measures will find this section exhaustive enough, but the reviewer would have liked more recognition of masterly inactivity and plain confession of therapeutic impotence. It is, however, only right to stress that the treatments suggested show a wide acquaintance with modern methods, and Dr. Preston no doubt meant this section to be a reminder rather than oecumenical.

NURSING IN THE TROPICS

Tropical Nursing. A Handbook for Nurses and Others going Abroad. By A. L. Gregg, M.D., M.Ch., B.A.O. Second edition. (Pp. 185. 6s.) London: Cassell and Co.

This handbook describes the symptoms, signs, and treatment of the commoner and more important tropical diseases from the standpoint of their practical nursing, the diseases being arranged in alphabetical order so that reference is easy. A section also deals with the technique of the simpler diagnostic and therapeutic procedures that a nurse in the Tropics may be called upon to carry out, for in the Tropics a nurse may have to do many things that at home would normally be performed by one of the junior medical officers. There is also a chapter on personal hygiene, which gives many useful hints to the nurse who may be about to take up her first appointment abroad.

The book is of convenient size, well printed, and free from serious errors. It will be of considerable value to those who—for example, now in military service—may be meeting tropical diseases for the first time, and to those whose work takes them to remote areas abroad where they will have to rely largely on their own knowledge, judgment, and initiative. It is moderately priced and should continue to enjoy its already well-deserved popularity among nurses dealing with tropical diseases.

Notes on Books

LANGDON-BROWN and HILTON'S book *Physiological Principles in Treatment* is now 34 years old, and reading it one has much the same impression as in reading *Hamlet*, that one has heard it somewhere else before. But this is really the highest praise one can give, for it shows that, as a result of this book and others of the same kind, the profession is now more physiologically minded than when Dr. Langdon Brown (as he then was) first wrote it. Indeed the very success of such books may diminish the demand for them. To-day the need is for a greater application of psychological ideas in medical treatment and for more applied physiology in the factory, the armed Forces, and in preventive medicine rather than at the bedside. There are one or two changes we should like to see in future editions. The newer alkalis, magnesium trisilicate, aluminium hydroxide, and aluminium phosphate, receive less attention than they deserve, and the biochemical basis of action of the sulphonamide drugs might have been more fully discussed. It is also doubtful whether wartime decreases in diabetes mellitus are due to restriction of carbohydrate, for there is a good deal to suggest that the incidence of diabetes is more closely correlated with the consumption of fat than of carbohydrate. These are minor criticisms, however, and the book is aimed at a worthy target. It does not make the mistake of Macaulay or the Americans of over-estimating the time and capabilities of the average student, and it tells him just as much as he ought to know if he is to preserve the physiological outlook through his first overwhelming clinical years. The publishers are Baillière, Tindall and Cox, and the price is 12s. 6d.

The appearance of the fifteenth edition of *Stedman's Practical Medical Dictionary* (London: Baillière, Tindall and Cox; 42s.) barely three years after its predecessor is clear evidence of the demand for this well-known reference book. In its preparation the editor, Dr. S. T. Garber, must have had a more than usually arduous task. Not only has the dictionary been brought up to date, but it has been entirely reset in a new type, chosen, after much deliberation and exhaustive tests, for its legibility and clearness—and that it possesses these qualities we certainly agree. The section on that ever-expanding subject the vitamins has been revised, and many new biochemical and chemotherapeutic substances are described. The entire terminology of the bacteria, too, has been revised to agree with the type-species concept incorporated in the International Rules of Botanical Nomenclature, and cross-references are made from the older to the newer titles. Fresh illustrations have been included and some old ones replaced. The introductory article on medical etymology will continue to appeal to the more literary-minded; and another useful section that has been retained is the nomenclature in Latin and English adopted by the Anatomical Society of Great Britain and Ireland, with B.N.A. equivalents. Those who do not allow themselves to be unduly disturbed by American spelling will welcome the latest edition of *Stedman's*.

