

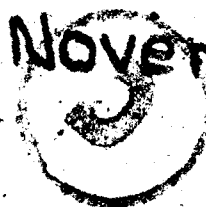
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Medical Practitioner

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The Medical Practitioner.

A Monthly Medical Journal *H&T* 1343

EDITED BY

Dr. M. S. Krishnamurthi Ayyar, M. B. & C. M.,

Retired Sanitary Commissioner to Travancore State

AND

Dr. V. Rama Kamath.

CONTENTS.

PAGE.

Editorial:—

Ourselves 1

Original Articles:—

Madras Medical Council Election. By Dr. V. Rama Kamath	2
Endocrinology. By Dr. M. S. Krishnamurthi Ayyar, M. B. & C. M.	4
Rural Medical Relief. By Dr. S. Ramasubbu L. M. & S.,	7
Notice. By Dr. V. Ramakamath	15

Abstracts:—

Atropine Fever	16
Treatment of Warts by Suggestions. By Dr. Lene Gramach Univ Hunt Klinik	17
Konigsberg 1 PR.	18

Notes on Treatment of Diseases.	18
Notes on Diagnoses, Therapeutics and other Medical subjects	19
News & Comments	20

Correspondents, Reviews, Reports etc.

The Second Andra Medical Conference with a Forward by Pattabi Sitaramayya	21
M. B. & C. M.	
Extract of the Proceedings of the Meeting of the Provincial Committee of the All Indian Medical Association held in Calcutta on 12-7-29.	26

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THE

Medical Practitioner

Vol. II

SEPTEMBER, 1929

[No. 1

Ourselves

The idea of starting a journal has been long in contemplation particularly ever since the holding of the Independent Medical Practitioners' Conference in the last week of December 1927, in Madras. In a province like Madras, with a population which is larger than that of England and Wales, there are but a few medical journals which can be counted on the fingers of one hand and of which only one is a monthly. In England and Wales, the number goes up to three figures including weeklies, fortnightlies, monthlies and quarterlies. Medical journals are needed not only for the spreading of knowledge of medicine among doctors but also to exercise some control over the medical profession including medical education. In all European countries and America, the medical relief of the general public rests with the independent medical practitioners and most of the hospitals, medical colleges and schools are opened, maintained and administered by private agencies. The General Medical Council in England and the Medical Association in all concerned were. All poss-
imate

members, are the chief agencies entrusted with the control of medical relief. Hospitals and colleges are being opened with their sanction. In India, however, the hospitals and colleges are owned and controlled by government, and the medical councils in which most of the members are government officers, are subordinate to government. The private medical practitioners are practically left alone. It is only of late that the government had made up their mind to recognise the existence of the private medical practitioners and had thrown open a few honorary appointments to them. It is time, therefore, that journals should be started to take up the question of medical relief in all its aspects and continuously agitate about the importance of private medical practitioners in connection with it. The scientific aspect of medical relief, concerning the treatment of diseases is chiefly and wholly dealt with in other journals. The object of the journal under reference is to devote a good part of it to medical politics for the regulation of medical relief. In this province medical relief is given by officers paid by government, local boards and municipalities, mission doctors and rural medical staff who

Dear Doctor,

7-9-1929

Doctor Rama Kamath came to me just, a few minutes ago, with my voting paper received by my brother Dr. _____ to my old address _____ Road. The cover was not opened; it bore a seal from the Royapettah post office and seems to be a genuine one; the one sent by you through Dr. _____ was not in any cover bearing any postal stamp, and evidently it must have originally belonged to some one else as it bore some other serial number which was struck. If you got this paper from the registrar's office how is it that the registrar did not send it to me by registered post? As my voting on such a paper is likely to be questioned, by Doctor Kamath who has come to know about it, I am really very sorry that you had recourse to such a procedure which is likely to bring me to trouble. So, I hastened to write to you so that you might not utilise that paper sent by you to me.

Yours faithfully,

(Sd.), _____

I am quite conscious of your ordeals and the disinterested service offered by many of you not for me personally but for the noble cause I ventured to represent. The trust you have imposed upon me by returning me to the Council with an overwhelming majority will not be misplaced by me. I am indebted to you all. My work has just commenced and we should all keep up this zeal. We have to be ever vigilant and active. The Medical Council is not the only place where we have to carry on our fight for getting our rights and privileges. There are other avenues of activities. I shall venture to enter all these fields and I appeal to you to be with me, for with your support and co-operation I am hopeful to give you a good record of work during my five years term of office in the Medical Council as your chosen representative.

Before closing, I wish to request such of those who for some reason or other voted for my rivals, to forget the events of election and take me quite cordially as one of their own and unreservedly utilise my services which will be as much devoted to them as to those who returned me to the Council. I take this opportunity for thanking all of you who have sent me congratulatory messages after the election and beg to be excused for not having expressed my gratitude individually as those messages are quite a good number.

Voting Analysis

1. Dr. V. Rama Kamath	...	628
3. „ V. A. Muthia Thevar	...	255
3. „ D. V. Venkappa	...	212
4. „ K. S. Venkatachala		
	Iyer, M.R.C.S. etc.	54
5. „ D. John Pillai	...	15
6. „ P. C. K. Kurup	...	9
7. „ A. P. Balaram	...	
8. „ Mohammad Khadir Khan	9	
Rejected	...	64
Invalid	...	12
		1267

ENDOCRINOLOGY

BY

Dr. M. S. KRISHNAMURTHI AYYAR,
M.B. & C.M.

Before endocrinology emerged as a science, organotherapy was practised for a long time. In Ayurveda which was compiled about B.C. 1800, mention is made of treatment of diseases by administering animal substances. The number of preparations of animal organs in the apothecary shops in London and the Continent was about 152 in 1765. Even today the writer

knows that in Travancore a certain kind of snake is skinned alive and poison glands taken, and the medicine prepared out of them, is given for the treatment of rheumatism. It was Claud Bernard who coined the words "Internal secretion" in 1855 to distinguish it from external secretion. In 1899 when he was 72 years old Brown Sequard found that he was weak and could not account for it by any disability in any of the organs of his body except the reproductive glands. So he made testicular extracts and injected it into himself. He found remarkable improvement on his health and strength. On the 1st of June 1899 he delivered his famous lecture before the Society de Biologie of Paris, and it may be said that endocrinology as a science was born on that day. In 1903 Drs. Sajous and Starling gave the name 'hormone' to internal secretion, and Sajous published his monumental work on "Internal secretions." But it is Dr. Harrower, who by his books, pamphlets, journals and preparation of endocrine glands for use, pushed on and brought into prominence the subject of endocrinology. The number of books, pamphlets and special journals published on endocrinology have considerably increased of late. At the present day the endocrinology has come to so much importance that it has replaced astronomy as a thriller. Dr. Biedl says as follows: "Formerly all organic correlation was assumed to be nervous; at the present day even the nervous relation is largely considered to be induced by chemical factors."

The position which endocrinology occupies in medical science and its intimate connection with human

beings from their very conception to their death, and also with the human race, will be evident when it is found that the three types of humanity now inhabiting the world are characterised by the predominance or otherwise of certain endocrine glands. The sharp pronounced nasalization of the face, the tendency to show eyebrow ridges, the prominent chins, the bulk and the stature of the body are the characteristics of pituitary prominence in the Caucasian race; the Negroes are characterised by adrenal prominence while the Mongolian shows the hypofunction of the thyroid. Coming to individuals not only the secondary sex characters but the sex itself are determined by endocrine glands. The human embryo is at first sexless, or to speak more correctly the two sexes are found in it. It is only by the predominating influence of one sex gland over the other, that the sex of the child is finally fixed. The stature of the body such as gigantism is caused by the overaction of the anterior pituitary while dwarfism is produced by the over activity of the thyroid. Short body and long limbs are produced by the activity of the thyroid while large body and short limbs by its inactivity. The soft moist skin and smooth handnails are due to the hyperaction of the thyroid and dry skin, and brittle nails are caused by its defective action. The pigmented skin is produced by the insufficient action of the adrenals while the pale skin brittle and ridged nails and thin, hair are caused by the hypofunction of the parathyroid. The several varieties of cataract in the eyes are determined by endocrine glands. The cataract of tetany found in young persons is produced by the hypo-

function of the parathyroid, the grey cataract in diabetes mellitus by the hypofunction of the pancreas (the insular portion); senile cataract is produced by the hypofunction of the gonads, and the inactivity of the hypophysis and suprarenals cause cataract of diabetes insipidus and zonular cataract respectively.

The growth of hair on the head is controlled by the thyroid, the hairs of the face and the terminal hairs by the sex glands; the adrenals govern the hair on the chest, abdomen and back and the pituitary the hairs on the extremities. On account of the presence of the thymus and pineal glands, there is no hair on the face of the child. The teeth are governed by endocrine glands. The eruption of the teeth is a thyro-pituitary function, their position in the jaw is a thyro-thymus-pituitary-suprarenal-gonad function; the quality of the teeth is a thyro-parathyroid-pituitary function. The thyro-parathyroid secretion increases the germicidal and antitoxic power of the blood by endowing the albuminous portion of the hemoglobin with sensitising properties. As such it is the blood constituent that Sir A. E. Wright has termed "Opsonin." Old age is not caused by the old age bacillus of Metchnikoff but is the result of atrophy of all endocrine glands. So much about the physical illness. Coming to the diseases of the mind—neuroses, as hysteria, are known to be connected with sex glands, while psychoses as dementia precox, paranoia etc., have at the bottom some defect of certain endocrine glands. The temperament and personality are concerned with endocrine glands. Thus there are the

adrenal personality, pituitary personality, thyroid personality and if the thymus persists thymocentric personality according to the predominance of the gland concerned at the time of puberty when the restraining action on the somatic system is removed. Leonard Williams says on speaking about the change in the mental condition brought on in menopause "When after I close the book with a sigh and be-think me of the saying of the French physician to the effect that our therapeutic ignorance with regard to menopause is undoubtedly responsible for the universal unpopularity of the mother-in-law." In the region of morality it has been found that the persistence of the thymus in the adult contributes to criminality. It was only in 1911 the existence of the vitamins was found out and named and now they have attained so much importance as to revolutionise the science of dietetics. There is not a single foodstuff advertised without naming the kind of vitamin it contains. These vitamins are considered to act through the endocrine glands. The close resemblance existing between certain deficiency diseases and endocrine glands have led many investigators to question whether vitamins may not be either the precursors of particular hormones or the hormones themselves stored within the glands. It is further said "that vitamins are to endocrine glands what the endocrines are to the bodily economy as a whole." It is abundantly clear from the above the all-embracing and intimate connection the endocrines have not only with physical, mental and moral aspects of the human beings but with the human race itself. It was the late Sir William

Osler who told Dr. Harrower "that surgeons had been having their innings this past decade, now it is our turn; and mark my word the internal secretions will be the bat with which most of the runs are made" Dr. Leonard Williams another eminent physician said as follows: "Still more earnestly I believe that the study of the whole field of internal secretions will enable us to detect and correct marked tendencies with a degree of success which have been denied to the older methods. The microbe—the seed—has ruled the immediate past, the future is with the soil—the endocrine glands." This last statement is applicable in all its entirety to India. Without taking into consideration the extreme poverty of the people and in consequence their low vitality—the soil—public health and other measures are undertaken at a great cost for the improvement of the surroundings—the seed. Another authority Lieut. Col. Fielding H. Garrison of the United States' Army says: "Since the development of the bacterial theory of infection, there is probably no pathological concept that has latterly so dominated modern medicine as the doctrine of the internal secretions of the ductless glands. Endocrinology has become so much connected with medicine that the internal secreting glands which already unfold before the astonished view of the seeing eye, a land of promise beside which the vast territories conquered by Lister and Pasteur are destined to pale into honourable insignificance. They come to us as peaceful conquerors who brook no denial, they lighten our darkness and show us miracles." It is now recognised "that endocrines

are functionally basic to all principles of physiology; in fact, endocrinology is physiology and no physician or surgeon can qualify adequately in any phase of medical science who is failing in knowledge of this subject. We must all be endocrinologist to practise successfully the art of healing which is our paramount function. Endocrinology is but a part of general physiology; the study of a type of biologic functional mechanism. General medical practitioner could no more ignore it than he could ignore the study of the central nervous system, the enzymes of the body or cell metabolism." While endocrinology has assumed such proportions and close bearing on medicine, it is really surprising that in India this subject is neither taught in medical colleges or schools nor examined before degrees or diplomas are granted.

RURAL MEDICAL RELIEF

BY

DR. S. RAMASUBBU, L. M. & S.
VIRAGNUR, SALEM DISTRICT

*Secretary, The Madras Provincial
Rural Medical Practitioner's
Association*

The problem of providing adequate medical relief to the poor people of India, especially the rural population, has not received that attention from the government and the public as it ought to have. Rural medical relief should be considered to be one of the first planks if not the first, in the programme of 'Rural Reconstruction' and it behoves the government and our legislators to do their best to 'mitigate' the great mass of unrelieved suffering in rural areas.

Very recently however, some of the local governments and the native states, having inaugurated schemes for providing 'skilled' medical aid to the rural population, but none of them upto the mark. In the Bombay Presidency village school-masters are trained in and required to render 'first aid.' First aid is good in itself, but can never be a substitute for the secondary or subsequent aids; and rendering it under the auspices of the state, is apt to engender in the unsophisticated villager, such a false idea of security as to make him delay seeking the proper, timely and effective aid. Little knowledge is dangerous, and it is not expedient to depute school-masters for first aid and stop there, especially when there are a number of qualified medical men unemployed and available for rural medical relief. In the Central Provinces, there are two schemes in vogue, one under the district councils, and the other under the Inspector General of Civil Hospitals, through the respective civil surgeons. The only available detail of the former scheme is, that of 'subsidising medical men who will settle in villages, at a distance of not less than 8 miles from the existing medical institutions.' In the other scheme, medical men of the assistant medical officer's qualifications, are offered an advance for equipment of Rs. 300 free of interest, and invited to practise for their own benefit, in specified villages, on an honorarium of Rs. 50 per month for three years, the advance to be repaid at the rate of Rs. 10 and Rs. 15 per month, in the second and third year's of practice respectively. The government patronage stops there; no restrictions are placed on the prac-

titioners, nor are they obliged to treat poor people free. They are merely private practitioners, and are given a 'retainer' to practise in the villages, for the benefit of the rural population. Unlike as in Madras, superannuated men are discarded; only young and energetic men are chosen, who are also eligible for entertainment in service. In the native states of Mysore and Baroda, somewhat similar scheme are in vogue, while in Bhavnagar one is under contemplation. In the Madras Presidency, a scheme for providing skilled medical aid to the 'necessitous poor' of the rural population, is in force since 1925, and as it concerns our native province, would bear a detailed description, just to understand its shortcomings.

The Madras scheme, as contained in G.O. No. 1522 P. H. dated 22-10-1924 states "that government strongly feel that some amelioration of the masses is urgently called for, and that for want of unlimited funds at their disposal, encouragement of private practitioners (allopathic) to settle down in villages for practice by the grant of money subsidies and supply of medicines from public funds, as being the cheapest and at the same time the best from many points of view, and thus 'to divert to the villager the large number of unemployed medical men who now congregate in towns for private practice', as also tend to solve the problem of unemployment to a material extent". According to this scheme a medical man has to practise in village fixed by the taluk board (to whom is entrusted the actual working of the scheme) in consultation with the district medical officer, and agree "to treat professionally and supply

medicines to all the necessitous poor of the locality (who are defined as persons or members of the families of persons whose monthly income does not exceed Rs. 30), who shall apply to him therefor; such treatment being given and medicines supplied free of all charges at the residence of the practitioner (Clause 2 of the agreement to be executed by the practitioner and the taluk board; G. O. No. 1994 P. H. dated 28-9-25.) In return, the taluk board will pay to the medical practitioner a sum of Rs. 400 per annum if an L. M. P. (since enhanced to Rs. 500) or Rs. 600 if a medical graduate, and an additional subsidy of Rs. 100 per year (since raised to Rs. 300) if he "shall engage, maintain, and employ a qualified midwife" as also supply him free of charge with medicines to a value of not less than Rs. 360 per year. (Clauses 6, 7 and 8 of the agreement amended by G. O. No. 2185 P. H. dated 3-11-27 and 942 P. H. dated 6-4-29). Such an agreement shall be subject to termination on giving to either of them 6 calendar months' notice in writing to that effect. But the taluk board shall not be entitled to terminate the agreement under this condition, unless it finds itself unable to maintain the dispensary on account of financial stringency (Clause 10 amended by G. O. 1756 P. H. dated 27-8-28.). "The taluk board shall however terminate this agreement at any time without notice on the event of an alleged breach by any practitioner of any agreement on his part, an appeal against which will lie to the Government of Madras whose decision will be final and binding on both the parties" (Clauses 11 and 12 of the agreement by G. O. No. 2185 P. H.

dated 3-11-27). Subject to the above conditions the medical man is an independent practitioner and he is entitled to practise for his benefit. He is expected to settle in his village and in no case can be transferred from place to place (G. O. No. Press 1154 P. H. dated 14-6-27): nor do such extraordinary duties as inoculation, festival or polling work, form part of the ordinary duties of the practitioners (Government Memorandum No. 29417—2 D-P.H. dated 26-10-27). The object of the scheme, therefore, is to provide some sort of employment to the unemployed medical men, and at the same time afford some degree of skilled medical aid to the necessitous poor. It is a pity that many of the taluk boards do not perceive this dual object of the scheme, or realise that adequate and skilled medical aid to the poor is incompatible with inadequate remuneration and unfair treatment to the practitioners, an attitude that has been the cause of too many resignations from the latter.

Though the actual working of the scheme is entrusted to the taluk boards, government contribute to them as grant the medical practitioners' subsidy for three rural dispensaries in a taluk board area, while the latter are to bear the cost on medicines; they are also at liberty to pay extra subsidies to the practitioners, and maintain as many extra rural dispensaries as their funds can permit. Licentiates of the Indian School of Medicine are now posted to these rural dispensaries on the same subsidy as L. M. Ps. There are about 400 such dispensaries in the presidency, excepting about 50 of which every one of the rest had its period of suspended animation on account of the resigna-

tions of the discontented medical officers, until resuscitated by other practitioners.

Such a sporadic working of these dispensaries may be ascribed to (1) the low subsidy to the practitioner and the inadequate scope for private practice existing at present in villages; and (2) a tendency on the part of the taluk boards to go behind the rules and treat the practitioners as mere subordinates. I should not however omit to single out for grateful mention, the existence of a few taluk boards and their presidents, of which mine is one, who have understood the spirit of the scheme, been so fair towards the practitioners, and even helped them with their extra subsidies, as to suffer their continuance in the villages longer than they expected.

I shall now pause to consider in detail, the difficulties rural practitioners labour under.

