

1347

The
medical Practitioner.

vol-I

no-10.11.12

July-August-September-1930

Reg. No. M. 2528.
VOL. I. No. 10.

JULY, '30.

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

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AND

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PUBLISHER'S NOTICE.

We regret that the current issue could not be published on the 15th as usual on account of partial strike of compositors in the People's Printing and Publishing House, Ltd. where the journal is being printed and we request our readers to excuse us for the unavoidable delay.

The Medical Practitioner has just closed the tenth month of its existence. All the qualified medical practitioners in service and outside, of all grades including the members of the I.M.S. must have judged by this time its utility consistent with the object for which the journal was started. We have two months more for the completion of one year. The one and the only sure way for us to gauge the opinion of our readers is the receipt of Rs. 1-8-0 from them which though it will never pay the cost of the journal, will serve to encourage the organisers for continuing their service to the profession with greater zeal and vigour. May we therefore earnestly request you, our kind readers, to be good enough to send your yearly subscription before the close of the year. i. e. October 1930.

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Business Notice.

While thanking the readers of "The Medical Practitioner" for utilising our services in the way indicated in our announcement, we have to remind them of our request published in these columns to enclose one anna stamp for reply in answering their queries concerning ourselves and in case they wish us to get the information from outside our office, to be good enough to enclose 4 annas stamps to cover the actual charges for conveyance etc. incurred on their behalf.

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THE Medical Practitioner

Annual Subscription Rs. 1-8-0.

Single Copy, As. 4

Vol. I]

JULY, 1930

[No. 10

THE SIMLA CONFERENCE.

Our readers must be aware that in the third week of last month, the Government of India convened a conference of representatives of Provincial Governments and the medical faculties of all the existing Universities of India to discuss about the situation created by the suspension of the recognition of the Indian Medical Degrees by the General Medical Council of Great Britain. Sir Fazli Hussain, the member in charge of the medical portfolio of the Government of India presided over this Conference. The Provincial Governments were represented by the Ministers and the Surgeons-General or the Inspectors-General of the respective provinces, and the Medical Faculties of the Universities were represented by one or two members of such faculties. The Director-General of Indian Medical Services was also present.

The following resolutions were passed:—

(i) This Conference requests the Government of India to ask the Secretary of State for India to so amend the rules as to enable graduates of Indian Universities, whose names are borne on the register of any of the provincial medical councils, to be recruited for the Indian Medical Service, either temporarily or permanently without the necessity of their qualification being registerable in England.

(ii) In the opinion of this Conference, it is desirable that the minimum uniform standard of qualifi-

cations for medical graduates of Indian Universities should be maintained.

(iii) This Conference is unanimously of opinion that it is desirable to promote co-operation between the various universities, and ensure co-ordination of their efforts in order that each university might be able to maintain the standard that could form the basis of reciprocal recognition with other countries.

It was also agreed by the representatives at the Conference to organise an All-India Medical Council whose function ought to be to collect all the information regarding the curriculum of studies, methods of teaching and the standards of examination for each University and the medical colleges in India, and to appoint in this connection committees from time to time to satisfy itself that the standards of particular institutions do not fall below the minimum prescribed qualification and to maintain a register which will contain the names of all Graduate doctors whose names are borne on the registers of the Provincial Medical Councils.

As regards the composition of the Council, the general consensus of opinion was that the Director General of the Indian Medical Services should be the President of the First Council, and, in addition to three members nominated by the Governor-General in Council, one member to be nominated by the Local Government of each province having a medical college and one member by the Medical

Faculty of each university in India and that one medical graduate from each province of not less than 10 years' standing, who should, in addition possess teaching experience of not less than 5 years as a professor, lecturer or reader in a medical institution and should be elected by graduates, whose name is borne on the Provincial Medical Register.

The Conference has recommended that a bill on the above lines should be published in the press and circulated to the Local Governments for opinion. It has also been agreed that the Local Governments should be asked to obtain the opinions of the Medical Faculties, the local Medical Councils and the leading Medical Unions and that the Provincial Governments should consider such opinions before submitting their views to the Government of India. The Honourable Sir Fazli Hussain assured the Conference that no avoidable delay would be allowed in drafting the Bill and inviting all concerned to express their opinion on it, and he also expressed the hope that it might be possible to introduce the Bill in the Legislative Assembly in the Winter Session of 1931.

It will be worthwhile for our readers to recollect about the proceedings of yet another Conference of the representatives of the Medical Faculties of all Indian Universities, which was organised by the Vice-President of the Bombay University and which met in Bombay on 11th May 1930, to discuss the situation brought about on account of the G. M. C.'s decision. The latter Conference consisted purely of Indians and though the Simla Conference consisted of important European element as represented by the Surgeons-General and Inspectors-General and the Director General of the Indian Medical Services, it is noteworthy that none of the European members of the Conference seems to have taken any active part regarding the decisions arrived at the Simla Conference. Perhaps they thought it wise not to put their lips against the

public opinion which the decision of the G. M. C. has brought about. We are almost certain that there would have been more than one amongst the Surgeons-General or Inspectors-General who attended the Conference that did not possess the British University medical qualifications. These gentlemen at least might have enlightened the Conference that in the British Isles medical education is not confined to Universities only and that there exist in those islands other non-university bodies who confer qualifications equal to and even higher than those of the universities. Those who gathered in Conference in Simla and others who met at Bombay earlier for the same purpose certainly betrayed want of imagination in not discussing about means and methods by which the future medical profession in this country could stand on a par with that of other civilised countries where there is one uniform standard of medical education, irrespective of the agencies that confer these medical qualifications.

Those that met in Conference in their zeal for securing a few posts in the Indian Medical Service, seem to have grossly neglected the welfare of 300 millions of people in this country to whom the few graduates turned out from the Universities cannot give adequate medical relief, as after all the graduates form nearly one fourth of the total strength of the qualified Allopathic practitioners. What about the medical education of the rest who do not possess university qualifications? Should it not be the duty of the proposed All India Medical Council to establish in this country a minimum uniform medical qualification, university or otherwise and bring all the medical men in one group and in one register as is the case in other civilised countries? Indians who attended the Simla Conference and elsewhere accused the G. M. C. on various grounds but did not think of their own brethren nearer at home possessing non-university qualifications. It is regretted that

their case was not thought of by their more fortunate brethren who had the privilege to attend the Simla Conference though they are four times the strength of the graduates.

We wish to point out most respectfully to the Honourable Sir Fazli Hussain who is the member in charge of the All India Medical Council Bill that the function of any Medical Council including that of the proposed All India one is to guide and control the medical education and registration of qualified medical men with the sole purpose of enabling the public to distinguish qualified from unqualified practitioners and that in 1858 when the British Medical Act was passed for the first time and when there existed in England and Wales Faculties and Universities who conferred medical diplomas, the Act provided registration of practitioners who did not pass any examination or possess any qualification but practised Allopathic system of Medicine before 1st August 1815. The particular Section 17 of the Medical Act 1858 ran as follows:—

"Any person who was actually practising medicine in England before the 1st day of August, 1815, shall, on payment of a fee to be fixed by the General Council, be entitled to be registered on producing to the registrar of the branch council for England, Scotland, or Ireland a declaration according to the form in Schedule (B) to this Act signed by him, or upon transmitting to such registrar information of his name and address, enclosing such declaration as aforesaid." (This section was in force till 1875.)

The declaration referred to ran as follows:—

I,.....residing at
.....in the county of
.....hereby declare that I was practising as a medical practitioner at.....in the county of.....
(Signed) (Name)
Dated this day of 18 ..

When such practitioners were allowed to be registered in the British

Medical Register, none including the G. M. C. can raise any objection to include the L. M. Ps., Military Assistant Surgeons and other non-university diploma holders in the contemplated all India Register.

The proposed constitution of an All-India Medical Council can never be acceptable, as such a council will be preponderantly official. It is reasonable, nay, desirable that the Council should have representatives, one from each teaching institution as is the case in the British Medical Council. But as these institutions are at present manned by officials, it is essential that representatives from such institutions should be chosen by the medical practitioners passed out of such institutions, and provision should be made to have as many Independent Medical Practitioners as there are members representing the teaching institutions as the Medical Council has to deal with Ethics and other problems connected with the Medical profession apart from Medical education. There is no need for nominations as those to be returned by the teaching institutions will be almost all officials. The President of the Council should be elected by the Council even for the first time. The Council formed on the above lines may look unweildy but we cannot forget the fact that India is a continent in itself and cannot but have such a really representative Council especially at present when matters concerning the medical profession are unfortunately the monopoly of the officials in Government service. As time goes on, there is bound to be a change in the teaching institutions (signs are not wanting at least in Bombay and Bengal Presidencies) and we hope it will not be far when our teaching institutions will be on the level of those in the British Isles manned by members of the Independent Medical Profession and it will be possible then to consider the desirability of lessening the number of members in the Council especially from the Independent Medical Profession. Till such

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time we should tolerate a bigger council.

We agree with Dr. Mehta, Dean of the King Edward Memorial Hospital, Bombay, that there is no need to rush the proposed Indian Medical Council Bill. But we are not one with him in accepting the resolutions of the Medical Faculties Conference recommending the appointment of Inter-University Medical Board. We would suggest a Board consisting of representatives of all the Medical Councils instead of Universities as the latter bodies can represent only one class of practitioners, *i.e.*, the smallest group of graduates, but the Medical Councils Board will be a really representative one, and the Government of India can surely institute such a Board even without special legislation and empower this Board with the duty of supervising medical education in India. The existing Medical Councils have powers of supervision contemplated in the proposed All-India Medical Council Bill, though it is a dead letter so far. We are of opinion that there is no need at least at present to institute an All India Council. The existing Provincial Councils could be reformed and made really representative institutions on the model of the G. M. C. and an All India Medical Board consisting of three representatives from each Provincial Council may be immediately instituted, to control medical education in India.

We ventured to give expression to our views regarding the proposed All India Medical Council in spite of our not approving of the same as we apprehend that there is every danger of the proposed Bill being rushed through. There is one conciliating factor amongst the resolutions passed and that is, that the Government of India has been requested to gather opinion from various bodies including the Medical Councils before formulating the Bill, and we trust the Independent Medical Profession, especially those not belonging to the universities will open their eyes and lose no time in

expressing their views in all possible ways before it is too late to mend.

Original Articles

ENDOCRINOLOGY

BY

DR. M. S. KRISHNAMURTHY AYYAR,
M. B. & C. M.,

X

Pituitary Body

This organ is also called hypophysis in distinction to epiphysis the pineal gland. It is not correctly a gland much less an endocrine gland. At any rate the posterior lobe is said to possess no secretory function and is only a mass of nerve tissue. The term hypophysis should refer according to Dr. Bell to the epithelial portion of the pituitary body *viz.*, the pars anterior and the pars intermedia. Of the three types of humanity inhabiting the world at present the Negro, the Mongal and the Caucasian, pituitary predominance is marked in the last. The sharp and pronounced nasalisation of the face, the tendency to show eyebrow ridges, the prominent chin, the bulk and the stature of the body are mainly determined by the pituitary gland.

Origin and Anatomy

The pituitary body rests in Sella Turcica, a cup-shaped depression in the sphenoid bone at the base of the skull. The average weight is about 60 to 70 centigrams. It is made up of two major parts; the anterior and posterior pituitary and suspended from the floor of the third ventricle by the infundibulum, a hollow stalk which widens to form the posterior lobe. Two smaller structures pars intermedia and the pars tuberalis are included in the pituitary body. The anterior lobe (pars glandularis) is derived from the buccal ectoderm (Rathke's pouch) is glandular in structure and partially surrounds the posterior lobe. Embryo-

logically this part develops as a tubular organ and in the adult the parts are separated by a cleft which is a survival of its original tubular structure. Some of the epithelial cells of the anterior lobe become separated from the main body and as a thin layer surround the body and the neck of the pars nervosa separating it from the intraglandular cleft. This layer of the epithelial cell is called the 'pars intermedia' and is adherent to the posterior lobe. The pars tuberalis appears to be a separate structure and extends along the stalk of the infundibulum. It is epithelial and is believed to have an embryological origin separate from the other structures. The anterior part is composed of masses of epithelial cells irregularly arranged in column formation with occasional crude acinus formation. The posterior lobe in its embryonic stage opens directly into the third ventricle through the infundibulum. It arises from the nervous tissue of the floor of the third ventricle and is composed of the neuroglia cells. There are hyalin, colloid or glandular masses between the neuroglia cells. The ependymal neuroglia cells seen here are found nowhere else in the body. Accessory pituitaries are rarely found and may result from embryological abnormality and occupy a position in or near the sella turcica. As a consequence of the embryological development in which a pouch from the buccal entoderm migrates into the cranium and subsequently becomes cut off by the development of the bony structure of the sphenoid, a canal sometimes persists in this bone--the canalis cranio-pharyngeus. The pharyngeal hypophysis is also a remnant of the organ in the pharynx and is a very small structure. The blood supply is derived from the internal carotids and from the circle of Willis. The vessels arise from about 20 small arterioles that reach the pituitary from the circle of Willis and pass along the infundibulum into the gland. The capillaries are very profuse in the anterior part and pass as sinus-like vessels between the

columns of the epithelial cells. The venous return is through the circular sinus. The nerve supply is chiefly from the sympathetic system and directly connects the pituitary body with the adrenals, thyroid, etc.

Physiology

There is difference of opinion regarding the functions of the pituitary body. Some authorities, chiefly Sajous, maintain that it has no secretory function at all but it is only a nerve organ; while others are of opinion that it is an organ of internal secretion and have separated the secretion of the anterior lobe and named it 'tethelin' and also identified two separate secretions in the posterior lobe *viz.*, Oxytocin and Vaso-pressin. The views of Sajous school have some force and may be briefly stated as follows. By the study of comparative anatomy and physiology it is seen that the anterior pituitary body represents "Osphradium" in the mollusca. This tests the respiratory fluids in them. It is an autoprotective mechanism and is connected with the adrenals and thyroid by the sympathetic nerve. On histological consideration none of the cells of the pituitary body particularly those in the posterior pituitary resemble secreting cells. The presence of ependymal neuroglia cells in the posterior pituitary, cells which are not found in any other part of the body, indicates that it is not a secreting organ. The posterior lobe situated as it is in Sella Turcica on the cushion of blood vessels and well protected makes one to believe that it is not merely a secretory organ but a more precious one. The cells of the posterior pituitary have neurons axis-cylinders, dendrites and gemmules resembling more like neurons in the brain than secretory cells. Acromegoly and the actions of the extracts of the pituitary gland can be explained otherwise without bringing into existence any secretion from the gland. The pituitary body is the governing centre of vital functions and of the body's immunizing functions. Nerves pass from the pituitary body to the spinal

cord; the posterior or neural lobe of the pituitary body is the seat of the sympathetic centre; it is also the seat of common sensibility and the general motor centre. The posterior pituitary body is the governing centre of the adrenals, the thermogenic and the respiratory centres. It is the centre where the chemical energy is transformed into nervous energy. According to the other school which endows it with internal secretory function the pituitary is concerned with skeletal growth and to some extent with metabolism especially of carbohydrates and profoundly induces the activity of unstripped muscles. The central incisors are controlled by it. The teeth are large and square and the interdental spaces are marked and middle incisors are prominent. The growth and development of lateral incisors indicate the position of the testes and ovaries. A twisted incisor indicates the torsion of the cord in the male and the ligament of the ovaries in the female. When there is complete absence of lateral incisors in a female, she will not bear children and her menstruation will be scanty and painful. The right lateral incisor controls the male and left the female generative organ. A person with poorly developed lateral incisors is much more likely to contract mumps than one with developed ones. Post pituitary controls the salt contents of the blood upon which its electrical conductivity and other properties depend; normally there is a fixed ratio of the salts in the blood which keeps them like the ratio in sea water. Hybernation is due to the seasonal wave of the activity of the pituitary. It controls the formation of the eyes. The orbit is roony and massive with thick bony margin and large widely spaced eyeballs. The anterior body furnishes more internal secretion than the posterior and exerts a profound influence on growth, development and nutrition particularly of the skeleton. It has probably some specific effect on sexual development. During pregnancy it undergoes marked hypertrophy it may be truly said that bad obstetric

phy. The posterior lobe gives rise to a substance which regulates the activity of the unstripped muscles. It also plays a part in general metabolism particularly carbohydrates and also in regulating diuresis.

THE POST NATAL CARE

BY

DR. P. VENKATAGIRI M. D.,
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The ante natal care of pregnant women has made some advance even in this country. The child welfare and the National Baby week have also made their ideals felt to some extent even in the remotest district in this presidency. But the post natal care of pregnant women is not engaging the serious attention of either the profession or the public to the extent that the importance of the subject deserves. It is little wonder that people have such poor ideas regarding this very important subject. They fancy that when a pregnant woman has somehow given birth to the child, all her troubles are over. How reckless, probably due to ignorance, the parturient woman and her relations are, can be gauged by the extent of the pathological lesions that often cripple a woman for life after her confinement. Large numbers of women are rendered worse in this country after child-birth. It is no doubt true that pregnancy, parturition and puerperium are physiological functions and hence normal functions of the female body but they differ from other physiological functions in that they are carried out solely for the benefit of the race and not the individual. Moreover the boundary between what is physiological and what is pathological is so ill defined and very little understood. It is no doubt true that the post natal care of women is a much neglected subject even to-day. Here is a wide field for the profession and the public in what may be termed preventive gynaecology; for

tries—the mismanaged pregnancy and the mishandled labour and puerperium very often, if the patient survives, contributes largely material for the talents of the gynaecologist. After all said and done, gynaecology will dwindle down to a considerable extent as a subject from the greater prominence it is gaining to-day but for bad midwifery. Even with the assistance of a skilled gynaecologist, many a woman after labour is crippled for life not only due to bad midwifery but also to want of proper post natal care and advice. Some of these unhappy women can be described as those who feel never well after child birth. It is proposed in this short article how much can be done to mitigate the existing evils and bring some measure of relief to these unfortunate victims due to acts of omission and commission. Hence whenever and wherever ante-natal clinic is established, a postnatal clinic also must be arranged and due prominence given to it.

Of course it is true that future work will have its foundation truly laid in the great advance of child welfare, for it is the child of to-day that becomes the mother of to-morrow. Hence the scope of child welfare must be extended and popularised even in the remotest village. The proper upbringing of the child and then of the girl must be the next concern of the nation. Social evils and customs that are contributory factors to post natal lesions such as child mothers, too early getting up on account of poverty or social life, ill paced motherhood, indiscriminate sexual intercourse are matters that require the serious attention of the nation. Again a proper ante-natal and natal care of pregnant women are factors that will greatly strengthen the foundation already laid on child welfare in reducing if not in eradicating the evils of post-natal ignorance. Hence much can be done to minimise post natal troubles by carefully managing pregnancy and labour. Therefore, as has been pointed above, true post natal care ought to begin from the very commencement

to be adequate and thoroughly useful. Not only labour and pregnancy must be properly managed but even the childhood, girlhood and womanhood ought to engage our serious attention.

The post natal care proper commences with the intelligent management of the puerperium. The puerperal woman needs rest after the strenuous endeavours of labour and the strain of pregnancy. Try to promote both mental and bodily rest. See to it that she does not get up too early from bed on account of social or domestic reasons. Clean room, clean bed, clean clothes and clean parts, in fact, cleanliness in everything should be scrupulously maintained. The condition of the breasts, bladder and bowels must be duly supervised. Sleep must be promoted and the nervous system guarded against worry, either from the child or the mother-in-law—that two important, domineering and nerve-shattering personality of many an Indian home. Bed exercises, passive movements and massage may tend to diminish or reduce many a post-natal complication as pendulous abdomen, flabby abdominal muscles, weakened and damaged recti muscles, retention of urine, flatulence, false after pains, retention of lochia and displacements of the uterus. The percentage of morbid puerperal cases is higher in this country than in the west for many reasons. The low vitality of the poorer classes is a great contributory factor in raising the percentage of morbidity. The ignorance of the barber midwife is another source of higher percentage of morbidity. The enervating climatic conditions, combined with various forms of tropical fevers with undermine the physical stamina, already poorly developed, or some of the other factors that contribute for higher morbidity rate. Death from puerperal sepsis is greater here than in the western countries but the damage to the generative organs in particular and to the health in general, is still greater than in western countries. Our lying-in hospitals permit the parturient women to stay only for a week or so and then discharge them

for want of accommodation; patients who are often not quite fit, are allowed to go home. Even if we have room, advice is neither understood nor availed of by many of the patients to stay in the hospital for a longer period. The children at home are without help and the poor mother has to rush home to work and look after them. Many a case of backward and downward displacement of the uterus and consequent ill-health, back ache, pain in the pelvis, leucorrhoea and menorrhagia can be traced to early getting up. Especially the hospital class of patients is often put to the necessity of working for her livelihood too early after her confinement; In such cases the parts have no time to involute properly with the result that we have to deal with later on, in a very radical manner, the backward and downward displacements of the uterus. The trauma of child birth sustained very often in instrumental and difficult labours have hardly time to heal before these patients are forced to work on account of their social conditions with the result, that further complications set in, resulting in gynaecological complaints as cystocle, rectocle, relaxed outlet, erosin and ectropian of the cervix, involution and displacements of the uterus, and pelvic inflammatory troubles of puerperal origin. Serious damage of the perineums, anal sphincter, the rectum and the bladder wall may require careful and immediate attention. Later on further operative treatment for the repair of the structures may be necessary. Through ignorance, poverty and fear many a woman who has sustained severe trauma cannot understand that only prolonged and careful treatment by competent doctors can restore her to usefulness and perfect health.

Infected cases require still further attention. Very often these cases of puerperal infections are insufficiently treated both in hospital and private practice. Those in hospital often insist on going home too early as soon

as the temperature falls down or even when there is some fever, the moment the patient feels somewhat better and the home cases discard the doctor very often, too early for fear of his fees.

The result of all such negligence is very often disastrous. Many a menstrual complaint as menorrhagia and dysmenorrhoea and inter-menstrual pain, pain in the lower abdomen and back ache can often be traced to this insufficient treatment of puerperal sepsis. That all-too-comprehensive a disease—pelvic inflammatory disease—comprising as it does, inflammatory troubles of the uterus and adnexa such as endometritis, metritis, salpingo ophoritis, pelvic peritonitis and pelvic cellulitis etc., may leave behind lingering sparks of chronic invalidism in the shape of pelvic adhesions, matted tubes and ovaries and fixed uterus which may further vex the woman through out life. These conditions require careful thorough and prolonged treatment. Repeated pelvic examinations may be necessary in some cases to note properly the progress of cases and also to institute operative help in time to clear out collections of pus, to separate adhesions and to put up the uterus in the normal position. Every woman must be thoroughly examined before she is discharged to see she is fit to go home and work and advised when again she must submit herself for yet another examination if it is found necessary. The home cases, even those that had apparently normal puerperium must be advised of the importance of examination at the end of 4 or 6 weeks after labour to find out whether all is well or whether there is any sub-involution and displacement of the uterus etc. It is also good practice to note the condition of the cervix for tear or erosion. It is needless to say that the vagina and vulva deserve also careful examination to find out if there is atresia of vagina and puerperal ulcers and to note the state of the discharge if any and the progress of involution of these parts. The post natal care is

still in its infancy and far from satisfactory and neither the profession nor the public have realised the importance of this subject in all its bearing for the good of the individual or the future well-being of the race.

SUMMARY.

I. A post natal clinic must be attached to every ante natal clinic.

II. Just as in ante-natal clinic, much propaganda work will be necessary before the public can rise up to the occasion to reap the full measure of benefit from the scheme.

III. Patient should be sufficiently advised about the importance of pelvic examination as a routine measure before she resumes her normal work at the termination of the puerperium, for, "a stitch in time" will remove many a source of future gynaecological complaints.

IV. Finally, a routine general examination of her health should be made so as to estimate the individual reaction to the strain of pregnancy and labour, specially the final effects of labour and puerperium on such vital organs as the heart, lungs, liver, kidney and the digestive and nervous system should be carefully noted.

V. In conclusion, advice must be given in suitable cases whether the individual may undergo the risk of future pregnancies or not; opinion should be carefully based on the findings of Nos. III and IV; advice, regarding what measures to be adopted to prevent conception if that is found absolutely necessary for the well-being of the individual or if further pregnancy is permissible, what ante-natal and natal care be sought for should be given to all post natal patients as a matter of routine.

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DENTAL SURGEON

289, Esplanade, Madras.

Abstracts.

THE TREATMENT OF SECONDARY ANEMIA.

BY

RUSSELL L. HADEN, M.D.

In every individual, blood destruction and blood regeneration are constantly going on. Normally there is a balance between these two processes by which the red-blood cells and the hemoglobin are kept at almost a fixed level. With a loss of the normal balance, there is either an anemia, in which the blood loss overbalances the gain, or a polycythemia, in which the gain over balances the loss. Anemia is by far the more common result.

Anemia is always a symptom of some underlying abnormal condition, which may or may not be apparent. Not infrequently the effects of the symptoms are more serious than those of the disease. An anemia due to a known cause is termed a secondary anemia: In general we designate as secondary the anemias with a color-index of one or less, excluding those with a colour-index above the normal. The latter constitute the macrocytic anemias, of which pernicious anemia is the best example.

COMMON CAUSES OF SECONDARY ANEMIA.

A very large number of diseases and diseased conditions may give rise to a secondary anemia. Perhaps 90 per cent of all the pathologic conditions seen in clinical medicine are associated at some time in their course with some degree of anemia. It is thus probably the most common of all symptoms of disease. The most important causes of secondary anemia may be placed in four groups, which will include a large percentage of all the cases of anemia seen by the clinician or hematologist. The groups with classic examples are:

1. **Acute and chronic hemorrhage**, as from trauma, uterine disturbance,

hemorrhoids, and ulceration of the gastro-intestinal tract.

2. **Malignancy.**—Anemia is common in malignant tumors in all locations. Malignancy of the stomach and colon usually show a high-grade anemia.

3. **Acute and chronic infections.**—as acute rheumatic fever, chronic sepsis in such surgical conditions as osteomyelitis, and chronic focal infection.

4. **Acute and chronic intoxications.**—Classic examples of this group are the anemias due to such poisons as lead, to metabolic disturbances such as myxedema associated with nephritis or anachylia gastrica.

Thus in every secondary anemia we have to consider the possibility of hemorrhage, malignancy or infection, and of intoxication. The problem of etiology cannot be stressed too strongly because the treatment of a secondary anemia is necessarily concerned, first of all, with the treatment of the underlying cause. The success of treatment in most cases will depend in a large measure on the completeness with which the cause can be eliminated. In determining the treatment to be instituted, the following questions must be answered in every case.

1. Has the cause been removed?
2. How much rest and what other general hygienic measures are needed?
3. Shall iron be given?
4. Is transfusion indicated?
5. What diet shall be prescribed?

The more important groups of secondary anemia will be considered from these different standpoints.

ACUTE HEMORRHAGIC ANEMIA.

The treatment of an anemia due to acute blood loss brings up some special problems. The sudden loss of one-third of the total blood volume is usually fatal unless immediately replaced. The serious aspect is the sudden decrease in circulating blood volume

Up to two-thirds of the original blood volume may be removed over a period of twenty-four hours without a lethal outcome. The blood volume is, in such a case, gradually replaced, although the hemoglobin is constantly falling.

The treatment of such an anemia must be directed towards replacement of the blood volume. The infusion of a salt solution is of some temporary value. Solutions of gum acacia of higher viscosity are seldom available for emergency use. Blood transfusions are always the treatment of choice, for thus both the blood volume and the oxygen-carrying constituent are replaced. The loss of two liters of blood, a persisting fall in blood pressure, or a pressure below 90 with other signs of circulatory failure, such as rapid pulse, should always be absolute indications for transfusion after acute blood loss. After tiding over the acute period, the problem of treatment is no different from that of chronic hemorrhagic anemia.

CHRONIC HEMORRHAGIC ANEMIA.

Often an anemia due to chronic blood loss is allowed to progress to a bone-marrow insufficiency evidenced by the microcytosis, the very low color-index, and a leukopenia. This is especially true of excessive uterine bleeding and of hemorrhoids.

The need for removal of the cause is apparent although often it is the part of wisdom to defer any operative procedure until the patient's general condition is improved. The first requisite in treatment is rest in bed. Rest is as just important in anemia as it is for a patient with active pulmonary tuberculosis. The importance of rest can not be emphasised too strongly.

Iron usually should be given. It is always indicated with a low color-index in which the red cells are not completely saturated with hemoglobin, as is usually found in a chronic hemorrhagic anemia. Iron has had the viture of a time-honoured use by master clinicians,

and now there is abundant experimental proof of its value in chronic hemorrhagic anemia. It should be given in large doses, preferably as the citrate or the chloride. Recently, copper and other inorganic elements have received much attention. Their value in clinical work is yet to be determined.

The need for transfusion is determined by a number of factors. It is always preferable to begin treatment on the assumption that it is far better for a patient to form his own blood than to have it given by transfusion. If the hemoglobin is 50 per cent or above, it is better to try the effect of rest, diet, and iron before transfusion is resorted to, unless there is need for haste in preparation for operation. If the hemoglobin is as low as 30 per cent, and usually when the hemoglobin is between 30 and 50 per cent, transfusion is indicated. With the hemoglobin at such a low level, the blood volume is also much decreased. This constitutes another indication for transfusion. I have been giving a transfusion of from 500 to 600 cc. of blood two or three times a week, until recovery is well under way.

The problem of diet is of the greatest interest at the present time, due largely to the experimental work of Whipple and his co-workers. In animals, an experimentally induced hemorrhagic anemia can be controlled at will, by diet. This fact has been largely overlooked by clinicians in the past. In secondary anemia, the most important thing is the completeness of the diet rather than the presence of any specific substance. It seems quite certain that liver has no specific effect as it does in pernicious anemia although it is one of the best sources of meat proteins, which are vitally necessary.

Whipple has shown that the least favourable groups of food for blood regeneration are the grains, bread-stuff, fish, dairy products, common vegetables, and some fruits. The most favourable are liver and kidney. In between these two groups come the

leafy vegetables, skeletal muscle apricots, prunes, raisins, and peaches. A most excellent diet for secondary anemia is that prepared by Minot and Murphy for patients with pernicious anemia, with the exception that less emphasis is placed on the use of liver.

THE ANEMIA OF MALIGNANCY.

The anemia of malignancy is so often the symptom of a condition for which there is no satisfactory treatment, that the treatment of the anemia is also necessarily unsatisfactory, but may be important in preparation for operation. Usually the anemia here is due to a depression of bone-marrow function but may be complicated with mechanical loss of blood as in carcinoma of the stomach or colon. As a rule the cells are completely saturated with hemoglobin. The difficulty is primarily in blood-cell formation. Iron is of little value. Transfusion is only a palliative measure but may be necessary as a pre-operative or post-operative measure. A full diet should be given.

ANEMIA OF INFECTION.

The anemia of infection may be due to increased blood destruction or to a depression of the normal bone-marrow activity. The latter is probably the more important factor. Often the infection, the causative factor, cannot be removed at all, as in acute rheumatic fever, or only partly so, as in osteomyelitis. In other cases, as in dental sepsis, removal may be possible. The course of the infection is markedly influenced by the anemia. No other primary causative condition is so affected by anemia since the resistance of the body to infection is, in a large measure dependent upon the state of the blood.

The presence of an infection is an added reason for insisting on rest and other hygienic measures. Usually iron should be given unless there are hemolytic jaundice and saturation of the red cells with hemoglobin, indi-

cating that there is already an excess of iron compounds.

Transfusion is of the greatest value in the anemia of infection, since it influences for good the primary condition, the infection, as well as the symptom, the anemia. It should be employed more often than has been the custom in the past.

Often a patient with an acute infection is kept for an extended period on a diet that furnishes few of the elements necessary for blood formation. The diet should be planned with anemia in mind, especially in chronic infections. This requires the inclusion in the diet of leafy vegetables, meat proteins, and the hemoglobin-forming fruits, apricots, prunes and peaches.

ACUTE AND CHRONIC INTOXICATION

This is an interesting group, due to widely differing causes, and brings up a number of individual problems in treatment. Lead poisoning is an excellent example. Hyperthyroidism is often associated with anemia, the treatment of the anemia being dependent upon the treatment of the thyroid condition. Anemia is almost a constant symptom of chronic nephritis.

Iron is usually indicated in this group. Transfusion is seldom necessary. Diet is most important. The need for rest in bed will vary with the intensity of the anemia. In chronic nephritis the meat proteins are usually interdicted, or allowed only in small amounts if there is nitrogen retention. In such cases, apricots, prunes, raisins and peaches should be given in as large amounts as possible.

There is one interesting class of anemias without known cause, which are of definite secondary type, always associated with achlorhydria, and probably belonging in the intoxication group. These cases show a most marked response to iodine given as the tincture with hydrochloric acid and iron. Hypothyroidism may perhaps be a factor here.

SUMMARY

In secondary anemia, the important points in treatment are:

1. Recognition and removal of the cause, if possible.
2. Rest in bed, if the anemia is marked.
3. Administration of iron, if the color-index is low.
4. The judicious use of transfusion, especially when the cause is remediable.
5. Planning of the diet to include ample calories, vitamins, meat proteins, and hemoglobin-forming vegetables and fruits.

(*The Medical Herald and Physical Therapist.*)

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TREATMENT OF BURNS WITH NORMAL HORSE SERUM.

S. R. Monteith and R. O. Clock discuss the treatment of burns with normal horse serum. After cleaning the wound, it is suggested that the burned area should be sprayed with normal horse serum from an ordinary oil atomizer. This should be repeated twice daily for the first few days. The rationale of using normal horse serum in the treatment of burns is dependent on the fact that the tissue cells require a physiological medium in which to multiply and build up the destroyed area; otherwise scar tissue will result. After spraying the burned area, rubber tissue or oiled silk should be applied to ensure the prolonged action of the serum. A small amount of cresol is added to the serum for preservative purposes. Summarising the method, they conclude (1) the

method of treating burns with normal horse serum as described above is simple and easily applied. It does not soil bed-linen or clothing (2). In their hand this method has yielded far better results than any other method that they have employed for the treatment of burns due to fire, hot water, or acids. (3) The important advantages of this method of treating burns are (a) absence of scar tissue (b) rapidity of formation of new epidermal tissue in all parts of the wound (c) freedom from pain (d) prevention of infection (e) elimination of toxemia by preventing the absorption of the toxins (4) Even when the destruction of tissue involves a large area, the wound becomes covered with sound healthy tissue and there is no contraction with resulting deformity; splints, traction or skin grafts are not required (5) When burns are treated by the author's method bacterial growth is inhibited by the cresol in the serum and pus formation is minimised (6) When burns of the skin bearing hair are treated with normal horse serum by this method, the denuded area becomes covered with healthy epidermal tissue which again bears hair. (7) They emphasize the value of the preliminary bath of warm physiological solution of sodium chloride. It not only facilitates removal of the devitalized tissue, but also prevents absorption of the toxins generated in the burn area (8) Normal horse serum containing cresol when sprayed on the burned area, coagulates the exuding tissue plasma and thus provides the healthy cells with physiological food, so that the cells can proliferate and form new healthy epidermal tissue (9) The serum should be applied at least twice daily to prevent drying of the tissues in the area affected by the burn, which would cause death of the cells (10). After the normal horse serum has been applied the wounded surface is protected with rubber tissue, which prevents evaporation and thus ensures prolonged action of the serum.—(*Medical Annual 1930*).

