relationship. It would constitute an idle exercise in mental gymnastics to try to determine which came first in any given case. Urinalysis may reveal infection, radiography a stone. Experience has shown that the majority of cases of urinary stone sooner or later develop infection, thus for practical purposes when seen together, infection may be considered secondary. It will be futile to drench the patient with the latest or the most expensive antibiotics without first removing the stone.

The patient with pyuria of short duration, with loin pains and fever and a negative radiograph, is a typical medical case where urinary antiseptics play a role. Almost anything will cure this patient, ranging all the way from increased fluid intake or citrus juices, to alkalinization with potassium citrate, to the cheap and common sulfa, to the still more common penicillin, to the more expensive and harder-to-get newer antibiotics. But patient and doctor may be disappointed. The causative microorganism may not be susceptible to the drug, or may develop a resistance to it. A preliminary methylene blue smear of the urinary sediment should indicate the corresponding urinary antiseptic. But the usual way, probably the lazy man's way, has been to try one urinary antiseptic after another, or to give them all at once. *B. Coli* is the commonest germ involved in pyelitis or pyelonephritis. Against this, penicillin is useless.

A word of caution must be enjoined in the use of urinary antiseptics. Sulfa drugs and antibiotics once absorbed into the blood are excreted almost completely by the kidneys. The urine, of all body excretions therefore, contains the highest concentration of the drug. For urinary tract infections, much smaller doses may more effectively be given. As a general rule only 1-2 grams daily of the sulfa drugs are required, for not more than 10 days. This minimal dosage will avoid

sulfonamide crystalluria or lower nephron nephrosis. There is a greater tendency to use more of the antibiotics and to relegate the sulfa drugs to the background. At recommended dosages the former are more effective against urinary infections, specially aureomycin and chloramphenicol. The Gram negative bacteria like *B. Coli* which are the frequent microorganisms associated with such infections are highly susceptible to antibiotics. For the coccal infections penicillin is still the best. Crystallization of sulfas in the urine and anuria due to lower nephron damage are more serious complications of this type of therapy than allergic reactions which might possibly attend penicillin or streptomycin therapy.

Most urinary tract infections will subside with such a regimen within one week. The occasional case which resists such therapy or which is really a recurrence of the same condition will require a reevaluation of the diagnosis. Foci of infection in the teeth, tonsils and nasal sinuses, in the prostate, in a constipated colon, must be sought for. Their correction will always improve the renal infection, but promiscuous pulling out of teeth, or yanking out of tonsils is not to be done for fear of leaving the patient a dental invalid without curing the renal infection. Finally a complete urologic study may have to be done.

Floating Kidney

A woman, for such the patient usually is, with vague abdominal symptoms of dragging pains, lumbar ache, flatulence, etc., in whom a kidney is palpated to be low and movable, would naturally be given the diagnosis of nephroptosis or floating kidney. To rush to do a kidney suspension operation would be courting disappointment in end results. An absolute indication for nephropexy would have to be established. Hydronephrosis must be shown by pyelography. A short period of corset wearing with resulting relief of symptoms must be observed. Then a nephropexy would be successful. The intimate relationship of the innervation of the kidney with that of the gastrointestinal tract through the celiac and other ganglia of the autonomic nervous system explains the confusing symptomatology of nephroptosis. Then too, similar symptoms arising from other abdominal organs might be mistakenly ascribed to a nephroptosis, if the kidney by coincidence should be low.

Ureteral Calculus

Colic resulting from the passage of a stone down the ureter is usually correctly diagnosed by the typical symptoms and the presence of red blood cells in the urine. But when it is associated paralytic ileus, peritonitis might be suspected, specially if the radiograph fails to show the shadow of the calculus through the gas-distended bowels. In such a predicament ureteric catheterization through the cystoscope and retrograde pyelography may clear the doubt. But when clinical and blood findings indicate acute appendicitis, let me be the first to emphasize that an appendectomy must be done regardless of red blood cells in the

urine or a shadow of stone in lower ureter. An inflamed appendix in the neighborhood of the ureter or bladder has oftentimes caused hematuria or painful frequent urination. Moreover a stone in the ureter does not usually require an immediate operation. An operation to remove the acutely inflamed appendix must be done even if there were a stone in the ureter at the same time.

Cystitis

Women may be afflicted with frequent urination of scanty amounts more or less associated with terminal dysuria. It is important to determine whether this is the first attack or one of a series. In the case of first attack of cystitis the common causes would be ascending infection from urethra, ingestion of spicy foods, trauma to the external genital or injudicious catheterization after an operation. The urine will be found to have pus cells and red cells. The whole attack subsides within one week, recovery being hastened by hot Sitz baths, alkaline drinks, and a sulfa drug at a dosage of 1 to 1½ grams daily for not more than 7 days. Sulfacetimide might be preferred because it is more effective against *B. Coli* germs, the common etiologic factor in this type of cystitis. For such a mild disease there could be possibly no excuse for the use of the more expensive antibiotics.

If the attack of cystitis is but one of a series of recurrences the management and treatment will be the same but a careful search for etiologic factors in the upper urinary tract or elsewhere must be performed. Plain radiography will detect urinary stone, an intravenous pyelography might lead one to suspect a kidney as the cause of pyuria. A cystoscopic examination many times is the only way of studying the causes of recurrent cystitis. The urethra may reveal a stricture, if a metal sound of size 20 Fr. is grasped tightly upon insertion. The inner margin of the urethral canal or the region of the internal vesical sphincter may show polyps. The base of the bladder or trigone may show congestion or small pin-point follicles. Finally both ureters must be catheterized. The segregated kidney urines are individually studied for pus cells and microorganisms then a retrograde pyelography performed. A careful vaginal inspection should be made for in many instances a chronic endocervicitis is found. The chronic leucorrhoeal discharge may be infecting the bladder by ascending infection from the urethra; or a cervical infection may be reaching the bladder through the rich lymphatic network that is between the cervix of the uterus and the bladder. A constipated state of the bowels provides a fertile source of *B. Coli* germs in recurrent cystitis. The treatment will follow the same general principles used for the first attack of cystitis but unless the primary cause is attended to recurrences are certain. Constipation and endocervicitis fall within the realm of general practice for their treatment. The other causes like urethral stricture and urinary stone will require special measures.

