

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

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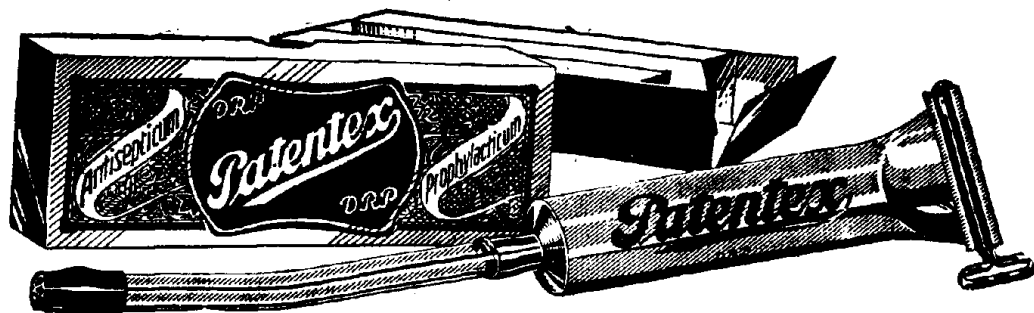
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Annual Subscription Rs. 1-8-0.

Single Copy As. 4.

VOL. II]

JULY, 1931.

[No. 10.

THE HONORARY SYSTEM OF MEDICAL SERVICE IN GOVERNMENT HOSPITALS.

(Continued from previous Issue.)

STAGE 1.

Before proceeding with the replacement of paid officers by honoraries, it is necessary to fix the number of paid appointments as a temporary measure, taking into consideration the small number of medical practitioners qualified and willing to take up the honorary appointments at present until sufficient number of doctors are trained as indicated in the last article, and become qualified for honorary appointments. The following list of appointments may therefore be continued for the present to be held by paid officers:—

IN THE MOFUSSIL HOSPITALS AND OTHER MEDICAL INSTITUTIONS.

(a) All District Medical Officers and such Civil Surgeons in charge of Civil Surgeoncies where there is provision for training of clinical assistants and one Assistant Surgeon for each District Medical Officer and one Resident Medical Officer for each District Headquarters Hospital.

(b) All full-timed Professors, Lecturers and Assistants in Medical Colleges and Schools.

(c) All the members of the Chemical Examiner's Department.

(d) All the members of the King Institute, Guindy and Pasteur Institute, Coonoor.

(e) All the medical members of Jail Department.

(f) All Lady Doctors employed in the Mofussil Stations.

IN THE CITY HOSPITALS.

(a) The Superintendent of the Government Hospital for Women and Children and one Resident Medical Officer.

(b) The Superintendent of the Government Ophthalmic Hospital and one Resident Medical Officer.

(c) The Superintendent of the Government Mental Hospital and one Resident Medical Officer.

(d) The Superintendent of the Government Victoria Hospital for Women and one Resident Medical Officer.

(e) One Surgeon, one Physician and one Resident Medical Officer of the General Hospital and the Superintendent who should be the Principal of the Medical College.

(f) The Superintendent of the Tuberculosis Hospital with one Resident Medical Officer.

(g) The Superintendent of the Government Royapettah Hospital with one Resident Medical Officer.

(h) The Superintendent, Government Royapuram Hospital who should also be the Superintendent of the Medical School and the Medical Inspector of Emigrants and one Dental Surgeon.

(i) One Medical Officer in charge of Ear, Nose and Throat Diseases, General Hospital.

(j) One Radiologist with an Assistant, one Venereologist and one Medical Officer in charge of Stores and two Sub-Assistant Surgeons in charge of the two Dispensaries in the General Hospital.

As referred to above, the Superintendent of the General Hospital and the Principal of the Medical College may be combined into one as was the case sometime back and a senior officer appointed for the post. He need not be given any professional work either in the College or in the Hospital. Similarly at Royapuram, the Superintendent of the Medical School and that of the Hospital, the Surgeon First District and the Medical Inspector of Emigrants may be combined into one and an Officer appointed for it. He need not have any professional work either in the Hospital, or in the School.

RETIREMENT OF MEDICAL OFFICERS.

Under the existing rules with the exception of the High Court Judge recruited as such, all Government Officers are entitled to full pension after 30 years' of Service or on the completion of the 55th year of his age. The members of the Judicial and Educational Departments have, besides the holidays granted to other departments, summer vacation extending to 6 to 8 weeks in a year. To treat all officers alike in the determination by the length of service is therefore not correct. Whatever may be for the other departments the officers of the Medical Department have practically no holidays; but on the other hand it is only on holidays they have got more work to do. They are not the masters of their own time. During the 24 hours in a day their services are called for. They are exposed to all kind of infection and however careful they may be, still, they are exposed to risk. Their work is always in unhappy and anxious surroundings. The mortality among medical men is the highest among that of the members of the learned profession. It is therefore but just and human that the length of service entitling to full pension in the case of medical officers working in hospitals should be longer than that of the members of the other departments.

