

## INDIA

**Early Bagassosis.**—Ganguly and Pal (*J. Indian M. A.* 24:253 [Jan. 1] 1955) reported on the importance of bagassosis, an industrial disease caused by the inhalation of bagasse dust. This is a waste product of sugar cane after the extraction of sugar and is used extensively as a raw material for manufacturing paper. Three cases of this disease are reported for the first time in India. The disease manifests itself as an acute allergic response to the dust, which probably contains a protein mixture that acts as an antigen. A bacterial infection is usually superimposed, causing acute bronchiolitis. Patients are brought to the hospital for fever, cough associated with tenacious sputum, dyspnea, and hemoptysis. If treated early the pulmonary condition resolves completely, but if left untreated it passes into a chronic stage with fibrosis, emphysema, and bronchiectasis. The three patients came from the same paper mill. Repeated sputum examination showed no acid-fast bacilli. Roentgenograms of the chest showed fine mottling or miliary nodules in the lungs. Complete rest and no contact with bagasse dust alone caused subsidence of symptoms. Injections of penicillin twice a day for about 10 days helped to control the disease. Roentgenograms after three months showed complete disappearance of the lesions. To prevent relapse these patients were advised not to work any more in a factory where bagasse dust was prevalent.

**Intragastric Oxygen for Ascariasis.**—At a meeting of one of the local medical societies in Bombay, D. D. Vora reported on the treatment of ascariasis with intragastric oxygen. The patient eats a light meal in the evening preceding treatment and takes a warm water enema the next morning. In a series of 31 patients good results were obtained in 20, in that no subsequent purging was required. No untoward side-effects were observed. In addition to being effective, this treatment is much cheaper than treatment with santonin and the other commonly used vermifuges.

## ITALY

**Symposium on Portal Hypertension.**—At the 56th convention of the Italian Society of Surgery in Rome Prof. Valdoni of Rome said that the hepatic artery should be ligated when the increased portal tension parallels the increased pressure in the hepatic artery. In patients in whom the portal hypertension is due to alterations in the spleen, the most logical procedure is to remove the spleen and perform a splenorenal anastomosis. For all other patients porta-caval anastomosis is performed. The speaker prefers a side-to-side anastomosis because this permits the blood arriving in the liver through the hepatic artery to flow through the anastomosis. The ligation of the portal vein at the hilus of the liver and the anastomosis of the stump to the inferior vena cava does not facilitate the flow of the arterial blood through the liver into the suprahepatic arteries. Side-to-side anastomosis presents great technical difficulties, which can often be overcome only by means of an interposed graft. Valdoni ligates and sections the inferior vena cava above the iliac veins and implants the proximal stump into the portal vein. This technique has the advantage of creating the maximal difference of pressure at the anastomosis, and this is one of the best means of maintaining the patency of the anastomosis. With this operation excellent results are obtained except in patients with cirrhosis of the liver, because in these patients uncontrollable capillary hemorrhage from the retroperitoneal vessels occurs after the operation.

According to Dr. Ruggeri of Naples, the operation of choice in hypertension due to cirrhosis of the liver is ligation of the hepatic artery. Professor Trivellini of Pisa, in comparing the various types of arterialization of the portal system, expressed a preference for end-to-end anastomosis of the splenic artery to the splenic vein after splenectomy. Unlike a porta-caval anastomosis and ligation of the hepatic artery, arterialization is the operation of choice for chronic hepatitis with jaundice and portal hypertension. There remains the question: To what should the improvement in the liver parenchyma that follows these operations be ascribed? Is it due to a decrease in the portal pressure?

## NORWAY

**Phenylindandione as an Anticoagulant.**—Dr. Rolf Jorde has had encouraging experiences with the use of phenylindandione as an anticoagulant in 30 patients: 12 with myocardial infarcts, 11 with angina pectoris, and 7 with thrombosis and embolism (*Nordisk medicin*, April 14, 1955). With only one exception, the treatment was started while the patients were in hospital, and the blood's content of prothrombin-proconvertin was determined by Cwren's method. When the patient left the hospital, written as well as oral instructions were given and the patients were requested to check the dosage schedule daily. On returning to the hospital for a check-up, they received further written instructions. Treatment lasted from 59 to 784 (average 339) days. In most cases the prothrombin-proconvertin level fluctuated between 10 and 30%, but some patients presented one or several higher peaks. In most instances this was due to a need for an increased dosage of phenylindandione. Fluctuations below 10% were rare. The patients were examined at intervals of about 17 days. During 84% of the 10,174 patient-days observed, the prothrombin-proconvertin level remained within the therapeutic range. It was necessary to give vitamin K because the prothrombin-proconvertin level was too low in only 2 cases. The first was that of a man, aged 42, whose phenylindandione treatment had to be discontinued on account of melena with a prothrombin-proconvertin level of only 24%. Blood transfusions supplemented by vitamin K given by mouth were followed by cessation of the melena and a rise of the prothrombin-proconvertin level to 80% after 24 hours. The other patient was a woman, aged 60, who bled profusely after the incision of a whitlow. Her prothrombin-proconvertin level rose from 20 to 60% when vitamin K was given. As she had not followed instructions properly, she was largely responsible for this mishap. To prevent similar mishaps, all the patients undergoing this treatment are warned verbally and in writing not to submit to any surgical operation without control of the prothrombin-proconvertin level and the advice of the physician in charge. Jorde concludes that phenylindandione is well suited to prolonged anticoagulant treatment under ambulatory conditions, for it is easier to maintain a steady prothrombin-proconvertin level with a constant dose of phenylindandione than with bishydroxycoumarin.

**Blood Tests for Cancer.**—At the pathological department of the Gade Institute in Bergen, Dr. Kristen Austarheim has investigated the claims made for certain blood tests said to be diagnostic of cancer. He chose the following three as they are comparatively easy, need no well-equipped laboratory, and are said by their sponsors to contribute much to an early diagnosis of malignant disease: Black's methylene blue test, the Black-Kleiner-Bolker heat turbidity test, and the Bolen test. Of the 316 persons examined, 56 had histologically verified cancers, 21 had cancers not thus verified, 12 had malignant reticulosis, 12 had benign neoplasms, 183 had nonneoplastic diseases, and 32 were healthy controls. Fourteen of the 56 patients in the first group were reexamined about one year after the completion of treatment to evaluate the prognostic significance of the tests. None of the tests gave impressive results. In 14.6% of the 89 cases of malignant disease, all three tests were negative, and, in 33% of the patients with nonmalignant diseases, there was a positive reaction to at least one of the tests; this was also the case with 9% of the presumably healthy controls. As compared with the other two, the Bolen test gave fewer false positive and false negative results, but none of the three could be considered suitable as screening tests in a mass survey. The trials were, however, encouraging when the tests were applied to patients a year after the completion of some form of treatment. Here there was good correlation between the findings of the tests and the clinical examination in most of the patients. It is therefore possible that such tests may be of value in giving a clue to the effectiveness of treatment. Austarheim concluded that the shortcomings of these tests were due to the fact that they depend on nonspecific physical and chemical changes in the blood. Thus they do not tell us much more than the sedimentation rate, which depends on the same conditions. He believes, however, that with the exercise of discretion, clinicians may find such tests of some value in individual cases.