Renal Tuberculosis

There is still another type of "cystitis" which defies all the skill of the practicing physician, even after its etiologic agent has been dis-

covered. Such is tuberculous cystitis, which may manifest itself simply as frequency of urination and the passage of slightly turbid urine. In a country like ours with a high incidence of pulmonary tuberculosis, the physician would do well to think of every case of chronic cystitis as possibly tuberculous. Tuberculosis of the bladder is always secondary to the kidneys or prostate gland, moreover, renal tuberculosis is always secondary to an extrarenal focus. These pathologic facts support the diagnostic acumen of the physician whenever he meets an intractable case of cystitis. Intractability really means that the usual therapeutic measures failed in alleviating the patient. The index of suspicion will be raised if the urinary sediment fails to demonstrate any microorganisms with the ordinary laboratory stain, although pus cells will be abundant. Bladder urine must be catheterized and repeatedly studied with special acid-fast stains for the tubercle bacillus. A culture of the urine for tuberculosis or guinea pig inoculation could not be done in the small laboratory. But I believe it is worthwhile for the sake of the patient to make arrangements to have these special tests made by competent laboratory workers. The former objection to the long wait of 4 to 6 weeks required for the guinea pig test no longer holds today because the period of waiting can with profit to the patient be judiciously spent with daily injections of one gram of streptomycin. True it is that this therapy so far has not shown any evidence of pathologic cure of caseous ulcerative lesions in the urinary tract but the infiltrating types of the disease or the acute inflammatory reactions attending thereon clear up quite rapidly. When the final report from the animal inoculation comes the patient is that much readier for operation which is still the most important part of treatment in urinary tract tuberculosis. The clinical diagnosis of urinary tract tuberculosis by the practicing physician is a rough indication of his awareness and health-mindedness. From this point onward the patient must be submitted to special urologic studies to determine the extent of involvement of the urinary tract. Nephrectomy in unilateral renal tuberculosis is still the treatment of choice. Streptomycin therapy in the preoperative period widens the possibilities for surgery, in the postoperative period diminishes morbidity and complications.

Prostatism

The patient past middle age who suddenly develops urinary retention requires catheterization for immediate relief. The successful introduction of a 16 Fr. rubber catheter eliminates the possibility of urethral stricture. After catheter has thus been inserted and urine completely evacuated, the diagnostic study may proceed at leisure. The commonest symptom elicited but which may not have seemed important to the patient is nocturnal frequency of a few months duration. The patient will then readily admit that he has been noticing a gradual diminution in the size and force of the stream of urine. The attack of urinary retention may have been precipitated by a head cold, wetting of the feet, ingestion of spicy foods, or alcoholic drink. Such an array of precipitating factors could conceivably take place after a duck-hunting expedition

over the week-end. The resulting acute congestion of the prostate gland throws into a sudden closure the pre-existing partial tightening of the urethra surrounded by the hypertrophied prostate. In some instances, a few days of catheter drainage by resting the bladder and adjacent prostatic urethra will so reduce the congestion as to allow the resumption of a quasi normal mode of urination. The rectal examination will of course have already revealed an enlarged, smooth, elastic prostate gland. This may reduce in size after a few days of catheter drainage but will still remain larger than normal. The catheter may diminish congestion but not the hypertrophy.

An attack of urinary retention produced by prostatic hypertrophy frequently predisposes to another attack. In the meantime the increasing amount of work required of the bladder to empty itself sooner or later leads to atonic dilatation and hydronephrosis. The physiologic derangement in the kidney is the most important and sometimes fatal complication of prostatic hypertrophy. The physical discomfort of difficult urination or retention brings the patient to his doctor, but the latter in alleviating the physical complaints must never lose sight of the renal factor.

As long as blood chemistry values for total non-protein nitrogen and urea indicate adequate renal function, temporizing medical measures are all right. When signs of nitrogen retention appear in the blood, surgical intervention must be seriously considered.

Prostatitis

When a patient is suffering from sciatic neuralgia intractable to the usual salicylate and B-complex therapy, or when there is pain or sensation of heat in the perineum and burning sensation on urination, the routine physical examination must emphasize the prostate. If it is found to be normal or slightly enlarged, boggy, occasionally slightly tender, it should be gently squeezed to obtain its secretion. A drop of the latter on a slide will show more than 10 pus cells per high power field whenever the prostate is chronically inflamed. If the pus cells are clumped together they are evidence of minute collections of pus within the substance of the prostate. Chronic prostatitis thus diagnosed can cause metastatic symptoms in the sciatic nerve or local symptoms in the posterior urethra.

It must be emphasized that chronic prostatitis will show gonococci in its secretion in only 30% of cases, the great majority being due to non-specific microorganisms, like *B. Coli* and staphylococci. The latter may come as secondary invaders after the gonococci have disappeared or may have reached the prostate through the blood stream from local areas of infection like the nasal sinuses, chronic gall bladder disease, the constipated colon, or kidney infection. The prostate pathologically speaking is in the paradoxical position of being liable to infection by gonococci from the urethra or non-specific germs from distant parts of the body. At the same time it is able to transmit its own infections to such structures as the sciatic nerve or iris of the eyeball.

The sulfa drugs and the commonly used antibiotics always favorably influence chronic prostatic infection. But I have not seen any patient with this disease who has fully recovered bacteriologically and permanently solely by their aid. The prostate gland, when chronically infected is in bad need of mechanical drainage, and not unlike a dirty sponge can only be cleaned of its purulent collections by manual squeezing. I have seen patients lately with chronic prostatic infection who had been referred for persistence of prostatic symptoms or intractable urethral discharge. When first seen by me they have already been treated extensively elsewhere with all the available antibiotic drugs, singly or in combination, so that pharmacologically speaking, there is nothing left for me to do. Yet by repeated prostatic massage, usually not oftener than once a week, their prostatic secretion has cleared under microscopic scrutiny, their glands have lost their boggy, have shrunk and become more elastic. Most of the symptoms have faded out, even without the use of a single antibiotic which, by their previous failure in the hands of others, have demonstrated to me that bacteriological cure can only be perpetuated through mechanical means.

In summary allow me to repeat that by virtue of the anatomic structure and function of the genito-urinary tract, infections constitute one of its most important diseases which can be perpetuated into a vicious cycle by mechanical factors or by foreign bodies such as calculi; that the mechanical problem of urinary obstruction caused by prostatic hypertrophy is overshadowed by the dire consequences of renal failure; that sulfa drugs and antibiotics always favorably influence genito-urinary infections, but a lasting bacteriologic cure will only take place if pre-existing obstruction has been removed; that renal tuberculosis constitutes an important problem in local medical practice.

OBSERVATIONS IN OBSTETRICS AND GYNECOLOGY ABROAD *

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Most of the hospitals I visited are teaching hospitals connected with medical schools. The most striking general impression they give is of wealth, of enormous and numerous buildings rising from ten to twenty stories high with many elevators. The hospitals are fully equipped and well manned. There is adequate pay for their personnel. Cleanliness and orderliness, as is to be expected, is the outstanding quality in most of them.

The Cook County Hospital and the Bellevue Hospital, each of which has over 1000 beds, are the least clean of all because of the great number of indigent Negro patients. The toilets which of course are separate for men and for women are very clean, equipped with running hot and cold water, soap, paper towels and toilet paper. The departments of obstetrics and gynecology whether separate (as in Johns Hopkins and in Boston Lying-in) or united (as in Cornell, Columbia, and University of Pennsylvania) have each in all the institutions visited three or more operating rooms of their own, (separate from the surgical department) four delivery rooms, eight or more labor rooms which may accommodate one or two patients, a complete X-ray unit with its corresponding personnel, a laboratory with three or more technicians who work exclusively for the department. In most of the teaching hospitals visited, the obstetrical or gynecological or obstetrico-gynecological (when united) department have a special laboratory for research work containing not only apparatuses and chemicals, but also a colony of animals—mice, guinea pigs, and monkeys for experimental purposes. So that in most cases, not only clinical work is done but research work is carried out with much activity. The hospitals that are specially equipped for research work are: The University of California Hospital, Chicago Lying-in, University of Pennsylvania Hospital, Peter Bent Bringham Hospital, Johns Hopkins and New Haven Hospital. The laboratory for research work also exists for other departments such as surgery, medicine, etc. The obstetrico-gynecologic department is a complete unit having not only wards, private rooms, labor rooms, delivery rooms, operating rooms, but also an X-ray unit, a blood bank, a library, a photographer and an artist for drawing specimens, laboratory facilities not only for routine examinations but for research work with sufficient personnel of doctors, nurses, technicians, attendants, ample linen, and material to work with. Each chief of a department and the one next

* Due to lack of space this report has been abridged.