In the adjoining State of Travancore, all officers of the Government are entitled to full pension after the completion of 25 years of service. In the case of Government Medical Officers in the Madras Province, 25 years may be fixed as a maximum length of service entitling for full pension and such officers who are put in 25 years of service may be compulsorily asked to retire on full pension. This arrangement is advantageous not only to Government, but the medical officers themselves and the public. In view of the Retrenchment contemplated in all Government Services and an extension of the system of honorary appointments in the medical department, the granting of full pension to officers who have put in 25 years of service will not only contribute to the saving of money, as the places falling vacant by such retirements need not be filled in but made honorary and the pensioned medical officers will be best suited and most of them willing to take up the honorary work. By this step 13 Civil Surgeons, 10 Civil Assistant Surgeons and 55 Sub-Assistant Surgeons may be retired before the end of July next and many of them will become available for honorary appointments for which they will be best qualified.

Honoraries in the City Hospitals

(1) In the General Hospital, the 2nd Surgeon, 3rd Surgeon, 2nd Physician 3rd Physician, 4th Physician and the Assistant for each of the above and also that of the 1st Physician and 1st Surgeon and 1st Assistant Resident Medical Officer, 2nd Assistant Resident Medical Officer, Assistant Surgeon, Venereal Wards, 2 Civil Assistant Surgeons and 3 Sub-Assistant Surgeons in the X-Ray Institute and 1 Civil Assistant Surgeon and 1 Sub-Assistant Surgeon undergoing training in that Institute may be replaced by honoraries. There are 5 Assistants to the Professor of Medicine and 7 Assistants to the Professor of Surgery. It is not known whether all these Assistants are full-timed officers attached to Medical College or part-timed officers employed

both in the College and the General Hospital. In the latter case giving 1 or 2 Assistants to each, for Professors of Medicine and Surgery the rest may be replaced by honoraries. Among the temporary Civil Assistant Surgeons, 10 are employed in the Medical College. If they are to be full-timed permanent officers they may be replaced by those Assistants who are replaced by the Honoraries in the General Hospital.

(2) In the Hospital for Women and Children, the 2nd Obstetric Physician and the 3rd, the 2 Civil Assistant Surgeons and 1 Sub-Assistant Surgeon may be replaced by honoraries.

(3) In the Government Ophthalmic Hospital, the Assistant Superintendent, 3 Civil Assistant Surgeons may be replaced by honoraries.

(4) In the Government Mental Hospital, 3 Civil Assistant Surgeons may be replaced by honoraries.

(5) In the Government Royapuram Hospital, 3 Civil Assistant Surgeons and 2 Sub-Assistant Surgeons may be replaced by honoraries.

(6) In the Rajah Sir Ramaswami Mudaliar's Lying-in Hospital, 1 Sub-Assistant Surgeon may be replaced by honorary.

(7) In the Government Royapettah Hospital, 2 Civil Assistant Surgeons, 2 Sub-Assistant Surgeons and 1 temporary Assistant Surgeon may be replaced by honoraries.

(8) In the Government Victoria Hospital for Women, 1 Assistant Superintendent and 1 Lady Apothecary may be replaced by honoraries.

All the temporary Civil Assistant Surgeons and Sub-Assistant Surgeons and all House Surgeons and Physicians may be employed as Clinical Assistants in the Presidency Hospitals.

THE PROBLEM OF OUT-PATIENT.

The world-wide depression which has seriously affected the Revenue receipts of the Government has forced them to stop further increase in the expenditure in all directions and in all departments. We have been pointing out in these columns more often than once, methods by which the Govern-

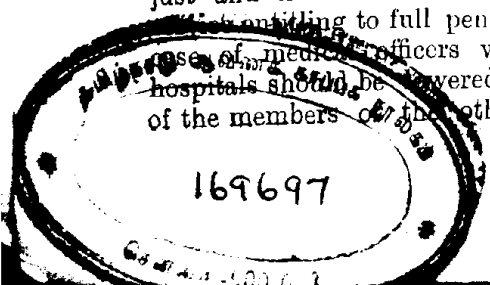
ment could save large amounts of money without affecting the efficiency of service in the Medical Department. The Out-Patient Department connected with all the hospitals is a huge drain with no commensurate benefit to those who seek out-patient treatment at the various hospitals. On an average not even half a minute is spent on a case at the Out-Patient Department nor is it possible in the present state of affairs to spend more time on each patient when the state and local board institutions have no control of an Almoner and even in England and Wales where all the voluntary and other charitable hospitals are under such control, the rise in the number of patients at the Out-Patient Department has been steadily increasing. The British Medical Association which usually guides the destinies of Medical Institutions in England and Wales thought it was detrimental to the interests of all concerned and more of the patients who go to the Out-Patient Department for medical advice, to run this department in the way it is being done at present. The Council appointed by the British Medical Association after carefully going into the question of treatment of illness at the Out-Patient Departments have arrived at certain conclusions whose summary with recommendations have been published in the British Medical Journal, dated Saturday, 21st February 1931, and they are:—

1. That a large amount of the work at present undertaken at the out-patient departments of voluntary hospitals is unnecessary and can be reduced.