Subsidy:—This is the chief consideration for the time being. To work any scheme fairly, zealously and successfully, the human agency should be amply paid to keep itself above want; and that is exactly what is lacking with the present scheme. It is true that very recently the government enhanced the subsidy of the L. M. P. from Rs. 400 to Rs. 500 (but not that of the medical graduates) and that some of the taluk boards were supplementing the original subsidy from their own funds. Still after paying about Rs. 20-30 per month on an average, towards house rent, establishment and contingencies etc., the practitioner has very little left out of his subsidy to call it a "living wage". Nor are the prospects of private practice any way bright under the present condition of enlightenment of the rural

population. Allopathy is a thing strange to them and should be offered free at the outset, if people should get convinced of its benefits and resort to allopathic medicos as often as is necessary. To the ordinary villager fate, destiny or divine wrath are the causes of diseases and propitiation of this or that deity, the remedy "par excellence"; medical relief is only secondary and then the village quack, who will also play the role of an exorcist as well as the guardian angel. While the poor hold such ideas, the rich call in the "Vaidyan" for minor maladies, and go to a renowned practitioner in towns for serious ailments. It will take some time, perhaps a generation, for the villager to regard the allopathic practitioner, even as much as a necessary evil. At present the practitioner's patients are few, of whom paying ones will be fewer still. As villagers are mainly agriculturists, and as agricultural income is precarious—depending on the seasons—the conscientious practitioner is faced with the further difficulty of drawing a sharp line between those that ought to be treated free, and those that are to be charged fees for their treatment. Even if the practitioner is sure of his discretion, the pioneer that he is, he has to be very lenient at the beginning, in charging fees, just to make himself popular, and attract patients to him. Perhaps if free medical institutions had been in existence in rural parts, a generation prior to this, the people's idea of the aetiology and treatment of diseases, would have so changed, as to ensure a large income from private practice to practitioners and the ultimate success of the present scheme. Parenthetically, I may add here, that

the time is ripe for conversion of all the urban medical institutions into poor infirmaries under honoraries, (of whom any number will come forward given fair chances and treatment). The savings effected thereby might well be utilised towards opening and maintaining free pucca medical institutions in rural areas, under amply paid and full-timed medical officers, and which might justifiably be converted into poor infirmaries, a generation hence. Such a system will be on a par with that obtaining elsewhere in Western countries, viz.—to make the treatment of the necessitous poor, a direct charge on the revenues of the state, but shift the burden of the treatment of the well-to-do, and the rich to their own shoulders. As it is, the present scheme is premature, and to give it a fair trial at least a subsidy of Rs. 100 and Rs. 150 per month for an L. M. P. and a medical graduate respectively should be given so as to attract them to the villages, and induce them to stay there. It is significant that since the beginning of the year, four medical graduates have resigned as their subsidy was not enhanced along with that of the L. M. P. At present there are only four graduates among 400 rural practitioners—a very low percentage indicative of the unattractive nature of the present subsidy and terms of indenture. The number of the unemployed among them is annually on the increase, and it is up to the government to wean them away from towns to the villages by offering them suitable subsidies and better terms. It is also understood that since the enhancement of the L. M. P. subsidy some of the taluk boards that were paying extra subsidies from their own

funds, now refuse to continue them. Legally they are right but it would be unfair of them to appropriate to themselves, what the practitioners fought hard for. The taluk boards cannot plead want of funds, to continue to give what they were affording till now, and I hope better counsels will prevail with them.

Attitude of the Taluk Boards towards Practitioners.

(a) *Supply of medicines and instruments:*—I am afraid the bad treatment meted out to rural practitioners by the local authorities—the taluk boards in particular—will prove to be the hard rock on which the scheme will very likely break, even if a tempting subsidy is offered. Many of them do not supply their rural practitioners drugs to the full value of Rs. 360 per year, or equip them with the midwifery, dental and other instruments mentioned in G. O. No. 7611 P. H. dated 7-4-25. It is also strange that a district medical officer—Tanjore did not choose to recommend the supply of midwifery instruments—to the Perambur dispensary—though he has recommended a steriliser for supply, a thing not even mentioned in the G.O.

(b) *Appointment of Midwives:*—Some practitioners have been denied the power of appointing midwives of their choice, though clause 7 of the agreement is very clear on the point. "If the practitioner shall engage, maintain and employ a qualified midwifethe taluk board shall pay to the practitioner an additional subsidy of Rs. 100 per year." G. O. No. 948 P.H. dated 6-4-29, has further complicated the matter, by deputing the D.M.O. to pay the subsidy direct to the midwife, instead of through the practitioner, who however is still

expected to countersign the midwife's bill for attendance on labour cases. This arrangement is likely to lead to conflict in professional matters between the practitioner and the midwife, and I personally know of such instances. The practitioners should have the power of appointing and controlling the duties of the midwives, denial of which power has been the cause of the absence of midwives in many a rural dispensary.

(c) *Location of rural dispensaries:—*

In choosing the villages for the location of rural dispensaries, there is a tendency on the part of some of the taluk boards to place them either in less central or populous places or too near to existing medical institutions especially of the neighbouring taluk boards. Such proximity will not only fail to attract the average of 30 patients a day, to every rural dispensary, but will spoil the scope for private practice and lead to unhealthy competition between neighbouring medical men. The result has been that the closure of some dispensaries have been ordered, while some others have been shifted to other places to ensure their better working. Kumarpalayam (Salem District), Manavalanallur (Tanjore District), Pongalur, Koduvai, and Puliampatti (Coimbatore District), Medur (Kistna District), and Chundi (Nellore District), are some of the places, whose rural dispensaries have had to be closed. There are still a good number that have not yet been *declared closed*, though the taluk boards concerned are not able to find medical men for them for months. As the closure of these dispensaries, would affect the future of the practitioners concerned, and leave them again unemployed, government have

been requested to direct the location of these dispensaries to central and populous places, to prescribe a minimum distance limit between medical institutions of any description and to limit, as a temporary measure, the number of rural dispensaries to three in a taluk board unless the demand in any locality justifies the opening of more.

(d) *Production of certificates with the bills:—*It is also learnt that the presidents of some taluk boards require their rural practitioners to produce along with their allowance bill every month, a certificate from the nearest taluk board member, to the effect that he (the practitioner) has treated all the necessitous poor free. No conscientious practitioner need object to the nature of the certificate, but to ask him to go to a member and get one is a humiliating condition inconsistent with his independent status. I wonder what the president himself would feel, if he were required to produce a certificate with his T.A. bill, from the president district board or the local M.L.C. to the effect that he did make the tours for which he claims the T.A. and that for *bona fide* reasons. I do not wish to expatiate further on this, but will straightway plead for the immediate annulment of this condition.

(e) *Festival inoculation and polling duties and transfer of practitioners:—*Besides, these rural practitioners are still asked to do festival, inoculation or polling work without extra remuneration; they are also transferred from place to place, though government have prohibited this as early as 1927. The practitioners of Sendurai (Trichy District), Perumanallur, and Pongalur (Coimbatore District)

and Kota Uratla (Vizagapatam District) were all transferred very recently. Any attempt on the practitioners' part to disobey such illegal orders, or assert their independence, has led to serious consequences. Kota Uratla is an instance, in point, and I will refer to it later.

(f) *Conversion of rural into regular dispensaries:—*I now come to the vexed question of conversion of rural into regular dispensaries. Those at Sendurai, Kota Uratla, Amarapur (Anantapur District) and Barkur (S. Canara District) were recently converted into regular ones; in the first two of which the existing practitioners were sent to the wall and new hands imported. As it is apprehended that many more rural dispensaries would be converted into regular ones and the claims of the existing practitioners overlooked, I would refer to the question at some length.

Rules do not contemplate either this "conversion" or the importing of new hands. Clauses 10 and 11 of the agreement amended by subsequent G.Os. exhaust the conditions under which a rural practitioner can be sent out of his place:—

(1) When he is not guilty of any breach of the terms of the agreement, his services can be dispensed with only when the taluk board is financially unable to maintain the dispensary, and that after six months' notice; and

(2) when he is guilty of any such breach, at any time, and without notice his services can be dispensed with.

The inference is clear: so long as a rural practitioner abides by the terms of the agreement, he cannot be sent

out for the sake of the "conversion" as it cannot mean financial stringency, but just the opposite—a surfeit of it, and the practitioner is legally entitled to continue in his place.

On moral considerations again, the practitioner's claims should not be overlooked. A rural dispensary, to justify such conversion should be having a large attendance from the poor; such would have been possible only if the practitioner was kind, energetic and efficient and had continuously lived in the place for a long time; also, he would have almost resolved upon settling in the place. If just at this time the taluk board should send him out by converting the dispensary into a regular one and bringing in a new hand, the former's position can be better imagined. After a zealous work of years, he would be again obliged to join the ranks of the unemployed, and turn "to other fields and pastures new".

It is also understood that the presidents do not either consult the D.M.O., or obtain the previous permission of the government, before such conversion; they simply communicate the fact after the event. The government spend much more over a rural dispensary than the taluk board, and so they (government) should have a greater voice on this question at any rate. "Conversions" however is *ultra vires* of the present scheme, and if the taluk boards desire it, they should obtain the previous permission of government, by convincing them with facts and figures of the need for it. In any case, justice and fair-play require that the existing practitioner should be allowed to continue in his place.

Judging, however, from the first two instances mentioned above, one is led to think that in effecting such conversions, the presidents were not actuated by any solicitude for the poor tax-payer, or the practitioner, but just to keep the latter out of the way, and provide for some protege of theirs. The conversion of Kota Uratla and its sequel is sufficiently illustrative of the ways of the presidents and taluk boards.

Kota Uratla is a village in the Narasapattam taluk board of the Vizag District, and had a rural dispensary there. Royavaram, Kothakota, Kintada and Kotapadu are villages in the same taluk board having rural dispensaries. Of all these Royavaram had always greater attendance than the rest, and its practitioner had lived there for nearly three years. All on a sudden, the president of the board, converted the rural dispensary at Kota Uratla into a regular one, appointed a new hand to it, transferred the existing practitioner in Royavaram, whose practitioner was in his turn, sent to Chinna Madina to open and run a new dispensary there. One can understand the president, if he brings in a new man to a regular L.F. dispensary elsewhere in preference to rural practitioners in the same area; but not this sort of invidious distinction and unnecessary transfers. Rumour goes however that in this particular instance the president was forced to effect this coup, to find a berth for a young L.M.P. friend of his, just out from school, and who had some stake at Kota Uratla. It seems the D. M. O. remonstrated with the president, in vain, and the aggrieved practitioners protested against the transfers and the overlooking of their

claims, while the one at Royavaram (who was almost the senior amongst the rural practitioners) did refuse to hand over charge of his dispensary to any one. The president got annoyed and wanted to dispense with the services of this particular practitioner. He, therefore, accused and called on this practitioner to explain for having taken fees from poor patients, and leaving head-quarters without the president's previous permission; to this the practitioner replied, that he was not guilty of such offences, and that as the president was under a misconception he (the practitioner) would explain himself fully at a next meeting of the board so that all the members might know what he had to say. This the practitioner did, and yet the president was not satisfied. He caused his board to pass a resolution terminating the services of the practitioner. The latter still refused to hand over charge of his dispensary to any one, has preferred an appeal to government, and continued in his place.

The above defects in the scheme, the difficulties the rural practitioners labour under, and some suggestions for the better success of the scheme, were brought to the notice of the government and the local authorities by the Madras Provincial Rural Medical Practitioners' Association. Besides (1) decent rates of subsidies to medical men of either qualifications, (2) fair treatment (3) non-intervention in the internal management of the rural dispensaries by the local authorities even in the matter of purchase of drugs, instruments etc., (4) eligibility of the practitioner for entertainment in service, and recognition of his right to continue in his place, even if a rural dispensary is converted into

a regular one, (5) provision of adequate scope for private practice to practitioners by locating the dispensaries in populous and central places, prescribing a distance limit between medical institutions and limiting their number to three rural dispensaries in a taluk area consistent with the needs of the locality, the association had requested the government to advance to practitioners sufficient money for the construction of compact and neat dispensaries (half as grant and half as loan) and to extend the system of medical inspection of school children to rural areas, and requisition of the rural practitioners' services for medical inspection of, and lecturing on hygiene and physiology to school-children in a specified area and on the reasonable remuneration to serve as a source of sure extra income. Further as there is no uniformity in the equipment or maintenance of these rural dispensaries even in the same district, and as a lay body like the taluk board cannot be expected to know the practical requirements of a rural dispensary it was also suggested that the whole thing be made a district concern and that the control, should vest in a technical and democratic body called the "the District Medical Council" composed mostly of non-official medical men with provision for adequate representation on it of rural practitioners and to run these dispensaries on lines similar to the grant-in-aid schools. Another point that was pressed for the acceptance of the government was to take away from the presidents of taluk boards, the power of dispensing with the services of rural practitioners under any circumstance, and to provide that in all cases of any alleged

breach of the terms of the agreement on the part of the practitioner or the local board, the D.M.O. or the Inspector of Local Boards and Municipalities, or any other impartial person, be deputed to enquire into such allegations, and report to the Surgeon General or any other competent person, an appeal against whose decision will lie to the local government. The principle underlying such a request, is that the taluk board is as much a party to the agreement as the practitioners, and should not be invested with such exclusive powers, especially when so much of "personal rule" is evident on their part. The object of the scheme is to make the practitioners eventually settle in the villages. I think such an object will be achieved, if government direct that as far as possible medical men that hail from, or near the village wherein a rural dispensary is to be located, or at any rate from the same district be appointed as rural practitioners. Rural practitioners should be given enough encouragement on the above lines, at this experimental stage of the scheme; else it is bound to fail. I would also suggest that as the scheme has worked for nearly five years, an expert committee be appointed by the government to examine the working of the scheme and advise them better ways and means to achieve the desired object.

"OM"

NOTICE

Medical Practitioners who have not received their registration certificates from the Registrar Medical Council, in spite of their having paid the necessary fees and who experienced considerable delay in getting the registration certificates are requested to inform the undersigned about the same as early as possible.

V. RAMAKAMATH,
Member Madras Medical Council.
Vepery, Madras.



ATROPINE FEVER.

(From the Journal of the American Medical Association issue of May 11, 1929.)

Almost all substances that are employed as therapeutic agents have shortcomings or "by-effects" that need to be taken into consideration along with the desired pharmacologic responses they elicit. Among these, atropine is no exception. Indeed, the changes that it can develop in the organism are so manifold that the alkaloid is employed in medicine for a number of seemingly unrelated purposes; and under these conditions an undesired reaction may be tolerated for the sake of securing a quite different simultaneous response. Thus the suppression of secretion by the drug may be the chief end sought in a given case, whereupon the mydriatic effect is tolerated as an inevitable concomitant possibility. Both these reactions may become incidents of the administration of atropine to abolish spasm of muscles of the alimentary tract. Accordingly, the use or the abandonment of the drug, or the dosage recommended, may depend on a balancing of desired versus undesired reactions. Among the latter is an occasional rise of temperature, the cause of which is not yet clearly established.

Many physicians appear to be unfamiliar with this "by-effect" and are liable to be misled by it. The possibility has been stressed by White of the Washington University School of Medicine in St. Louis in connection with the increasing use of atropine in

the so called true colic of early infancy. Some gastropastic or enterospastic infants require enough atropine to produce a flush. Some will flush after the first dose, other after later doses. The time and extent of pupillary dilation vary with the infant. Even the degree of the much desired gastro-intestinal relaxation will vary; whether a given patient will have fever with these manifestations is impossible to predict.

There are many familiar causes of febrile response in infants. Infections, athrepsia and anhydremia are illustrative of common conditions in the management of young children who exhibit a significant rise in temperature. The problem of differentiation is further complicated by the demonstration that leukocytosis may follow the administration of the atropine, a manifestation that White has confirmed. The length of time required for the production of fever with atropine seems to vary. According to Benzing, the fever usually starts three or four hours after oral or subcutaneous administration—with the peak in from six to eight hours—and disappears after the drug is discontinued. The flushing provoked at times by atropine need not be disconcerting; for, as White has pointed out, the strong vasomotor reaction of atropine is constant in the healthy person and seems to be a compensating phenomenon to counteract the temperature-rising action of the drug. In spite of the occasionally striking by-effects of atropine, he concludes that it remains a safe drug for use in the vago-genic gastro-enterospasm or "colic" of early infancy. The important feature is for every clinician to realise, as he does

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in the case of the possible mydriatic and mouth-parching propensities, that the belladonna alkaloid may give occasion for unexpected irregularities on the temperature charts of his youthful patient.

**TREATMENT OF WARTS
BY SUGGESTION.**

BY

DR. LENE GRUMACH, UNIV. HAUT
KLINIK KONIGSBERG I. PR.*(Referate nach Munch. Med. Wo.
1927, Nr. 26.)*

It is of course common knowledge that warts are amenable to treatment by suggestion, as witness the large number of magical formulæ which at one time or another have been used to charm them away. Purely physical treatment is, however, also frequently adopted by dermatologists and neurologists. Kraft-Ebing thought that the hypnotic treatment of warts was very promising, whilst Brocq (Arch. f. Derm 151) is also of this opinion, and recommends it specially in verruca vulgaris and plana. Other authors who take the same view are Bonjour and Rachewsky (Zbl. f. Haut. u. Geschl. 10). Jadassohn on the other hand (Arch. f. Derm. 151) has never had any success in the treatment of warts on these lines. While considering this question it is interesting to note that it has frequently been observed that the removal of one wart causes all the others to disappear and that psychic disturbances may bring about a sudden cure of warts.

Grumach (Munch. med. Wo. 1927, 26) attempted to rid a number of patients of their warts by treating them on these lines. At intervals of 8-14

days they were given injections of 1½-1 c. c. of physiological salt solution into the muscles of the upper arm, and they were told that this was a new and powerful remedy which would cause the warts to disappear and leave no scar. The patients were also told that during the injection they would feel a slight burning sensation and a heaviness in the wart covered area, this being a good sign. Eighteen cases were treated by suggestion in this way, and in most of them the suggested feeling of burning was experienced either during the injection or at any rate on the same day. It actually prevented one patient from working for a week. Sometimes the effect manifested itself very slowly, but the treatment failed in only two cases. The first signs of healing showed themselves often, after 5 to 8 days, mostly in the second or third week. The warts disappeared, as a rule, after 4 weeks, but sometimes it took as long as 4 months. Distilled water was tried in some cases and was equally successful. The history of one patient showed clearly that it was all a matter of suggestions; she was a patient with chronic eczema of the hand and was also subject to warts and also she did not care whether she got rid of them or not, she was treated by suggestion. Local treatment cured the eczema, but when she came back 6 months later with a recurrence of the eczema it was seen that the suggestion had had no effect whatever on the warts. Another patient was a girl aged 8, who for 3 years had had numerous rough warts on the back of her hands,—the only treatment she received was two salt injections in three days, and all the warts disappeared. Three months later there was still no trace of them.

Notes on Treatment of Diseases.

It is proposed to publish regularly the notes on treatment of diseases arranged in alphabetical order. Authorities will be quoted as far as possible.

Abcess—Abortive treatment particularly when a gland is involved as in Bubo—Inject into the centre of the inflamed area 5 to 10 minims of 2 per cent solution of phenol or paint externally with a strong solution of silver nitrate—20 to 40 grains to an ounce or tincture iodine until the surface becomes black. In the tubercular abscess drain the cavity by aspiration and inject an aetherial solution of iodoform and allow it to remain in it if the abscess is a small one; not more than 20 grains of iodoform to be used as large doses cause poisoning (*Hare Practical Medicine*).

2. Apply freely an ointment consisting of ichthyol 4 drams and menthol 15 grains, ext. belladonna 24 grains and Iodex one ounce or ung-iodex to be applied twice a day.

3. Pelvic—Milk intra-muscular injection. Ordinary cow's milk may be used. It is centrifuged, the fat removed and the remaining put in a boiling water bath for 10 minutes. The injection is made in the gluteal region and the initial dose is 5 cc. followed in 2 days by another of 10 cc.; subsequently every 2 days. (N. B.) Sterile fat-free milk is available in ampoules under the name of Lactogen (*Clinical Medicine and Surgery*.)

4. Cold—Aspirate and inject 10 cc. weekly once of the following Calot's modifying fluid which consists of olive oil 70 parts, ether 30 parts, creasote 5 parts, guaiacol 1

part and iodoform 10 parts. The best olive oil is shaken up with absolute alcohol, 1 part of alcohol with 100 parts of olive oil, to remove certain impurities from the oil. The mixture is left in a filter funnel for about 12 hours. The alcohol floats on the surface, carrying the impurity with it and the pure oil can be run off below. The oil is then sterilised by boiling for 15 minutes. The creasote, guaiacol and iodoform are then triturated in a sterilised mortar and added to the oil when it has cooled below 60° C. The ether is then added when the mixture is cold. The result is a clear light brown fluid which should be kept in a dark place in a flask with a rubber cap (*Journal of American Medical Association*.)

