baby's head and face must be dried thoroughly to prevent chafing and excoriation of the skin, most particularly behind the ears.

Then, too, there will be the general care of the baby—hygiene, bathings, care of the buttocks, and particularly care of the umbilical cord. The child must be weighed twice weekly. A diet must be drawn up. If possible the mother should feed her baby, the milk being expressed if advisable. Otherwise artificial feeding must be instituted.

The baby is kept isolated until a conjunctival swab is negative. FLORENCE IBBETSON.

QUESTION FOR NEXT MONTH.

How would you clean after use, and put away, the following: (*a*) Gum-elastic catheter; (*b*) pair of rubber gloves; (*c*) bed mackintosh; (*d*) feeder with spirit; (*e*) Higginson's syringe.

THE DYSENTERIES.

BY W. E. COOKE, ASSOCIATE PHYSICIAN, HOSPITAL FOR TROPICAL DISEASES, LONDON.

(*Continued from page* 89.)

AMOEBIC DYSENTERY.

This disease is widespread in the tropics and sub-tropics.

Cause.—A minute jelly-like organism about four times the diameter of a red blood corpuscle, the Entamœbæ histolytica. In adverse surroundings the active amœbæ develop a thick covering and become cysts. These cysts, about half the size of the amœbæ, can live in water and damp soil.

Infection is acquired in the same manner as in bacillary dysentery, the cysts entering the body through the mouth. Carriers exist.

Pathology.—The amœbic cysts when swallowed pass down to the colon and there become active forms again. These burrow into the mucous membrane forming cavities, and these cavities getting bigger form ulcers. The ulcers may be all sizes, from pin-point to about half an inch in diameter. The cavity wall may come away as a slough and lead to severe bleeding. Perforation can take place.

The irritation from the amœbæ causes the excess of mucus and the frequent peristalsis. The blood comes from the ulcers. The active amœbæ are found in the stools in the acute cases and the cyst forms in the chronic cases.

Incubation Period.—This varies, but in outbreaks is usually from seven to fifteen days.

Symptoms.—The onset may be acute or gradual. Fatigue, anorexia, loss of weight, vague abdominal discomfort, and tenderness over the course of the colon are noticed. Diarrhœa with four or more stools daily may persist for days. In acute attacks severe diarrhœa and pain with evacuation, and progressive weakness are seen. Fever is absent unless the liver gets inflamed (hepatitis). The stools are offensive and infective.

Chronic amœbic dysentery often follows untreated or insufficiently treated attacks. Alternative constipation and diarrhœa occur, or feelings of persistent indigestion with looseness of the stools, wasting, sallow complexion, coated tongue, and neurasthenia may be present.

Complications.—Severe hæmorrhage, or perforation through an ulcer causing peritonitis may occur, but the commonest complication is inflammation of the liver (hepatitis), and this may go on to abscess formation. Abscesses have been recorded in other parts of the body, such as the brain and lungs.

Diagnosis.—This is made certain by seeing, with the microscope, the parasites in slide preparations made from the stools. The absence of pyrexia, the appearance of the stools and the absence of acute toxic symptoms help in diagnosis..

The following table may help:—

Bacillary Stool.	*Amœbic Stool.*
Odourless after first fæcal motions. Small in amount but very frequent. Bright red blood and clean mucus, not mixed.	Very offensive smell. Decomposing blood. Larger in amount and less frequent. Dark blood with mucus and fæces.

Sigmoidoscopy may enable a diagnosis to be made. The sigmoidoscope consists of a metal tube into which a solid pointed part, the obturator, fits, and which can be inserted into the rectum. After insertion the obturator is withdrawn and replaced by an electric lamp connected to a small battery, and a glass eye-piece then fits over the end of the tube. By looking through the tube, the bowel can be inspected as it is illuminated by the lamp. The tube is passed up the bowel by direct vision, and is facilitated in passing by air being pumped into it by means of an attached bellows. Ulcers or other lesions of the bowel can be thus seen. By means of a long-handled forceps or spoon scrapings of the ulcers may be taken, and these scrapings, examined on a slide under the microscope, often show the amœbæ when stool examinations have failed to show an amœbic infection.

The sigmoidoscope is sterilised before use by boiling. The lamp and its attachment are not boiled but cleaned by spirit before and after use. A finger-stall and lubricant should always be provided as an examination of the rectum with the finger should always be made before the sigmoidoscope is introduced. Except in acute cases the patient is prepared for sigmoidoscopy by lavage of the bowel.

Treatment.—Rest in bed. A saline aperient or a little castor-oil may be given at the onset, and opium or chlorodyne for the pain. If the patient has already had frequent stools no aperient is given. If the patient is too exhausted to use the bed-pan, grease the buttocks with zinc ointment and pack them with napkins or pads to receive the motion.

Keep the patient warm and give fluids frequently. Tepid glucose water, rice water, weak tea, diluted milk, etc.

Drugs.—Emetine is practically a specific remedy. It will probably be ordered to be given by hypodermic injection deeply subcutaneously or intramuscularly. Care must be taken to ensure sterility of the solution of the drug, syringe, needle and skin of the patient, or inflammation or abscess may follow. The dose is usually one grain daily (divided doses may be given) for ten days for patients in hospital.

The pulse must be watched closely during this treatment as too much emetine causes weakness of the heart, paralysis of the muscles and increase of the diarrhœa, so towards the end of the course patients should be strictly confined to bed and should use the bed-pan.

Stools should be inspected daily and afterwards disinfected and the nurse must be careful of her hands.

Turpentine stupes may relieve the abdominal pain. In treating natives and ambulatory patients not more than from three to six daily injections of emetine (grain 1) should be given.

Other Drugs.—Ipecacuanha (from which emetine is derived) is given by mouth on an empty stomach in doses of 5 to 60 grains. It is very nauseating.

Emetine Bismuth Iodide (E.B.I.), a bright red powder, is given by mouth in doses of from one to three grains in capsules. It acts better than emetine with chronic and relapsing patients. It is given at night and as it causes salivation, nausea and vomiting, it is best given as follows.

The patient should be in bed throughout the course of the treatment which lasts ten or twelve days. Very light

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