2. That the volume of work at present undertaken at the out-patient departments is such that the best use cannot be made of the services of the members of the hospital staffs.

3. That there is considerable wastage of public money and of professional time and skill.

4. That the existing internal and external checks at present employed are not sufficiently stringent.



5. That further checks and safeguards should be established at all voluntary hospitals before treatment is undertaken at the out-patient department.

6. That the primary object of the out-patient department should be for consultation.

7. That while there should be adequate opportunities for consultation purposes between the private practitioner and members of the visiting medical staffs at out-patient departments, practitioners should not countenance the use of that department by their patients, except in the ways laid down in this memorandum.

8. That the casualty department should be available to any emergency.

9. That only such treatment should be given at the department as cannot in the best interests of the patient be obtained elsewhere under the usual arrangements as between private practitioner and private patient, or under contract arrangements.

10. That cases admitted for treatment at out-patient departments should be reviewed at intervals by the medical staffs.

11. That no person, except in cases of emergency, should be accepted for treatment as an out-patient at a voluntary hospital unless he brings a recommendation from a private medical practitioner, a provident or other dispensary, a public clinic, or from a public assistance medical officer of a local authority.

We realise that in our country where the only agency which is responsible for medical relief in hospital is the government with a despotic adviser in the person of Surgeon-General or Inspector-General, with a profession having no organisation (such organisations not even being possible these days) and with the general mentality of the public regarding hospital attendance is what we see to-day, it will certainly be not possible to bring about the salutary changes advocated by the Council of the British Medical Association all at once. But we feel the present time, when the government on their own accord have appointed in each Province and even at the Central Seat, committees to go into the question of retrenchment, is

most propitious to write out at least what best could be done to lessen the irresponsible wasteful expenditure at the Out-Patient Department of the Hospitals. The treatment here is as irresponsible and wasteful to the welfare of those who seek it. Yet we are afraid neither the government nor their advisers all of whom are the members of the British Medical Association have as yet not initiated a policy of check on this department and curtailed the expenditure of Medical Relief.

In England and Wales whose population is about 40,000,000 against 45,000,000 of the Madras Presidency the number of Out-Patients treated is about 1/5 of the number treated in all the hospitals excluding the Madras City Hospitals. In London which has a population of about 7,000,000 the number of out-patients treated was 1,760,807 in the year 1929. In the city of Madras which has a population of nearly 600,000 about 1/12 of the population in London the number of out-patients treated was 7,94,400 during the same period. It will thus be seen that the rate in the city of Madras is more than five times the rate obtained in London and if the number treated in London is condemned as too large, the state of affairs in Madras city deserves condemnation more than five times.

There are likely to be objections from some quarters or other to bring about reforms suggested by the Council of the British Medical Association in this province. The first objection will doubtless be that the poor who cannot afford the medical attendance would be deprived of the help they are now getting from the State. For the matter of medical relief only those people who cannot procure the necessities of life should be considered to be poor and never a wage-earner, however small the wage be. Can the State afford to supply food and other necessities of life to all those who require it? Can it give free

service in other matters such as legal and engineering when those who are in need of such advice plead poverty?—certainly not—then, why should indiscriminate service be rendered only in the matter of medical relief? Free medical service in the dispensaries in the form of first aids only is the legitimate responsibility of local bodies such as Municipalities, Taluk Boards, as nothing more than first aids could be done at the Out-Patient Department. Serious cases requiring care and attention either surgical or medical have to be attended to by the bed side and not at the Out-Patient Department. In case the indiscriminate Out-Patient Department has a stringent check and give treatment only to the necessitous poor, others will surely go to the general practitioners making suitable arrangements with them for medical service depending upon their paying capacity.

Other objections are not of serious consequence, yet we shall mention them. The popularity of medical institution is at present gauged by the attendance at the Out-Patient Department, the larger the number of patients, the greater the popularity it commands and also the approbation of the authorities who run these institutions. The members of the profession know well what Out-Patient popularity means. The merit and skill, not in professional matters, but in the gift of tongue is what is required to make even an irresponsible department popular. The other objection may likely be that if a hospital is deprived of Out-Patient Department of the nature now in existence it may reduce the material required for the education of students undergoing training in such hospitals. The majority of cases that attend the Out-Patient Department is of trivial nature. The student will certainly get more benefited from the careful study of a smaller number of cases under the direction of a Physician or a

Surgeon who will not have to work against time in rushing through the trivial cases that now attend the Out-Patient Department of a hospital. An inordinate number of trivial cases wastes the time of the consultants if they ever attend the Out-Patient which is not usually done in India and the attention of students usually wearies and they get at the habit of careless observation and hasty diagnosis. Such unavoidable carelessness usually tends to erroneous and in-efficient treatment.