Preparations and Appliances

SOME USEFUL OPHTHALMIC SULPHONAMIDE PREPARATIONS

Dr. I. LLOYD JOHNSTONE (Worcester) writes:

Considerable attention has been given to the subject of local application of sulphonamides in ophthalmology. The early idea that this class of therapeutic agent was without effect when topically administered is no longer tenable. Without going into a review of the literature reference may be made to the work of Robson and Scott (1942), using sulphacetamide on experimentally produced corneal ulcers, and to an earlier clinical study of hypopyon ulcer effectively treated with sulphapyridine or sulphanilamide powder, or with soluseptasine as drops or by subconjunctival injection (Johnstone, 1941).

A need has been felt for a vehicle for these drugs which would keep them in contact with the diseased tissues in sufficient concentration and yet not insulate them. Such vehicles have been found, but, unfortunately, are in short supply. Messrs. May and Baker have made a sulphathiazole ointment (10%) in a soft wax base, and Messrs. Boots (Nottingham) an ointment of sulphacetamide (10%) in a water-miscible base of the appearance and texture of a cold cream. Both of these products are proving useful in various types of blepharitis, from acute abscess of the lid to the extremely chronic blepharitis with slight redness, itching, and scaliness of the lid margins. A case of dermatitis of the face from constant bathing with tears in a child with phlyctenular keratoconjunctivitis cleared up quickly with the sulphathiazole (thiazamide) ointment after being resistant to other forms of treatment.

Burns of the lids can be treated with the sulphacetamide cream, while burns involving the globe need an oily emulsion of the same drug. Unemul (Universal Emulsifiers Ltd.) has been used as an emulsifier, but there is difficulty in getting a stable emulsion unless a homogenizer is employed. A useful prescription is: sulphacetamide solution (from a 30% ampoule) 10%, water 25%, glycerin 30%, unemul 5%, cod-liver oil to 100%. Atropine sulphate (1%) must be added when the cornea is involved.

The dramatic effect of sulphapyridine in ophthalmia neonatorum will bear emphasis here. One-eighth of a tablet given with or after each feed will clear the condition in 48 hours. The treatment should be continued for a further 24 hours after apparent clinical cure. If this treatment is started early there should be no need to send a case to hospital. Local treatment of the eyes is reduced to a minimum. While discharge lasts it should be gently bathed away with cotton-wool pledgets soaked in warm saline. This should be repeated just often enough to prevent the lids from sticking. A drop of liquid paraffin or of 5% argyrol may be instilled each time, but so effective is the sulphapyridine that the drops can generally be omitted except as a memorial tribute to the past.

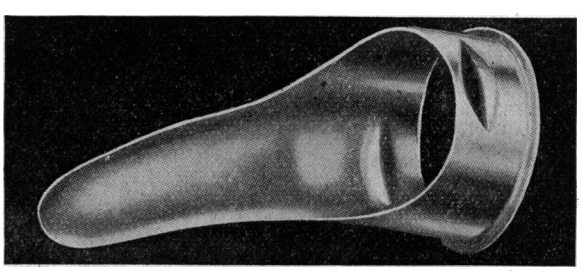
REFERENCES

Johnstone, I. L. (1941). *British Medical Journal*, 1, 887.
Robson, J. M., and Scott, G. I. (1942). Ibid., 1, 5.

MOUTH GAG FOR LARYNGOSCOPY

Surgeon Commander H. PARRY-PRICE (Banbury, Oxon) writes:

I enclose an illustration of a mouth gag that has been made at my suggestion by Messrs. A. Charles King as an aid to direct laryngoscopy. Some patients have awkward gaps in the upper front teeth, and some difficulty may be experienced when



passing a laryngoscope for direct-vision intubation. There is a gutter into which the teeth fit, and the spatula-like end controls the tongue. I find that with a preliminary spray of 2% percaine, followed by pentothal intravenously, it is perfectly easy to insert this prop and pass the tracheal tube.