Notes on Diagnoses, Therapeutics, and other Medical Subjects

Lime-water—The addition of lime-water to milk is not always good as it occasionally irritates the mucus membrane. In place of lime, gelatine is useful; a teaspoonful of good gelatine or isinglass is added to half a tumbler of cold water and after shaking for 3 hours put in a saucer of boiled water and dissolve the gelatine when it forms a jelly. A teaspoonful of this jelly is to be added to the milk and this prevents curdling.

Blood pressure. The blood pressure in the pulmonary artery is 20 mm. and at the height of respiration 1 per cent of the whole blood in the body is found in the lungs. The corpuscular surface has been estimated at 3,200 sq. metres and in a man's muscle there

are 2,000 capillaries in a square millimetre and if a man's muscles weigh 50 kilograms the total length of the capillaries is something like 10,000 kilometres or $2\frac{1}{2}$ times round the globe and the total surface is 6,300 sq. metres. The systolic blood pressure at the brachial artery among Europeans, Bengalis and Chinese are 111 to 130, 90 to 115, and 111 respectively. The maximum blood pressure admissible for a life insurance in America for a man of 20 is 137, of 40, 144; of 55, 150; the diastolic pressure is $\frac{2}{3}$ of the systolic and the pulse is $\frac{1}{3}$ of the systolic.

News and Comments

We learn that during the last Madras Medical Council election many of the practitioners belonging to the L.M.P. class brought to the notice of Dr. Kamath their grievances in the matter of countersigning of medical certificates granted by them, certificates given in connection with life insurance companies and the inspection of school children etc. All matters affecting the rights and privileges of the practitioners in general and of the L.M.P. class in special, will receive due consideration in our columns.

MEDICAL GRADUATES AS SUB-ASSISTANT SURGEONS

In order to go behind the order of the Government in the matter of competitive examination for Civil Assistant Surgeons, we understand that three graduates have been selected for appointments as Sub-Assistant Surgeons in higher

grades overlooking the claims of Sub-Assistant Surgeons already in service in lower grades with a view to promote these graduates two Civil Assistant Surgeons grade when vacancies occur amongst those reserved for Sub-Assistant Surgeons. We invite the attention of the members of the Legislative Council to this injustice and trust that this back door method of recruiting Civil Assistant Surgeons will be put an end to.

A government order has been issued giving the revised rules for the appointments of honorary surgeons and physicians to government hospitals. This subject will receive the editorial attention in our next issue.

The Government of India have agreed as an experimental measure to the reduction from Rs. 31 to Rs. 5 of the rate of fees prescribed by them in 1914 for a Wassermann reaction test undertaken at the King Institute, Guindy, in respect of requisitions made by the medical practitioners in the city. So far so good; but why this invidious distinction between city and mofussil practitioners? We have information that the Director, King Institute has rightly brought to the notice of the government that all the practitioners throughout the province should be treated alike in the matter of this concession. We trust that the government will give effect to the suggestion.

According to a Reuter telegram which appeared in newspapers, Sir Donald Macalister who quite recently presided over the General Medical Council, London, seems to have

remarked that the Indian medical education including examinations do not come up to the English standard Does this medical knight know that that the medical education and examination in this country are practically under the control of the Surgeon-General and his I.M.S. lieutenants?

* * *

A deputation of the officers of the Madras Medical Service, consisting of Doctors Appu Nedungadi, Kesava Pai, Thirumurthy and five others waited on the Health Minister last May and pressed for his consideration, (1) notification of appointments as soon as they are contemplated and minimum qualifications considered necessary for them, (2) selection of suitable men for such appointments from among them with due consideration to seniority and with a minimum service of 10 or more years, (3) formation of a teaching cadre (4) Appointing for acting vacancies those that have special training in those subjects (5) increase of facilities for study leave, and (6) recruiting of professors as a rule from amongst assistant professors.

* * *

It is a matter of great satisfaction to learn that the Assembly Standing Finance Committee has rightly turned down the Government's proposal to appoint a commissioner for supervising, as the agent of the British Medical Council, the medical education in India. It will be remembered that the independent medical profession throughout India protested against this appointment. We are highly grateful to the Standing Finance Committee for having stood up for the

independence and dignity of the medical profession in India and we fervently hope that the Assembly would turn down yet another proposal of the government to have the All-India Research Institute at Dehra Dun instead of locating the same in any of the important cities in India.

* * *

The Madras Government will introduce in the current session of the Legislative Council an amending bill with a view to give representation to the Andhra University in the Medical Council. The effect of this bill will be that the Madras and Andhra Universities will each send one representative to the Council and the graduates belonging to both the universities will have to elect two instead of three as at present. This amendment will not affect the total strength of the Medical Council which will continue to be fifteen.

* * *

The British Empire Leprosy Association has a Council in India to co-ordinate with them and the latter Council has appointed survey parties to tackle the problem of lepers in this country. Such a leprosy survey party which was working in the Villippuram Taluk in Southern India had revealed three things (1) the 1921 census figure is about 1/10th. of the actual number (2) that if proper treatment is afforded, a large number of lepers would come as out-door patients and (3) that leprosy could be eradicated by attaching treatment centres to the existing dispensaries. We trust the above practical suggestion to combat this grave malady will

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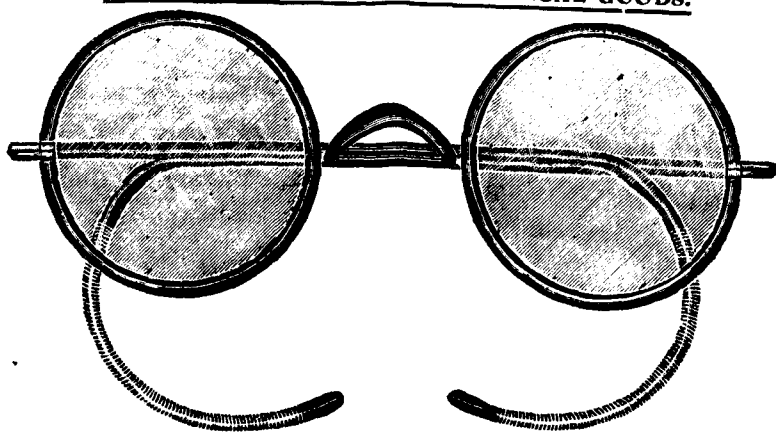
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The West London Medicinal Society awarded, in May last, a gold medal to Sir Ronald Ross for his distinguished services in connection with malaria. Sir Ronald is now 72 years old.

* * *

A deputation of the unemployed B.S.Sc. of Madras numbering about 15 waited on the Surgeon-General early this month and pressed their claims for the following special appointments (1) appointments in the King Institute, Guindy (2) lectureships in hygiene in the various medical schools in the presidency (3) appointment as public analysts (4) appointment of full-timed medical inspectors of schools and (5) appointment as port health officers in the presidency. The claims put forth by them seem to be modest and reasonable and we are glad to note that Col. Hingston the Ag-Surgeon-General assured the deputation that he would do whatever that was possible in the direction suggested by the deputationists.

* * *

The Hon'ble Sir Ibrahim Jaffer and the Hon'ble Dr. U. Rama Rao have given notice of resolutions in the Council of State autumn session, more or less to the effect, for the appointment of a committee consisting of officials and non-officials to report on the following points: (1) the most suitable place for locating the Central Medical Research Institute, (2) the constitution of the governing body of the Indian Research Fund Association and (3) recruitment of Medical Research appointments.

* * *

During the last session of the local Legislative Council Mr. S. Satya-murthy, M. L. C. elicited from the Government in reply to his interpellations, that the Government had passed a G.O. that non-official medical men and women were clearly eligible for membership to state hospital committees and regarding rural medical relief scheme, the Government were in receipt of resolutions passed at the Rural Medical Practitioners Conference and that the Government had recently improved the status and position of rural medical practitioners by increasing their subsidy from Rs. 400 to Rs. 500 and making their position under taluk boards more secure and that the Government had addressed the local bodies to consider the claims of the rural medical practitioners already in charge of a particular locality when regular dispensaries are started in that place.

* * *

Correspondence, Reviews, Reports etc.

THE SECOND ANDHRA MEDICAL CONFERENCE

WITH A FOREWORD BY
DR. PATTABI SEETHARAMYIA
M.B. & C.M.

I am asked to introduce the report of the proceedings of the second Andhra Medical Conference to the public in a few words. That is hardly necessary. Medical men, wherever they are, introduce themselves to the public. There is a light that cannot be hid under a bushel, much less can the report of the proceedings of their conferences. It is now evident that medical practitioners belong to the most honourable profession—in the

world. Their work blesses those that carry it on and those for whom it is carried on. But the respect they can command—whether personal or professional,—is in proportion to the measure and the merits of their qualities of head and heart, to use a hackneyed phrase. Mere efficiency carries a doctor little way in life. He needs to exhibit what we call character even more than the lawyer and the teacher, the engineer and the government servant. There is no restriction to the liberty enjoyed by a doctor in private homes except that imposed by his own sense of propriety and dignity. And an unwary practitioner is easily apt to betray himself into unenviable situations. The doctor is the confidant of many a family, the consultant in match-making, the friend of the disabled, oftentimes the leader of local public activities and public life and in fact he is anything from the giver of life and health to the 'undertaker'. That is no joke. Not seldom is it the duty of the practitioner not merely to make the way of the dying person smooth to heaven but also to lay him low in his last moments and lend a helping shoulder in taking him to his eternal rest.

With the practitioner, the young graduate, wafted from an up-to-date operation theatre with its shining instruments, faultless asepsis, well-dressed ward boys and sprightly nurses, to an up-country station where he finds all his hopes dashed to the ground and discovers that he is his own assistant, chloroformist, the ward boy and nurse, thoti and barber, the standards of efficiency are bound to suffer heavily, both in respect of examination, diagnosis and treatment. As for research, precious little time is

left in the midst of emergencies of the cases as well as the overwork of the practitioner. One is under the circumstances perilously near getting to be slipshod in one's work and nothing but a stern sense of duty and of high idealism may keep one to the correct standards of study and effort in the daily task that crowds in upon one. A rigid observance of principles in the treatment of disease and a religious scrupulousness in setting about the diagnosis—it is these that will establish a reputation for thoroughness and efficiency. But neither honesty nor efficiency will endear a doctor to his constituents. Both are easily apt to breed self-righteousness and arrogance unless they are tempered by a sense of humanity (a real Bhuta Daya) a genuine sympathy for the man in distress and his relations. When, therefore, a practitioner is imbued with a high sense of honour and honesty, and animated by an equally exacting standard of efficiency and humanity, he may aspire to the first place in his profession. But being or becoming a first class doctor is only part of his mission in life. He must likewise aspire to become a first class citizen patriot, one that carries the miseries of his fellow citizens on his capacious shoulders even as he carries the sufferings of his fellow creatures in his capacious heart. The prizes of public life are fast falling to the lot of doctors for it is they that enjoy real independence—not the lawyers who are merely "officers of courts", nor teachers who are alike the slaves of their employers and the subjects of their department. A wide field of national service is open to the doctors and the days that are coming are

bound to widen yet more the opportunities available to them. For influence and wealth, for leadership and altruism the doctor's calling stands far above any other and it shall be our proud task not to allow this noble profession to degenerate into a trade. Rather shall it be our aim, endeavour and study to consecrate ourselves through it, to the service of those who are less well placed than ourselves in life and raise through our labours and sacrifices the general standard of culture and character in the nation.

Resolutions.

No. 1. This conference places on record its heart-felt condolences for the death of Dr. K. D. Sastry of Northern India.

No. 2. Resolved that the Andhra Medical Association already formed should organise itself on more efficient lines in the direction of forming and affiliating branch associations in several parts of the province.

No. 3. Resolved to approve of the rules and regulations passed by the general body of the Andhra Medical Association at its Ellore sessions as amended to-day by the addition of article 2 A.

No. 4. Resolved that the formation of co-operative stores by medical practitioners be encouraged in as many places as possible.

No. 5. Resolved that the government be requested to supply quinine free for the extermination of malaria in Andhra Desa.

No. 6. Resolved that the government be requested to maintain a well equipped laboratory in Head quarter hospitals, which should be open to the whole profession on equal terms.

No. 7. This conference condemns the policy of locating *The Central Medical Research Institute* at Dehradun and considers that the disadvantages outweigh the advantages of such a selection.

Condemns further the reservation of 23 posts to the I. M. S. against 7 to others and also the policy of granting administrative salaries ranging up to Rs. 2,500 to these incumbents and recommends instead—1. that the C. R. I. be located in a place where there is a medical college and hospital and adequate laboratories and a scientific atmosphere conducive to medical research, such as Madras, Bombay or Calutta, and 2. that the recruitment should be made by open advertisement by an independent committee such as the Public Service Commission.

No. 8. That this conference recommends to government that they should avail themselves of the opportunity afforded by *The Rockefeller Foundation* to send as many Indians as possible to America for specialising in the various subjects for which the scholarships are offered.

No. 9. This conference reaffirms last year's resolution that the L. M. P. Diploma be abolished and attempts at unification be made to have only one minimum qualification both for service and study.

No. 10. This conference learns with anxiety that the Guntur Medical School is to be abandoned and this, after the buildings have been completed and urges that the institution should be started immediately and worked as a college.

No. 11. This conference urges that it is derogatory to the Andhra University and inconvenient to the students thereof to have a system of conjoint medical examinations along with the Madras University and that in any case, time has arrived for a scheme of independent medical examination being inaugurated for the Andhra University.

No. 12. This conference regrets that the committee on medical Education appointed by the government, does not contain any member belonging to the L. M. P. Class, though this class of practitioners form the largest group representing the medical profession, both in service and private practice and therefore this conference requests the government to co-opt at least two practitioners of not less than 15 years' standing who command respect and confidence of the medical profession and these two members should be allowed equal rights and privileges which other members of the Committee enjoy.

No. 13. Resolved to recommend to Government that the time has arrived when more and more restrictions should be placed on the liberty of state-employed doctors to have private practice in cities and large towns.

No. 14. Resolved that the honorary medical officers be appointed in state hospitals more extensively than now.

No. 15. This conference demands the appointment of a committee of the Madras Legislative Council: (1) to investigate the

question of employing honorary medical officers in state and local board medical institutions both in the city and in the mofussil and (2) to improve and popularise the scheme of rural medical relief.

No. 16. This conference condemns the prevailing policy of compelling all medical institutions to purchase medicines only from the Government Medical Stores and points out that this limitation has often times worked a great hardship, especially when the stocks run out in the stores; besides its being opposed to the recommendation of the Madras Legislative Council that as far as possible all stores must be purchased in India from Indian manufactories.

No. 17. This conference points out with regret that while the *Lee Commission Recommendations* are sufficiently *halting* in so far as the rights of Indians in the medical departments are concerned, government have not *implemented* the few that are favourable to Indians, although they have hastened to adopt those favourable to the I. M. S.

No. 18. Resolved that the medical profession in the Andhra Desa do encourage life insurance with indigenous companies *only* as far as possible.

No. 19. This conference urges on the public and on the government the desirability of forming an *All India General Medical Council* independent of *The General Medical Council of England* and desires that the university medical education in India should be taken charge of by such an *All-India General Medical Council*.

No. 20. This conference condemns the policy of proposed open recruitment of professors in medical colleges and points out that greater facilities for study leave on deputation be afforded to the Indians in service so as to qualify them the better for such professorial places.

No. 21. This conference demands the immediate publication of the recommendations of the committee constituted to enquire into the medical education of this province for public information and criticism before government deems it fit to take any action on the same.

No. 22. This conference is of opinion that medical inspection of schools and colleges be made compulsory and as well as teaching of hygiene and physiology and that every teaching institution do employ a whole-time medical officer for these purposes.

No. 23. This conference recommends to the government the desirability of amending the Madras Medical Registration Act so as to make it a truly representative body with a non-official majority and an elected president.

No. 24. This conference regrets that the Madras Medical Council has stopped without assigning specific reasons the election of a member to represent the Registered Medical Practitioners in the 3rd Group of the Medical Register and did not order a *de novo* election on the day they stopped election which was in full swing and thus deprived the 3rd Group of their full complement of representation in the Council as it exists today.

No. 25. This conference notes with regret that the Madras Medical

Council failed to have an up-to-date Medical Register as is required by the statute and also did not even fix the dates for all the proceedings in connection with election that they stopped, at their meeting on 4th March 1929, though they sanctioned the money required to run the election.

No. 26. This conference desires to bring to the notice of the Medical Council that in case a fresh election were to be held to fill in the existing vacancy in the Medical Council to represent the Group 3 of Registered Medical Practitioners, they should make good the postal charges incurred by such of the practitioners as had returned the voting papers duly filling the same as required by the Registrar of the Medical Council.

No. 27. This conference urges on every one of its members the desirability of wearing Khadi, both for themselves and their dependants and the use of Khadi in professional business as also the import of all available chemicals, vaccines, and sera from Indian enterprises wherever available.

No. 28. This conference requests the University of this province to allow medical practitioners with L. M. P. qualifications to appear for university degrees with an additional course not exceeding two years in such of the subjects decided by the University as is being done in England.

No. 29. This conference requests the government to permit private medical practitioners the use of the district medical libraries charging Rs. 2 a year to those who are of ten years standing or below and Rs. 3 a year for all those of above 10 years standing.

EXTRACT OF THE PROCEEDINGS OF THE MEETING OF THE PROVINCIAL EXECUTIVE COMMITTEE OF THE ALL INDIAN MEDICAL ASSOCIATION HELD IN CALCUTTA ON 12-7-29.

The committee considered the extracts of the Fletcher Committee's recommendations regarding the organisation of medical research in India and resolves as follows :—

That the committee considers the action of the Government of India on the report of the committee on the organisation of medical research in India under the chairmanship of Sir Walter Fletcher, to establish a Central Medical Institute at Dehradun to be not only hasty and ill-considered but definitely inimical to the advancement of medical research in India for the following reasons :—

(a) that, while Dehradun may have environmental advantages to the staff it is entirely unsuitable for co-ordinative research in India as visualised by the Fletcher Committee. No scientific atmosphere conducive to the progress of medical research exists there and to attempt to create what already exists in cities like Calcutta or Bombay will result in an unnecessary waste of public money which could have advantageously be employed otherwise;

(b) that apart from the money which would have to be spent to reproduce conditions suitable for sound medical research the mere establishment of such an institute will entail considerable initial expenditure. The alterations necessary for the existing Chandbagh building will alone require an immediate outlay of Rs. 6,00,000 while further extensions will necessitate the expenditure of still larger sums of money which

seems to be quite unnecessary as Dehradun cannot be an improvement on the existing institute at Kasauli;

(c) that medical research is essentially dependent on extensive clinical facilities and that the team work emphasised by the Fletcher Committee requires the co-operation of workers in the allied sciences, such facilities are not, and cannot in future, be available at Dehradun.

This committee is also of opinion that the Selection Board, which is composed mainly of I. M. S. officers is not liberal in its constitution, and should therefore be changed.

This committee views with apprehension the reservation of 23 out of 30 appointments for I.M.S. officers. Such reservation must naturally exclude competent men outside the service from the advantages of employment in the institute and the facilities of research afforded by it. This must retard the progress of medicine and surgery in this country, for experience everywhere and in all the sciences proves that progress depends on affording equal opportunities to all workers.

This committee is equally concerned about the inadequate salaries for officers below the rank of assistant directors. This must result in the recruitment of officers of inferior research accomplishments, who will be unable to undertake the work of their superior officers when the latter are absent either on leave or through ill health, as must frequently occur. Moreover, the disparity in salaries will cause discontent among the junior officers, a detrimental psychological factor which will naturally increase with the intellectual capacity of the officers concerned. Such a feeling an

only have a retrogressive effect on their work.

