CASE 1.—An Englishman, 38 years of age, had lived some years in Rhodesia. He had several attacks of malaria which had lately become more frequent and more severe, so that he had obtained leave of absence for a trip home. I saw him the day he came aboard in Cape Town. He was a tall, emaciated man, with a leaden hue of countenance. He had an attack of ague the following day and thence every other day for three attacks (tertian form). The patient went through the usual three stages of the "ague fit," the temperature each time reaching 104.5°F . He was treated at first with 30 grains of bisulphate of quinine per os in the 24 hours. He was accustomed to take such quantities. In the second attack he vomited every dose and the quinine was therefore injected into the rectum. After the third attack I bethought me of the acid hydrochloride which I had among my own remedies and I boiled 10 grains in a test tube and injected it in the gluteus muscle, following this by 5 grains of the same salt in cachet three times a day. From that time he had no more attacks. He got stronger and left his bed and came on deck and remained free for the rest of the voyage.

CASE 2.—An Argentinian, aged 28 years, arrived in Uyuni, Bolivia, having walked and ridden on mule back a long distance from Salta in the Argentine Republic. He described how he had literally dragged his way along, suffering off and on the whole journey from attacks of ague. He told me that it was no use giving him quinine as it usually made him worse. This man had two attacks in the hospital at Uyuni at the same time on following days (quotidian form). After the second attack I treated him with injections exactly as in Case 1, and he had no more attacks. He took a mixture of iron and quinine phosphate for a month after, when he left the place quite well.

CASE 3.—A Chilian, 23 years of age. He had an attack of malaria a year ago in Africa. He had a rigor while in the consulting-room, when his temperature rose to 104.5°F . It fell the same evening to normal. The second and third days he had an attack at 10 A.M.—i.e., three attacks in all on following days at the same time (quotidian). He was treated in the same way and was kept in a week later for observation.

It will be noted that the dose (10 grains) is in excess of that given in the books. Martindale says $\frac{1}{2}$ to 2 grains hypodermically. The solution of 10 grains in a drachm of water boiled in a test-tube is injected deep in the deltoid or gluteus muscle with aseptic precaution. I am aware that three cases do not form an important criterion, but I think the success of these three warrants its further trial. I may say I have not treated any other cases of malaria than these three since I first read of the method.

Antofagasta, Chile.

FORMATION OF THE UPPER LIP BY AN EXTENSION OF THE FOREHEAD FLAP IN RHINOPLASTIC OPERATIONS.

BY MOTILAL T. AVASIA, L.M.S.

THE formation of an artificial nose by a flap from the forehead, as practised in the so-called Indian operation, is a more feasible procedure in mutilation of the organ than some of the other methods; it has the advantage of curing the patient of another unsightliness. When the nose is cut the upper lip usually goes with it, leaving a permanent disfigurement and exposing the upper line of the teeth. The new lip can be formed by a flap from the cheek, but it causes additional scarring and distortion of the face, so that it is best to devise a flap from the forehead for forming a new lip. When the flap is taken from the forehead for forming a new nose, a flap proportionate to the size of the lost upper lip should also be dissected out, *continuous with* the columnar portion of the nasal flap, so that its blood-supply is ensured from the same source until it is permanently fixed in its new position. The labial flap must be united on either side to freshened edges of the skin at each angle of the mouth. The shape of the forehead flap with the labial accessory is something as follows (see illustration). The portions A, B, and C represent respectively the labial flap, the columna, and the nasal flap in outline.

The operative procedure in ordinary rhinoplastic operation by forehead-flap requires to be varied in the following particulars when the accessory labial flap is added to the main nasal flap. 1. The root of the flap ought to be about two

lines larger. 2. It is difficult to suture the columna, so that the alternative procedure must be adopted of freshening the site for its implantation and keeping the columna in position by the help of plugs inserted into the newly formed anterior nares and by the pressure of dressings, and ensuring recumbency for a week. 3. The extremities of the labial flap must be sutured to corresponding gaps at the angles of the mouth, and the flap should be taken about one inch longer

and a quarter of an inch wider than actually required as shown by measurement. 4. Horse-hair previously sterilised in hot water and carbolic solution (1 in 40) is the best material for suturing, as it causes no tension; the late Dr. Shah used the same material probably for the same reason. The hair may be doubled if a single thread is found too weak for holding its charge in position. 5. The under surface of the labial flap must be protected from contact with the fluids of the mouth by a pad of carbolised lint; this may not be essential, but I could find no drawback to it in the cases in which I have used it. 6. A pad of lint should also be placed on the upper surface of the lip-flap and the latter should be secured in position by strips of plaster. 7. The mouth should be syringed out with weak carbolic lotion once a day and the patient kept on milk or any other liquid diet. The first and the second dressings must be done by the operating surgeon himself for several reasons. I mention the following case in illustration of the result of the operation. A woman, aged 25 years, had her nose cut off and also the upper lip when she presented herself for treatment. On Jan. 7th last an attempt was made to form a new lip along with the nose in accordance with the technique described above. She was discharged 35 days after operation with the lip flap united completely and thus with much of her disfigurement remedied.

State Hospital, Junagar, Kathiawar.

Medical Societies.

BRIGHTON AND SUSSEX MEDICO-CHIRURGICAL SOCIETY.

Exhibition of Cases.—President's Address.

THE first meeting of this society for the new session was held on Sept. 3rd. The officers for the year are Mr. C. J. Jacomb-Hood, President, and Mr. W. A. Bowring and Dr. L. A. Parry, honorary secretaries.

Dr. WALTER BROADBENT exhibited a case of Tuberculous Laryngitis and a case of Splenic Leucocythæmia. He also showed a skiagram of Cervical Ribs which had been diagnosed as an innominate aneurysm.

Mr. BOWRING showed for Dr. F. J. PALEY a case of Periosteal Sarcoma of the Thigh, which had necessitated amputation at the hip-joint.

THE PRESIDENT then delivered his official address on Theology and Medicine, in which he considered "the obstacle which was presented to the progress of medicine for over 1000 years by the theological view of disease." Nothing in the evolution of human thought, he said, appears more inevitable than the idea of supernatural intervention in producing and curing disease. The causes of disease are so intricate that they are reached only after ages of scientific labour. In those periods when man sees everywhere miracle and nowhere law, when he attributes all things which