Notes on Treatment of Diseases.

N.B.—These notes are intended to supplement the treatment given in ordinary text books and neither to be expected nor possible to be exhaustive.

Buerger's disease:—Thrombo angitis obliterans—characterised by claudication and eventually gangrene. Radium chloride from 25 to 75 microgram has given relief to the excruciating pain in one week.

2. Intravenous injection of typhoid vaccine so as to produce a mild protein shock gives relief, the injection to be given once in five days so as to produce slight fever (*A. J. M. A.*).

Baldness:—Pellidol ointment.

Barlow's Disease:—In infantile scurvy caused by taking proprietary foods, fresh cow's milk, meat juice, mashed potato, orange or lemon juice to be given three times a day (*Osler*).

Beriberi:—Adrenaline injection daily and a mixture of digitalis and Iodide (*I. M. G.*)

Blackwater fever:—Caffein citras grains 5 three times a day, hot fomentation over the loins and hot water enemas to stimulate diuresis.

2. Haemostyl (*Knowles*).

3. Injection of Quinine hydrochloride (*I. M. G.*)

Bedsore:—When the skin is red and angry looking but still intact a solution of silver nitrate 20 grains to one ounce should be thoroughly painted over the part (*Hare*).

Biliousness:—At the commencement podophyllin 1/6th of a grain if the stools are dark or calomel 1 grain divided into 6 powders one every 15 minutes followed if the stools are light brown, by a saline after four hours. As a preventive horse riding and bending exercise with the feet below the chest drawer is useful; for bilious headache caffen is of no use.

Bacillus coli Infantum:—This is very common in India among infants. In the acute form it resembles typhoid fever, tubercular meningitis, kalaazar malarial fever etc. The urine should be examined for acidity and pus cells. For treatment potassium citrate 10 grains with dextrose (powder) 10 grains to be given every two hours with water until the urine becomes alkaline. If no effect is seen urotropine grains 2 with acid sodium phosphate 6 grains every four hours and if the stools are offensive salol 2 grains in powder to be given, if there is distention of the abdomen dextrose may be left out. For collapse brandy is the best. If there be convulsions or high temperature dover's powder and as perin 1 to 2 grains each may be given (*Armitage*).

2. In chronic cases potassium citrate 10 to 20 grains with lemon squash until urine becomes alkaline.

Blepharitis:—Ungt Hydragryri oxidi Flava and ungt resorsin 2 per cent in equal parts to be rubbed into the lid (*Medical Annual*).

2. After washing the crust with warm soda bicarb solution ammoniated mercury one percent in vaseline may be rubbed (*M. T. T.*)

3. Protargol 10 per cent or Argyrol 20 per cent may be used (*M. T. T.*)

Bilharzia Hæmatobia:—Emetine is good to be given either by injection or by mouth.

2. Stibenyl (a tartrated antimony) is good.

3. Intramuscular injection of Fonadin (*C.E.*)

Bone Fractures:—Osmic acid injections are good for union of fractured bones one per cent solution to be injected at the seat of the fracture about 6 injections at an interval of 6 days is required.

Bradycardia:—In children atropine will prevent the attacks. In elderly persons caffeine is good. In persons with low blood pressure ephedrine is

good (*Medical Clinics of North America*).

Breast engorgement:—Hot water fomentation to be avoided.

Notes on Diagnosis, Therapeutics and other Medical subjects.

High blood Pressure:—High pressure is found in gout; during presclerotic stage mercury as purgative and theobromine as a diuretic and massage are useful. Amyl nitrite is useful only in emergencies, but trinitrin or erythrol tetranitrate one grain 3 times a day before the attack. Thyroid before the onset of tachycardia is useful. Ovarian extract is good for women. Pot. Iodide in 10 grain dose is good and small doses increase vasodilation and tension.—(*Leonard Williams*.)

2. Sulphocyanate of soda grain $2\frac{1}{2}$ to be given three times a day will produce a fall in blood pressure. Both in normal and abnormal persons.

3. Liver extract is good and any untoward symptoms may be met by giving ephedrine. The liver extract is given intramuscularly into the arm followed by massage; begin with 0.55 cc. until at the end of two weeks ten times this dose is reached.—(*Medical Annual*.)

4. Mistletoe in the form of *intrait de gui*, the dose is 2.5 to 5 cc. of 2 per cent solution thrice a day before meals. The following observations of Leonard Williams are worthy of note in this connection. It must not be concluded that an abnormally high blood pressure is of necessity so evil a thing that when discovered all our efforts must be directed to its immediate reduction. So far is this from being the case that a rapid reduction of arterial pressure as by means of nitrite of amyl may very easily be attended by fatal results. We have to remember that the arterial pressure must always be higher than the venous

pressure. If it is not, the medulla is starved and the patient dies. If therefore the venous pressure is unduly high as for example in mitral stenosis there must be a coincident and corresponding rise in arterial pressure and the manometer will register a very high figure. The indication here is not to reduce the pressure in the arteries but in the veins. To attempt the former is to interfere with nature's disposition for the continuance of life. The same considerations apply when the arterial pressure rises in response to an augmented intracranial pressure. In order to secure that the blood shall reach the medulla in spite of the obstacle thus provided the blood pressure in the arteries is increased commensurately with the increase of pressure inside the cranium. Here again the manometer will show a very high figure; but if we allow ourselves to be beguiled into reducing the arterial pressure by venesection or other means we shall surely place the patient in imminent danger of his life. It is essential to remember that high blood pressure is not a disease *per se* and although in many cases the majority, perhaps, it is very desirable that it should be reduced, there are nevertheless others in which its thoughtless reduction would certainly be attended by very serious consequences.

"THE TREATMENT OF PUERPERAL INFECTION WITH SALTS OF ARSENIC."

"Salts of arsenic seem to constitute the medication of choice in puerperal infection, even in non-luetic patients. This treatment should be instituted as soon as puerperal infection is clinically evident, and all other treatment, should be excluded. The arsenical treatment will generally suffice to arrest the symptoms, to prevent aggravation of the infection, and to render other methods superfluous.

Since January, 1924, M. Riviere (*Gaz. Hebd. Sci. Méd.*, January 6th, 1929, p. 2) recommends the use of arsenic salts in the treatment of puerperal

fever. Encouraged by good results he has, since 1925 aimed at the prevention of puerperal fever by the same means. Arsenic has been given in all cases in which fever might be expected. Riviere's figures for four years are 3,667 accouchements with only three deaths, giving a mortality of 0.08 per cent.; of this number, 169 were definitely septic, though in varying degree. Among them were women who had had multiple interventions before admission to hospital, frequently without aseptic or even antiseptic precautions. The author has now arrived at a systematic method of treatment: at the first rise of temperature of genital origin, without waiting for absolute clinical confirmation, arsenic is administered; subcutaneous injections of Sulfarsenol proved most satisfactory. For treatment 0.12 to 0.18 cg. in severe cases was given; this dose was repeated from one to nine times according to the resistance, and the gravity of the infection.

J. Vergely (*Journ. de Med. Bordeaux et du Sud-Ouest*, April 10th, 1928, p. 265) reports a method of treating puerperal fever with Sulfarsenol. In a series of 2,223 accouchements there were 500 cases of fever, the mortality was 0.089 per cent., and the morbidity (which remained unchanged) 22.04 per cent. An axillary temperature of 99.5° for twelve hours, if of genital origin, was arbitrarily looked upon as "fever." As the result of experience it was found that the prophylactic use of Sulfarsenol was not required so long as there was no sepsis, but as soon as there arose a doubt about asepsis as, for example, when the membranes had been long ruptured, or when several digital examinations had been made, or in forceps cases, manual dilatations, or digital curetting then a dose of Sulfarsenol should be given. In the author's cases a dose of 12 cg., was always administered immediately after any intervention, and the result was invariably satisfactory; if pyrexia ensued it was generally only slight. In the few cases in which the temperature rose in spite of an initial dose,

a second injection of 12 or 18 cg., was given each time there was a notable rise, and could, if necessary, be repeated daily. Vergely states that Sulfarsenol has advantages of being a superior bactericide; it is the least toxic of the arseno-benzenes, can be given hypodermically, and is not painful when properly diluted. A possible disadvantage is a toxic erythema. A few cases showed a morbilliform eruption with a sharp rise of temperature, both of which disappeared in forty-eight hours. Contraindications are grave hepatic troubles and uræmia. It can be used in eclampsia if the albuminuria is carefully watched. The author states that this method is of special value for a practitioner working alone because it is easily used.

P. Delmas and Bremond (Bull. Soc. D'Obstet. et de Gynecol. de Paris, April, 1928, p. 433) advocate the use of Sulfarsenol in the prophylaxis of puerperal infection; this treatment, first instituted by Riviere, has been systematically employed at the Montpellier Maternity Hospital since the end of last year in all accouchements when there was doubt as to asepsis. The drug is injected into the subcutaneous cellular tissues of the external surface of the thigh in doses of 12 cg. (about $1\frac{1}{2}$ grains). At first one injection was given on the day of the confinement only. In a second series of cases the injections were administered on each of the four days following labour. No better results were obtained by the latter method, and it need only be employed in the cases most exposed to infection. In only one case were there toxic manifestations. These symptoms lasted about forty-eight hours, and were noted chiefly in non-albuminuric cases; the injections were well tolerated by the albuminuric patients.

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TUBERCULOSIS—SIGNS & TESTS

Pre-tubercular stage:—(a) constant tendency to catch cold (b) Trache-cordia (c) Albuminuria (d) Dyspepsia (e) Mental hebetude and muscular debility (f) Suppression of mensus (g) Evening fever (h) Optimistic temperament (i) Exalted sexual appetite (j) Palenes particularly of the soft palate. (k) Functional aphonia (l) Dyspnoea (m) Low blood pressure (n) Slight paresis of the vocal cord (o) Inequality of the pupils (p) Plurisy accompanied by little or no fever (q) Ulnæ reflex.

Actual Tuberculosis:—Ring test:—

Cover the serum of a tuberculosis patient with a 0.2 per cent solution of trycreasol in physiological solution. In tuberculosis a cloud forms at the junction of the two surfaces (J. A. M. A.)

Pottinger Sign:—A very fine needle is drawn over the skin served by the second cervical to 10th dorsal nerves in horizontal lines and the patient being asked to say when he feels more sudden at one point than in another. This can be obtained even before the temperature starts to rise (I. M. J.)

Vonpirquit test simplified:—The effective method of applying vonpirquit's test is to make a simple puncture with an ordinary sewing needle and to penetrate the epithelium through a drop of tuberculine (I. M. D.)

Moisturales:—If heard above the hilum about the level of the third rib anteriorly heard at the height of deep inspiration and on forcible expiration is a characteristic sign (C. M. & S.)

The Alarm Zone:—In the middle of an oblique line drawn from the spinus process of the seventh cervical vertebra to the projecting inner tubercle of the spine of the scapula, the apex of the lung is most superficial and any altered vascular murmur increased vocal resonance etc noted in this area indicate tuberculosis.

Albumen in the sputum:—Its absence negatives tuberculosis and thus

differentiates tuberculosis from Asthma and pulmonary edema in which it is absent. Recently discharged sputum free from saliva or blood is taken in a sedimentary glass and equal volume of water added and triturated with a glass rod. A few drops of ascetic acid are added to coagulate the mucus and then filtered, one or two crystals of NACL being added to permit the coagulation of Albumen. The presence of Albumen is tested with ordinary heat (Martinet).

Subnormal temperatures are not always to be taken as evidence of tuberculosis. To distinguish these cases from normal, pyramidon 15 grains must be given; if the temperature falls down even in small doses the suspicion is tuberculosis and if the fall is gradual on increasing doses or none at all tuberculosis may be excluded (C. E.)

The Paper test:—A piece of strong rough paper is cut into slips about half an inch wide and one inch long and placed for a week in a mixture of equal parts of chloroform and ether. The skin of the forearm is cleansed with ether and then excoriated in two places with the strip of the paper wrapped around the finger of the operator, by two or three rubs; then a drop of tuberculine is placed on the excoriation and covered with gauze and inspected after 48 hours. If any inflammation is observed it indicates Tuberculosis.

HEREDITARY SYPHILIS.

Extracts taken from reports presented at the

CONFERENCE ON HEREDITARY SYPHILIS,

held in Paris, October 5 to 7, 1925.

"Treatment of Hereditary Syphilis occurring in infancy and early childhood."

BY DOCTOR MARCEL PINARD.

Physician to the Paris Hospitals.

"Sulfarsenol, simply dissolved in distilled water, has been adopted by

the majority of writers because of the simplicity of its application and its tolerability, as well as because of its efficacy, which is equal to that of other neoarsenobenzenes, provided identical dosage be employed.

"It is necessary to protest against false interpretations. There is a tendency to consider intravenous injections excellent and subcutaneous injections very inferior, simply because those favouring subcutaneous injections employ 914 in adult cases. The latter is painful and is often given in doses which are too small, a practice which is injurious. The method which is clearly and definitely a bad one is the use of arsenical medication in inadequate doses, because it renders the treponema resistant to arsenic. This method constitutes only a dangerous reactivation, and not a competent treatment. The good method, on the other hand, is one utilizing arsenical medication in sufficient doses, whether administered by the intravenous, subcutaneous or intra-muscular route.

"**The method of choice:**—This method consists of intensive arsenical medication. It has the immense advantage of being applicable by any physician, in any environment, at the hospital or at the dispensary, in the city or in rural regions. With such an active and well tolerated substance as Sulfarsenol, subcutaneous treatment is thus rendered readily available. We have been faithful to this method for six years. Previous to our experience with Sulfarsenol no other medication which we tried gave similar results. Together with our associate, P. Girard, we have given some 12,000 injections to more than 600 children affected with hereditary Syphilis. Untoward effects have proved very rare and have never been grave. With this series of gravely affected children, the total mortality has been 8 per cent, while of 1000 children selected at random, 200 or 20 per cent succumbed before reaching the age of two years, according to Blechmann."

DIRECTIONS

First weigh the child.

For abnormally small infants of, say, two to three pounds, begin with test doses of about two or three milligrammes of Sulfarsenol, say half of the contents of "A" dose. Gradually increase to 1 cgm., then $1\frac{1}{2}$ or 2 cgms. The smaller doses are preparatory or test doses, and at first may be given every three days if no contra-indications appear.

The doses of $1\frac{1}{2}$ or 2 cgms. are the curative treatment, are given once weekly, and should be continued for seven or eight weeks.

For infants of from 4 to 7 pounds in weight the initial test doses may begin at 5 mgrs., i.e., one ampoule of dose "A" gradually increased to curative doses of 2 ctg. every week or five days, or for six or seven pound infants dose E (3 ctgr.) once weekly.

For older children of, say, 10 lbs. weight, there would be no harm in still giving one initial dose of A, then B, then C, then D, and after that the curative treatment may be one ampoule "E" dose (3 ctgr.) every five days.

At 14 lbs. weight the initial preparatory doses may still be the same, but the curative doses may be up to one ampoule No. 1 (6 ctgr.) once a week.

Older children are treated in the same proportion.

If you begin with a few small doses and gradually work up to half a milligramme per pound weight per week of treatment, you cannot go far wrong.

"BISMUTH CIRCULATING" AND "BISMUTH DEPOSITS".

It does not matter how much Bismuth you put into a muscle. So long as the Bismuth remains in the muscle it does not begin to do any good. It only begins to do good after it has gone into circulation. When an insoluble Bismuth is injected some of it goes

into circulation and does good, the remainder remains in the muscle as useless and sometimes even dangerous deposits.

When Benzo Bismuth is given, all the Bismuth contained goes into circulation and does good. There is no deposit. The dose contained in the Benzo Bismuth Ampoule is quite sufficient. For an ordinary Indian, the dose is 2 ampoules per week but for a man of 11 stones or more 3 ampoules per week can be given. These doses represent 8 or 12 centigrammes of Bismuth metal per week. When big doses such as 15 centigrammes or 20 centigrammes of Insoluble Bismuth are given, they do not yield to the circulation any more Bismuth than that contained in average amount of Benzo Bismuth usually given per week.

"THE TREATMENT OF GONORRHOEAL RHEUMATISM WITH ORGANIC ARSENICAL COMPOUNDS"

Among the numerous chemotherapeutic measures proposed for combating gonorrhoeal rheumatism, we have had occasion to test, with complete success, subcutaneous injections of arsenical compounds of the type represented by Sulfarsenol, in three cases differing in their aspects and development.....

Arsenic appears to act solely by increasing the means of defence of which the organism may avail itself in combating an infection which constitutes a true septicaemia.

We therefore conclude that this method of chemotherapy is worthy of employment in the treatment of gonorrhoeal rheumatism.

1. It may be easily applied, and it is at the disposal of every practitioner. It is but slightly painful, whether used intramuscularly or subcutaneously. Because of its usually rapid action, it permits the application of a limited number of injections. Injections of 18 to 30 cg. each may be repeated to total 5 to 8, at intervals which are

generally of two days each. Not only do patients tolerate these doses well without manifesting signs of intolerance, but their general condition improves very rapidly. Asthenia and anemia disappear, the weight increases and the appetite returns.

2. Its efficacy is sure, as evidenced particularly by our first case given above. Its rapid action upon the painful factor permits early mobilisation of the affected articulations, an advantage which is not the least of those possessed by this therapy, in view of the familiar tendency of gonorrhoeal rheumatism to produce ankylosis.

3. It should be noted that this treatment has no effect upon concomitant urethritis which, after a phase of decline resumes the progress which it manifests on its own account. For that matter, this occurs similarly with the use of intravenous serotherapy, which leaves the urethritis to be dealt with by the classic method of treatment.

(*Journal des Sciences Medicales de Lille*).

News and Comments.

The results of the three elections held on 24th, 25th and 28th last month have been published. Major Cruickshank, Dr. S. Rangachari and Dr. U. Rama Rau have been returned to represent the I, II and III groups respectively. Elsewhere in these columns is published a letter addressed to us by an agent of one of the candidates representing the III group which is well worth reading. Our forecast in these columns last month has turned to be true. The Returning Officer refused to have a scrutiny and he solved the muddle referred to in these columns by opening all covers containing the ballot papers on the 24th June itself, for without doing so, he could not arrive at the result of election fixed for that day. He seems to have been lucky in getting the help of a member of the Medical Council alleged to have been appointed

by the President of the Council. There is no authority vested in the President to function for the Council. We are authoritatively informed that another candidate belonging to the III Group addressed a petition to the President bringing to his notice all the irregularities in the procedure adopted by the Returning Officer. So the President had enough time to summon an extraordinary meeting of the Council. On a similar occasion when Dr. V. Rama Kamath brought to the notice of the Government the illegal procedure adopted by the Returning Officer in holding election without the sanction of the Council, the then President thought it fit to bring to the notice of the Council the illegal procedure complained against by Dr. Kamath and an election which was in full swing was stopped and a *de novo* election held. If as alleged, the President of the Council advised the Returning Officer to open the covers containing ballot papers on earlier days than those fixed by the Council, even if it to be in the presence of a member of the Council authorised by the President, his action is highly objectionable as it is illegal. The Medical Council which is in itself a Court to hear and decide election offences and other irregularities has power on its motion to institute an enquiry and set aside an election. It is rather doubtful whether the Council will start an enquiry on its own accord of course at the instance of the President. The fact that the President of the Council did not report to the Council the irregularity as complained about by a candidate and allowed the election to run, while on a similar occasion, an election which was in full swing had been stopped and a fresh nomination and election ordered, gives weight to our apprehension. Yet we shall wait and see.

* * *

We cannot feel nervous of anybody including Dr. U. Rama Rau in spite of his certificate granted to the Registrar, Medical Council, contained in the libellous statement made by him.

in the columns of "The Hindu", in connection with his recent election, and referred to in these columns, in bringing to the notice of the medical profession facts about the unsatisfactory state of affairs in the Registrar's Office, till we are satisfied that the Medical Council directs its attention to set right matters complained about. We have stated in these columns more than once that there have been many instances where it took several months for the Registrar to register the names of the practitioners who applied for registration or at least to send the registration certificates; the last case that has come to our notice was that of one Dr. Jayaram who remitted to the Registrar Rs. 15/12 in December 1929 and got his registration certificate in June 1930 and that after a reminder from Dr. V. Rama Kamath who interfered on behalf of this unfortunate practitioner. We now learn that large amounts of fees received by the Registrar have been retained in hand in spite of Rule VII (1) of the Madras Medical Registration Act, which runs as under:—

"All moneys payable to the Council shall be received by the Registrar who may retain in his hands a sum not exceeding Rs. 100 and shall remit any amount in excess of that maximum to the Bank of Madras, where an account in the name of the Council shall be opened."

Does this circumstance explain the delay in registration or is it possible to retain such large amounts for other purposes not mentioned in the Medical Act, can only be explained by those who seem to know the Registrar at close quarters.

The Registrar seems to have cultivated yet another habit regarding money transactions. He is said to draw a lump sum of Rs. 75 and sometimes more from the funds of the Medical Council debiting this amount in his cash book as cost of stamps, but the stamps are not bought for entire amount shown for the purpose. He must be capable of ready explanations in money matters or else how could he stand the

scrutiny of the Examiner of Local Fund Accounts. He might explain that it is difficult to get stamps for the whole amount drawn. We ask why not buy stamps in small quantities. Will the Examiner of Local Fund Accounts have courage to report these irregularities to the Council in spite of Dr. U. Rama Rau's certificate, or now that the election is over, is it likely that Dr. Rama Rau withdraws the certificate issued during election or will he take 5 years more to consider this question? All the same we will continue our duty to those interested in the good working of the Madras Medical Registration Act, without fear or favour.

* * * *

Travelling Allowance to medical practitioners in criminal cases has been the subject of comments by some of the readers of "The Medical Practitioner," and even this month we have received two or three communications on the subject. We regret we could not publish any more letters on this subject as the subject matter concerned is the same as has appeared in our journal more than once. Our readers might remember that Dr. M.G. Subramania Iyer, L.M.P. of Devakottah addressed a letter on this subject to the President, Madras Medical Council dated 15-2-1930, and as this letter did not reach the President, Dr. Subramania Iyer requested Dr. V. Rama Kamath, Member, Madras Medical Council, to move this subject in the Medical Council, at its March session. What Dr. Rama Kamath did and what happened in the Council during the discussion of the subject can be made public only after the October session of the Council, but we have information from another source which being not marked confidential, we venture to mention, subject to correction. The Government view seems to be that T. A. and batta to private medical practitioners summoned to attend criminal courts are governed by Rule 87 of the Criminal Rules of Practice, and the Government are not in a mood to change the

existing rule. We publish in tabular form the T. A. and batta contemplated under Rule 87 of the Criminal Rules of Practice, which runs thus:—

"Non-official witnesses are entitled to travelling allowances under two different scales as shown below, according as they are (1) Europeans or

East Indians, or (2) Natives. Persons falling under either of these descriptions are for the purpose of these rules, divided into three classes; and the Judge or Magistrate before whom they are required to appear either as complainants or as witnesses shall be careful to fix the class with due regard to the station in life which they occupy.

(1)	Europeans and Eurasians.			Indians.		
	First Class.	Second Class.	Third Class.	First Class.	Second Class.	Third Class.
Travelling allowance by rail	First Class fare.	Second Class fare.	Third Class fare.	First Class fare.	Second Class fare.	Third Class fare.
By public motor service	Do.	Do.	Do.	Do.	Do.	Do.
By road, otherwise than by public motor service.	8 annas per mile	4 annas per mile	2 annas per mile	6 annas per mile	2 annas per mile	3 pies per mile
By sea or canal	Actual expenses of passage.			Actual expenses of passage.		
Batta not to exceed	3 rupees per diem	1 rupee per diem	8 annas per diem	1 rupee per diem	8 annas per diem	4 annas per diem

If there are only two classes, the first and second class witnesses will be paid the higher class fare and the third class the lower class fare.

It is regrettable that apart from the medical profession, the public have not so far protested against the racial distinction shown in the matter of travelling allowances, and even with the meagre allowance allowed to the Indians, the judiciary, especially the subordinate section, do not seem to be careful to fix the class with due regard to the station in life which the witnesses occupy, though they are required to do so under Rule 87, and one has to depend upon the whims and caprices of the magistracy who, from the reports we have received so far, seem to be very discourteous to the medical practitioners, especially of the rural areas, who are summoned to give evidence in criminal courts by the police. There does not seem to be

any uniformity even in the matter of injustice meted out to these practitioners as will be evidenced from the experience of Dr. S. Ramasubbu, and Dr. Devadoss S. John, the Rural Medical Practitioners of Viraganur and Venkatagiri Kota, whose letters on this subject appeared in the May and June issues of this journal respectively. What one Magistrate allows, another Magistrate denies and a third one does not even care for the opinion of a District and Sessions Judge in this matter. There does not seem to be much trouble when the doctors are summoned to give evidence by private parties. Many a time, cases of accidents, of poisoning and of serious injuries in criminal cases are brought to the rural practitioners for

treatment. These practitioners will be quite justified in a way to refuse treating these cases unless the police assure them that they will be paid sufficient 'rates' when called upon to give evidence at Courts on the strength of the existing G. O. No. Mis. P. H. 811 dated 27-4-1927 which says:-

"If the rates paid to them are in their opinion insufficient, they should be advised not to take up cases involving their attendance at Courts unless absolutely necessary."

The Government must have forgotten while framing this G. O. that the treatment of cases precedes payment of 'rates at Courts' and the last three words 'unless absolutely necessary' give rise to the necessity of using discretion, by whom it is not mentioned in the G. O. So the rural practitioners are likely to be hauled up by somebody or other if, in their opinion, 'to take up cases' was 'absolutely necessary'. This apart, the rural practitioners like others in the profession cannot refuse treatment to anybody, and if they do so, they will be liable to be reported to the medical council for such default. Under the circumstances, the Medical Council is bound to take up this matter and get justice done to the medical practitioners in the matter of Travelling Allowance and Batta. In the meanwhile, we will suggest to the rural medical practitioners to authorise the Secretary of their Association to address the Surgeon General immediately on this subject requesting the Surgeon General to bring to the notice of the Government the desirability of having a uniform scale of Travelling Allowances and Batta for rural medical practitioners, especially as these are not treated as servants of Government or employees of local fund nor treated with the status of Independent Medical Practitioners when it suits the purpose of those who wish to get services from these practitioners but do not care to pay for them. Though we are of opinion that all practitioners whether in Government employ or in private practice should be treated alike in the matter of payment

of T.A. and Batta while called upon to give evidence in their professional capacities, whether it be for Government or for private parties, we will for the time being suggest a practical solution and that is that the Government should pass a G. O. calling upon the Judiciary that for the purpose of giving evidence in Government cases, the rural practitioners should be treated as 'second class' with regard to their status in life.

We learn that the Surgeon General with the Government of Madras has communicated a memorandum on or about the 29th March 1930 to the District Medical Officers intimating to them amongst other things regarding the treatment of Policemen in medical institutions, that they should always be sent to the nearest Government, Local Fund or Municipal Hospitals in charge of Gazetted Medical Officers. We are not concerned about other details contained in the memorandum except the remark of the Surgeon-General that the Gazetted Medical Officers alone should treat the Policemen. Some of the Government, Local Fund and Municipal Hospitals are in charge of non-gazetted medical officers and if these are found fit to treat the public in such institutions, it is beyond anybody's comprehension why the Policemen alone should have invidious distinction in the matter of medical treatment. Those that are in service cannot but swallow this gratuitous insult. If any of the non-gazetted officers were found wanting in the matter of treatment to policemen, the Surgeon General can surely apply a better remedy than a generalised insult of the nature implicated in this memorandum. We hope that the representatives of the medical men who cannot generally aspire to be Gazetted Medical Officers would raise up this question in the Medical Council as such a treatment will not be tolerated in the medical profession in any other civilised country in the world.

As mentioned in our editorial columns in the last issue, we learn that work is going on briskly regarding re-shuffling of the Departments of Anatomy, Physiology and Hygiene. The necessity of transferring the Anatomy Department elsewhere seems to be on account of want of space for this Department in the place where it is at present, especially as another Department of Embryology has been added on to it. We are afraid that the cubical space occupied by the physiology department is much less than the space now occupied by the Anatomy Department where it is at present and that there will not be any extra space for the contemplated embryology department in the upstairs premises where the Anatomy department is now to be shifted. This apart, the verandahs outside the main hall in the upstairs premises where the Anatomy department is to be now shifted are unsuitable for the purpose of dissections for which they are now contemplated, as these verandahs are unprotected from the sun and the students will necessarily feel most uncomfortable, being exposed to the sun for the major portion of the day.

In this connection, it will not be out of place to bring to the notice of our readers the condition of the new buildings in the General Hospital extension, to convince them that the authorities are not usually alive to the sanitary and other principles involved in the shifting of buildings and will justify our fears that the same history will repeat in the reshuffling referred to above. The rule that is being strictly enforced in all progressive communities to prevent over-building, laying down that not more than 2/3 or 3/4 of the site must be built upon and the remaining 1/3 or 1/4 should be left as an open space, has been violated with regard to the extension scheme of the General Hospital which is full of sick and infirm, though such a rule ought to have been observed in detail in case of a hospital which is full of sick and infirm patients.

Not only does it appear that the site is being over-built, but that the

height of the buildings and their proximity to each other, are such as to bring them within the category of obstructive buildings, not only obstructive of light and ventilation of the neighbouring wards, but on a large scale cutting off the free flow of air from the south east to the adjoining parts of the town. At present there are gaps in the General Hospital and Medical College buildings which allow of a considerable free flow of air towards the very congested streets of Park Town, even if the Railway Offices do cut off a good deal of it. The new buildings that are being erected will in effect present a solid barrier against perflation from the southeast and the prevailing breeze will not reach the crowded streets that so badly need them.

The neglect of these sanitary principles is, however, nothing when compared with their action in the matter of erecting a cowshed in the hospital compound in a corner which is already congested and any amount of special pleading will not get over this sanitary sin. A cowshed however clean is an evil, and no cowshed can be kept so clean as not to be a nuisance for a considerable period during the twenty four hours. Even in western countries where cowsheds are lined with vitreous tiles and resemble operating theatres the tendency is to remove them ever further from the towns into the country.

Government buildings are not amenable to local bye-laws and regulations; they are a law to themselves!

Sanitary conscience of Government Departments appears to be asleep and needs waking up.

It is most regrettable that the Government have thought it fit to delete Clause 7 in the form of Agreement appended to G. O. No. 1994 P. H. dated 20-9-1925 wherein the subsidised rural medical practitioner had power to engage and maintain and employ a midwife in his dispensary, the Government paying Rs. 100 as an additional subsidy to the rural medical practitioner for the services

of such midwife. Later, another G. O. was passed, No. 942 P. H. dated 6th April 1929, enhancing the subsidy of the midwife from Rs. 100 to Rs. 300 per annum, and the Government directed that the subsidy due to the midwife should be paid by the Taluk Board direct to the midwife instead of through the rural medical practitioner as mentioned in the previous G. O.

We are at a loss to understand what made the Government to remove the power of appointment of the midwife from the Rural Medical Practitioner and vest the same in the Taluk Board. Does the payment of a higher subsidy to the midwife incapacitate the rural practitioner from exercising his discretion in the matter of choosing an assistant to work under him. A midwife will not have enough work to engage herself all time, and it will not be possible under the altered circumstances for the rural practitioner to control the midwife and exercise discipline over her. As such, it will not be possible for the rural practitioner to get from the midwife any assistance at the dispensary in the examination of women and children and for dressing them in surgical work etc. The Government seem to have minded more the prestige of the Taluk Board than the interests of the rural medical relief scheme and have thus made the Rural medical Practitioners realise the fears that the rural medical relief scheme is after all an eye-wash.

The Government have recently inaugurated a scheme for the training and employment of Nursing Orderlies in the State Hospitals, and sanctioned a monthly pay ranging from Rs. 15 to Rs. 35 in the Mofussil and Rs. 20 to Rs. 40 in the City of Madras. The scheme is really a good one, but in this and other matters of medical relief, the Government concentrate their attention regarding the welfare of the patients in the State Hospitals only, as if their responsibility ceases with the few that are treated in the Government institutions, without minding their responsibility towards those treated outside State Hospitals. It would have been a well thought of and comprehensive scheme in case the Government paid stipends especially in the initial stages, and trained a

large number of such orderlies so that they could be available not only for Government Hospital service but also for services of the public both in the hospitals and outside.

We have received a communication from Dr. Jivaraj N. Mehta, M.D., M.R.C.S., expressing disappointment at the resolutions passed at the Simla Medical Conference, which we regret we are unable to publish in full in these columns, due to want of space. We however give below a summary of the important points dealt with in this communication for the information of our readers.

He is of opinion that the composition of the Conference was unsatisfactory in that the independent medical profession was not represented. The resolutions passed at the Conference were not circulated to the Universities which were called upon to send their representatives and the hurry with which the Government have rushed through the Conference before the Simon Commission's recommendations and their bearing on the enlistment of European officers in this country, particularly in the Army could be understood, seems to be not without significance.

The Conference has adopted a very strange recommendation by which distinguished medical practitioners who may have no teaching experience to their credit though they may be useful to the profession in ways other than those concerned with teaching, will not be eligible for election from the Registered Medical Practitioners' constituency. The harmful effect of this recommendation would be that three-fourths will be Govt. officers as almost all the medical institutions are entirely staffed, with very few exceptions, by Govt. Officers. With the help of a council which would predominantly be an official body, it would be rendered comparatively easy for a large official control over the independent profession.

One other important resolution passed at the Conference is that by which the Govt. of India have been requested to ask the Secretary of State to so amend the rules as to permit of the recruitment to I.M.S. the holders of Indian degrees without the necessity of their qualifications being registrable in England. This resolution does not preclude the holders of British qualifications from continuing to hold appointments in this country. If the independence of the proposed All India Medical Council is to be real and genuine and not a mere eye-wash, no person not holding a medical qualification registrable in this country can ever possibly hold any medical appointment in this country, either Civil or Military.

His views are really commendable except that he has totally forgotten about the largest bulk of the independent medical profession not holding university qualifications and about whom we have referred at length in our editorial columns.

THE MYSTERY OF THE POLYPEPTIDES.