That this committee registers its disapprobation of the non-publication of the Fletcher Committee's report, in spite of the requests made by other representative medical bodies to the Government of India to publish the report at an early date. The action of the Government of India in this respect can only produce in minds of non-official medical men a feeling that their opinions on a matter which intimately concerns their profession and the needs of their country are not only considered unworthy of perusal, but are not even required. They naturally feel, therefore, that the Government of India intends to proceed in this matter, as the appointment of a committee to advise on the alterations necessary for the building at Chandbagh and a grant of Rs. 6,00,000 from the Indian Medical Research Fund Association seems to show, in the face of general medical opposition in the country.

That this committee believes the governing body of the Indian Medical Research Fund Association, which consists entirely of government officials, to be too narrowly constituted to be really cognisant of the needs of medical research in this country. The mere fact that the resources of the fund have already been reduced by the grant for the Chandbagh alterations, a grant which will naturally affect genuine medical research in other parts of India, seems to indicate the necessity for more liberal opinion on the governing body.

That this committee records its sense of gratitude and appreciation of

the generous offer of the Rockefeller Foundation to establish a public health institute at Calcutta; it regrets, however, that the proposed salaries of the junior staff of this institute are entirely incommensurate with the work expected (or, which should be expected) from them. These proposals of government are entirely opposed to the high standards of research under the ægis of the Rockefeller Foundation and this committee trusts that India will not be behind other countries in appreciating this fact.

Resolved that copy of the resolutions be forwarded to the press and to the Secretary, Government of India. Department of Health, Education and Lands.

The secretary placed a press report regarding a conference convened by the Government of India regarding the formation of a Central All-India Medical Council for India.

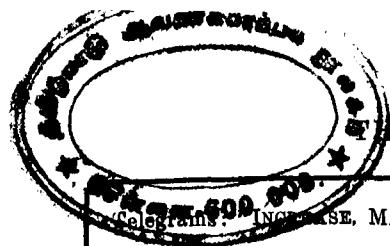
Resolved that the secretary be authorised to publish a statement regarding the same in the papers.

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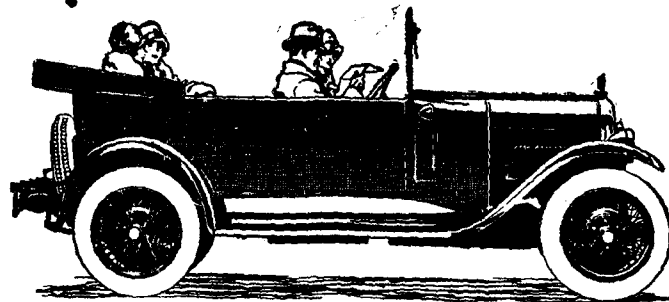
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The Medical Practitioner

A Monthly Medical Journal

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CONTENTS.

Editorial:—

Honorary Surgeons and Physicians, extension of the system to District Headquarters Hospitals ... 29

Annual report of the Health officer, Madras, For the year 1928 ... 32

Original Articles:—

Endocrinology By Dr. M. S. Krishnamurthy Ayyar ... 34

The Madras Medical Registration Act By Dr. V. Ramakamath ... 36

Abstracts:—

The Problems of Fever ... 38

Action of the extract of the Posterior Lobe of the Pituitary, in Health, in Diabetes insipidus and in Renal Sclerosis ... 40

Artificial Leukocytosis By Norman M. Smith M.D. ... 41

Notes on Treatment of Diseases ... 42

Notes on Diagnoses, Therapeutics etc. ... 43

News & Comments ... 44

Published Notices ... 47

Correspondence, Reviews, Reports etc. ... 48

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NOVEMBER, 1929

[No. 2

HONORARY SURGEONS AND PHYSICIANS EXTENSION OF THE SYSTEM TO DISTRICT HEADQUARTER HOSPITALS

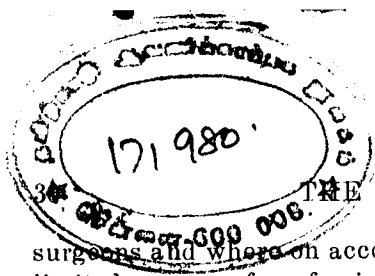
The order of the Government on the above subject is published elsewhere with the revised rules regulating the appointments of honorary officers. The orders were passed on 31-5-29 and it was stated therein that they would be brought into operation on 1-7-29; till now no appointments have been gazetted.

The order itself does not seem to be clear and it discloses a few anomalies and inconsistencies. Beyond the expression of a wish to extend the system, there are no indications to show how the wish, however earnest it may be, is to be carried into effect, notwithstanding that an interval of six years has elapsed since the inauguration of the system; but on the other hand the action taken since the passing of the G.O. in the matter of appointments made in the department will lead one to infer that no sincere attempt is likely to be made to bring the system into operation to any appreciable extent in the near future.

Though in the heading of the G. O. and in para 1 of the revised rules, the

system is said to extend to district headquarter hospitals—by which is meant the hospitals located in headquarter towns of the districts and placed under district medical officers, in para 2 of the orders it is stated that honorary surgeons and physicians "will be appointed to all government hospitals." It is not clear what is meant by government hospitals. There are several government hospitals in places which are not district headquarters. Does it mean that the system would be extended to those hospitals also? Whatever it may be, the first appointment under the new system, contemplated and about to be made, is the appointment of an honorary officer to the government hospital at Bezwada, which is not the headquarter hospital of the district.

In the case of government hospitals in the Madras city and in district headquarter hospitals where only senior officers are appointed as superintendents and district medical officers, and where the professional work will be such as will not overlap the administrative work, the honorary officers can have no objection to work, confining their duties to the professional side alone. But in the case of other hospitals which are usually placed under civil assistant



surgeons and where on account of the limited scope of professional work, as compared with that in the city or district headquarter hospitals, there is likely to be overlapping between the professional and administrative work, it is not possible for honorary men to work with the paid officers in charge without friction arising between them. The paid medical officers in charge of these hospitals may be conveniently replaced by honorary officers, and for the non-professional management of these hospitals, non-medical men may be appointed as is the case in hospitals in Europe and America.

In the revised rules, it is laid down under qualifications that graduates who possess medical qualifications registrable in the United Kingdom or equivalent qualification is eligible for the appointments. As L. M. & S. degree of the Madras University and L. M. P. of the Madras Government, are not registrable in the United Kingdom, candidates possessing these qualifications are not eligible for the appointments. If this be the case, the order looks anomalous. As per the system, honorary assistant surgeons also may be appointed under honorary surgeons and physicians or under paid surgeons and physicians. At present selected L.M.Ps are appointed as paid civil assistant surgeons while according to the rules they are not eligible for appointments as honorary assistant surgeons. The anomaly does not end here. There are now some district medical officers and assistant surgeons who possess only L. M. & S. degree and are, therefore, under the rule not eligible for appointment as honorary surgeons and physicians or assistant surgeons

but according to the G. O. honorary assistant surgeons are to work under them. This is rather awkward to say the least. The restrictions, therefore, that only candidates possessing qualifications registrable in the United Kingdom, should be withdrawn and the appointments made open to all registered medical practitioners according to their merits.

The system of the appointment of honorary officers was sanctioned in 1923 and it was worked on as an experimental measure for six years, in the city of Madras and the number of officers so appointed was about six. Certainly the experimental period is too long and not heard of in any other departments either here or in any other country. At this rate, its extension to all the district headquarter hospitals will take a long time and the further extension to all other government hospitals will take several decades. This slow and hesitating movement, is more or less due to the existing system of the administration of the medical department. The department is a transferred subject but the I.M.S. officers in the department including the Surgeon-General are not wholly under the Minister in charge. However enthusiastic the Minister may be, without the sympathy and co-operation of the Surgeon-General, who is the head of the department, he cannot do anything to advance the system. It is unfortunate that since the inauguration of the system, more than four officers held the office of the Surgeon-General and these men have had varying degrees of appreciation of and sympathy with the system. If one Surgeon-General is favourably inclined towards it, his successor may be against

it and as the result of this forward and backward movements no progress is possible.

The appointment of Surgeons-General is not quite satisfactory. It seems to be made more in the interests of the persons appointed than in those of the department. The persons appointed as Surgeons-General either take long leave immediately after the appointment so as to get enhanced leave allowance, or are promoted to higher appointments. As in the case of members of the Executive Council, the term of life of the appointment should be fixed, say at least three years and the officer appointed should be made to stick to the appointment for the full term.

If it is the sincere intention of the Government to bring the system into operation, no new paid appointments either temporary, acting or permanent should be made in the department. It is seen however, that since the date of the G.O. sanctioning the extension of the system, some temporary and permanent appointments have been made. Granting that for the present, all the district medical officers and superintendents of hospitals and professors and lecturers in medical colleges and schools are to be permanent paid officers, still, there are a large number of sub-assistant surgeons and assistant surgeons left attached to the several hospitals in the Province and these should be gradually replaced by the honorary officers. Taking on an average that 20 places fall vacant yearly among paid officers, and if honorary officers are appointed for all of them it will take several years to have all the paid officers replaced. Therefore it stands to reason, that if the system

is to advance, no new appointments either temporary, acting or permanent should be made in the department. As vacancies occur whatever may be the kind, permanent, temporary or acting, honorary men alone should be appointed for them.

The honorary officers, if they are to do their duty satisfactorily should be properly trained and equipped. In countries where medical science has advanced considerably, as in America, and Europe, where mere possession of degrees or diplomas is not considered sufficient for its holder to practice, he has to undergo practical training and licensed at the end of the course, as fit to undertake practice. Even in India, this practice is observed in the case of law graduates who are required to undergo apprenticeship and pass an examination at the end, if they are to practice in the High Courts. The persons turned out from the medical colleges and schools, should therefore be appointed as house surgeons and physicians in all district headquarter hospitals, presidency hospitals in the city and other big hospitals for a period, say at least, a year and then granted license to practice medicine. To attract good set of men and to give them encouragement the honorary officers may be deputed, at the cost of Government to foreign countries to study and improve their knowledge and keep them up-to-date. If necessary, they may be required as a condition, to serve as honorary officers for a fixed term after their return from deputation.

We hope that the Government will take all these points into consideration and if necessary appoint a committee of experienced medical men to

help and advise the Minister in the fulfilment, as early as possible, of the objects of the system.

ANNUAL REPORT OF THE HEALTH OFFICER MADRAS CORPORATION

FOR THE YEAR 1928

The report is as usual bulky extending over 236 pages excluding the addenda and corrigenda page and bigger than that of the Director of Public Health, Madras, which deals with the public health of the whole province of Madras and contains only 139 pages including the four pages of the orders of the Government on the report. Some improvement is, however, noticed in the printing and get-up of the report when compared with the last report. The report can be conveniently reduced to half its size by closer printing and the use of uniform types for the statements and tables following as a model, the Public Health Department's report where 60 lines are printed on a page against 24 on a page as on page 81 of the Health Officer's report. All the statements found at the end may be serially numbered and a list of them supplied at the beginning of the report for ready reference. The smaller tables in the body of the report may be printed at the side to facilitate easy reference. The headings of the tables should be clearly shown so as to enable the reader to understand to which part of the report they relate. It is not known in what connection tables on pages 92 and 93 are exhibited. It is possible to print most of the tables found in the body of the report lengthwise instead of breadthwise so as to minimise the

turning over pages in referring to them. By attending to all these details and removing all photographs which are out of place in a report like this, the report may be made attractive, readable, handy and less costly. So much for the printing and get-up of the report.

As a reason for the out-break of cholera is given importation from outside. This is an out-of-date argument hardly used at the present day when the origin and spread of epidemics are better understood. It is not practicable to prevent importation but what is possible in a place with a well organised staff, is to detect importation and deal with it promptly. The Health Officer complains that the citizens fail to co-operate with the department and over one-fourth of the population of the city is living amongst surroundings without the fundamental requirements of a sanitary existence viz. pure air, wholesome water, suitable nourishment and decent housing. The sanitation of the surroundings—pure air and wholesome water—entirely depends upon the Corporation and they are responsible for them. Even as regards the nourishment it is the duty of the Corporation to see that foodstuffs are not adulterated and impoverished as regards their nourishing properties. Poverty is the cause for the want of decent housing and also for the want of nutritious food. While tuberculosis is closely connected with ill-ventilation nutrition occupies a more important place, not only in connection with tuberculosis but other diseases also. In order to obtain correct statistics and find out the correct causes of conditions favouring incidence of different diseases, it is necessary that

additional columns should be opened in the birth register to note the order of birth, age of mother, the interval between the last birth and this birth and in the death register columns to note particularly in case of deaths of infants (1) how long they lived in the houses where they died, (2) whether the deliveries were attended by qualified midwives, (3) the sanitation of the houses and streets and (4) economic conditions of the parents. The sanitary inspectors or the medical officers in charge of dispensaries which are opened in almost every division should, on the report of deaths by the inspectors, proceed to the houses and make necessary enquiries to fill the above columns. Such statistics will be of immense use. Dr. Adiseshan of the Public Health Department, has given some useful information on these points in his special report made as the result of his research conducted in four municipal towns in the presidency.

Great trouble is taken to show lowest mortality of cases of cholera treated in hospitals by deducting moribund cases without giving the rate including them and the rate has to be worked out by the readers themselves. In a disease like cholera the incubation period of which is very short and the development so rapid as to cause death in a few hours, the difference between moribund and ordinary cases will hardly be intelligible to the public. The practice of excluding moribund cases in order to show low mortality rates is not very desirable. The death-rate including the moribund cases which works out at 44.6 per cent does not differ materially from 51.9 per cent the mortality in the city, so as to attract

patients to the hospitals, particularly when in the last year, the unsatisfactory state of the hospitals was brought to the notice of the public by Dr. Malayya and others.

In the last report pains were taken to work out the rate of mortality of infants of one month and under, to the total infant mortality, but this time the rate of mortality of infants whose births were attended by child welfare scheme and who were inspected till they completed the first year are shown. There must be some uniformity in dealing with the subject so that comparison may be instituted easily. The mere fact that the general death-rate, the infant and maternal mortality have increased shows beyond doubt that in spite of the endeavours to show the benefit of the child welfare scheme, the scheme is not working satisfactorily and adequately to the money spent on it.

As long as communal representation in councils and offices are provided in this province, statistics concerning each community as regards births, still-births, deaths, maternity deaths, infant deaths and causes of all deaths should be published. In the last report infant death-rate in each community of the Hindus were published while in this report no information is furnished, though on page 24 it is stated that in table C. would be found figures of infant deaths according to different "communities" but no such figures are found; the figures given there are only for "races". No uniformity is observed in the supply of information in this matter also in the report. The corrected birth and death-rates as calculated on the estimated

population given as 47.0 and 52.8 respectively are higher than those calculated on the census population. This is obviously incorrect. The correct rates as worked out comes to 44.2 birth-rate, 49.8 death-rate against 44.9 and 50.5 respectively calculated on the census population.

On the whole the report is a dismal one and with a general mortality of over 50 per mille and high infantile and maternal mortality, the city of Madras cannot escape being considered as a "death trap" for the unfortunate inhabitants living in it. There is no use of blaming the citizens for want of co-operation. The whole question of public health turns round the prosperity of the people and as long as pinching poverty continues among the people no improvement is possible. The cost of establishment and the multiplication of appointments, not only in the Corporation but in the province also, are too high and unnecessary for a poor country like India. All endeavour should be made to cut them down and utilize the savings for the openings of avenues as industry etc., for the people to earn decent livelihood. It was expected as the result of the reform investing non-officials, the representatives of the people, with powers of administration, the expenditure on the establishment etc would be cut down. Not only the expenditure has risen enormously since the inauguration of the reform but the pay of individual officers and the number of appointments have been inordinately increased. The country has become poorer since. We hope better results would be achieved after the Dominion Status is given to the country as fore-

shadowed in the recent announcement made by the Viceroy.

Original Articles

ENDOCRINOLOGY.

BY

DR. M. S. KRISHNAMURTHI AYYAR.

II

ENDOCRINES AND AUTONOMIC NERVOUS SYSTEM,

The origin and development of autonomic nervous system.

The action of the autonomic nervous system and the endocrine glands are so intimately related and their processes so interdependent that it is impossible to consider the one without the other, for the tonicity and irritability of the autonomic nervous system is regulated through the endocrine glands. The nomenclature description of the autonomic nervous system varies. It is called autonomic, vegetative, involuntary or sympathetic system. It is also called chromaffin system because a solution of potassium bichromate stains the chromaffin tissues brown. The chromaffin tissues are derived from the primordial ectoderm or the outer layer of the embryo and develop in close connection with the sympathetic nervous system. The medullary portion of the suprarenal glands is the outgrowth of the sympathetic system and contains a large portion of chromaffin tissues and the posterior lobe of the pituitary gland also contains chromaffin tissues. In the human embryo, when 5 weeks old, primordial sympathetic cells begin

to migrate from the larger sympathetic group in the abdomen. The migration of the cells continues throughout the fetal life. For a time the imbedded sympathetic cells remain in the premature stage. Only in the beginning of the fourth month in the human embryo, their chromaffin properties develop. The chromaffin property disappears within 12 to 30 hours after death. Besides the collection of chromaffin cells in the medullary portion of the suprarenal glands and the posterior lobe of the pituitary glands outlying matter of these tissues are found. Among these are the carotid glands, the tympanic glands, and the parasympathetic organ of Zuckerkandl situated in front of the bifurcation of the aorta. The carotid glands each about the size of a grain of rice, lie in or near the crotch of the bifurcation of the carotid arteries. The tympanic glands are small groups situated in apposition to the nerve of Jacobson in the tympanic canal on either side of the body. The common embryological origin of the sympathetic nervous tissue and the chromaffin organs is even more strikingly shown in the fact that collections of chromaffin cells may be found imbedded in sympathetic ganglia, wherever the latter may be situated. Such collections have been frequently noted in the left stellate ganglion, in the various peripheral sympathetic ganglia, such of those of the celiac, abdominal, aortic, inferior mesenteric and superior and inferior hypoglossal plexuses. Other relatively uncommon sites noted have been the point of entrance of superior vena cava into the heart, the pulmonary arteries, the root of the superior mesenteric artery, the intestinal wall, the abdominal nerve plexuses down

to a point deep within the pelvis, the prostate glands, the ovaries, the broad ligaments, the paradidymus and the root of the left coronary artery. Gradual retrogression and diminution in size of many of the subsidiary paraganglia begin after birth.

Its division and distribution.

The autonomic nervous system is divided into two parts namely the sympathetic proper and the parasympathetic. The former consists of the thoraco-lumbar portion of the autonomic system comprising a chain of ganglia on each side of the vertebral column, one ganglion for each vertebra and extending from the 1st thoracic to the 4th or 5th lumbar vertebra. The latter consists of cervico-sacral portion of the autonomic system. In the cervical region on each side the uniform segmental arrangement is not typical, and consists of 3 ganglia, the superior, middle and inferior. It includes also fibres lying for the most part in the vagus (the bulbar portion) and also to a lesser extent, on the 3rd, 7th, 9th and 11th cranial nerves, and the sacral portion consisting of fibres leaving the cord by the nerve trunks of the 2nd, 3rd and 4th sacral nerves, and also the fibres from the mid-brain which pass through the oculo-motor nerve through the ciliary ganglion into the ciliary muscles of eye. Through the vagus by far the most important part of the parasympathetic, are supplied fibres to the heart, the bronchi, esophagus, stomach, intestines and pancreas. From the sacral portion through the nervous erigens are supplied the descending colon, rectum, anus and genital organs. That part

of the autonomic system in the intestines described as the plexuses of Auerbach and Meissner is not closely related to either of the sympathetic or parasympathetic and is placed on a special class of its own. From the sympathetic nervous system the efferent fibres leave the spinal cord by the anterior roots pass into the sympathetic chain by the white *rami communicantes* and end around a nerve cell in the first ganglion they reach. Here a new non-medullated post-ganglionic fibre starts which is distributed to the blood vessels, skin, glands, abdominal and pelvic viscera. This portion most nearly represents the primitive segmental arrangements of lower forms. From this portion vasomotor, sweat and pilomotor fibres pass to the surface of the body and to the viscera. The efferent fibres from the parasympathetic leave the spinal cord but unlike the sympathetic proper they have their ganglionic station close to their destination.

