

219

p. 1
1929.

9
1

The Deccan Medical Journal

vol-6

NO-1

April-1929



JL

Lm 216, N2/4

N29.6.1

160871

Price B. G. Rs. 1-8-0
Foreign 2sh Post Free.
Annual Subscription B. G. Rs. 5
From the Editor.

Vol. VI. No. 1
April 1929.

THE
Deccan Medical Journal

PUBLISHED BY
The Hyderabad Medical Association

Vishu
CONTENTS

NOTES OF LECTURE ON APPENDICITIS

BY CAPT. S. C. ALAGAPPAN, M. B. B. S., F. R. C. S. E.:
I. M. S.

PHOTOPHOBIA—BY DR. K. P. POPAT, L. R. C. P. & S. L. M. 17

LEPROSY—BY DR. M. G. A. YAMINI, L. M. & S. 23

FOUR CASES DEMONSTRATED

BY CAPT. S. C. ALAGAPPAN, M. B. B. S., F. R. C. S. E.:
I. M. S. 35

ABSTRACTS AND NEWS 41

ANNUAL REPORT OF THE HYDERABAD BRANCH OF THE

B. M. A. FOR 1928 54

COL. JOHN NORMAN WALKER 59

EDITORIAL

DIRECTOR OF THE MEDICAL DEPARTMENT, HYDERABAD,
DECCAN 60

POST GRADUATE NOTES

i. PEPTIC ULCER 62

ii. CLINICAL NOTES 65

EDITOR

V. R. GORAKSHAKAR, B. A., M. B., Ch. B., (Edin.)
OSMANIA-GENERAL HOSPITAL,
HYDERABAD-DECCAN



The Bengal Immunity Co. Ltd.

ESTABLISHED 1919

The Premier Establishment for the Manufacture of
Sera, Vaccines, Injectuins and other
Organotherapeutic Products

Awarded Gold Medals at the All-India Medical Exhibitions

DIRECTORS:

Hon'ble Sir Nilratan Sircar, Kt. M.A.,
M.D.

Rai Harinath Ghosh, Bahadur M. D.
Hari Sankar Paul Esqr. of Messrs B. K.
Paul & Co.

Dr. K. Ghosh, D. T. M. & H., (Cantab).

Dr. Indu Bhasan Basu, M. D.

Captain Narendra Nath Dutta, M. B.,
Managing Director.

HON. WORKING COMMITTEE.

Dr. Bidhan Chandra Ray, M. D., M. R.
C. P., F. R. C. S. (Engl.)

Dr. Harinath Ghosh, M.D., Rai Bahadur.
Dr. P. Nandy, M. D.

Dr. A. Chakravarty B. Sc., M. B.

Dr. Manindra Nath De M. B. (Cal),
M. R. C. P., (Lond.)

Dr. Dharendra Nath Banerjee M.B. (Cal)
M. D. (Berlin)

Dr. H. Ghose M. B.

Dr. D. R. Dhar M. B., T. M. (Cal).
M. R. C. P. (Lond.)

Dr. B. B. Sen M. Sc., M. B.

Captain N. N. Dutta, M. B.

Dr. B. C. Das, B. Sc., M. B., Secretary.

Laboratory fitted up with most up-to-date apparatus. Works carried
on under the direct supervision of Medical Experts and hence products
absolutely genuine and reliable.

Vaccines prepared from highly virulent Strains

Our Sera—A Speciality

The only fresh and genuine Sera in the market

Anti-Dysenteric, Anti-Streptococcal, Tetanus and
Diphtheria Antitoxic and Normal Horse Sera

Liberal Commission allowed to Trade and Profession. For Terms,
Lists and Literature, please write to Managing Director,

153, Dharamtolla Street, Calcutta

Telegram: "INJECTULE,"

13 JUL 1929

Notes of lecture delivered

BY

CAPT. S. C. ALAGAPPAN, M. B. B. S., F. R. C. S.,
I. M. S.,

*on 16th March 1929, under the auspices of Hyderabad
Branch of the B. M. A. on Appendicitis.*

DEVELOPMENT.

(1) Alimentary canal appears in the Foetus
in the form of a longitudinal tube, suspended by a
Dorsal mesentery.

(2) Then it becomes differentiated into Fore-
gut, Midgut and Hindgut.

(3) In the 6th week of Foetal life, a projec-
tion appears in the alimentary canal, which forms
the coecal diverticulum, which enlarges equally in
all directions upto the end of 4th month.

(4) From the 5th month, the lateral side of the
coecum continues to increase in size, whereas the
medial side lags behind in development and the apical

part of the coecal diverticulum does not develop at all, thereby retaining its tubular shape and forms the appendix.

(5) At the same time, a rotation of the Hindgut over the Midgut takes place and the coecal diverticulum comes to be placed below the liver bud.

(6) In higher vertebrata, e. g. plant and higher apes, who have assumed the erect posture, the caecum descends down from the Hypochondriac (or below the liver) position to the Iliac position, dragging the appendix and its Mesentery with it. This descent is more or less complete at birth.

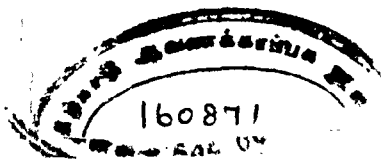
(7) The longitudinal muscular coat of the caecum and colon assume a specialised development, thereby forming the Taenia Coli. This gives rise to the formation of saccules and pouches in the caecum.

(8) As we have seen above, the lateral and medial halves of the coecal diverticulum differ in their mode of development. At birth, the appendix is still the tapered apex of the caecum. Soon after birth, during childhood the development of the saccules of the caecum, thrust the orifice of the appendix into an asymmetrical position.

COMPARATIVE ANATOMY.

(1) The appendix is present as a distinct structure only in human beings, anthropoid apes and certain rodents.

(2) A corresponding lymphoid diverticulum of the coecal apex is present in most mammals.



219
1-10-21/1124
1129.5.1

219

(3) In birds, the appendix is divided. The appendix is occasionally double in malformed human infants, with right and left Mesenteries.

(4) It is present in most mammalia, with a herbivorous habit.

(5) It is not vestigial in nature any more than is the Tonsil.

DEVELOPMENTAL ABNORMALITIES.

(1) The rotation of the bowel might not take place. Then the caecum and the appendix will be behind the small intestine on the left side.

(2) Also the rotation might take place in the opposite direction. Then the appendix will lie in the left Iliac Fossa.

(3) The appendix and caecum might lie in any position from the right hypochondriac to the right iliac region, owing to imperfect descent.

(4) The appendix may be double, with two distinct mesenteries, as stated above.

(5) The artery to appendix is in most cases caught behind the terminal part of the Ileum, during the descent of the appendix.

ANATOMY.

(1) Its length may vary from $\frac{3}{4}$ " to 9".

(2) Its size may be very small or it may be as thick as one's thumb.

(3) Its position may vary like the hands of a clock.

(4) In the great majority of cases, it possesses a mesentery, known as the Meso-appendix, which is derived from the left leaf of the Mesentery, which may or may not be infiltrated with fat, depending on the amount of vegetable intake.

(5) The artery to the appendix, derived from the Ileo-colic branch of the Superior Mesenteric is a vessel of some considerable size, running along the free border of the Meso-appendix behind the terminal ileum and giving branches across to the appendix, all along its course. It very often gives a recurrent twig, which arises close to the origin of the main artery, loops down on itself, to supply the proximal part of the appendix.

(6) The lymphatics open into the glands on the medial aspect of the caecum.

(7) The nerve supply is derived from the superior Mesenteric sympathetic plexus. The appendicular plexus arises from 12th thoracic and 1st lumbar segment of the sp. cord.

HISTOLOGY.

(1) The serous coat, derived from the peritoneum is, in most cases, complete.

(2) The muscular coat consists of longitudinal, circular and spiral muscle fibres. The longitudinal muscular coat is a prolongation of the Taenia coli of the caecum.

(3) The sub-mucous coat is almost entirely occupied by large masses of lymphoid tissue.

(4) The Tunica muscularis mucosae is thin and ill defined.

(5) The mucous coat resembles that of large intestine, but the glands of Lieberkuhn are fewer.

APPLIED ANATOMY.

(1) There is nothing definite about the appendix. Its size, length and position are all variable. The appendix may even be absent.

(2) The Meso Appendix being free, renders it liable to be kinked, twisted or snared. It also allows the appendix to occupy any position it likes.

(3) The Artery to appendix, being single, gives rise to severe gangrenous inflammation of the appendix, if thrombosed. And thrombosis is very liable to occur, owing to pressure by faecal matter in the terminal part of the ileum during its retroileal course.

(4) The presence of large masses of lymphoid tissue in its submucous coat renders it very prone to infection.

(5) The normal action of peristalsis in the appendix is from the apex to base, as will be seen from its development; and is, therefore, capable of expelling any faecal matter or foreign body that might get into its lumen back into the caecum.

(6) The aperture of the appendix into the caecum is, in most cases, guarded by a tiny valve, called the valve of Gerlach. If this valve should become swollen by inflammation, it will naturally occlude the orifice and thereby prevent the contents of appendix from getting back into the caecum.

(7) The appendix is entirely surrounded by peritoneum and projects free into the peritoneal cavity. So, any inflammation, involving its serous coat, is liable to result in general peritonitis.

PHYSIOLOGY.

(1) We know nothing so far, regarding the function of the appendix.

(2) It is not a developmental relic as is often alleged.

(3) The predominant lymphoid element in its submucous coat has given it the name of 'Abdominal Tonsil'.

(4) The fact remains that things unwanted, like orange pips, segments of Tape-Worm, shot, Faecal concretions, etc. tend to be segregated inside the appendix.

(5) In 40% of people, it tends to undergo atrophy and obliteration after middle life though it has been found intact even after 79.

AETIOLOGY.

(1) It has been stated by orthopaedic Surgeons that a certain type of people, who are tall, thin, with narrow back, lordotic spine, scaphoid or boat shaped abdomen, with shallow subcostal angle, with tendency to visceroptosis are very liable to appendicitis. In people of this description, the caecum is unduly large and prolapses very readily into the wound. The Operating Surgeon, who removes the appendix in such a case, has to consider the question

of plication, pexy or suspension of the caecum. In such cases, the caecum is also of a bluish tinge.

Such a discolouration, is not due to pigmentation, but is due to passive congestion, resulting from visceroptosis. It would appear that people, who are broad backed, pot bellied, with square shoulders and short thick necks are not so liable to appendicitis. (cochhane).

(2) Either entry of infected foreign matter into the lumen, or thrombosis of the single main vessel, which is very probable owing to its retro-ileal position, accounts for inflammation of the appendix.

(3) Tuberculosis, malignant disease and specific disease have also been known to affect the appendix.

BACTERIOLOGY.

(1) The latest theory regarding the bacteriology of appendicitis is that it is due to an intra-mural infection by the streptococcus pyogenes (Rosenow)

(2) Appendicitis, cholecystitis, gastric and duodenal ulceration are all supposed to be allied to each other forming one symptom complex due to one common infection, i. e. the streptococcus. So, patients, who are liable to such an infection, get appendectomy, cholecystectomy or gastrojejunostomy performed on them, depending on the symptoms manifested by them and, some times, on the enthusiasm of the Surgeon, in the particular field concerned. Those few patients, who are unfortunate enough to be indefinite in their symptoms, get their appendices taken

out first, gall bladder next and gastro-jejunostomy performed on them last. And still they may go on with their old indefinite symptoms, along with the super-added benefits conferred on them by the Surgeon.