Fischer devised a means of combining molecules of similar or dissimilar aminoacids with each other, and when he obtained a pure substance containing in a single molecule many amino acid groups, he called the product a Polypeptide.

When proteins are subjected to prolonged digestive processes by enzymes, acids and alkalies, if the action is carried far enough, that is much beyond the stage at which the usual peptones are produced, then substances are obtained which present certain similarities to Fischer's Polypeptides.

Although there is no proof that any of these ultra digested proteins are constituted exactly like Fischer's Polypeptides, the similarity is so great that by common usage both classes of products are called by the same generic term.

Polypeptides are possible in millions of different forms. Chemically they possess so many properties in common that one can hardly be distinguished from another without submitting them to some destructive process. Physiologically each one is different from and distinguishable from its nearest relation. No two Polypeptides give exactly the same physiological responses.

From the nature of proteins and from the variability of enzyme action according to Hydrogen Ion concentration, temperature, time etc., it is not possible to produce invariably the same Polypeptide from a given protein experimentally. Nature may succeed in performing such a miracle because she can distinguish infallibly one from another, and direct (within the limits of healthy function) the process for the formation of one Polypeptide or another.

The scientist can often separate active principles in a pure state, because they possess distinctive properties by which they can be recogniz-

ed, but the Polypeptides are best left to nature.

So far as concerns young persons, with a vigorous metabolic functionment, any protein mixture will nourish provided it contains the necessary aminoacids (and some times even, as usual with infants, the aminoacids themselves may be different from those required).

In the treatment of deranged gland function on the other hand, in so far as this can be corrected by assistance to the nutrition of the gland, experience amply demonstrates that the gland substances provided should have suffered as little change as possible between the time of collection and the time of administration.

We have heard of some manufacturers who claim even to leave the water content unchanged, which, of course, is absurd. The water may be present, but in a changed position, which involves a changed function.

In the preparation of opocrins we have the best ideal attainable in practice. That is the original gland substance in its original condition, all except for the quantity of water, which is extracted under conditions as to temperature, freedom from bacterial contamination etc. which ensure no change.

Immediately after the manufacturing process is completed, the tablets are carefully coated to protect them from contamination, oxidation and other atmospheric effects.

Opocrin Hepar (tablets), although they contain but a small proportion of those stimulating hormones which act on the blood forming process, yet have a marked effect on pernicious anemia cases, which lasts over a long time, because the nutrition of the hepatic tissue is assisted. As a result the liver has a tendency to resume normal function, so that some permanent curative effects may be confidently expected.

In cases of Diabetes also, where that other Opocrin product, Pancrepa-

tine, is administered numberless reports of their apparently curative effects are received. Countless cases which would ordinarily require continued use of Insulin become either free from their troubles or at least amenable to dietetic treatment without medicine after a few months of taking Pancrepatine tablets with meals.

Pancrepatine tablets give the desired effect in all cases of diabetes but in a small percentage of cases of Diabetes, they may be considered as a specific only second to Insulin, and possessing advantages over that product in all cases except the dangerously bad ones.

These advantages include a total absence of all contraindications, a complete freedom from dangers of Insulin shock, the facility of administering an oral remedy over the daily trouble of injections and comparative laxity of dietetic regime.

Homovir is another Opocrin product which brings frequent testimony regarding its efficacy. Homovir is a pluriglandular product containing all the gland substances commonly deficient in cases of decreased mental and muscular vigour, in impotency and neurasthenia combined with small doses of Yohimbin.

The tablets provide the unchanged gland proteins together with their hormones and Yohimbin, while the injections of Homovir represent the active hormones with Yohimbin. The ampoules require to be free from proteins on account of protein shock.

ON USING SAND INSTEAD OF SALT.

There are a thousand different ways of making a similar mistake. For the sake of an old friendship, or because of cheapness, or because some other products from the same firm have proved good, or because we have observed some temporary benefit, we have many ways of being deluded into using something "just as good".

Of course the "sand" is made to look like "salt" and to taste like it, and may give an ephemeral effect of the same kind. It may even contain some genuine "salt" mixed with it, but how much?

Where a drug is given for the relief of a symptom, the sampling method is a legitimate and necessary procedure.

A febrifuge, a laxative, a sedative and a hundred others can be easily and effectively tried by samples.

But when it comes to testing Arsenicals, why, we might use a substitute for Sulfarsenol, 606 or 914 etc., for years, and not know the final outcome not know whether we had been using "sand" or "salt".

ON KEEPING UP A REPUTATION.

Arsenic by itself, even mineral arsenic in ordinary doses of 3 or 4 mm. of the liquor taken with meals twice or three times a day can often dispel all the symptoms of active Syphilis, because it stimulates the nourishment of the tissues so that it goes on much more quickly than the disease can destroy them.

Arsenic in any form will dispel the symptoms for the time being.

Even a small dose of the ordinary compounds, made up to 0.45 or 0.60 with inert substances for sale at a cheap price, can produce such temporary effect. Sometimes the most useless for antisyphilitic purposes produce the most marked and immediate results owing to liberation of mineral arsenic.

When the symptoms are cleared up the patient goes away and thinks he is better. Then after a month or two or three, the symptoms reappear and he says to himself "That doctor is no good"; so he goes to another doctor. The first doctor does not see him again and never realises that he has lost a patient and what is worse he has lost a little piece out of his reputation. Of course, other doctors are also at the same time dropping their reputation piece by piece and pieces dropped by

one are picked up by another for temporary retention.

The doctor who uses a good preparation giving a permanent effect and a permanent satisfaction keeps all these pieces of reputation which he picks up even though the same patient may not come back to him again for the same trouble, having been cured permanently of that.

There may be cases however, where it might be inadvisable to alter a calcium prescription for a patient who had been long accustomed to another calcium treatment.

For instance, some doctors like Pharmasol Collo Calcium oral A.F.D. for their T. B. cases, and where that has already proven its suitability there need be no urgency to change to another form of calcium.

Also, where a patient has been accustomed to intravenous injections of a soluble calcium salt, its sudden cessation might easily endanger life. A discreet physician will consider each case on its merits.

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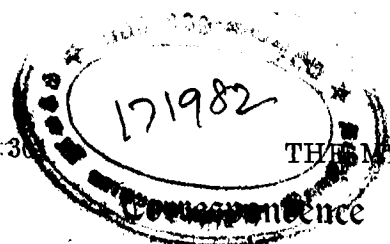
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LETTERS TO THE EDITOR.

Medical Council Elections.

Sir,

I think it would amuse your readers to go through the following facts about the Medical Election held yesterday for electing a member to represent the III group in the Register. The scrutiny and counting of votes began at 11 A. M. in the presence of Dr. U. Rama Rao, Dr. V. Krishna Menon (who arrived about 10 minutes later), myself, Agent for Dr. Sarma and Dr. Venkataswami Chetty, a nominated member of the Council and District Medical Officer, Chingleput, and the Clerk of the Returning Officer.

I strongly objected to the presence of Dr. Venkataswami Chetty as he has nothing to do with the elections but the Returning Officer told me that Dr. Chetty was appointed by the President of the Council to assist the Returning Officer while doing scrutiny and counting.

The Returning Officer drew up a heap of broken covers containing the voting papers and when asked both by myself and Dr. Krishna Menon what they were, he informed us that he opened the covers containing the voting papers on the 24th and 25th as these papers got mixed up with those connected with the election on those two dates and the papers contained in opened covers were the voting papers belonging to the III Group. Myself and Dr. Menon objected to the procedure adopted by him in opening the covers containing the voting papers on earlier dates than that fixed by the Medical Council in the absence of the candidates or their representatives. The Returning Officer replied there was no necessity for him to send for the candidates as he had been empowered to scrutinise the voting papers himself and this he did under instructions from the President, Medical Council who deputed

Dr. Venkataswami Chetty to assist him in this work.

I leave it to you and your readers to judge whether the Returning Officer was justified in opening the covers containing the votes prior to the date fixed by the Council under whatever circumstance. If this could be allowed, there was no need of scrutiny even yesterday, and the Returning Officer might have done everything for himself.

It will not be out of place for me to mention that from the opened covers which contained as many as 824 voting papers, one of the candidates got as many as 822 votes and the same candidate got only 106 from amongst the unopened covers. Those who are conversant with the rules of election will at once realise the deplorable procedure adopted by the Returning Officer in taking upon himself the responsibility of opening the covers containing voting papers. His unwarranted action has naturally given room to grave suspicions. His procedure baffles the very purpose of the election. The Returning Officer was not capable of devising a plan to differentiate the voting papers belonging to three elections without opening the cover containing the votes, which he could have easily done by instructing the voters of the three respective groups to send their voting paper in covers of three different colours, and such covers might have been easily supplied by the Returning Officer to the voters along with the ballot papers. It is really scandalous that on account of the incompetence of the Returning Officer, the result of the elections have to be vitiated. We also saw a large number of unopened covers which we were informed, contained voting papers belonging to the III Group and received by the Returning Officer after the 20th instant. When I questioned the Returning Officer why he didn't open them though he gave clear instructions to the voters in the ballot paper that the last day for the return of those papers was

1930]

28th June, the Returning Officer replied that the date 28th appearing in the ballot paper, was not correct and subsequent to his posting of the ballot paper, he had sent intimation to the voters that the last day for the return of voting papers was 20th June and not 28th June. My argument that he was wrong in not sending such instruction by registered post as he did with regard to the voting papers, could not convince the Registrar though the fact that a large number of voters submitted their voting papers after 20th June conclusively proved that I was right and the Returning Officer was wrong. Yet he refused to open these covers and seems to have sent them to the waste paper basket. We also saw a few voting papers belonging to the 1st and 2nd groups mixed up in the huge bundle of opened covers containing the votes referred to by me above and those belonged to the two elections which took place on the 24th and 25th.

You and your readers must be aware that there is a counterfoil attached to the ballot paper which contained the signature of the voters. The purpose of such signatures must be to find out if the name of the person who signed a particular counterfoil was in the Medical Register. This counterfoil could not be shown to the candidates during the scrutiny, but even the Returning Officer did not verify whether the names contained in the counterfoil were found in the Register though he was asked to do the same. Hence it was impossible for us who went there for the purpose of scrutiny to know whether those who recorded their votes were registered practitioners at all, and even if they were registered practitioners, whether they did not vote more than once.

It would have been most graceful and added to the weight of our protests if the sitting member Dr. U. Rama Rao who was also with us had joined in our protest, but it was most disheartening to us when he mentioned that he didn't care to be present at the scrutiny and counting

of votes during the three previous elections when he was returned to the Council. I was arguing within my mind why he should be present at the scrutiny and counting in this election but my youth and humble position prevented me from opening my mouth with this gentleman. Whatever be the results of the election, I should certainly congratulate those who had the courage to oppose Dr. Rama Rau; for, if there was no contest nobody would have known that there is really something rotten in the State of Denmark. Will not the eminent Doctors constituting the Madras Medical Council diagnose the disease and apply the correct remedy, as it is highly essential in the interest of the prestige of a body like the Madras Medical Council that the elections should be managed in a manner prescribed by the Madras Medical Act and not in the way the present Registrar has been holding them.

NAGABHUSHANAM.

"Pancrepatine A, F. D."

In the Treatment of Diabetes.

Sir,

I trust the following report of a case of Diabetes Mellitus treated with Pancrepatine, A.F.D. will interest your readers. A young man, Hardi Bandhu Pattanaik, an Oriya Hindu aged about 28 years was admitted as an in-patient in the Charitable Hospital, Khurda on 2-9-1929 with the following symptoms:—

- (1) Rapid loss of flesh.
- (2) Frequent micturation 30 or 40 times a day.
- (3) Burning sensation in body, intense thirst, smarting in urethra during micturation.
- (4) Troublesome pruritus all over body.
- (5) Intense vertigo and feeling of extreme weakness and lassitude.

Urine was examined and found to contain 50 grains of sugar per ounce, and a trace of Acetone and Albumen. No deposit on centrifugalisation.

5L
Lsm 211, N30MP N 30.1.10-12

urine clear, strongly acid, specific gravity 10.45. On admission, he was put on the following diet :—

(1) Sags and leafy green vegetables 1 lb, (2) Brown tea without sugar 2 pints, (3) Mustard Oil $\frac{1}{2}$ Oz. (4) Salt $\frac{1}{2}$ Oz, (5) Black pepper $\frac{1}{2}$ Oz. A mixture containing Sodii-bicarb 1 dram, Sodii tart $\frac{1}{2}$ dram, Sodii citras $\frac{1}{2}$ dram and Aqua ad one ounce, was also given to him three times a day. Seven days after this treatment the symptoms improved a bit. Constipation which was very troublesome before was markedly relieved but the sugar contents of the urine did not come down below 30 grains to the ounce. The patient was then starved completely and was given only black tea whenever he felt thirsty and was confined to bed. The sugar came down to 10 grains to the ounce and remained so even after 48 hours of fasting. As he could not stand the starvation any longer, I was forced to put him on the following dietary :—

(1) Coarse Atta 1 Lb, (2) Ghee 1 oz, (3) Green Vegetables 4 Oz, (4) Dal 2 Oz, (5) Milk $\frac{1}{2}$ pint. (6) Egg one, (7) Salts and Condiments to taste, and commenced using Insulin A. B. Brand hypodermically. He required 90 units or $4\frac{1}{2}$ c.c. to keep him sugar free. The Insulin treatment was continued in this dosage for fifteen days, any attempt to reduce the dose brought back sugar in the urine, Benedict's Solution being always used for the Sugar test. I then used Synthelein B (Schering), and with this in combination with Insulin, I could bring down the dose of the latter to 2 c.c. or 40 units, but as Synthelein B upset the stomach of the patient causing severe colic, I had to give it up. I then combined Insulin treatment with Pancrepatine, A. F. D., more as an experiment as I had not had much faith in Pancreas preparation per mouth. The patient was given 2 tablets of the drug after food thrice a day, and with this addition I was able to bring down the dose of Insulin to 30 units contrary to my expectation,

then the dose of Insulin was gradually brought down to 10 units when a slight trace of sugar reappeared in the urine. But instead of increasing the dose of Insulin I increased the dose of Pancrepatine to 3 tablets t. i. d. and his urine was again completely sugar free after about a week. I then completely stopped giving Insulin for the week following when on examination his urine showed presence of sugar. As it was my desire to try the efficacy of Pancrepatine A. F. D., I did not recommence Insulin but increased the dose of Pancrepatine, to 4 tablets t. i. d. and after a week's use the patient's urine was again free from sugar. He was then discharged from the hospital and was asked to see me a month after his discharge, which he did and on examination, I found the urine quite free from sugar and the patient improved in health every way. The diet he was having was (1) Atta 1 Lb, (2) Green vegetables—4 Oz, (3) Meat or, Fish—3 oz, (4) Eggs—2, (5) Milk 2 cups, (6) Ghee—2 oz or Mustard Oil and Salt and Spices to taste in 24 hours and 12 Tablets of Pancrepatine A. F. D. He was also taking a tumbler of cold water early in the morning with $\frac{1}{2}$ a teaspoonful of Sodii-bicarb as advised.

A rigid dietary is certainly to be trusted more than any drugs in the treatment of diabetes, but in those cases where a rigid diet does not appreciably reduce the sugar in the urine, and also in cases where to keep urine sugar free the diet has got to be reduced to the extent of causing the patient lose his health or feel weak, Pancrepatine A. F. D. 3 or 4 tablets, per dose after food which must not be less than the minimum Caloric requirement of the patient is worthy of trial before actually commencing Insulin treatment which is without doubt risky, particularly where facilities do not exist for testing the blood sugar, and the dosage of Insulin has got to be manipulated from the quantity of the urinary sugar only. Of course Insulin is the ideal preparation in cases of Diabetic Coma or in Surgical or

applications. But I suggest that in ordinary uncomplicated cases of Diabetes, particularly where facilities of testing blood sugar do not exist, Pancrepatine A. F. D. is worthy of a trial before commencing Insulin treatment by those who are interested in the treatment of Diabetes.

S. GHOSH, M.B.,
Captain.

B. & O. Provincial Medical Service,
Officer in Charge, Charitable Hospital,
Khurda P.O., (Dt. Puri).

Lessons from the Rayavaram Rural Dispensary Episode.

SIR,

Certain inferences are obvious from the Rayavaram Rural Dispensary episode referred to in your previous issue. The president of the Taluk Board did not either seem to understand the rules governing rural practitioners or did not care to abide by them. In this case the medical practitioner's fault seems to be that he refused to be transferred from his place and the only course left open to the President was to frame charges against the practitioner, two of which could not be considered as charges with any stretch of imagination and the third one was vague and general. No explanation was considered sufficient and the practitioner was eventually sacked. An appeal to Government was unavailing without even a word being said against the President's irregular orders.

This is not the first instance of the 'absolute rule' of Presidents of Taluk Boards over rural practitioners. I know of many such which were not brought to public notice as the present one, for the simple reason that the aggrieved practitioners, had by then got so disgusted with their life and work in the villages that they considered the President's tyranny as the last straw on the camel's back, and they resigned their jobs, without pursuing the matter further. Even as early as 1927, we rural practitioners had grave misgivings about the attitude of these Presidents towards us, and at our first

Conference held in June 1927, had requested the Government to remove from the Presidents the power of dispensing with the services of rural practitioners, and to make provision in the agreement that in cases of breach of the terms of agreement by either party, a third party such as the District Medical Officer, the Surgeon-General or the Inspector-General of Local Boards and Municipalities be deputed to enquire into the allegations and report their findings to Government whose decision will be final and binding on both the parties. The Taluk Boards are never to lose, and it is only the poor rural practitioners that would come to grief whether they go behind the terms of the agreement or incur the wrath of their Presidents. To save an honest dutiful rural practitioner from the tyranny of the local authorities, some such safeguard as suggested above would be absolutely indicated, and I would respectfully request the Government to adopt the suggestion in the interests of Rural medical relief scheme.

VIRAGANUR, } S. RAMASUBBU, L.M. & S.,
Salem Dt. } Secretary,
The Madras Provincial Rural
27-6-1930. } Medical Practitioners'
Association.

RURAL MEDICAL RELIEF

An appeal to the Rural Medical Practitioners of the Madras Presidency.

DEAR DOCTOR,

I hope that you are aware of the fact that there is an Association of the Rural Medical Practitioners of this Presidency, and you might be in receipt of the proceedings of its I and II annual conferences. If you are not aware of the association, even after four years of its existence, it is high time for you to know about it, and I hasten to assure you that you can have the copies of those proceedings from the Secretary of the Provincial Rural Medical Practitioner's Association, Madras (Dr. S. Rama-

subbu, L. M. & S., Viraganur, Salem Dt.)

This association has lived for nearly over four years during which period a lot of silent work has been done. An article on rural medical relief scheme by Dr. S. Ramasubbu which appeared in the first issue of "The Medical Practitioner" will give you a clear idea of the activities and achievements of our association during its existence, copies of which can be had from the Managing Editor of "The Medical Practitioner", 147, Purasawalkam High Road, Vepery, Madras. For instance, the enhancement of subsidy by Rs. 100 a year, which we (L. M. Ps.) are getting now is the result of the hard labour of the united efforts of the Association.

It is quite plain that the association has acquired some momentum, and our united and sustained efforts are needed to stimulate it further. Every thing depends upon our own exertion. Self-help is the best help and you should be never satisfied with the impression that your friends are doing everything for you. You should feel it your duty to give your sincere hand for the association and strengthen it with your moral and material support. If all the Rural Medical Practitioners (about 400 in this Presidency), enlist themselves as members of the association the association will grow in strength and will be able to discharge its duties to the entire satisfaction of every member.

Our association is fortunate in having a very energetic Secretary in the person of Dr. S. Ramasubbu, L.M. & S., Viraganur, Salem Dt., who is sacrificing much of his professional work, time and energy for the common cause of the Association, and I appeal to you to co-operate with him and help him to make the Association a real power to espouse our cause. An annual subscription of Rs. 2. to this association is not very much in consideration of the benefits we receive in return. If every one of us does not make up his mind to enlist himself as a subscriber and send his quota of

Rs. 2 a year, it will be a hard task for the Secretary to run the association with a few members.

As it is not possible for all of us in the Presidency to meet very often, District Associations have been formed in several places and it is highly desirable that each District has its own branch, of course, affiliated to the Presidency Association. I suggest that a monthly subscription of annas four only may be levied to meet the expenses of the District Association. The District Associations should meet at least once a year and communicate to the General Secretary of the provincial Association the subject-matter discussed at the District Conferences. The provincial Association should in its turn organise yearly meetings of the delegates from the Districts and should chalk out a plan of work for the year discussing ways and means to improve our lot in every way not excluding the professional aspect of it.

It will not be out of place for me to mention that we have an excellent medium, "The Medical Practitioner" whose editors have been doing all that is possible for them to bring to the notice of the medical profession, the public and the government the importance of the Rural Medical Relief Scheme, its possibilities to give cheap, efficient medical relief to the masses and the necessity for those who run the scheme to understand the spirit and purpose, for which the scheme has been started. Several of our grievances have been prominently brought to the notice of all concerned and it is our duty to be subscribers of this journal and co-operate with the Editors in their onerous task to make the Rural Medical Relief Scheme a reality.

BELLAMKONDA,
GUNTUR DISTRICT,
2nd July 1930,

C. V. SUBBA, RAO.
L.M. & S., (Hyd),
Rural Medical Practitioner, and Secretary.
Rural Medical Practitioners' Association
Guntur District.

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List of postings of Sub-Assistant Surgeons for the month of June 1930.

Name of Sub-Assistant Surgeon.	From	To
1. Dr. B. Jayaram	Leave	Govt. Tuberculosis Instt, Egmore, Madras.
2. " C. Padmanabha Menon	Govt. Hd. qrs. Hospl., Calicut.	At the disposal of the President, T. B. Chirakkal, Malabar Dt.
3. " T. R. Subramania Iyer	Leave	Branch Dy., Palghat.
4. " K. Krishnamurthy	do	Taluk Hd. qrs. L. F. Dispensary, Podili, Nellore Dt.
5. " V. Venkatrama Doss	Govt. Hospl. Tirupati, Chittoor Dt.	Govt. Hospl. Coujeeveram, Chingleput Dt.
6. " K. Gopalaswamy Ayyangar	Govt. Hospl. Conjeeveram Chingleput Dt	King Edward Memorial Hospl., Secunderabad.
7. " T. Joga Rao	Govt. Hd. qrs. Hospl. Berhampur, Ganjam Dt	At the disposal of the D. M. O., Ganjam for Agency duty.
8. " K. P. Chidambaram	Taluk Hd. qrs. L. F. Dy., Darsi, Nellore Dt.	do do
9. " G. J. Gopalakrishnan	Police hospital, Salem.	At the disposal of the Civil Surgeon, Vizag Agency.
10. " M. Rama Rao	L. F. Hospl. Kurupam, Vizag Dt.	Taluk Hd. qrs. L. F. Dy., Siruguppa, Bellary Dt.
11. " V. Venkataramanjulu Naidu	Taluk Hd. qrs. L. F. Dy., Siruguppa, Bellary Dt.	Govt. Hd. qrs. Hospl., Bellary.
12. " G. K. Kuppuswamayya	Govt. Hd. qrs. Hospl., Chittoor.	Taluk Hd. qrs. L. F. Dy., Chandragiri, Chittoor Dt.
13. " L. V. Jaganatha Rao	Taluk Hd. qrs. L. F. Dy., Chandragiri Chittoor Dt.	At the disposal of the Collector of N. Arcot.
14. " V. Sankararama Iyer	I/C, Leprosy Clinic, Villupuram, S. Arcot Dt.	Calcutta School of Tropical Medicine for training.
15. " G. Subbarayudu	Asst. Lecturer in Physiology Medl. School, Royapuram	do do
16. " M. V. Gopalan	L. F. Hospl. Atmakur, Nellore Dt.	do do
17. " L. A. Ramaswamy Iyer	Govt. Hd. qrs. Hospl., Calicut.	Taluk Hd. qrs. L. F. Dy., Badagara, Malabar Dt.
18. " T. A. Gopalakrishna Rao	Taluk Hd. qrs. L. F. Dy., Badagara, Malabar Dt.	At the disposal of the P. D. B., Malabar.
19. " K. N. Subrahmaniam Ayyar	R. D., Govt. Hd. qrs. Hospl., Calicut.	Govt. Hospl., Palghat, Malabar Dt.
20. " K. P. Sankaran	Govt. Hospl. Palghat, Malabar Dt.	At the disposal of the P. D. B., Malabar.
21. " M. Gopala Menon	Leave	Taluk Hd. qrs. L. F. Dy., Nilakkottai, Madura Dt.
22. " A. R. Venkata Rao	Govt. Hospl., Kanigiri, Nellore Dt.	At the disposal of the I. G. of Prisons, Ootacamund.
23. " P. V. Subba Rao	Central Jail, Vizagapatam.	Taluk Hd. qrs. L. F. Dy., Atmakur, Nellore Dt.
24. " Mrs. Nandama Moses	Govt. Hospl. Ongole, Guntur Dt.	Govt. W. & C. Hospl., Adoni, Bellary Dt.
25. " Miss. L. Borges	Govt. W. & C. Hospl., Adoni, Bellary Dt.	Presidency Jail for women, Vellore, N. Arcot Dt.
26. " " A. Pankajam	Presidency Jail for women, Vellore.	R. D., Govt. Hd. qrs. Hospital, Chingleput.
27. " A. Padamadhan	Sultan's Battery, Malabar Dt.	Govt. Hospl., Manantoddy, Malabar Dt.
28. " S. Venkataswamy	Leave	R. D., King George Hospl., Vizagapatam.
29. " S. V. Krishna Rao	do	Taluk Hd. qrs. L. F. Dy., Giddalur, Kurnool Dt.
30. " P. V. Subba Rao	Central Jail, Vizagapatam.	Govt. Hospl. Kanigiri, Nellore Dt.
31. " S. Thyagaraja Chetty	L. F. Dy., Andipatti, Madura Dt.	At the disposal of the I. G. of Prisons, Ootacamund.

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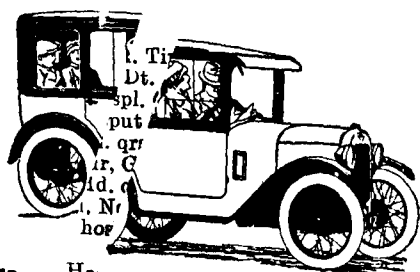
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The Medical Practitioner

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,
Member, Madras Medical Council.

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PUBLISHER'S NOTICE.

Once again may we request our readers to excuse us in not being able to publish even this issue on 15th. The cause of delay referred to here regarding last issue has necessarily set back our work and it may take a couple of months more for us to reach normal conditions.

The Medical Practitioner has just closed the tenth month of its existence. All the qualified medical practitioners in service and outside, of all grades including the members of the I.M.S. must have judged by this time its utility consistent with the object for which the journal was started. We have one month more for the completion of one year. The one and the only sure way for us to gauge the opinion of our readers is the receipt of Rs. 1-8-0 from them which though it will never pay the cost of the journal, will serve to encourage the organisers for continuing their service to the profession with greater zeal and vigour. May we therefore earnestly request you, our kind readers, to be good enough to send your yearly subscription before the close of the year. i. e. October 1930.

MEDICAL PRACTITIONERS' SERVICE BUREAU

Business Notice.

In spite of our special request in these columns, some of the readers of *The Medical Practitioner* are forgetting to enclose stamps for answering their queries. May we respectfully point out that the readers of this journal are over 4000 and it so happens that everyday we have to answer a large number of queries and each reply costs us in addition to postal charges something more. So may we request you readers to enclose stamps for reply without fail

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BIOCHOLINE

An important discovery

NEWS by recent mails from France describe a new treatment for Tuberculosis.

It would seem that so long ago as February this year (1930), Professors Jacques Carles and Francois Leuret published in the "Bulletin del'Academie de Medicine," an article on the treatment of Tuberculosis. They claimed that they had got a percentage of 25 per cent of cures in Tuberculosis using Biocholine in subcutaneous injections, while in the class of patients so treated previously their percentage of cures had never exceeded 4 per cent.

We often hear about such discoveries in the realms of Tuberculosis, but where the Biocholine treatment seems to differ particularly from previous discoveries is in the fact that other workers, besides the discoverers themselves, confirm the reports of Professors Jacques Carles and Francois Leuret, even to the extent of the relative value of the old and the new treatments.

It would appear that the treatment is founded on the finding that where Tuberculosis becomes active the relative proportions of glucose to cholesterin in the blood becomes abnormal, cholesterin percentage being reduced. Biocholine is a specially purified and biologically tested Choline Hydrochloride, which, given as daily or alternate-day injections, gradually increases the cholesterin content of the blood and so disposes of that condition which permits Tuberculosis to become acute.

N. B.—For additional information on the subject, please read page No. 325 of the current issue of *The Medical Practitioner*.

We are eagerly awaiting further news about Biocholine and shall be happy to forward copies of any literature we may receive to any doctor who may be interested.

We suggest that physicians and surgeons who are interested should register their names in advance for immediate information.

Probably only a few copies will be sent from Europe, and reprinting will take some time.

For further particulars apply to:—

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THE Medical Practitioner

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Vol. I]

AUGUST, 1930

[No. 11

THE MALAYAN MEDICAL SERVICE

Comparisons are usually odious, yet many a time, they are useful in arriving at right conclusions. We have at our disposal useful facts and figures regarding State Medical Relief in Federated Malay States, Straits Settlements and the Native States, all the three units of administration in Malay. In the matter of medical relief and all other administrative machinery, the British hold the suzerainty in Malay and as is usual with them they have implanted or trying to implant their own civilization in Malay, of course, keeping the original inhabitants under complete subjugation. We in India are now able at least to talk much, though we have not been able to do as much as we talk. In Malay, freedom of talk is not allowed and it may perhaps take a few centuries to get such freedom, yet if one does not care to know who rules him and how he is ruled, he need not feel sorry to be a citizen or rather a resident in Malay. We shall attempt to give details of the medical administration in Malay as briefly as possible, bringing to the notice of our readers many of the items which are worth introducing in our country. Of course there are certain things in Indian Medical Administration which will be worth introducing in Malay but it will be too much for us to expect the British Government at Malay to listen to us. All the same we hope that a comparison of the two administrations

under the self-same Government who are promulgating different theories in different places and yet claim what they do is the best, will interest all those concerned in the matter of state medical relief whether here or elsewhere. Having said so much by way of introduction, we shall briefly narrate the details of medical administration in Malay.

As referred to by us above, though there are three different administrations in Malay comprising of Federated Malay States, the Straits Settlements and the Native States, the reins of all the three groups are in the hands of the British Raj, and as the Federated Malay States is the biggest of these units, we have for the purpose of comparison concerned ourselves only with the medical administration of Federated Malay States. Here as in the other two units of administration, the Medical Department is under the direct control of an Officer designated "Principal Medical Officer." This Officer resembles in all details the Surgeon General in India and has under him both the Departments of Medicine, the curative as well as the preventive, otherwise known as the Public Health Department. The pay of this Officer is 1,200 dollars which at the rate of Rs. 1-8-0 a dollar approximately works out to Rs. 1800 per mensem, i.e., Rs. 1200 less than what our provincial Surgeon Generals are drawing in India. The grade next to the Principal Medical Officer is that of the chief Health Officer of the rank of

the old Sanitary Commissioner in the Provinces in India and this Chief Health Officer is directly under the Principal Medical Officer as the Sanitary Commissioner was under the Surgeon General here, in olden days. The other graded officers are styled as Medical Officers, Deputy Medical Officers, Assistant Medical Officers and Assistant Surgeons. The appointments are on a time scale pay ranging from 500 to 1,100 dollars in the case of Europeans who are recruited from England and 250 to 500 dollars in the case of Asiatics appointed locally. The European is started as Assistant Medical Officer and the Asiatic with British registrable qualification is started as an Assistant Surgeon. The highest office which the European can aspire is that of the Principal Medical Officer with a pay of 1,200 dollars and the Asiatic that of a Deputy Medical Officer on 500-15-560 dollars. There is no such cadre as the I. M. S. for military service. The recruitment for superior service is just the same as it was here about a quarter of a century ago when no Indian could aspire for the post of a District Medical Officer in the ordinary course, though regarding emoluments, those in subordinate grade get proportionately more than the Assistant Surgeons are getting here even now. The original inhabitants of the place, the Malaysians are very backward in the matter of education and the majority of Officers holding the post of Assistant Surgeons are graduates of one or the other Indian Universities and consequently it has not been possible for them to aspire for more than what has been reserved for them.

Dressers and Hospital Assistants form part of the authorized establishment in the Medical Department. These are usually trained locally. A large number of them consists of compounders from India, and here and there may also be seen Indians holding L. M. P. or L. M. & S. qualifications taking up the post of Senior dressers on a salary ranging from 150 to 200 dollars or very near this amount. The ordinary dressers start on an initial

salary of 50 dollars. Their work is to act as ward dressers, dispensers, microscopists etc., to look after the patients in the hospital and to carry out any instructions that may be given by the Medical Officers, Deputy Medical Officers, Assistant Medical Officers, and Assistant Surgeons etc. They do not at any time act for the qualified medical staff except that that they may be left in charge of out-patients in small dispensaries under the supervision of a visiting Medical Officer.

There is only one teaching institution in Singapore called the King Edward VII College of Medicine which trains students and grants the L. M. & S. diploma. Apart from private students, the government pays stipends for a large number of candidates and recruitment for the post of Assistant Surgeons is restricted to these Government indentured students and when these are not available, outsiders are recruited, many a time temporarily. It will not be out of place to mention that all professors in this teaching institution get a uniform salary of 1000 dollars whatever be the subject they may teach, and there is no such thing as extra teaching allowance.

Two distinct features which are noticeable in the matter of medical relief by the state in Malay are that the unit of medical relief is always a hospital and not a dispensary as is the case in India and that medical Officers in state service are prohibited from having private practice, they being allowed only consultation private practice, the officers of the Assistant Surgeon's grade being denied even this. The medical men in service seem to be, or rather have to be contented with their lot, and being conscious of their limitations and ambitions, are more faithful to their work and could be said to be more responsible to their duties than they would have been if they were allowed private practice. The ideal followed in Malay in making a hospital and not a dispensary as the unit of medical

relief has been a good check towards the medical expenditure, for one has to be more cautious to start a hospital than a dispensary where no responsible work of any sort could be achieved, the popularity or otherwise of the institution having to be gauged by the number of out-patients attending such institutions which could be easily tampered with by unscrupulous men. The net result of these features has been the non-existence of a spirit of exclusiveness between the state-paid and independent medical practitioners and the existence of a vast field of work for the members of the Independent Medical profession. Consequently many European private practitioners have settled in the important towns in Malay and if the people of the land were more educated than they are now, medical affairs in Malay would not have been far behind those obtaining in England or other civilised countries.