Dr. Acosta-Sison represented the Republic of the Philippines, the Philippine Medical Association and the Philippine Obstetric and Gynecologic Society at the First International Congress and Fourth American Congress of Obstetrics and Gynecology held at New York City on May 15-19, 1950.

At the Centennial Graduation of the Woman's Medical College, Pennsylvania, she was awarded the Honorary Degree of Doctor of Science.—THE EDITOR

to him have each an office and a secretary, who also has an office of her own.

Residents

A new graduate enters the hospital service as an interne. If he is desirable, he is promoted at the end of one year to assistant resident and yearly he is promoted until he gets to be chief resident at the 4th year. The appointment is renewed every year so that if he does not come up to the standard, he is not reappointed within the period of his residency. No resident stays longer than four or five years. If he is good material after he leaves the residency, he may be appointed assistant instructor, and later instructor but *without salary*. In both Johns Hopkins and University of Pennsylvania, there is a long list of instructors in the various departments none of whom receive salary. All the compensation the instructors get is the prestige of being connected with a credited institution. Most of the instructors work in the dispensary.

Source of Income of Hospitals

With the exception of the San Francisco County Hospital, the Cook County Hospital of Chicago, and the Bellevue Hospital of New York, the above listed hospitals are privately endowed.

Do the Patients Pay?

In all the hospitals whether privately endowed or supported by the city where the hospital is located, the patients are classified as private and clinic patients. The private patients pay the regular fee of a private room costing from \$12.00 (New Haven) to \$30.00 (New York) per day plus the doctor's fee (ranging from \$200.00 for normal delivery to over \$1,000.00 for abnormal delivery) of the attending physician belonging to the non-resident staff.

The clinic patients who are used for teaching medical students pay from \$85.00 (U.C. hospital) to \$180.00 (Cornell University Hospital) for the prenatal care, delivery, hospitalization and postnatal care of a maternity case. These patients are assisted by the residents under the supervision of a ranking member of the staff or the chief of the department. All patients who apply as clinic patients are investigated as to their financial status. With some patients it is the life insurance company in which they are insured that pays their bill. For absolutely indigent patients who have neither income nor money, the city pays the bill, so that the hospital receives money for each patient treated.

And though each patient pays, all the hospitals complain of deficit in their funds. Their expenses always exceed their earnings.

Prenatal Care

This is a very important work in all maternity hospitals. It is taken care of in the outpatient department. All the patients that deliver in a given maternity hospital have been registered in the outpatient department where they are regularly examined, advised and treated until they

are finally delivered. Anyone who has a blood pressure higher than 140° systolic is hospitalized and when the blood pressure cannot be lowered within four days, pregnancy is discontinued. The low salt diet during pregnancy as a prevention of toxemia is well recognized and insisted upon, specially in Chicago Lying-in Hospital (connected with the Chicago University). The influence of diet is specially insisted upon in Boston Lying-in (Harvard University) where a nutritionist also takes part in the prenatal care, specially cases that are hypertensive or that gain undue body weight. Such women while they are counselled to ingest adequate protein, are prohibited from overloading themselves with starchy food like pies, potato chips, spinach, ice cream, peanuts, fatty and salty foods. But they are counselled to take one quart of milk daily.

In New Haven Hospital (connected with Yale Medical School), the prenatal care consists of not only the regular examination and instructions as carried out in other hospitals, but also in the regular performance of certain regular exercises with the view of facilitating easy normal delivery. The New Haven Hospital under the directorship of Herbert Thoms believes in what is called natural childbirth. During labor analgesia is not encouraged but if the patient asks for it, she is given the sedative as in other hospitals.

Obstetric Analgesia

Most clinics use demerol and scopolamin either alone or in conjunction with a barbiturate after labor has well started and inhalation anesthesia during the perineal stage. Outlet forceps is often done to hasten delivery. In premature pregnancies, however, no analgesia is given for the sake of the baby. The Stanford University Hospital uses caudal anesthesia routinely when the cervix is 3 cm. dilated. Johns Hopkins Hospital uses caudal anesthesia for certain cases. Most hospitals, aside from those mentioned above, are against the use or do not care to use caudal anesthesia not only because of its high technicality, and of the necessity of having enough personnel to continually attend the patient, but because such a method of anesthesia is not without danger. They have had complications from the use of caudal anesthesia as urinary incontinence and prolonged semiparesis of the lower extremities. I have seen caudal anesthesia skilfully administered by young residents of Stanford University Hospital and its quick analgesic effect.

Special Construction of Wards in Certain Hospitals

The University of Pennsylvania Hospital and the Boston Lying-in Hospital have at the end of each ward a rounded solarium walled in by glass windows. The solarium has plenty of fresh air and sunshine. It is used as a social hall for walking patients.

Operative Gynecology

I tried to observe as many obstetrical and gynecological operations as possible in all the hospitals visited. But the greatest number of major surgical operations I saw was at Stanford University Hospital in San Francisco, Chicago Lying-in Hospital, the Cornell University Hospital,

the Memorial Hospital, the Beth Israel Hospital, and the French Hospital of New York, the Montreal General Hospital, the Royal Victoria Hospital, the hospital of the University of Pennsylvania and the Johns Hopkins Hospital.

I was fortunate to have attended a three-day clinical demonstration of the Montreal gynecologists in honor of the distinguished British obstetricians and gynecologists who attended the International Congress.

During this time, the top Montreal surgeons and the English surgeons took turns in performing difficult major operations. In the afternoon, obstetrical and gynecological papers were read, after which I took an active part in the discussion that followed. My comments were favorably received.

Anesthesia for Gynecological Operations

Different hospitals use different forms of anesthesia. The Chicago Lying-in Hospital uses continuous spinal anesthesia. The anesthesiologist is a woman doctor. In Montreal, spinal anesthesia is also used and the anesthesiologist is a physician. The rest of the hospitals like the University of Pennsylvania Hospital, Johns Hopkins, Cornell University and the rest use inhalation anesthesia of a mixture of ether, nitrous oxide, and oxygen. Others use cyclopropane anesthesia. In some clinics, like Johns Hopkins, the anesthetist is a nurse. Most hospitals have doctors as anesthesiologist. And not only does he give the anesthesia but he also is the one who pays attention to the general condition of the patient, giving her intravenous glucose or blood, or any stimulant that he may think necessary. This enables the surgeon to concentrate his attention on his operative work.