The Special Retrenchment Officer has begun his work well. He knows that the work entrusted to him is likely to make him unpopular, yet he has been very judicious in applying the Axe well. He has not been unmindful of the Technical Departments such as Medical, Engineering, etc.; The reform suggested by us in the State Hospitals in the Out-Patient Department is not at all drastic. We have only repeated what the Council of the British Medical Association considers about this problem. It is neither the intention of that Council nor ours to close the Out-Patient Department in State Hospitals. Both of us advocate salutary changes which will mean a saving of a large sum of money to the government and efficient responsible medical relief to the community. It will not be out of place to mention here what we said about this subject sometime ago in these columns that in Federated Malay States and the adjoining native states, the unit of medical relief is a hospital and not a dispensary and such a system works quite satisfactorily. The Medical institutions in that country are entirely controlled by the Britisher as it is here. Yet it has been possible for them to conceive of a good ideal—why not in India?

The experiment can be with advantage started in the Madras City immediately, where, there is neither a dearth of general practitioners nor Out-Patient Dispensaries which are run by the city Corporation.

Original Articles

DISEASES OF INFANCY AND CHILDHOOD—GLEANINGS

BY

DR. M. L. KAMATH, B.A., M.D.C.M.,

SUPERINTENDENT, GOVT.

ROYAPETTAH HOSPITAL, MADRAS.

(Contd. from previous issue.)

Bacillus Coli Infections.

I cannot too strongly emphasise the importance of recognising coli infections in childhood as the cause of a good many conditions of ill health. No infection is more often missed being discovered when it ought to be than one due to the presence of bacillus coli in the urine. One cannot but be impressed, on closer study, with the frequency of mutations, the diversity of symptoms and the too frequent tendency towards chronicity and relapse.

Children under ten years, are those that are frequently affected and amongst them, female children oftener than male. It is interesting to note that bottle-fed infants are more susceptible than the breast-fed. Other infections and debilitating conditions predispose to coli affections.

Types of Coli Infections met with.

A: Urinary type, usually in the form of pyelitis, is the most easily recognised type of bacillus coli infection which sets in, often abruptly, with frequency of micturition followed by acute pain in the lumbar region. There is a sharp rise of temperature running as high as 104° to 105° F accompanied by vomiting and abdominal tenderness. The course of fever may be remittant or intermittant. Constipation is more common though diarrhoea is sometimes a feature. The pulse is rapid, sweating is profuse and chills may punctuate the course. Tenderness and pain are usually present in the kidney region and the organ may be found to be

enlarged. The right kidney is the one more frequently affected which is explained as due to lymphatic connection between it and the caecum and ascending colon.

The urine is strongly acid, becomes offensive after standing. There may be a trace of albumen in it, and under the microscope, one will note teeming bacilli and a few pus cells.

This type is liable to produce chronic infective renal lesions such as pyelonephritis,—later renal calculus.

B: Next common type is the intestinal one. These are less severe in their onset. Diarrhoea usually with vomiting is the most prominent symptom. Temperature does not usually go beyond 102° F. There is diffuse abdominal tenderness, most marked in the right lower quadrant. The absence of rigidity and of cutaneous hyperaesthesia, abdominal reflexes normal and the low degree of leucocytosis should help to distinguish this condition from appendicitis for which it may be easily mistaken. The microscopic examination of urine will clinch the diagnosis.

Bacillus coli, either alone or with other organisms as streptococcus faecalis, are as much the cause of colitis in children as in adults.

C: A more severe type resembling typhoid is occasionally met with. The diagnosis in these cases must depend on blood culture, agglutination reactions and identifying the organism in the urine.

The depressing effects of many an intestinal derangement on the central nervous system is ameliorated by treatment directed against this bacillus. The exact role played by the bacillus coli in these conditions, is however, uncertain. The improvement that results may excuse one in inferring that these are probably related as cause and effect.

In some children phosphaturia may result from the decomposition of urine

in the urinary tract. Such phosphaturia may sometimes intensify the nervous symptoms which might be associated with this organism.

The most important point in connection with these infections is to remember them in our differential diagnosis and to recognise bacillus coli as the possible cause of as much disability as congenital syphilis or tuberculosis.

Regarding treatment, to prevent it from becoming chronic,—a feature due to its more resistant character—curative measures must continue for a long period after all signs and symptoms have cleared. It is as necessary for the coli infected patient to have his urine examined from time to time as it is for the syphilitic to have repeated Wassermann tests.

Typhoid Fever.

Typhoid fever is a frequent occurrence in childhood though it runs a milder course. It is rather rare to meet with it before 3rd year

During the last six months there have been 31 cases of typhoid fever at the Royapettah Hospital between the ages of 2½ and 12 years, the sexes being almost equally balanced. Twenty five went home convalescent, three had their temperature normal and three before that, though they were progressing satisfactorily. I should think this, a lucky series, even considering the mild course of the disease in infancy and childhood (all were widal positive 1 in 200).

Bronchitis is a constant feature and sometimes there is broncho-pneumonia. In the above series four cases had this complication.

Diarrhoea is sometimes met with. Tympanitis and meteorism are rare; hæmorrhage and perforation rarer. In the above series there was suppurative parotitis in two of the above 31 cases, both recovered.

