population of a whole region is always an arduous undertaking, and one must not place confidence, after what we have said, in those who believe that this scourge, so old and so diffused, can be curbed by one only of the many means I have mentioned. In the future, if and when a mode of immunising man even in countries where malaria is severe is found, then the task will be much simplified.

At present to him who asks us how public prophylaxis is to be effected in a complete manner, we can reply by indicating the means above described, and adding *unum facere et alterum non omittere*.

REFERENCES.

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THE SALINE TREATMENT OF DYSENTERY :

WITH NOTES OF 555 CONSECUTIVE CASES WITH 6 DEATHS.

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In an article published in December, 1898,¹ I gave details of 102 consecutive cases of dysentery treated by a saturated solution of sulphate of magnesium, with only 1 death. I now give an account of 453 more cases of the same disease, with only 5 deaths. This makes a total of 555 cases of dysentery treated by salines, with only 6 deaths, or a percentage case-mortality of only 1.08. The 453 cases here referred to I have met with in Bhagalpur. They are of all types and forms, just as they occurred from day to day. The monthly distribution of these cases is as follows :

	Cases.		Cases.
1898, November	39	1899, June	31
„ December	18	„ July	48
1899, January	11	„ August	63
„ February	16	„ September	36
„ March	29	„ October	37
„ April	34	„ November	50
„ May	27	„ December	24
Total, 453.			

Duration of Treatment.

The number of days in hospital for the whole of these cases was 4,894, an average of 10 days for each case. The period in hospital varied from 7 to 90 days. In the vast majority of the cases of acute dysentery the period of the stay in hospital was from 8 to 12 days.

Relapses.

I made a careful nominal roll of all cases admitted to hospital during a period of fifteen months in order to determine to what extent relapse occurred. I find on checking this roll that out of 453 cases there were only 69 relapses, or 1 in every 6.5 cases. Moreover, of these 69 relapsing cases, 47 had only two attacks during the period, 15 had three attacks, and 7 had four attacks; all the rest, 384 in number, had only one attack each—a fact which of itself speaks for the efficiency of this method of treatment. I may add that the majority of these patients were long-term prisoners, and mostly under observation during the whole of this period.

As regards the interval between the relapses, I find that there were 9 relapses within two weeks of the discharge from hospital as apparently cured; 10 relapses within one month, 25 within two months, 9 within three months, 9 within four months, 4 within six months, and 3 at periods over six months. Of course it is well nigh impossible to say that the cases here called “relapses” were not sometimes reinfections, but my experience is that dysentery is essentially a relapsing disease. This is shown not only by the same patient coming back to hospital with the same complaint, but I have been able to see cases *post mortem* who died of other diseases in which partially healed-up ulceration remained, which must have dated from a former known attack some months previously.

Etiology.

In such a case it is easy to understand that any slight irritation could start another attack of dysentery. This paper does not attempt to deal with etiology, but I may mention

that, though I have very frequently found the *amœba coli*, yet there was not a single case of liver abscess among them.

Mode of Administration of Saline.

I now turn to the main purpose of this paper—the saline treatment of dysentery. The 102 cases I reported over a year ago were all treated with magnesium sulphate, which I found to act admirably, promptly, and efficiently. It happened that I ran short of that drug and took to sodium sulphate, and was so pleased with the results that I have continued its use ever since. The following mixture will be found satisfactory for general use :

R. Sodii sulphatis 5j
Aque fœniculi ad 5iv

Of this mixture 3ss is given three or four times a day. Purgation should be free but gentle, and when bright yellow stools without a trace of blood or mucus are passed, then the drug should be stopped, but resumed at once if blood or mucus reappear in the stools. It is usually found that after five or six stools all blood and mucus have disappeared from the stools, but in many cases they reappear in a day or so; in such cases sodium sulphate must again be given.

This highly yellow “bilious” stool is characteristic of this drug. The only other drug I know which produces such stools is one, of unknown name, which was sent to me by Dr. Maberly, of Capetown. I used it in a few fever cases, and found that it produced copious yellow bile stools, to the great relief of the patients.

For chronic and relapsing cases I tried olive oil for some time, but gave it up as of no special value; now I treat these cases chiefly by dieting and patience. On their first coming to hospital I gave them sodium sulphate for one, or at most two, doses, and then bismuth and soda or other intestinal antiseptics. For every exacerbation—that is, for every return of blood and mucus—a dose of sodium sulphate is given, or if scybala are passed a dose of castor oil and laudanum. Intestinal worms are not infrequent in chronic cases, and when such are seen or suspected *santonin* or *male fern* should be given. I have come to consider salines (except in the limited doses mentioned above) as harmful in cases where there is ulceration of the great intestine. In ordinary cases the acute stage under this treatment is over by the third or fourth day, and if the stools remain free from dysenteric products I give a tonic of iron or *nux vomica* and *quassia*.

Diet.

Important and useful as is the saline treatment, yet dieting is equally so. For native patients (to whom alone the above figures refer) I have used the following diet during the past fifteen months, and can strongly recommend it :

For new acute cases I give what is known in India as *mar* and *dahi* 8 ounces of each two or three times a day. *Mar* is made as follows : 1 lb. of fine well-cleaned rice is thoroughly boiled with 3 pints of water, and then strained. There should then result a white starchy substance of the consistence of porridge. *Dahi* is only “tyre,” and is made daily from the milk. The two are mixed together by the patient, and eaten. This is given at 10 A.M. and 5 P.M. At 7 A.M. half the quantity is also given, except when bael fruit is in season, when bael is given instead of the *mar*. All the above patients were kept on this diet for two or three days, till the stools become semisolid, when rice milk and soup is added. Full rice diet is only given when the patient has passed solid-formed stools for one or two days.

When bael fruit is obtainable it is good to give it along with the *dahi* for the early morning meal. This is especially necessary for chronic cases, to whom also mango pickle or other antiscorbutic is also given. The bael is given in the form of a sherbet, with sugar, in the form so well known in India.

REFERENCE.

¹ *Indian Medical Gazette*, vol. xxxiii, No. 12, December, 1899.

PRESENTATION.—Mr. Lennox Browne has retired from the active staff of the Central London Throat and Ear Hospital, but will continue to be identified with the institution as Consulting Surgeon. His colleagues on the Committee and medical staff have in the past week presented him with an illuminated address recording the high appreciation of the energy, devotion, and skill which he has exercised on behalf of the hospital since its foundation in 1874. Accompanying the address was a gift of old English furniture for use in his country home.