Being engaged whole time in their legitimate duties, it has been possible for state paid medical officers to concentrate their undivided attention in medical relief, in a variety of ways and more intensively than we find in India. There are not to be seen so many departments and inter-departments under different heads in the same administration, one Principal Medical Officer being able to manage all sorts of miscellaneous activities, concerning the vital question of preservation of the health of the public entrusted to his care. Apart from the work of medical relief in its curative side, the Principal Medical Officer controls Public Health. The Public Health Department in Malay not only deals with sanitation, preventable and communicable diseases and vital statistics as is the case in India but has other multifarious duties such as Inspection of Schools, Public Health Education, Infant Welfare work including Post Natal and Ante Natal care of women. The administration of Prisons is also entrusted to the Principal Medical Officer and he is the Official head of the Veterinary Department.

What we find in India, especially in Madras, is quite the reverse of what we see at Malay. The Medical Department is divided and sub-divided under different agencies and one usually finds clashing of interests between departments and departments under the same head. There are instances where the work turned out by one is now carried out by two, at times more than two. Even the hours of attendance by the Medical Officers in one or two hospitals have been changed to suit the convenience of its officers who are engaged in private practice. The right of private practice which has been allowed to state paid medical officers in this province is being misused as adverted in the columns of this journal on several occasions, and Officers even in the superior grade are now engaging themselves in the running of private Nursing Homes with the result that these officers cannot devote their legitimate time and energy for the work entrusted to them in the State Hospitals. The contention put forward by these Officers seems to be that they do it more in public interest than with an idea of adding more to their income. We would like those who are responsible for the good medical administration in this province to copy what is being done by the Malay Medical Department in the matter of giving effective and efficient medical relief by opening additional wards in the State Hospitals and equipping them to suit the conveniences of those who go into these hospitals for special treatment and charge them consistent with the convenience afforded to them including individual attention and pay a portion of the fee collected from the patients for major operations to the specialist in charge of such work, in which case, there will be less room for demoralisation and indiscipline and more credit to those who put a stop to the illegitimate practices which are now in vogue among the State paid medical Officers in this province. If private practice is not allowed to state paid officers, they will devote all their attention and energy on the work for

which they are paid by the state, and the work in the medical institutions will be turned out more satisfactorily and with much less cost, there being no need for multiplication of appointments on account of the officers engaging themselves in private work.

The Malay Medical Department has much and even more to copy from India regarding the treatment of the Asiatic staff in the superior branch of the Medical Service. Progress is the rule of existence though its rate may depend upon various circumstances, many a time beyond the control of those who hanker after such progress. Sooner or later it is bound to come. If the progress is hastened unasked without agitation on the part of those who are kept under permanent subjugation even in the matter of doing humanitarian service in Medical Institutions, it will have a most beneficial effect and bring about peace and contentment in the otherwise well administered medical department in Malay. Obstruction to progress, if long continued, is bound to recoil sooner or later. This is the work of nature, some may say, of Providence. In India, years ago, matters were more or less the same or perhaps worse and the spirit of competition in private practice by brother Officers in the same institution naturally led to jealousy even in the distribution of work of service to the patients. But fortunately affairs in Malay are much better and could be easily compromised as private practice is not allowed. The feeling of inferiority for the Asiatic which runs rampant in Malay due to various causes has been mainly responsible for not entrusting the assistant surgeons with more responsible work in the medical institutions and lifting them up to the rank of Medical Officers. We are told on good authority that the Assistant Surgeons are not allowed to do responsible work especially in surgical side in spite of their experience and qualification. Why not permit young energetic medical men who are not allowed even consultation private prac-

tice outside, to do work which they are capable to do instead of make them rust. The work now entrusted to Assistant Surgeons in some institutions can as well be turned out by the Dressers or Hospital Assistants. If these qualified medical men are kept away from their legitimate work, why employ them at all and waste more public funds? There is an awakening everywhere and just like the grains under the weight and pressure of a heavy stone sprout out strong and healthy stalk, any obstruction to progress will bring about a strong awakening, if not immediately, in the course of time, and let it not be said then that the worth of the Asiatic Medical Officers was recognised after agitation. The present Principal Medical Officer, Dr. C. J. Wilson is full of imagination having vast and varied experience and is quite conscious of what is going on outside Malay. And we hope he will soon find his way to satisfy the legitimate aspirations of his Asiatic Assistants. It has been possible for this Officer to lift up one or two Asiatic Assistant Surgeons to the Grade of Deputy Medical Officers and give them a maximum pay of 800 dollars. It will not cost anybody anything more if the Assistant Surgeons are given more responsible work in Medical institutions; and if the present Principal Medical Officer who is likely to be elevated to a still higher and more responsible position in the Malayan Medical Service, brings about these reforms in the F. M. S. medical service before he hands over charge of his present office, he will not only earn the everlasting gratitude of his Asiatic Assistants but will also be able to bring about reforms more easily throughout Malay in the near future.

Dear Reader,

Will you please show your appreciation of the services of "The Medical Practitioner" by remitting the yearly subscription which is only Rs. 1-8-0.

V. Rama Kamath.

HOUSE PHYSICIANS AND SURGEONS

A notice appears in the "Fort St. George Gazette" and newspapers inviting candidates for appointment as house surgeons and physicians in the state hospitals in the city of Madras and mofusil and as demonstrators in the medical colleges at Madras or Vizag. The applicants should be Madrasees and graduates of the Madras or Andhra University. Certain number of house surgeons and physicians would be given a subsistence allowance of Rs 50 each and provided with free quarters if available and all the demonstrators it is believed, though not so stated, will be paid. The maximum age limit is fixed as 28 but exception will be made in rare cases. Appointments of Civil Assistant Surgeons in 1932 and 1933 will be made from among the panel of house surgeons and physicians and demonstrators. At the outset we wish to know whether no house surgeons and physicians or demonstrators for the medical schools are to be recruited from among the L. M. Ps? It is not known why some house physicians and surgeons are to be paid subsistence allowance and not others and how these two classes are to be determined. Is it by communal considerations or by competitive examination or by the pecuniary condition of the candidates or by the usual favouritism? If it is thought necessary that for appointments in state hospitals preliminary practical training as house surgeons and physicians is necessary, is it not all the more so with other candidates turned out from medical colleges and schools who set up immediately private practice? In fact all candidates that are turned out from medical institutions should be appointed as house surgeons and physicians in big hospitals for a period of at least one year before they can be allowed to set up private practice. In America the graduates and other diploma holders are required to serve as interns in hospitals and licensed afterwards to entitle them to set up private practice.

This can be easily arranged in Madras if only paid medical subordinates including assistant surgeons now attached to the city and district headquarters hospitals are all taken away and in their places candidates turned out from medical institutions are appointed as honorary physicians and surgeons. While there is some meaning in recruiting assistant surgeons from among the house surgeons and physicians the recruitment from the demonstrators is meaningless. As far as medical practice is concerned, they are in no way better than raw candidates turned out from medical institutions. As long as there is no early prospect of making the teaching staff honorary and as some members of the teaching staff are not allowed private practice, it may be advantageous to recruit the teaching staff from among the demonstrators. There are about 100 honorary officers in the department and if they are to replace paid men as it is evidently the object of the honorary system, what is the meaning of the panel from which assistant surgeons are to be selected? The Government does not seem to possess any policy with regard to the medical relief of the Province and its actions including the publication of the notification referred to above goes to show that the administration is simply drifting.

Original Articles.

ENDOCRINOLOGY.

BY

DR. M. S. KRISHNAMURTHY AYYAR,
M.B. & C.M.

XI

PITUITARY BODY (contd.)

Pharmacology:

The actions of the pituitary glands are many and differ according to the parts used. Thus the posterior part has actions quite different from those of the anterior. The important actions pertaining to the posterior may be

briefly considered under the following heads.

Vascular system:—The blood vessels contract; the blood pressure rises and the action of the heart becomes slow; the rise in the blood pressure is more prolonged than that produced by epinephrine and the capillaries of the coronary, pulmonary, and the cerebral vessels also contract. The effects last for half an hour. The peculiarity of the action consists in that a second injection given a short time subsequent to the first, produces no effect and there may even be a slight fall in the pressure.

Muscular system:—The unstripped muscles all over the body—intestines bladder, uterus, stomach and spleen are all stimulated and show marked contraction. It is supposed that the action is directly on the muscle cells and not through nerves unlike in the case of adrenaline.

Urinary system:—Though the blood vessels in the body are contracted the vessels of the kidney are dilated and diuresis is caused thereby. The total nitrogen, urea and ammonia are increased while the total nitrogen and iron in the blood are decreased.

Generative system:—The action on the uterus is pronounced and may be said to be specific. The contraction occurs both in the pregnant and non-pregnant uterus. The increase in the volume of milk produced by the action of the pituitary is said to be the result of the contraction of the muscular tissue around the alveoli of the mammary gland and not due to the stimulation of the cells.

Metabolism:—Posterior pituitary causes the lowering of the carbohydrate tolerance and produces glycosuria and polyuria.

The secretion from the anterior lobe is indispensable for life and is related to the growth and development particularly of the skeleton and the sexual organs.

Disorders of the Pituitary gland (ACCORDING TO WILLIAM ENGELBAK)

Anterior lobe:—The hypofunction of the anterior lobe in the preadolescent stage is characterised by defective growth (Lorain-Levi dwarfism), short stature, small extremities, acromiaria smallness of the extremities, hypoplastic sex glands, large upper teeth, defective mentality, sterility and impotence, subnormal temperature, slow pulse, hypotension, normal basic metabolic rate and carbohydrate tolerance. In the postadolescent stage are found defective growth except long bones, normal or increased stature, small extremities, gonad dysfunctions as amenorrhea or metrorrhagia, upper teeth large and separated, average mentality, sterility and impotence, subnormal temperature, slow pulse, hypotension, normal basic metabolism and carbohydrate tolerance.

The hyperfunction in the preadolescent stage produces gigantism, normal or eunuchoid giant, large and prominent extremities, bones long and slender, large and well developed gonads, upper incisors large and separated, excessive growth of hair especially on the body, mentality indefinite and apathetic, normal sex activity, pulse, temperature and blood pressure normal. The over function in postadolescent stage is characterised by acromegaly, short stocky and stooped body, tarso longer than extremities, extra large feet and hand, prognathism, clubbed fingers, bones short and thick, large and well developed gonads, separation of the upper incisors constant and lower frequently, overgrowth of hair obtains especially in extremities, bright mentality, talkative, sex activity increased, pulse, temperature blood pressure normal.

Posterior Pituitary:—The chief signs and symptoms of the hyperaction of the posterior pituitary are greatly thickened nose, prominence of the superciliary ridges, tendency to increase tufting of terminal phalanges, coarse heavy and overhanging eyebrows,

Diagnostic tests

tendency to excessive growth of hair, protruding thick lips, enlarged tongue, overgrowth of bony structures (gigantism before puberty and bone deformities later) widely spaced teeth, enlarged sella turcica, hypertrophied thickened and wrinkled skin, hypertrophied nails, short and square hands, diminished carbohydrate tolerance, impaired vision, amenorrhea, headache which is frontal and temporal extending to the vertex and never the entire head and it is accompanied by vertigo, dull mentality, and increased basal metabolism.

The hypofunction is characterised by adiposity, small and atrophied sex organs, fat pads around the malleoli, increased development of the mammary glands, deposits of fat around the buttocks and the neck, alabaster like skin, amenorrhea, slow pulse, sluggish mentality, short stature and failure of development, low basal metabolism, increased carbohydrate tolerance, childlike voice, fatigability, sterility, irregular menstruation, subnormal temperature, polyuria, lack of hair growth, infantile uterus, low blood pressure, absence of half-moons in the fingers, small black moles all over the body, spaced and underdeveloped upper lateral incisors, tapering of the second and third phalanges, thickening of the basal phalanges, hypertrophy of the nails and headache which is splitting.

Anterior and posterior lobes:—Hypoactivity of both causes Frohlich's type (Dystrophia Aedeposs genitalis) with or without polyuria while hyperactivity produces gigantism or acromegaly with increased basal metabolism and decreased sugar tolerance with no adiposity.

Hyperactivity of the anterior and hypoactivity of the posterior lobe cause gigantism, acromegaly with polyuria while hypoactivity of the anterior and hyperactivity of the posterior cause genital aplasia, nanism, amenorrhea with pituitary glycosuria, increased metabolism and decreased sugar tolerance.

1. Carbohydrate Tolerance test:—Weigh the patient. Multiply this weight in pounds by 0.8; the result is the number of grams of dextrose with which the patient should be fed in the morning, without breakfast. It is usually given in the form of lemonade. Test the urine for sugar at hourly intervals four or five times. If no sugar appears, i.e., if there is an increased carbohydrate tolerance, the case is likely to be one of pituitary sluggishness, and it indicates that pituitary is in order.

Just as increased carbohydrate tolerance is suggestive of hypopituitarism so a very low sugar tolerance is indicative of the opposite condition—hyperpituitarism—and not infrequently there may be glycosuria.

Cushing's Thermic reaction:—This test consists in the hypodermic administration of a solution of pituitary (anterior lobe). If the patient's pituitary activity is insufficient, there will be a distinct rise of temperature and possibly sweating.

Ocular changes:—Because of its location at the base of the brain, a definite increase in the size of the pituitary gland may produce various eye symptoms. There may be bitemporal, hemianopsia with the outer fields of vision impaired. There may also be ocular palsies or alterations in the colour vision. In well advanced tumours, epileptoid attacks known as uncinate fits may occur.

Sellar Radiography:—An X-ray examination of the sella turcica is more frequently of value in a negative than in a positive way.

Therapeutics

Pituitary preparations are administered in the form of desiccated gland substance by the mouth and hypodermically in the form of extracts of the posterior lobe. The anterior pituitary gland is given in 1 to 2 grain doses and the whole pituitary in 1 to 2 grains. Solution of the posterior pituitary

is prepared in ampoules for hypodermic injection. Sublingual administration of either solution, powder or tablets seems to eliminate the danger of personal idiosyncrasy and indicated whenever the stimulation of the smooth muscles is desired. Though "tethlin" the active principle of anterior lobe is isolated nothing is known of its chemical constitution and is not used in therapeutics generally. From the posterior pituitary two different hormones are separated viz. "oxitocin" and "vasopressin". The one contracts the uterus and the other raises the blood pressure; but they have not yet been brought into practical use.

Amenorrhoea.—In the treatment of amenorrhoea when ovarian therapy has failed pituitary treatment may be effective.

Asthma.—Pituitary extract has been recommended for asthma and is said to be slower in its action than epinephrine but more lasting and to allviate not only the immediate spasm but to lessen recurring attacks. Combination of the two have been found to be advantageous.

Bladder retention.—In the retention of the urine and partial paralysis following operations, injection of pituitary solution has been found of value. It is also used with advantage in incontinence of urine and nocturnal incontinence in adults and in children.

Diabetes Insipidus.—Hypodermic injection of posterior lobe extracts often act almost as a specific causing the output of urine to be decreased, raising the specific gravity of the urine and relieving the thirst and the headache.

Dysmenorrhoea.—Posterior pituitary is indicated in cases of utero-ovarian hyperemia and in congested dysmenorrhoea.

Epilepsy.—In such cases of epilepsy which shows pituitary disease, pituitary extract is of marked value.

Headache.—In pituitary headaches which is characterised by its situation

between the temples and deep in behind the eyes the whole pituitary gland is useful.

Intestinal paresis.—In intestinal paresis following abdominal and gynaecological operations and in chronic constipation, pituitary gland is useful.

Labour.—Pituitary extract is very useful in labour but should only be given late in the second stage when the pains have become slow and weak owing to the uterine inertia and in cases of normal presentation.

Menopause.—In the distressing and frequently acute symptoms attending the menopause pituitary therapy is of value.

Menorrhagia and Metrorrhagia.—Pituitary is one of the potent agent in the treatment of menorrhagia and metrorrhagia. If there is no evident cause for menorrhagia or for too frequent menstruation in young girls mammary gland and pituitary gland may be combined.

Sepsis.—In puerperal infection and in all septic conditions posterior pituitary is useful to be given by intramuscular injection.

Shock.—Pituitary extract is a valuable agent in the treatment of and as a prophylactic for shock. One distinct advantage over epinephrine is the longer period say about 8 hours the pressure effect is maintained after a single injection.

Sub-involution.—In acute cases the action achieved is direct and prompt; calcium salts may be given advantageously with pituitary extracts.

Uterine haemorrhage.—Pituitary extract is exceedingly useful in uterine haemorrhage. In post partum haemorrhage pituitarin may be followed by ergot.

Contra-indications.

The general contraindications for the use of pituitary preparations are (a) kidney disease (b) organic heart disease (c) high blood pressure (d) following operations on the intestines

(e) arterio-sclerosis and (f) induction of labour if there is disproportion between the fetal head and the mother's pelvis and in abnormal presentations.

MEDICAL ETHICS

BY

DR. V. RAMA KAMATH,
Member, Madras Medical Council.

Every profession has its own system of principles and rules of duty and the medical profession which is considered to be one of the noblest, if not the noblest profession, has formulated a code of ethics which is the most stringent of the codes now existing. The object of all codes of Ethics is to protect the dignity of the profession and whatever has been inculcated in the Medical Ethics is for the good of the community in whose interest more than in the individual interest of the medical men, the Code of Medical Ethics has been formulated in all civilised countries. The Medical Councils which were brought into existence by statutes all over the world and which in India came into existence only 15 years ago are entrusted with the work that those who by virtue of registration come under the control of the Medical Councils, respect the Code of Ethics published by these bodies. As in the case of the enactment of the Medical Registration Act wherein the framers copied almost *verbatim* all the sections from the British Medical Act leaving out such of the sections in the British Act which would bring the medical profession to the same prominence of public utility as that obtaining in the British Isles, the Medical Councils in India, especially the one at Madras has copied the Code of Medical Ethics as published by the General Medical Council of the United Kingdom with no regard to the local conditions. It is common knowledge that the Ethics as published by the Madras Medical Council is observed more in its breach, for it never suits the local conditions. Those who were responsible to publish the Code of Medical

Ethics in the United Kingdom and elsewhere did so, basing upon their experience of the state of the society with whom the members of the medical profession have to deal and the working of the sections of the Medical Act, and it took them years before they published such a code with the authority of law. What the Madras Medical Council has done was to foist on us a code of Medical Ethics by passing a comprehensive resolution which adopted the British Code of Medical Ethics without considering whether such ethics was compatible with the existing conditions in Madras, and it is no wonder that nobody feels the existence of any ethics at all in the medical profession. It has been repeatedly mentioned in the columns of *The Medical Practitioner* that those who are responsible for the running of the Medical Council in this province are callous and negligent in the matter of running the affairs of this Council, and if these continue in the manner they do now, time will not be far when attempts will have to be made to repeal the Medical Registration Act, as this enactment is more a barrier to the progress and prosperity of the medical profession. Attempts are being made to wake up the authorities to their sense of responsibility as it is next to impossibility to wake up the medical professional least, for some years till it grows into a homogeneous community instead of the now existing heterogeneous mass with air-tight compartments regarding qualifications status etc., on account of the existence of a distinct group of state-paid practitioners.

If the Medical Council has a distinct majority of members not holding Government appointments, the affairs of the Council would have been quite different from what it is to-day, and we would have had a code of Medical Ethics consistent with the needs and wants of the profession.

Herebelow I have enumerated the main items regarding medical ethics published by the Madras Medical Council for the information of the

registered medical practitioners, and I shall deal with each of them in the next issue bringing to the notice of the profession alterations necessary to suit the Indian conditions, and shall with pleasure publish in the columns of this journal any suggestions from the members of the profession regarding the modifications that should be brought about in Medical Ethics in the interest of the profession, without affecting its dignity in the least. I appeal to all brethren in the profession to help me and co-operate with me in this task so that I could voice their views before the Medical Council with some authority when this subject is likely to be discussed before the Council at my initiation early in October.

The main items dealt with in the code of Medical Ethics as published by the Madras Medical Council are the following:—

- (i) Advertising and Canvassing.
- (ii) Certificates, notifications, reports etc.
- (iii) Unqualified Assistants and covering.
- (iv) Association with unqualified persons.
- (v) Deriving pecuniary profit from the sale of secret remedies.
- (vi) Entering into any compact with a Pharmacist to receive a share in the profit arising from the sale of medicines prescribed or medical or surgical appliances.
- (vii) Publishing or sanctioning publication of report of cases or operations or letters of thanks from patients in non-professional newspapers or journals.
- (viii) Keeping an open shop for the sale of medicines, medical and surgical appliances other than prescribed by himself or any other registered practitioner.

(ix) Agreeing to attend on patients on the terms of "No cure, no pay".

The other matter mentioned in the Medical Ethics for the guidance of the practitioners in their relationship

with one another in the exercise of their profession, is as under:—

(1) No member * should meet in consultation any practitioner who is not registered, but this rule does not apply to practitioners who are registered elsewhere and who are temporarily resident in or passing through this Presidency, provided their qualification is granted by a body recognized by the Madras Medical Council.

(2) Every member should endeavour to observe punctuality in consultation appointments. If the medical attendant has not arrived within a reasonable time (e.g., a quarter of an hour after the appointed hour) the consultant, shall be at liberty to see the patient alone, and should leave his conclusions in writing in a closed envelope.

(3) The duty of announcing to the patient's friends the result of the consultation shall be mutually arranged between the medical attendant and consultant.

(4) Differences of opinion should not be divulged unnecessarily; but when there is an irreconcilable difference of opinion, the circumstances should be frankly and impartially explained to the patient's friends. It is open to them to seek further advice either, as is preferable, in consultation with those already in attendance, or with the medical attendant only.

(5) The attendance of a consulting practitioner should cease when the consultation is concluded, unless another appointment is arranged by the medical attendant.

(6) When it becomes the duty of a practitioner occupying an official position to see and report upon a case of illness or injury, he should, as a matter of courtesy, whenever practicable, communicate with the practitioner in attendance, so as to give him the option of being present. The practitioner seeing the case officially should scrupulously avoid interference

* "Member" means a member of the medical profession who is a registered practitioner.

with, or remark upon the treatment or diagnosis that has been adopted.

(7) When a consultant in his room sees a patient at the request of his medical attendant, it is his duty to write to the latter, stating his opinion of the case, with the mode of treatment he thinks should be adopted.

(8) A member entrusted with the care of the practice of a professional friend, during sickness or absence, should not charge either the patient or the absent practitioner for his services, except in the case of a special arrangement between the practitioners.

(9) A member called upon in an emergency to visit a patient, who, under ordinary circumstances, would have been attended by another practitioner, should, when the emergency is provided for, retire in favour of the ordinary medical attendant, but shall be entitled to charge the patient for his services.

(10) When a member is called to a case of *obstetric* emergency during the temporary absence from any cause of the proper medical attendant, he should cease his attendance when the emergency has been provided for, or on the arrival of the proper medical attendant; but if in the meantime he has assisted at the patient's delivery, or has been detained for a considerable time, he shall be entitled to receive a portion of the fee. Nevertheless the emergency practitioner shall be entitled to attend in a subsequent confinement if asked to do so; but if he has attended at the request of a practitioner, he should obtain the consent of the original attendant before doing so.

(11) When a member is consulted by a patient whom he has previously attended during the course of the same illness at the request of another practitioner, he may propose a consultation with the said practitioner, but should decline to take charge of the case.

(12) When a member is requested to attend a patient already under the

care of another practitioner (the case not being one of emergency), he should decline to do so, except in consultation with the practitioner in attendance or, in case the consultation be not agreed to, until the practitioner in attendance has been informed (in writing, if possible) that his services are no longer desired.

(13) When a practitioner is consulted at his own residence, it is not necessary for him to inquire if the patient is under the care of another practitioner, but if that fact should transpire, the interest of the patient or courtesy may require that the medical attendant be informed of the consultation and its results.

(14) No member should receive commissions from trades-people in return for recommending them or their wares or from dentists for recommending patients, nor should he pay commissions to hotel proprietors, lodging-house keepers, monthly nurses, midwives, or others for introduction to cases.

(15) Members should not permit their names to appear on any premises of which they hold no tenancy, except in widespread country districts. This does not apply to legitimate branch surgeries.

(16) A scale of fees should not be publicly exhibited.

(17) There are no fixed fees in the medical profession, if by that expression is meant a tariff regulated by some recognized rule to which either a patient or a practitioner can appeal; but there are customary fees which vary with the place, the status of the practitioner and other circumstances. Fees are reduceable at the discretion of the practitioner.

(18) There is no rule that medical practitioners should not charge one another for their services, but it should be regarded as a pleasure and privilege to give one's services freely to a professional brother, his wife and children or to a medical student.

(19) The application to patients of new methods of treatment which

have not been thoroughly tested, is an experiment to which medical men have no right to subject them without due cause. Unless the medical man is satisfied that, in a given case, the patient is suffering from a condition which has not been, or cannot be, relieved by the usual means, that there is reasonable prospect of the new remedy affording relief and that it is harmless, he has no right to use the new remedy.

(20) Care should be taken in using or encouraging the use of patent or proprietary foods or medicines; before recommending or sanctioning them the practitioner should acquire some general knowledge of their composition and evidence that their claim to be wholesome and serviceable is well founded.

(21) It is a grave breach of professional propriety for a medical practitioner to take any part in the manufacture, or sale, of a proprietary food or medicine or to have his name in any way associated with it. Medical men should also be cautious how they lend themselves to the puffing of these articles.

(22) A medical practitioner is justified in refusing to continue attendance on a case—

(a) where he finds another practitioner is in attendance;

(b) where other remedies than those prescribed by him are being used;

(c) where his remedies are refused;

(d) where he is convinced the illness is an imposture, and he is being made a party to a false pretence;

(e) where the patient persists in the abuse of opium, alcohol, chloral, or similar poisons.

He is not in any way bound to give up a case because he cannot cure it so long as the patient desires his services.

(23) A medical practitioner is under an obligation to his patient to preserve

his secrets, and in legal matters should, except with the patient's consent, answer questions only at the express direction of the Judge or Magistrate presiding in a Court of law.

A medical practitioner is not bound to answer questions put to him by policemen, solicitors, vakils, or other non-judicial persons.

(24) No medical practitioner should volunteer to give evidence in a Court of law against any person who had been under his professional care. He should only appear on subpoena.

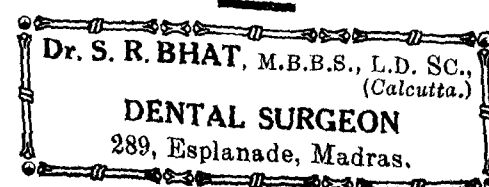
(25) Medical Officers of Health should not ordinarily visit a patient under the care of a medical practitioner without notice and should not express doubt or dissent with respect to the diagnosis before the patient or his friends. A Medical Officer of Health or Sanitary authority ought not to demand a statement of the symptoms upon which a diagnosis of a notifiable disease was based by any medical practitioner.

(26) It is the duty of medical practitioners as citizens to assist cordially in carrying out the provisions of the Public Health Acts especially with regard to the notification of diseases so as to enable the Public Health Authorities to take preventive measures to check the spread of epidemics.

(27) Any member of the medical profession may be called "Dr." by courtesy but no one should assume the title by placing it on his door plate visiting card, etc., who does not possess the doctor's degree of a University.

(28) No medical practitioner should write prescriptions in a private formula of which only a particular pharmacist has the key. Such secret prescriptions are unprofessional.

(To be continued.)



Abstract

TREATMENT OF LOBAR PNEUMONIA BY INTRAPULMONARY INJECTIONS OF PATIENT'S WHOLE BLOOD

BY

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Therapeutic application of auto-genous immunity principles and protective antibodies formulated by pneumococcic infection, has frequently been practised in combating postoperative pneumonia, influenzal pneumonia, and to a lesser degree, lobar pneumonia. To the first of these, autohemotherapy has been applied by intramuscular blood injection; influenzal pneumonia has been subjected to treatment by transfusion of convalescent (immune) citrated blood and by the injection of convalescent human serum; while a few reports testify to the usefulness of intramuscular injection of a patient's blood in lobar pneumonia. The present paper emphasises the feasibility of introducing whole blood (and other appropriate agents) into an apparently unutilised zone, the intrapulmonary tissues.

AUTOGENOUS IMMUNE BODIES

The existence of abundant evidence that human blood serum is endowed with immune substances of varying degrees of resistance, during the course of lobar pneumonia, furnishes the rationale for all modes of treatment and to enhance their effectiveness.

Kolmer states that pneumococci produce small amounts of exogenous toxins, larger quantities of endotoxins and a gross in-like substance "S" (Avery), influencing phagocytosis. Recovery from pneumonia, according to this writer, is due largely to the development of protective antibody, just as the quantities of the various toxins in lung and blood are of

primary importance in prognosis. Kolmer further attributes the favourable effect of antibody solution or serum, upon Type IV infections (for which antibody is lacking), to non-specific protein reaction.

Cole supports Tillet's demonstration of "non-type-specific humoral factors" concerned in immunity to the pneumococcus, but restates his conviction of the relatively greater importance of antibodies specific to the existing type and evaluates most highly, in prognosis, the presence or absence of septicemia. Neufeld and Dochez have shown that when recovery from pneumonia occurs, the patient's blood has acquired the same immunologic factors contained in immune horse serum. It is not unreasonable to suppose, therefore, that insufficient antibody formation and deficient antibody concentration in the blood and pulmonary tissue are the principal factors in pneumonia mortality.

AUTOHEMOTHERAPY

During the past decade, in America, attention has virtually disregarded the natural immunologic substances elaborated during the course of pneumonia. In their stead, interest has been centered upon the typing of pneumococci and production of specific antisera. MacLachlan and Fetter, McGuire and Redden and Ross with Hund reported amazingly good results from the use of convalescent serum, immune citrated blood, and whole blood in influenzal pneumonia. These agents were employed intravenously, during the influenza epidemic of 1918, and have since received little or no attention.

It is to European writers that the possibilities of utilizing the inherent immunologic properties of patient's blood have most appealed. Autohemotherapy has assumed an important part in the treatment of postoperative pneumonia upon the continent, its application having witnessed a gradual restriction from a wide field of infectious diseases, to postoperative

pulmonary infections and pneumonia. The sites of blood injection have been almost exclusively intramuscular and, to a very limited extent, intravenous (defibrinated blood.)

Bellibone in an extensive review of the earliest literature of autohemotherapy, found its chief application in certain types of tuberculous pleuritis. The revival of the procedure by Vorschutz and Tenckhoff and its exclusive application to postoperative and lobar pneumonia have resulted in extensive use of the method, and reports which are generally favorable. Vorschutz and Tenckhoff report 3 lobar pneumonia cases with favorable termination.

The central interest of these and other continental investigators has been postoperative pneumonia, though Rhode and Kaum report success in the application of autohemotherapy to lobar pneumonia. The former states that the method is almost always successful in early cases. Favorable reports upon postoperative cases have issued from Graefe and Schaak. Schwartz used autohemotherapy in 120 cases of postoperative pneumonia and bronchitis. Four fatal cases revealed lobar pneumonia at autopsy. He considered that autohemotherapy has reduced the mortality of postoperative pneumonia 75 per cent. Siegenfeld writes that Elfstamet-Grafstom reported the treatment of croupous pneumonia by intramuscular injections of patient's blood in 1898. Siegenfeld recommended injection of not more than 20 cc. of blood (in order to conform to Schultz Arndt's law). He strongly favours autohemotherapy as a therapeutic agent, but condemns it as a prophylactic. Rausche used the method in a controlled series of postoperative cases, the mortality of the treated cases being 4 per cent, and of the others 18 per cent (alternate cases). He proposes the term "therapy with irritant bodies", and attributes much of its effect to the decomposition products of blood albumin acting upon the vegetative nervous system and the reticulo-endothelial system. He found

that systemic blood pressure was raised and gastric secretion altered by intramuscular injections.

Koning on the other hand, is not convinced of the efficacy of autohemotherapy and considers simple blood-letting as effective. Rieder, in a controlled series, concluded that the blood injections had no effect on the characteristically abrupt temperature curve of postoperative pneumonia, and expressed the belief that the method was not effective in the greater number of cases.

These writers support Vorschutz's theory, that the action of the whole blood, when injected intramuscularly, is dependent upon albuminous decomposition products (globulins, pseudoglobulins and euglobulins), and upon the liberation of specific antibodies in the "division" of injected blood.

INJECTION OF BLOOD INTO CONSOLIDATED LUNG

It is my premise that whatever virtues, both specific and derivative, obtain in whole blood of pneumonia patients, their application to the treatment of the disease is better served by introduction into the diseased pulmonary area than by injection into a distant muscular focus. "Division" of blood must occur as effectively in the former site, and in addition, the direct action of available antibody is obtained where its presence in concentration is most urgently required; i.e., where the toxins and endotoxins of pneumonia are in greatest concentration.

Other advantages of delivering blood in extra measure to the afflicted pulmonary area are:

1. Restoration of the blood supply of the consolidated lung to a volume more nearly approximating that of the normal lung.

2. Increase of antibody volume delivered to the afflicted lobe, in proportion to the increase in blood-supply.

3. A diminution in the increased hydrogenion content of the consoli-

dated lung, by the injection of blood withdrawn from the systemic circulation.

4. A mechanical and irritant action, resulting from the introduction of blood under moderate pressure. This may be thought to facilitate the loosening of fibrinous intra-acinar exudate, and by stimulation of leukocytosis, to hasten its liquefaction.

5. The relief of cardiac embarrassment by withdrawal of blood from the systemic circulation and its disposal in the periphery of the lung, where it cannot materially increase the blood pressure at the hilus.

Accordingly, I have subjected 38 consecutive cases of lobar pneumonia to intra-pulmonary injections of autogenous whole blood. This number is, of course, too small to establish a basis for authentic conclusions, but the experience it has afforded yields observations of some interest. It may confidently be said that this radical method of treatment has not proved injurious. There is, indeed, evidence to indicate that it may be a definite benefit.

TECHNIC.

The skin over the antecubital fossa, corresponding to the side of the affected lung, is prepared with tincture of iodine and alcohol. A tourniquet is adjusted above the elbow, and 20 cc., of venous blood are withdrawn into a Luer syringe. The tourniquet is removed, a small piece of gauze is placed at the site of the puncture, the elbow flexed and the patient turned on his opposite (sound) side by an assistant. The skin overlying the area to be injected is wiped briskly with an iodine and an alcohol sponge. The needle (of the usual intravenous type, 20-22 gage) is introduced to its full length, with syringe attached, through an intercostal space (speed may be assured by using the palpating thumb as a guide). With the shoulder of the needle held firmly against the skin, injection is carried with ordinary pressure on the piston. Should coughing or deep breathing cause movement

of the needle, the injection is immediately halted and the syringe held lightly, to facilitate its counter-movement with the needle point. Unnecessary laceration of pulmonary tissue is thus avoided. If draping of the chest is done, it should be performed by an assistant, in order that the operator's time may be conserved.