Delirium is sometimes troublesome. This was present, in three cases only

of the above series, and did not require anything stronger than bromides to allay it.

Nephritis is a rare complication or sequel; so are cancrum oris, epilytitis, inflammation of mitral cusps and arteritis.

For the last 5 years and over, I am giving sufferers from this fever, as a routine, Lock's fluid and Urotropin dosage proportionate to the age.

Some Affections of the Respiratory Tract.

I will not take your time in detailing to you the various physical signs and symptoms of the commoner respiratory diseases met with in childhood, particularly of the later period. They are practically the same as in later life. I will only refer to some of the special features characteristic of such affections as observed in infancy and early childhood and to those only that have practical bearings.

While bronchitis is a common accompaniment of many infections met with at all ages, its incidence as a primary affection is practically confined to the period of infancy, to be precise, the period of primary dentition.

This frequency of bronchitis in infancy or early childhood is no doubt dependent partly on the special anatomical features which the respiratory tract presents at this period. The respiratory mucosa is very vascular and further the loose, excessive submucous or sub-epithelial tissue of the whole of the respiratory apparatus, by permitting the vessels to dilate without resistance, forms a condition of constant hyperæmia. Added to this, the smallness of the nostrils in infancy and early childhood (which too readily get blocked by an ordinary attack of cold or with adenoids, if present) and the comparatively shorter length of the air passages, will facilitate the rapid extension of the mischief from them above to the lung alveoli below.

The special liability, at this period of the lung tissue to collapse, may lead one astray in mistaking an ordinary bronchitis for an attack of broncho-pneumonia and this point is to be borne in mind in the interpretation of physical signs met with at this period. The evident distress and the apparent gravity of the condition in some severe cases of bronchitis are due to the readiness with which emphysema occurs due to the very elastic nature of the chest wall and lungs in young children, supplemented by the strain on the right heart.

Bronchial asthma met with in later life, when viewed in retrospect, will be seen to have had its beginnings in infancy or early childhood. Asthma in older children does in noway differ from asthma in adults. The asthmatic attack in infancy can be easily mistaken for an ordinary attack of bronchitis; but the suddenness of its onset, frequent recurrence and ready subsidence, the often wheezy character of expiration, more important still, the migratory character of physical signs from one portion of the lung to another or from one lung to the other and the characteristic blood picture will help in diagnosing this condition in early infancy.

Correct diagnosis is important for, the condition is very amenable to treatment at this period and, if left untreated, may very likely lead to an asthma habit or an emphysematous condition of the lungs and thus render the child an invalid in its very teens.

Pneumococcal infections.

The pneumococcus is a remarkable organism whose pathogenicity is strikingly variable in different animals; while, it can produce in some animals a fatal septicaemia, the pneumococcal infections in man are usually localised. Children, however, are more susceptible than adults. In the former, generalised infection of serous cavities is not very uncommon and it is very striking that

in inflammations due to the pneumococcus in all parts other than lungs and pleura there should be remarkable absence of symptoms.

Pneumococcal otitis media, pericarditis, peritonitis and arthritis are all painless within a few hours of the onset; the only evidence of persistent inflammation is the swinging temperature and an accelerated pulse; and in the case of peritonitis or arthritis, steadily increasing tumescence may in addition be observed. Further, in peritonitis, there is an absence of permanent and persistent rigidity. The striking symptoms and absence of toxæmia in tubercular peritonitis it may be noted, contrast very remarkably with the absence of signs of peritonitis and the presence of progressive toxæmia in the pneumococcal variety.

Pneumonia.

Pneumonia, one of the commonest of all acute infections, is remarkable in many respects; it ushers itself with striking symptoms, runs a short course and ends for good or evil with equal dramatic suddenness.

The mode of onset varies—vomiting of an explosive nature is a frequent initial symptom. It may cease in a couple of days or may occasionally persist throughout the attack. Pain in the abdomen is another well-known mode of invasion; this may be associated with tenderness and rigidity in the right iliac fossa. The indefiniteness of localisation, particularly in the younger children, with the almost constant vomiting, the sudden rise of temperature and, perhaps, aided in some cases by the delayed appearance of the physical signs, are sufficient to excite, at first, a suspicion of appendicitis, contrariwise, appendicitis may simulate pneumonia. Rapidity of respirations out of proportion to pulse rate of fever, hot dry burning skin (calor mordax) flushed cheeks and herpes labialis, when present, will help in distinguishing the

supra-abdominal from an abdominal condition. It is true that a pneumococcal peritonitis may complicate pneumonia but, as it is often a late complication, the diagnosis is not likely to be in doubt, and if occurs early, there may be evidence of fluid in the abdomen along with the physical signs in the chest.

A pseudo-abdominal onset is frequent in most infectious diseases of childhood; but, nowhere is it better marked than in pneumonia.

Pneumonia may declare with symptoms of meningitis or meningism.

