Prognosis in Hypertension

Dr. H. O. GUNEWARDENE (Colombo, Ceylon) writes: It is very interesting to read Dr. Platt's observations upon hypertension and albuminuria in the *Journal* of July 21st (p. 138). For many years I have found that a persistent diastolic pressure of 130 or over, and a urine showing what I have chosen to describe as a " cigarette-puff density " of albuminuria to the heat test, is reliable ground on which to base a very bad prognosis, even in the absence of serious changes in the retina. I have used this expression as regards the albuminuria in order to indicate in a simple way that the quantity of albumin need not be much. It may be anything above this quantity. Here is an illustrative case:

M. R. C., aged 39, married, seen by a doctor, sought advice as he was rejected by an insurance company, being a case with high blood pressure. Condition on examination: Apex beat, quarter of an inch external to nipple line; pulse 72; blood pressure 200/140; lungs normal; spleen ++ (malarial); liver normal; urine, specific gravity 1005, albumin +, no sugar. Micturition was twice nightly and four to five times a day. There were no arterial changes in the fundi. Treatment was by (1) lacto-vegetarian diet, with weekly fasts; (2) elixir sodium sulphocyanate (P. D. and Co.), as directed; and (3) potassium iodide, potassium bromide, and magnesium sulphates. This patient died within nine months from cerebral haemorrhage.

These two observations seem to be quite enough in most cases, whatever the pathology of the kidney. When a patient comes with a single specimen to the general practitioner's consulting room, or even to a specialist, one is often obliged to give a prognosis if possible without the help of so many renal function tests—at least when the patients cannot afford to pay the biochemist or are unwilling to attend hospital.

Treatment of Dysmenorrhoea in Virgins

Dr. NUTTING FRASER (St. John's, Newfoundland) writes: In the *Journal* of August 11th (p. 257) you review Dr. James Young's *Text-Book of Gynaecology* in a very favourable way, expressing views which those of us who have read the book will heartily endorse. You do not agree with him that " an infected cervix is a common cause of pain in women," and I would like to state that my experience quite coincides with the opinion expressed in Dr. Young's book. I find that many of the cases of severe dysmenorrhoea in young girls are caused by an infected cervix, and medicine is powerless to relieve the distress. Of course, we all hesitate to examine a virgin, and such examination calls for a general anaesthetic. But if the small rectal speculum, commonly used for injecting haemorrhoids, is used, an examination can be satisfactorily made without any injury to the hymen. The cervix can be exposed, drawn down, and cauterized. Five years ago a lady asked me to treat her maid for dysmenorrhoea, the pain being so severe that she lost a couple of days each month. Medicine proved ineffectual, but the patient was desperate, and would submit to anything that might give relief. An examination was thus decided upon and was made under an anaesthetic. The cervix was badly eroded and exuded pus. Both lips were deeply cauterized, and up to the present time the result has been a complete relief of the pain. Menstruation is regular and painless. Following this case I have treated many others in the same way, and always successfully, and I would like to draw attention to the fact that the rectal speculum can be used like the old Ferguson speculum, and need not damage the hymen.