In approximately 80 per cent of injections, hemoptysis occurs. This takes place, in most instances, towards the end or after the conclusion of the injection. Should it occur early, the injection need not be discontinued, unless coughing is paroxysmal or distressing (in only three of 216 injections). Pain is seldom severe. Coughing may be entirely absent, or may last for 30 minutes or longer. The patient should be advised that some blood may be expectorated after the treatment. Coughing is, of course, more noticeable in pleural involvement and when opiates have not been employed.

It is important to carry out the entire technic with a moderate degree of speed, to avoid coagulation of blood. Should unusual force be required to complete the injection, it should at once be discontinued. A prohibitive decrease in coagulation time is noted in a small percentage of pneumonia cases.

If delay in technic has permitted coagulation, blood may be withdrawn and injected with a fresh needle and syringe.

ROUTINE INJECTION TREATMENT.

In cases of ordinary severity, one injection a day has been employed. In obviously grave cases, two or more have been given. Logically, it would seem desirable to give three or four injections every 24 hours for the first two or three days in early cases. Unfortunately, very few early cases were available for treatment in this series, the average time of hospital admission or first treatment being 6.2 days after the onset of the illness. Severe cardiac embarrassment, marked dyspnea and distress upon turning,

and profound depression are contraindications. The technic may be carried out without removing a low back rest.

An effort should be made to diversify the sites of injection, in order that different areas of consolidated tissue may be subjected to therapeutics. In lower-lobe involvement, the initial injection is usually made beneath the tip of the scapular angle; succeeding injections in the vertebral and paravertebral lines, above and below this level, in the scapular line (9th and 10th interspaces) and in the posterior and middle axillary lines. In upper lobe disease, injections are made posteriorly; anteriorly in the midclavicular line (2nd and 3rd interspaces, on the right side); in the apex of the axilla; and in the anterior axillary line. If the procedure is well borne, in multilobar involvement, two injections may be made at the same sitting.

With the exception of cough reflex, no definite reaction has been observed to follow whole blood injection. There have been no instances of collapse, syncope, significant pulmonary hemorrhage nor pulmonary edema. Two hundred and sixteen blood injections have been given, without any evidence of injury or deleterious effect.

The needle employed penetrates the periphery of the lung from 1 to 4 cm., depending upon the thickness of the chest wall and the presence of pleural thickening or effusion. Injection has been made through effusions in 2 cases, without incident. Thoracentesis and aspiration was practiced in 2 cases; and, in 2, thoracotomy with rib resection was done for empyema. All of these patients recovered. Experience with lung puncture, thus employed, in pneumonia has not indicated that it encourages the development of empyema nor prejudices its successful treatment.

No complications attributable to the procedure have been witnessed. Three of nine cases brought to autopsy

have revealed from one to three small blood clots in the consolidated lung, indicating incomplete distribution of the injected blood before the onset of coagulation. In the remaining 6 postmortem examinations, no assured evidence that injections had been made could be disclosed in the affected areas.

SUPPLEMENTARY TREATMENT

The principles of supportive treatment have emphasized rapid and complete digitalization; administration of fluids by hypodermoclysis, in toxic and dehydrated cases (especially important in tropical pneumonia); careful attention to nutrition; avoidance of drastic catharsis; assistance in feeding and the use of bed pans; and the exhibition of opiates to insure comparative freedom from pain. Oxygen was not employed.

ANALYSIS OF CASES

Of particular interest is the elapsed time before hospitalization or treatment. This is essentially the same for both groups of cases, a finding at variance with the usual experience. The age of the patient appears to have been more directly related to mortality than was the duration of illness. Of the recovery group, the average age was 24.5 years; while of those who succumbed to it was 37.6 years. Of 12 fatal cases, 4 were admitted in grave and 6 in poor condition; while of 26 who recovered, 2 were considered grave and 9 in poor condition, when first seen. Of the 38 patients, 3 were negroes and the rest Central American natives, a race notoriously unresistant to pulmonary infections.

Attention should be directed to the rather large number of complicating diseases in both lists. It should be borne in mind that the average hemoglobin content of natives of the laboring classes, of the Guatemalan littoral, is seldom over 70 per cent. Only unusually severe degrees of anemia are recorded. In the majority of fatal cases, more than one lobe was involved. A further unfavorable factor

in the treatment of pneumonia in the American tropics is the fact that a majority of cases are caused by Type IV organisms, as shown by Clark.

RESULTS OF TREATMENT

Of 38 persons subjected to treatment, 12 died—a mortality of 31 per cent. Of those who died, one succumbed 24 days after recovery from pneumonia, autopsy revealing both lungs clear, the cause of death being multiple (pneumococcal) abscesses of the kidneys. During the years 1922-27, the pneumonia mortality of the Guatemala Division averaged 39.9 per cent.

For comparison, in a recent summary of the effect of the administration of refined, concentrated, specific antibody serum (Felton's), under somewhat more advantageous circumstances, Park et al report a general mortality rate of 27.5 per cent with serum and 33.2 per cent without serum. Cecil and Sutliff, in a similar summary of recent cases in Bellevue Hospital, New York, report a mortality rate of 30.0 per cent in treated cases, 39.2 per cent in untreated cases. The character of the clinical material of the latter series corresponds closely to that reported in the present paper.

COMMENT

It must be emphasized that a larger number of cases than the series here presented is necessary to properly evaluate any method of treatment.

For this reason, no claim can be made in support of the suggested procedure. It is highly significant, however, that injection into consolidated lung can be made without danger. In this manner, solutions of sodium chloride, sodium citrate, Mercurochrome, convalescent serum and pneumococcus antibody solution (Huntoon) have been more recently used by the writer, without untoward effect.

The combined intrapulmonary and intravenous routes probably offer the most effective means of employing specific antibody serums in the treatment of pneumonia.

SUMMARY

1. Intralobar injection of patient's whole blood has been practised in 38 cases of lobar pneumonia without untoward results, and possibly with benefit.

2. The practicability of intrapulmonary therapeutics by suitable agents has been emphasized. *Clinical Medicine and Surgery*.—June 1930.

Notes on Treatment of Diseases.

N.B.—These notes are intended to supplement the treatment given in ordinary text books and neither to be expected nor possible to be exhaustive.

Boils:—Calcium Sulphide 1 gr. in pill 3 or 4 times a day; over the boil ichthyol ointment 15%, if the boils come in successive crops stock anti-staphylococci Vaccine is better than autovaccine. The injection of colloid manganese is useful; if all these fail emetine hydrochloride 1/3rd. of a gr. every other day by injection. The boils should not be allowed to scale; sugar and soap washing is good (*Leonard Williams*) Pharmasol Trimine (A.F.D.) consisting of colossal manganese, Ferrum and Zinc is of great value in increasing the efficacy of vaccine treatment.

2. The surface of the boil should be painted with Silver nitrate 20 gr. to one ounce. Ext. Belladonna and opii to relieve pain Ichthyol 1 dram, Emplastrum Plumbi and Emplastrum Resinae each drams 2 to be applied over the part. Inject a few mms. of a 5 per cent solution of phenol into the apex of the boil. For the boil in the ear, the best dressing after washing with hot water is Iodoform grs. 4, menthol grs. 2, petrolatum dr. 1, and smear this with cotton wool and insert it into the ear twice a day (Hare).

3. The following may be applied over each boil; boric acid 4 parts, precipitated sulphur 4 parts, carbolic petroleum 30 parts; Hematoxyl 1 pill

with water after each meal is good (*Joslin*).

4. For boils in the lips not ready for the operation, the following plaster may be applied; emplastrum diachyti ounce 2, emplastrum saponis 1 oz. Cerae japonicæ $\frac{1}{2}$ dr., petrolati 2 drams and acidi salicylic 1 dr., this gives instantaneous relief if applied till the core comes out (*Practical Medicine*).

5. In old persons injection of Pharmasol Manganese (A. F. D.) or emetine chloride is good; externally an ointment of glycerine and ichthyol in equal parts (*Leonard Williams*).

6. Remove the pointing heads by forceps and paint the boil and surrounding parts with formalin 10:100 dilution of 4.0 per cent of formaldehyde.

7. Stannoxyd (A. F. D.) internally in the form of tablets or liquid or externally in the form of ointment has very good effect.

8. To abort boils the following ointment is to be applied both morning and evening, mentholi gr. 15, ung. belladonna 2 dr., ung. iodox 2 ounces.

9. In summer boils particularly in children, hypodermic injection of sodium cacodylate given on alternate days is recommended, not more than 4 injections are necessary (*I. M. J.*)

10. Besredka's anti-virus is satisfactory for local application; strips of gauze dipped in the anti-virus are bound over the pustule. Salicylic soap plaster or lead plaster is good for causing rapid masceration of the skin before the boil is opened; for boils in the scalp remove the hair or cut it short and apply cloths wet with ichthyol (*Indian Medical Digest*).

11. Bacteriophage subcutaneous injection on two successive days of 2 c. c. of lysed filtrate containing the bacteriophage (*C. M. S.*) or Bacte-pyophage (A. F. D.) composed of Bacteriophages specially adopted to dissolve the germs is very good.

12. Manganese butyrate 1 per cent solution to be given from 1 to 1.5 cc. at 4 or 5 days interval; the boils were cured even in such cases in which the

blood sugar is not too high (*Journal of Chemo-therapy*).

12. Pharmasol Stanocol (A. F. D.) colloidal Tin Hydroxide works well in the case of boils due to Staphyococcal infections.

Bubo:—A small incision is made and the matter is allowed to escape. Two days after an injection of Mercier's solution 1 to 1.5 cc is given and the nozzle is kept in the incision for a minute; every two days the injection is to be repeated and on the whole 5 injections are required. Mercier's solution consists of Iodoform 10 parts guaiacol 10, Eucalyptol 10, Alcohol 95 per cent 10. Balsam of Peru 30 and Ether 100 (*J.A.M.A.*)

Diagnosis, Therapeutics etc.

Tubercular meningitis in children:—Brudzinski's neck sign; this appears earlier and is more constant than Kernig's or Babinski's signs; it consists in lifting of the hand with the elbows flexed, on bilateral pressure applied below the zygomatic process.

2. Pubic sign:—It consists in drawing back the legs when compression is applied to pubis (*J.A.M.A.*)

3. Kernig's sign:—With the thighs flexed at right angles over the abdomen, the leg can be extended upon the thigh as straight as possible, if not meningitis is present.

4. Brudumi's sign:—Flexing the head on the chest causes flexion of the legs and hips and knee joints and flexing of one leg on the trunk produces the same movement on the other leg.

5. Contra-lateral sign:—This occurs in infants and young children, when passive flexion of the lower limb is made on one side, a similar movement takes place in the opposite side. This sign consists in an involuntary flexion of the legs at the hip and knee joints when the patient's head is flexed on the chest (*Blumer*).

6. Pandy's reaction:—One drop of spinal fluid is mixed with several cc. of a six per cent solution of phenol in a test tube when a bluish cloudiness will appear at the point of junction in a few minutes (*Scherer*).

7. Mercuric chloroide test:—If one cc of spinal fluid is added to one cc of three per cent sulpho-salicylic acid and to another one cc of spinal fluid a like amount of one per cent of mercuric chloride is added then in tubercular meningitis, the protein which settles down on standing 24 hours is more voluminous in the mercury tube whereas in epidemic menengitis it is more voluminous in the sulpho salicylic acid tube (*Barker*).

Miliary tuberculosis in children:—The development of phlyctenules in the conjunctiva and especially at the edge of the cornea is a definite sign.

2. The small papular tuberculide of the skin is quite common during the first few years and is a reliable sign. Excessive hair on the back and extremities and long and curved eyelashes (*Scherer*).

3. Intestinal colic and ear-ache in children is differentiated as follows:—In intestinal colic the lower hip is drawn in, the hands clenched, the legs drawn up and the body stiff and bent forwards. In ear-ache the child will pluck or rub at the ear, borrow the head on the pillow and arch the body backwards.

TREATMENT OF TUBERCULOSIS BY BIOCHOLINE

BY

M. M. JACQUES CHARLES AND
FRANGO IS LEURET.

The study of the conditions of resistance to bacillary infection in an organism, leads one to think that the inaptitude to contract tuberculosis or to suffer evolutionary tuberculosis is dependent in man and animal on a fixed chemical state in the blood.

As a result of the analysis of more than 100 samples, in the blood of

man and animals experimented upon, the makers think that the resistance to tuberculosis is dependent on the equilibrium of the ratio of GLYCEMA CHOLESTEROLEMIA.

Everytime that this ratio, changes, especially by the falling off of the Cholesterine, tuberculosis takes an active and grave form.

Every time the Glycemia changes, the Cholesterolemia lessens as if, in order to maintain a normal rate in the blood, the Cholesterol had need of concentration of a determined sweetness,

On the other hand, every time that one sees a tuberculosis showing spontaneous tendencies towards its cure, one notices a normal glycemia and an appreciable increase of the ratio of Cholesterine in the blood which often goes beyond the normal and which in any case exceeds the limit of simple physiological variations.

Starting from this basis we have tried for many years to increase by different means the rate of Cholesterol in the blood without lessening in any untoward way the glycemia necessary for the upkeep of the Cholesterolemia.

We have been driven to abandon successively the ingestion of Cholesterine and the injection of Cholesterine which remains in large proportions at the injected spot and which is practically not utilised; and in the process of pharmacological researches we have been led to use Biocholine in subcutaneous injections.

It is a simple, painless and inoffensive medicine, which used in doses of 2 Centigrammes every day of every two days, continuously and without interruption, brings a steady, regular and important increase of the Cholesterolemia without modifying the glycemia.

This chemical modification of the blood is accompanied by particularly impressive clinical results whatever may be the kind of tuberculosis under treatment, and even in the case of

evolutionary and ulcerous pulmonary tuberculosis and in desperate cases which, treated with this method as a last resource, have shown unexpected improvements, now and then important, even to the increase of life for several months against all hopes.

In current cases this method gives in a few weeks real clinical cures even in open pulmonary tuberculosis.

In every patient under this treatment one sees in a few weeks the temperature becoming stable about normal, the cough and expectoration diminish and even disappear, the appetite comes back sometimes intense anemia decreases, the intestinal functions improve, weight increases with a marked rapidity reaching sometimes 1 Kilogram, per week.

Besides, all the patients experience a sensation of Euphoria which leads them to demand energetically the administration of the medicine when for any reason it has been stopped. The best and most striking results are of course obtained in external tuberculosis. Tubercular Glands get soft, fistulous and healed in a very short time.

It is the same with cold ulcers which though running for several months get healed.

Up to the present time, we have 32 observations of various tuberculous infections out of which we may count eight clinical cures some of which date from over a year and still keep up. Of these eight cures two are of grave open pulmonary tuberculosis cured without sanatorium treatment, and without accompaniment of any other treatment. Besides these eight cures there are ten cases of important and unexpected improvements considering the gravity of the cases under treatment.

The method advised here gives therefore a percentage of nearly 3 per cent of clinical cures and numerous improvements. It is inoffensive

even in Hemoptoiques and in most advanced cases it is generally useful.

We have still several patients under treatment. All the observations are to be published *In Extenso*.

TREATMENT OF DIARRHOEAS OF ALL SORTS, DYSENTERY, INTESTINAL FERMENTATIONS, ACUTE AND CRONIC ENTERITIS, MICRO-MEMBRANOUS ENTEROCOLITIS. ETC.

Dr. Doumer, Professor of the Medical Faculty of Lille, France, has shown that the treatment of intestinal fermentation, diarrhoea and enteritis by lactic ferments is so frequently ineffective, because there is not introduced together with the ferment, any substance upon which the ferment can develop and so indefinitely proliferate in the large intestine.

It is not sufficient, as Metchnikoff thought, to introduce lactic ferments in abundance, it is indispensable to add a product to confine their activity.

Now, the necessary product for the development of lactic ferments is starch, but unfortunately it has the great inconvenience of being completely transformed in the primary portions of the digestive tract and only rarely arrives intact in the intestines. Professor Doumer conceived the idea of coating the starch granules with a sufficient thickness of paraffine, melting at the proper temperature, which would allow the starch to arrive intact in the intestine. As there is always in the intestine a certain quantity of lactic bacilli, these, provided with their proper culture medium, can proliferate and produce there, an enormous quantity of ferment.

Numerous experiments were carried out by Professor Doumer to control the practice of his theory, and invariably the result obtained were undeniable.

The following are his conclusions published in an article in the "Gazette des Hopitaux".

"In a patient where intestinal tube was the seat of very intense putrid fermentations and who, after various treatments, including lactic bacilli, showed no improvement, I gave paraffined starch. After 8 days of regular administration I noticed improvement, the indican, previously abundant in the urine, completely disappeared, and at the same time the stools lost the penetrating infected odour that had persisted for several years".

It was this research that induced other workers to test the method, their results have been published: Thesis by Feron, Articles by Sterne (Nancy), Professor J. Minet, Professor G. Lemonie, M. Gouttiere, etc., and induced us to prepare under the name of AMIDAL DRAGEES, a preparation of paraffined starch ready for use in the treatment of diarrhoeas, enteritis, etc., caused by intestinal fermentation.

N. B.—The Amidal Dragees can be had from the Anglo-French Drug Co., (Eastern) Limited Bombay.

TREATMENT OF TRACHOMA WITH COPPER.

Since the earliest history of Trachoma as a recognized disease, copper preparations of various kinds have been used in its treatment. The only objections to their use have been the pain occasioned by their application and the fact that when the inflammation is acute and pus organisms are present in the secretion, either the copper is liable to be precipitated and thus lose its antiseptic action or else it cannot be used in concentrated forms strong enough to control the condition. For this reason it is usual in such cases to have recourse to that most painful remedy, Perchloride of Mercury. To obtain a copper preparation for Trachoma which should be free from objection, those two difficulties have to be overcome.

Citrates of copper have long been recommended as preferable to the sulphate, but they, like the sulphate, are precipitated by alkaline pus, are usually acid in reaction, and but slightly soluble in water.

In France there has been produced a neutral compound of Citrosyl Boro Cuprate (Trachomol A.F.D.) which is soluble in the lachrymal secretions without inducing either a corrosive alkalinity or an irritant acid solution. Further, the copper remains soluble even in alkaline pus. Trachomol, when applied to the eyelid, proves so free from the incidence of pain that the eye can be opened immediately after its application and the patient can proceed with ordinary duties within a minute or two afterwards. Trachomol can be so safely used that the use of Perchloride of Mercury may now be discarded completely in the disease.

So long as the granulations continue to secrete pus, or a thick gelatinous fluid, the application of 10% Trachomol should be continued twice or three times a day. As the cicatrices begin to form or if the granules have an unbroken surface, the 5% Trachomol is sufficient, and in these cases this is the strength that should be used.

Trachoma is as a rule such a chronic condition, and so liable to relapse, that after the patient is apparently cured, advice may be given to continue the occasional application of Trachomol 2½%, at first once or twice a day, and later twice or three times a week. As often as the doctor can see the patient, the eyelid should be inverted and the Trachomol smeared on the inner surface. At other times the patient, should apply the ointment twice or three times a day by drawing back the eyelid sufficiently to insert the ointment.

N. B. Iodides or any form of iodine, used either internally, externally on the skin, or by injection, can form a very irritating compound with copper. In scrofula and other cases where it is imperative that iodide should be given the use of Trachomol should be avoided until the necessity for iodide has disappeared.

THE PITUITARY GLAND

The Pituitary body is a ductless Gland about the size of a pea, and consists of two entirely distinct lobes which are connected with each other by a strip of tissue. Without doubt, this ductless gland has a great deal to do with animal economy, but the two lobes, the anterior and the posterior, are quite different in nature. At least one Hormone is secreted by each lobe. The physiological activity of the Pituitary gland is associated in some way with that of the Thyroid gland. As the Thyroid affects general growth and nutrition, so also does Tethelin, the hormone secreted by the anterior lobe of the Pituitary gland, stimulate the general growth of the body and modify nutrition, especially sexual nutrition. From the Posterior lobe, a definite hormone in watery solution can be obtained. This hormone, as yet un-named, has a specific action on plain muscle. With the exception of Histamine, $C_9H_9N_3$, the chief amine in Extract of Ergot—and a few heavy metals such as Barium, no other drug has such an active action on Uterine muscle. It causes powerful contraction of the Uterus, and so can be used very beneficially in cases of advanced labour with uterine atony. An excellent preparation for this purpose in Obstetrics is Pituitobine A. F. D. which is a specially purified extract of the Posterior Lobe, sterilised and physiologically standardised on the uterus of the guinea pig and also with respect to its blood pressure raising property. On account of its vaso constrictive and hemostatic action, Pituitobine is also successfully used in dysmenorrhea and menorrhagia, and its hemostatic action is valuable before operations in cases of anaemia through hemorrhage, and after, to control hemorrhage.

News and Comments

We understand that the Surgeon General on the deputation of the B. S. Scs. who waited upon him last September recommended to the Government that

they should be preferred to other medical graduates and L.M.Ps for the conduction of the medical inspection of schools as they had had special training for that work. On this recommendation which was forwarded through the Director of Public Instruction, the latter is said to have made an extraordinary observation viz. that an ordinary medical graduate is much better qualified than a medical graduate specialised in Sanitation in addition, to undertake the medical inspection and he therefore dissented strongly from the recommendation of the Surgeon General. We expect that the head of the Educational Department will use words that correctly express his views. We are at a loss to know how a mere graduate in medicine is superior, nay much more superior to a graduate who besides holding the medical degree like the former, possesses an additional degree unless it means that any addition to medical degree must be obtained at the sacrifice of his medical knowledge. Further he speaks of specialists in sanitation but forgets the statement made by the Surgeon General that the B.S.Sc. have had special training in medical inspection which the ordinary medical graduate does not possess. As sanitation of a school affects the health of the student, a knowledge in that subject is of great advantage in the inspection of the health of the children. The orders of the Government are indeed most interesting and reminds one of the following story. One person made a contract for the purchase of certain quantity of corn at a certain rate; when he came actually to take delivery of the corn he measured it in the usual way by putting the corn into the measure; the owner objected to it and said that it should be measured by putting the corn on the opposite side i.e. the base of the measure. As there is no specification in the contract as to how the corn is to be measured the case went up to an arbitrator who settled, disagreeing with the views of both the parties, that the corn should be measured by the side of the measure between the top and the base.

The Government is silent as regards the point whether an ordinary graduate in medicine is superior to one who besides being a medical graduate possesses in addition qualifications in Sanitation and medical inspection, and orders that the claims of B. S. Scs should be preferred to those of L.M.Ps wherever possible. This apart, there is already much heartburning among the independent practitioners that the paid medical officers encroach upon their practice and there is also a great deal of unemployment among medical men. It is therefore necessary that the medical inspection of schools should be left entirely to private medical practitioners in all places where they are available rather than to service men. Both statesmanship and justice demand such a course and the inspection itself can be better conducted by private men as they can spare more time for this work than Government paid men with their multifarious work in the hospitals.

* * * *

The results of the final B. S. Sc. have been published and all the candidates that went up for the examination have passed and they will go to swell up the existing number of unemployed B. S. Scs. Perhaps if the examination had been held and the results published before the opening of the medical college the cent per cent success might have influenced the admission of candidates in the B. S. Sc class. In spite of the postponement of the date of application for admission into the class and as we understand, in spite of canvassing, the number of admission into the B. S. Sc. class is only one. There was a talk for the abolition of the B. S. Sc. and this might have been directly responsible in not attracting more than one student to B. S. Sc. class. The stepmotherly way in which the B. S. Scs. are treated both by the public bodies and medical department, is yet another factor which had made this course unpopular. The reshuffling of the location of the departments in the Madras Medical college referred to in

these columns a couple of months ago seemed to have confirmed the doubts lurking in the minds of students who thought it wise not to join a class which is likely to be abolished soon. A serious situation has been thus brought about for which those responsible for the running of the Medical College are mainly to blame; the question will naturally arise whether for the training of a solitary student, such a big and highly paid staff including the newly appointed sanitary engineer is required.

There are now about 18 L. M. Ps. undergoing training for second class health officers. If it is thought that even for the training of second class health officers, such a highly paid staff is necessary and if the training given to the second class health officers is the same as for the B. S. Scs., one may pertinently ask the question why not allow the L. M. Ps. undergoing second class health officers course to appear for the B. S. Sc? We understand that in the examination for the Diploma for which both the B. S. Sc. candidates and the second class health officers appear, the latter some times come out better than the former. If the training is the same and staff is the same why should the L. M. Ps. be debarred from appearing for the B. S. Sc? If they are considered incompetent for holding the B.S.Sc. degree what is the meaning of giving them the same training as the B. S. Sc. and by the same staff?

* * * *

The Government have passed a revised G.O. No. 1395 P.H. dated 5th August 1930, issuing a revised memorandum of information and the rules for the grant of concessions to patients desiring to undergo anti-rabic treatment. We are not concerned with the details of the concessions but we will be failing in our duty if we do not bring to the notice of the authorities that they have made an omission in the matter of empowering persons to grant the concessions, especially in the rural areas where immediate attention is required regarding the

despatch of patients to the institutions where anti-rabic treatment is given. They ought to have included in the list of Officers granting such concessions, the Rural Medical Practitioners, who being professional men are certainly better qualified to be entrusted with this work than anybody else in Government service. Even in urban areas, it would have been justifiable to empower private medical practitioners with the granting of such concessions as contemplated in the memorandum. After all the object of these concessions is that the people who are bitten by mad dogs should have immediate attention regarding anti-rabic treatment, and nobody else could do it better than the medical man who alone could realise the urgency of the case and the desirability of despatching the patients with the least delay to the nearest institution where anti-rabic treatment is given. Even in the matter of law and order, Government have thought it fit to entrust the work to laymen and have been appointing them as Honorary Magistrates both in the mufussal and in the Presidency Towns. If laymen could be entrusted with the administration of law and order, is it too much for the Government to stretch their imagination and entrust private medical practitioners with work of this nature and see that the money utilised for anti-rabic treatment is spent in the best direction?

Delay in the matter of Registration of the names of the Medical Practitioners in the Madras Medical Register does not seem to be restricted to the mofussil members of the profession. We have mentioned in these columns that it took over six months for some of the practitioners to get their Registration Certificates. The City practitioners do not seem to be exceptions to such delays. We understand that a prominent member of the profession sent an application about one and a half months ago with Rs. 15-12-0 in the form of a cheque to the Registrar. The prac-

itioner did not receive his registration certificate till the 9th inst. and the Registrar has not even acknowledged receipt of the cheque though the practitioner has information from his bank that the cheque had been cashed on 11th July 1930. The President of the Council who was informed about this inordinate delay has, we understand, promised to enquire into the matter. The result of this enquiry will, we hope, give everybody a clue whether it is worth anybody's while to make legitimate complaints regarding the working of the Medical Registration Act in this province.

The Rural Medical Practitioner of Rayavaram about whose case we commented in these columns in the June issue, has, we understand appealed to the Government a second time for the grant of the subsidy for the period he actually worked after the expiry of the agreement between him and the Taluk Board till the date when he actually handed over charge of the Rural Dispensary. As was said by us on the last occasion, equity and fair play demand that this Rural Medical Practitioner should be given his subsidy as claimed by him. In the terms of the agreement between the Rural Medical Practitioner and the Taluk Board, there is the right of appeal to Government whenever differences arose between the parties. The Government were aware at the time they received the appeal that the Rural Medical Practitioner did not hand over charge on the date of expiry of the term of his agreement as demanded by the Taluk Board but did not pass any preliminary order calling upon the Rural Medical Practitioner to hand over charge of the dispensary, and the District Medical Officer on behalf of the Government actually inspected this dispensary during the period of appeal and both this Officer and the Taluk Board have passed the returns submitted by this practitioner. After all the amount claimed is a small one. Will the Government be merciful or bring about more discon-

tent in the Rural Medical Relief Scheme?

It is difficult for anybody to gauge the attitude of the Government regarding the Rural Medical Relief Scheme which was started primarily to encourage private medical practitioners to settle in the villages. We now find that the scheme is being utilised to drive away private practitioners already settled in villages on their own accord without the help of the Government subsidy. We referred in these columns in April to such a case in the Palghat Taluk Board where, in a village called Koduvayur, the Taluk Board had started a rural dispensary though there were more than one qualified practitioners in the locality. One of the practitioners had appealed to the Government against such action of the Palghat Taluk Board. We understand that the following G. O. has been passed on this appeal:—

G. O. No. Ms. 1638 P. H., dated 5th July 1930:—"The petitioner is informed that the appointment of medical practitioners to rural dispensaries vests with the Taluk Board and the Government are unable to interfere in the matter."

The above G. O. is quite contrary to Memorandum No. 6499 I. P. H. dated 16-3-25 issued by the Government to the President, Taluk Board, Udipi, which runs thus:—

"To the President, Taluk Board, for reference and early reply. The opening of a Dispensary at Shirva where a private medical man has already settled without a promise of subsidy and sending of another doctor to the same place to compete with him are wholly inconsistent with the main object of the Rural Medical Scheme which is to extend medical relief in rural areas."

As mentioned above the theory enunciated in the G. O. of 1930 is contrary to the memorandum issued

in 1925. The latter memorandum was issued as a result of a complaint from a practitioner at Shirva who had eventually to leave the place to avoid unwholesome and unequal competition, as the net result of this complaint and the controversy between the Government and the Udipi Taluk Board was the conversion of the then newly started Rural Dispensary into a pucca L. F. dispensary. This practitioner settled in another village called Kaup in Udipi Taluk and is now being pursued by the Udipi Taluk Board who have thought it fit to drive this unfortunate practitioner even from Kaup where he seems to be doing very good work regarding medical relief. We learn that this practitioner has appealed to the Government through the Surgeon General and trust that the Surgeon General will point out to the Government the injustice done to the Independent Medical Profession in general and to this unfortunate practitioner in particular, who is driven from one village to another by the Udipi Taluk Board who seem to be more keen in solving the unemployment problem in interested quarters than successfully running the Rural Medical Relief Scheme.

We note with pleasure that Rao Bahadur Dr. Tirumurthi is to act as the Vice-Chancellor of the Andhra University in the place of Mr. C. R. Reddi who had tendered his resignation on account of the present political situation. The fact that Dr. Tirumurti was elected to this position by the unanimous vote of the Senate of the Andhra University proves the popularity of Dr. Tirumurti amongst those who are responsible for the running of the Andhra University. Apart from his attainments, Dr. Tirumurti's amiable disposition and passionate love for the work with which he is entrusted and his sense of responsibility in executing his work, have earned for him an unique reputation as is evidenced by his being elevated to the position of the Vice-Chancellor of the Andhra

University within a few months of his appointment as Acting Principal of the Medical College, Vizagapatam, which position no Indian has so far occupied in this Province.

The Vizagapatam Medical Association passed the following two resolutions at its business meeting held on the 6th August 1930:—

- (1) Recording their "joy to see Rao Bahadur Dr. Tirumurti, being selected and recommended to the Vice-Chancellorship of the Andhra University by the Senate in addition to his present duties as Principal, Medical College, Vizagapatam, a Unique Honour."
- (2) Recording their "deep sorrow at the loss of Dr. Kugler of Guntur, who was the founder of the Women's Mission Hospital, Guntur, at the ripe age of 75 and who worked, lived, and died in the Andhra Desa for our women, an irreparable loss."

Transfers of the Officers in Government service depend upon various circumstances and do not seem to be governed by any rule or custom though it is said that there are rules governing them. In the Medical Department one cannot even depend upon a transfer once made. There are instances where unfortunate subordinates are tossed like a football and sometimes even worse than a football; for a foot-ball is kicked to reach a goal and not after. In the Medical Department, there does not seem to be even a goal at times; a person is transferred from one station to another, to be told at the latter station that another person from whom charge has to be taken was not willing to leave the place and consequently at the instance, it is alleged, of a higher magnate than the Head of the Department, is kept in the same place, and the one that has come to relieve is being tossed to yet another place with no security of a stay anywhere at least for some months to come. We can blame nobody in the present state of affairs

except the ill-luck of the person who has to suffer.

We learn with much interest that the British Medical Association at its last annual meeting approved of a scheme for the establishment of a General Medical Service for the nation, to provide service for every class of population, both in preventive as well as curative medicine, and have recommended to the Government that medical benefits under the present National Health Insurance Act be extended to include dependents of all persons insured thereunder. The scheme has provided for a comprehensive dental, pathological, pharmaceutical ambulance services and the establishment of home hospitals where the patients could be treated by their own Doctors. It is also expected that the scheme based on contributory system would be largely self-supporting.

We are under the British Government for over a century and a half, and yet the Government have not found its way to establish in this country the system of medical relief obtaining in the British Isles where every attempt is being made by the members of the independent medical profession as is evidenced by the activities of the British Medical Association to take complete control of medical relief both in its curative as well as preventive aspects. The scheme referred to above and contemplated by the British Medical Association proves beyond a shadow of doubt that the only way of giving medical aid to the people of all grades is to entrust this work solely to the profession and not to the paid agencies of the Government.

We welcome the news that the Government are contemplating about the desirability of entrusting the Port Health work to the Director of Public Health. Our country is far behind the times in bringing about this much needed reform which was long overdue, in the interest of Preventive Medicine,

PUBLISHER'S NOTICE.

The original articles on Endocrinology, the Editorials and the News and Comments columns of "The Medical Practitioner" seem to have attracted the attention of not only the medical profession but also a few members of the public outside the profession including amongst them Advocates and Judges of the High Court, almost all of whom when they send their subscriptions to enrol them as subscribers, request us to send them the back issues of the Journal so that they can have a connected series of the First Volume. November, December and January issues of "The Medical Practitioner" are out of stock. For want of correct addresses, some of our readers did receive extra copies of the journal, and such of them who could spare the November, December and January issues, are earnestly requested to send them back to us. We trust our readers will appreciate the earnestness and necessity of the request and oblige us by complying the same.

Correspondence

LETTERS TO THE EDITOR

Birth Control

Sir,

Though a bit late, still none the less sincerely, do I write to dissociate myself from your views as regards birth control, as expressed in more than one issue of your journal.

Birth control is a positively sinful act, in committing which, man usurps the power that belongs to God alone. If, for some good reason, the family is to be limited, it is self-control that should be exercised, and not, by any means, birth control. That this is possible with the supernatural help of God, is shown in the case of many individuals in this world both in the past and present.

Moreover the means of provision for large families that God may give, can be improved as has been shown in the

case of many countries in Europe where the families are, on an average, large. Some of these means are, increasing the produce of land by improved methods of agriculture, starting of co-operative societies and various industrial works by Government as well as philanthropic financiers, improvement of labour conditions by decentralization, better wages etc. and also by simple and frugal living.

