

ABSTRACTS

NOSE

Packing for Nasal Bleeding. KARL MUSSER HOUSER, M.D. (Philadelphia).
Jour. A.M.A., September 21st, 1946, cxxxii, 144.

In spontaneous nasal hæmorrhage or in severe bleeding following nasal surgery the writer uses half inch oxidized cellulose gauze packing. It is inserted in sufficient quantity and with sufficient pressure to control the bleeding but removal is unnecessary. In about 48 hours it becomes a jelly-like mass and comes away without instrumentation. It does not become foul smelling like ordinary gauze packing. It may be used with a post nasal pack.

ANGUS A. CAMPBELL.

EAR

Penicillin in Infections involving the Central Nervous System and Skull
H. C. NAFFZIGER, M.D., HELEN WARMER, A.B., WALTER E. STERN, M.D.,
ROBERTA FENLON, M.D. and H. J. MCCORKLE, M.D. (San Francisco).
Jour. A.M.A., August 10th, 1946, cxxxii, 1,183.

During the past two years the writers have treated with penicillin 37 patients who had infections involving the skull and central nervous system. Of a group of twelve patients with pneumococcic meningitis nine recovered. The cerebrospinal fluid cultures of all patients who survived were sterile after 24 to 72 hours of combined systemic and intrathecal treatment with penicillin. Two patients with streptococcal and one with staphylococcal meningitis recovered although one of the former was left with a severe mental impairment.

In the treatment of eight patients with osteomyelitis of the frontal bone the immediate results were good but recurrences took place in all cases unless radical surgical excision of the infected areas was carried out as well.

In early acute infections originating in the middle ear, the results of penicillin therapy alone were good but well established acute or chronic infections of mastoid origin usually require surgical procedures in addition.

ANGUS A. CAMPBELL.

The Use of Residual Hearing. A. C. FURSTENBERG, M.D., Ann Arbor.
(Michigan). *Jour. A.M.A.*, September 21st, 1946, cxxxii, 138.

None of the present plans for the prevention of deafness is ideal. The point where prevention terminates and therapeutic procedures begin must be clearly discerned. In children a mass of adenoids encroaching on the eustachian tubes is an important ætiological factor. After the removal of adenoids, radiant energy may be useful in the destruction of lymphoid tissue responsible for the occlusion of the eustachian tubes.

Otosclerosis is a pathological and clinical entity which has successfully

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concealed its aetiology and has resisted all forms of medical treatment. The fenestration operation stands as the only therapeutic measure which has been of any service to patients with this disease.

In patients with chronic progressive deafness, it is futile to operate on their noses, remove their tonsils or inflate their eustachian tubes, but they should be given a true story of their affliction. They require the combined available talents of the otologist, psychologist, psychiatrist, physicist, acoustic engineer and speech expert.

For patients unable to hear ordinary conversational voice, a hearing aid should be recommended regardless of the curve expressed by the audiometer. In most instances it will be found that the air conduction instrument with a well-fitting ear piece is the one of choice.

The power to interpret sounds conveyed through a hearing aid often takes months of diligent effort on the part of the patient. He cannot adjust himself to one of these instruments in two or three days. He must learn a new language. The hearing aid should be adjusted to the good ear, worn all the time and the patient trained to interpret only those sounds that are transmitted through the instrument.

ANGUS A. CAMPBELL.

MISCELLANEOUS

Hemophilus Influenzae Meningitis Treated with Streptomycin.

HATTIE E. ALEXANDER, M.D., GRACE LEIDY (New York),
GEOFFREY RAKE, M.B. and RICHARD DONOVICK, PH.D. (New Brunswick,
N.J.). *Jour. A.M.A.* October 26th, 1946, cxxxii, 434.

Twenty-five patients with influenzal meningitis were treated with streptomycin alone or with other agents. No evidence of permanent kidney damage was noted.