(3) Our old friend, *Bacillus Coli*, is not so liable to be blamed in the causation of appendicitis, though he may be associated with and add to the virulence of the *streptococcus pyogenes*.

(4) *Anaerobic* organisms play an important part in gangrenous appendicitis.

MORBID ANATOMY.

(1) If we remember the clinical picture presented by Acute Tonsillitis, it is not difficult to imagine the pathological appearance of Acute appendicitis.

(2) The mucous membrane, or perhaps the whole appendix may be intensely red, swollen, highly inflamed and angry looking. The inflammation may go to gangrene of part or whole of appendix in severe cases.

(3) There may be pus-formation inside the appendix or outside, when a localised abscess has formed, with or without perforation: or, there may be collection of only serous fluid inside the appendix or outside.

(4) The appendix may be adherent, in part or its whole extent, may be twisted, kinked or snared or may present only fibrinous lymph exudate on its serous aspect.

(5) The lumen of the appendix may be obliterated in part or its whole extent or may present one or more strictures owing to previous inflammation.

SYMPTOMS.

(1) The first symptom usually noticed and complained of by the patient is pain in the right side of abdomen, anywhere from the right Hypochondriac to the right iliac region. In typical cases the pain is referred to the right iliac fossa.

(2) Vomiting may or may not occur. It is usually present, when there is involvement of the serous coat.

(3) Constipation may or may not be complained of. In rare instances, there may be diarrhoea.

(4) Fever may or may not be present.

SIGNS.

(1) Tenderness, on deep palpation, can usually be elicited either in the right iliac or right lumbar region. There may be Hyperaesthesia of the skin over Mc Burney's point.

(2) Rigidity of overlying abdominal muscles may or may not be present, depending on the amount of involvement of the serous coat.

(2) Rigidity of overlying abdominal muscles iliac fossa. Fluctuation owing to abscess formation is usually not elicited and is unwise to attempt to elicit owing to danger of rupture.

(4) Temperature is usually normal or even subnormal. In some cases, it is 99° F. In exceptional cases, it is above 100° F.

(5) Pulse rate is usually above normal, and ranges from 80 to 90 p. m. It may be as low as 50 to 60 p. m.

(6) Tongue is usually furred.

DIAGNOSIS.

(1) A consideration of the above signs and symptoms usually lead to a correct diagnosis, though one seldom gets the typical clinical picture.

(2) The patient may feel extraordinarily well, in spite of serious disease of appendix being present and vice versa too. I have actually had cases brought to me from the Parade Ground and so forth with gangrenous appendicitis.

(3) A rising pulse rate, taken along with other symptoms, is very useful in establishing the presence of inflammation.

(4) The importance of Rectal Examination in making a diagnosis of appendicitis cannot be overestimated.

DIFFERENTIAL DIAGNOSIS.

(1) Cholecystitis and pyelitis should be excluded in cases of Retro-coecal Appendicitis.

(2) Inflammation of Fallopian Tube and Ovary will have to be excluded in females.

(3) Gastric and Duodenal ulcer should be diagnosed from in cases of perforation.

(4) There are heaps of instances in which appendicectomy has been performed, when the real trouble was in the Thorax, with pneumonia or pleurisy on the right side.

TREATMENT.

(1) There are usually two 'don'ts' to be observed in these cases. First is 'Don't give a purgative of any sort'. Second is 'Don't give opium in any form, until a diagnosis has been arrived at'.

(2) Medical treatment is useless, except as a temporary and palliative measure. It may even prove dangerous, owing to sudden development of acute symptoms, consequent upon delay in operating.

(3) I always believe in operating as soon as a diagnosis has been made, irrespective of the duration of time that has elapsed from the beginning of the attack. Because, in my opinion, an honest and a patient attempt on the part of the Surgeon to remove the appendix is almost always successful even though appendix may be very adherent, with a large amount of overlying Omentum. The number of cases of appendix, that cannot be removed, owing to its very adherent nature, or perhaps, in most cases, owing to the inexperience of the Surgeon, are very few indeed. I have had only one such instance during all my practice, where the appendix was embedded in the wall of the caecum and had to be left there, with a view to avoid rupture of the caecum. In such few instances, where the Surgeon is unable to remove the appendix, he can, at least, satisfy himself by allowing for drain-

age by opening the abdomen and seeing things for himself with a view to facilitate future interference. I have never had a case of general peritonitis ensuing, owing to interference at a so-called inopportune moment. On the other hand, I have seen cases die of general peritonitis, owing to delay in operating by temporising.

(4) All the various incisions used for appendectomy resolve themselves into two main types, i. e. the muscle splitting or grid iron incision and the Para Rectal incision. The tendency of most modern Surgeons, I find, is to do their appendicectomies, through the Para Rectal Route, instead of through the Grid iron route. And the only reason adduced by them in support of the Para Recta incision, in preference to the other, is that it gives one an opportunity of examining the Gall Bladder and Duodenum. I would like to know in what percentage of cases, owing to difficulty in diagnosis, the Surgeons who use the Para Rectal Route have had to do a cholecystectomy or a Gastrojejunostomy, through that incision. I should say the answer will be very few or perhaps Nil. Even granting there are few cases, where these operations might have to be performed after opening the abdomen I would like to know how far a cholecystectomy or a gastro-jejunostomy could be successfully performed through an infra-umbilical, right Para Rectal incision.

The Grid-iron incision has several points to recommend for itself, though it might be old fashioned.

(a) It gives one a direct and straight approach to the site of the lesion. (b) It is never

followed by a Ventral Hernia, as the sutures are all crossing each other unlike in the para rectal method, where they are in the same line. (c) Drainage is much better effected through a grid iron than a para rectal incision. (d) in cases of abscess formation there is no danger of general peritonitis in the grid-iron route, as there is in the para-rectal route, where one has to wade through healthy structures before one gets to the diseased area. (e) The incision by the para rectal method, has to be unduly long in order to give sufficient exposure in cases of Retro-Coccal, Pelvic or Adhesive appendicitis. (f) Also a good deal of packing to prevent the prolapse of small intestine is necessary in the Para Rectal incision, whereas little or no packing is necessary in the grid-iron incision. (g) There is no division of nerves at all in the grid iron route, as there is in the para rectal method. So far as incisions are concerned, I must say I am still old fashioned, preferring the grid-iron route to the other. My only reason in still being old fashioned, in this respect is that progress in Surgery must be justified, pari passu, by increased efficiency. And any modern progressive step adapted, leading to diminished efficiency thereby, surely cannot have very much to speak for itself. A small grid iron incision about 1½" long at Mc Burney's point gives ample room for the removal of even adherent and gangrenous appendicitis. In few cases where additional room was required and in years gone by, when I did not possess so much experience as I do now, I have some times divided the Internal oblique and Transversalis vertically downward, close

to their attachment to Rectal sheath, thereby forming a triangular flap, which could be turned downwards, thereby giving ample room for the operation, and which could be quite efficiently stitched up after the operation. Such a small incision, I usually make now-a-days, leaves very little damage on the abdominal wall.

(5) After the skin and subcutaneous tissues have been divided and the muscles split, the peritoneum is divided in the same direction as the skin incision. Then three retractors are used, one on the medial, one on the lateral and one on the inferior aspect. Then the coecum is brought out with the help of a piece of gauze, dipped in saline. If the appendix is adherent, generally gentle gauge dissection frees the same. Any bands present, must be clamped and divided.

(6) The Meso-appendix, with its artery, must be ligatured at as low a site as possible and then must be free from tags of Meso-appendix.

(7) Then the purse-string suture must be put in, on a sufficiently wide circle in order to allow of easy invagination.

(8) Then the appendix must be efficiently crushed at its base, and ligatured.

(9) Then the parts below the ligature being protected by gauze or pads, the assistant gets hold of the stump at the ligature with dissecting Forceps with his left hand and holds pure carbolic on a probe in his right hand. This little manoeuvre prevents

the stump from retracting into the abdomen before invagination is completed. Then the Surgeon divides the appendix between the clamp and the ligature cleanly with a scalpel, while the assistant, soon after, cauterises the inside of the stump. Then the invagination of the stump is proceeded with.

(10) The question of invaginating the stump of the Meso-Appendix should also be considered, where necessary.

(11) It is essential to peritonise all raw areas as far as possible, with a view to prevent the formation of subsequent adhesions. With this object in view, Mr. Wilkie of Edinburgh pours about an ounce of autoclaved liquid paraffin in the operated area, before closing the abdomen.

(12) The abdominal wall must then be sutured in layers.

AFTER TREATMENT.

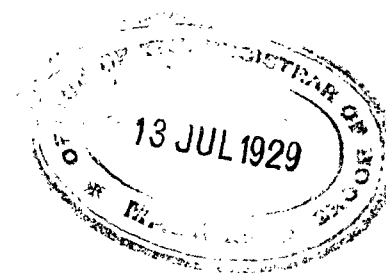
(1) As soon as the patient recovers from the effects of anaesthesia, the Head end of the bed is blocked up to a height of one foot. After 12 hours, the patient is put up in Fowler's position.

(2) An enema (soap and water) is administered on the morning of 3rd day: and a purgative, an ounce of Mag. Sulph dissolved in two ounces of water, is given on the morning of 4th day.

(3) They are usually kept on milk diet till the temperature drops to normal, when ordinary diet is resumed.

(4) Stitches are removed usually on the 8th day, unless there are indications to remove them earlier.

(5) Patients are allowed up after 12 to 15 days, as it is unwise, in my opinion, to allow too much liberty to Indian patients who are inclined to be inquisitive about their dressings and so forth and who usually overstep the limits of safety in the matter of exercise allowed for them.



Photophobia

(Intolerance to light).

BY

DR. K. P. POPAT, L. R. C. P. & S. L. M.

PHOTOPHOBIA is a symptom complained of by about seventy-five per cent of people and hence you will find in Hyderabad every second man using Wilson Goggles, Amulets etc.

Causes:—Error in refraction especially astigmatism, excessive glare, weakness due to general diseases, poor nutrition, disease of the eye: granular lids, conjunctivitis, solaris pterygium, keratitis, iritis, cyclitis, albinism, coloboma, large iridectomy, hyperaesthesia of the retina, electric ophthalmia frequently observed amongst workers with arc and other forms of electric lights, eye-strain due to working at night in bad light, neurasthenia, hysteria, weakness or strain of the sphincter muscle of the iris, ciliary muscle or of the extrinsic ocular muscles.

Symptoms:—The lids are screwed up, the brows puckered and the iris kept in a state of constant con-

stant contraction in order to exclude the light. *The expenditure of the nervous energy required to bring this protective mechanism into play tends to produce brain fatigue and drowsiness.* Generally it is attended with some of the following symptoms: watering, burning, itching, headache in the sun, physical and mental exhaustion in the sun, nervousness, wrinkles round the eyes, falling off of the eye-lashes.

Treatment:—In each case the above mentioned causes should be detected and treated.

The above mentioned symptoms should be carefully noted as they invariably suggest the cause and disease.

The refraction of the eye should be examined under a mydriatic and astigmatism even of .25 Diop-ter should be corrected.

The conditions under which the eyes are used must be determined.