A resemblance between the clinical manifestations of the Gram positive Fraenkel's diplococcus and the Gram negative diplococcus of Weichselbaum has been noted for over quarter of a century. Fever in both, rapid pulse—though rapid changes in pulse and temperature are more marked in the latter,—skin eruption so common in the latter as to have earned the synonym of spotted fever; just as pneumonia complicates some cases of cerebrospinal fever, meningitis is sometimes present in pneumonia. These resemblances are better marked in childhood than in later life.

On account of the histological peculiarities of the child's lung, the physical signs are often those of broncho-pneumonia. For reasons already stated, the hila and apical portions are more favourite sites to be attacked.

Prognosis is generally good unless when empyema, meningitis or pericarditis complicate.

In malarial areas, the benign as well as the malignant tertian parasite sometimes produces physical signs of pneumonia. The headache, vomiting and hot burning skin, common to both make dissimulation easier. An examination of the blood and the evanescent nature of the physical signs in malaria settle the diagnosis.

SCHOOL HEALTH

By

DR. V. S. MAHADEVAN, L.M. & S., B.S.Sc.

(Continued from previous Issue.)

School Medical Service in Madras Presidency, has its rudiments in casual inspection of boys during the time of epidemics like Malaria and Smallpox. I remember, in 1904, when I was a boy studying in an elementary school in Madras a medical unit who were investigating the "splenic index" in Madras during an epidemic of malaria at that time, examined all the boys in our school only for enlarged spleen. Beyond this, nothing was done till 1920, when the Government by G. O. No. 208 sanctioned a system of grant-in-aid of medical inspection of pupils, in recognised secondary schools managed by local bodies and private committees. But, the scheme was kept in abeyance till 1925 when G. O. No. 641, Law and Education was issued embodying certain proposals for the conduct of medical inspection. I do not like to dilate much on the history of the school medical service in Madras as most of you are familiar with the provisions of the various G. O's issued subsequent to 1925. But, to state briefly, G. O. 641 provides only for the medical inspection of pupils, the treatment being left to be arranged by parents, this inspection to be done once a year and all the medical inspectors would as far as possible be local registered medical practitioners or Civil Assistant Surgeons under Government employ with university degrees in Medicine. In places where graduates were not available, Sub-Assistant Surgeons were eligible to act as School Medical Inspectors. G. O. No. 399 of 1930, states that graduates in Medicine with Public Health qualifications, like the B.S.Sc., degree are to be recommended and given preference to L.M.Ps. and others. But I regret to note that some local and private bodies are ignoring the G. O. and appointing their own favourites as medical inspectors. The

G.O. No. 641 further defines the duties of school medical officers, the maintenance and submitting of records of medical inspection, the fees payable to the medical officer—12 As for first inspection, 6 As. for reinspection. Finally, it states that the Director of Public Instruction will be in charge of all arrangements, necessary for the conduct of medical inspection in schools and that he will issue in consultation with the Surgeon-General and the Director of Public Health such further instructions as may be found necessary from time to time.

In 1926, G. O. No. 655 Law and Education and G. O. No. 2242 were both issued. The former laid down that the introduction of compulsory medical inspection should be a condition for recognition of secondary schools under private management, with effect from May 1927. The latter G. O. directs that the same condition shall hold good in secondary schools under local bodies also. In a subsequent G. O. No. 16 of 1928 medical inspection was made compulsory in Arts colleges for men and women; and managers of elementary schools for boys in areas where compulsory elementary education has been introduced with effect from 1st April 1928, were asked to introduce medical inspection at their option. Under this provision medical inspection was introduced in Madras City by appointment of ten doctors, for about 15,000 boys, studying in aided elementary schools of the city; and in the compulsory elementary education area of Saidapet Taluk about ten medical inspectors were appointed to examine about 11,000 students. For the schools under the management of the corporation of Madras two full-timed medical officers carry on the medical inspection work. There are 24 out of a total of 81 municipalities which have introduced compulsory education for 1929-30 under the Elementary Education Act of 1930; but medical inspection was conducted in 29 areas where compulsory

elementary education has been introduced. We find that in all the rural areas, medical inspection is unknown; consequently about three million students in our Presidency are suffering from some defect or other due to ignorance, squalor and filth.

The scheme as it now stands, is defective in many ways. The Medical Inspector is concerned only to note the defects in pupils and those cases of defective health are referred to parents for treatment and in the majority of cases the parents pay no attention to the intimation card sent to them. Consequently during the reinspection in the succeeding year, the same boys appear with the same defects untreated and in most cases the diseases having far advanced. Again, an intimation is sent to the parent as in the previous year with the same result. Medical inspection is done only a month or two after the reopening of the school; and the reports have to be submitted before October. Seasonal diseases like bronchitis, fevers, measles could not find a place as there is no continuity of inspection throughout the year by full-timed medical inspectors.

