Hay Fever.

Scheppgrell (New York Med. Journ., 9th December 1915) in a statistical inquiry into this disease dissipates several fallacious ideas generally held. One idea, that hay fever does not occur south of the thirty-fifth parallel of latitude, he found to be quite erroneous, for it is just as common among the Southern States as in States north of that degree. Again, the farming population and negroes, both popularly supposed to be to a large extent immune, were found to be just as frequently affected as other people, the farmers being especially prone to it. There appear to be two forms of hay fever—the spring and summer and the autumn varieties; the former being mainly caused by the pollen of grasses and the latter chiefly due to the pollen of ragweeds. Attacks of the malady occur simply when the amount of pollen in the atmosphere becomes too great for the degree of immunity of the individuals concerned, but they occur most frequently while the florescence of the pollen-producing weeds is at its height, and the season of incidence may be delayed by rains which prevent the spread of the pollen, or advanced by weather conditions which accelerate its growth, or shortened by the early onset of frost in autumn. It was found by a circular to physicians in Louisiana that the percentage of persons who suffer from hay fever is about 1 per cent. of the entire population; but it is less common in wooded districts and above an elevation of 6000 feet. The autumn form is more than twice as common as the summer form.

Recurrent Tuberculous Pleurisy.

Piéry draws attention to a mild form of pulmonary tuberculosis (Presse Méd., 21st December 1916) which he states is extremely common though its real nature is generally unrecognised. It occurs as a localised pleurisy about the fissures of the lungs, often accompanied by a slight pneumonia, with rise of temperature and general symptoms like dyspepsia, palpitation, loss of weight, etc. The symptoms pass off in 3 or 4 weeks, but there is a great tendency to recurrence after a
short time. This condition is very liable to affect soldiers, the writer finds, and it demands treatment in hospital, where after a few weeks the pyrexia passes off, and where a stay of six weeks under suitable conditions of rest in bed, etc., will generally effect a cure and allow the soldier to return as an effective.

Strophanthlin in Acute Cardiac Failure.

Hay (Liverpool Med. Chir. Journ., No. 69, 1916) records the use of large doses of strophanthlin administered intravenously with good result in threatened death from cardiac failure. Acute cardiac failure is in many cases due to auricular fibrillation, which can be recognised by dilatation of the ventricles, dyspnoea, cyanosis, precordial pain, oedema, and particularly by increased rate of the heart-beat with great irregularity in force and frequency (the delirium cordis of old writers). Of all drugs those of the digitalis group are most useful in steadying the heart while in this condition, but the onset of the cardiac failure is sometimes so sudden, and the downward progress so rapid, that medication by the mouth may be too slow to be of any service. Again, at times the patient's stomach is so sensitive that it will not tolerate any member of the digitalis group. In such cases strophanthlin injected into a vein produces immediate and definite slowing of the heart and rapid amelioration of the patient's condition, and has without doubt saved many lives. The writer usually injects it in dose of 0.6 to 1 milligram (\(\frac{1}{100}\) to \(\frac{1}{3}\) of a grain); the slowing shows itself within half an hour, and the dose can be repeated in a few hours if necessary.

Treatment of Diabetes.

Moses (Med. Record, December 1916) gives a résumé of the views on treatment of this disease at the present. Guelpa about 1909 was the first to recommend the fasting treatment combined with purgation, and a definite programme for fasting and subsequent increase of diet has been drawn up by Allen. In fat, elderly, and long-standing cases the fat and protein are successively omitted from the food, and the carbohydrate is gradually decreased; while in ordinary cases the patient simply ceases to take food, and maintains this fast for two days; during the fast, water, tea and coffee are allowed, and if at the end of two days the urine is not sugar-free the fast is continued with the addition of a little clear meat broth; thereafter carbohydrate is gradually added to the diet, 5 grammes at a time. After the urine has been sugar-free two days, protein in the form of eggs, and later of meat, is gradually added, and later still fat is given in limited amount. If sugar reappears, fasting for 24 hours is resumed, with subsequent diminution of the diet. A small amount of alcohol is regularly allowed in cases of threatened acidosis.
TREATMENT OF ANTERIOR POLIOMYELITIS.

So many children have been affected by the recent epidemic of anterior poliomyelitis that their orthopaedic after-treatment has become a matter of great importance. Whitman, Wright, and Bartine contribute papers on this subject (ibid.). This epidemic has been remarkable for its high death-rate on the one hand and for the large number of complete recoveries, amounting possibly to 20 per cent., on the other. Prevention of deformity is the most important part of the treatment from first to last. It develops insidiously and rapidly, its first indication being a sense of discomfort when a habitual attitude is changed. Preventive treatment consists in moving all the joints of any affected part through their full range of movement at least twice daily. Postures should be alternated and attitudes that lead to deformity should be restrained. Massage is useful for improvement of nutrition, and warm baths both improve the circulation and allow of greater freedom in movement as weak limbs are floated up against gravity. Electricity is not found of much benefit by the writer in young children, who are apt to be frightened by it. Muscle training, aided sometimes by operative treatment, such as regrafting of muscular attachments, and often by braces designed to prevent deformity and permit locomotion, is very important. It has been found from previous epidemics, e.g. that of 1907, that while signs of recovery should begin at once it is impossible to predict the degree of final paralysis in any case, and improvement may continue for many years. J. D. C.

Surgery.

UNDER THE CHARGE OF

J. W. STRUTHERS, F.R.C.S., D. P. D. WILKIE, F.R.C.S.,
AND JAMES M. GRAHAM, F.R.C.S.

THE TREATMENT OF WOUNDS OF THE THORACIC DUCT.

HARRISON (Brit. Journ. of Surg., October 1916) discusses the treatment of wounds of the thoracic duct and describes a case of his own in which the divided end of the duct was successfully sutured to the external jugular vein.

Four methods of treatment are available—suture, implantation into a vein, ligation of the duct, and tamponade of the wound in the neck.

Repair by suturing the wound is the ideal method of treatment, and in five cases reported all were successful. When the wound is merely a slit this may be sutured, or if the duct has been completely divided it may be possible to join end to end.

When suture of the duct is impossible the next most rational proceeding is to implant the cut end of the duct into an adjacent vein.