Occupations:—The welders working with acetylene torch, electricians, moulders etc., should protect the eyes from fierce swirl of electrons throwing millions of ultra-violet rays so fierce that the cones of the retina are entirely bleached of the visual purple and continued exposure results in blindness. *Dark cobalt blue glasses prevent harm to the retina.*

Glass-blower's cataract is due to harmful infra-red radiations for which Fieuzal no. 4 or 5, or peacock blue afford best prophylaxis.

If the lighting conditions are at fault or suspected, suggestions for their improvement may be made.

Certain kinds of work:—Fine engraving etc., where the work is to be done at usually short distances, lenses to relieve the accommodation and convergence may be given.

There are three kinds of glare: Veiling glare, dazzle glare, and blinding glare.

At the sea-side protection against glare is helpful to those who are not acclimatised *and in such cases absorption of ultra-violet is indicated.* It must be intimated that these glasses be worn only for the purpose they were designed for, and not constant in and out of doors.

Amber glasses cut off almost all the chemical rays and admit light enough for easy vision. They make a dark day seem brighter and soften the glare on a sunny day.

Automobile goggles with side leather shields are dangerous for town wear as they cut off side vision, which is essential for protection against accident.

In Hyderabad one sees children and grown up people using moulded goggles with air bubbles and surface defects, yellow, green, blue, red etc., with leather cups from irresponsible stores and pedlars. It is only natural for children to want to ape their elders, not knowing that unconsciously they are creating a condition that later on will cause much eye-trouble, that will require treatment or glasses to overcome. *Parents should know that every dark tinted lens will make the retina so sensitive that darker and darker tints are resorted to, leading to pathological ciliary and retinal functions, nervousness, irrita-*

bility and the above mentioned symptoms. Tinted plano lenses must be perfectly plane on both surfaces, equally thick throughout, ground and not moulded and free from surface imperfections etc.

In the year 1912 Sir William Crookes invented scientific *absorption glare glass*. Genuine Crookes glass was first introduced in America by American Optical Co., *but there was no restriction on the use of the name Crookes by patent*, so the Indian market is flooded with imitation Crookes from Japan and Germany at cut prices, *with the result that the public do not receive the full benefit of Crookes' labours*. Crookes affords general shade without disfiguring the appearance or altering the colour value of objects and very much appreciated by sensitive persons. It contains cerium nitrate and cuts off twenty-seven per cent of all heat rays, practically all the ultra-violet rays and transmits ninety-nine per cent of light. It is especially recommended in errors of refraction. Crookes B tint contains cerium-nitrate, uramic-oxide, nickel-oxide, and cobalt sulphate and is recommended if very great glare or heat is encountered. It can be obtained in various shades A, A², B, B².

Wide rim hats are advisable to persons suffering from glare.

If the eyes are extremely sensitive inspite of the correction of refraction and absorption lenses, the following drugs are found beneficial: Cocaine-hydrochlor, Argyrol, and in extreme cases the lids should be everted and painted right back to conjunctival

reflection twice weekly with two percent silver-nitrate.

The following cases will prove inadvisability of using tinted glasses indiscriminately:

M. A., student, Mohammadan aged nineteen, suffering from intolerance to light, scanty lashes, burning, watering, and slight occasional difficulty in near vision at night, for which he wanted plano Crookes glasses, as his father an official in H. E. H. the Nizam's service had one and he recommended it. He was told that Crookes Plano with the above symptoms would be worse than poison and that he should get his eyes examined retinoscopically under a mydriatic to which he agreed and the following correction was prescribed for constant use in crown, toric form, being a sportsman:—

R. E.	.25 D sph. c	.25 D cylinder axis 55
L. E.	.	D cylinder axis horizontal.

He reported two months after that he did not require Crookes' lenses as the compound crown lenses had relieved almost all his symptoms and was able to bear sun's light without trouble.

Photophobia in the above case was due to strain of the ciliary muscles, which was relieved by the above correction.

B. P. a Hindu official aged thirty-four, having out-door work, complained of photophobia, foreign-body sensation, burning and occasional redness for which he tried Wilson goggles or darker and darker tint without benefit and then his friends advised him

to try Crookes and he selected in Bombay from a cheap optician dark Crookes, which were not Crookes but Japanese imitation Crookes of darker tint than C which aggravated the trouble.

He was advised treatment for granular lids and within three months, photophobia disappeared and he felt no necessity for tinted lenses.

Similar cases are found in great number by the medical men doing eye-work, *whose duty should be to prevent the use of above mentioned cheap tinted lenses, and thus avoiding the harm to the internal mechanism of the eye, ciliary muscle and retina.*

organisms have been cultured. Leprologists seem to believe that the L. B. dies in fresh air (Here is a vast field for research.)

MODES OF INFECTION.

The infection takes place through the skin and mucous membrane by inoculation. The development and course of the disease depends upon the virulence of infection and resistance in the body of the person infected. The climatic conditions play their role while the cleanliness and Hygienic principles impart their influence to the disease. To prove this we shall have to follow the course from the infection to the development of the disease and its terminations. L. B. enter the body and lie dormant in the lymphatics of the skin. They multiply very slowly without any external signs and trouble. If the resistance of the patient is strong, the infection is overcome without the least trouble and notice. But if resistance falls short the L. B. multiply and infect the nerve. Some symptoms as described in the definition appear, and at this juncture we may not isolate the L. B. but there are manifestations of the disease. This is called the A. I. stage. Even this stage is overcome if the resistance of the patient is great. On the other hand the L. B. might so develop that they cannot any longer be contained by the glands or nerves. So they emerge out from their hiding places and enter the blood circulation through the Vena Cava and constitutional symptoms appear. Leprologists have invariably disputed this question and are now of opinion that the L. B. have no specific effect on the inter-

nal organs. They are also of opinion that no leper dies of the disease unless complicated. In fine it could be concluded that Leprosy is a self curing disease depending upon the personal resistance of the individual involved. But on the testis it has a specific action of producing partial sterility. There is no great land mark of differentiation between the Nerve and the Skin Lesions. It has been invariably noticed when the Nerve lesions are at their height the skin lesions subside and vice versa. The course of the disease may be illustrated by a parabolic curve. The vertical indicating the number of Bacilli in the body and the horizontal the duration of the disease. The greater the natural resistance of the patient the flatter will be the curve, the less the resistance the abrupt is the rise. After reaching its climax it descends again to the Base line. In other words Leprosy is a self healing disease, but the bad effects that it produces in its course gives a shuddering appearance to a Leper. The Nerve type is A. I. and the skin type is called the B stage, both ending in A II.

The disease is easy to diagnose with its full manifestations in B stage.

DIAGNOSIS.

The diagnosis is more difficult in the early stage. In the beginning a patient goes to you only with a depigmented patch or Anaesthesia. Either of these might have failed to be recognised by the patient until he was driven to the necessity of noticing it by chance. I know of instance where clever and educated people were unaware of it though they

had the infection. A case has come to my notice where a young man clever and capable sat playing at cards with his friends. His friend on the opposite side involuntarily placed his hands while engaged in the game with a lighted cigarette exactly touching the thigh of the patient in question and the patient had not felt the burning sensation until the smoker turned and noticed the position of the fire to the amazement of the whole party and to the utter astonishment of the person in question who had lost his feel of sensation. Thus the patient got the stimulus to investigate the cause. He was proclaimed a leper after examination. This is a living example who is undergoing a course of treatment with promising progress. There is another case which has come to my notice. The patient was placed wrongly under a course of antisyphilitic treatment under an eminent man, for a long period and he all of a sudden developed the skin type characteristic of Leprosy. The patient now is undergoing a course of leprotic treatment. I could cite many such cases which would go to prove the ignorance of Medical profession in the line. So a knowledge of this disease is very essential for the profession. It won't be out of place if I mention that many a leper has been operated on undiagnosed. The problem of diagnosis varies according to the state of the disease. In all cases a thorough examination of the patient is essential in good light with stripped off clothes except at the loins. A very careful history to be taken illuminating the history of contact in the family or with friends. Test the body area for anaesthesia and depigmentation.

Examine for thickening of nerves. Take ear clips, skin clips, of any suspected areas in all suspicious cases. Enquire for any feeling of abnormal sensation, numbness—hot and cold sensation. Nasal discharge in advanced cases is positive, but other manifestations are enough. If all this is done mechanically there is no possibility of the escape of detection. During incubation as we have called it the dormant stage which might also be called the latent, the diagnosis is very difficult, but the following cardinal signs of dry rhinitis, with occasional bleeding owing to cracks more marked in hot weather, disturbance of sensation in arms and legs, tingling and pain for very short time during nights and slight neuritis are always suspicious. To sum-up, the whole diagnosis occupies the place of signs and symptoms. Before we finish the diagnosis I have to explain the modern view about the disease. Leprosy is a self curing disease running a pretty long course and finally terminating into a non-infectious one which is termed as the burnt-off-one. But the figurative changes are such that the individual possesses the characteristic appearances of a leper. As this is a disease affecting the constitution of the individual who is very much weakened and as a rule he is in an attitude of laziness, he is an easy prey to any other fatal complication. If complications set in the Lepers die a premature death. The version of the leprologist is that no leper dies of simple leprosy. On the other hand the disease is comparable to tubercle and the contrast is that tubercle is more disastrous than Leprosy. Before we close the diagnosis I have to enumerate the *complications* (Diff: Diagnosis).

Syphilis—Anaesthesia absent—L. B. absent—
—Wasserman's test and Kahns test positive.
Leucoderma—Anaesthesia absent, L. B. absent—
only depigmentation present.
Tinea Alba and Tinea versicularis—L. B. &
anaesthesia absent.
Psoriasis—Anaesthesia absent, L. B. absent, patches scaly.
Beriberi—Anaesthesia is present, distribution is
unlike Leprosy (Tenderness of calves) L. B.
absent.
Urticaria sometimes mistaken for leprosy.
L. B. absent.
Nerve diseases Syringo—Myelia is mistaken for
leprosy.

PRESENCE AND ABSENCE OF LEPROSY.

Diagnose any pre-disposing cause. Diagnose the stage of the disease and whether it is active or inactive. The above given points are helpful in basing the prognosis of a case of leprosy. Pot: Iod: helps very much in the diagnosis. Its uses are of great importance in two respects. The drug assists to diagnose doubtful early cases. The second consists in cases where leprosy has existed, it assists to know whether it is still active or whether the A II stage has been reached. If KI is given in increasing doses upto 240 Grains twice a week and if leprosy is present re-action will probably occur. The re-action of leprosy involves a different subject in the study of the disease. The reaction might be due to disease itself or artificially produced by drugs i. e., redness

and enlargement of old leisons, formation of fresh leisons, pain in the nerves and joints, rise of temp: and subsidence of this phenomenon partly, or completely after a day or two.

TREATMENT.

In a chronic disease like leprosy in which we have not as yet found any drug which could be called a specific (here again an ample field for research) the treatment may be general or special. The former attends to the condition of the patients. If we could recapitulate we remember that resistance plays the important role. The condition of the patient is of first importance. After having seen to this end the other course shall be to use Anti-Leprotic measures.

General.—Treatment accompanying diseases such as Syphilis, Worms, Malaria, other skin diseases, Dysentery, Constipation.

Diet.—Needs a careful attention (well cooked easily digestible and well assimilable with least stimulants).

Exercise.—Is very important. Long walks up to 20 miles daily is preferable, increased gradually.

Hygiene and climatic conditions should be very favourable.—Dry and warm countries are the best.