As regards the authorities cited in favour of birth control, the high positions they occupy do not necessarily give them the hall mark of infallibility in all matters involving questions of morality. On page 201 of the April issue, it is said "Is not the raising of the age of marriage of girls, one of the methods of birth control". As long as the birth of children, after marriage, is not by any means prevented, certainly no birth control is practised by raising the age of marriage, though I agree with you that the children born may be fewer. Those that advocate raising of the age evidently do so to prevent the evils of premature marriage and not to limit the number of offsprings. This is very evident when they are opposed to birth control at the same time.

I think it is but right that people should not marry below a certain reasonable age. The Roman Catholic Church to which I belong prohibits the marriage of girls below 14 and boys below 16.

23, Perambur
Barracks
Road, Vepery,
Madras,
11th July 1930.

W. J. FERNANDEZ,
L. M. & S.

[Epidemics such as Plague, Small-pox etc. are even now attributed, by some religionists to visitation from Gods and still steps are taken to prevent them and control deaths by adopting sanitary measures. Human beings harness nature and utilise it for their use as for instance; Telegraph, Telephone and Aeroplane etc. and their action is not considered sinful. If it is not sinful to control death, why should the control of births be considered so? Authorities are quoted in the journal with the

object that the readers may go through their writings and form their own opinion in the matter. If after reading the letter of the correspondent, some think that birth-control is sinful let them by all means hold that view. Birth-control does not mean, as one would be led to believe after reading the letter, only prevention of birth, but its regulation. As human beings in distinction to other animals are expected to regulate their lives, and one of the functions, nay the chief function, is reproduction, it requires more regulation than others. There are several methods for regulating births, depending upon the intelligence, capacity, economic condition, and social and religious habits of different persons. If some have sufficient will power to practise self-control, let them resort to it and all honour is due to them. The raising of the age of marriage is only one of the means of regulation and not preventing births. The reproductive age of women is determined by the climate, food etc. and not by the religion they follow.—*Editor.*

EYE-TREATMENT

Sir,

The following methods of treatment carried out at the Henderson Eye Institute, the Ophthalmic branch of the Civil Hospital, Bijapur, Bombay Presidency, may interest your readers.

KERATOMALACIA AND XEROPHTHALMIA

This disease is very common in Bijapur District and in Southern India in general. Through ignorance of feeding and rearing babies, who are mostly fed on a wrong diet, this disease is prevailing. The deficiencies in the essential elements of diet during fever and other illnesses cause weakness and emaciation. Still the mother goes on giving the same wrong diet. Diarrhoea sets in and gets worse day by day. There is at first night blindness, dryness of part of cornea and conjunctiva exposed in the palpebral aperture. Lustre of cornea and conjunctiva is diminished; slowly a haze of increasing density forms over the cornea and advances to ulceration, sloughing, perforation and even to panophthalmitis. The prognosis of these cases if they arrive early is most promising. A dose of santonine is first administered and often a lot of

worms pass. Eyes are treated with instillations of drops of pure cod-liver oil daily and dionine occasionally, and a little yellow ointment, a pad and a bandage. Fever and diarrhoea are met with quinine and astringents. Milk injections 1 to 3 cc. for children below 5 years are given intramuscularly once in 4 to 6 days to stimulate leucocyte formation and phagocytosis. Cod-liver oil is rubbed on the whole body especially to parts like abdomen, axilla and groins. The patients are fed on albumen water and thin milk mixed with lime water. Under this line of treatment many early cases are cured.

TRACHOMA

These cases are common. We touch the averted lids with copper sulphate solution 10% once daily. For fleshy and prominent granulations, expression with knapp's roller forceps and brushing with 10% copper Sulphate solution in glycerine is done. The eyes are then daily washed with H. P. lotion and argyrol and yellow ointment put in. When the inflammation subsides i. e., after about a week or 10 days, $\frac{1}{2}$ to 1 cc. of 1% solution of copper sulphate with novocain is injected underneath the conjunctive just behind the tarsus and repeated once a week for 3 or 4 weeks. This line of treatment has met with success in many cases.

GLAUCOMA.

Glaucoma cases are treated first with Eserine and adrenalin and then submitted to operations, Iridectomy for acute and Trephining (Sclero corneal) for chronic cases. For very high tension an intravenous injection of sodium chloride 11½% solution is given upto about $\frac{1}{2}$ pint at a time. This reduces the tension and enables Trephining to be done safely.

TREPHINING WITH IRIDECTOMY.

Trephining with Iridectomy is often done for staphyloma of cornea in cases where the cornea is not much thinned. By this, a big bit of Iris can

be removed and staphyloma reduced. For big staphyloma with thinning of cornea nothing short of enucleation is of any use. Trephining with Iridectomy is also successfully done for adherent opacity cornea where the anterior chamber is very shallow and is in close contact with the back of cornea. In these cases the usual Optical Iridectomy often fails as the Iris lies close to the cornea and Iris forceps fail to bring any portion of Iris out. In such cases Sclero-corneal Trephining brings up a knuck of Iris in the wound and Iridectomy can be performed easily.

RECENT STAPHYLOMATA.

Recent staphylomata are often treated successfully with continued use of Eserine, Dionine, Adrenalin Chloride and pressure-bandage. On reduction of the staphyloma, iridectomy or Trephining with Iridectomy is done for restoration of vision.

CATARACT.

Both methods (intra and extra capsular) are done according to indications. There has been during the year under report not a single case of Iris prolapse nor sepsis nor large vitreous escapes. By washing the eyes with H. P. 1 in 6000 before and after cocain anaesthesia, sepsis is completely abolished from our Eye Institute for the last 10 years.

The canthus is generally split to enlarge the palpebral aperture and minimize the danger of squeezing. As B. P. Banaji says "It gives a broader field for operation, lessens the squeezing power of the lids, drains away the conjunctival fluids and lessens the chances of the instruments becoming contaminated by coming in contact with lid borders. It is absolutely free from any bad effect."

ULCER CORNEA

Ulcers of cornea are successfully treated with atropine and bandage, silvering of the lids also being done for some days, as these ulcers are generally due to conjunctivitis. Septic Ulcers and Hypopyon ulcers are

canterised with camphor and carbolic (equal parts of camphor and carbolic) and paracentesis of anterior chamber are repeated as required. A few iodine injections intravenously hasten the cure.

FUNDUS CASES

For papillitis retinitis pigmentosa and optic atrophy or optic neuritis besides treating the root cause such as syphilis, Septic tonsils and Pyorrhea, Iodine—injections ($\frac{1}{2}$ grain pot: Iodide and $\frac{1}{2}$ grain Iodum in 10 CC. distilled water) are given intravenously once every 3 or 4 days till about 6 injections are given. Mercurial ointment for rubbing to the temples daily, and deep cyanide injections (Cyanide of mercury 1 in 2000 with novocain) $\frac{1}{4}$ to 1 cc. once in about 8 days are given. Many cases have improved markedly on this line of treatment, and a notable feature is the rapidity with which the vision often improves after one or two intravenous Iodine injections. Where there are no prominent veins, the following is given intramuscularly.

Sodium Iodide gr.250; Iodum (crystals) gr. 200; carbolic acid 3 drams; distilled water 4000 cc. Of this 10 cc. are given in the muscles (preferably gluteal) every 6 or 8 days. The mixture should not be stirred.

I am highly obliged to the Civil Surgeon and Chairman, Blind Relief Association, Bijapur for kind permission to publish this.

E. R. SHETTI, L.C.P. & S. (Bom.)
Medical Officer,
Henderson Eye-Institute
Civil Hospital, Bijapur,
Bombay Presidency.

Reviews.

The Seventh Annual Report of the Nowrosjee Wadia Maternity Hospital, Bombay, for the year 1929.

We congratulate the management and the staff of the Hospital for the good work done during the year 1929. The Hospital is evidently becoming

popular as the increase in the number of patients show. The Maternity Hospital is a private institution under the management of a private body. The number of patients that were given relief in the hospital and the number of child births attended to are more than those in the world famed Rotunda Hospital, Dublin. Authorities in India, particularly in Madras, are obsessed with the idea that the honorary system of hospital appointments are foreign to the Indian intellect and culture, and though after much hesitation and misgivings, the honorary system was introduced in Madras, still the honorary officers are not properly treated and are given only subordinate position in hospitals. The fact that the Nowrosjee Wadia Maternity Hospital, an institution which is bigger as regards the number of patients treated, than the Rotunda Hospital, Dublin, is not only officered by honorary staff but administered by an Honorary Superintendent, establishes beyond any shadow of doubt, the competency of honorary men to administer big institutions and the compatibility of Indian intellect and culture, with the honorary system of medical appointments. If the present inauguration of the honorary system does not meet with success, it is not due to any incapacity of honorary officers but to the annoyance and bosing over by the Government paid medical officers, set over the honorary men, in authority.

The Report of the All-India Blind Relief Association Bombay, for the year 1929.

This Association which is affiliated to the International Association for Prevention of Blindness, Paris, was started in Bombay in 1919, and there are six centres at present in the Province. The Association is evidently doing good work. Blindness is to a large extent, a preventible disease, but as only a few patients that attend the hospital or come under treatment, on account of ignorance, do so only after

the diseases become far advanced, only palliative treatment is possible. The diseases which lead to blindness, partial or entire, are at the beginning easily amenable to treatment. These diseases affect children largely. As stated by an eminent ophthalmologist, "The schools show a large number of children suffering from conjunctivitis, granular lids etc. and the presence of these diseases in the schools is an indication of the extent to which they prevail among the general population. These cases if taken in time will readily yield to treatment of simple kind. Neglect, however, often leads to loss or impairment of vision so that it is almost a truism to say that most of the blindness at least among the young or middle aged is preventible." As Indians are generally apathetic from various causes, and postpone to the last moment to get themselves treated for diseases which are slight at the beginning, it is important that in schools the eyes of students should be examined by medical men and early treatment undertaken. The spending of large amount of money in the opening of hospitals where only diseases, more or less advanced, come for treatment which can be expected to be only palliative, is like spending large amount of money in funerals and making them grand and impressive. If treatment is to be effective at all, it must be given early at the onset of the disease. It is therefore necessary that for schools, school medical clinics should be opened, where diseases can be diagnosed at the onset and treated. The student should be taught hygiene and physiology. Lastly there is the medical inspection of schools. All these can be attended to if medical men are appointed as teachers in schools.

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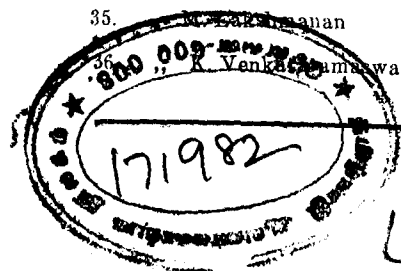
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List of postings of Sub-Assistant Surgeons for the month of July 1930.

Name of Sub-Assistant Surgeon.	From	To
1. Dr. V. Krishnamurthy	Under orders of transfer to Hd. quarters Hl. Nellore.	L. F. Dy. Darsi.
2. " M. Lakshminarasimham	Hd. quarters Hl. Masulipatam.	c/o, President. Dt. Board, Guntur.
3. " D. Suryanarayana	L. F. Dy. Achampeta (Guntur)	L. F. Dy. Sattanepalle (Kistna).
4. " C. Kameswara Rao	From Leave	L. F. Dy. Surada (Ganjam).
5. " M. Pichumani Ayyar	From Leave	c/o, President. Dt. Board, Coimbatore.
6. " S. Sengaliappan	L. F. Dy Bunglowpudur (Coimbatore)	c/o. Civil Surgeon, Vizag. Agency.
7. " R. Purusothama Rao	From Leave	Hd. quarters Hl. Berhampur (Ganjam)
8. " V. Kameswara Rao	Govt. Hd. quarters Hl. Ellore (West Godavari).	L. F. Dy. Gajapatinagaram (Vizag.)
9. " P. P. Narayanan Nair	Govt. Hd. quarters Hl. Salem.	c/o, President, Dt. Board, Salem.
10. " M. V. Anantan Nair	From Leave	Govt. Hd. quarters Hl. Madura.
11. " T. P. Balaji Rao	Govt. Hd. quarters Hl. Madura	Leprosy work, South Arcot Division.
12. " M. Lakshmanan	From Leave	Govt. Hl. Kanigiri.
13. " M. Kunjunni Menon	Spl. Asst. Agent. Baliguda, Russelkonda (Ganjam Agency)	King Institute, Guindy.
14. " P. V. Subba Rao	Under orders of transfer to Govt. Hd. quarters Hl. Nellore	c/o President, Dt. Board, Nellore
15. " K. Pichu Ayyar	L. F. Dy. Kota.	Govt. Hd. quarters Hl. Madura.
16. " K. Ramachandran	Govt. Hl. Kodaikanal.	c/o. Principal, Forest College, Coimbatore.
17. " K. Ramachandran	L. F. Dy. Melur (Madura)	Govt. Hl. Kodaikanal.
18. " L. V. Jagannadha Rao	Govt. Hd. quarters Hl. Vellore.	Govt. Hd. quarters Hl. Bellary.
19. " A. Subramanyam	Police Hl. Coimbatore	c/o, I. G. of Prisons, Madras.
20. " P. Mangapathi Rao	Govt. Hl. Nuzvid (Kistna)	Govt. Hl. Adoni (Bellary).
21. " I. Iswara Rao Naidu	Govt. Hl. Adoni	c/o, President. Dt. Board, Bellary
22. " V. Subbaramayya	L. F. Dy. Kanaka (Bellary)	Govt. Hl. Royadrag
23. " D. Suryanarayana	Govt. Hl. Royadrag (Bellary)	Govt. Hl. Nuzvid.
24. " K. Narayanan Nair	From Leave	c/o, Civil Surgeon, Vizag. Agency.
25. " M. Gopala Menon	From Leave	Govt. Hd. quarters Hl. Madura.
26. " J. T. Moses	Govt. Hd. quarters Hl. Madura	L. F. Dy. Nilakottai (Madura)
27. " Y. Suryanarayana-murthy	L. F. Hl. Ramachandrapuram.	Govt. Hl. Tuni.
28. " M. A. Subramanya Pillai	From Leave	L. F. Dy. Aruppukottai (Ramnad)
29. " D. Mathuranayagam Pillai	L. F. Dy. Aruppukottai	L. F. Dy. Tiruppattur (Ramnad)
30. " V. Muthuswami Ayyar	L. F. Dy. Tiruppattur	c/o, President, Dt. Board, Salem.
31. " S. Gopal Pai	L. F. Dy. Palakode (Salem)	Govt. Hd. quarters Hl. Salem.
32. " I. P. Sankara Menon,	From Leave	c/o Civil Surgeon, Vizag. Agency.
33. " R. Gopalakrishnan	From Leave	Govt. Hd. quarters Hl. Ootacamund.
34. " P. Sitaramayya	Govt. Hd. quarters Hl. Nellore.	c/o, President, Dt. Board, Nellore.
35. " K. V. Venkataswami	From Leave	Govt. Hd. quarters Hl. Nellore and then Govt. Hl. Kanigiri.
		L. F. Dy. Royachotti. (Chuddapah)



6m 21, 11 30.10-12

Name of Sub-Assistant Surgeon.	From	To
37. " S. V. Ramanayya	L. F. Dy. Royachotti	Govt. Hd. quarters Hl. Masulipatam.
38. " Y. Suryanarayana-murthy	Govt. Hd. quarters Hl. Cocanada.	L. F. Hl. Ramachandrapuram
39. " M. S. Kuppuswami	Munl. Dy. Kurnool	L. F. Dy. Musiri (Trichy)
40. " V. G. Parthasarathy Naidu	Govt. Hl. Srirangam.	c/o President, Dst. Board Trichy
41. " D. Krishnamurthy	Govt. Dy. Royagada (Ganjam Agency)	Govt. Hdquarters Hl. Madura.
42. " K. V. Mahadevan	L. F. Dy. Pattikonda (Kurnool)	Govt. Hdquarters Hl. Chittoor.
43. " P. A. Nainar	Govt. Hd. quarters Hl. Chittoor.	L. F. Dy. Pattikonda
44. " P. Ananda Rao	L. F. Hl. Karkal (South Kanara).	Govt. Hd. quarters Hl. Mangalore
45. " P. A. Nainar	Under orders of transfer to L. F. Dy. Pattikonda	Govt. Hd. quarters Hl. Madura.

THE KEY STONE.

Somewhere within the Molecule of one of the special proteins in the Islands of Langerhans may be the Keystone around which that Molecule is built up. Around the Keystone we can envisage the hormogen groups in a dense formation, and outside that further group of hormogen Aminoacids net work formation.

Overlapping and covering the hormogen tissue we should find the prohormones perhaps as sessile protuberances.

Interspread with the prohormone branches we might find filaments bearing their fruit in the form of ripe insulin, but still fixed to the body of the molecule.

Near by we might find another and different protein Molecule ready to secrete the enzyme which would cause the severance of the ripe insulin from its parent molecule.

When that insulin is required, and not before, then the enzyme is set free to act on its neighbour the fixed insulin, to set it free on its mission of glucose oxidation.

This thought picture brings to mind one or two important points. (1) A protein molecule of any sort is hundreds of times larger than the molecule of any known hormone. Probably a single molecule of Langerhans protein contains a hundred times as much, or more, of pro-insulin than of insulin. We might argue that the manufacture of insulin is not an economic method of using the tissue, quite apart from the expensive alcohol etc., used in the process. (2) All protein Molecules are delicately balanced structures. Heat, acids, alkalies, metallic salts, any ill advised chemical process can completely change the nature of any protein substance. One preparation of Pancreas may therefore be absolutely different from all other Pancreas products.

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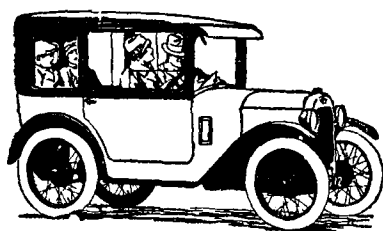
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VOL. 1. No. 12.

SEPTEMBER, '30.

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,
Member, Madras Medical Council.

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A WARNING TO THE L.M.P.s. AND THE MEDICAL PRACTITIONERS WITH NO UNIVERSITY QUALIFICATIONS.

"The Medical Practitioner" has been keenly watching the developments at Simla regarding the enactment of an All India Medical Council Bill which is likely to come for discussion in the Legislative Assembly at its Winter Sessions in 1931. Though the Hon'ble Sir Fazli Hussain, member in charge of the Medical portfolio of the Government of India, gave an assurance to those assembled in Conference in Simla in the third week of June last that the proposed Bill will be submitted to all the Local Governments for gathering opinion from all those interested in the Medical education in this country such as Provincial Medical Councils etc., there are no signs as yet of any such action having been taken by the India Government. It is all the more necessary that those that are likely to be affected adversely by the passing of the proposed All India Act should be forewarned and take all necessary action that lies in their power to protest in time against the injustice done to a section of the Medical profession which is three times the strength of the Indian Medical graduates for whom alone ostensibly the proposed legislation seems to have been contemplated, its real purpose being to allay the wrath of that most powerful and influential body the General Medical Council of Great Britain.

The editorial appearing in the July issue and the references now and again made in the several issues of "The Medical Practitioner" seem to have opened the eyes of a few doctors without University qualifications who have approached the editors of this journal to organise a Conference to discuss about this problem. In the present disorganised condition of the medical profession, the best and the most effective, but yet the cheapest and convenient way, of protesting against the formation of an All India Council which has no representation and hence any concern for the largest section of the medical practitioners in this country, will be to send protests individually by all those likely to be affected by the passing of this legislation in the form of a memorial to the Government of India. So, it is contemplated by the editorial staff of "The Medical Practitioner" to draft such a memorial and send it for approval to all the registered medical practitioners in this province not excluding those with University qualifications and collect the same and take them in person to the member in charge of medical portfolio of the Government of India, by one of the representatives of "The Medical Practitioner" on behalf of its readers who number as many as those appearing in the official register of the Madras Medical Council. If this idea is approved, necessary action will be taken towards the object in view and it is earnestly requested that such of the readers of "The Medical Practitioner" who approve of this idea will kindly intimate the same to the undersigned so that speedy action may be taken before it is too late to mend.

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THE MEDICAL PRACTITIONER

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Vol. I]

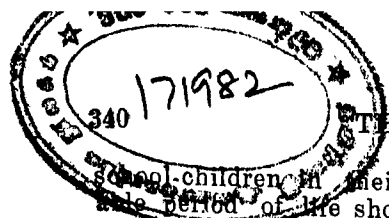
SEPTEMBER, 1930

[No. 12

BABY WEEK CELEBRATIONS AND PUBLIC HEALTH.

Information of the celebration of the Baby Week and Childwelfare is published in the newspapers every day and it is seen from them that it has become almost an anniversary in each and every town or big village throughout the Province. The cost of the celebration amounts to several lakhs of rupees annually and the celebration consists in exhibitions, shows, distributions of prizes, dramatic performances and lectures. If these are intended to bring down the death rate, both general and infantile, the correct indications of the progress of public health and the statistics published show that the death-rates have not been showing any signs of decrease but on the other hand tend to rise year after year particularly in places where these celebrations are conducted. It is an open secret that these celebrations are not the result of the spontaneous movement on the part of the general public but brought into existence chiefly by the Public Health Department with the assistance of other State departments. The administration of the Public Health Department if judged by the mortality rates, infant and general, cannot be considered to be satisfactory and these celebrations would appear to be conducted to justify the existence of the department in the eyes of the public. If it is thought as stated by Col. Russell, Director of Public Health in one of his reports that the "tamashas" like these celebrations are necessary and

appreciated by Indians, it can be said without fear of contradiction that it is an insult to the intelligence of the people. Even the most illiterate simply laugh at these celebrations and say that the officers have to bring about these celebrations to show that everything is being done for the welfare of the people. With the money wasted in these *tamashas* which even do not satisfy children, substantial improvement can be made in Public Health for which the people will be grateful. Taking for instance Namakkal, a union town in Salem District, where on account of scarcity of water people purchase water not only for drinking purposes but that required for household purposes also. The water itself is so very bad that the drinking water is distinguished by its reddish colour from the green coloured water used for household purposes. This is going on in the place where within a distance of 10 miles the river Cauvery runs in full flood. Is it not possible with the amount of money wasted on these *tamashas* annually in the Province to supply the town with water from the Cauvery? Will not the people be more grateful and appreciate this than these *tamashas*? By this arrangement some of the towns where water supply is scarce can be provided with good water in course of time. If the lectures and demonstrations are to be of any use they must be arranged for and regularly given in schools. The subject of hygiene and physiology should be made compulsory in elementary and secondary schools and the



school-children in their impressionable period of life should be well grounded in the knowledge of hygiene and correct living, as stated by the Rt. Hon'ble Viscount of Burnham in his Presidential address at the International Health Conference held in connection with the League of Nations, "that it is desirable that some systematic teaching in the subject of hygiene to form part of the instructions of every boy and girl during school time." Coming nearer home, in the 5th Conference of the All India Teachers' Association held in 1929 in Madras in the paper on "The Physique of our school boys and Beasley Committee recommendations" read by Mr. V. R. Krishnaswami Ayyangar of Voorhees College, Vellore, he pointed out that the ideal scheme would be combining physical director and medical inspector in one—a medical man—and attaching him to the staff of the school as recommended by the Minister of Education sometime ago in the local Legislative Council, and the opening of clinics for the treatment of children requiring such treatment, as mere intimation of the illness to the parents was of no practical use. Again, Mr. Shiralbar, B.A., Physical Director, Indore, said that the money now spent on education of the defectives on the same lines as those of the normal was all misspent. Health education should be our slogan, for as Dr. Burnham has said, "instruction can wait, but the demands of health are imperative". In England for the purpose of medical inspection of schools the School Medical Service is in existence consisting of 1257 Medical officers. We have pointed out in several of our issues the necessity and economy of the appointment of medical men as part time teachers in schools and entrusting them not only with the teaching of hygiene and physiology, but with the work of medical inspection and conduct of school medical clinics. It is a pity that the most sensible and practical recommendation of the Minister of Education referred to above has not been approved and acted upon. Evi-

dently the Minister of Public Health was not in agreement in this matter with the Minister of Education. Education and Public Health should be combined and placed under one Minister and such combination is recommended by a speaker in the First International Conference mentioned above. Unfortunately in Madras in the distribution of the portfolios to the Ministers, neither the subjects that are closely connected with one another are given to one Minister nor is he given the particular subject in which he had had practical knowledge and experience. As an instance, we may point out that Diwan Bahadur Arogyaswami Mudaliar who held a high place in the Engineering department before he became a Minister was not given the portfolio of the Public Works Department and the Portfolio of Public Health department was separated from that of Medical Department and they were given to two Ministers. As Public Health, Hospitals, Education and Local and Municipal Departments are all intimately connected with one another all these should be in charge of one Minister and if such has been the case the undignified spectacle exhibited and commented upon in our last issue in connection with the medical inspection when the Surgeon General under the Public Health Minister recommended that preference should be shown to B. S. Scs. in the matter of medical inspection of schools, the Director of Public Instruction under the Minister of education strongly objected to the recommendation and made the extraordinary statement that mere medical graduates are superior to those who in addition to medical degrees possess public health qualifications including medical inspection of schools, would not have appeared.

Dr. S. R. BHAT, M.B.B.S., L.D. SC.,
(Calcutta.)
DENTAL SURGEON
289, Esplanade, Madras.

THE LATE CAPT. N. R. UBHAYA, DIRECTOR OF PUBLIC HEALTH, MADRAS.

It is with profound regret that we have to record the death of Capt. N. R. Ubhaya, Director of Public Health, Madras, which took place on 26-8-'30 at his residence in Madras.

It is reported that the death was sudden evidently due to failure of heart, and it is known from those who knew him intimately that he was not feeling quite happy in the region of the heart ever since he returned from War Service, where he had to pass through most trying conditions, both in active service and as a prisoner. All the same, neither in office nor at home, he made it appear, till a few minutes before death, that he was ailing at all from any illness, much less the grave heart trouble to which he succumbed so suddenly.

The late Capt. N. R. Ubhaya was born in Mangalore, South Kanara Dt. in 1880. He belonged to a very respectable and ancient family of Saraswat Brahmins, his grandfather being a well-to-do landholder of the district who lived up to the grand old age of about 95 years. He matriculated from St. Aloysius College, Mangalore and passed the First in Arts examination from the Presidency College Madras and soon after joined the Madras Medical College. After undergoing 3 or 4 years course in the Medical College (his studies were interrupted for a time, but he had his heart in the medical profession), he proceeded to Edinburgh in 1911 and within 18 months obtained the Diplomas of L.R.C.P. & L.R.C.S. of Edinburgh and L.F.P. & B. of the Glasgow Universities. After a year's further course at Glasgow he obtained the Diploma in Public Health and returned to India in December 1913.

Shortly after his return to India Lieut. Col. (then Captain) A.J.H. Russell later on his chief in the Public Health Department and his predecessor in the office of the Director of Public Health, then special Malaria Officer, in the Corporation of

Madras, took him as his assistant. When this temporary appointment ceased he acted for a time as Assistant Health Officer in the Madras Corporation under the Late Dr. MacDonald and later was in charge of cholera parties in the Madura District. When the Great War broke out in August 1914 he was among the first to volunteer his services. He was offered a temporary commission in the I.M.S. in 1915 and soon after was despatched to the Mesopotomian Front where he served for a time in the base hospital at Amara. He was then placed in medical charge of the 119th Light Infantry which was stationed on the right bank of the Tigris prior to the march to Baghdad. He was one of the garrison at Kut-el-Amara under the command of General Sir Charles Townshend which was besieged by the Turks for a period of about 6 months and eventually taken prisoner with the whole of the surviving garrison on the 29th April 1916. He was one of several I. M. S. officers captured along with him one other of whom is now in the Madras service as Chemical Examiner to Government viz., Lieut Col. Clive Newcomb, I.M.S. and another as District Medical Officer, Salem, Major N.K. Bal, I.M.S. For 2½ years he was a prisoner in the hands of the Turks at Ras-el-ain in Asia Minor where his sufferings, especially in the early days of captivity were very great. The prisoners were put on to work under a German firm of Railway contractors in charge of the construction of a railway from Ras-el-ain to Baghdad. When the Armistic was declared in November 1918 he was released and repatriated to India in January 1919. After a brief holiday and short spell of service attached to a regiment in Bangalore he was again called to field service in the Afghan War. He was there stationed in Multan. He was demobilised in 1920 and appointed Deputy Sanitary Commissioner Southern Division, Coimbatore. When the Public Health Department was reorganised in 1923 he became one of the Assistant Directors of Public Health

with headquarters in Madras and placed in charge of Vaccination and Epidemics Departments. In September 1924 he proceeded on a year's study leave to Great Britain and the Continent where he made a special study of Child welfare and Maternity Relief and Public Health propaganda and took a course of study in the London School of Tropical Medicine. He returned to India in October 1925. When Lieut. Col. A. J. H. Russell proceeded on leave preparatory to retirement in June 1928, Capt. Ubhaya was selected by the Madras Government to succeed him in the headship of the Public Health Department which he has since administered with great success and ability to the entire satisfaction of the public and the Government and we refer our readers to the obituary notice appearing elsewhere issued by the Government appreciating his work. He was held in great respect and esteem by all who came into contact with him whether officials or otherwise and was loved and admired by all his subordinates. He was kind and accessible to all. The remarkable demonstration of sympathy at his sudden and untimely death testified to the regard in which he was held by all who came in touch with him. His outstanding characteristics were straightforwardness, sterling honesty and devotion to duty. Above all he was every inch a gentleman.

His death is a great loss not only to his relations and friends, but also to the Medical profession. We offer our heart-felt condolence and sympathy to Mrs. Ubhaya, and pray God to give her enough strength to bear the irreparable loss.

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Original Articles

ENDOCRINOLOGY

BY

DR. M. S. KRISHNAMURTHY AYYAR
M. B. & C. M.,

XII

Testes

The testes or the male sexual glands and the importance of which is well recognised even by the ancients in India as the worship of Phallus among the Hindus shows. It is the fountain head of all energy, the "Elan-vital" of Burgson and the "libido" of Freud. It conduces not only to long life but to intelligence, strength and health. Thomas Parr who lived to nearly 153 years had been accused of having committed a sexual offence in his 102th year and punished. He married a widow 18 years later in his 120th year. Drakenburg a Dane who lived 146 years married in his 111th year a widow aged 60 years and after her death fell in love in his 130th year with a young farmer girl. Peter Albrecht, who lived to 123 years married in his 83rd year and had seven children. Goethe in his 81st year astonished his audience by the uninterrupted current of his ideas and also the extraordinary richness of his invention. This fact has been proved by injection of extract of testes by Brownsequard on his own body in his 72nd year and by Steinach at present by tying and removing a portion of the spermatid cord and by Voronoff by grafting.

Anatomy, Physiology and Pharmacology

The testes in man descend in early life from the abdominal cavity through the inguinal canal to the scrotum. Two kinds of structures are present (1) the interstitial cells (Leydeg) which gives rise to the internal secretion and spermatogenic giving rise to the semen. The male and the female sex are said to depend upon the mendelian characters and the predominance of one over the other determines the sex ultimately. It is only in the

third month of the life of the embryo the sexually indifferent character is lost, and secondary sex organs become established. Only by the assumption of hermaphrodite primitive genital trace that the cases in which complete alteration of single sex characteristic or even of the entire sexual characteristic that takes place during life is explained. This is also supported by the fact that the spermin is said to be found in the blood of the females and is useful in the treatment of dysmenorrhoea. The metabolism rate is increased by over 50 percent by the administration of the extract of testes. The vision is improved, the hairs become black and the skin loses its wrinkles if the extract is given.

Clinical types.

Essential Infantilism—The testes are small; the scrotum atrophied and the penis is short and incapable of erection; There may be the absence of spermatozoa in the seminal fluid.

Cryptorchidism—This is also known as "undescended testicle." Two forms are described—the abdominal and the inguinal. Occasionally this condition is accompanied by testicular mal-development with lack of all the functions.

Eunuchoidism: This condition is presumed to be an acquired disorder of the interstitial cells of Leydig. The eunuchoid is so named from the similarity in form to the eunuch or castrate and in addition to the retrogressive changes in the secondary sex characteristic avirilism reduction of facial, axillary and pubic hair, general atrophy etc.

Sexual Neurasthenia—A functional sexual disturbance characterised by the lack of sexual desire and power.

Senility and pre-senility—According to Lorand "A man is as old as his internal secretions" and the condition called the old age is nothing but a gradual waning in the endocrine functions with the accompanying reduced cellular activities and unavoidable

toxemia which finally overburdens the body and allows the vital organs to fail. The condition called senility is merely old age and the pre-senility is premature aging which may range from progeria, (infantile senility) to a premature loss of virility.

Hyper-gonadism—It is characterised by early secondary sex hair growth, premature dentition, rapid growth, partial early gigantism, early closure of epiphyses, premature ossification, erethism, mentality modified by premature sex development, enlarged genitalia with premature function (pubertas praecox) and increased metabolism.

Hypo-gonadism—It is characterised by pale sallow wrinkled skin, feminine hair distribution, hypotrichosis, increased height, tall thin type usual, longer legs and arms, small head, broad pelvis, delayed epiphyseal union, upper measure i.e. symphysis to vertex, exceeds lower i.e. symphysis to soles. Vaso-motor atonia, cold extremities, small larynx, childlike soprano voice, loss of aggressiveness, neurasthenic state; fears, phobias, depression, sex organs hypoplastic, no sexual impulse; prostatic atrophy; gradual loss of libido and potentia, anaemia usual; fat deposits on lower abdomen and breasts; trochanteric obesity, basal metabolic rate low. Other endocrine glands especially the pituitary are involved. Lack of normal emotions and will power. The nervous system is dull relaxed and clumsy.

Therapeutics

The preparation of the testes used generally is the dessicated substance. It is given in two to five grain doses three times a day. Orchic substance either alone or better combined with other endocrine substance is useful in the treatment of all sexual neuroses, in all forms of neurasthenia and as a general tonic of the aged both males and females and in diabetes. Orchic substance is rich in phosphorus bearing compounds, nuclealbumen etc. and this has been held to account for its effects in medicine.

MEDICAL ETHICS

BY

DR. V. RAMA KAMATH.

Before attempting to suggest modifications in the existing Code of Medical Ethics, it is desirable that the readers should have an idea of the state of affairs of the medical profession in British Isles whose code was copied by the Local Medical Council verbatim, without any modifications.