THE FIRST INTERNATIONAL CONGRESS AND FOURTH AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

The congress was well attended by scientists, not only from the United States, who of course formed the largest number, but from all over the world. Most of them were great obstetricians and gynecologists, though some were pediatricians and psychiatrists. Many were directors of hospitals and superintendents of nurses.

The papers were all interesting but it was impossible to listen to all of them. Because of their great number, the conferences were held simultaneously in three different rooms. The countries that were represented by those who read papers were: the United States, Canada, England, Ireland, Scotland, Sweden, Holland, Switzerland, Norway, Germany, Austria, Australia, France, Belgium, Spain, Finland, Yugoslavia, Africa, Palestine, Japan, India, Formosa, Philippines, Cuba, Argentina, Brazil, Chile, Uruguay, and Mexico. The invited guest-delegate from Czechoslovakia withdrew his acceptance at the last moment because of his belief that "science and politics cannot be dissociated." Commenting on this statement, the Chairman of the Program Committee said that he thought that science was universal, knowing no distinction as to race, color, creed, nationality, or political affiliation, and he regretted very much the absence of the Czechoslovakian delegate.

One of the big surprises I had in the Congress was that India, of whom we know more for its mysticism, its philosophic theories, its caste divisions and practices, and pre-war Gandhi's civil disobedience rather than for scientific accomplishments, was represented by a native delegate, a gynecologist-surgeon who advocated a most radical operation for cancer of the cervix, using the same technique as that presented by the delegate from Graz, Austria. Both devised the same technique but independently of one another. The operation consists of extraperitoneal lymphadenectomy and vaginal panhysterectomy. Wertheim performed his radical operation from above. So does Meigs who is more radical than Wertheim, and so does Brunshwig who is the most radical operator in advanced cases, for in addition to panhysterectomy and lymphadenectomy, he removes also the bladder and rectum. Schauta, who is as radical as Wertheim, operated entirely from below.

Another paper that attracted much attention was one presented by Rosa of Belgium concerning a new method of prenatal sex diagnosis. He withdraws by aspiration 20 c.c. of amniotic fluid from the upper abdomen at the site of the small parts. He stains the cells of the amniotic fluid with Papanicolaou's stain. If the cells stain pink, it means the cells contain glycogen and the baby is female. If the cells stain blue, the baby is male. I would say that this method is not entirely without danger and needs much caution.

Dr. Reid of Boston read a paper on "Postpartum Hemorrhage Associated with Alterations in the Coagulation Mechanism." He said that the remedy for such cases is the injection of fibrinogen in addition to blood transfusion.

Vitamin A had been found to have curative value by Hymans of New York, in the treatment of leukoplakia vulvae.

Vitamin A was also found to prevent the recurrence of bleeding by Medina of Brazil in cases of metrorrhagia of puberty treated by spleen irradiation.

There were symposia on different interesting obstetrical topics such as cesarean section, toxemias of pregnancy, thrombo-embolic disease and diabetes of pregnancy.

There was only one paper dealing on chorioepithelioma and it was presented by the Philippine delegate. The title of the article was "The Clinical Diagnosis of Uterine Chorioepithelioma." Long before the Congress, an eminent pathologist remarked to the author of the article that chorioepithelioma cannot be diagnosed clinically. He claimed it can only be diagnosed by the microscope; and that one should not perform any radical operation until the microscopic diagnosis is established. Other doctors wondered why there was such a relatively high incidence of chorioepithelioma in the Philippines.

After the reading of the article, the first remark was made by Dr. Whitacre, an American obstetrician, who is now Professor and Head of the Department of Obstetrics and Gynecology of the University of Tennessee, who happened to be in Manila during the Japanese occupation. He said that he had seen "several cases clinically diagnosed by Dr. Acos-

ta-Sison as chorioepithelioma where the diagnosis was confirmed either by the microscopic examination of the hysterectomized uterus or at autopsy." He further stated that in the few months he stayed in Manila he saw more cases of chorioepithelioma than he had ever noted in his many years of practice in the United States.

The remarks of the commentator confirmed the fact that uterine chorioepithelioma can be diagnosed clinically which would lead to an early removal of the uterus before metastasis occurs.

Dr. Herbert Thoms, Professor of Obstetrics and Gynecology, Yale University School of Medicine and Head of the Obstetrico-Gynecological Department, New Haven Hospital, is the American obstetrician who with some modifications is carrying out the principle and practice of Natural Childbirth as first enunciated by Sir Grantly Dick Read wherein the normal pregnant woman from the early months of pregnancy is prepared psychologically and physically for natural delivery without prolonged analgesia that will cause asphyxia to the baby. It is the safest procedure for both the mother and the baby. Dr. Thoms honored me with a gift of his book "Training for Childbirth." He took me to see how a class of prospective mothers were taught how to perform exercises conducive to a natural delivery. The psychosomatic approach rather than sedative drugs is employed among the prospective mothers so as to insure the normalcy of their condition and of that of their offspring. Sedatives or light anesthesia is employed only when there is necessity. It is not employed as a routine for all women in labor as is done in many clinics.

New Haven Hospital is also experimenting on the practice of "rooming in" which means that the newborn baby is kept in the same room with the mother. The department of pediatrics which has a psychiatrist in its staff works in close cooperation with the department of obstetrics and heartily endorses the rooming-in project. The psychiatrist believes that rooming-in has a satisfying emotional effect on the mother and a wholesome influence on the foundation of the personality of the child. Some mothers like the arrangement for the sight and nearness of their baby makes them content and happy. Other mothers would rather have their babies in the nursery for they do not wish to be disturbed while resting. The hospital is endeavoring to cement greater unity between the mother, father and child by allowing the father not only help his wife during delivery but also hold his child at visiting hours. During such times he is made to don on sterile gown. What they try to do is what our poor families do as a matter of course, the only exception is that the father is made to wash his hands and to put on a sterile gown. The authorities of the hospital believe that the child needs for its normal development as much love and affection as adequate and balanced food.

I left the hospital and its personnel with much respect for the principles they endeavor to carry into practice.

REVIEW ON MATERNAL DEATHS

By the Committee on Maternal Mortality
Philippine Obstetrical and Gynecological Society

NOTE:

This review on maternal deaths was started in June, 1950 on the suggestion and guidance of Dr. C. P. Manahan. To start with, materials from only five big hospitals in the City of Manila — Philippine General Hospital, North General Hospital, Sto. Tomas University Hospital, Maternity and Children's Hospital and St. Luke's Hospital — were collected. It is hoped, however, that other hospitals, clinics and private physicians will soon send their cases for review to the Committee. With the analysis of these cases we may better understand our obstetric problems, reduce our maternal and fetal mortality and elevate the standard of our obstetric practice. For lack of space only abstracts of the case histories and discussions can be presented here.

The Committee meets every month to select the instructive cases from those submitted and these in turn are discussed in the meeting of the Society. Strict anonymity is observed in the presentation of the cases. For particulars, please communicate with the Secretary-Treasurer, Philippine Obstetrical and Gynecological Society.