The mental factor is the most *important stage*.

Special.—Injections of Hydnocarpus oil and its preparations. External applications such as Trichlor. Acetic Acid.

Surgical treatment when indicated.

Mercury.—Has been used for many centuries and is a common drug in Indian villages.

Arsenic was considered harmful but now it is recognised as a tonic in small doses.

Antimony.—Injections have been reputed in advance cases in small doses. Strychnine has been much used.

Local Treatment.—Excision of nodules, application of ointments to ulcers, amputation of digits etc., Electric currents—Sera and vaccine prepared from nodules have shown benefit.

Lastly but not the least Chaulmugra and its allied oils have been of very much repute. In the beginning the oils were used by many methods: by mouth—by enunctions and massage. Later on extract of oils, sodium preparations, Ester of oil by intravenous and infiltration were used.

The other oils are Olive oil, Codliver oil, Hydnocarpus oil, Linseed and Soyabin oils. It has been found that a common quality of the cells that have been beneficial in Leprosy contain more saturated Fatty Acids. The degree of their saturation is tested by Iodine. Linseed oil, Codliver oil, and Olive oil are of benefit but it is proved that non-saturated acids do so in greater degree—Hydnocarpus oil possesses the specific property above all.

GENERAL HEALTH ESSENTIALS.

Test your contacts with KI (Reaction watched)
if no reaction add Hydnocarpus oil intramuscularly—
dose 2 to 10 c. c.
its

If no reaction produced the case is put down for A II.

KI leaves the system in 48 hours—best allow a longer period and sedimentation test applied—if no reaction, inject oil and watch for six months the sedimentation test.

Iodide is expensive, it is very useful in all stages but nerve cases do not need it—rest is essential in the course of KI in nerve cases—Sedimentation is the guide.

Sodium Hydnocarpus.—Is very good in B I, B II cases. In skin cases sod. Hyd. mixed with blood intravenously 8 c. c. The reaction appears within 2 hours. Intravenously easy—if do not succeed put into the buttock;

Change for esters.—Are the best for nerve Leprosy.

Sedative drugs are of much use—Pot. Antimoni Tartarate.

MEDICINES AND DOSES.

Esters.—(2 c. c. to 10 c. c.) by subcutaneous infiltrations.

(Exercise permits easy absorptions. Infiltrations into lesions preferred on a small scale by a cold method. By exposing the oil with Sulphuric acid and Alcohol in a bottle to the Sun light, Esters are obtained. If needed on a commercial scale, they could be prepared by ordinary apparatus with arrangements for a water-bath and auto-clave for

sterilization in much lesser time and economical means for, to obtain ready made Esters is expensive.

Hydnocarpus Oil;—4% creosoted—thick bore needle to be used—the oil becomes thinner on heating.

Sodium Hydnocarpus Anthalmentica—Intervenously blood mixed (2 c. c. to 8 c. c.)

Tri-chlor—acetic acid:—for painting externally (aqueous solution).

1 in 1 for nodules.

1 in 2 for, 1 in 1 and 1 in 5 for patches—start with the diluted strength.

1 in 7 for Nasal paints.

POTASSIUM ANTIMONY TARTARATE.

1½ c. c. (5 grs. to 20 c.c. distilled water) to allay reactions. Ephedrine Sulph. O. 5 grms. or adrenaline chloride 1 in 1000 3 m. in 30 m. of normal saline to be injected and to be repeated in 5 minutes if pains do not subside.

NOSE DROPS.

Esters, Camphor, and creosote. 1 ounce each with twelve ounces of olive oil form a good instillation into the nose.

Thai—poonjii is the name given to the combination of 2 parts of *Hydnocarpus* fruit of the selected seeds and *Canabis Indica* one part. Of this ½ drgm dose thrice a day after food have given marvellous results without the assistance of the Medical

man—the economical and successful method of controlling the disease in the illiterate circle.

It could be concluded that the will to get better is very important and strong determination of the welfare depends in no small measure on himself. Hydnocarpus oil and other drugs can do little by themselves in the absence of adjuvants to treatment, as appropriate diet and exercise. The leprologists have found that the treatment is most favourable in A1 cases. B1 less favourable yet there is a great chance of success. B2 still less favourable. B3 takes longest to be cured. A-2 bacilli die out but the deformity remains. Precautions for common cleanliness are essential. Those who come in contact are to observe scrupulously clean habits, fresh air and timely diet with abundance of vegetables. This article has been drawn up especially to meet the demand of the Medical practitioners who have not had the chance of visiting a leper home to observe the different stages of the disease. My thanks are due to the Dichpally Institute where I had the chance of seeing over 400 cases who are kept and treated over there.

Four cases Demonstrated

BY

CAPT. S. C. ALAGAPPAN

M. B. B. S., F. R. C. S. E., I. M. S.,

on 16th May 1929, under the auspices of the Hyderabad Branch of the British Medical Association.

I

Name.—Rifleman K.

Disease.—Septicaemia (Due to Streptococcus

History.—On 31-1-29, patient fell from bicycle and hurt left knee. Developed Suppurative Bursitis of left Prepatellar Bursa on 6-2-29. Aspirated on 6-2-29 and incised on 7-2-29. There was severe Haemorrhage from the wound in the evening. Adrenalin was used locally and Haemoplastin 6 c. c. was injected hypodermically. During the night patient passed 6 motions of pure blood. On 7-2-29 his urine

was bloody. Then, an infection by Sterepto-coccus Haemolyticus was suspected and Anti-Streptococcal Serum 20 c. c. was given intravenously morning and evening Patient was also given Calcilactas (Grs. XV every 4th hour) by mouth. On 9-2-29, patient developed purpuric spots all over his body, particularly on Mucous membranes and Conjunctiva of right eye. In the mean time, Strep. Haemolyticus was isolated from his blood. Patient continued to have a remittent type of fever, bloody diarrhoea and haematuria though he was never actually ill at any time. All the acute symptoms subsided gradually about 14 days after the onset of original symptoms. Sero-therapy was continued for one week. Recovery and convalescence were uneventful.

The incubation period of this case works out to be 7 days; and the duration of the Disease 14 days.

II

Name. Rifleman F.

Disease. Acute Pemphigus.

History. Admitted on 8—2—29 for Fever N. Y. D. The same afternoon patient developed vesicular rash, affecting skin and mucous membranes, with the exception of face. The eruptions resembled a severe type of chicken-pox. On 9—2—29, rash was noticed on his face, but the forehead was free throughout the course of the disease. Conjunctiva, Corneae and Mucous Membrane of the mouth up to the Pharynx were severely affected. On 13—2—29 haemorrhage occurred into most of the eruptions, which gradually assumed a pemphigoid nature. Patient's general condition became exceedingly critical: and deglutition became practically impossible owing to severe Stomatitis and Glossitis. Examination of the exudate from the rash showed only few pus cells and pyogenic cocci. Blood culture and exudate culture were sterile. On 13—2—29 Anti-streptococcal Serum 20 c. c. was given intravenously, as recommended by Colonel T. G. F. Paterson D. S. O., K. H. P., It brought the temperature down to 100°F. the following day. Sero-therapy was kept up for one week. Patient recovered on 16th day after the appearance of the eruption.

III

Name. Driver J.

Disease. Compression Brain.

History. On 28—10—1928 patient was thrown down from an A. T. Cart and sustained a severe bruise over right parietal area. Soon after the injury, patient developed typical hemiplegia of the left side. He was never unconscious. Temperature subnormal. Pulse 54. Skiagram revealed no fracture.

Treatment. In addition to general treatment lumbar puncture was done 5 times. On the first 2 occasions, there was actual blood in C. S. Fluid. The tension was above normal on all occasions.

Present state. Patient can walk about now though there is still a certain amount of Paresis of the left side.

This case illustrates the value of Repeated Lumbar puncture for effecting Decompression.

IV

Name. Sepoy S.

Disease. Injury, Bilateral, Both Wrists.

History. On 25—1—29, patient slipped while washing his clothes and fell on both palms. On X-Ray examination the following lesions were revealed.

- | | |
|-------------------------|---|
| (A) <i>Right Wrist.</i> | (1) Severe Impacted Colles' Fracture. |
| | (2) Fracture of Styloid process of Ulna. |
| | (3) Fracture of Scaphoid. |
| | (4) Incomplete fracture of Shaft of Ulna. |
| (B) <i>Left Wrist.</i> | (1) Vertical Fracture of Inner aspect of Lower End of Radius. |
| | (2) Separation of Lower Epiphysis of Radius. |
| | (3) Fracture of Styloid Process of Ulna. |

This case is of interest owing to the multiplicity of bone lesions and owing to involvement of both wrists. Colles' Fracture on the Right Side was severe, impacted and of the Reversed shaped type. Reduction was effected on the X-Ray Table, with the

aid of a General Anaesthetic & Intermittent Screen Control, by Wilkie's Method: Disimpaction was carried out first by Extension applied to the lower fragment between the Thenar Eminences of Both hands and Counter Extension applied by an Assistant through the Fore-Arm. After disimpaction, the lower fragment was adducted towards the Ulnar side. Antero-posterior Splints were applied and Suspension in a Sling was maintained for a Fortnight. Massage and Passive movements were started from the fourth day after reduction. Recovery was uneventful. Patient regained perfect functional use of both wrists.

Abstracts

TREATMENT OF CERTAIN SKIN DISEASES WITH INSULIN.

S. Neymark, in (Dermatologische Wochenschrift) states that while there is, as yet, there is no positive indication for the use of Insulin, it appears to have a certain influence in many diseases of the skin. It is especially useful in cases where hyperglycemia, as a sign of endocrine disturbance exists, or in those cases where blood-sugar is normal but a relative acidosis or decrease in the alkaline reserve can be demonstrated. Isolated cases of Psoriasis, eczema, erythema, pruritis, lichen ruber accuminatum, and skin neuroses were improved with Treatment; especially worthy of note was the rapid disappearance of pruritis. Considerable improvement, and in one case, a cure was secured in leg ulcers; in these cases local dressings with 20 to 40 units seemed to work better than the subcutaneous or intradermal injections.—The Doctor, January 1929.

UNUSUAL CASE OF POLYDACTYLIA.

A case is reported (Deutsche Med. Woch.) by Howitz of a boy with six fingers on each hand and

six toes on each foot. The six fingers are rudimentary. The roentgenogram shows absence of a metacarpal bone corresponding to the rudimentary finger, but the centre of ossification of the head is indicated. Active motion in the rudimentary finger is not present. The sixth toes are in line with the other toes and are the same length as fifth. In a roentgenogram of the foot the fifth meta-tarsal seen to be thicker than the others and bifurcated. The fifth toe would seem corresponding branch of the fourth metacarpal is to be actually the supplementary member, since the thinner than the lateral branch and takes an abnormal direction.—*Journal of American Medical Association*.

STERILIZATION OF THE MENTALLY UNFIT

One of Switzerland's Cantons has passed a new law for the sterilization of the mentally unfit, on condition that medical intervention first be recommended by a physician. This is considered to be the most drastic law of the kind ever adopted in Switzerland or even in Europe, and its passage was due mainly to the efforts of Swiss women during recent years. Other cantons are said to be likely to follow the example—*Medical Journal and Record*.

LARDOSIS AS A CAUSE OF POSTURAL ALBUMINURIA.