The afferent paths of the autonomic nervous system is not as clearly understood as the efferent and the autonomic system is frequently described as an efferent or motor system only. Afferent visceral fibres are however found in the 9th and 11th cranial nerves extending from the viscera, through the same course as those of the efferent nerves. The afferent fibres of the vagus are of this kind. The afferent pathway through the central nervous system does not lead to the cerebral cortex but to lower parts of the brain. As voluntary motor impulses arise from definite motor areas in the cortex, there is no mechanism for the initiation of motor impulses over them and the automatic actions are almost wholly removed

from voluntary control. Some impulses however, undoubtedly do reach consciousness over these visceral afferent pathways and give rise to sensations of visceral disease and pain, so that neurotic or neuropathic individuals may be aware of such sensations, which furnish a real basis for the sensations and fears of the hypochondriac.

For most of the purely autonomic reflexes, however, and those in which there is no question of impulses arising from the surface of the body and aiding in adaptive mechanism of the organism to its environment, a much shorter and simpler arc is presumed. This is called *axon reflex* in which the reflex lies in the autonomic ganglion contained in or near the organ itself and not in the spinal cord. These reflexes are allied to those found in lower organisms and their action corresponds to "tropism". As the autonomic nervous system is the oldest nervous system which man possesses in common with lower animals, the similarity between the tropism and axon reflexes becomes apparent.

THE MADRAS MEDICAL REGISTRATION ACT.

BY

DR. V. RAMA KAMATH.

There are over 4,000 medical practitioners of all grades in the medical register and it is really a painful fact that a large number do not seem to know the purpose of the Medical Registration Act and the functions and responsibilities of the Medical Council. If they had known them the affairs of the independent medical profession would not be what it is today. The Medical Registration Act contains only

24 sections and is a very easy reading and every practitioner who registers his name is entitled to get a free copy of an up-to-date medical register in which also is printed the Medical Act for the information of the practitioner.

The first three sections in the Medical Registration Act deal with mere definitions of technical terms found in the several sections of the Act. Section 4 is the most important one explaining the purpose for which the Medical Registration Act was introduced. It is highly liberal in spirit, and all medical men are treated as equals in the matter of special privileges for granting certificates required by law and for holding appointments under the Government. But for the existence of this section none would have cared to spend Rs. 15 and got himself registered. It is very unfortunate that the Government which was responsible for the framing of this section which gave equal privileges to all medical men irrespective of their qualifications, had thought it fit to snatch away these privileges by issuing executive orders which set at naught the very law it had passed. Though the certificates issued by registered medical practitioners are legally valid, the Government had given option to the heads of their departments to believe or disbelieve the certificates issued by the private medical practitioners and send their certificates for being countersigned by medical officers in government service. This course is against law and ethics enunciated in the Madras Medical Registration Act. In section 4 of the Act, it is clearly stated that certificates issued by registered practitioners are valid. The Madras Medical Council have published a code of medical

ethics which requires the government medical officer who countersigns the medical certificate granted by a private medical practitioner, to communicate as a matter of courtesy whenever practicable, with the latter so as to give him an option of being present when the medical officer examines the case for countersigning the certificate and enjoins on him to scrupulously avoid interference with or make remarks upon, the diagnosis or treatment that has been adopted. The countersigning of the medical certificates granted by the private practitioners, without respecting the section 4 of the Madras Medical Registration Act and the ethics published thereunder, has a most demoralising effect on the profession. The certificates given by the government-paid medical officers of the rank of superintendents, district medical officers and civil surgeons are exempted from countersignature even if they are found defective, and they are, consequently, tempted to do what the Government guard against in the case of private medical practitioners. The Government will not be wanting in records or evidence to show that after the passing of the Madras Medical Registration Act there has been more complaints against government-paid medical officers in the higher grades in the matter of granting certificates than against the rank and file of the independent medical profession. It may be argued that the Surgeon-General has an efficient check over the medical officers in government service. The answer will be, why ask these medical officers to spend Rs. 15 for registering their names and how many have been sent out of service under

the Medical Registration Act, for issuing false certificates? It can be asserted without fear of contradiction that if this check had been exercised at all, it never went beyond the sub-assistant surgeons and a few unfortunate assistant surgeons. The check exercised in the cases of bigger men in service does not extend beyond a transfer involving a change of immediate surroundings. It is really strange and inexplicable that the Government which gave the heads of their departments the option of believing or disbelieving private practitioners and adopted the most novel procedure of requiring the countersigning of their medical certificates, forgot at the time that they had provided a most efficient control to guard against the infamous conduct of medical men both in their service and outside, by the creation of a Medical Council presided over by the Surgeon-General. This Council, defective as it is today, has a statutory control over the whole medical profession, the government as well as the private, and vast powers to deal with those who abuse the rights and privileges conferred upon them by the Medical Registration Act.

Other sections of the Medical Registration Act will be dealt with in subsequent issues of the journal and this article will end here with a warning to the Government as well as to the Council which have so far allowed the Madras Medical Registration Act to be treated as a dead letter without protesting against the executive orders of the Government which have usurped the powers of the Medical Council. Members of the independent medical profession who do not care

either to enter government service and who could afford to make an honest living by virtue of their qualifications and learning and who scornfully discard to earn anything more by the issuing of the certificates, notifications, reports and other documents of kindred nature required of them in their professional capacity, are realising that the Medical Registration Act has so far served as a net to bring the independent medical profession under the control of an official-ridden Medical Council with the Surgeon-General as its President. The bait of the so-called special privileges they get by registering themselves will not and cannot attract them any more.

Abstracts.

THE PROBLEMS OF CHOLERA.

From the Journal of American Medical Assn. of May 18, 1929.

Half a century has passed since Robert Koch, then working in Egypt, described the vibrio of cholera. The insusceptibility of the common laboratory animals to the disease has made it difficult to furnish as convincing direct experimental demonstrations of the etiologic potency of *vibrio cholerae* as has been the case in some of the other infectious diseases. Nevertheless, in the course of time sufficient evidence has accumulated in other ways to leave no doubt today that Koch's vibrio is the specific infective agent in cholera. For prophylactic purposes Ferrau and Haffkine have inoculated more than half a million men with living cultures of the cholera vibrio without causing the disease in a single case. Hence the comment that "you can eat cholera,

you can drink cholera, but you cannot catch it."

An effort to explain the existing confusion has been made by d'Herelle, well known for his pioneer investigation of the bacteriophage, who has lately come to the United States to join the faculty of the Yale School of Medicine. He points out that the pathogenicity of the cholera vibrio has been studied too exclusively in the laboratory rather than at the bedside of the patients within regions where epidemics of cholera are rampant. When the bacteriologist, as d'Herelle insists, has wished to study the characteristics of the cholera vibrio, he has turned to old laboratory cultures, vibrios which have been maintained for years outside their natural environment. He may be able to add a new culture medium to the innumerable ones that have already been described, and this may indeed be useful although there is no organism more readily cultivable. "And what shall we say," d'Herelle adds "of the results obtained by those who have undertaken to study the pathogenesis of cholera by animal inoculation, by attempting with old strains of the vibrio to infect guinea-pigs and rabbits, animals that are completely refractory?"

According to d'Herelle and contrary to what many others seem to think, the mere presence of vibrios in the intestine does not necessarily lead to any of the symptoms of cholera. The fact that these simple diarrhoeal conditions associated with the vibrios often disappear spontaneously without the individual exhibiting any of the symptoms of cholera is ample proof of this. For true cholera to develop, it is necessary that the vibrios invade and

multiply in the intestinal mucosa in the region of the glands of Lieberkuhn and in the interstitial glandular tissue. It is essential, then, that the vibrio be virulent; that is, capable of growing in vivo. In the last analysis, virulence according to d'Herelle, is the property of secreting enzymes capable of breaking down the protein of certain cells of the host. This permits the organisms to assimilate the products of cleavage and to multiply in situ. Following the Yale Bacteriologist one might, indeed, speak of "virulent enzymes". When, as the result of disuse, the faculty of secreting these enzymes is diminished or lost, the virulence of the organism is attenuated or lost. But we can readily believe that a vibrio in which this property is diminished may be able to regain it in the intestine when the mucosa is irritated by any cause whatever. Finding in its environment the proteins liberated through some fortuitous destruction of the cells of the mucosa, the vibrio utilises them, the production of virulent enzymes increases, and the organism thus becomes able to break down the proteins of living cells in situ.

The virulence of the cholera vibrio and its consequent pathogenicity depend on the relative potency of the bacteriophage that acts as its concomitant and antagonist. According to d'Herelle, recovery from the cholera does not take place through acquisition of a true immunity. Epidemics of cholera have shown that it is not an immunizing disease, for it has been noted that a single individual may contract cholera several times during the course of a single epidemic. The same is true of dysentery. D'Herelle points out that in cholera, especially,

one may frequently see severe cases in which the symptoms disappear suddenly within a few hours after the onset of the disease. In other patients death may occur only after the disease has persisted for ten or twelve days. If the immunity is able to develop so quickly in cases of the first type, how is it that it is not established yet in cases of the latter type, even after twelve days? As a matter of fact, everything known concerning acquired immunity shows that it is not such an inconstant process. Indeed, everything indicates that immunity is only established after recovery; that it is a result and not the cause of recovery.

To one who champions such views, the introduction of bacteriophage obviously becomes the chief hope for combating cholera. The patients should be caused, early in the disease to ingest a bacteriophage of high virulence. In this way it should be possible to avoid the failures in the natural adaptation of the intestinal bacteriophage, and to reproduce at will the natural processes of recovery. This method has been applied under d'Herelle's direction in some tens of thousands of cases of bacillary dysentery, and recovery always takes place within 24 hours. The outlook for cholera likewise is promising.

The epidemiology of cholera furnishes further perplexing problems. The carrier has often been drawn into the picture. According to d'Herelle the carrier of the vibrio is not infectious and his experiments have further shown that all carriers of the vibrio are likewise carriers of the bacteriophage virulent for the pathogenic organism. Within the carrier of the vibrio the same phenomena take place

as those occurring in the normal individual with reference to *B. Coli*. There is within the intestine a perpetual secondary culture, that is to say, a bacteriophage-vibrio symbiosis, and the carrier of the vibrio, instead of being infectious, propagates the recovery.

ACTION OF THE EXTRACT OF THE POSTERIOR LOBE OF THE PITUITARY, IN HEALTH, IN DIABETES INSIPIDUS AND IN RENAL SCLEROSIS.

Dr. Eduardo Coelho, N. B. (Comptes rend. des Seances de la Soc. de Biol. 1928, Nr. 6.)

The effect on the urinary output of extract of the posterior lobe of the pituitary was investigated by Coelho (Seances de la Soc. de Biol. 1928, 6) in a large series of cases, which included normal individuals and others who had polyuria either of renal or hypophysial origin. The preparation used was 'Hypophysin' (Hoechst). The subjects of the test were given about 1500 c. c. of fluid to drink in the space of half-an-hour on two successive mornings. The amount of urine excreted during the next four hours was then measured. On the second day they were given a subcutaneous injection of 1 c. c. of 'Hypophysin' one hour after the fluid had been drunk. The result was a marked diminution in the excretion of urine the amount of the excretion being as follows:

In normal individuals the urine excreted on the day of the injection was 50% of that on the previous day. In cases of renal sclerosis, 45%, and in cases of diabetes insipidus, 30%.

The results of the experiments disprove the suggestion that there is any specific limitation of the diuresis in diabetes insipidus by extract of the posterior lobe of the pituitary. There is, however, a more marked checking of the diuresis in cases of polyuria than there is in normal individuals. It was also observed that after the administration of the water and the injection of pituitary extract, the concentration of the urine rose. A further fact which emerged was that under similar conditions the simultaneous administration of 'Hypophysin' and "Insulin" (10 Units) did not in any way affect the intensity of the action of 'Hypophysin' on the output of urine.

The author assumes that the pituitary extract brings about a contraction of the vasa afferentia, so that an insufficient volume of blood reaches the glomeruli. It is also possible that the extract acts directly or indirectly on the nervous mechanism of the blood vessels, and that it stimulates the secretory cells of the kidney, causing them to produce smaller quantities of a more concentrated urine.

ARTIFICIAL LEUKOCYTOSIS

BY

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MINNEAPOLIS, MINN.

(*Extracted from Clinical Medicine & Surgery, Vol 36, No. 6*)

Last June my attention was called to the use intramuscular injections of a 1 in 3,000 solution of hydrochloric acid in the treatment of various pathologic conditions, by Dr. Burr Ferguson, of Birmingham, Ala., and by the work of Dr. Granville Hanes, of St. Louis,

who first used HCl by local injection in pruritus ani, with marked success, in several hundred cases. Dr. Ferguson stated that he had successfully treated the same symptoms many times by injections of HCl into the tissues of abdominal wall. He contended, and I think rightly so, that the success attained by both methods was due entirely to the leukocytosis caused by the injection, and not to its local effect.

From my experience in some 750 injections of HCl during the last seven months, I believe firmly that the increase in the number of white blood cells was the curative factor. Raising the leukocyte count is in strict conformity to natural processes and body resistance depends on white blood cells, their number, vigor and activity. Nature uses these cells as a defence in all cases of trouble. I wish to impress upon you the importance of these two statements and quote the following extracts.

Metchnikoff, in 1907, published his book "Immunity in Infectious Diseases". He described dozens of brilliant experiments and concluded that phagocytes eat microbes. Invading microbes were seen to be digested within these cells, in the same fashion that a morsel of food is taken up by any other single-celled animal. Metchnikoff concluded, early in his immunological studies, that the defensive mechanism of the body depends on this phagocytic digestion.

Metchnikoff has proven that immunity or a state of health is dependent on the fact that phagocytes eat microbes, and that the defensive mechanisms of the body depend on this digestion. Vaughan claims that leukocytes manufacture a certain

amount of complement to kill and digest microbes, the amount and availability of complement depending on the number, vigor and activity of the white blood cells. Carrel states that leukocytes have growth-activating substances which they are able to set free where such substances are required. His final conclusion is: "The existence of mechanisms causing leukocytes to invade tissues in need of repair is certain." Ferguson has proven, by hundreds of experiments, that intramuscular injections of 1 in 3000 hydrochloric acid are always followed by leukocytosis, particularly of the polymorphonuclear variety.

Considering the work of Metchnikoff, Vaughan, Carrel and Ferguson, it must necessarily follow that increasing the number of white blood cells by 20, 40, 60 or 100 per cent increases the body protection and resistance in the same proportion and equally advances the patient's chance to recover.

A number of other conditions have been successfully treated with HCl; viz. acute otitis media, lung abscess, infarct of retina, impetigo circinata and erythema nodosum.

I believe remarkable results can be obtained with artificial leukocytosis by injections of HCl, but it must be used with caution; it is not a cure-all; it does not remove the cause; it is not always indicated; and other rational treatment must not be neglected.

As the injection will be painful, an injection of 10 cc of $\frac{1}{2}$ to 1 % of procaine solution is made deep into the gluteal muscles, followed immediately and through the same needle, by

10 cc of 1 in 3000 solution of HCl. The injection should be given from 1 to 3 times a week.

Notes on Treatment of Diseases.

Acne—1. Local application of sulphur 1 dr. glycerine 1 ounce aqua rose 8 ounces to be applied twice a day. If there is much inflammation, use the following:—sulphur iodide 30 grains, cerati 1 ounce, apply night and morning. (*Hare.*)

2. Staphylococci vaccine is useful.

3. Sulphur precipitate 1 dram, adeps lanæ hydrosus 1 ounce, to be applied twice externally.

4. Thyroid gland twice or thrice a day and the dose diminished when improvement begins but continued for a long time.

5. For external application, use acid salicylic 2 parts, sulphur precipitate 10 parts, zinc oxide 20 parts, amyl tritica 20 parts, oil ricine 10 parts and vaseline 50 parts. (*Endocrine Survey.*)

6. Suprarenal gland 2 grains is good (*Medical Annual 1925.*)

7. Thyroid gland 1 grain with corpus luteum 4 grains for girls, and for boys either suprarenal gland 2 grains or hypophysis sicca $\frac{1}{4}$ grain (*Sajous Internal Medicine.*)

8. For acne following the use of bromides especially in women, liq-arsenicalis should be given along with it.

9. Sponge the face with hot towel every night and pinch up the skin between and squeeze out as many comedones as possible and wipe the

face with 40 per cent alcoholic solution. (*Progressive Medicine.*)

10. Iodex externally and internally and manganese and yeast.

Notes on Diagnoses, Therapeutics, and other Medical Subjects.

The types of cases in which valarian is indicated—are palpitation, something rising in the throat, flatulent eructations, rumbling of the bowels, sense of pressure on the vortex, desire to be alone, lack of interest in home and social surroundings, fear of something going to happen, unrestful sleep accompanied by disturbing dreams, lack of mental concentration and general depression so marked at times that the thought of suicide creeps into the mind—in other words the first stage of melancholia.

In mercuric and arsenic poisoning—sodium thiosulphate is the best antidote. This may be given either intravenously or by the mouth. In the former case 10 c. c. of 5 per cent solution which contains .05 grams to be used on the 1st day, 0.3 grams on the 2nd day, 0.45 grams on the 3rd day, 0.6 grams on the 4th day, 0.9 grams on the 6th day, 1.2 grams on the 8th day and 1.8 grams in the later stage. 2 grams in physiological salt solution 120 to 200 c. c. and the dose may be increased to 10 grams.

Pepper causes 10 times more cirrhosis of the liver than gin.

The prevention of shock. An abundant store of glycogen in the liver of the body is the best possible means of preventive against shock. The practice of giving patients 8 to 10 ounces of milk sugar between the last meal in the night and before operation is good.

Purgatives. Aloes only acts after it becomes dissolved in the bile, while castor oil after it has been split into active substances by the pancreatic ferments; excessive dose of castor oil does not do any harm and the doses between the children and adult do not vary much. Saline does not suit all persons. Sodium phosphate is good but does not dissolve in cold water and therefore hot water should be used. It is good in jaundice and in children. Calomel has no action in the liver and the green colour of the stools is due to the prevention of the decomposition of the bile by the antiseptic action of calomel. Calomel should be followed by a saline.

Bitters do not stimulate the secretion of gastric juice. The old belief is not supported in science but on the other hand it hinders gastric digestion.

Quinine if given intravenously is present in the blood for 27 hours, intramuscularly for 52 hours and by the mouth for 30 hours. Quinine in a single dose or even in a small dose may produce temporary blindness.

Blood in the body. There are 14 pints of blood in the body. Each minute 5 pints of blood are thrown into the circulation, and when doing heavy work about 30 pints are thrown into the circulation. During ordinary work the whole blood circulates twice a minute. Brain contains $\frac{1}{5}$ th of the blood of the whole body. As the total quantity of the blood within the brain cannot undergo any considerable change, provision for more or less blood is afforded by the change in the velocity of the blood. The rate of blood flow in the aorta is 30 ft. per second; the systemic circulation takes 33

seconds and pulmonary circulation 15 seconds. The blood supply of each 100 grams of tissue per minute is as follows—stomach 22 c.c., intestines 71 c.c., spleen 58 c.c. liver 84 c.c., brain 136 c.c., kidney 150 c.c., thyroid gland 560 cc. The main velocity of the blood in the carotid artery is 300 m.m. per second; in the jugular vein 115 m.m.; capillaries 0.5. Pulse wave travels at the rate of 17 miles per hour and the blood velocity is $1\frac{1}{2}$ miles per hour. Pulse rate in the brain is 15 to 20 per second.

