

not destroy all larvæ; many must be and are retained in the growth entanglement.

As larval destruction does not give the results that are desired, other methods have to be resorted to. I would advocate, firstly, that all barracks should have their doors, windows, and ventilators covered with fine wire-gauze. Desirable doors and windows to be so constructed that they could be opened at will. Undoubtedly, such a covering will keep a certain amount of breeze out, but I venture to think that with the lessened irritation from mosquitoes a better night's rest would be obtained.

In barracks, for British troops, where electric fans could be fitted, this mode of protection could be most easily fixed. The fans would not be interfered with, and adequate ventilation could be provided for, by means of suction and force fans. Over the force fans tatties could be arranged, thus ensuring a continuous stream of cool air being poured into the barrack.

Not only will mosquitoes be kept out but also flies, which is a very important factor in the prophylaxis of enteric. Unless the meshes of the gauze be very fine sand-flies will gain entry, but in less numbers. Can it be possible that sand-flies are a factor to contend with in malaria propagation?

If such a work be carried out by a contractor, very careful supervision will be necessary, or the gauze will be cut too small with the result that the edges will burst out and a seeming protection will be worse than a snare.

Although adequate protection can be procured during the sleeping hours, yet after nightfall, individuals can be bitten by mosquitoes when outside the protected barrack, but on the whole this is probably a minor point.

To obviate this, in barracks that are to be built in the future, let very careful attention be paid to the choosing of the sites.

If it is impossible to choose a site where no cultivation takes place for some miles to the windward side, let a site be so chosen that there are no inhabitants in the wind-swept area or if there are, have them moved to one side, and especially so in close proximity to the barracks. Then behind the barracks or the leeward side, have the quarters for followers and their children built so that if they do infect mosquitoes; these latter can be swept away by the wind and out of harm's way.

No doubt the gauze method of protecting buildings would cost a large initial outlay, yet with the results obtained in Italy and elsewhere, it certainly seems worthy of a trial, especially so when the saving in the cost of quinine is taken into consideration.

A time when many people are infected is probably during the time when dining in the open air is prevalent. Bites around the ankle are frequent, but only a little care is necessary in the way of Wellington boots or putties.

My experiences of quinine prophylaxis (liquid method) point out that the results are not as good as they ought to be. The reasons I believe, are that firstly a very inadequate dose is given, and in many cases immediate vomiting is induced. Even though this form of prophylaxis does good in that should a man have an attack of fever, he will in the majority of cases remain in hospital but three days. Thus with the liquid method of quinine prophylaxis good is undoubtedly done, and good to such an extent that it is worth continuing in a military outpost where it is necessary to keep the fighting men up to strength as much as possible. In a cantonment where the fullest possible strength is not so necessary, such a method is waste of money.

With the tabloid form of administration far better results ought to be obtained.* The correct dose will be given and vomiting but very rarely produced. I was able to satisfy myself that tabloids are far superior and probably adequate from the experience I had with a wing of a regiment marching up to Tibet through the Teesta Valley last June. All men got through without an attack of malaria, and I could not trace any case afterwards that was malaria due to infection in the Teesta Valley.

Mosquito curtains as such and in the shape of gauze doors and windows seem to be the prophylaxis which will give us the best results in the near future.

CATARACT COUCHING.

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COUCHING of the cataractous lens is probably as immemorial in the East as is the inoculation of the small-pox virus, possibly much more so, and I presume that it was introduced into Europe from the East as was the inoculation of the small-pox virus. In India at the present time there exists the caste of lens couchers—*ravals*—who travel over the country couching cataractous lenses, and I know one of them who comes to southern Europe every summer at the present time to perform this operation, and from all appearance he must be doing well from a money point of view.

We may look on couching the cataractous lens as a very retrograde proceeding, but when we find it seriously brought before the British Medical Association Meeting of 1901 by Mr. Henry Power, and an article published on it in the *Ophthalmic Review*, April, 1903, by Major Maynard, Indian Medical Service, who gives no very decided opinion as to its merits when compared with extraction, yet who leaves it to be inferred that he is on the whole an advocate

* Tablets should be available when a new and well organised Medical Store Depot and Factory is started under Government in India.—ED., *I. M. G.*

of the operation, such inference has been drawn, and, so far as I know, has not been challenged; considering that in Europe our opportunities for observing the results of this operation are very small indeed, it might be interesting to have the results of my observations extending over several years in the neighbourhood, which is the headquarters of the *navals* of India, and having had charge in that neighbourhood for several years of the largest ophthalmic hospital in the world as far as cataract is concerned.

There might have been a justification for the operation fifty years ago, when making a large open wound in the eye was a serious matter, but at the present time when we can extract cataract without fear of sepsis the justification for couching with a probe puncture has passed away unless it can show better results. There is no year in which I do not see over 100 cases which have been submitted to couching. I am satisfied that the vast majority of them go bad immediately either from suppuration or iridocyclitis, and I am disposed to think more from iridocyclitis than from suppuration. A large proportion of the remainder are but imperfectly couched, a portion of the suspensory ligament being left undetached, the result being that the lens floats up on this as on a hinge to its original position behind the pupil, which causes the patient to come to hospital to have it extracted. The few cases which look perfect I can imagine being regarded as miraculous. The eye has been touched and the blind patient sees, and I have no doubt but that he sees better for a short time after the operation than a case of extraction would if the capsule be left behind. This is the class of couched lenses which is of real interest to us as if we proceed to do the operation this is the best we could aspire to attain by the operation. In this class my observation is that while the eye looks beautiful there follows a slow and steadily progressive degeneration of the vitreous and of the retina, such as we see in *retinitis pigmentosa sine pigmento*, which leaves vision in the least rapid cases very poor at four years after the operation, and a few years further on leaves no vision at all. This, in my observation, is the invariable sequence; there may be exceptions—I have not seen them—they must be few.

Assume that suppuration could be avoided by doing the operation aseptically, from the large proportion of iridocyclitis which follows, presumably from the dislocated lens acting violently as a foreign body, and the progressive degeneration of the retina which follows in the best results, presumably from the lens acting mildly as a foreign body, I am of opinion that lens couching at the present time is an operation which should not be practised outside the ranks of charlatans.

As to the operation, it is far from being a simple one. The object of the coucher is to

completely dislocate the lens and to drop it down behind the iris. A clumsy operator often ruptures the lens capsule and goes no further—with evident results. It is no easy matter to completely dislocate the lens, and in my observation the partial dislocation is more frequent than the complete dislocation in the hands of adepts in the art.

A PTERYGIUM OF BACILLI.

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THE following case presents some points of considerable interest:—

The patient, a Balti cooly, came to hospital, complaining of a growth on the left eye. He gave the history of a blow from a stick on the closed eye. The growth made its appearance shortly after this accident; according to his statement it is one year old.

The situation and dimensions of the growth are clearly shown in the photograph and call for



little further description. It is seen to occupy an area of conjunctiva and cornea corresponding in size to that of a pterygium, but here its resemblance to the latter ends; the growth under description is composed entirely of bacilli. It is snow-white in colour and is raised about $\frac{1}{2}$ in. above the corneal and conjunctival surfaces. The white colour of its corneal portion is very striking, and stands out very markedly against the dark-brown of the patient's iris. The conjunctival portion is by contrast less striking. Underlying the growth and conjunctiva, and at the corneo-sclerotic margin, is a dark coloured patch which looks like extravasated blood. This