There is still much controversy concerning the factors of production and the causation of lardosis causing postural albuminuria. Various theories have been advanced as to the cause of postural albuminu-

ria. Erlanger and Hooker believed that the diminished pulse pressure was the cause and that the amount of albumin excreted varied inversely to the magnitude of pulse pressure. Mason and Erickson, Bass and Wessler came to similar conclusions. Tissier advanced the theory that the developmental defects of the glomeruli, with the consequence increased permeability of the kidney, were the responsible factor. Jehle believed that mechanical interference with the renal circulation, such as is possible through the effect of marked lardosis, was the sole cause. Acute renal venous stasis ensues with retardation of venous circulation. Owing to anatomic peculiarities, this stasis is more pronounced on the left side than on the right side.

In the author's study of postural albuminuria, they frequently found it difficult to determine to their satisfaction whether the arthostatic albuminuria was due to a lordotic condition or to some other factors.

They selected a group of 25 crippled children and young adults. In 19 of this group, the deformity was due to a residual paralysis of poliomyelitis; 3 children had had severe rickets in infancy; in three others deformity was the result of a congenital, spastic paralysis. The types of deformities were those of simple lordosis and of lordosis associated with various degrees of scoliosis of the dorsal and lumbar spine.

The patients were observed for six months. All urinalyses were made on morning and afternoon

six toes on each foot. The six fingers are rudimentary. The roentgenogram shows absence of a metacarpal bone corresponding to the rudimentary finger, but the centre of ossification of the head is indicated. Active motion in the rudimentary finger is not present. The sixth toes are in line with the other toes and are the same length as fifth. In a roentgenogram of the foot the fifth meta-tarsal seen to be thicker than the others and bifurcated. The fifth toe would seem corresponding branch of the fourth metacarpal is to be actually the supplementary member, since the thinner than the lateral branch and takes an abnormal direction.—*Journal of American Medical Association*.

STERILIZATION OF THE MENTALLY UNFIT

One of Switzerland's Cantons has passed a new law for the sterilization of the mentally unfit, on condition that medical intervention first be recommended by a physician. This is considered to be the most drastic law of the kind ever adopted in Switzerland or even in Europe, and its passage was due mainly to the efforts of Swiss women during recent years. Other cantons are said to be likely to follow the example—*Medical Journal and Record*.

LARDOSIS AS A CAUSE OF POSTURAL ALBUMINURIA.

There is still much controversy concerning the factors of production and the causation of lardosis causing postural albuminuria. Various theories have been advanced as to the cause of postural albuminuria.

ria. Erlanger and Hooker believed that the diminished pulse pressure was the cause and that the amount of albumin excreted varied inversely to the magnitude of pulse pressure. Mason and Erickson, Bass and Wessler came to similar conclusions. Tissier advanced the theory that the developmental defects of the glomeruli, with the consequence increased permeability of the kidney, were the responsible factor. Jehle believed that mechanical interference with the renal circulation, such as is possible through the effect of marked lardosis, was the sole cause. Acute renal venous stasis ensues with retardation of venous circulation. Owing to anatomic peculiarities, this stasis is more pronounced on the left side than on the right side.

In the author's study of postural albuminuria, they frequently found it difficult to determine to their satisfaction whether the arthostatic albuminuria was due to a lordotic condition or to some other factors.

They selected a group of 25 crippled children and young adults. In 19 of this group, the deformity was due to a residual paralysis of poliomyelitis; 3 children had had severe rickets in infancy; in three others deformity was the result of a congenital, spastic paralysis. The types of deformities were those of simple lordosis and of lordosis associated with various degrees of scoliosis of the dorsal and lumbar spine.

The patients were observed for six months. All urinalyses were made on morning and afternoon

specimens. The mothers were instructed to collect specimens of urine before the children got out of their beds. Only those cases in which microscopic observations in the routine urinalyses were persistently negative were included in this group. The urine was alkalized in cases of positive albuminuria and the effect on the excretion of albumin was studied. Plasma proteins (fibrin, globulin, albumin), amino-acids and urea nitrogen were determined.

Contrary to expectation, only three of this group of 25 definitely lordotic children showed a persistent tendency to the orthostatic type of albuminuria. This was not higher proportionately than in other group of postural albuminuria, without definite lordosis. Three others showed the tendency inconsistently. Removal of orthopedic appliances was followed by no observable change in excretion of albumin. The alkalization of urine did not have any particular effect on the excretion of albumin. The blood chemistry did not show any essential deviation from the normal.

As a result of their observations, the authors believe that exaggerated lordosis is an unimportant factor in the production of orthostotic albuminuria.

A Case of Latent Syphilis Interesting for Its Infectiousness and Serologic Behaviour.

Alfred Cohn, reports the following interesting case in *Deutsche Medizinische Wochenschrift* (54: 1295, August 1928).

Upon evidence of syphilitic infection a girl twenty years old was treated with 3 gm. of Neosalvarsan and 15 c. c. of Bismogenol. Six months later the patient was examined by the author as she expected to marry within the year. Physical examination showed subacute blepharitis, but no signs of syphilis of the skin, glands or mucous membrane. Serologic tests of the blood proved negative. Antisyphilitic treatment was begun and the patient was forbidden to marry for three years. Three months later the patient confessed to having had intercourse with her future husband and had infected him by biting him upon the lower lip. The man showed primary symptoms on the lower lip with positive spirochetes. Before infecting her fiancé the woman had received 2 gm. of neosalvarsan and 11 c. c. of bismobenal. Clinical examination gave no suspicious results. The Wasserman reaction was negative, but the complement binding reaction with a Kroo spirochetal antigen was repeatedly strongly positive.

This case shows that in spite of the lack of all clinical symptoms, in spite of the antisyphilitic treatment and in spite of the negative Wasserman reaction, the case was still infectious. Only the complement binding of the serum with the spirochetal antichetal antigen was strongly positive. *International Medical Digest, December 1928.*

DIABETES INCIPIDUS.

BY

HELEN BOURQUIN.

(*American Journal of Physiology*, 79: 362, Jan. 1927)

Diabetes incipidus has been reduced in dogs by the cauterization of the floor of the third ventricle. The mammillary bodies are the site of effective lesion. Diabetes incipidus is an irritation rather than a deficiency phenomenon. It is produced by a slight injury to the proper area but not by severe injury to or depression of that area. The diuresis must be due to a substance produced at the site of causative disturbance as a result of irritation, which acts directly or indirectly as a diuretic for:

A. The hypophysis would not seem to be responsible for it since hypophysectomy without injury to the proper area in the floor of the third ventricle fails to produce diabetes incipidus which, however, is produced in hypophysectomized animals by injury to that area, results confirming Roussy (1925).

B. The thirst of diabetes incipidus is secondary to diuresis for diuresis develops in operated animals restricted to their average pre-operative water intake and quickly produces manifestations of desiccation in diabetic animals deprived of water.

C. Neither the autonomic or somatic nervous systems are concerned in the diuresis for diabetes incipidus runs its typical course after transection of the spinal cord at the level of the eighth cervical vertebra, double vagotomy below the diaphragm, and paralysis of the parasympathetic nervous system with atropin.

Cross transfusions between severely diabetic and normal animals performed under novocain anaesthesia failed to alter per minute volume urine output in period of from 4 to 6 minutes in others. The latter result was never obtained in cross transfusions between normal animals.

LIGHT THERAPY IN DEFICIENCY DISEASES OF CHILDREN

BY

PERCIVAL NICHOLSON.

(*Atlantic Medical Journal*, 31: 537-542 (May) 1928)

Ultra violet light from the air cooled mercurry-vapour quartz lamp is a specific in tetany, rickets, and spasmophilia, and is very valuable as a general tonic in depressed bodily states, such as anorexis and some case of anaemia, and in poor nutrition. Ultra-violet light holds out some hope as an aid in preventing the development of diabetes, and by its general tonic effect, is a valuable help in preventive medicine. The experimental and clinical data are so definite and convincing with regard to the value of ultra-violet light in deficiency diseases of children that there can no longer be a by doubt as to the practical value of this for of treatment. *International Medical Digest*, August 1928.

News.

Behramji Taraporewala, L. R. C. P. & S., D. T. M., D. P. H., Civil Surgeon, Warrangal has been appointed as the Chemical Examiner to the Government form 15th Dai 1338 F.

Syed Mahmudul Hussan L. M. & S., Medical Officer, Kamareddy has been posted as an Assistant Surgeon in the Osmania General Hospital.

K. S. D. Jalnawala L. M. & S., Medical Officer Latur has been to Nanded as Officiating Civil Surgeon.

Kareem Abbas L. M. & S. has been transfered from the Osmania General Hospital to the Musheerabad Dispensary.

Abdul Ali Khan L. M. & S. has been appointed as an Assistant Surgeon in the Osmania General Hospital.

M. Reinapurkar L. M. & S., Assistant Surgeon Asifabad, has been posted as Medical Officer at Jalne.

C. Cuppaswamy L. M. P., has been promoted to the rank of an Assistant Surgeon and posted to Pathri.

Vishwanatham L. M. P. has been confirmed in his appointment as a Sub-Assistant Surgeon at Rajura-Manickgarh.

S. Raghavender Rao L. M. & S., has been transferred from Rajura-Manickgarh to the Osmania General Hospital but as his services have been lent temporarily to the Osmania University, T. S. Kamble L. M. & S. will work for him till his return.

Ramakrishna Reddy L. M. & S. has been confirmed as a Sub-Assistant Surgeon D. V. John has been dismissed from service and in his place at Parendra A. B. S. Modaliar L. M. & S. has been posted.

K. Sreenivasan L. M. & S. has been transferred from Nalgonda to Alampur.

C. Rungacharry L. M. & S., Medical Officer Alampur has been posted to Nalgonda Civil Dispensary in place of K. Sreenivasan.

Mir Ali Hasan M. B., B. S., has been appointed as an Assistant Surgeon and is posted to Asifabad.

V. V. Garde L. M. & S., Medical Officer Central Jail, Warrangal has been posted as Officiating Civil Surgeon at Warrangal.

Sitapati Rao L. M. & S., has been confirmed as Assistant Surgeon in the vacancy caused by the retirement of Abdul Salam L. M. & S.

B. S. Naidu M. C. P. S. (National) has been appointed as a temporary Assistant Surgeon at Nizamabad.

M. Sitaramiah, L. M. & S. District Sanitary Assistant Asifabad has been transferred to the Civil Dispensary at Beedar.

B. S. Madhava Rao L. M. & S. has been appointed District Sanitary Assistant at Beed.

The following Medical Officers were selected this year for undergoing training in Leprosy at the Dichpally Leper Asylum. Their expenses were paid by the British Empire Leprosy Relief Association.

R. K. Garde L. M. & S.

Gulam Ali Yemani L. M. & S.

R. K. S. Iyengar L. M. & S.

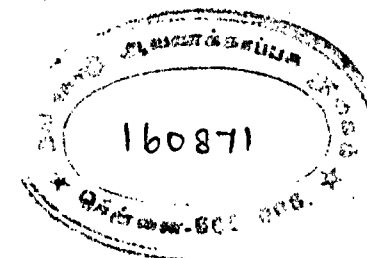
L. B. Phatak L. M. & S.

Ramamurthy L. M. P. Residency Bazars Health Officer.

Deva Asirvadam L. M. & S. (Madura Mission).