Unless we have penal clauses, full-timed medical officers, and treatment centres as in England, the present scheme is a mere waste of money. In 1928 the Government of Madras with a view to formulate a scheme of school medical service, issued a report on medical inspection of secondary and middle schools of the Presidency. Therein the Surgeon-General advocates routine and special inspections and copying of the system of medical examinations of pupils as in England, with slight alterations; the nucleus of the school medical service suggested for Madras is one school medical officer for each district with an M. B. qualification who has served as house-surgeon and house-physician with special attention to ear, nose, throat, skin diseases and

pediatrics. The District school medical officer is to be assisted by a number of experienced full-time and part-time medical inspectors, for each district; It has also been suggested that a central Medical Staff is necessary to check and tabulate inspection reports.

The report stresses the necessity of teaching hygiene in every school and suggests that the existing dispensaries and hospitals will be able to serve as school clinics; the report refers to the lack of specialists, and school nurses, inadequacy of equipment of hospitals and suggests the following remedial measures:—

1. A school for training health visitors and attention to infant and pre-school child, training of medical men in diseases of children.
2. Training of specialists in eye, ear, nose, throat and skin diseases for employment in the mofussal.
3. The establishment of a dental school to train dentists.
4. The training of school nurses.
5. The gradual development of existing dispensaries and hospitals.
6. Improvement in the nutrition of children, by demonstrations and provision of school meals by charitable bodies.
7. Encouragement for well trained medical graduates to settle in the mofussal, and extension of scheme of subsidised medical practitioners.
8. The encouragement of voluntary care committees, to look after the treatment of defective children and supply of milk and food.

There are two suggestions about School Medical Service. The Beasley Committee recommends regarding the medical inspection of schools, a closer co-operation between the Physical Director and Medical Inspector, and combining both the work in one, by deputing the medical inspector, to undergo a course of physical training, and attaching him to the staff of the school. Then the value of such inspector would be enhanced if

his services are judiciously engaged by schools authorities.

In its issue of May 1930 "The Medical Practitioner" advocates "that Hygiene and Physiology should be made compulsory subjects in all schools and taught only by medical men. These medical men may be entrusted with the duty of conducting Medical Inspection of schools and they need not be full-timed employees. For a school or group of schools in a place one medical man may be appointed to teach Hygiene and Physiology and made to conduct medical inspection in the schools. He will thus be able to keep under observation pupils for whom observation is essential to diagnose the disease. In his leisure hours he may have private practice and thus supplement the rural Medical Relief Organisation."

Uncleanliness.

The first heading in the School Medical Inspection Report is "uncleanliness of head and body" Among 1,153 boys medically examined for 1930 in Madras City Elementary Schools about 6% i.e., 196 boys come under this heading. Figures are not available for England and Wales. Personal cleanliness is one of the most important items usually neglected by the teachers especially in elementary schools. The habit of cleanliness acquired in schools will remain throughout life; and hence the necessity of enforcing cleanliness among school boys. Dirt over head and body are the precursors of skin diseases due to bacteria and fungus.

In 1927-28 out of 141,613 pupils in Madras Secondary Schools, 10,411 boys or 7.35% suffered from skin diseases. The rate is 1.30% for 1928 and 1.2% for 1929 in England and Wales Elementary Schools. It is 8.00% for 1929 in Madras City Elementary Schools.

Malnutrition.

10.98% in 1927-28 in boys of Secondary Schools in Madras Presidency, 0.95% in 1929 in England and Wales. 11.30% in 1930 in Madras City Elementary Schools. A very big gap in the percentages of incidence in Madras

and England and Wales cannot be accounted for easily. There is good deal of misconception among medical inspectors and the people about the term "malnutrition." Many are under the impression that it denotes subnormal nutrition and others say that it is largely due to the economic conditions. Nutrition is not an alternative term for "food." The malnourished may lack fresh air and suffer from many diseases. It is not an easy matter to find out the causes of malnutrition except by elaborate tests.

The first scientific method of estimating nutrition is by "Basal metabolism test" of energy requirements of the body. Even this is not sufficient. Habit and custom play a large part; and emotional and aesthetic states of body affect appetite and nutrition. Another important factor in estimating nutrition is the quantity and quality of the diet which determines growth and vigour. The diet must have sufficient energy of high calorific value, with due proportions of proteins, carbohydrates, fat and salts according to habits and age of the child. Vitamins play a large part in controlling nutrition. According to Maccarison, vitamins are the sparks which ignite the fuel mixture of a petrol driven engine liberating its energy. Besides, the physique of a child may vary according to heredity, race, family, etc. It may be slim and short and yet be of normal nutrition. According to James Kerr, malnutrition is an individual and not a group problem. It may be an indication of many acute or chronic diseases of childhood.

