

of the realization of regarding our patients as such—and not merely as cases. She also dealt with the relation of doctors and nurses one with the other—and reminded us that our aim is the same—i.e. to do the very best we can for our patients. It is hoped that this admirable paper may be published in full in the near future.

The afternoon and final meeting proved a great disappointment to one and all. One of the nurses from the American army nurse corps was to have read a paper on "Methods of Hospital Training in America," but alas, owing to the disturbances, Karachi was "out of bounds" for both British and American army nurses. The nurses in Karachi and area will, however, benefit as the American army nurse promised to give the address at some date in the near future.

Two most interesting films were shown by Dr. one on Eclampsia and another showing the bulk of a baby, and it was a matter of great regret that we were unable to see the A. R. P. display so kindly arranged for by Dr.

As was stated in the September number, our gratitude is due to all those who worked so hard to make the Conference a success.

All regretted that Major Gray, the Inspector-General, was unable to attend the Conference and the following note from him was very much appreciated:—

"I very much regret my inability to be present at the Conference of trained nurses which has been opened by Lady Dow to-day. I wish you all success in the noble work which you are engaged in. Nursing is such an important part of the treatment of all cases of injury and sickness that I assess its value very highly: For, without adequate nursing, all medical and surgical skill is incomplete. In fact, in surgical cases, the pre-operative and post-operative care may make all the difference possible in the results obtained—and on the medical side, nursing is the real and important factor.

"I have had personal experience of nursing while I have been ill, both as a surgical and a medical patient, and I have the greatest appreciation of just how much a kindly hand, a smoothed-out pillow, a timely drink, or that little extra tucking in of a sheet, may make all the difference between rest and unrest.

"The profession of nursing requires many attributes. Not only the professional knowledge which you learn, but the tact that is required, not only in dealing with patients but also with relations who are, not unnaturally, in a state of anxiety about the sick person.

"I know that you all will willingly accept the extra work which is necessarily your part during these war days and smilingly carry on the work of helping to heal which has been gifted to you, and I hope that you will all inspire and encourage others to join the noble service, of which you are a part."

A Simple Continuous Gastric Suction Drainage

By SUNDARAM MOSES, MALE NURSE, ELLEN T. COWEN MEMORIAL HOSPITAL, KOLAR.

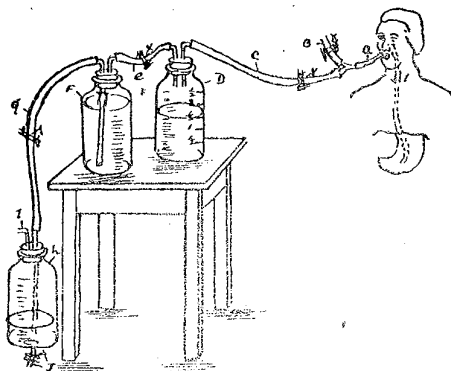
Purpose:—To remove from stomach and upper intestinal tract, gas and fluid due to intestinal obstruction or due to irritation of intestines as found in peritonitis; and to relieve nausea and vomiting; to evacuate the stomach; to detect bleeding in cases of hæmorrhage due to ulceration of the duodenum or stomach, and as a prophylactic measure in post-operative conditions.

The patient must be prepared by the nurse with proper explanation about the benefit of this treatment.

The bottle (d) in the figure is the trap bottle, where the vacuum is created by the syphonage working between the bottles (f and h).

Fill the bottle (f) with water nearly to the top and keep a little water in the bottle (h). Connect all the tubes as shown in the figure. Then the tube (e) is disconnected from the short glass tube of the bottle (f). By blowing into the same short glass tube on bottle (f) syphonage is started, and the tube (e) is again connected. As the bottle (f) gets empty of water a vacuum is created in the bottle (d) and draws into it the stomach contents. While there is a little water in the bottle (f), empty the bottle (h) of water through (j) out-let and fill the bottle (f) again by taking the cork out

of it. Close the screw on tube (e) before taking the cork out of the bottle (f). After putting the cork in tightly open the screw on the tube (e). To keep up the same syphonage throughout, keep a little water in both of the bottles (f and h) and end of the tube (g) in the water while you transfer water from (h) to (f). If a bottle with the drainage connection (j) is not available, remove corks of both the bottles (f and h) and transfer water. Close screw on tube (e) before opening the bottle (f). Put a screw on tube (g) and close screw when you open the bottle and you will keep up the syphonage. After fixing the corks, open all the screws except on (b). When the trap bottle (d) is full, empty it by closing the screws on tubes (e) and (c). When the nasal tube does not work, wash it with measured clean sodium bicarbonate solution through the tube (b) remembering to close screw on tube (c). After cleaning, close screw on (b) and open screw on (c).



In some cases fluids can be given through the tube (b). These should be measured and recorded. Alkaline mouth wash can be given during suction to avoid dry mouth and to avoid accumulation of thick mucus in the mouth. Chewing gums or fruit lozenges can be given to stimulate salivation to avoid parotitis. Anything given by mouth or through the tube (b) should be measured and recorded.

The nasal catheter or duodenal tube is sterilized and kept in a basin of cracked ice at least for 5 minutes. It can be introduced then through the nose without lubricant by the doctor and the adhesive applied by the nurse to hold the catheter in good position. Connect the catheter or duodenal tube to the Y tube connected to the tube (c) leading to the bottle (d).

It is safe and convenient to fix the apparatus on a table of $3\frac{1}{2}$ feet in height behind the head of the patient's cot.

Cholera And Its Treatment

By DR. COLIN D. TORPY, M.M.F. (B.), I.M.D.,

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At the present time, the subject of cholera and its treatment occupies the front page of topics of medical interest, as the home of cholera is considered to be the delta of the Ganges; and we in Bengal, would indeed be guilty of gross ignorance, if we could not lead the rest of India in the correct methods of the treatment of a disease, which no matter where it breaks out, be it sporadically or in epidemic form, its source can be successfully traced back to lower Bengal.

Like the poor, cholera has been with us right through the ages, and history has it on record that the disease has been accurately described as far back as 400 B.C. by the learned Sanskrits. It was, however, not till the year 1817 that the disease became to be known as cholera when, in this year, a severe epidemic broke out in India. The causative organism up till then remained unknown, and it was not until over another sixty years—thanks to the eminent German bacteriologist, KOCH,—that the Cholera vibrio was finally discovered by him in Egypt, and his findings easily corroborated a year later in India. The year 1883 is a red-letter day in the history of cholera, as with the finding of the C. vibrio, prophylactic measures, always more important than the cure itself, were put into force.

The Cholera vibrio is a very actively motile Comma bacillus possessing a terminal flagellum or tail. It is very easily cultured on agar, potato, broth and gelatine media, producing in the last mentioned a typical liquefaction. It grows best at an optimum