Medical relief in British Isles is entirely controlled by the Independent medical profession and as reported in the News and Comments columns of this journal last month, the British Medical Association has recently inaugurated a scheme including in its activities even the preventive medical relief. Though there are various bodies who confer medical degrees or diplomas, the minimum medical education has been standardised and no invidious distinction is made or shown regarding medical qualifications, all registered medical practitioners being entitled to equal rights and privileges either in the exercise of the profession or employment in hospitals or other medical institutions, public or private. There does not exist in the British Isles so many systems of medicines as in India and quacks cannot deceive the public so easily as they do in this country. Originally medical relief in hospitals was introduced in that country by Religious orders since 597 A.D. The Monasteries performed the functions of local bodies temporal as well as spiritual. The spiritual heads not only established hospitals but ran schools and were the natural protectors of the poor. The first General Hospital in England named St. John was built in 1084 by Lanfrane, an Italian who was made the Archbishop of Canterbury by William the Conqueror. This institution was the fore-runner of many such hospitals which gradually came under the management of the lay public. Almost all of them were voluntary in nature supported by voluntary subscriptions, the permanent staff consisting of Honorary Physicians who ren-

dered voluntary and gratuitous service, and the management of these institutions being in the hands of unpaid Voluntary Board elected by the subscribers.

The history of Ancient India regarding matters medical is outside the scope and purpose of this article. Nothing need be said about it here excepting the fact that even in India the healing art was also in the hands of Rishis, the great Dhanvanthri being the origin founder of the Ayurvedic system of medicine. As the present day civilisation advanced, there has been a tendency for more materialisation with the result that the healing art became a trade in those Isles. Materialism necessarily brought about a spirit of competition resulting in ambition to acquire wealth and fame. Competition, not being always healthy, need was felt in that country to formulate a code of Ethics suiting the conditions in those Isles. How could this code said to be workable in that country, be foisted on the medical profession in India especially in Madras where conditions are quite different. The profession here is not of one variety, there being two distinct groups, the state-paid practitioners and the private practitioners. There is no uniformity, even in these two groups. The Government medical men are classed again under 4 different heads, the District Surgeon, the Civil Surgeon, the Assistant Surgeon and the Sub Assistant Surgeon whose duties and responsibilities vary. The private practitioners are classed under three heads in the Medical Register, viz., (1) those whose names are in the British Register, (2) Madras University graduates and (3) a heterogeneous mass consisting mainly of those with L.M.P. qualifications and other medical men who cannot be put under the first two heads. All those practitioners in the register who are not in Government service are denied the rights and privileges enjoyed by those in service. Though the idea of voluntary hospitals was not foreign to Ancient India, all hospitals and other medical institutions dealing with allopathic

system of medicine were started, administered and managed by the Government or local bodies with a paid staff who are nominally called full-timed officers though they spend their time in private practice of a remunerative nature. The Medical Officers in charge of the institutions are in sole charge of finance and other administrative details and are answerable only to one that is the Surgeon-General. There being no restriction for admission and treatment of the rich either in the out-patient or in-patient department of the State hospitals, the Government medical men have more chances of knowing the public and to be known and recognised by them. These officers, being allowed private practice, could command the same with less publicity than the private practitioners could do. The up-to-date appliances and apparatus available in State hospitals makes them more attractive to the public than the poorly equipped surgeries of private practitioners who find it naturally impossible to compete with the State-paid practitioners with their vast resources, in the Government hospitals. In addition to these facilities of publicity which medical men in Government service can only enjoy, the rights and privileges of private practice allowed to these officers in addition to high salaries, are being misused by them. One finds in the City of Madras Government medical men running chemists' shops, bacteriological laboratories, patronising chemists and druggists and conducting private hospitals as a trade, and though these activities appear as glaring abuses, the Government servants are said to have reported to the authorities that they do so more in public interest than for private gain and so, those who run these trades are considered innocent so far.

These activities apart, which have naturally earned for these Government paid practitioners a better scope to be known to the public than the members of the Independent Medical

Profession, fairs are being held every year under the auspices of one or the other Associations whose chief office-bearers are medical men in Government service and exhibits are shown from various medical institutions whose staff is engaged in active private practice of one variety or other, and in all these functions, members of the independent medical profession are in the background if they are anything at all in these activities. It should not be considered that anybody is jealous of the position occupied by the State-paid practitioners nor is it the intention of anybody that they should be debarred from taking part in public activities of the nature referred to above; what has been said is with the object of bringing to the notice of the readers the inequalities in the matter of rights and privileges and the helplessness of the independent medical profession even in the matter of social work which serves either directly or indirectly to popularise the Government paid practitioners, keeping the members of the independent medical profession in the background regarding such publicity. In British Isles, the conditions are quite different. The Independent medical profession being the sole guardians in matters medical, all of them have equal rights and privileges and enjoy unfettered all the advantages of publicity in the exercise of the profession in one capacity or other.

Having said so much about the conditions of the medical profession in this country in comparison to that obtaining in British Isles, let us find out what are the items in the present code that hinders the growth and prosperity of the profession and what changes are to be brought about in this code so that in the present state of affairs of medical relief in State hospitals, with peculiar rights enjoyed by the full-timed State-paid practitioners who run these institutions, the members of the independent medical profession do not suffer more than it is necessary or possible.

The matter dealt with in the Code of Medical Ethics could be divided under the following heads:—

- (1) Publicity and advertisement.
- (2) Covering unqualified and unregistered practitioners.
- (3) Duties and responsibilities of the profession towards the public.
- (4) Conduct and relationship and behaviour of medical practitioners towards one another.

Publicity and advertisement

For reasons referred to above regarding inequality of chances of publicity between the State-paid practitioners and the Independent medical practitioners, it is desirable to deal elaborately what constitutes Publicity and Advertisement, whether this could be permitted in India both in the interest of the public and the profession and to what extent and within what limits.

The terms Publicity and Advertisement are correlative, meaning and implying the same sense except that the latter term indicates publicity by an individual or a group of individuals for his or their benefit more than the benefit to the public. The three functions of the medical profession, relief cure and prevention are like the three graces, faith, hope and charity, the greatest of them being prevention. In the matter of relief and cure, Government paid practitioners get enough publicity, and they, being allowed private practice unlike the full-timed Government servants in other departments or the full-timed Government medical men in other countries, are in a much better position to be known.

Quacks and practitioners of other systems of medicine advertise and it will be within the experience of many of the readers what baneful effect it has on the minds of the public and how difficult it is for the qualified practitioners to get himself recognised more in the interest of the patient than that of himself. In British Isles, the medical profession is allowed publicity within its own boundaries

in the medical journals. As the medical profession exists for the benefit of the public they should be educated where and how they could get efficient and scientific medical aid. The State hospitals and dispensaries in India serve the purpose of popularising most effectively the State-paid practitioners.

Means and methods should be found to popularise the independent medical profession. The medical journals will not serve this purpose as the lay public are not interested in them as they are in newspapers. It is the duty of the Medical Council in India to guard the interest of the profession as a whole and they should standardise the methods adopted by the profession in the matter of publicity and advertisement so that they are not harmful to the public or to the dignity of the profession. The Code of Ethics as it now stands does not permit the practitioners to solicit private practice either personally or by advertisement in newspapers, by placards or by the distribution of circulars, cards or handbills. These restrictions are all right in the British Isles where the State paid practitioners do not exist. In India especially in Madras, the State paid practitioners form a distinct group drawing high salaries, especially those in the I. M. S. in Civil employ, and the Provincial servicemen, and as mentioned above they solicit private practice in addition, as a trade for their own benefit. The institutions where these practitioners work serve them well in the matter of publicity and in addition, one generally finds signboards here and there especially in this City where the official rank and designation of these practitioners are being published below or above the hours of consultation. The private medical practitioners are denied the privilege of publicity which they might earn in case they are allowed to serve the public in the hospitals as freely as is the case in British Isles. This want of publicity could be made good by allowing them to solicit private practice by harmless methods which should be standardised by the Council

so that this privilege is not misused. The private practitioners should be allowed to make simple announcements say, for a specified period mentioning his name and qualification, the place and hours of consultation and in case he is a specialist, to mention the speciality. So much for relief and cure but regarding prevention, rules of Ethics should be more lax than it is now. This has been felt in England and Wales and America in the interest of the public, and an individual private practitioner or a group of individuals should be treated in the same way with regard to publicity of their activities, as the Government paid practitioners are, either individually or in groups, representing associations interested in Public Health and Welfare. It will not be out of place to quote here a few sentences found in *The Medical Mentor*, the official Journal of American Medical Editors' and Authors' Association, in an article on Publicity by Dr. Arthur M. Corwin, M.D.:—

"To insure prevention, however, you must know enough to do it yourself, a knowledge acquired only by extensive, laborious propaganda. The public needs considerable educating as to the importance of calling him early before the bridge is impassable. A recognition by the people of the danger signals of serious diseases, depending upon the prompt use of a knife or anti-toxin, is still far from adequate. Here the newspaper and medical magazine writers are helpful but have merely begun to scratch the surface. Physicians in every city and town should limber up their quills and uncork their ink pots in this line of service.

"The education of the people in matters of personal hygiene and public health (which means the health of the individual and the healthfulness

of his environment) must be conducted by physicians if we are to fulfill the largest part of our work. If we had more *esprit de corps*, knew what we wanted, agreed upon and held together, we should be more respected by the audience we claim to want."

Vital questions often affecting the health of the nation such as temperance are now left by the Independent medical profession to lawyers, clergy and other unqualified laymen. Preventive medicine in regard to Social Hygiene is usually conducted these days by a few interested people forming some eugenic societies here and there while the profession snores peacefully on. If the profession is to-day suffering from an economic draught and the medical man finds his income insufficient, it only means that there are no organised associations of medical men to eliminate quackery, witchcraft and such deceitful trades and the Independent medical profession merits severe criticism from the public which now either ignores or dictates to them.

Covering unqualified and unregistered practitioners. The code of ethics as it is published prohibits a registered medical practitioner from associating himself with any unqualified or unregistered practitioner. But these rules are observed by those in authority in breach and made applicable when any member or members of the Independent medical profession is involved. A few months after the Medical Registration Act was passed in this Province one prominent member of the Independent medical profession, the late Dr. Krishnaswamy Iyer, M.D., was charged with the offence of covering for associating himself with an Ayurvedic institution, which charge eventually ended in smoke due to agitation by the public and not members of the profession either in Government service or in private practice. What do we find to-day? In the biggest State hospital which is also the seat of training of medical students, the X-Ray department is

under the control of a non-medical man, and qualified and registered State paid practitioners are assisting him in the treatment of patients.

Practitioners who are eligible to be in the British medical register but have not registered themselves in the British register and other practitioners though registered here but who do not possess qualifications registrable in Great Britain, should be treated as persons with whom those registered in the British Register should not associate themselves and as such the names of such practitioners should be erased from the British Register. We find quite the reverse in practice. The State paid practitioners belonging to the I. M. S. service who are in the British Register are associating themselves with Sub Assistant Surgeons and Assistant Surgeons with L. M. P. and L. M. & S. qualifications both the latter class of practitioners being not eligible to be registered in the British Register, the I. M. S. officers ought to have been charged for the offence of covering. The General Medical Council which recently made so much noise in this country regarding medical education, do not find it perhaps convenient to tackle this naughty question of covering.

Yet quite recently, the President, Madras Medical Council ruled that the association by registered practitioners with the practitioners passed out from the Government School of Indian medicine amounts to covering. As was commented in the columns of this journal regarding this subject, this decision is inconsistent so long as registered medical practitioners are allowed to be teachers of the students trained in that institution in subjects like Surgery including Operative Surgery. The time and stage had passed when those in authority in the Allopathic system of medicine ought to have protested successfully against the starting of an institution by the Government which appeared to them of doubtful utility to the public. Now that so many students are let out from

this State recognised institution and allowed to treat the members of the public, how can the Medical Council deny these members of the medical profession the benefit of consultations by the registered practitioners?

There are here and there qualified practitioners of the Allopathic system who do not wish or care to be registered. Association by a registered practitioner with these men amounts to breach of medical ethics. Another matter is worth mentioning and that is employing compounders and nurses as Anaesthetics by registered practitioners. Strictly speaking, this amounts to infamous conduct. Yet this is being allowed especially in State Hospitals.

Any Ethics if it is to be respected and followed should be above convenience. It is necessary that such of the rules that cannot be worked should be either repealed or modified. From actual practice, we find that one day or other, a registered practitioner comes in contact with an unregistered practitioner and out of pure humanitarian reasons, the registered practitioner cannot but associate himself with the unregistered practitioner. If the Government prohibited unregistered practitioners from practising, and if a registered practitioner associated with such an unregistered person, then such an act may be considered as a crime. But so long as the Government cannot put an end to quackery and allows or rather connives at unethical practices in their own Medical Administration, rules regarding covering should be modified to a large extent, so that the morale of those responsible to run the Medical Council is not questioned.

Duties and Responsibilities of the Profession towards the Public, Etc.

Regarding "Duties and Responsibilities of the Profession towards the Public and Conduct, Relationship and Behaviour of Medical Men towards one another", there need not be any

modifications as good morals enunciated in these rules cannot have two standards, however much the Indian conditions may differ from those obtaining in the British Isles.

Apart from the morals enunciated with regard to the duties of the profession towards the members of the public and for the guidance of the profession itself, there is one rule in the present Code of Ethics, which prohibits the members of the Medical profession from exhibiting publicly scale of fees for professional services. Ordinarily it is not possible to conceive of any harm to the public, much less to the dignity of the profession, if the patients knew beforehand how much they have to pay for services to be rendered by the medical man, so that they may be prepared to meet the same.

There is yet another rule under which practitioners suffer with regard to the realisation of their fees for services rendered and that is "when a member is requested to attend a patient already under the care of another practitioner (the case not being one of emergency) he should decline to do so, except in consultation with the practitioner in attendance or, in case the consultation be not agreed to, until the practitioner in attendance has been informed (in writing, if possible) that his services are no longer desired." Generally practitioners especially the senior amongst them do not respect this rule and the aggrieved junior practitioners, do not feel bold on account of the influence the senior practitioners command, to report such cases to the Council and get their grievances redressed with the result that they not only lose their prestige but also suffer materially by not being able to realise their fees for services rendered till they were stopped. So, it may be desirable to guard the interest of such aggrieved practitioners at least in the matter of realisation of their fees, by amending the existing rule adding to it after "desired" "and that he has paid his fees in full".

It is an irony, though not strange, in the existing state of affairs, that the medical Registration Act, which was passed in this country for the benefit of the medical profession, is today being worked in a way detrimental to the interests of the majority belonging to it. Ways and means have been suggested in the previous articles dealing with the Medical Registration Act and which appeared in the earlier issues of this journal as to how and why the Medical Registration Act has to be amended so as to make it really useful for those for whom it was enacted. That is a large question which must be dealt with by the legislature, but as regards the Code of Medical Ethics the medical Council are its own masters, and it is expected that the Council will consider all points of view dispassionately and modify the Code in a way most suitable to the local conditions.

Abstract

MANAGEMENT OF SQUINT IN CHILDREN.

BY

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There seems to be more confusion and misunderstanding in regard to properly advising the parents of a child afflicted with squint than there is in any other subject in ophthalmology. This discussion will be handled from the view-point of the pediatrician or family physician, and only the fundamental principles that might aid in arriving at the proper conclusion will be presented.

The management of squint in children is one of the most definite procedures in the practice of ophthalmology. Although the majority of cases differ widely, in most cases it is not difficult to decide on a definite procedure, and usually the results are uniformly satisfactory.

To understand the management of squint, there are a few fundamentals of the anatomy and physiology of the eye with which one must be thoroughly acquainted. The explanation of the processes involved is not so intricate as it may seem at first. The third nerve supplies the internal rectus, the ciliary body, and the iris, controlling the size of the pupil. In order to see clearly an object within 18 inches, the lens increases its refractive power so that the rays of light will come to a focus on the retina. This is accomplished by stimulating the circular muscle of the ciliary body, thereby relaxing the ligamentum pectinatum. The elastic lens becomes more spherical, bringing the rays of light to a focus on the retina. At the same time, in order to have both eyes focused on the same object, the eyes must turn in, or converge, and the pupils become smaller. One will readily see that the whole process is accomplished by stimulation of the third nerve of each eye. If the patient is far-sighted, it is necessary to go through the same process to see a distant object clearly, as to look at a near object, in so far as the ciliary body is concerned. Being part of the same process, naturally the stimulus is also transmitted to the internal rectus. The result is, therefore, too much stimulation for the distance the patient is looking; or in other words, the eyes tend to turn in. On the other hand, if the patient is near-sighted (myopic), the crystalline lenses are too spherical to look at a near object, and it is not necessary to send the usual stimulus to the ciliary body. As a result, no stimulation is sent to the internal recti, and the eyes tend to turn out, depending upon the distance of the object at which the patient is looking.

When dealing with a child there are only four facts to bear in mind:

1. If an eye squints for any length of time, the child will develop an amblyopia ex anopsia in the squinting eye.

2. Unless binocular single vision is developed before the age of six, it will be very difficult to develop it thereafter in the majority of cases.

3. Binocular single vision is quite essential in estimating the third dimension.

4. All squints should be corrected as soon as possible. This applies to children beginning at the age of one year.

The family physician is usually the first one to see the child who is developing squint. The mother says, "When the child is tired or indisposed, one of his eyes turns in or out." When the physician examines the child later, he finds that the eyes are perfectly straight. This does not indicate that the case should be dismissed lightly or that the child will outgrow the condition. In many of these cases, should the child develop a debilitating disease, the eyes will become definitely crossed. Most of these children have a high refractive error, and if this is corrected early it will definitely prevent the squint.

To demonstrate a latent tendency for squinting, have the child fix his vision on a small, definite, distant object, and, with a small screen held in each hand, first cover one eye, then the other, and observe the movements of the eyes. If there is latent convergent squint, the covered eye will turn out when it is uncovered, and *vice versa*. An up-and-down deviation can be demonstrated in the same manner. Should a tendency for squinting be discovered, the child should be refracted under cyclo-plegic, such as homatropine, to determine the existing refractive condition of the eye. If the child has a tendency to convergent squint and hyperopia or far-sightedness is found, it should be corrected. Also, should a child have a tendency to a divergent squint and be near-sighted, this should be corrected. On the other hand, should the opposite condition be found, it should not be corrected, unless it is of a high

degree. If a high degree of astigmatism is found in higher divergent or convergent squint, it should be corrected.

If the child has a definitely established squint, no time should be lost in obtaining refraction under atropine and pushing the correction with lenses as rapidly as possible until it approaches the full atropine correction. The non-squinting eye should be covered each day for half a day until the vision of the squinting eye has returned to normal. After having the child up to the full correction with normal vision in both eyes for six months, if there is still over 15 degrees of squint, it should be corrected by a tucking operation or an advancement of the weak internal or external rectus muscles of the involved eye. The term *weak muscle* is merely a practical one, because in most cases it is merely insufficient stimulation from the brain or a hyper-stimulation of the stronger muscle.

In alternating squint, the vision does not usually deteriorate in either eye. In a child who has an inherited alternating squint, the possibility of correcting it with glasses is remote. However, an accurate refraction should be done and, if the patient is found to have a fairly marked error, an effort should be made to correct it with glasses. If the squint is not improved within a year, it will be necessary to operate as it would be useless to try any longer. The operation should be performed as soon as possible and should be followed by exercises with the Worth amblyoscope in an effort to develop binocular single vision before the child gets too old. In cases of alternating strabismus, it is not at all uncommon to have the child complain of double vision for a month or two after the operation. However if the squint is fully corrected, there is no occasion for alarm, since it may soon be overcome by exercising. In these cases it is sometimes necessary to advance both external recti before a full correction

is obtained. But by ~~some~~ effort they usually are fully corrected. If attended to before the age of six, the chances of developing binocular single vision are very good.

Advancement of the weak muscle is nearly always preferable to a tenotomy of the stronger, because, in advancing or tucking the weaker muscle, one merely reinforces the deficient muscle, while in tenotomy one weakens a perfectly normal muscle and in a few years the eye is quite likely to turn out. This condition is worse than the original convergent strabismus. Even though the child has been neglected, and is found to have a squint of several years' standing, the eyes may be straightened perfectly by operation. Although the chances of developing binocular single vision are not good, one should not give up hope. I have had a number of patients in their twenties develop binocular single vision through persistent exercise.

If the patient is in the late teens and the squinting eye is amblyopic, the eyes may still be straightened, but it is usually impossible to persuade the patient cover the non-squinting eye for a sufficiently long time to restore the vision, and, naturally, with good vision only in one eye, it is impossible to develop binocular single vision.

SUMMARY.

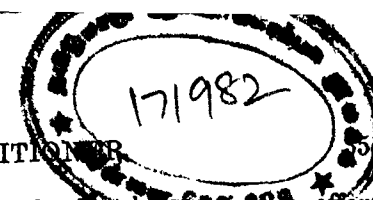
A squinting eye usually develops amblyopia ex anopsia. In most cases, it is very difficult to develop binocular single vision after the age of six. A child with squint is placed under a terrible handicap in school, and, should the condition continue to adult life, it leaves the patient labouring under a permanent handicap. Therefore, all squints should be corrected as early as possible.—*The Medical Herald*, June 1930.

Dear Reader,

If you have not already remitted your subscription will you kindly do it to-day.

The Medical Practitioner just completed one year's service to you.

V. Rama Kamath.



JL

N30MP N30.1.10-12

A CASE OF ENCEPHALITIS LETHARGICA OF SEVERE TYPE

TREATED SUCCESSFULLY BY
INJECTIONS OF ELECTROCOLLOIDAL
GOLD AND SILVER

BY

ARTHUR W. FULLER, M.D. EDIN.

As a good deal of attention is being given at the present time to encephalitis lethargica and its treatment, especially by medical officers of health, the following clinical report may be of interest.

The patient, a lady aged 68, after complaining of recurring pain in the right temporal region for a few weeks, had an attack of vertigo in the street; she was brought home and relapsed speedily into a condition of stupor from which, however, she could be aroused. Sir William Willcox was called in consultation, and the diagnosis of encephalitis lethargica was made, with a grave prognosis. The cerebrospinal fluid, which was examined by Dr. A. B. Porteous, was found to be normal, except for a very slight lymphocytosis, there being no excess of globulin. Cultures were sterile and no T.B. present.

SYMPTOMS AND COURSE OF THE DISEASE.

The face was expressionless and mask-like. The mental condition was stuporose alternating with delirium, especially at night. She spoke with great difficulty and hardly above a whisper. There was spasmodic twitching of the face and muscles of the neck, and she complained of pain on the right side of the face and temporal region, also of frontal headache. The antra and nasal sinuses were examined by Sir James Dundas-Grant and found normal. The urine showed a trace of sugar. All the reflexes were present. There was no diplopia, but the ocular movements were performed with difficulty, especially the upward and downward, the horizontal movements being much less impaired; bilateral

ptosis was also present. There was great dryness of the throat and deglutition was very slow. The patient lay almost immobile, except for involuntary movements of the right arm and hand resembling those of paralysis agitans.

Third day: The general asthenia was more marked, the stupor increased, and incontinence of urine and faeces supervened. The temperature rose to 102° F. and then dropped in the evening to 100°, with a morning drop to 99°, probably as the result of the fever mixture which was given. The pulse-rate was about 90 per minute and became very small and weak at times, necessitating the administration of small doses of brandy. The left arm was now completely paralysed and she could only move the legs a little and with difficulty.

Fifth day: There was considerable erythema on the buttocks and round the hip-joint.

Sixth day: There were increased spasmodic twitchings of the face, eyelids, and right hand and leg, great stiffness of the neck muscles, increased difficulty in articulations and swallowing, and deep stupor, from which it was extremely hard to rouse the patient.

Seventh day: The temperature rose to 103°. It was now almost impossible to rouse the patient, and feeding by the mouth had become quite impossible. The respirations, which had been about 28, suddenly rose to 52 on the eighth day.

There appeared little chance of recovery, but, knowing that electrocolloidal metals, particularly colloids of silver and a combination of silver and gold, had been employed successfully in the treatment of general infections, I decided to give an intravenous injection of 0.05 per cent, suspension of gold-silver colloid. The first result was a return to consciousness within an hour, the temperature dropped one degree, the respirations became 36 per minute instead of 52, and the pulse, which had been 140, fell to 120.

Next day the temperature rose again to 102° at 10 P. M. when another intravenous injection was given. After this the temperature commenced to fall steadily, and at 2 P. M. the following day it was 99°. There was a marked improvement both in swallowing and in articulation, and the patient was much more easily aroused. The maximum temperature at night was now only 101°. Two more injections were given on this and the following evening, intramuscularly. They were then suspended altogether for a few days, but the improvement persisted.

On the tenth day the mental condition was markedly better, but there was still incontinence of urine and faeces. The maximum evening temperature was 100°.

On the twelfth day there was some powers of movement in the left arm and hand.

On the fourteenth day her speech was almost normal, albeit a little slow, and she moved her arms and legs more readily, but there was still some nocturnal delirium. The maximum temperature, which had shown a slight improvement each day, was now 99°: the ophthalmoplegia became less marked, the fibrillary muscular movements and twitching of the face and neck muscles subsided, and the power of voluntary movement gradually returned.

On the sixteenth day the silver-gold colloidal injections were resumed daily for four days, as the mental condition was not satisfactory and was not improving *pari passu* with the other symptoms, for she still had some nocturnal delirium and illusions. The result was marked, for she began to take an interest in her surroundings, to converse intelligently, the delirium at night was less, and the incontinence ceased a few days later. The temperature was now normal at night.

At the end of four weeks the patient could sit up and eat simple ordinary diet. There was still asthenia, but she

was gaining strength steadily. At the end of five weeks she was able to walk about her room and her mental condition was nearly normal, her memory being fairly good.

At the end of the sixth week, beyond general debility, there were no abnormal symptoms except that sometimes she complained of sleeplessness and some stiffness of the muscles of the neck.

It is now five months since the acute symptoms subsided; there are no abnormal physical or mental signs, and she is resuming her usual social life.

REMARKS ON TREATMENT

Besides the gold-silver injections, which acted like a specific in this case, the great desideratum is good nursing, which happily was available. The stuporose, almost comatose, condition of the patient, the complete incontinence and general utter helplessness, are a heavy tax both on the skill and patience of the nurses. The subsidiary treatments included the use of an ice-bag and various analgesics for the pains in the head, which at times were very severe, antiseptic swabbing of the mouth and the administration, during sleepless and restless periods, of mild hypnotics. But beyond all these in importance is the question of nutrition. In this case rectal feeding never had to be resorted to. Stimulants must be given occasionally, and both brandy and hypodermic injections of liq. strychninae m. v. were administered, when there were signs of collapse, which were not infrequent. Milk, Brand's meat juice, malted milk, coffee, Allenbury's food, Eaton, jellies, &c., were all found useful during the acute stage.

With regard to the colloids, their action is that of a protein stimulant; but, unlike many other stimulants, there appears to be no subsequent depression if given in small enough doses. There is a reaction, of course, but it is a reaction against the disease, similar to that produced by a vaccine.

and is not a severe one. Their advantage over vaccines in cases where the specific organism cannot be isolated lies in the fact that they are always ready to hand and can be given at once either as a substitute for, or as a preliminary to, vaccine therapy, and with as good if not better results. It would be interesting to know if the gold-silver colloids have been used before in this country in epidemic encephalitis, for the most gratifying results of their employment in this case has been that the changed mental condition and various types of paralysis so frequently observed as sequelæ have not occurred.

Among other treatments recommended for this disease are intramuscular injections of 4 c.cm. of a 25 per cent. solution of magnesium sulphate (Edwin Matthew, *THE LANCET*, 1924, i., 1157); intravenous injections of sod. salicylate 1-30 solution have been used with reported good results by Rathery, Gournay, Courcoux, and Maignant. A vaccine has been made from the fixed virus of encephalitis lethargica and improvement from its use has been reported, but the evidence is inconclusive.

The bacteriology of the disease is at present unsatisfactory, but Loewe, Strauss, and Thelimer have grown an organism resembling that of Flexner in poliomyelitis.

The infectivity is very low and contacts rarely appear to suffer.

The clinical picture is that of a general infection, and the organism is probably a filtering bacillus producing a virus, which has a selective action on the brain and spinal cord by way of the cerebrospinal fluid, the symptoms varying according to the damage which may result, whether in the meninges, cerebral hemispheres, basal ganglia, pyramidal tracts, &c. The incontinence which is so constant a symptom is mainly due to the lethargy and general stuporose condition.

The after-treatment is the treatment of convalescence, with special reference to abundance of rest and sleep

and rigid exclusion of all excitement, the avoidance of strong tonics, and the recognition that the time may be considerable before complete restoration takes place.—*The Lancet*.

ORARGOL.

(A.F.D.)

AN electrically prepared suspension of colloidal silver and gold, the most active antiseptics of all the colloidal metals used against infectious conditions.

Indicated in the same diseases as colloidal silver, Orargol has a superior action because of the addition of the powerfully anti-infectious colloidal gold, also for the reason that the particles of both metals are in a state of much finer sub-division—and therefore, more active—than can be obtained by chemical means.

Notes on Treatment of Diseases.

N. B.—These notes are intended to supplement the treatment given in ordinary text books and neither to be expected nor possible to be exhaustive.

Bronchitis:—In the early stage before secretion is established, hot foot bath followed by a glass of lemonade with whisky or a dose of Dover's powder before going to bed is good. In children the chest may be well rubbed with camphor liniment and aconite given internally as follows; Tinct. aconite mms 24, Spt. Aether. Nitrosi drams 2 and water one ounce half a teaspoonful of this to children and a dessertspoonful to adults in water every hour to be followed if aborted, by Syrup Ipecac 1 to 2 drams Pot. Citras 4 drams and water 6 ounces; a dessertspoonful of this to a child five years, every four hours or Syrup of Ipecac one ounce, succs lemonis one ounce, pot. bicarb 4 drams

Spt. Aether nitrosi one ounce, water add six ounces; a dessertspoonful of this to an adult every four hours.

During the second stage when the secretion is established, a tea to dessertspoonful to be taken every four hours of the following; Ammonium chloride 2 drams, fluid extract of Liquorice 2 drams, water 3 ounces. If the cough is troublesome morphia or heroin may be added and the following mixture to be given every six hours in dessertspoonful doses, Ammon chloride one dram Ammon carb, one dram Ammon bromide one dram, fluid extract of Liquorice 4 drams and water six ounces. Creasol syrup (A. F. D) soothes the pain and inflammation of the bronchi and makes the secretion less purulent.

During the third stage if the secretion is too much, terpin hydras 10 grains with heroin is useful and also strychnine and atropine. (*Hare*)

2. In Bronchitis with profuse muco-purulent expectoration, creasote may be given as follows in tablespoonful doses in a wine glass of water three times a day. Creasote 3 drams, Tinct. Gent. Co. one ounce, Spt. Vini rect 7 ounces vinum zerici. one pint (*Hare*). Histogenol (A.F.D.) an arsenophosphorated organic compound with nuclein is an excellent restorative and powerful stimulant at this stage.

3. In capillary Bronchitis of children and in early stage of eruptive fevers when there is torpid or poorly developed rash, mustard oil with wet pack is useful (*Hare*)

4. *Bronchitis Acute:*—If there is dyspnea, nitrite of sodium in one grain doses is good. To enhance the exudation, Ammon chloride grains 10, syrup Tolu with water one ounce every three hours. If the convalescence is delayed, Ammon. iodide to be given in place of chloride or Ammon. carbonas with pot. iodide may be given. (*Modern Medicine*).

5. For adults, Quinine and acetylsalicylic acid each grains two and acetanilide grain ½ to be given every

two or three hours to lessen the severity (*Modern Medicine*).

6. Bronchitis Sub-acute in children between one and five years, Vinum ipecac one dram, Tinct. scillae ½ a dram, Syrup Tolu 4 drams, water one ounce a teaspoonful every two to three hours,

7. Bronchitis chronic in children; creasote in the form of "proposote" in 10 mms. doses 3 times a day after meals.

8. In old persons Pot. Iodide 7 to 10 grains, thyroid extract ½ a grain with pot. bicarb and infusion senega is good; starvation for one or two days; If there is bronchorea in place of pot. iodide 20 mms. of Terepene Hydras with Tolu should be given. If there is bad smell creasote mms 3 in capsules is useful (*Leonard Williams*).

9. Pulmo-calcium (A.F.D.) containing all the principles of the tribasic phosphate, carbonates and other salts of lime and magnesia is specially indicated for children and old persons as a recalcifier and builder of the lung tissue and may be given with great advantage during convalescence.

10. When there is much phlegm on rising from the bed in morning the following may be given in a glassful of water on rising from bed:—Soda bicarb. grs. 20; sodium chloride grs. 5, spt. chloroform mms. 10, aqua anesi one ounce. (*Rudolf*).

11. Tinct. Iodine half to one dram to one ounce of turpentine liniment to be applied at night (*Modern Medicine*).

12. In children; oil of amber in proportion of one to three parts of olive oil to be applied locally over the chest back and front (*Hare*).

13. In children emetine is valuable. It is followed by a fall in temperature.

14. Broncho pneumonia:—calomel 1/8th to 1/6th of a grain with soda bicarb every two hours for a child of one year old till the bowels move; sodium and pot. iodide 1 to 3 grains or iodoform ½ a grain is useful for children; cold bath or cold pack; mustard and linseed poultice one to

four over the chest and back four times a day.

Tinct. Belladonna mms 2 every hour for a child. When cardiac failure threatens, adrenaline 1—1000 ms 3 in a syringe full of saline intramuscularly, internally 3 mms of pituitrine, ammon. chloride $\frac{1}{4}$ gr. to a child of 1 year old and $\frac{1}{2}$ gr. for two to three years and five grams to adult every two hours.

15. Injection Therapy in Bronchitis.—In acute Bronchitis especially of

septic nature and in post operative cases Septicemine A. F. D. (a combination of Iodine and Formaldehyde) may be tried with success along with internal drug treatment. Other preparations of equal therapeutic indication which may be given intramuscularly or intravenously are Guaiacol and Iodine A. F. D.; and Hexamethy lenamine A. F. D. which can be had in ampoules.

Notes on Diagnosis, Therapeutics and other Medical Subjects.

