

Citrate added to each ounce to make the milk more easily digestible; while the food should be given with a teaspoon and very slowly. If the doctor thinks it advisable he will order Lacto-peptin or Benger's Liquor Pancreaticus to be given after the milk for the same purpose.

The juice of fresh fruit such as grapes, oranges, pomegranates, and limes in small quantities is a part of the routine treatment. Strawberries have been found to act as a specific. Be careful that you get thoroughly good ones; start with one for each feed and then go on gradually increasing the number till the patient is able to take about 300 a day.

Drugs as prescribed by the physician will usually consist of those which stimulate the flow of gastric juice and increase the appetite. In spite of diarrhoea, the patient must have 1 teaspoonful of Oleum Ricini every five days to keep the bowels fairly open. Before giving any pungent or carminative mixture, swab out the mouth with Glycerine c Boracis and Cocaine to allay the soreness. The Salisbury treatment of Sprue consists in giving minced underdone meat and hot water, as also fruit juice. Beware of sour milk or butter milk, for it leads to fermentation in the stomach and intestines which we must try to avoid. Sir Patrick Manson advises small injections of the Arsenate of Iron.

In conclusion, three-quarters of the treatment of Sprue rests in the nursing. Therefore every nurse who takes up a case of Sprue must first and last remember that the patient must be entirely under her control; while she herself must implicitly follow the physician's instructions.

OPHTHALMIA NEONATORUM.

By Miss L. E. MACKENZIE.

ON this subject Dr. Sydney Stephenson, Ophthalmic Surgeon to Queen Charlotte's Hospital, London has a most interesting and instructive article in *The Practitioner* for September 1914. He mentions that from April 1st 1914, cases of ophthalmia neonatorum were compulsorily notifiable by medical practitioners in England and Wales including London. Dr. Stephenson's experience is that the disease is less frequent in hospitals than it used to be twenty-five years ago, though other surgeons have not the same opinion. Dr. Ernest Thompson of the Glasgow Eye Infirmary finds from statistics (1894-1906) that the disease is not less in that industrial centre. Dr. J. Jameson Evans of Birmingham also notes no decrease in the last twenty years. Doubtless owing to compulsory notification, many cases before suppressed are now officially on record, and this may explain the apparent want of improvement. The British Medical Association Committee on Ophthalmia Neonatorum in 1909 was constrained to admit that "cases of Ophthalmia have been found to occur amongst cases attended by medical practitioners, as well as amongst those attended by midwives." Of 62 cases

seen by Dr. Stephenson in Hospital work, 37 had been attended by medical men. Stephen Mayon investigated 162 cases, 90 of these had been attended by medical men and 72 by midwives. From the Report for 1912 of the Massachusetts Eye and Ear Infirmary we see, "out of 388 cases of ophthalmia in this infirmary 360 had been attended by physicians, and only 10 by midwives." According to the report of the Committee of the American Medical Association on Prevention of Blindness published in New York in 1912, twice as many infections occur in the practice of the physicians as of the midwives. Dr. Stephenson refers to the rules of the Central Midwives Board, by which every midwife is compelled to adopt simple precautions to prevent ophthalmia in every case she attends. For neglect of this duty midwives have again and again been struck off the rolls. He urges that such precautionary measures should be adopted equally by medical practitioners. For prophylaxis there seems to be an unanimity of opinion in favour of the 1 per cent solution of silver nitrate, of which a single drop is to be applied to the baby's eyes as soon as possible after the birth of the head. The use of the 1 per cent silver acetate, and 5 per cent sophol are also advocated, but Dr. Stephenson considers that the simple precautions of careful cleansing of the baby's eyelids and knuckles, and scrupulous care about the first bath, in short the strictest attention to asepsis in the broadest sense are quite efficacious.

Regarding the causes of ophthalmia neonatorum, taking a broad survey of every 100 cases of the disorder, 65 per cent are due to gonococci, 10 per cent to pneumococci, 5 per cent to *B. coli*, and 5 per cent to other organisms. Cramer surmises that some of the amicrobic cases may be due to injuries sustained by the conjunctiva while the baby is still *in utero*. Damage during the act of birth may also be the cause of infection. Another cause may probably be the use of too strong antiseptics, as a strong solution of silver nitrate, in the baby's eyes.

Ophthalmia is due to transfer, direct or indirect, of infective material from the maternal passages, the infant often blinks into its conjunctival sac infective material clinging about the eyelids or eyelashes, or rubs it in with its knuckles. It is rare, however, that inoculation takes place during the passage of the head through the vagina, though it may do so in face presentations, application of forceps, or digital exploration by midwives. That some babies are born with ophthalmia has been known for years. The explanation being, early rupture of the membranes and escape of the *liquor amnii* before the completion of the second stage of labour, allowing the infant's eyes to be infected with the gonococci, or other micro-organisms present in the maternal passages.

Kühne, Haussman, and Hellendall have proved that penetration of the intact *liquor amnii* by bacteria is possible. It is known that micro-organisms, especially the gonococcus, may lurk in the recesses of the uterine mucosa as the result of a latent gonorrhoea, and it is probable they may pass through the *chorion* and *amnion* and so reach the *liquor amnii*. They can then, during the later months of pregnancy when the baby's eyelids are no

longer adherent, infect the conjunctival sac. It has been found that when the *liquor amnii* is brownish in colour, muddy in consistence, and offensive in smell, ophthalmia neonatorum often results. Usually an ophthalmia that begins on the seventh day or later is due to secondary infection; while one that commences twenty-four hours after birth is due to intra-uterine infection.

Among the complications of ophthalmia neonatorum are mentioned arthritis of one or more of the larger joints; abscesses in connection with bone, parotid bubo, and various skin lesions.

Main points in the treatment are the removal of every trace of pus as soon as it is formed, needing unremitting care and attention, and the use of weak antiseptics; such as boric acid (saturated solution) potassium or calcium permanganate 1-5000—corrosive sublimate 1-10,000. Dr. Stephenson himself, inclines to use only saline lotion 1-4 per cent, considering antiseptics too drastic for an infant's eyes. For obstinate cases he uses silver nitrate 1 or 2 per cent, painted over the everted conjunctiva once in 24 hours.

NEW MEMBER.

TRAINED NURSES' ASSOCIATION OF INDIA.

<i>Name.</i>	<i>Training.</i>	<i>Present Appointment</i>
Beatrice Etta Yates	J. J. Hospital. Bombay. Government Maternity Hospital, Madras,	Private Nursing, No. 5 Colaba Causeway, Bombay.

PRIZE COMPETITION.

The prize of Rs. 5-0-0 for the November competition has been won by Nurse Manoramabai Bhatoolekar of the Cama Hospital, Bombay. The paper will appear in the January number.

The competition for January is "write what you know about Cholera and its treatment and Nursing" and for February the subject will be "Tetanus" of which fuller particulars will be given next month.

Superintendents are asked to make these competitions known amongst their nurses and where Indian nurses are competing to help with the translation. Both papers must be sent in. See "Special Notices" page v.