CASE NO. 1

R.F., 35 yrs., para V, admitted for labor pains and bloody discharge. Obstetrical history, good. Pregnancy, at term and course, normal. Labor pains with a little bloody discharge, at the start, was noticed since 24 hrs. prior to admission. They were irregular and weak until 12 hrs. later when they became intense for about 9 hrs. following which the pains became weaker and associated with gas pains and general body weakness. Husband denies any history suggestive of (salag) Kristeller's maneuver or administration of oxytocics. On admission patient showed a B.P. of 106/65 and a pulse of 120/min.; temp. 38°C. Heart and lungs, apparently normal. Cervix 7 cm. dilated; bag, ruptured, L.O.P., floating head; some bloody vaginal discharge; no placenta palpable. Uterine contractions, weak, no definite tenderness. Abdomen, distended and tympanitic; no fetal heart sounds audible. RC—2,220,000; Hb—62%, 9.0 Gm., Type O.

Patient was given crystalline penicillin 100,000 U. initial dose and 50,000 subsequently every 3 hrs. Dextrose 5% in N.S.S., 1000 c.c. with 1 c.c. (20u) pituitrin, given "I.V." in 3 hrs. and 15 min. Patient developed chills. Internal examination 3 hrs. after admission showed the cervix 7 cm. dilated, head floating, bleeding slight. Patient was quiet.

Internal examination 6 hrs. after admission, cervix 7-8 cm.; head, floating; uterine contractions, weak. Palpation showed superficiality of fetal parts and tenderness of the abdomen. Vaginal discharge—dark blood. Tympanism was more marked. Patient, dyspneic and nauseated.

A consultant on seeing the patient opined that the case was one of rupture of the uterus and decided on a hysterectomy under spinal pontocaine-procaine anesthesia. Patient's BP 100/60 to 110/70, pulse rate 120/min. Preparatory to surgery 10% glucose sol. 1000 c.c. and 250 c.c. type O blood were given followed by 400 c.c. more of type O blood. Before spinal anesthesia, BP was 96/60. After this, it dropped to 80/60 followed by sudden severe vaginal bleeding and symptoms of shock from which patient did not recover.

Autopsy findings: Hemoperitoneum severe (1—1-1/2 liters) secondary to ruptured uterus.

COMMENTS:

It is likely that the patient had at least an incomplete rupture of the uterus with concealed hemorrhage and a primary shock on admission. The rbc and the Hb % values were very low, the pulse rate was high and the patient, weak. Pituitrin may have rendered the situation worse on account of its effect on the rupture of the uterus and constriction of the coronary arteries with the resultant hypoxia of the myocardium. The remarkable quietness of the patient may have been a sign of shock which may have lead one astray. The spinal anesthesia probably rendered worse the condition of shock by vasodilation and relaxation of the uterus leading to more hemorrhage from the uterine wound. A better choice of anesthesia, endotracheal cyclopropane-curare or local anesthesia, plus more blood and at a faster rate, might have saved the patient.

CASE NO. 2

S. Y., 44 yrs., was admitted as a walking patient for abdominal enlargement of one year duration, vaginal spotting for 20 days, and amenorrhea of 2 months. The enlargement of the abdomen was very gradual. It started only as a guava fruit in size at the hypogastrium. This was painless and did not bother the patient until after it had progressed in size reaching the level of the navel. Twenty days before admission and after missing two menstrual periods, she noticed slight vaginal bleeding consisting of tiny blood clots. No pain or tenderness. Internal examination revealed gestational changes in the cervix. Body of the uterus was asymmetrically enlarged, more in the right side, this part being more doughy in consistency. Presence of pregnancy was confirmed by two pregnancy tests (male frog.)

A myomectomy was done for an intramural fibroid about the size of a man's fist. Seven hrs. after operation, the patient showed signs of internal hemorrhage, so the abdomen was opened up again and 2 liters of blood were found in the peritoneal cavity. The myometrium was also infiltrated with blood. A subtotal hysterectomy, under ether anesthesia, was performed while blood was being forced. The patient however died with symptoms of shock six hrs. after operation.

Autopsy: Hemoperitoneum, 1800 c.c.; anemia, severe, secondary; pregnancy, 2 mos.

COMMENTS:

The presence of slight vaginal bleeding which was likely due to a threatened abortion did not justify surgery, especially because the operation in itself would likely hasten the abortion. The location of the tumor was not likely to cause an obstacle to the progress of pregnancy and labor. The surgery could have been postponed until period of

viability when section (if necessary) and enucleation could have been done or possibly after puerperium when the uterus is at rest and not as bloody.

CASE NO. 3

P. V., 22 yrs., primigravida, admitted for labor pains of 9 hrs. duration. Menstrual history and size of the abdomen revealed a full-term pregnancy. BP was 122/82, slight edema of lower extremities.

Internal examination revealed the cervix 4 cm. dilated, effaced; bag, intact; head, engaged in R.O.P. Heart and lungs, normal. Seven hrs. after admission, the bag ruptured spontaneously followed by stronger and more frequent pains. Four hrs. after the bag ruptured, she developed convulsions, tonic and clonic. At the height of the convulsions the pressure rose 200/110. Morphine and magnesium sulphate were given. Immediately after convulsions the pressure dropped to 130/80. Six minutes after the attack of convulsions, the cervix was found almost fully dilated and the patient was delivered by low forceps. Soon after delivery the pressure dropped to 0/0. Cardio-respiratory stimulants were given and patient regained consciousness after 35 min. Blood transfusion was started but 15 min. later the patient again lapsed into unconsciousness and died 15 hrs. after admission.

Blood examination taken 1 min. before death revealed Hb—55%, RBC—2,350,000; WBC—32,000; polys—76%, Stabs—14%, segmented—62%, lymphos—32%, monos—2%.

NPN—33.3 mgm %

Urinalysis—was normal

Blood culture—no growth.

Diagnosis: Eclampsia, intra-partum?

Obstetric shock?

- Autopsy: 1. Congestion of the visceral organs, especially the liver, spleen and kidneys.
2. Subinvolution, uterus
3. Cerebral edema.

COMMENTS:

There is sufficient clinical evidence to warrant the diagnosis of eclampsia. What is ambiguous is the cause of the shock. For proper evaluation of preventable or non-preventable factors, we should have the following data: (1) cervical dilation at extraction, (2) ease of application of forceps, (3) estimated blood loss. One of the most frequent causes of death in eclampsia is shock—not necessarily from blood loss. One of the outstanding physico-chemical changes in eclampsia is the reduction in blood volume, and hemo-concentration giving the clinical picture of a shock. The sudden release of intra-abdominal pressure in this case may have precipitated a shock. The low red cell count suggests a hemorrhage but this was taken just a minute before death and besides the autopsy report showed congestion of the viscera. The count was more apparent than real.

This case should remind us of the importance of frequent blood pressure determinations in the patient in labor, even if the pressure is normal but especially so, if there is an elevation. An impending attack of convulsions or vascular accident may be detected on time and prevented perhaps.