On the 16th March 1929 a meeting of the Hyderabad Branch of the British Medical Association was held in the Indian Station Hospital, Tirumalgiri. The Staff of the Hospital were at Home to the Members of the Association and other guests. An Address was presented to the Officer Commanding, Col. Patterson D. S. O. I. M. S. on the occasion of his being appointed as an Honorary Physician to the King.

7L
16216/12/27
112/11/11



Then some interesting cases were demonstrated and the members present took a keen interest in them though there was not much discussion. Capt. Alagappan I. M. S. read his paper on Appendicitis a summary report of which is given elsewhere.

Under the auspices of the Students Union, Osmania General Hospital Dr. Benjamin M. B., B. S., of the Madanapalle Sanatorium delivered a lecture on the treatment of Tuberculosis, in the Osmania Medical College premises on 2nd April at 4-45 P. M. The learned lecturer first dwelt on the climatic effect on the course of the disease and said that the best climatic condition for the favourable course was a fair amount of coolness with a certain amount of moisture. He then described in detail the routine treatment carried on in the sanatorium and said that the success depended on the regulation of the exercise and rest in each individual case according to the amount of reaction that was produced on exertion. Describing the Pneumothorax treatment he gave its full history and dwelt chiefly on the complications and dangers it is likely to give rise to in case of a misadventure. He demonstrated to the audience the apparatus that was lent for the occasion by Dr. S. W. Hardikar.

On 1st March 1929, the annual meeting of the Hyderabad Branch of the British Medical Association for the election of the Office Bearers was held at the "Golden Threshold". Major Naidu the retiring President of this Branch was "At Home" to the members on the occasion. The following Office bearers were elected for the ensuing year.

President:—Col. Franklin I. M. S.

Secretary:—Latif Sayeed M. B., Ch. B.

Members of the Council:—

Major M. G. Naidu M. B. C. M.

Capt. K. N. Wagharay M. M., B. S.

Lt. B. S. Raj L. R. C. P. & S.

Major Anderson R. A. M. C.

Capt. Allagappan I. M. S.

After the elections were over Dr. S. W. Hardikar M. D., M. R. C. P. E., demonstrated a case of Oriental Sore and also Leishman-Donovan bodies from the scrapings from the same case. He then read a paper on "The present position of the Medical profession in Hyderabad".

Annual Report of the Hyderabad Branch of the British Medical Association for 1928.

The Hyderabad Branch of the British Medical Association has completed its sixth year after its revival in the Hyderabad Administered Areas. The Officers of the branch were:—

President—

Major M. G. Naidu, M. B. C. M.

Secretary and Treasurer—

Lt.-Col. W. M. Anderson, C. I. E., M. D., I. M. S.

Council Members—

1. R. N. Coorlawala Esq., F. R. C. S., D. P. H.
2. S. P. Taylor Esq., M. B., Ch. B., B. Sc.
3. M. A. Lateef Sayeed Esq., M. B., Ch. B.,
(Edin).
4. B. S. Raj Esq., L. R. C. P. & S.
5. Major C. B. C. Anderson, R. A. M. C.
6. Captain S. C. Alagappan, I. M. S.

The latter two members were co-opted by the Council, on the 10th August 1928, as resolved in the Annual General Meeting of the branch held on the 9th March last year. It is a matter of regret that Colonel Anderson, who should have been here today to read this report as Secretary, has proceeded home on retirement: the Council electing the undersigned to act as Secretary and Treasurer from 9th November last. The retiring Secretary, Lt.-Colonel W. M. Anderson, I. M. S., was elected to represent this branch at the next annual meeting which commences on the 19th July in Manchester.

The undersigned had the pleasure of representing the branch at the annual general meeting held in Cardiff and to share in the wonderful hospitality extended to Representatives in general and to the overseas Representatives in particular.

Membership.

The members on the roll at the close of the year number forty, with nineteen Associates as against thirty and twenty.

Meetings.

The following meetings were held:—

- | | |
|--------------|----------|
| (1) Council | .. Four. |
| (2) Clinical | .. One. |
| (3) General | .. Two. |

The meetings at which clinical and other matters were considered included:—

(a) A very instructive lecture on the Differential diagnosis of Dysenteries delivered by Major W. Walker, M. C., R. A. M. C. This was followed by an exhibition of a few clinical cases, the most interesting one being that of a girl child, aged four years, with a large hairy mole covering practically the whole of the left half of the face.

(b) Another lecture on the "Thomas Split" was ably delivered by Captain S. C. Algappan, I. M. S. Skiagrams relating to the subject were also shewn and the lecture was much appreciated.

(c) A third lecture was delivered by the Leprosy expert Dr. Muir on "Leprosy, its spread and prevention". Eighty members of the medical profession of Hyderabad and Secunderabad assembled to hear this most instructive lecture. Dr. Lowe, M. B., Ch. B., Medical Officer in charge of the Leper Home at Dichpali also spoke at some length and gave a striking demonstration of the early diagnosis of leprosy.

Question of Local Interest.

It is a matter of regret that the scheme for the construction of a Tuberculosis Sanatorium locally has fallen through and the matter has been dropped *sine die*.

Accounts.

The audited financial statement for the year under report is subjoined below for information:—

FINANCIAL STATEMENT FOR 1928.

RECEIPTS.			PAYMENTS.		
	Rs.	a. p.		Rs.	a. p.
Opening balance on 1st January 1928	...	787 11 5	Printing and Stationery	14	0 0
Subscription	...	556 0 0	Postage	...	7 1 0
With journal	476 0 0		Clerk	...	120 0 0
Without „	80 0 0		Conveyance charges	...	35 14 0
Capitation grant received from the Head Office, London	43 8 0		Remittance to the Head Office £ 25-10-0	342	15 0
Interest on fixed deposit	17 8 0		Balance on hand on December 31st, 1928	...	884 12 0
B. G. Rs.	...	1404 11 5	B. G. Rs.	...	1404 11 5

* Fixed Deposit with the Imperial

Bank of India.	Rs. 500	0 0
In Current account.	„ 348	12 0
In Cash with the Treasurer.	„ 36	0 0
	„ 884	12 0

M. G. NAIDU, M. B. C. M.,
President,
*Hyderabad Branch of the
British Medical Association.*

E. H. HUNT, M. A., F. R. C. S.,
Hon. Secretary,
*Hyderabad Branch of the
British Medical Association.*

Verified with the bank pass book and other supporting vouchers and found correct.

K. JIVANJEE,
Hon. Auditor.

In conclusion, it is pleasing to note that the working of this branch is, on the whole, satisfactory and that all the meetings convened under its auspices have been attended.

E. H. HUNT, M. A., F. R. C. S.,
Hon. Secretary,
*Hyderabad Branch of the
British Medical Association.*

COL. JOHN NORMAN-WALKER,

M. R. C. P. LONDON, D. T. M. H. CAMBRIDGE, I. M. S.

(Retired).

Col. J. Norman—Walker has been appointed Director Medical and Sanitation Departments, H. E. H. the Nizam's Government. The following is a brief note of his appointments in India. 1899-1903 Military Service with the Punjab Frontier Force. 1903-1921 Civil employment in the United Provinces—for a short time Professor of Medicine—Lucknow. 1921-1923 Civil Surgeon Delhi. 1923-1927 Surgeon to H. E. the Viceroy (promoted Brevet Colonel 1927). 1927-1929 Inspector General of Civil Hospitals Central Provinces—also Officiated as Director of Public Health. He has seen War Service in China, N. W. Frontier and the Great War and was mentioned in the Despatches.

The Deccan Medical Journal April 1929.

The Director of the Medical Department, Hyderabad (Deccan.)

We are glad to welcome Col. John Norman-Walker who has taken over charge of the Medical Department this month. The first and most important task before him, we presume, is the organization of the new Osmania Hospital. A scheme has already been sanctioned for this purpose and Col. Norman-Walker will put it into force with alterations and modifications he may deem it necessary to make. A large hospital with nearly 500 beds requires a good governing body. Col. Norman-Walker with his vast experience in India is bound to formulate a good working scheme for the hospital and very soon we shall have our hospital working in full swing.

There is great need for an entirely separate ward for the Tuberculosis cases. We suggested in our last

issue that the top terrace might be made use of for this purpose until such time as a separate hospital is built for Tuberculosis patients. The hospital statistics would show that tuberculosis is much prevalent in Hyderabad. Admission to Hospital cannot always be refused to cases of Tuberculosis. The Isolation Hospital is not available for such cases during the Plague Epidemic. We, therefore, again in this issue venture to suggest that the roof terrace may be utilised for this purpose. The Medical College Hospital of Calcutta keeps T. B. cases on the top terrace and has a Diphtheria Ward as well there.

There is also need of a good Laboratory. Until about 7 years ago there was only a small room for urine examination and when about that time an entirely medical side was created in the hospital the physicians by their successful attempts in clinical laboratory work done at great disadvantage convinced the authorities of the advantages of a fully equipped laboratory a fairly good laboratory was established. This laboratory when enlarged and fully equipped will be of great help to the Physicians and Surgeons of the Hospital. Besides this general laboratory, however, as suggested in our last issue, the physicians require smaller laboratories attached to their respective wards to enable them to do research and other work requiring their own supervision. We are confident that under the direction and guidance of Col. Norman-Walker we shall soon have all that is necessary to make our hospital a pattern institution of its kind in the Deccan.

Post Graduate Notes.

i. PEPTIC ULCER.

*(An abstract of an address by Professor Wilkie of
Edinburgh, published in the B. M. J.
of 23—3—29.)*

MANY factors singly or combined may produce gastric ulcer. Blood infection, deranged or interrupted nerve supply, retrograde venous embolism may cause ulceration. It may be a manifestation of deficiency disease. It has been shown to follow adrenalectomy.

Gastric Ulcer is met with in relatively healthy young adult males. Its symptoms are periodic. Hyperacidity, is present in the early stages. Painful spasm relieved by swallowing anything is the rule. Very often there is dental infection and in many cases there is history of acute or chronic appendicular trouble. Constipation, worry, overwork, loss of sleep, excessive smoking and irregular meals, precipitate or aggravate the condition.

Multiple acute ulcers may be widespread but the chronic ulcer is localized to the lesser curvature of the stomach.

Gastric and duodenal ulcers are frequently found together and so the cause of both must be one and the same.

A certain degree of gastritis accompanies and probably precedes ulceration.

It is a blood-borne infection which settles in the lymph follicles of the stomach and duodenum, some of which soften and erupt on the surface, the devitalized tissue undergoing digestion and leaving small follicular ulcers. The infection is streptococcal in type and the primary source is usually the teeth or tonsils and possibly, in some cases, the appendix. In many cases pure culture of streptococcus has been obtained from the base of an excised ulcer. In others a coincident streptococcal infection of the gallbladder and appendix has been found. There is thus the probability of there being a selective affinity of the streptococcus for the stomach and duodenum.

Acute Ulcers in stomach and duodenum generally tend to heal. A certain number of such ulcers become chronic and these are restricted to lesser curvature of the stomach and the first part of the duodenum. The lesser curvature is rich in follicles, is comparatively a fixed part and is capable of little expansion; not so the greater curvature. A defect in the lining at the lesser curvature remains open and is in the direct traffic route of the entering food. So too the first part of the duodenum has a smooth unfolded

mucus membrane, rich in lymph follicles and receives the acid chyme. This explains the site of the chronic ulcer. Hyperacidity and spasm may explain the chronicity of the ulcer.