EXAMINATION OF BLOOD OF EUROPEANS AND BENGALIS BY COL. MCKEY AND MUKHERJEE

Constituents	Europeans	Bengalis
R. B. C.	5,00,0000	530,0000 per c. m. m.
W. B. C.	6000 to 8000	9000
Haemoglobin	100 per cent.	81 per cent
Specific Gravity	1054 to 1057	1055 to 1058
Proteins	19.17 %	18.23%
Total solids	21.13 %	20.12%
Coagulation	4.7 minutes	1.75 to 2.5 minutes
Sugar	0.08 %	0.13 %
Urea	0.03 to 1 %	0.13 %
Blood-pressure	111 to 130 mm.	90 to 115 mm

Hydrogen Ions.—Hydrogen Ions are atoms of Hydrogen which have lost an electron and thus are positively charged. The acidity of the solution depends upon the number of hydrogen ions contained in it and the alkalinity on the number of hydroxylions (O. H. Ions) When H or O. H. ions are equal in number in a solution the reaction is neutral. If H Ions is in excess it is acid and O. H. ions is in excess it is alkaline. The P. H. is the Hydrogen Ion concentration. The P. H. of water is 7. the numbers from 7 to 1 represent in increasing degree of acidity and those from 7 to 13 an increasing degree of alkalinity. The P. H. value is most conveniently tested by a series of coloured indicators each of which is changed into a characteristic colour by P. H. ranging between a very narrow and definite limit and thus Thymol blue changes into red and yellow between 1.2 to 2.8 P. H. Bromophenol blue from yellow to blue

between 2.8 and 4.6 P. H.; Phenol red from yellow to red between 6.8 and 8.4 P. H.; Thymol violet from yellow of blue to violet between 9 and 13 P. H.; A substance which resists the change of P. H. on addition of an alkaline or acid is said to exert a buffer action and the presence of such substance is important. The P. H. of Pancreatic juice is 8.3; the P. H. of blood, tears and human milk is 7.4, 7.2, and 7.1, respectively. The P. H. of Saliva and cow's milk 6.9 and 6.7; The P. H. of adult gastric juice 0.9 to 1.6; the optimum P. H. for growth of bacillus colloid is 5 of yeast 2.5; the trypsin functions best at 8 and pepsin 1.4; the P. H. of lime juice is 2.2, of wines 2.8, to 3.8 and of Beer 3.9 to 4.7.

Albuminuria.

To distinguish between vascular and renal albuminuria three glass tubes are used.—The first half an ounce

of urine passed is put into a small glass tube, then the bulk is passed into a large glass tube and the last ounce to be passed into a third tube; the first urine will show the largest quantity of albumin.

To distinguish, between functional and organic, give calcium lactate 15 grains and if the albumin disappears it is functional.

3. Albuminuria is found in cardiac disease, spinal injuries, myxedema, Grave's disease, Tonsillitis, Hepatic affections, Migrane, Epilepsy. Tuberculosis and Asthma, Bronchitis and after the use of cubebs or turpentine, mercury, quinine, arsenic and phosphorus and is also found in climacterium when the period is expected. In order to distinguish whether the albumen is due to Nephritis or some harmless damage the ratio of albumin to globulin should be ascertained and also the amount of output of diastase in the urine.

4. In newborn infants, albuminuria is common and continued till the 14th day and then disappears.

The matter of qualitative difference of proteins is of no small consequence in Diabetes; it may account for what is proved by experience that rice serves the races that rely on it as an exclusive source of protein while wheat is only suitable for races which take much more varied dietary. Rice contains a better protein than wheat and wheat better than maize (Hopkin).

2. The biological values of protein estimated in terms of body protein which their digestion will spare from loss are meat 104, cow's milk 100, fish 95, rice 88, cauliflower 84, crab meat 79, Potato 79, Yeast 71, casain 70, Nutrose, 69, Spinac 64, Peas 56; Wheatflour 40, Cornflour 30 (Robertson).

EXTRACTS FROM STANDARD LITERATURE.

Lancet 1923, 1, 70.

"Sulfarsenol in the Treatment of Syphilis and of some of the Complications of Gonorrhoea."

"For the treatment of the complications of gonorrhoea the intravenous route is the best. I have tried this drug on patients with most of the complications that are to be met with, such as arthritis, rheumatism, hyperkeratosis, and epididymitis. The results were remarkably good, but the effect in epididymitis was extraordinary. I have treated nearly 300 cases of this complication with Sulfarsenol, and have never failed to stop the pain in a few hours and reduce the temperature and swelling in a few days, the average time in bed being 4-5 days. Patients previously in very great pain who had to be given morphia, slept peacefully a few hours after an injection of Sulfarsenol. It has been my custom to give a dose of 0.12 g., followed in 48 hours by an injection 0.18 g. In all but four cases no more injections were necessary. In these cases the temperature went up a day or so later, and the pain returned. I then gave an 0.18 g., followed by another injection 48 hours later of 0.3 g., with the result that the temperature dropped to normal and the pain disappeared. They did not relapse again. These cases of epididymitis were free from gonorrhoea in the average number of days of cases with no complications."

F. CARMINOW DOBLE, M.R.C.S., Eng.

Officer in charge,
Gonorrhoeal Division,
Military Hospital,
Rochester Row,
London, S. W.

News and Comments.

GOVERNMENT OF MADRAS.
PUBLIC (SERVICES) DEPARTMENT.

G. O. No. 1196, Ms.

Dated 11th September 1930.

Order:—The following notification will be published in the Fort St. George Gazette;—

OBITUARY NOTICE.

His Excellency the Governor in Council and His Excellency the Governor acting with Ministers has received with deep regret intelligence of the sudden death on the 26th August 1930 of Captain N.R. Ubhaya, L.R.C.P. & S., D.P.H. acting Director of Public Health. He was the head of the department for more than two years—a period marked by notable expansion and development in the department. His Excellency the Governor in Council and His Excellency the Governor acting with Ministers desires to place on record his high appreciation of the valuable services rendered by Captain Ubhaya.

(By order of the Governor in Council)

C. B. COTTERELL,
Chief Secretary.

We draw the attention of our readers, the Rural Medical Practitioners, to a notification appearing elsewhere from the Secretary, The Madras Provincial Rural Medical Practitioners' Association, appealing to the members of the Association to pay all the arrears of subscription so as to enable him to publish a booklet containing all the Government Orders, circulars, and other rules pertaining to the Rural Medical Relief Scheme. It is within our knowledge and of many more interested in this scheme that many a time aggrieved Rural Medical Practitioners lose a splendid case for want of knowledge of certain technicalities based upon Government orders and circulars and we commend the publi-

cation of a booklet referred to above and trust that every Rural Medical Practitioner co-operates and helps the secretary in this his onerous task.

We note with some satisfaction that the Government are pleased to commend to the Local bodies, the payment of a daily allowance of Rs. 5 to Rural Medical Practitioners if they are requisitioned to do epidemic duties. Though these Practitioners have to be thankful to all concerned for this small mercy, we are of opinion that the allowance is too meagre, taking into consideration that at times these practitioners have to undergo great hardships in the matter of conveyance, boarding and lodging in the dirty infected villages. We trust that this daily allowance of Rs. 5 does not deprive them of the usual travelling expenses.

It will not be out of place for us to draw the attention of the Rural Medical Practitioners that persistent agitation conducted by zealous workers is bound to bear fruits though not always as speedily as one would expect. There is no dearth for zeal, but when this is to be counted in the shape of rupees, annas and pies, it dries up into no action, and consequently many a zealous worker had to give up his work for want of sinews in shape of money. If the medical profession cultivates the ideal spirit of co-operation, one for all and all for one, many a naughty problem concerning medical relief, especially in rural areas, may be handled with greater chances of success.

Seven Advisory Committees have been recently constituted by the Government for the city Government Hospitals, as there were demands for such Committees which were pressed by people's representatives on the floor of the Legislative Council on more than one occasion (as far as we remember).

The object of these Committees is said to be to keep the Surgeon-General

informed as to the needs of the hospitals as viewed by the public. The Committee is to be an advisory body without executive authority, which as usual would be in the hands of the Superintendents of the hospitals. The Superintendents may carry on the suggestions and recommendations of the Committee as far as practicable and if they cannot accept the suggestions and recommendations of the Committee, the matter is to be referred to the Surgeon-General, whose decision seems to be final.

We find that these Committees are formed on the basis of similar Committees in England and Wales in the matter of representation of different types of experience, but in the matter of selection of the members for these Committees, the principle adopted by the Government regarding the management by these Committees is quite the reverse of that adopted by the Voluntary Hospitals Commission in England and Wales, where the large majority of the members of the Committee are chosen by election and not by nomination and the Committees are entrusted with the executive functions and are answerable only to the Ministry of Health. It may be argued that the formation of hospitals in the country of our rulers is on Voluntary System, the public volunteering to contribute to the funds of the hospital, donations and subscriptions and as such, it is but right that members of the Committee should be chosen by election from those who make these contributions and in India the whole expenditure for the hospitals is met by the Government and so the Government should have persons in the Committee in whom they have confidence. If the Government is a private body, the argument may be sound but the Government is not a private body and spends money for hospitals from the money they collect from the people in this country. If it is the intention of the Government to entrust people with the management of their own affairs, there is no better training-ground, least risky, than entrusting them with the management of hospit-

als, especially so when such persons are selected by the Government. Even if such Committees are to be mere advisory boards and if the final authority is to be still vested in one person, the Surgeon-General, no useful purpose will be served by such Committees. In the country of our rulers, autocratic control is considered to be a real danger in any organization of hospitals or of any other voluntary social service as is evidenced in a book "Hospital Organization and Management" recently published in England with an introduction by the Hon. Sir Arthur Stanley, G.B.E., C.B., M.V.O. (now His Excellency the Governor of this Province), and it is a strange irony that during the tenure of office of this personage as the Head of all Administrations in this Province, Hospital Committees without 'real life' are to be constituted merely as advisory boards and to continue to be under the autocratic control of one Government Official and such control to be considered not a 'danger.' There can't be two standards for good principles one for England and another for India in humanitarian work of the kind under reference.

It will not be out of place to bring to the notice of all concerned that even in the selection of the personnel of these Committees the Government has not followed completely the formula laid down by the Voluntary Hospitals Commission, wherein, amongst the representatives forming the Committee, there was a place for the members of the medical profession outside the hospital staff. The only two lady members of the profession, who are at the head of Mission Hospitals in the City and who are nominated to serve in these Committees, cannot be said to be representatives of the profession in the city in any sense, as they are running institutions similar to those run by the Government.

We understand that 97 candidates appeared before the Selection Committee for the recruitment of House Surgeons and House Physicians and 75

have been selected from amongst them, they being eligible for competition for the posts of Assistant Surgeons in Government Service. Out of these 97 candidates, there were 16 Lady Apothecaries all of whom are being selected.

Selections for the post of Lady Sub-Assistant Surgeons was also conducted by the same Committee, 27 Lady Sub-Assistant Surgeons being selected from among 28 applicants. We hear that there are still some more vacancies for the post of Lady Sub-Assistant Surgeons, and if more appeared, there would have been a chance of their being taken in.

As regards the recruitment of male Sub-Assistant Surgeons, applications were not called in on the last occasion as some of those selected last year have not been as yet absorbed in service for want of vacancies. There seems to be distant hope of these vacancies being filled up by the end of current year when there is likely to be a selection for this class of medical officers.

We also learn with authority that the Government have fixed the age-limit at 27 for Sub-Assistant Surgeons and at 30 for Assistant Surgeons, and there will be no room for complaint of favouritism on this count in future.

Our readers might remember that we protested against the appointment of medical Graduates as Sub-Assistant Surgeons in our very first issue last October, and we now find this infection has spread in the Department of Public Health also. The inability of the Government to find posts for some of the unemployed B. S. Scs. seems to have deprived them of sound judgment in filling the posts of II Class Health Officers reserved for those with L. M. P. qualifications. The corollary of this situation brought about by the Government should also be solved by the Government itself, or else the occasional somersault principles advocated by Government under the influence of favouritism are likely to upset the machinery of Medical and Public Health administration. Basing on the solution of this corollary the

Government should in future appoint as a matter of routine Sub-Assistant Surgeons as Assistant Surgeons and II Class Health Officers with L. M. P. qualification as I Class Health Officers. The system of several doors for entry into a same department and several compartments for those doing almost the same work is bad enough. To open back-doors and allowing favourites to get in, whenever the Government likes will certainly lead to degradation and demoralisation in these services.

About 10 months ago, Sub-Assistant Surgeons on jail duty submitted memorials to the Government regarding their grievances. Nothing is heard till today as to what action Government had taken concerning these memorials. We sympathise with the Law Member who is burdened with heavy work due to the present political situation, but will he please in his turn sympathise with the hard-working Sub-Assistant Surgeons whose work has become more onerous and trying as the strength of the inmates into jails is daily increasing due to the same cause for which he has our sympathies. 'All work and no pay' policy till now advocated by the Government regarding these hard-working subordinates who have no other way to add to their resources unlike their more fortunate brethren outside the jails, may have an adverse effect on the administration of jails, of which signs are not wanting.

The Hon. Secretary, The Indian Medical Association, has sent us the following matter for publication:—

The question of affiliation of the Patna Medical Association to the Indian Medical Association was discussed at a general meeting of the Patna Medical Association on the 19th July 1930. The general meeting referred the matter to the Executive Committee of the Patna Medical Association.

The Executive Committee of the Patna Medical Association at its

meeting held on the 11th August 1930 decided to affiliate to the Indian Medical Association as its Patna Branch.

We have received copies of communications that passed between Dr. V. Krishna Menon who was a candidate for election to represent the III Group, and the President, Madras Medical Council, on the subject of the election for that group. The letter from Dr. Krishna Menon is dated 10th June 1930 and points out certain irregularities in the conduct of the elections almost all of which have already been commented upon in these columns in the previous issues. The attention of our readers is however drawn to these irregularities once again as complained of by Dr. V. Krishna Menon, so that the readers might understand that the doubts and difficulties as well as the discontent with respect to certain improper and illegal procedure followed by the Returning Officer in this election, as voiced by us in these columns have been felt by a member of the profession who was himself a candidate for the election. The items of the complaint referred to above are:—

(i) The Medical Register was not properly compiled and was not up-to-date and the 1929 register was not published at all. It was therefore quite likely that there would have been many in service and out of service, whose names were not registered with correct addresses and to whom neither the precepts nor the voting papers would have reached.

(ii) Two different dates were fixed for the return of the voting papers, 20th June in the precept and 28th June in the voting paper. This necessarily confused the voters, and several of the voters had taken the latter intimation as superseding the former and sent their voting papers after the 20th June, which were

considered by the Returning Officer as invalid.

(iii) The Returning Officer displayed his want of sagacity in not giving any distinguishing marks on the covers for the return of the voting papers so as to indicate from the very sight of the covers as to which group each of them belonged and consequently opened, all the covers on a date prior to that fixed for scrutiny for the election under reference.

(iv) The word "Hon'ble" was prefixed to the name of one of the candidates though the person concerned had resigned his membership of the Council of State months ago and was not therefore entitled to this distinction. Undue prominence given by the Registrar to a City member of the Council by printing his name first and the other names in alphabetical order in the ballot paper is quite likely to have misled the voters.

(v) The last but not least of the various irregularities pointed out was, that relating to the printing in the ballot paper of the serial numbers of the voters as they appear in the medical register, which defeats the very object of an election by ballot, as it would be possible to find out from the serial number of the voting papers who voted for whom.

In pointing out these irregularities Dr. Krishna Menon had requested the President in his letter to call for an emergent meeting of the Council and stop the election and start *de novo* proceedings. The President replied that, as he had to go to Simla at that time, he would enquire into the matter in detail after his return. Meanwhile Dr. Krishna Menon had also lodged a written complaint with the Returning Officer against the 'illegal and

irregular' procedure adopted on the date of the scrutiny of the votes. The President of the Council, on the 29th July 1930, wrote to Dr. Krishna Menon as follows:—

"On investigation of your complaints, I have not found evidence of improper procedure in the Council affairs and intended to take no further action in the matter."

It is very fortunate that the President has not ruled that the complaint made by this candidate is frivolous. The President's reply indicates at its best or worst that he was not able to gather evidence which he could have easily done by calling upon the Returning Officer to produce:—

(i) The Medical Register for 1929 and

(ii) The precept and a copy of the ballot paper in which two different dates for the return of the ballot papers were mentioned, and wherein the 4th and 5th allegations could have been very easily verified.

After being satisfied that there was a *prima facie* case, the President ought to have called an emergent meeting of the Council and ought not to have taken the responsibility upon himself in a matter which had to be decided not by him but by the Council. We do not wish to say anything further at this stage, but will be failing in our duty if we do not point out to the President and the members of the Council that they should not take undue advantage of the want of organisation in the medical profession which, if it existed in our country, would not have allowed matters to drift in the way they are at present. We have commented enough on all these allegations and in our humble way suggested ways and means to rectify the irregularities, days before the election took place. Yet the authorities concerned paid no heed. The "don't care" policy might create a 'calm' for the time-being but usually a 'storm' follows a 'calm' and it is difficult for one to gauge the effects of a storm.

We are glad to learn that Major A.M.V. Hesterlow, I.M.S., M.B., C.H.B., (University of Edin. and University College, London), B.Sc. (P.H.) (University of Edin.), D.T.M. & H. (Edin.) has been appointed as Director of Public Health, Madras and we congratulate those who have been responsible in making this choice which is the best both in the interest of Public Health and efficient and peaceful administration. Major Hesterlow born and bred up in India has had exceptional opportunities of studying health problems in England and Scotland, having undergone his medical studies at the University of Edinburgh and in University College, London and it is expected that he would take whatever that is best from the west without losing sight of the conditions prevailing in our country and make his administration both efficient and popular. His amiable disposition and regard for his country which he does not disown though an Anglo-Indian by birth, will surely help him a good way in solving many health problems which are conducive for the welfare of our country and in this onerous task he will not only command help and co-operation from his department but also from the medical profession and the general public.

We are informed that the post of the professor of Hygiene, Medical College, Madras which since 1926 was occupied by Major Hesterlow, now vacant on account of his being elevated to the headship of the Public Health Department, will be filled in by Dr. A. Thirumaliah, L.M.S., L.R.C.P., L.R.C.S., (Edin.) L.R.F.P.S., (Glas.) and D.P.H., (Camb.).

Errata.

On page 332 of the last issue we published two resolutions received by us from the Secretary, Vizianagram Medical Association. We regret for the "printer's devil" the Vizianagram Medical Association wrongly printed as Vizagapatam Medical Association.

Notice.

It is proposed to print in a booklet form, for the benefit of the rural medical practitioners, all the Government orders, circulars, and other rules pertaining to the rural medical relief scheme, the approximate cost of a copy of which would be half a rupee. As funds would be required for the initial expenses, all rural practitioners who have not paid up their subscriptions till now are requested to remit the same to the undersigned without any further delay.

1st Sept. 1930. } S. RAMASUBBU, L.M. & S.
Viraganur, } Secretary,
Salem Dt. } The Madras Provincial Rural
Medical Practitioners' Association.

Correspondence.

LETTERS TO THE EDITOR.

Medical Inspection of Schools.

SIR,

Kindly excuse me if I have to trouble you again for the publication of this letter.

In your editorial note under my last letter on "Medical Inspection of Schools" you have tried to answer my objections and I think I have to explain myself a little further with regard to your note as I find from references to me from a number of my medical Inspector colleagues that I owe such an explanation to you and to your numerous readers through you. I have been individually writing to a few explaining myself but I think I can easily reach a large number of your reading public by your kindly publishing this letter.

You have said in your note that nothing disparaging was implied in your remarks that it is necessary to give a few months training to all medical inspectors before they engage in medical inspection work so that their medical inspection reports may be uniform in standard and hence become suitable for purposes of comparison. In answer to that I have to thank you first for being so very careful in wording your remarks as not to injure the susceptibility of the B.S.Sc. graduate, and to mention to you that medical inspection of schools and school children being a Public Health Subject and its scope essentially preventive, it is in the nature of things that the Government have thought it fit to encourage public health degree holders e.g. the B.S.Sc.s in the appointment of medical inspectors of schools. Regarding the training of which you are so particular, I shall take the liberty of referring you to G. O. No. 934 dated 22nd September 1925. (Law and Education). You will find in it and in the several annexures to the G. O., that the originators of the G. O. have been at some

pains to prescribe a few methods for conducting medical inspection of children, and sanitary inspection of school buildings, boarding schools and hostels, detailing therein certain standards and some general guidance in the use of set words or phrases to denote the nature and degree of certain diseases all of which are found printed in the schedules of medical inspection. This G. O. appears to be sufficiently instructive and by paying attention to it I think it is possible for medical inspectors to minimise to great extent the difficulty arising in composing medical reports lacking in uniformity in standard for purposes of statistical preparation. While it is a fact that the classification of diseases and defects adopted in the medical inspection report forms is not ideal and perfect and that amplification of certain items such as *nervous diseases*—under which Rickets is mentioned and *contagious and infectious disease* from which Malaria should be separated and given as a distinct item, and also the last item *other diseases*; for the purpose of preparing accurate and useful statistics regarding the very common infections and other diseases prevalent in these parts, I think the G. O., referred to gives sufficient information to guide the medical inspector to submit uniform returns or reports on the medical inspection done by him. There are I know medical inspectors who have pleaded to me complete ignorance of such G. O.s on medical inspection as 641 and 934 of 1925, no. 44 of 1926 and no. 399 of 1930 which I think it is the duty of employing authorities to put in to the hands of their medical inspectors of schools before they commence their work of medical inspection.

Lastly I have to draw your attention to the fact that the purpose of my last letter to you was not mainly whether the few months training referred to by you is or is not necessary, but whether there was some justification for the G. O. issued by Government encouraging the employment of B.S.Sc.s as medical inspectors and my view is that there is some justification.

for the reasons stated above. The argument put forth by you that in England Medical Practitioners without special public health qualifications conduct quite successfully medical inspection of Schools does not I think vitiate in any manner the spirit in which the G.O. has been issued. Permit me also to offer a few remarks on your statement that it is necessary to have special knowledge of child psychology, dietetics and vitamins, and endocrinology to do medical inspection work properly and that these subjects are not taught in the health officers' class. Dietetics and Vitamins are very important subjects in Public health work and the student in the health officer's class spends a good portion of time in having to attend lectures and demonstrations on these subjects and in addition does a lot of work on food chemistry. Child psychology or that portion of it relating to the mental and moral welfare of the school child is part of mental hygiene a subject in the B.Sc. course or any other Public health course. So health officers or those holding a diploma in Public health are expected to have some knowledge of these two subjects i.e., dietetics and mental hygiene. As to Endocrinology every medical graduate or licenciate has some knowledge of this subject given during his training in his medical course to enable him to pick out such evident cases of endocrine deficiency as it is not possible to detect during the few minutes he is asked to devote to the medical inspection of each school child.

A. CHANDRAMOULI, L.M.S., B.S.Sc.

(The view expressed by us regarding this question cannot but remain unaltered. We never make any insinuations on those with Public Health qualifications regarding their work of the nature under reference. We still hold the view that a general practitioner can satisfactorily conduct the inspection of school-children, and if anybody was found wanting, it is not the fault of his qualifications, but his own incapacity. The additional fact brought to our notice that the Government have published in-

structions as to how the school inspection should be conducted makes the work of any practitioner easier, even without special Public Health qualifications. It is not the study of books, so much as the study of the human system, that makes the practitioner competent in this work and one without command of general practice cannot with all his knowledge of books cope up with the work of finding out defects and diseases, especially in school-children, where the practitioner has to come to conclusions many a time after keen observation, as no proper assistance will be available otherwise.—Ed.)

BIRTH CONTROL.

DEAR EDITOR,

With regard to your editorial comment on my letter regarding birth-control in the August issue of the Medical Practitioner, I have to make the following remarks:—

(1) In your statements on the subject in the previous issues, you always used the word "birth-control", but in the present issue, you bring in the word "regulation of birth", which is certainly not identical with birth-control as commonly understood. If any one should, after reading my letter, have misunderstood you, as you fear, I don't think the blame is mine.

(2) Epidemics are certainly visitations from God sometimes and man is quite justified in trying to control mortality by all morally lawful means; for, in so doing, he only uses his legitimate right of preserving life, which is certainly different from prevention of birth (by interference with conception etc.), as the latter case is one of usurpation of the right of creation which does not belong to man.

(3) The forces of nature were made for man's use, and there is nothing wrong in diverting them into some other channel whenever required. This is quite different from perverting the laws of Nature and trying to deliberately destroy potential life.

(4) I quite agree with you that human beings should regulate their lives as regards reproduction, the regulation being effected by continency whenever necessary.

(5) The reproductive age of women is certainly not determined by the religion they follow. I never said so. My statement was that too early a marriage was detrimental, as resulting in moral and physical evils, even apart from the question of reproduction, and that the Church, to which I belong, was safeguarding the occurrence of these evils by the prohibition of premature marriages. The Church, though, it neither does determine the reproductive age nor any other physiological functions of women, has every right to legislate for its adherents regarding the age of marriage, and when it does so, takes every point into consideration, including the question of reproductive age.

23, Perambur, Baracks)
Road, Vepery, Madras,) W. J. FERNANDEZ.

[Modern medical science curative and preventive could not have advanced to the present condition, if each step of advancement had to be sanctioned by religion of which there are several in the world with the tenets, dogmas and practices of one conflicting with those of others. Anesthetics were once considered to be against religion and condemned consequently. Now, twilight sleep is considered irreligious. Surgery and midwifery could not have advanced if they were guided by religion. If vaccines and serum prepared by killing animals and used for prevention and treatment of diseases are considered morally legal by one religion, they are considered sinful by another; taking of animal food including eggs is condemned by one religion as it involves the killing of life manifest or potential. If it is considered morally lawful to prevent deaths why the prevention of birth is considered immoral and unlawful as birth is considered by certain religion to be sinful and efforts are being made during life by doing philanthropical acts to prevent re-births

and secure union with the eternal. The correspondent seems to enter more and more into the realm of religion and as the policy of this journal is to avoid religious discussions this matter must end here. Ed].

Reviews

TRACHOMOL.

We are obliged to Messrs. The Anglo-French Drug Co (Eastern) Ltd. Bombay, for the supply of tubes of Trachomol, a neutral compound of Citrocyll Boro Cuprate. We have been using this preparation in cases of Trachoma for over two months and gave the same for trial to two other practitioners for getting independent opinion before we could say anything about the Copper Compound.

Copper still holds a very prominent place in the treatment of Trachoma in spite of the pain and irritation it produces in the eyes soon after its application and a skilful ophthalmic surgeon of wide experience still uses the crude copper in preference to many other preparations now in the market. This new preparation of copper prepared in the French laboratories is soluble in the lachrymal secretions and does not produce either a corrosive alkalinity or irritant acidity. This is an ideal preparation for the use of fastidious patients and the mode of its application is as simple as its after-effects not painful. For general practitioners and for use as a matter of routine, this neutral compound of copper will surely have a bright future and we can safely commend this preparation to those interested in eye-work, as it can be safely used by the patient himself. Trachoma is an obstinate and inveterate malady requiring long-continued treatment and many patients will certainly like the idea of having with them a preparation of the same therapeutic indications, as the pure copper which they could use themselves without causing much pain and discomfort.

THE ALL-INDIA MISSIONS TABLET INDUSTRY.

We refer our readers to an advertisement appearing elsewhere regarding the All India Missions Tablet Industry at Bowringpet, South India, which is being conducted by the Missionaries belonging to the Methodist Church and is under the able management of Dr. Hugh H. Linn, M. D. assisted by Dr. Alexander of the Miraj Medical School and Mr. Arulmani George of Lucknow Christian College. This institution prepares compressed tablets of several varieties putting in it drugs indicated for various diseases and have published a booklet which contains the formulae of the tablets prepared at this institution almost all of which are useful to busy practitioners and travellers and lay men interested in the art of healing. The

indications for the use of these tablets is printed in this booklet.

It is hardly necessary to call the attention of the medical profession to many points in favour of freshly and correctly prepared compressed tablets for the use of patients. Tablets therapy seems to be very popular in an advanced country like America and signs are not wanting that it will be so in India. Dr. Hugh H. Linn informs us that thousands of these tablets are being prepared daily and sent to all parts of India, Burma, Arabia and Ceylon and even East Africa. We commend this institution to the members of the medical profession in this country, for, the patronage of an institution of this nature not only helps the profession, but also a Missionary Society which is interested in the healing of the sick.

THE No. 1 TO No. 10 COURSE OF SULFARSENOL.

While we do not think that this method of dosage is superior to Lt. Col. Harnett's system, we give these particulars as a correct way of using it, because many physicians remain under the impression that No. 1 dose should be the first dose, even in adult cases.

Time.	Dose.	Total to date.
1st day	No. 1 or 6 ctgr.	6 ctgr.
3rd day	No. 2 or 12 "	18 "
5th day	No. 3 or 18 "	36 "
8th day	No. 4 or 24 "	50 "
14th day	No. 5 or 30 "	80 "
20th day	No. 6 or 36 "	126 "
28th day	No. 7 or 42 "	168 "
36th day	No. 8 or 48 "	216 "
46th day	No. 9 or 54 "	260 "
56th day	No. 10 or 60 "	320 "

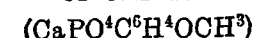
Of course, if any untoward symptoms should arise during the course, the periods between subsequent injections should be extended. The above is for an average Indian of say 100lb to 120lb in weight. For heavier or lighter patients the time may be shortened or lengthened.

A careful comparison will show that the amount of Sulfarsenol given in the period is equal to Lt. Col. Harnett's course B, which is recommended for cases later than secondary.

For primary or secondary cases a further three doses of No. 8 or No. 10 would be required afterwards to complete Lt. Col. Harnett's quantities.

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Creosal has none of the inconveniences of guaiacol; it has no odour, no unpleasant flavour, and is accepted by the most fastidious patients.

"Bulletin de l'Academie de Medecine," 1893. Communication of DR. BALLAND. Professeur ALBERT ROBIN: *Traite de*

Therapeutique, Paris 1898

Thesis presented at the Faculte de Medecine, Paris, on Creosal by

Dr. PEPIN.

Creosal was discovered by two chemists, MM. BUBOIS et LECOQ, and the results obtained by this product have obviously demonstrated that therapeutics now possess a first-class weapon to fight against pulmonary affections and consumptive diseases.

Creosal A. F. D. has rapidly found favour with the medical profession following the memorandum of Dr. BALLAND, Laureat a la Faculte de Medecine de Paris, addressed to the Academie, and practitioners of all countries have confirmed the results obtained by this learned observer.

(a) *Paris Hospitals.*—From Lariboisiere, Saint-Louis, Necker, Saint-Antoine, Saint-Joseph, etc., Creosal has been reported as the foremost improvement on guaiacol and phosphoric acid. Dr. TENNESSON, of the Saint-Louis Hospital, affirmed that he considered Creosal the best-tolerated preparation, no other approaching it in the intensiveness of its effects and the rapidity of its action.

(b) Prof. ALBERT ROBIN has mentioned Creosal in his treatise on therapeutics.

(c) Dr. H. BALLAND has tried Creosal in many cases (about 300) of bronchitis and tuberculous catarrh of the first and second stages, and its efficacy has been evident. (Communications to the Academie de Medecine).

(d) Dr. BLIND.—Physiological experiments by Dr. BLIND, Laureat de l'Academie et de la Faculte de Medecine de Paris, formerly chief of Laboratory at the Necker Hospital, have demonstrated that Creosal is absorbed and carried by the blood to all parts of the body and that it exercises its beneficial action wherever there are lesions, specially in the respiratory organs.

(e) Dr. NOGUE in his treatise of "Posologie Infantile" advises the use of Creosal for children, in capillary bronchitis, broncho-pneumonia, tuberculosis, rachitism, etc.

(f) Dr. KESTNER, formerly attached at the Mulhouse Hospital, has used Creosal, with great success, in pulmonary tuberculosis, at all periods, acute and chronic bronchitis (10 cases children). He stated that Creosal was well tolerated by patients even at much higher doses than those used for other creosote preparations reputed as being well digested; in his opinion the therapeutic value of Creosal is very superior.

(g) Dr. LORIOT, author of a thesis on Creosote combinations (Societe d'Editions Scientifiques, Paris), acknowledges the therapeutic value of Creosal which he tried with success at Saint-Joseph Hospital.

(h) Dr. TOURNIER has used Creosal for 7 years with the best results in tuberculosis of the first and second stages, and even at the third stage, in adults and children; he has obtained great success in subacute bronchitis with a tendency to become chronic, in broncho-pneumonia, and capillary bronchitis in children. The author has never observed the least intolerance or the slightest inconvenience.

from the administration of Creosal, even in children.

(i) Dr. PEGURIER (Nice) has tried Creosal and uses it frequently at his clinic.

(j) Dr. RUFFIER, in attendance in a sanatorium, has used Creosal for many years with great success, and has summarised the results of his observations in a book edited by Maloine (Causes, effets et remèdes de la demineralisation organique).

(k) Dr. PEPIN has stated in his thesis to the Faculté de Médecine de Paris, some observations in favour of the use of Creosal in the treatment of tuberculosis.

SYRUP CREOSAL A.F.D.

Syrup Creosal contains 50 centigrammes of Creosal per tablespoonful. It keeps good indefinitely in all climates. It is an excellent specific for coughs of whatever origin, nervous, spasmodic, recent or chronic, nasal, laryngeal, bronchial, gastric, hepatic.

In ordinary colds or simple tracheal bronchitis, Syrup Creosal soothes the pain and inflammation of the bronchi, relieves respiratory oppression and produces a state of comparative ease,

an excellent condition for localisation of the cold. The amount of sputum is reduced, secretions become less purulent and a rapid improvement in the general health of the patient is observed.

Apart from the above therapeutic efforts, Syrup Creosal is a powerful recalcifier and as such of great value in the specific treatment of tubercular conditions.

Dosage.—*Adults.*—Men.—One tablespoonful in the morning and two tablespoonfuls at bedtime.

Women.—One tablespoonful morning and evening.

These doses may be increased.

Children.—From 2 to 4 years of age.—Mix a tablespoonful of Syrup Creosal with 4 tablespoonfuls of simple syrup or syrup of tolu and give a tea spoonful of the mixture every two hours.

Above 4 years of age.—A teaspoonful of Syrup Creosal, pure or diluted, every three or four hours according to age.

In whooping cough Syrup Creosal speedily diminishes both the frequency and severity of the attacks while its remineralising action benefits the general health of the child.

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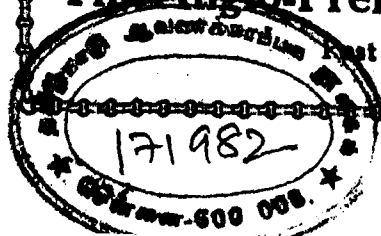
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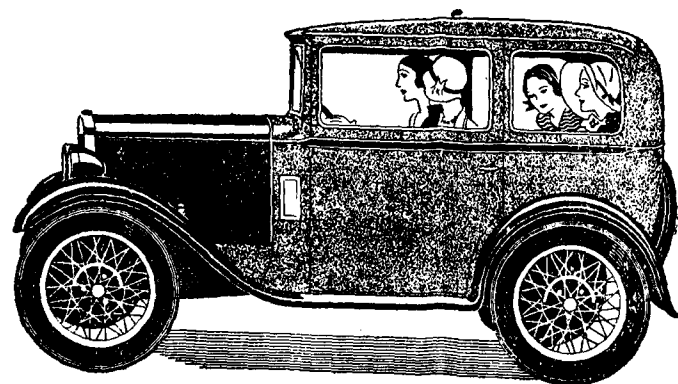
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