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1950-1951

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Editorial

THE FOURTH GENERAL ASSEMBLY OF THE WORLD MEDICAL ASSOCIATION

The Fourth General Assembly of the World Medical Association held in New York City from October 16 to 20, 1950 was a huge success. The report of Dr. Jose R. Reyes, who served as the official delegate of our Council to this Assembly, is published elsewhere in this issue. This report will give our readers an idea of the accomplishments of this international medical meeting, which are of great importance to medicine throughout the world as well as of interest to the general public.

The WMA now includes in its membership the national medical associations of thirty-nine countries. Since its foundation, this organization has: (1) adopted the Declaration of Geneva, a statement of the moral principles to guide every physician in his work — the Declaration which has led to the adoption of an international series of principles of medical ethics; (2) completed a survey of medical education throughout the world; and (3) made a survey of social security obtaining in various nations, and an analysis of the extent to which these systems conform with the principles adopted by the World Medical Association.

In process of investigation are: (a) practice by non-medical practitioners in 24 countries; (b) regulations concerning medical advertising in 23 countries; (c) postgraduate medical education in 32 countries; (d) the status of the medical profession and medical man power in 23 countries; and (e) hospital facilities and pharmaceutical problems.

The Bulletin of the World Medical Association is published quarterly in English, French, and Spanish within one cover. It brings to the member associations the accomplishments of this world organization.

The Philippine Medical Association is deeply indebted to Drs. Jose R. Reyes, Daniel Ledesma, and Saturnino Ador Dionisio for having represented our Association in this Fourth General Assembly of the WMA.—A.S.F.

Miscellaneous

ABSTRACTS FROM CURRENT LITERATURE

ABSTRACTORS

Honorina Acosta-Sison, M.D.
Jose R. Cruz, M.D.
Felisa Nicolas-Fernando, M.D.
Trinidad P. Pesigan, M.D.
Porfirio M. Recio, M.D.

X-RAY THERAPY OF PRIMARY INOPERABLE CARCINOMA OF THE BREAST, by Ruth J. Guttman, *Radiology*, 54:4, 567-571, April, 1950.

This is a study of 82 patients with primary cancer of the breast treated during the past eight years.

Irradiation is well tolerated specially if the patients receive vitamin B, 50 mgs. t.i.d. It is advised to powder rather than apply an ointment to the skin. The skin changes include fibrosis and telangiectasia without any ulceration. There may be fibrosis of both fat and muscle. There may also be pneumonitis and fibrosis of the lung resulting in shortness of breath, and dyspnea on exertion, which will gradually decrease after one year.

These patients with "ulcerating inoperable carcinoma of the breast often show a remarkable immediate and sometimes even long-lasting improvement, with relief of pain, swelling, and discharge after X-ray therapy."

X-ray treatment when carefully given "cannot do any harm; it is apparent that it should be tried in every case of primary inoperable cancer of the breast. Furthermore, the course of treatment should not be stopped before its therapeutically warranted termination. X-ray treatment has proven its value by improving the condition of the patient, in numerous cases by making existence more tolerable, and sometimes even restoration to normal life."

The dose used is 3000-4000 r at the center of the tumor. For the chest wall use 120 kv filter 3 mm. Al. 30 cm. target distance. A single exposure is 400 r the total for each field is 2400-2800 r.—P.R.

EARLY DIAGNOSIS OF MALIGNANCIES—LABORATORY AIDS, by J. P. Tollmann, *The Neb. State M. J.*, 35:7, 216-217, July, 1950.

The specimen sent to the pathologist must be representative of the lesion or else an unsatisfactory diagnosis may be made. It is preferable to obtain the tissue by knife rather than by cautery, because the latter distorts the architecture of the cells. The specimen should be placed in an adequate fixative, usually formalin, whose volume should be 5-10 times that of the specimen.

For smears taken for cancer cells, immediate fixation is necessary in equal parts of absolute ethyl alcohol and ether or absolute methyl alcohol and ether. Then it may be allowed to dry and stained even after a few days time.—P.R.

EARLY DIAGNOSIS OF MALIGNANCIES OF THE BREAST, by Herbert Davis, *The Neb. State M. J.*, 35:7, 205-210, July, 1950.

One out of every 30-35 women develop cancer of the breast; the disease is only 15% common in man. The patients may see the physician because of a lump, pain, discharge from the nipple, or asymmetry of the breasts. The breasts should be examined in the course of all physical examinations; Horgensen discovered by this method, carcinoma of the breast in 3.4% of patients to be operated upon. The early manifestations include retraction of the nipple, drawing of the skin over the tumor, deformity of the breast. Use the flat of the hand to examine lumps in the breast; never pick the breast between the fingers.

Schirrus cancer has a hard tumor with indefinite infiltrating borders, growing slowly, tending to be contractile and causing retraction of the skin over the tumor and shrinking of that portion of the breast. Medullary cancer is softer, grows rapidly and is expansile. Paget's disease presents an ulcerated nipple and a lump deeper in the breast. Comedo-carcinoma or duct carcinoma with discharge from the nipple, if diffuse is slow growing, but if localized it involves the areolar area. It grows slowly, metastasizes late and may be cured in 85% of cases. Gelatinous cancer occurs in 1-3% of cases. It is slow growing, metastasizes late, with protrusion and enlargement of the nipple; it feels cystic and may have a transparent lump. Inflammatory cancer occurs in 4% of cases specially among young women, during pregnancy and lactation; it is very malign, appears like erysipelas and kills in 18 months; it is due to a blockage of the lymphatics of the breast. Sarcoma may be primary but commonly arises from adenofibroma; it is an encapsulated lump which has been there for years then grows rapidly later; it metastasizes by the blood stream and thus the glands are not affected. In chronic mastitis the breast is painful and diffusely nodular; there is no surgical importance.—P.R.

EARLY DIAGNOSIS OF MALIGNANCY OF THE STOMACH AND COLON,
by Raymond Wyrens, *The Neb. State M.J.*, 35:7, 213-215, July, 1950.

The picture of cancer of the stomach as described in books is that of advanced cancer. The aids for an early diagnosis are (1) careful history, (2) X-ray of the stomach, (3) gastroscopy, (4) examine the stomach contents for malign cells.

Patients who have been previously free from digestive symptoms and who develop vague epigastric distress, anemia, or mild nausea, epigastric fullness and eructation, and which persist should be subjected to X-ray. This may result in taking many normal X-ray but the number of resectable lesions that will be encountered will justify this procedure. Cancer of the stomach is to be suspected in (1) an ulcer of short duration in a patient over 50 years of age; (2) lesion in the greater curvature or the pre-pyloric area, (3) ulcer 2.5 c.m. or more in diameter, (4) there is no free HCl, (5) a defect on the lesser curvature that does not heal.

Partial gastrectomy of suspicious lesions is justified even if the lesions turn out to be an ulcer because the operation is a good treatment for ulcer itself.