Fresh air, sunlight, and change of diet have an immediate beneficial influence. Bearing in mind the three main etiological factors: infection, nervous influence and a possible dietary vitamin deficiency the treatment should be in the direction of the removal of septic foci in the mouth, of giving rest in the recumbent position, ensuring of adequate sleep, cutting down of tobacco, giving small meals of fresh vitamin-rich fluid food at frequent intervals and supplying of alkali. The healing of gastroduodenal ulceration may thus be almost ensured in all but old standing and neglected cases.

The rationale of surgical treatment we shall deal with in our next number.

ii. CLINICAL NOTES.

TWO cases of malaria of the cerebral type: one of them was a boy of 10 years. He was admitted with high fever and tremors of both hands and fingers. He was not unconscious but the movements of hands and fingers were constant—not stopping during sleep even. They were not tremors—they were somewhat of the choreic type without the element of jerkiness in them. Blood was examined in the routine way and signet rings found. The red corpuscles containing them were shrunken and crenated suggesting Quartan or malignant type of malaria. Clinical features were those of the Quartan type. Quin. Bi-hydrochlor (grs. V) was injected at once and the involuntary movements immediately stopped. Another injection two days later brought about complete cure. In this case without the detection of the malarial parasites one could not suspect cerebral type of malaria.

The second case was that of a young man of 25 years, strong and well built. He came in an unconscious condition, in the night, with high fever. Poi-

The Deccan Medical Journal.

PUBLISHED quarterly by the Hyderabad Medical Association. The only journal of its kind in His Exalted Highness the Nizam's Dominions and consequently the best medium of advertisement for Chemical, Pharmaceutical and Surgical Manufacturers. Articles of special interest to the profession from experts appear in every issue.

Editorial Committee :—

*Editor—V. R. GORAKSHAKAR, B. A., M. B.,
CH. B.*

*Assistant Editor—S. RAGHAVENDER RAO,
L. M. & S.*

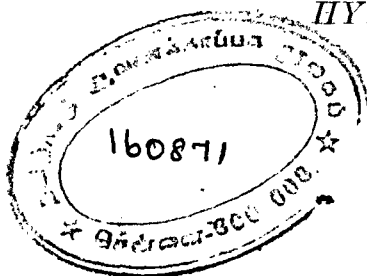
The members of the Committee—The above and

*CAPT. K. N. WAGHARAY, M. B., B. S.,
S. E. DAVID, M. R. C. P., L. M.,
MISS A. SHAW, M. B., B. S., D. T. M. & H.*

<i>Rates of advertisement :—</i>	<i>Rs. a. p.</i>
Full page ordinary	30 0 0
Half page ordinary	15 0 0
Quarter page ordinary	8 0 0
Back cover outside	50 per cent. extra.
Front cover inside	60 per cent. extra.
For four issues prepaid	10 per cent. discount
Back cover inside	25 per cent. extra.
For two issues prepaid	5 do do

*For further particulars apply to
THE EDITOR,*

*THE DECCAN MEDICAL JOURNAL,
B 1195 Near King Koti,
HYDERABAD-DECCAN.*



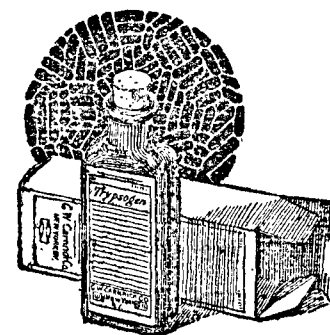
70

DIABETES MELLITUS

PANCREAS THERAPY has made diabetes mellitus a curable as well as a controllable disease. It is necessary, however, to use all the active principles of the pancreas to cure diabetes.

TRYPSOGEN

contains all of the active elements of the pancreas. It, therefore, is capable of correcting the defective digestion and absorption as well.



Bottles of 100, 500, 1,000 Tablets

On sale by all the Leading Chemists.



G. W. CARNRICK CO.

Dependable Gland Products

224 Mt. Pleasant Avenue

Newark, N. J.

U. S. A.

[Write for
a
Clinical Sample]

Reviews.

The Antiseptic Silver Jubilee number: We have received this valuable issue and congratulate the Editor in bringing out such a useful number. It gives the history of the journal from its first appearance 25 years ago till now. The Antiseptic has by its writings done much good to the Medical Profession in India and we wish it the same success in future. The credit is especially due to the late Dr. Nair and to Dr. U. Rama Rao. The special feature of the Journal, we have noticed, is that its pages are open to contributions from Medical men of all grades of qualifications and standing. The subscription is small and the information obtained by reading the Journal is very valuable. We venture to suggest that considering the success it has already achieved an advance might be made by improving the printing and the general get up of the Journal if it is possible to do so without raising the subscription. If the style of the Jubilee Number is kept up it will be a great advance.

The Hyderabad Medical Association.

THE membership is open to all persons holding medical and Surgical qualifications according to the Western System and the chief object of the Association is to promote Medical and Surgical knowledge by reading of papers, demonstration of cases and discussions, in monthly meetings.

The Office of the Association is in the Osmania Medical College, Afzulgunj, and the meetings are ordinarily held in the Osmania General Hospital.

President—R. N. COORLAWALA, F. R. C. S., (ENG.), D. P. H., ETC.

Vice-President—MAJOR MOHAMED ASHRAFF, M. B., CH. B.

Secretary and Treasurer—MAJOR FARHAT ALI, B. A., M. B., CH. B.

Editor of the Journal—V. R. GORAKSHAKAR, B. A., M. B., CH. B.

Managing Committee—The above Office-bearers and

KHURSHEID HUSSAIN, M. B., CH. B.

H. J. CHINYOY, L. R. C. P. & S.,

LATEEF SAYEED, M. B., CH. B.,

CAPT. K. N. WAGHARAY, M. B., B. S.,

B. S. RAJ, L. R. C. P. & S.,

MISS K. S. KANGA, L. R. C. P. & S.

Every member has to pay an annual subscription of O. S. Rs. 12.

Only the Sub-Assistant Surgeons will pay half the above rate but the subscription will, in any case, be payable for the whole year in advance and every member will receive free a copy of the Quarterly Journal of the Association.

Psychotherapy and the General Practitioner

"We must not lose sight of the fact that people have faith in local treatment, that it appeals to their imagination and that—just to this extent—it carries with it *psychotherapeutic potency*. From all these considerations may be coined the therapeutic maxim: 'Use appropriate topical treatment in all conditions in which it is justifiable'."

B. Fantus, M.D. ("The Technic of Medication", A. M. A. Press, 1926).

FROM time immemorial psychotherapy has played a large, though often unrecognized, part in all successful treatment. The application of the general principles of psychotherapy includes all measures, apart from the physical, of influencing the patient and of helping him to overcome disease.

The sensation of pain certainly belongs within the compass of the psychotherapist. The pain sensation is exhausting, the fight against the pain decreases the resistance of the individual, and interferes with the normal flow of the mental life. The psychotherapeutic effort, directed toward removing the source of the pathologic disturbance, inhibits the pain by filling the mind

with agreeable feelings and pleasant ideas, until the normal equilibrium is again restored.

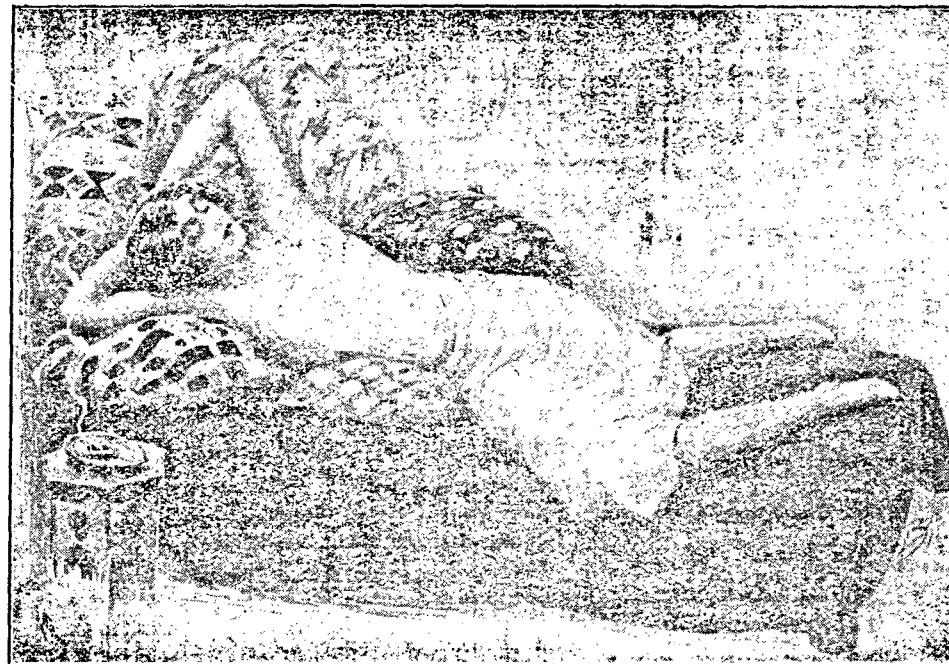
Antiphlogistine

is not entirely based on its psychotherapeutic potency. In countless numbers of cases, its timely application has really served to bring more rapid relief from the physical pain, together with obliteration of the concomitant mental distress. The ever-increasing use of this plastic, analgesic, hygroscopic dressing by the Medical Profession the world over is the best evidence of its merits in the treatment of superficial and deep-seated inflammatory and congestive conditions.

Samples upon Request

THE DENVER CHEMICAL MFG. CO.

163 Varick Street, New York City.



"DOWN AND OUT"

Many of these cases result from endocrinal disturbances of the sex glands. Nature must be aided over the rough places by hormonal assistance.

Ovacoids For Women

containing the hormones or autacoids of the ovary and anterior pituitary, and

Testacoids For Men

containing the hormones or autacoids of the testicle and prostate, each with a little organic phosphorus, will render the service necessary to enable Nature to complete the work of rehabilitation.

Some physicians desire an aqueous solution for subcutaneous injection to supplement the oral administration of Ovacoids and Testacoids.

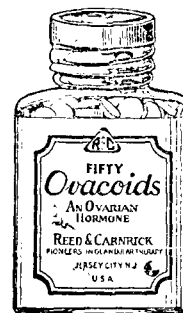
Ampacoids

for weekly or semi-weekly injection are prepared for that purpose.

These sterile solutions include

- AMPACOIDS, Ovary, each representing 15 grains of fresh ovary,
- AMPACOIDS, Testicle, each representing 30 grains of fresh testicle,
- AMPACOIDS, Prostate, each representing 10 grain fresh prostate.

Ovacoids, Testacoids, and Ampacoids offer physicians the most effective treatment for gonadal dysfunctions.



REED & CARNRICK, Jersey City, N. J., U. S. A.