Adrenaline and Cerebral Haemorrhage

Dr. A. J. DUNLEVY (Ogmore Vale, Glamorgan) writes: The history of this case may prove of sufficient interest for publication. I must state that the treatment was accidental, but I think the case worth recording as an observation. Whilst acting as locumtenent I was called to see a woman who was supposed to have swallowed some liniment in mistake for brandy. She certainly may have tasted the liniment, but she had not swallowed any. I gave the usual milk and albumin treatment, and satisfied myself that she was all right before I left her. I was called to the same patient that afternoon and found her unconscious, with stertorous breathing. I had been told by her own doctor that this patient had a bad heart. Without waiting to do any examination I gave 1/100 grain adrenaline and 1/30 strychnine. After I had given the injections I discovered that there was a hemiplegia of the left side, and that the case was really one of cerebral haemorrhage. I felt that I had made a grave error in treatment. I saw the patient later that night and found her a little better. Next morning she was conscious, and felt quite well; in fact, it was with difficulty that she was persuaded to stay in bed, as she felt so fit. I think the original " poison " fright probably caused the cerebral haemorrhage. We know that adrenaline constricts the vaso-constrictor nerves, but I think that it is generally understood that the cerebral vessels are not supplied with vaso-constrictor nerves. Hitherto, I thought that adrenaline would have been contraindicated owing to the danger of the raised blood pressure driving more blood into the ruptured lenticular striate branch of the middle cerebral artery. In this case I used adrenaline accidentally, and I wonder if the raised blood pressure retarded the haemorrhage by slowing the rate of extravasation (Marie's law); the constriction of the aorta and large blood vessels serving also to reduce the haemorrhage. The case may interest your readers, as, personally, I am convinced that adrenaline is well worth trying in these cases, which are so often left to nature to cure.

Labour and Heart Disease

Dr. CHARLES J. HILL AITKEN (Kilnhurst, near Rotherham) writes: In connexion with two *Epitome* paragraphs dealing with the above subject (No. 131, August 18th, and No. 150, August 25th) I read in the late D. Berry Hart's *Midwifery* the following statement: " I early advocated the view, which has also been brought forward by Dr. Angus MacDonald and others, that the serious results in the third stage were due to an embarrassment of the right side of the heart . . . and that thus the best thing for the patient was not to hinder loss of blood in the third stage, but rather to see that the patient lost blood to a fair amount, and that if there were any doubt of this she should be bled from the arm " (p. 337). This was written in 1912, and Dr. Angus MacDonald died a great many years ago.

Medical Work in Basutoland

Dr. N. M. MACFARLANE, late principal medical officer in Basutoland, has compiled a record of medical work in this Territory. It is of special interest at the present time when there is a general movement to develop health services for native populations, for it shows how one small native State proceeded. The Territory of 11,000 square miles is populated by over half a million natives. Dr. Macfarlane describes the early work of the missionaries, who were solely responsible for scientific medicine until the appointment of the first Government medical officer in 1875. Details are given of the energetic pioneer work of the early officers, Drs. E. B. Hartley, H. S. Taylor, L. C. Daumas, and S. C. Reed. Small hospitals and free dispensaries came into being, and in the last decade of last century the medical work was growing apace. The South African War brought further expansion; the existing small hospital at Maseru was enlarged and modernized, and new ones were opened elsewhere. One achievement of this period was the almost complete eradication of small-pox, which had previously been endemic for many years. More than half a million vaccinations had been performed, and it had been made compulsory for all natives leaving the Territory to carry a vaccination certificate signed by a medical officer. The first leprosy asylum was established by one of the enlightened native chiefs, and this led the way to the opening of the Basutoland asylum in 1913. The usual difficulties followed its being conducted more as a house of detention than as a hospital. Despite the difficulty of financing a rapidly growing medical service, progress continued; sanitary areas were defined, and more medical officers of districts were appointed by the Government. Active work against leprosy continued, and paved the way for the complete survey some four or five years ago. The leprosy organization was inevitably planned on a rather expensive basis, its inception having preceded the more recent discoveries which have led to great economies.

A Schedule to the "National Formulary"

The Paddington Medical Society has issued a revised edition of their *Schedule to the National Formulary*, which shows the approximate and the relative cost of the formulae and of the dispensing fees in the *National Formulary* (1933). Copies can be obtained (price 1s.) on application to the honorary secretary, Paddington Medical Society, 81, Elgin Avenue, London, W.9.

Vacancies

Notifications of offices vacant in universities, medical colleges, and of vacant resident and other appointments at hospitals, will be found at pages 35, 36, 37, 38, 39, 40, 41, and 44 of our advertisement columns, and advertisements as to partnerships, assistantships, and locumtenencies at pages 42 and 43.

A short summary of vacant posts notified in the advertisement columns appears in the *Supplement* at page 172.