To control colonic cancer we must be conscious of the precancerous lesions as polyps and remove them. Cancer may be diagnosed early by (1) complete physical examination; (2) rectodigital examination (3) sigmoidoscopy; (4) barium enema of the colon. 70% of all cancer of the colon can be palpated by the finger or even seen through a sigmoidoscope; 75% of cancer of the rectum have been previously treated as hemorrhoids; therefore it is safe to consider all cases of hemorrhoids as malign unless proven otherwise. Cancer of the right colon causes vague abdominal pain, anemia. The patient complains of weakness and fatigue; there may be a change in the bowel habit in 1/3 of cases and a mass may be palpable.—P.R.

SOCIETY ACTIVITIES

WORLD MEDICAL ASSOCIATION.—As official delegate of the Philippine Medical Association to the Fourth General Assembly of the World Medical Association, Dr. Jose R. Reyes, Director of the North General Hospital, has submitted the following report to the Council.

The Council
Philippine Medical Association
(Through the Secretary-Treasurer)
Manila

Sirs:

I have the honor to report on the results of the Fourth General Assembly of the World Medical Association, which was held in New York City from October 16-20, 1950, and which I was privileged to attend as the official representative of the Philippine Medical Association. For this, incidentally, I am grateful to the members of the Council; for it was quite an experience to have come in contact with the officers and the other delegates of various medical societies throughout the world. I was afforded all the privileges, courtesies, and honors accorded to all delegates — accommodations at the Roosevelt Hotel, free exchange of ideas with the rest of the delegates, and invitations to all social affairs in connection with the convention.

Dr. Jose Jose, the other official delegate of the Philippine Medical Association, was unable to attend the convention; and he was replaced by the senior alternate, Dr. Daniel Ledesma, formerly President of the Philippine Medical Association. Dr. Saturnino Ador Dionisio, the other alternate delegate, was present in all the deliberations; and he was accorded the same privileges as the official delegates.

The meeting was held in the big Assembly Hall of the Roosevelt Hotel. The procedure was patterned after that of the United Nations. Three languages — English, French, and Spanish — were used, and the guests as well as the delegates were provided with earpieces, so that they could listen to the deliberations in any of the three languages of their choice. Most of the deliberations were televised. Each country represented in the assembly was assigned a special table with the corresponding national flag decorating it. On these tables were the things needed by the delegates — programs, stationery, printed materials, etc.

Scientific and business sessions, hospital visits, and social affairs made the convention lively and interesting; and they were well attended. The ladies of the delegates were accorded the same privileges and courtesies as their husbands.

The reports of the various committees, copies of which appear in the printed program, were all approved by the Congress in session. I am forwarding to you a copy each of this official program, a pamphlet on the Standing Orders of the World Medical Association, the Constitution of that organization, the ladies' program, and summaries of some of the scientific papers read in the convention.

I wish to report further that the 5th Annual Convention will be held next year in Sweden, and that Dr. Dag Kuntson of that country is the President-elect for the coming year.

Respectfully,

(Sgd.) JOSE R. REYES, M.D.
Philippine Delegate, WMA

The NUEVA ECIJA MEDICAL SOCIETY and its Woman's Auxiliary held a scientific monthly meeting on November 5, 1950, at the Nurses' Hall of the Nueva Ecija Provincial Hospital in Cabanatuan City with Dr. Luis F. Torres, Jr. and Dr. Florencio N. Quintos, Urologist and Pediatrician respectively of the University of the Philippines as guest speakers.

Dr. Torres, Fellow of the American College of Surgeons and of the Philippine College of Surgeons and Assistant Professor of Urology, U.P., spoke on "Genito-Urinary Infections in Private Practice." He was introduced by Dr. Eduardo Agustin, District Health Officer for Nueva Ecija and President of the Medical Society.

Dr. Quintos, Associate Professor of Pediatrics, U.P. and member of the Philippine Pediatric Society, spoke on "Recent Advances in Treatments of Common Infections in Children." Dr. Herminia Castelo-Sotto, Puericulture Center physician of Cabanatuan City, introduced him.

Dr. Potenciano P. Garcia of the Carmen Surgical and Maternity Clinic of Cuyapo, Nueva Ecija, acted as master of ceremonies.

In charge of the preparations for the affair were the officers of the Nueva Ecija Medical Society and its Woman's Auxiliary.

The BAGUIO MEDICAL SOCIETY gave a welcome dinner in honor of Dr. Fernando D. Manalo, Medical Director of Notre Dame Hospital, Baguio, at the Rice Bowl Restaurant on November 28, 1950. Dr. Manalo has just arrived after six months' observation in the different hospitals and clinics of Europe and America. He gave a very inspiring talk to the members of the Baguio Medical Society of his experiences and on modern trends in medicine he observed abroad. He recommended to the members to make observation trips if and when they can afford to do so because of its educational and scientific values.

After the dinner, the annual election of officers for the year 1950-1951 was held. The following were elected: President, Dr. Justo R. Rosales; Vice-President, Dr. Teofilo V. Mendoza (reelected); Secretary-Treasurer, Dr. Dominador R. Narvaez (reelected); Councilors: Drs. Fernando D. Manalo (reelected), Andres Angara and Ernesto L. M. Abellera; PRO, Dr. Jose Martinez.

The LAGUNA MEDICAL SOCIETY held its Business and Scientific Meeting at the Municipal Hall, Calamba, Laguna, on November 26, 1950 with Hon. Juan Salcedo, Jr. as Guest Speaker. The program was as follows:

- | | |
|--------------------------|-------------------------|
| Business Meeting | 9:30 A.M. to 10:00 A.M. |
| Scientific Meeting | 10:30 A.M. to 1:00 P.M. |
1. Opening Remarks By Dr. Sesinando Rizal, Mayor of Calamba, Laguna.
 2. "Quinoline, a Strong Fungicide in the Treatment of Dermatomycosis" .. By Drs. E. Y. Garcia, V. Rodriguez, G. Tan and E. Trinidad, Dept. of Bacteriology and Parasitology, College of Medicine, Manila Central University.
 3. "Fundamentals of Malnutrition and Its Recognition" By Hon. Juan Salcedo, Jr., Secretary of Health.
 4. Closing Remarks By Dr. Roman Kamatoy, President, Laguna Medical Society.

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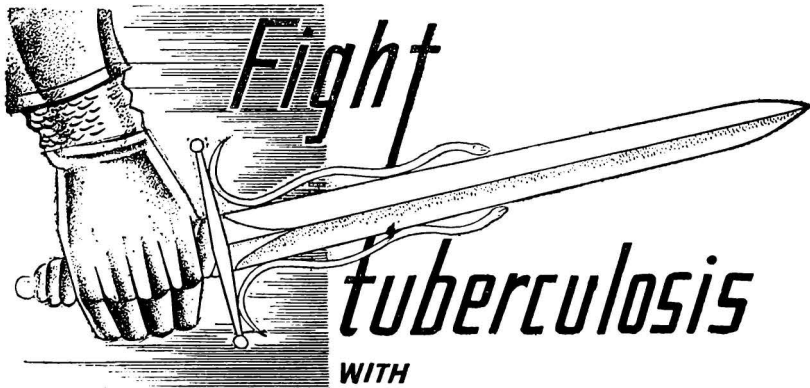
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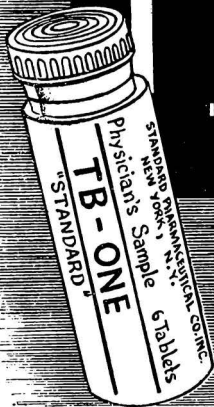
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HOMOGENIZED.**