News and Comments

RURAL MEDICAL RELIEF

Though the journal is only one month old communications have been received from half-a-dozen rural medical practitioners bitterly complaining against the high-handed action of the presidents of the local boards under whom they are serving. The nature of the grievances complained against are categorically and elaborately explained by Dr. Ramasubbu in his article which appeared in the last issue. Dr. Ramasubbu has referred to a few specific cases one of which is from the Narasapatam Taluk Board and the aggrieved rural practitioner whose service have been terminated by an alleged illegal order of this Board, has refused to hand over charge and appealed to the Government. The matter will be watched with interest as the decision of the Government on this, will materially affect the growth of the rural medical relief in general.

DR. KAMATH'S RESOLUTIONS

Dr. V. Rama Kamath, Member Medical Council posted on 12-10-29 from Bangalore a letter addressed to the Registrar giving notice of his intention to move the following resolutions at the October meeting of the Madras Medical Council.

(1) A committee of three members of the Council including the mover of the resolution be appointed to reorganise the office of the Registrar and the staff of the Council.

(2) The Council is of opinion that the practice of getting the certificates, granted by private medical practitioners, countersigned by practitioners in government service is against the principles and spirit of the Madras Medical Registration Act and recommend to Government to put a stop to this practice.

(3) Resolved to recognise with retrospective effect the L.M. & S. diploma granted by the Oosmania Medical College in lieu of the "Assistant Surgeon" diploma originally granted by the said college, since changed as above, as this change had been given retrospective effect by an order of H.E.H. the Nizam's Government.

A day later Dr. Kamath sent another letter by post from Mysore referring therein that he had posted the previous day the resolutions to the Registrar, to get authenticated information from Oosmania College about the change in the diploma of "Assistant Surgeon". Dr. Kamath has in his possession a reply to his second letter informing him that the Registrar had

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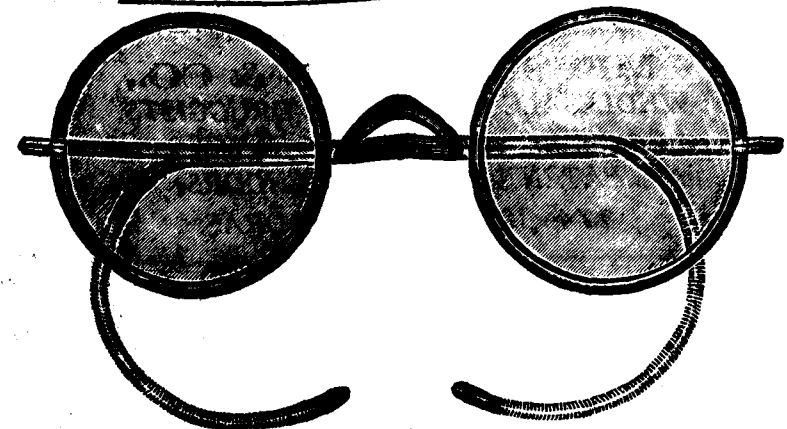
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2. *Designation.*—Honorary officers will be designated as follows:

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" Surgeon
" Ophthalmic Surgeon
" Otolaryngologist
" Pathologist.
etc. etc.

The designation of each honorary officer, will depend on his academic qualifications and standing in the profession and on the nature of the duties assigned to him.

3. *Qualifications.*—Candidates for appointments should have medical qualifications registrable in the United Kingdom or equivalent qualifications and should produce evidence of being specially qualified for the work to be entrusted to them. The age-limit for appointment is fixed at 55 years, but this condition may be relaxed by the Government in exceptional cases.

4. *Duties.*—Honorary officers should conform to the rules in the hospital in which they are working as far as they relate to the care of patients.

5. A specified number of beds for surgical or medical cases will be allotted to each honorary surgeon or physician who will be entirely responsible for the treatment and care of the patients in his charge. On the day or days fixed as admission days for the particular ward in charge of each honorary officer, he will be expected to attend at the hospital during the recognized working hours. He will also visit the patients in his charge daily or more than once daily should that be necessary and answer all emergent calls relating to these patients. In the case of teaching institutions the honorary officers shall be present at the respective hospitals on such days and at such hours as may be necessary for the proper instruction of the students—vide rule 10.

6. In the case of large hospitals, the honorary surgeon or physician will be given an assistant to help him, who may also be an honorary worker.

7. Honorary officers with special qualifications will as far as practicable be placed in independent charge of special departments, e.g., (i) eye, (ii) ear, nose and throat, (iii) radiology, (iv) venereal

diseases, etc., and given full scope to work up successful clinics.

8. Honorary assistant surgeons will perform such duties as may be assigned to them by the Superintendents of the hospitals.

9. If for any reason they are unable to attend during hospital hours, they should inform the Superintendent in time to enable the Superintendent to arrange for their work.

10. In the hospitals which form training grounds for medical students, the honorary officers will be responsible for imparting clinical instruction to students in connection with the beds in their charge in accordance with such plans as may be laid down by the professor in charge of the medical or surgical unit or by the Superintendent of the hospital.

11. Honorary officers will issue the necessary certificates for patients under their treatment, but shall not, except at the special request of the Superintendent or in his absence of the senior medical officer in charge, deal with any ward cases other than those assigned to them or with cases arising in the out-patient department or with the other miscellaneous work of the hospitals.

12. *General rules.*—Honorary officers will be allowed the use of the respective hospital libraries and, in the case of teaching institutions, of the libraries of the college or school attached to them.

13. They must abide by the Government rules in force in regard to the acceptance of fees from patients by the staff of the hospital.

14. The entire management and control of the hospitals and the discipline of the staff are vested in the respective Superintendents. Honorary officers will be expected to observe all rules in force or issued from time to time and to report all instances of neglect or inattention or other breaches of discipline relating to their wards to the Superintendents who will deal with them. They may freely consult the Superintendents on any points in respect of which they consider the rules to admit of improvement but must abide by any decision the latter may arrive at.

The Superintendents will at the same time be instructed to give the fullest possible scope to the honorary workers and thus make the scheme a success.

Correspondence, Reviews, Reports etc.

GOVERNMENT OF MADRAS LOCAL SELF-GOVERNMENT DEPARTMENT

(PUBLIC HEALTH)

G. O. No. 1373, P.H., 31st May 1929

*Honorary surgeons and physicians—
Extension of the system to District
Headquarter Hospitals—Orders passed.*

Order—No. 1373, P. H.,
dated 31st May, 1929

In 1923, on the recommendation of the Medical and Public Health Retrenchment Committee, the Government sanctioned the appointment of selected private medical practitioners as honorary surgeons or physicians to the Government medical institutions in Madras City. The honorary officers so appointed were supernumerary to the paid staff and each officer was placed in charge of a certain number of beds in the hospital to which he was attached. The system has been in force for over five years and from the reports obtained from the Superintendents of the hospitals the Government consider that it has worked satisfactorily. They have accordingly in consultation with the Surgeon-General decided to extend the system to the mufassal hospitals and are pleased to pass the following orders.

2. Honorary surgeons and physicians will now be appointed to all Government hospitals so far as suitable persons are available, and no distinction will be made in this respect between hospitals which are used for teaching medical students and hospitals which are not so used. The honorary officers should be supernumerary to the paid staff, as at present, and wherever practicable, they should be placed in independent charge of special departments such as the eye, the ear, nose and throat, the radiological or venereal disease department, and given free scope to work up successful clinics. In the larger hospitals, each honorary surgeon or physician should have the charge of a specified number of beds with an assistant to help him, who may also be an honorary worker. The designation and status of the honorary

officers will vary according to their qualifications and standing in the profession and the nature of the work entrusted to them.

3. The rules framed by the Government to regulate the appointment of honorary officers have been revised and a copy of the revised rules is appended to this.

4. The Government desire that immediate steps should be taken to give effect to the extension of the system and that honorary officers should be appointed in as many hospitals as possible by the 1st July 1929. The Surgeon-General is requested to direct all District Medical Officers and Superintendents of headquarter hospitals to submit all applications for the appointment of honorary officers received by them with their recommendations as early as possible. The proposals relating to all districts and to hospitals in Madras City should be consolidated and submitted to the Government, with the Surgeon-General's remarks, not later than the 20th June 1929.

5. Medical practitioners who wish their names to be considered for honorary appointments should forward their applications direct to the Superintendents of the hospitals in which they desire to be employed.

(By order of the Government, Ministry
of Public Health)

HILTON BROWN,
Secretary to Government.

To the Surgeon-General, Madras.

.. Secretary, South Indian Medical
Union.

Editor's Table.

[Annexure.

ANNEXURE

Rules relating to the appointment of Honorary Medical Officers in Government hospitals in the Madras Presidency

Honorary medical officers will be appointed to all Government hospitals in Madras City and to all district headquarter hospitals. Appointment will be made by the Government on the recommendation of the Surgeon-General. The honorary officers in Madras City will be liable to transfer from one institution to another at the discretion of the Government. The appointments will be termi-

munity from entering government service till the Government feel that communal balance is established? Why all this show of unworkable orders and double distillation?

NEW EXCISE RULES.

Registered medical practitioners are allowed to stock without license morphia to the extent of 120 grains or preparations of opium whose alkaloidal contents do not exceed 120 grains of morphia and to stock cocaine to the extent of half an ounce for the use of their profession and not for sale and till recently they were not required to keep an account of these two drugs or their preparations. Under the new excise rules every practitioner in service or in private practice is required to keep an account of the drugs, their description and quantity with the names and addresses of the patients for whom they were used and the account books will be checked by an excise officer not below the rank of an assistant inspector. The rules are as hard as they are unworkable. We trust the medical profession will protest against these rules in time. There is absolutely no need for the members of the medical profession to be checked by any extraneous body so long as they are under the control of the statutory body as the Medical Council and there is enough provision in the Medical Registration Act if any practitioner abuses his rights and privileges. Fines inflicted in police courts for violation of excise rules cannot remedy the evils for which the fines are inflicted. Infamous conduct on the part of a practitioner can be more efficiently dealt with both in the interest of the public and the pro-

fession by suspending him from practice or by removing him from the medical register. We appeal to the Government to revise the excise rules regarding the medical profession, and require the Medical Council to deal with excise cases and not the police courts.

Publisher's Notice.

Subscribers are requested to write their names and addresses legibly to avoid misdirection of the journal.

As under the rules governing the registration of newspapers in post office, the issue of the journal pertaining to a month, should be dispatched on a particular day in the same month, the month given in the last issue of the journal was changed from September to October, and in consequence the month of this issue is given as November. The journal, therefore, should be considered to have commenced from October last.

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MEDICAL GRADUATES AS SUB-ASSISTANT SURGEONS.

Comments in our column in the last issue have attracted the attention of at least one M. L. C. who, we are authoritatively informed, has sent in his interpellations on this subject which will be very likely be answered at the next meeting of the Legislative Council and duly published in this journal.

MADRAS SURGEON-GENERALSHIP.

We are reliably informed that Col. Megaw who has been appointed as Director-General of Medical Service in succession to Col. Symons, will return to Madras in the second week of February and take charge of his office as Surgeon-General. He will lieved at the end of March. Nothing is known as certain as to who will succeed Col. Megaw as Surgeon-General though surmises are made in the press that the choice will be between Col. Graham, Public Health Commissioner and Col. Sprawson, Inspector-General of Medical Service in the United Provinces. The importation of officers from outside is not without advantage, at least they come with an open mind and are free from petty prejudices, likes and dislikes. All the same there are signs that the claims of Col. Hingston will not be so easily overlooked.

A COMMUNAL G. O.

In the issue of the Fort St. George Gazette dated 9th October '29 new rules are published to regulate the method of recruitment, conditions of service, pay allowances etc., based on communal lines. The G.O. is too long to

be published here and we refer those interested in the subject to the Fort. St. George Gazette. The Government cannot be congratulated on this their novel venture which instead of giving satisfaction to particular communities will surely frustrate the very purpose for which this special G. O. has been promulgated. We learn that considerable difficulties are already being felt in the matter of selection apart from communal complications. Out of 36 candidates who sat for competitive examination only four seem to have scored 60 per cent of the marks which is the minimum prescribed by the rule. It is reported that there are likely to be 20 or 22 vacancies in the assistant surgeon grade and out of the four who secured 60 per cent of marks three are Brahmins. There is nothing difficult for the Government to do. They will perhaps pass another G. O. lowering the percentage of marks. There are not only several main communities but a number of subdivisions in each community, and the Government will have to get over this difficulty when more than two candidates belonging to non-Brahmin community but of different subdivisions have to be selected and this can be only done by having recourse to the usual practice of favouritism, to combat which this communal G. O. is brought into existence. There now exists a selection committee to choose candidates for the competitive examination with a view to do communal justice. After that a second selection among those who have secured the minimum marks in the competitive examination, again on communal basis, is unsatisfactory and unjust. Why not then totally debar any particular com-

addressed the Principal, Oosmania College, though the Registrar had not acknowledged the receipt of the resolutions. It is strange that the Registrar could not get the resolutions by post; it is stranger still, that though the subject matter of the resolutions was mentioned in a subsequent letter to the Registrar, he did not choose to inform Dr. Kamath about the non-receipt of the resolutions. The President of the Council was also addressed on this subject but so far no reply has been received from him also. Dr. Kamath personally reminded the President on the 28th ultimo when the Council met for the October session. Comments are not necessary. Fortunately, Dr. Kamath's term of office continues for five years. He may try next time if communications sent to the Registrar by registered post will reach his office safe and even after receipt this way, if they will reach the Council as the office of the Registrar is in a private building in Royapettah, the President's office (Surgeon-General's office) at the far end of Mount Road, near Saidapet and the Council meets at the Madras Medical College.

CLINGING TO CUSTOM.

There has been a grave irregularity with regard to rule 5 under section 24 (2) of the Madras Medical Registration Act for the convening of meeting of the Council. We understand that mofussil members do not receive copies of the documents and evidences in penal cases. There was a striking instance of an election held some months ago which put the candidates and the Council to lot of expense and inconvenience. In spite of this

it is sad to think that the Registrar has not shown any improvement. We learn that the Registrar's action in this matter is governed by a prevailing custom. But it will be a serious thing, indeed, if custom is held above law and reason. And we earnestly hope that steps will be taken to avoid such serious irregularities in the future.

PAID HONORARY OFFICERS.

Dr. Sadagopan, Honorary Physician, Government Royapuram Hospital, and Dr. Krishna Menon, Honorary Physician, Government General Hospital, have been given part-time work on regular pay, the former as Lecturer in Royapuram Medical School, and the latter as 4th Physician in the General Hospital. We offer our congratulations to them personally. The two questions that emerge from the appointments demand consideration. The first is whether, as servants of Government, they can discharge their honorary work with the independence permitted to honoraries; and whether they can continue as members of the South Indian Medical Union, an association of independent medical practitioners?

The second question for consideration is whether the Government particularly now, after the extension of the system of honorary appointments, could appoint paid officers to the vacant places and if so, whether the honorary men should be so appointed. It is clear from this that the Government has no serious intention of extending this system.

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. M. S. Krishnamurthi Ayyar, M. B. & C. M.,

Retired Sanitary Commissioner, Travancore State,

AND

Dr. V. Rama Kamath

CONTENTS.

	PAGE
Editorials:—	
New year Greetings	51
Administration Report of the Director of Public Health, Madras, 1928	52
The Sub-Assistant Surgeons and Jail Duty	57
Original Articles:—	
Endocrinology, By Dr. M. S. Krishnamurthi Ayyar	58
The Madras Medical Registration Act, By Dr. V. Ramakamath	60
Abstracts:—	
Tonsillectomy	62
The Tannic Acid Treatment of Burns and Scalds	64
Notes on Treatment of Diseases	65
Notes on Diagnosis, Therapeutics and other Subjects	66
News & Comments	67
Correspondence, Reviews, Reports etc.	71

Dr. S. R. BHAT

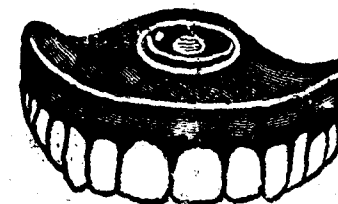
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THE Medical Practitioner

Vol. 1]

DECEMBER, 1929

[No. 3

NEW YEAR GREETINGS

We offer our cordial greetings to our readers for the new year which we hope, owing to the proposed grant of the Dominion Status, will be an eventful one, and one of the events will surely be in connection with the advancement of the medical profession in Madras. We are endeavouring to our best, as you will see in the journals so far published, to advance the cause of the independent medical profession on which rests the medical relief of the public at large. Both the Government and the independent medical practitioners should co-operate to bring about the uplift of the profession to the position which it should legitimately attain. On behalf of the independent medical profession, we shall continue to try our best through the medium of the journal and by other means, to help the Government to raise the status and position of the independent medical profession, but for this purpose, the support and co-operation of the private practitioners are required to run the journal. As the ultimate goal of medicine is prevention of diseases, we shall devote special attention to the cause of public health. The activities and usefulness of the rural medical staff and the taluk health inspectors, the lowest units of the Medical and Public Health Service, working in remotest villages, are not properly appreciated and adequately rewarded and we shall bring to the notice of the public and Government the useful work they are doing, and the difficulties and inconveniences they labour under, for proper remedies to be taken. As the readers to whom we have been sending the journal during the last three months could have formed their opinion of the usefulness of it, as we have not received till now from any one to discontinue and as its subscription is the lowest of all medical journals in India or elsewhere, we are sure that they are willing to subscribe for it. We earnestly request, therefore, that before the new year begins that all who have not as yet sent their subscription will send it by M. O. Thanking you all for the support given, we once more wish you all a happy new year.

ADMINISTRATION REPORT OF THE DIRECTOR OF PUBLIC HEALTH, MADRAS, 1928.

The Report is interesting, instructive, readable and handy. We join with the Government in offering our congratulations to Capt. Ubhaya, the Ag. Director, on the satisfactory conduct of the administration of the Department.

VITAL STATISTICS.

Vital statistics are to a nation what book-keeping is to a bank. The persons who suffer from the failure of a bank are not the paid employees of the bank but the shareholders and depositors. So the absence of correct vital statistics of a nation affects the people more than the government employees. The angle of vision of the government employees must be changed and they should look upon the people, from whom the tax is collected, as their masters and their welfare their chief concern. The Dominion Status which India is expected to get will perhaps change the angle of vision of the government servants and until then the book-keeping of the nation viz., vital statistics will continue to be unsatisfactory.

Before education (primary), raising the age of marriage of boys and girls, and vaccination are made compulsory vital statistics, the foundation of all these, should have been made compulsory as in Travancore. In the province of Madras only in municipalities where vital statistics are compulsory, the municipal authorities are responsible for their collection, and the revenue authorities are entrusted with the work in other parts of the province. The suggestion of the Director to make vital statistics

compulsory in all places each with a population of 2,000 and more is certainly good. There are, according to the last census, about 4,000 such villages with a total population of 11½ millions and if vital statistics are made compulsory in all of them and in the existing union towns also, the population for whom book-keeping is provided will amount to 18½ millions including the population of municipalities. We would go a step further and make all these villages as sub-unions and provide them with conservancy staff and entrust the sanitary inspectors of the conservancy with vital statistics duties. This will give considerable relief to the revenue authorities. In Travancore, besides municipalities, there are conservancy towns each with a population between 1,000 and 5,000 under the direct control of the Sanitary Commissioner. Vital statistics are compulsory in those towns and sanitary overseers in charge of them are made responsible not only for the collection of vital statistics but also for vaccination and sanitation. In the whole of India, Travancore is one of the few if not the only territory where the incidence of small-pox is low and within the State the lowest incidence is found in those conservancy towns. In the same way it is possible to entrust the three units of public health viz., vital statistics, vaccination and sanitation to the sanitary inspectors in those villages and union towns or combine the offices of the vaccinator and vital statistics registrar into one to work under the sanitary inspector in big towns. The district and taluk health officers are now finding out omissions in the vital statistics registration in the places they visit and

the number of such omissions is very large. We are afraid lest the revenue authorities would make the mistake of considering that the health officers are the constituted agency for finding out omissions of vital statistics and report them if the omissions are detected by them fall.