It is clear that streptomycin therapy alone brings about complete recovery when the meningitis is of average severity but when the infection is severe, streptomycin is limited in its ability to cure the patient. In the severe infections the writers feel that therapeutic failure will be reduced to a minimum by the initial use of three agents, i.e., rabbit serum, sulfadiazine and streptomycin.

The article has five charts, seven tables and a bibliography.

ANGUS A. CAMPBELL.

Streptomycin in the Treatment of Infections. A Report of One Thousand Cases by The Committee on Chemotherapeutic and other Agents, National Research Council. Jour. A.M.A., September 7th, 1946, cxxxii, 4.

The committee directed the investigation toward those infections that were most likely to be benefited by the drug and to those that were resistant to penicillin and the sulfonamides. Streptomycin is dispensed either as a sulphate or a hydrochloride, both of which are extremely soluble. The total volume injected should be kept as small as possible and the site of the injection changed each time.

The intramuscular route is the one of choice but subcutaneous, topical or intrathecal routes may be used. In meningitis, intermittent intramuscular and intrathecal injections are necessary. There are no advantages in giving it

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intravenously. Oral administration is useless in systemic infections and if the drug be nebulized in bronchial infection, very little streptomycin is absorbed through the lungs.

There were a hundred cases of *Hæmophilus influenzae* meningitis reported, of these 66 were cured clinically and bacteriologically while under treatment, thirteen improved under treatment and finally recovered, one improved but relapsed, three showed no effect and seventeen died. Late treatment after other forms of therapy have failed is most unfavourable.

Streptomycin is extremely effective in tularæmia, but has little or no effect on typhoid.

Results are striking in infections of the middle ear caused by Gram-negative organisms. It was used prophylactically with satisfactory results in three cases.

The article is lengthy, has eight tables and bibliography.

ANGUS A. CAMPBELL.

Development of Streptomycin Resistance during Treatment. MAXWELL FINLAND, M.D., RODERICK MURRAY, M.D., H. WILLIAM HARRIS, M.D., LAWRENCE KILHAM, M.D. and MANSON MEADS, M.D., (with the technical assistance of CLARE WILCOX, Boston). *Jour. A.M.A.* September 7th, 1946, cxxxii, 16.

The early laboratory and clinical experiences with streptomycin have already indicated that acquired resistance may be of considerably greater importance with this agent than with penicillin or the sulfonamides.

Of twelve cases with various Gram-negative bacilli treated with streptomycin, eight failed to show any beneficial effects. The failure in each instance was associated with a rapid development of extreme resistance to streptomycin.

ANGUS A. CAMPBELL.

Streptomycin. Its Clinical Uses and Limitations. DONALD R. NICHOLS, M.D. and WALLACE E. HERRELL, M.D. (Rochester, Minn.). *Jour. A.M.A.*, September 28th, 1946, cxxxii, 200.

Streptomycin has been found to be active in vitro to a variety of gram-negative and Gram-positive bacteria. Various strains of the same bacterial species may differ widely in their sensitivity to streptomycin.

Oral administration is of little or no value in systemic disease.

Intramuscular administration is the method of choice but the drug may be given intravenously, subcutaneously and intrathecally. Streptomycin introduced into the tracheo-bronchial tree by nebulization is not absorbed into the blood stream in significant amounts. It is of definite value in the preparation for pulmonary resection in cases of bronchiectasis. Further investigation into the treatment of non-surgical bronchiectasis appears to be indicated. Streptomycin does not exert a rapidly curative effect on clinical tuberculosis. *Hæmophilus influenzae* and tularæmia respond satisfactorily to treatment with this drug.

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Temporary symptomatic improvement occurs in the treatment of ozæna. Best results are obtained when the organism is *Proteus vulgaris* or *Aerobacter aerogenes*.

Meningitis due to *Hæmophilus influenzae* responds satisfactorily.

Streptomycin is of doubtful value in osteomyelitis.

The elimination of the organisms sensitive to streptomycin frequently may favour the growth of bacteria which are sensitive to penicillin. There is no contra-indication to the simultaneous use of both streptomycin and penicillin.

ANGUS A. CAMPBELL.