**ACIDIFIED WITH A
PURE CULTURE OF THE
BENEFICIAL LACTIC-ACID
PRODUCING ORGANISM -
STREPTOCOCCUS LACTIS.**

**MODIFIED BY
THE ADDITION OF
GLUCOSE, SUCROSE
AND STARCH.**

**FORTIFIED WITH
VITAMINS A, B., C, D
AND IRON**

**NUTRIENTS
IN SUITABLE
PROPORTIONS FOR
INFANT NUTRITION.**

NET WEIGHT 1 POUND

Polargon
NESTLE

PRODUCT

Specially bred, acidified and homogenized cow's milk, modified by the addition of glucose, sucrose and starch, to which has been added iron, citric, ascorbic, thiamin, hydrochloric, nicotinic acid and irradiated 7 dehydrocholesterol

PREPARED BY
NESTLE'S MILK PRODUCTS, INC., NEW YORK, U.S.A.

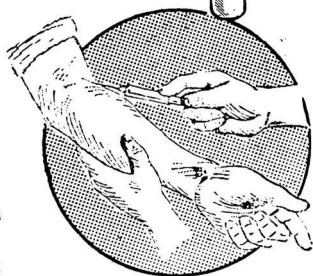
PALUDRINE

for

MALADIA MALARIA



BY THE INTRAVENOUS ROUTE



'Paludrine' is extremely well tolerated and in normal dosage produces no unpleasant symptoms of any kind.

Indications:— For the treatment of any type of malaria as an alternative to oral administration. Intravenous injection of 'Paludrine' Lactate is indicated particularly, however, when for any reason it is impossible or impracticable to give 'Paludrine' by the mouth, or when unusually heavy infections in the blood make it necessary.

Administration:— 'Paludrine' Lactate should be given by slow intravenous injection. It may be diluted with distilled water for convenience if required, but must not be diluted with physiological saline, with which it forms a precipitate.

Dosage:— One ampoule every 3 hours.

PACKINGS:— Ampoule of 2 c.c. (containing 0.1 gramme) 5 in a box.

'Paludrine' (proguanil) is known chemically as N_1 -*p*-chlorophenyl- N_5 -isopropylbiguanide.

IMPERIAL CHEMICAL (PHARMACEUTICALS) LIMITED
MANCHESTER, ENGLAND

Distributors:

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The claims of 'Dettol' do not rest on any single quality desirable in an antiseptic, but rather upon the combination of several essential properties. It can be used at fully effective strengths with safety; that is, without risk of poisoning, discomfort, or damage to tissue. It retains a high bactericidal potency in the presence of blood, it is stable, and agreeable in use.



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THE MODERN ANTISEPTIC

Mono-chloro-xylenol
Terpineol

4.3%
6%

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Through the daily use of Ovaltine, nutritional deficiencies can readily be prevented in children. Made with milk as directed, this dietary supplement

supplies all the nutrients considered essential, in balanced ratio and in generous quantity. Three glassfuls daily, in conjunction with even an average diet, raises the intake of all nutrients to optimal levels.

Because of its delightful taste, Ovaltine is rarely refused. Chocolate Flavored Ovaltine, again in full supply, has long been a favorite with children who regard it as a special treat; its nutritional composition is virtually identical with that of plain Ovaltine.

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FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



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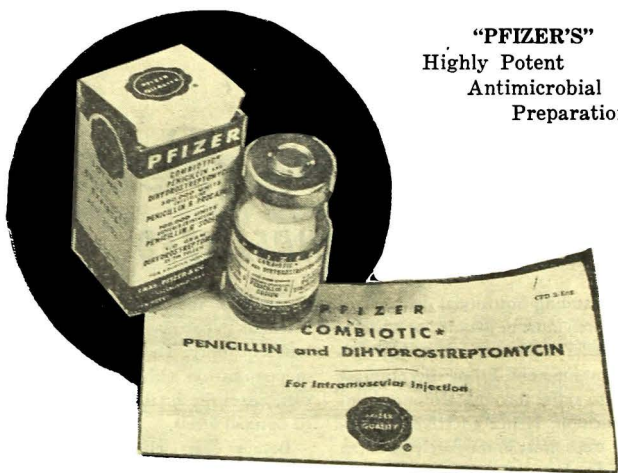
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in the treatment of
RHEUMATISM GOUT LITHAEMIA

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The Magnesium, Sodium, Strontium, Lithium and potassium salts as combined in SALVITAE, with Sodium-Forma-Benzoate, afford the ideal eliminant and is thoroughly reliable as an alkalinizing agent.

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Permit No. 960—June 25, 1928

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Strontii Lactas	-----	.30 Gm.
Lithii Carbonas	-----	.15 "
Caffein et Quininae Citras	-----	.80 "
Sodii-Formo-Benzoas	-----	1.60 "
Calcii Lacto-Phosphas	-----	.15 "
Potassii et Sodii Citro-Tartras	-----	68.00 "
Magnesi Sulphas	-----	8.00 "
Sodii Sulphas	-----	30.00 "
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		100.00 Gm.



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Pulvule No. 311	Each Pulvule Contains:	Pulvule No. 312	Each Pulvule Contains:
Sodium 5-Phenyl-5 Thienyl Hydantoin	0.13 Gm.	Sodium 5-Phenyl-5 Thienyl Hydantoin	0.26 Gm.
Starch, q.s. to make the con- tents of one pulvule weigh in a hard gelatin capsule	0.252 Gm.	Starch, q.s. to make the con- tents of one pulvule weigh enclosed in a hard gelatin cap- sule colored pink with F. D. & C. Red No. 3	0.453 Gm.

*to make the
common cold
less common*

CORICIDIN

CORICIDIN*

(antihistaminic—antipyretic—analgesic)

*with Chlor-Trimeton**
antihistaminic therapy

- ... prevents or aborts colds in 90% of cases when initiated within the first hour of symptoms.¹
- ... shortens duration and decreases severity of an established cold.^{1,2}
- ... reduces the spread of infection to others by eliminating sneezing, lacrimation, rhinorrhea and coughing.¹

DOSAGE AND TIMING: Two CORICIDIN tablets at the very first indication of a cold, then one tablet every three or four hours for three or four days. In established colds, one tablet every three or four hours for palliative effect.

COMPOSITION: Chlor-Trimeton 2.0 mg. (1/30 gr.) with Acetylsalicylic acid 0.23 Gm. (3½ gr.), Acetophenetidin 0.15 Gm. (2½ gr.) and Caffeine 0.03 Gm. (½ gr.).

PACKAGING: CORICIDIN tablets, tubes of 12; bottles of 100 and 1000.

BIBLIOGRAPHY:

1. Brewster, J. M.: U. S. Nav. M. Bull. 49:1, 1949.
2. Murray, H. G.: Indust. Med. 18:215, 1949.

*T.M.

Schering CORPORATION
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