INFANT AND MATERNAL MORTALITY AND CHILD WELFARE.

It is indeed pleasing to note that the Director has thought it necessary to institute special enquiries in four municipal towns in the province about infant and maternal mortality and in Dr. Adishesan a competent officer is found and the report of the enquiry reflects credit on him. The information got from the research is of much use not only as regards public health but in respect of social and economic conditions of the people. It is possible to collect such information in the vital statistics registers, if additional columns are opened in them without resorting to special occasional researches. In the birth register additional columns to note the age of mother, order of birth, and the interval from the last birth may be opened and in the death register, particularly in the case of death of infants, additional columns to note (1) how long they lived in the houses in which they died, (2) the sanitation of the houses and streets and (3) the economic condition of the parents. There can be no difficulty in collecting the above information in places where vital statistics are compulsory and if vital statistics are made compulsory in all unions and villages each with a population of 2,000 and more as suggested above,

the figures so obtained for a total population of 18½ millions out of a population of .42 millions in the whole province, may fairly represent the conditions in the province. In Travancore such additional columns have been opened in the vital statistics registers and information collected were found useful in the last census.

Under maternal mortality, deaths occurring within 15 days of confinement are returned. It was, we believe sometime back that deaths occurring within 30 days were returned under this heading. The fixing of any period of time is purely arbitrary. Deaths from child-birth are either due to puerperal septicemia or puerperal affections (other than septicemia such as accidents and diseases of pregnancy and labour.) The maternal mortality rate as found by the research was 17.9 per 1,000 births and by the latter is meant livebirths. If still-births which may be estimated at 5% of the live-births and if the mortality rate due to the former which is found to be 5½ times more than that occurring after live-births are added, the maternal mortality on total births including still-births will considerably be more than 17.9 per 1,000 births.

The child welfare scheme as at present worked is not suited to the country under the existing conditions prevailing here. It was organised in imitation of that in vogue in European and American countries where the conditions of the people are quite different from those in India. If the object is, as appears to be from the publication of state-

portion to the maximum pay as in the case of the district and taluk health officers. The pay may be raised to Rs. 150.

MEDICAL INSPECTION OF SCHOOLS AND PROPAGANDA.

The medical inspection of schools as at present conducted by paying a few annas for each pupil examined looks more like a meaningless formality and does not indicate any recognition of its importance. The classification of diseases provided for in the return lacks insight and significance of inspection. Rickets is classed under diseases of the nervous system and itch under mal-nutrition. The correct classification with a view to take substantial remedial steps would be deficiency diseases, infectious diseases etc. As prevention is better than cure the predisposition to and the early appearance of diseases should be detected and proper remedies taken against them. For this purpose children in elementary schools require inspection more than grown-up pupils in secondary schools and colleges. The Director complains that many elementary schools are left without inspection. Some diseases may require time for diagnosis and such pupils should be kept under observation. Even in hospitals where patients with actual diseases attend for treatment some have to be kept under observation for several days before correct diagnosis is made. For incipient diseases a few minutes' examination as done in the schools is of very little use if not misleading. It is not possible under the coolie system in which inspection is being done now for proper examination to be made. For each school or group of schools in the

same place, a school medical officer should be attached. In Japan the number of school physicians for schools is 11,765 and they are attached to 17,421 schools.

In the Report the number of lectures delivered under the propaganda scheme is noted with satisfaction. Persons who are illiterate do not attend the lectures and those who are educated do not care for them. The few persons that attend them are mostly vagabonds who have nothing else to do and they attend more for tamash than for instruction. The Hon. Dr. Hoops said with considerable truth that "Having once raised a really properly educated body of medical men, the next immediate step is the diffusion of knowledge concerning the origin and the mode of prevalence of the spread of diseases throughout the population at large. The adult is, as a rule, too case-hardened to benefit but the schoolboy is still impressionable. Hygiene should be a subject at every school, and so taught that the subject becomes interesting and is liked." The best teacher to teach hygiene in an interesting way is the medical man. If for teaching mathematics, science etc., teachers specially trained and qualified in those subjects are required why not for teaching hygiene medical men who are specially qualified in the subject should not be appointed? If they are appointed they may conduct medical inspection of schools as well and for hostels attached to the schools they may be appointed as wardens so that the selection of food and its preparation may be done correctly with reference to its caloric and vitamin values. The medical men need not be full-timed employees and may be appointed for each school or group of

schools in a place and they can devote their leisure hours for private practice in those places. There are at present 46,883 elementary and 637 secondary schools in the province. If for each or group of schools a medical man is appointed, the number will be sufficiently large and they can supplement the rural medical staff for giving adequate medical relief in rural areas. This is on the whole a cheap and satisfactory arrangement.

MINISTER OF HEALTH.

The extreme case of imitation found in the Public Health Department pertains to the name given to the Minister in charge of the Medical and Sanitary Departments. He is designated as Minister of Health in imitation of a similar office in England. While there is no Civil Medical Department there and the Public Health Department is the chief one under the Minister, the designation is appropriate, whereas here the Civil Medical Department under the Surgeon-General is the chief department on which is spent several times the money spent on the Public Health Department and the latter only occupies a secondary place. The designation, therefore, of the Minister of Public Health is rather inappropriate. If it is so named in anticipation of doing away gradually with the Civil Medical Department and concentrate the work on the Public Health Department, it is well and good. No science has improved as long as it is under government control and medical science is not an exception to it. It may not be known to all, that even Sir Roland Ross, while he was attached to the Civil Service and directed his attention to the investigation of malaria, was put to much difficulty and transferred to the

Military Department. It is understood that Col. Russell, the permanent Director, would not revert to his permanent appointment in Madras and for that place no I. M. S. officer can have any claim unlike in the case of the office of the Surgeon-General for which the claims of all I. M. S. officers have to be satisfied before it can be included in the Provincial Cadre. A beginning may now be made, if the Minister of Public Health wishes to advance the public health service and to justify his designation, by appointing the Ag. Director of Public Health as the Chief Medical Officer of Health directly under him, as is the case in England, giving him an assistant to help him if necessary in out-door inspection. He will then not only guide the working of the Public Health Department but give considerable help to the Minister in the control of the Civil Medical Department. We hope that the inauguration of the Dominion Status will commence with this very desirable change.

THE SUB-ASSISTANT SURGEONS AND JAIL DUTY.

The sub-asst. surgeons on jail duty have addressed a memorial to the Government setting forth certain grievances consequent on the failure of the Government to give effect to the recommendations of the Indian Jails Committee. The lot of this class of subordinates which one of them describes as the "depressed class" of the medical profession is hard indeed and their duties unpopular. In tacit recognition of this fact, Government have ruled that every sub-asst. surgeon has to do his turn of service in the jail. It is however urged by the memorialists that as a result of the period of such service having been

fixed at three years, a fair proportion manage to retire before their turn comes and thus escape the unpleasant duty. The inequality of treatment which this involves is calculated to cause discontent among them, if it does not give rise to under-hand attempt on the part of the subordinates to put off the evil day until the time of retirement arrives. As a compensation for the unattractive nature of the work the Committee recommended the grant of rent-free quarters, duty or grade allowance and rewards. These recommendations have not been given effect to in this province though they have been given to a greater or less extent in the sister-provinces.

The sub-asst. surgeon attached to jails has to undergo a sort of confinement day and night in the jail premises and pass his time among criminals. He cannot, situated as he is, supplement his income by private practice. It is, therefore, no wonder that every one tries to avoid this duty. The memorialists, therefore, request that the period of service may be reduced to two years and that they may be granted an allowance of thirty to seventy rupees per mensem, according to their grade, free quarters and to allot a sum of Rs. 6,000 a year as reward to be given for meritorious work.

On a consideration of the whole case, we think, the proper solution lies in the creation of a separate cadre for jail service. In that event these subordinates will have a permanent interest in their duty instead of taking it, as a passing evil and looking forward to the day of their deliverance. The pay and prospects should, however, be so regulated as to attract good material and to compensate for the hardships which this service

entails. The period of three years fixed under the present arrangement is required to gain a bare experience of the work and if by that time the incumbent is withdrawn this experience will be lost to the Jail Department. The extra allowance granted to him will, therefore, be a practical waste. Hence our suggestion. If this suggestion is accepted we would recommend that the scale of pay of this class be fixed at Rs. 150—10—300 with rent-free quarters. This will do away with the need for the other allowances prayed for by the memorialists.

Original Articles.

ENDOCRINOLOGY.

BY

DR. M. S. KRISHNAMURTHI AYYAR.

III

AUTONOMIC NERVOUS SYSTEM.

The action and antagonism between the sympathetic and parasympathetic systems.

Between the sympathetic and parasympathetic there is the general definite physiological antagonism, so that the predominance of the one or the other determines the functional activity of the autonomic system. The general effects of the sympathetic are for the preparation of the body for quick violent reaction to its environment. In this it prepares for the action of the skeletal muscles under voluntary control and consists of acceleration of the heart, increased blood-supply to the muscles, diminution of blood-supply to the periphery, dilatation of the pupils, inhibition of activity of gastro-intestinal tract with diminution of its blood-supply, erection of the hair and secretion of sweat glands. In these effects the sym-

pathetic prepares the animal for its offensive and defensive reactions. The effects of the parasympathetic are to slow the action of the heart, increase the function of the digestive tract, stimulate the activity of the salivary and digestive glands, and aid in the general upbuilding of the body. The general effect is, therefore, of conserving bodily resources, building up a reserve of energy and energy-yielding material to be called upon and used in time of need by the action of the sympathetic. The action of the sympathetic is katabolic while that of the parasympathetic is anabolic. Of the endocrine glands thyroid, adrenals and pituitary are closely connected with the sympathetic system and are katabolic. Epinephrine the active principle of the medullary portion of the suprarenal glands excites only those tissues innervated by the sympathetic and its effect is always one of furthering normal activity. The action may be either one of stimulation or inhibition. Parathyroid, pancreas, and thymus are connected with the parasympathetic system and are anabolic.

Vagotonia and Sympathicotonia and their tests.

Clinically two distinct types have been discovered based on the antagonism between the sympathetic and parasympathetic nervous system and they are vagotonia in which parasympathetic predominates and sympathicotonia in which the sympathetic exerts the dominant action. Vagotonia is characterised by contracted pupils not easily dilated by atropine, wide palpebral fissure, salivation and lachrymation, tendency to diarrhoea and sweating, or to colic and constipation depending upon the extent of the

stimulation, increase of secretions and motility of the intestine, strong and slow pulsation of the heart and irregular pulse, low blood-pressure, irregularities of respiration, eosinophilia, hyperacidity, irregularity and occasional spasm of the esophagus, pylorus, gall bladder and colon, cold extremities, bronchial spasm and tendency to incontinence of urine and feces. Marked improvement of the symptoms follows the administration of atropine, while pilocarpine aggravates the symptoms and a hypodermic injection may serve to establish a diagnosis. Vagotonia is much more common in the young or at least in those of middle age than in those of more advanced years. Vagotonia is associated with anaphylaxis. Sympathicotonia is characterised by a tendency to tachycardia, large pupils, scanty lachrymation, lessened secretion of the mucosa of the nasopharynx and of the gastro-intestinal tract, hypochlorhydria, relaxation of the muscles of the intestines, increased pulse rate, and blood-pressure and retardation of the passage of food from stomach to intestines. It is associated with immunity through the endocrine system. These two conditions may be distinguished by the following test.

Achner's sign: By pressure over the eyeball, in vagotonia there is lowering of the pulse and increase in sympathicotonia.

2. A subcutaneous injection of one mg. of epinephrine is followed in normal persons within two minutes by a rise of blood-pressure of 15 to 20 m.m. and the blood-pressure will return to normal in 45 minutes. In vagotonia there is a primary lowering of the blood-pressure and is found in diabetes, hypertention, bronchial

far to seek. Almost all of them are men in service and they enjoy special rights and privileges by virtue of their office and which are denied to their less fortunate brothers in private practice and consequently the former cannot feel to the extent they would have done if all the medical men were on equal footing. The private practitioners who are in the Medical Register cannot afford to be apathetic. They should all attempt to mend matters which can only be done by amending the existing Act. The Council should be so constituted as to have a solid non-official majority with a president to be elected by the Council. All registered practitioners should be treated alike not only in the matter of rights and privileges which they get by virtue of being registered but also in the matter of holding appointments in hospitals and similar medical institutions. The Registrar should be a whole-timed officer and need not necessarily be a medical man. If he is to be a medical man he should not be allowed private practice. In the exercise of his profession he may commit an act like other practitioners commit and which may come under the purview of the Medical Act. As the Registrar is the officer to initiate proceedings against the infamous conduct complained of to the Council and in case a Registrar who is also a private practitioner is involved in any penal case, it cannot be expected of him to initiate proceedings against himself. So no time should be lost in protesting against the appointment of a Registrar who is private practitioner. There is no need that the Registrar should possess a knowledge of medicine, surgery and midwifery. An Art or a Law graduate can easily be got for the

pay the Council now spends on its Registrar. In other provinces non-medical registrars are doing their work splendidly. Why not in Madras? Even if there were to be sentimental objections for having a non-medical Registrar the Council can advertise and get from amongst retired service officers excellent medical men. Under no circumstances the holding of the post of the Registrar by a practising doctor could be tolerated.

Abstracts.

TONSILLECTOMY.

(ENDOCRINE SURVEY OCT, '29)

The case for and against tonsillectomy has been fought for years. Especially since J. N. MacKenzie (Maryland Med. Jour., 1912, lv. p. 138) recorded his eloquent objections to "The Massacre of the Tonsil," the popularity of this operation has experienced various ebbs and tides, and many physicians have made increasing attempts to avoid the removal of these important little organs, particularly in children in whom their loss cannot possibly be indifferent.

If the operation of tonsillectomy were always done perfectly, the possibility would exist to judge the case of the operation on its own merits. Unfortunately, the procedure often fails to yield the expected benefit to the patient. The reason for this partial or total failure may lie in the fact that the operation has not been complete, more or less lymph tissue being retained. There may have been injury to the pillars of the fauces, or other accidents may have taken place.

To the student of endocrinology, the problem of the tonsil is by no means indifferent, if only for the reason that

an infected tonsil has repeatedly been incriminated as a potent cause of hyperthyroidism. We do know that focal infections anywhere, including the tonsils, must involve a strain on several of the endocrine organs, and for that reason we are concerned in this matter.

We are interested in some pointed remarks on the subject which were made by Dr. George B. McAuliffe (Med. Rev. of Rev., March, 1929) while speaking on "The Perfect Tonsillectomy." He says: "The search for focal infections as the cause of toxic inflammation of the joints, heart, eye, and other organs, has singled out the tonsils next to the teeth as the easiest found focus, and a wholesale attack on the tonsils has resulted in indiscriminate operations in all ages from infancy to old age. Internists have been responsible for this as much as the specialists and the laity has been educated to believe that the tonsils are unnecessary and harmful structures. This opinion has been supported by the fact that many patients show no untoward systemic results of tonsillectomy, but feel apparently better without them. The cry is always that the tonsils are diseased, but on what proof this is based is not entirely obvious.

"If the tonsils become diseased, is it not more likely that they would become more so in late age than in infancy? Yet it is mainly the young who have operation, and the aged are left alone.

"We see throat after throat present an aspect that would lead one to think that the operations were blindly done. Throats with pillars gone, especially the posterior, faucial opening distorted by cicatricial contraction, some

with bits of tonsillar tissue still flourishing, some with the lingual end growing up into the fossa, looking as if the tonsils were half excised. Throats such as these have perhaps had two or three operations to get rid of all the lymphoid material, and yet have sore throats without tonsils. Some throats have no tonsils but one or two crypts, going into the constrictors, the seat occasionally of severe streptococcic infections.

"These results have developed an internecine war between specialists, and no tonsillectomist is free from criticism. I doubt if any operator has escaped censure in his tonsil work. Nowhere in the medical field is there more criticism than in tonsil operations, a criticism which comes from men who have the same results as those they criticise. If all tonsils were of the firm, globular type and nicely encapsulated, this would not obtain, but unfortunately the majority are of the discrete type with fingers reaching into the constrictor muscles, perhaps joined by a lymphoid bridge to the lingual masses."

Dr. J. A. Stucky, from whose discussion of "The Responsibility of Ophthalmologists and Otolaryngologists for the Conservation of Public Health" (Jour. Tennessee State Med. Assn., May, 1929, xxii, No. 1.) we have taken the foregoing quotation, has frequently urged greater discrimination in the selection of cases for the operation. In personal communications to us, Dr. Stucky has more than once related cases that had been picked out for tonsillectomy and in which the establishment and observance of a suitable diet, sometimes with the addition of indicated endocrine therapy, caused a complete retrogression of the

enlargement so that tonsillectomy no longer was necessary. We believe that this observation is important and that it justifies persistent attempts to treat tonsils, even though they may be under grave suspicion, before ordering their execution.

We have the impression that the question is by no means decided. We ourselves cannot but maintain the view-point that we established many years ago, namely, to fight tonsillectomy as long as possible, more especially in infants and small children. We are willing to have it done only when the tonsils are so large as to constitute a danger, or so badly destroyed as to be absolutely incurable. In all other cases, we insist upon treatment consisting of tonic and endocrine therapy and of proper diet.

THE TANNIC ACID TREATMENT OF BURNS AND SCALDS.

(THE PRACTITIONER FEB. 1929.)

This article by Gertrude Herzfeld, Surgeon to the Royal Edinburgh Hospital points out the many advantages offered by the tannic acid treatment—the principal ones being:

- (a) Prevention of local sepsis.
- (b) Prevention of absorption from the affected tissues.
- (c) Painless dressing of the burned area.
- (d) Rapid healing and a minimum of scar formation.

For this purpose the use of a 2.5 per cent solution of tannic acid in sterile water is advocated. The solution must be freshly prepared for every application. The correct strength for a solution is obtained by using a package of 110 grains of

tannic acid dissolved in 8 ounces of water.

Before applying the solution with an ordinary spray, the burned surface should be cleaned with methylated spirit, all blisters should be opened and the overlying epithelium should be removed and final cleansing with ether to dry the part is advisable. A general anaesthetic for the preliminary cleansing may be necessary.

The tannic acid solution produces a local coagulum over the raw surface which must not be disturbed, nothing must come in touch with it. Body warmth of the patient can be maintained by a cage cover with an electric bulb.

The tannic acid is applied every hour until there is a definite sign of coagulum formation, which at first is yellowish, then becomes brown and finally black. No further applications are necessary.

The solution is absolutely non-injurious to the healthy skin—eyes nose and mouth should be protected from the solution.

After the coagulum separates, especially in second degree burns, the healing is usually complete.

It should be noted, however, that this treatment is not applicable to cases of burns which have been treated previously for longer than 12 hours by other methods, or where toxemia through absorption has occurred.

Furthermore, skilled nursing is required for which the patients should be placed in a hospital.

Notes on the Treatment of Diseases.