OVACOIDS, TESTACOIDS AND AMPACOIDS are obtainable from all Chemists, or through

MULLER AND PHIPPS (ASIA) LIMITED

Hong Kong, Prince's Building

Colombo, 46 Keyzer Street

Cairo, P. O. Box 1764

MULLER AND PHIPPS (MANILA) LIMITED

Manila, Pacific Building

MULLER AND PHIPPS (CHINA) LIMITED

Shanghai, No. 24 The Bund

MULLER AND PHIPPS (HAWAII) LIMITED

Honolulu, 1015 Fort Street

MULLER AND PHIPPS (INDIA) LIMITED

Calcutta, 21 Old Court House Street

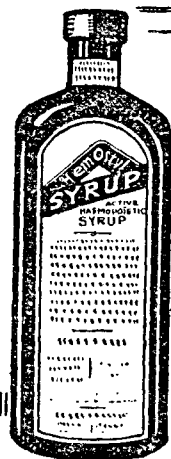
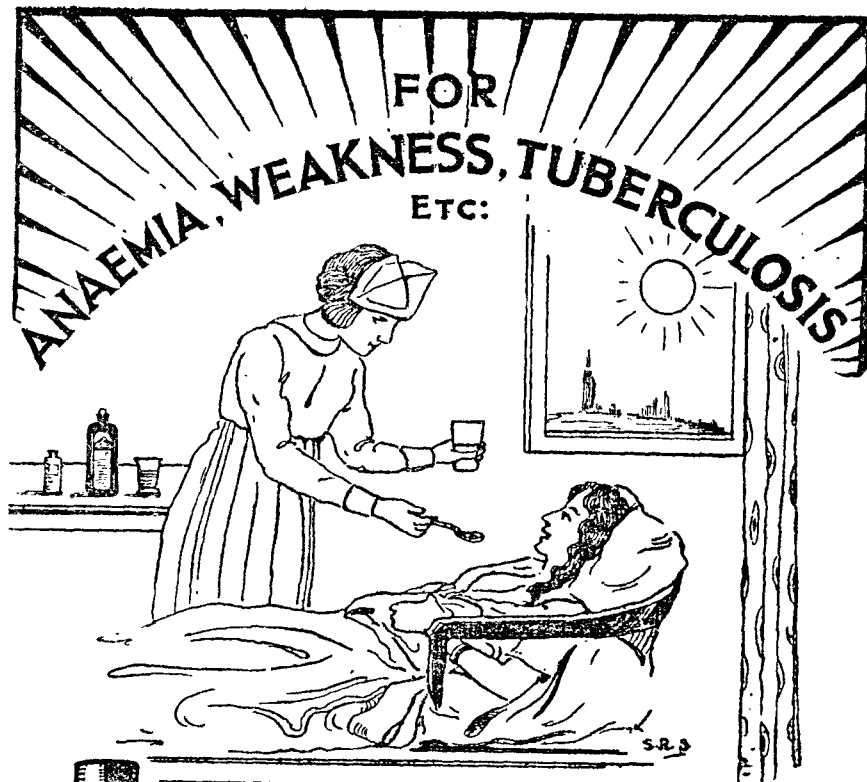
Bombay, 14-16 Green Street

Madras, 21 Sunkurama Chetty Street

Karachi, 726 Napier Road

Rangoon, 4-5 Shafraz Road

COATES & COOPER, 41, Great Tower St., London, E. C. 3, England



CURE YOURSELF
BY THE MOST REMARKABLE DISCOVERY:

**DR. ROUSSEL'S
HEMOSTYL**

A SCIENTIFIC FRENCH PREPARATION, HIGHLY RECOMMENDED & LARGELY PRESCRIBED BY ALL LEADING DOCTORS THROUGHOUT THE WORLD. AGREEABLE TO THE TASTE. PARTICULARLY EFFICACIOUS FOR DEBILITY FOLLOWING MALARIA, INFLUENZA, CHILD BIRTH, Etc & ALL RUNDOWN CONDITIONS

AGENTS FOR INDIA.

KAHN & KAHN

Jehangir Wadia Buildings, Esplanade Road, BOMBAY,
14, Clive Street CALCUTTA.

Stockists at Madras:—

Messrs. Sri Krishna Bros, Post Box. 166, MADRAS.

Please Note:—The genuine package bears the RED LABEL,

"Hemostyl Specially Prepared for Tropical Countries."

BEWARE of IMITATIONS without such Labels.

V

"TREPARSOL"

New French Discovery. SURE CURE for
SYPHILIS & AMOEBIASIS

In Tablets

No Injection Necessary

Sole Agents for India.—

KAHN & KAHN,

Jehangir Wadia Building,
14, Clive Street,

P. O. Box. 105, Bombay.

P. O. Box. 315, Calcutta.

Stockists at Madras:—

Messrs. Sri Krishna Brothers, Post Box 166, Madras.

The Patna Journal of Medicine

(The Journal of the Patna Medical Association).

Edited by

H. HYDERALIKHAN, F. R. C. S. E.,

BANKIPORE, PATNA.

ONE OF THE MOST UP-TO-DATE JOURNALS
IN INDIA.

Articles by Experts.

January 1927—Special Endocrinology Number.

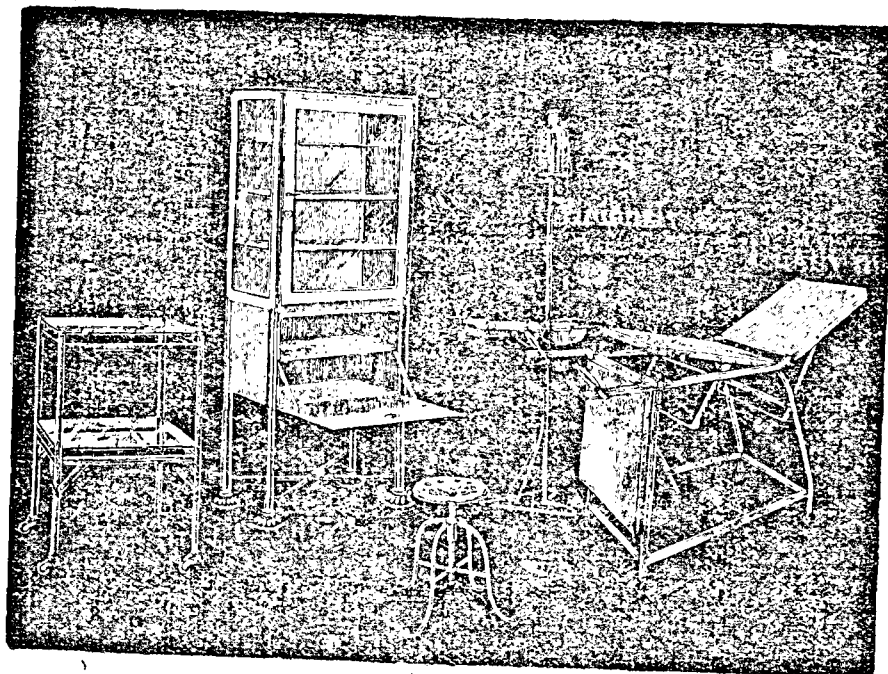
July 1927—Special Educational Number.

Price Re. 1/4. Annual Rs. 4/6.

Post free from the Editor.

vi

QUALITY of DISTINCTION



THE FOREMOST HOUSE IN INDIA

FOR

Aseptic Furniture & Steel Boxes, etc.

ASEPTIC CABINETS, OPERATION TABLES,
DRESSING WAGONS, WARD LOCKERS,
STOOLS, HIGH PRESSURE AND STEAM
STERILIZERS, BEDSTEADS, BED SCREENS,
LOTION AND IRRIGATOR STANDS, GLASS
AND ENAMELLED WARE, SURGICAL
INSTRUMENTS, ETC., ETC.

AND ALSO

STEEL OFFICE AND DRESS BOXES

CATALOGUES FREE ON DEMAND

ALLIBHOY VALLIJEE & SONS

By Appointment
to H. M. the King.

ALVI WORKS 26 GOLD AND
MULTAN CANTT., PUNJAB SILVER MEDALS.

Telegrams : 'DESPATCH BOX'

THE ANTISEPTIC

Silver Jubilee, April 1929

The Antiseptic, the oldest Monthly Medical Journal in Southern India edited by Hon'ble U. Rama Rau and U. Krishna Rau, M.B.,B.S. will complete its 25th year of existence and its April 1929 issue which will be out on or about the 30th April 1929 will constitute its Silver Jubilee Edition. This Special Edition which will be of the usual royal octavo size of the regular issues of the Journal will contain 256 pages or 4 times the usual number. Among those whose contributions will appear therein may be mentioned :

Dr. James Burnet, M.A., M.D., F.R.C.P.
(Edin.)

M. I. Balfour, C.B.E., M.B.

C. F. Chenoy, M.B., B.S., (Bom.), D.T.M.,
D.P.H. (Lond.)

N. N. Dey, L.R.C.P., L.R.C.S., (Edin.) L.F.
P.S. (Glas.)

Jahar Lal Das, D.P.H. M. R. San, I. (Lond.)
D. R. Dhar, M.B., D.T.M. (Cal.), M.R.C.P.
(Lond.)

Lieut. P. C. Dutta, I.M.S., M.B., (Cal.), F.R.
C.S. (Edin.), D.G.O. (Dub.), L.M. (Rot.)

Col. J. Frollano De Mello, M. D. (Oporto)
D.T.M. Lisbon.

Dr. P. V. Gharpure, M.D.

Dr. Ezendranath Ghosh, M. Sc., M.D.

Suresh Chandra Das Gupta, L.M.S.

M. D. Joshi, M.B., B.S., D.M.R.E.

V. M. Kaikini, B.A., M.B., B.S., F.R.C.S.,
(Edin.)

Rao Bahadur Dr. M. Kesava Pai, M.D.

Major Lebarndie, M.D., M.S.P.E., (Paris).

J. P. Lockhart Mummery, B.A., B.C., F.R.
C.S.

Dr. E. Muir, M.D., F.R.C.S.

Dr. H. C. Menkel, M.D.

H. B. Mylvaganam, F.R.C.S.

Frank Noronha, M.B., C.M., D.P.M. (Eng.)

V. D. Nimbkar, F.R.C.S., (Edin.)

R. K. Paul, M.Sc., M.B.

P. S. Pybus, M.S., F.R.C.S.

S. B. Surti, F.R.C.S., D.P.H., (Irel.) L.M.
& S. (Bom.)

S. Subba Rao, B.A., M.B., (Madras), M.R.C.S.,
(Eng.) D. P. H. (Cantab.)

Y. C. Shrikhande, M.B., B.Sc.

Rao Sahib T. S. Tirumurti, B.A., M.B., C.M.,
D.T.M. & H., (Lond.)

Dr. Ch. W. F. Winckel.

A. Winkler Williams, M.B.C.M., D.P.H.

G. Zacariah, M.R.C.S., L.R.C.P.,

Dr. T. Purushothamdas Patel, M.D., (Lond.)

G. Raghunatha Rau, D.T.M.

Khan Bahadur D. J. Asana, L.M.S., F.C.P.S.,
B.M.S.

Dr. W. Chodzko, M.D.

Dr. Subodh Mitra, M.D. (Berlin.) M.B. (Cal.)
F.R.C.S. (Edin.)

∴ The Special Edition will be sent free to the Subscribers of the Antiseptic. To non-subscribers it is priced Rs. 2. (Foreign 4 sh.) inclusive of postage. Annual subscription to the Antiseptic, is Rs. 5. Foreign 10 sh. inclusive of postage payable in advance. Subscription may begin from any period for not less than a year. Every volume begins with the January issue. Back numbers of current volume are available. Specimen copy of ordinary issues will be sent free to members of the Medical Profession.

As only limited extra copies of the Special Edition will be printed those desirous of obtaining a copy of it are requested to remit immediately to the undersigned either Rs. 2, (4 sh.) for a single copy or enlist themselves as subscribers and remit Rs. 5 (10 sh.) for a year.

Manager, "The Antiseptic" P. O. Box 166, Madras.