Acromegaly:—This is due to perversion, and not to hypofunction of the hypophysis. In severe head-ache or paresthesia pituitrin good. In the sthenic stage quinine hydrobromide 5gr. with ergotine 1 gr. after meals and massage to the parts will do good. In the asthenic stage thyroid gland 1 gr. post-pituitary $\frac{1}{2}$ gr. and suprarenal glands 2 gr. in males; ovarian substance in females is recommended (Sajous.)

Abortion:—To prevent frequent abortion corpus luteum is good. (Endocrine Survey.)

No. 2. Placental extract may be given by the mouth. (Harrower.)

No. 3. Irradiated ergosterol is good. (Journal of Chemo-therapy.)

Adams-Stokes' syndrome:—Ephedrine 0.05 gm. in capsules by mouth once a day. (J. A. M. A.)

No. 2. Barium chloride 30 m.g. four times a day by mouth. (J. A. M. A.)

Achlorhydria:—This is a familial disease and the person is short, fatty, with widely separated eyes and large jaw angles. Hydrochloric acid dilute 1 dr. to be taken before meals. (Practical Medicine.)

Addison's disease:—15 m. (1 c.c.) of vaparole pituitary (B.W.) is good. For diarrhoea accompanying this disease bismuth is the best remedy to be taken with adrenalin. For tuberculosis causing this disease creasote 5 m. may be added to adrenalin. (Sajous.)

Adrenal apoplexy:—For the threatened onset of this disease characterised by high blood-pressure, purpuric

spots and high fever there is nothing like giving physiologic saline solution either by rectum or subcutaneously or intra-venously. Antipyrine or other coal tar products should not be given. As to drugs amyl nitras by inhalation or nitroglycerine or chloral hydras or veratrum viride are useful. For children sweet spirits of nitre. (Sajous.)

Albuminuria:—In pregnancy thyroid is very effective. (Endocrine Survey.)

No. 2. In acute albuminuria iso- or hyper-tonic glucose solution or lactose solution has a marked effect. (Martinetti.)

No. 3. To the milk given for this disease common salt should be added at the rate of 50 gr. to a pint. (Sajous.)

No. 4. In early pregnancy albuminuria is the early symptom of dehydration. This may be relieved by three intra-muscular injections, at weekly intervals, of manganese butyrate 2 c.c. of 1% solution (McDonagh.)

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Notes on Diagnosis, Therapeutics and other Subjects.

TESTS FOR TYPHOID FEVER OTHER THAN WIDAL

Marris Atropine test:—The patient should lie horizontally and to remain in complete rest throughout the test which is not to be applied until at least one hour has elapsed since the last meal. The pulse rate is counted minute by minute until it is steady. Ten minutes of such counting is sufficient. Atropine sulphate 1/33 of a grain is then injected hypodermically over the biceps region. An interval of 25 minutes is allowed to elapse and the pulse is again counted minute by minute for 15 to 20 minutes until it is clear that any rise which might have followed the injection is allowed to pass off. If after the injection of atropine the pulse rate rises less than 14 beats per minute the test is positive. (*"Recent Advances in Medicine" by Beaumont.*)

No. 2. Macroscopic test:—The oxalated serum (1 to 50 or 100) and dead or living organism is mixed. There will be a complete precipitation and the precipitate falls down and the supernatant fluid becomes clear. (*Osler.*)

No. 3. Ophthalmic reaction:—A solution of 1/3 to 1/2 m. g. of typho-protein is instilled into the conjunctival sack. A typical reaction with redness of the lower lids and canalicula is developed within 6 hours. (*Osler.*)

No. 4. Pulse temperature ratio:—Though the temperature is high the pulse rate does not rise in proportion. Generally, for every rise of 1 degree in temperature the pulse rate rises by 10 per minute.

No. 5. The expressionless abdomen:—Loss of outlines of the muscles

and general shape in adults, and in children, puffiness with gurgling and slight tenderness in the lower right quadrant. (*Armitage.*)

INSULIN—ITS USES IN DISEASES OTHER THAN DIABETES MELLITUS.

Wasting Disease:—The treatment by insulin is especially indicated in loss of weight based upon status asthenicus or consequent to states of exhaustion following puerperal fever or radical operations, besides all constitutionally conditioned dropping complaints of the abdominal organs. Feverish local and general diseases and carcinomatous cachexia form an absolute contra-indication, vasomotor diathesis a relative contra-indication. Duration of the cure—3 weeks; smallest possible doses. The result shows itself in striking increase in appetite and in rapid gain in weight.

Glenard's disease:—The number of insulin units administered oscillated between 2,460 and 3,560. In all cases, very significant increases in weight occurred from 4.50 to 10, 20 kg. m. Appetite improved; the subjective findings improved. It is self-evident in diseases of this kind that other measures must also be taken into consideration, such as, washing out of the stomach, suitable dietetic regulations, vibratory massage, fresh air treatment, in any case, fixation of the kidney by surgery.

Basedow's disease:—The individual symptoms of this disease were set aside and many were improved.

Carcinoma:—Insulin also had a very favorable influence on icterus in carcinoma of the liver. The decrease of icterus in all cases, the disappearance of pruritus in several cases and the

improvement of general condition in the majority of the cases were striking. In individual cases transitory gains in weight were noted. Naturally, a cure was neither expected nor obtained; but in a desperate disease of this kind, such as the carcinomatous diseases of the liver are, a harmless remedy is very desirable. On the basis of his observations, Jaksch believes that a broad field opens up for insulin therapy in the realm of the liver affections of the most diverse kind, to combat a very annoying symptom, icterus with its sequela.

Tuberculosis:—The best measure of a promising result in insulin therapy and of a correct dosage is the gain in appetite, which is greatly improved even after the first few days of treatment. Contra-indications for the application of insulin are admittedly cases with tendency to hemorrhages, which apparently can be evoked by insulin; also during menstruation the insulin treatment should be suspended for this reason. Cases coming under consideration for the use of insulin are the more chronic types without fever or sub-febrile. Also, pneumo-thorax cases, which show a tendency to weight decline, so far as this is not caused by active tuberculous processes, seem to be quite suitable for insulin forced alimentation treatment.

Respecting the use of insulin in active tuberculosis, the indications have not yet been definitely established. The psychic influences of the medication on the patient must be pointed out. When the appetite improves, the patients again have more hope, especially when they have previously taken all possible agents for stimulating appetite without any result whatever. In the majority of the patients the general condition improves with astonishing rapidity. An improvement of clinical symptoms was not to be expected from this therapy from the outset; however, this sometimes occurred in proportion to the general physical improvement.

Hyperemesis:—Report concerning ten cases of hyperemesis which were treated with insulin. In 7 cases the

examination of acetone and diacetic acid turned out positive. Under insulin administration in the first months of pregnancy, the body weight rose steeply, while the acetone content of the urine sank rapidly. In several cases, when no insulin was given, the increase in weight was soon lost, the acetonuria again rapidly assumed its former height, whereby the purely substitutional character of insulin in hyperemesis is shown.

News and Comments.

Under the auspices of the South Indian Branch of the British Medical Association Col. McCarrison addressed a gathering of medical practitioners and students on 24-10-29 on the subject of the causation of stone, goitre and beri-beri. As a result of experiments conducted by him, he discovered (1) that diet composed almost entirely of cereal grains with some vegetable oil could cause stone in the bladder, (2) that by adding cow's milk to the diet stone could be completely prevented, (3) that the cereal grains varied in stone-producing properties and lastly, (4) that the development of stone was due fully or in part to the absence from the diet of certain factors. These were fat-soluble vitamins A or D or both and suitable protein. The above were negative factors in producing stone, lime being the positive factor as stone usually occurred amongst people using hard water.

Goitre was due to relative deficiency of iodine in the system, the positive goitre-producing agencies were insanitary conditions of life involving contamination of food and drink by human excreta, bacterial agencies and excess of certain substances in the food notably fat. Goitre could be cured by absolute cleanliness in surroundings and iodization of water.

Beri-beri was caused on account of low content of vitamin B. in the diet and not due to absolute deficiency as there is no such thing in nature.

He concluded by emphasising the importance of accurate dietetic analysis of disease production and then to

correct the diet. This he said should be the first rule of therapy in all medical practice remembering that in the perfection of metabolic processes by nutrition control lay the true means of turning the body to perfect harmony.

Though some European and American authorities are of opinion that excremental contamination has very little to do with the causation of goitre, there is no question that such contamination is bad in other ways and should be avoided. We are afraid whether the medical officers who prescribe diets to their patients have any idea of their constituents and know their caloric and vitamin values. At any rate when Dr. Sinclair was the Surgeon-General of Madras, he used to question during his inspection of hospitals, the medical officers in charge about the constituents of the diets they prescribe and he invariably found them to be ignorant of them. Of course in his days vitamins were not discovered. Col. McCarrison will be interested to know whether the rice used in hospitals is mill-polished or hand-pounded, and whether the vegetables and rice are steamed without exposure to air, or boiled exposed to air. Medical men must know that in the treatment of diseases diet is as important if not more than medicines and vaccines. While so much care and study are made in the preparation of medicines and vaccines, the preparation of food is left to ignorant cooks.

On 23-10-29 Col. Hingston organised a conference of medical men and others interested in maternity and child welfare work at Giffard School with the idea of carrying on ante-natal clinics, co-ordinating the work at the Government Maternity Hospital with other institutions in the city including the child welfare scheme of the Madras Corporation. The private practitioners have also been invited to the work of co-ordination and they are to treat their own cases in the maternity hospitals. Starting of maternity homes to treat only

normal cases is to be encouraged and an external department is to be attached to the Government Maternity Hospital and a few staff nurses, pupil midwives and house surgeons are to form a unit to go out to patients' houses to render first aids. Scholarships are to be given to graduates to conduct research in ante-natal work.

Col. Hingston's idea is splendid, but the results to be achieved in checking maternal as well as infantile mortality is rather doubtful. Highly organised associations in the West have not been able to lessen the infantile mortality by such activities. A committee of eminent medical men in England have come to this decision recently. Maternity and child welfare schemes have their own place in lessening human sufferings under suitable conditions. To achieve even this satisfactorily every practitioner or groups of them should be made to co-operate with Col. Hingston and suitable facilities should be given to them to carry on this propaganda in places where they are needed. Such and similar activities to be useful to the public should be divested entirely from government control and private agencies encouraged and entrusted with the work.

As long as birth-rate continues high, infant death-rate also will remain high. Two-thirds of infant deaths and all still-births are more or less due to the poor condition of health of the mothers, brought on by poverty. As referred to elsewhere in this issue the Hon'ble Dr. Hoops, has said that all these—baby weeks, milk depots ante-natal and post-natal clinics etc., were of no avail unless we remove the sources of evil viz., overcrowding and bad feeding. These two are the outcome of poverty. All our endeavours should be to cut down the expenditure in all possible ways including the money spent on the so-called child welfare and maternity schemes.

There exists a Health Propaganda Board in the city of Madras. The name itself indicates clearly the purpose for which the Health Board came into

existence. On the 22nd October 1929 there was the annual gathering of this body and advantage was taken of this meeting for propagating radiology as it is practised in the Government General Hospital, Madras. Radiology has its own importance in medicine and surgery. How far the general public will understand a subject which interests only specialists and not easily understandable at times even by ordinary general medical practitioners, should be considered by those concerned in health propaganda. The lectures on radiology by Capt. Bernard and on the use of X-ray by Dr. Santhanakrishna Pillai would have attracted the attention of the medical profession more than of a lay audience who are not likely to remember anything after the meeting is over except that Capt. Bernard and Dr. Santhanakrishna Pillai are in charge and sub-charge of the X-ray Institute of the General Hospital. May we suggest to the Health Propaganda Board that lectures like those from Col. McCarrison on dietetics would be more useful and appropriate health propaganda?

Twenty honorary appointments have since been made under the Revised Rules extending the system of honorary appointments in government hospitals. Of these thirteen are either honorary physicians or assistant surgeons, four honorary surgeons and three honorary physicians. Eight appointments are made in the presidency hospitals and in the district headquarter hospitals of Coimbatore 2 appointments, Mangalore 2, Madura 2, Calicut 2, Nellore 1, and Guntur 1. The other two appointments are made in the government hospitals of Cocanada and Bezwada which are not headquarters of districts. Two of the appointments were given to persons holding the L.M.S. degree of the Madras University which is not registrable in the United Kingdom. It is surprising that at Tanjore where there are several big hospitals and a large number of practitioners no appointments are made.

The beginning made in the matter of appointments is good but to make them popular, to attract practitioners and to extend the system, some of the defects in the order as shown below should be removed.

As district medical officers are at present allowed private practice and so likely to come into conflict with private practitioners, it is but natural that neither the private practitioners would be like to send their applications through district medical officers nor would the district medical officers would send the applications with their recommendations to the Surgeon-General. The rule, therefore, that applications should be sent through district medical officers should be cancelled. A committee of four or five independent medical practitioners presided over by the Surgeon-General should be formed and all applications should be required to be sent to the committee direct.

Private practitioners who depend solely on private practice for their maintenance cannot spend the best part of the day in hospitals as honorary officers unless they are assured that their private practice will not be interfered with by government paid medical officers. For this purpose all government paid medical officers should be debarred from private practice in places where there are a sufficient number of private practitioners to meet the demands of the public at those places, and they may, if necessary, be allowed consultant practice if they are called upon for this purpose by *bona fide* medical practitioners. This condition is *sine qua non* both for the development of the independent medical profession and for extension of the honorary appointments. The Government, after much agitation, passed a ruling prohibiting medical officers attached to medical colleges and schools from undertaking private practice. That the rule is observed more in the breach than in the observance will be evident if proper enquiries are made. These officers and others attached to hospitals adopt the practice of employing

paid assistants from the junior medical practitioners to get cases and to attend them as the so-called consultants though in practice they are in charge of them.

To facilitate the formation of a thoroughly efficient medical profession from which competent persons for honorary appointments may be recruited, it is absolutely necessary that candidates passing out of the medical colleges and schools should be appointed as house physicians or surgeons and to give them adequate practical training. There are about 200 paid assistants in the presidency, district and mofussil hospitals under the officers in charge of them. These may be replaced by house surgeons and physicians. By this step, not only money may be saved by doing away with paid appointments but proper training may be given to students, fresh from colleges and schools, befitting them to undertake private practice.

* * * *

Dr. K. K. Muthukumaraswami, Factory Medical Officer, E.I.D. & S.F. Ltd., Nellikuppam, South Arcot District, has elaborated a scheme which he styles as "The All-India Medical Practitioners Benefit Fund," to help the members of the families of deceased medical practitioners or their dependents and it is to be registered under the "Indian Companies' Act." It should be under the management of a board of directors consisting of five elected members, two joint secretaries and a president. The two secretaries should be paid an honorarium or fixed pay to be decided by the board of management. The members of the board of management are to be elected periodically but the president and the two secretaries are to hold office for life unless removed by the board of management for misconduct or other reasons.

All qualified practitioners are to be members of the Fund who should pay an entrance fee of Rs. five and a rupee

for each call as soon as the death of a member is notified and the money has to be remitted to the Fund within a couple of months' notice. If a member neglects payment for three consecutive calls his name will be struck from the roll with or without forfeiture of his claims according to the decision of the managing board whose decision is to be final. Out of the amount collected on the death of a member 80 p.c. should go to the family of the deceased and 15 p.c. towards reserve fund and 5 p.c. for management. The wish of the deceased which he is to make on a special declaration form, as to whom the amount to be paid, to be kept strictly confidential. The reserve fund to be utilised for the benefit of the medical profession in financing at low rate of interest (4 to 6%) medical men for starting their professional life including journalism or for similar purposes beneficial to the medical profession. The loan so granted to be repaid in small easy instalments to be decided by the board of management.

Death certificate is to be issued by a medical practitioner or a district official, municipal chairman or village munsiff.

The money belonging to the Benefit Fund should be invested in the Imperial Bank.

The idea conveyed in the above scheme is certainly commendable. It is contemplated to hold a conference of the medical practitioners of this province during the Easter holidays and we would suggest that this subject may be discussed in the conference and if enough encouragement is forthcoming, launch a scheme at least for the benefit of the practitioners of this province.

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Some of the taluk board presidents who have relations or friends among medical men seem to have found out an easy method of finding employment for them in rural areas, either by dis-

placing one who is already there on some pretext or other or starting a rural dispensary in a place where there are private practitioners practising without the help of subsidies. In the Palghat Taluk Board, we learn, that in a village where there are already two long-standing medical practitioners, a rural dispensary has recently been started. This is against the principle of rural medical relief enunciated by the Government. We suggest to the aggrieved practitioners to bring such injustice to the notice of the Government through the Surgeon-General and we have the assurance that the Government will take notice of such cases.

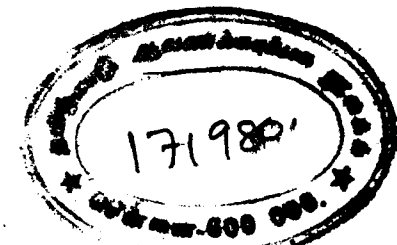
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As the Legislative Assembly has vetoed the appointment of a Commissioner for Medical Education in India and the Government of India has accepted the resolution of the Assembly, Sir Donald MacAlister, from his presidential chair of the General Medical Council of Great Britain, has hurled his thunderbolt upon the poor Indian medical graduates that their qualifications would not entitle them to take post-graduate course in Great Britain and declared that before February next when the next meeting of the General Medical Council of Great Britain would be held, if the Legislative Assembly and the Government of India would not reconsider the matter and appoint a Commissioner, the thunderbolt would not be taken back. From the above it is evident that Indian degrees would not be accepted as qualifications for appointments in Great Britain. The Indians are not very anxious either for appointments in Great Britain or for undergoing post-graduate course there. After all Great Britain is not the foremost country in the world, where medicine has advanced considerably. There are Germany, France, America and even Japan where, if necessary, the Indian graduates can undergo post-graduate course. The Government of India and the Legislative Assembly,

we hope, will organize an All-India Medical Council and include in its fold all medical practitioners whether graduates or holders of diploma granted by the several provincial governments and declare that practitioners holding only degrees or diplomas granted by Great Britain are ineligible for appointments or for setting up private practice in India. If it is not possible to enforce this rule as regards the medical appointments in the Military Service, there should be no hesitation in applying this rule to the appointments in civil hospitals, colleges, schools, research institutions, railways and private practice among civil population. We may point out to Sir Donald MacAlister that the real losers would be the British qualification-holders, and not those possessing Indian qualifications.

Reviews Correspondence Etc.

The Bulletin of the South Indian Medical Union:—The S.I.M.U. has followed the principle of better late than never in starting a monthly bulletin the first issue of which was received by us with thanks. We cordially welcome the bulletin. The Editorial Board consists of thoroughly qualified persons one of whom is an experienced journalist. The articles contained in the journal are highly interesting and readable. We miss, however, publication of any of the transaction of the Union in its bulletin which one would expect in a periodical bulletin of an association. We wish the journal every success.



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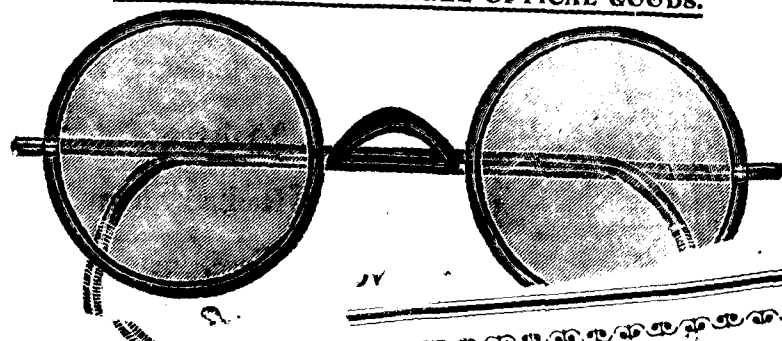
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