When we consider the host of adverse factors that contribute to malnutrition we should pay most attention to nutrition which is everything in childhood; Sir George Newman says "Nutrition consists in the total well-being and right functioning of the whole body. Height, weight, substance, colour, elasticity,

balance and carriage of the body the effective functioning of the nervous system, heart, lungs, and alimentary tract, the readiness and relative strength of the muscular system, a well-co-ordinated and alert harmony. Healthy skin, blood muscle, fat, nerve—they are all involved in the harmony. Malnutrition is the opposite; and if the body be ill-nourished and "below-par" the mind and spirit of the child are by that much injured and impaired and its total capacity reduced." Different authors have different methods of estimating nutrition in boys. The method commonly employed in England is the Quetelet Index of Nutrition:—

$$\frac{\text{Weight} \times 100}{\text{Height in cms.}}$$

An improvement on this method is Livis Index:—

$$\frac{100\sqrt{\text{Weight}}}{\text{Height}} = \frac{100\sqrt{\text{Weight}}}{\text{Height}}$$

According to this (Lavis Index) it is classified as excellent, normal, or inferior. It is variable with age and often fails to pick out an under-nourished individual. It is about 2.3 to 2.4 for children between 8 and 14 years in England; and in Madras very much below 2.0.

To combat malnutrition in schools, the first essential is instruction of pupils and parents in food values especially those grown and eaten in the locality in which the school is situated; and make the best use of the best and cheap foodstuffs of the place. Secondly demonstration classes in cooking and extended use of parents' days in the interests of children's health are important. Teaching of hygiene in schools, constitution of care committees, effective following up of debilitated and defective children, and the investigation of absentee children and their home surroundings are the lines on which work should be done to combat malnutrition.

Abstracts

THE TREATMENT OF ZOSTER

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AND

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The radicular distribution of zoster is familiar to all physicians. The same is true of its unilateral tendency. Under conditions of present knowledge, neurologists ascribe to zoster an infectious cause, referable to a filterable virus, and there seems to be no doubt of the contagious character of the affection. The visible lesion appears on the skin, affecting the Malpighian layer, while the accompanying nervous lesion consists of radiculitis, with meningeal reaction.

The region in which the typical eruption will appear is at first painful and burning and erythematous plaques appear, soon becoming covered with fine, distinct vesicles, arranged in groups and sometimes confluent. Sensation is altered in the affected territory. Hyperesthesia occurs, sometimes followed by hypoesthesia. Lumbar puncture made during the eruption often yields highly albuminous cerebrospinal fluid, containing a large proportion of lymphocytes. Zoster is cured, but its duration is very variable, ranging from three to several weeks and leaving permanent effects, consisting of white, depressed and indelible scars. Here we remind the reader of the syphilitic lesions which may simulate those of zoster; they are, however, quite painless.

While the most extensive forms of zoster are never very painful in children, pain is acute in older patients. Aged people suffer especially,

not only during the eruption, but a long time after it ceases. A condition characterized by the patient as quite intolerable remains sometimes unrelieved. Pain may not diminish with time, and in such cases assumes a causalgic character which is really unbearable and resists analgesic therapy. The literature abounds in minute descriptions of the affection, is thoroughly sifted from the viewpoint of differential diagnosis and is very limited with respect to treatment.

Treatments differing widely have been proposed. In order to limit ourselves to recent literature, we mention the newer methods of treatment suggested, and often abandoned, since 1923: use of the infrared (JACOBSON) and ultra-violet (DELMERM, BIZE and AMYOT) rays, surgical section in grave cases (SICARD, RAMOND), superficial radiotherapy, intravenous injections of sulphuretted solutions and autohemotherapy. This enumeration suffices in itself. It means that all these methods have very unequal value.

On reading of the arsenical treatment of certain nervous affections, one of us thought of applying specific treatment to zoster. This quite empirical attempt was not, however, without some foundation. Clinicians have known for a long time the relations between zoster and the arsenobenzolic treatment of syphilis. NETTER first described "arsenical zoster" due to enhancement of zosterian and varicellar virus by arsenical intoxication (1) The existence of "arsenical zoster," occurring even after mild treatment, was verified in infants by FRUHWALD, (2) in acute arsenical intoxication by OBARSKI and (3) in specific test treatment in the presence

- (1) NETTER.—*Bull. Soc. Pediatrice*, 23—7—429, 1925.
- (2) FRUHWALD.—*Dermatol Woch.*, 79—49—1579, 1924.
- (3) OBARSKI.—*Polska Gaz. Lek.*, 6—5—90, 1927.
- (4) WEBER.—*Brit. Journ. Chil. Dis.*, 26—108, 1929.

of negative Wassermann reactions by PARKES WEBBER (4).

On reading these cases, one is struck by the mild character of this "arsenical zoster." The query is well founded if the same arsenical treatment which reveals latent zoster, which assumes a mild course, may not be utilised for relieving pain in spontaneous zoster. We have examined the literature and treatment concerning zoster appearing since 1923. Nowhere have we found any indication of this simple and effective method of treatment, whose value is shown by our cases, of which we summarize four.

Case 214.

C—(Cath.), aged 15 and 1/2 years, presented herself with zoster following the distribution of branches of the inferior maxillary nerve. The entire affected region was very painful. A single intramuscular injection given, of 12 centigrams Sulfarsenol. Pain became relieved during the day, and ceased by the next morning. The course of the zoster continued normally, without pain. (Negative B. G.)

Case 546.

De R..., aged 70, presented in July, 1930, typical zoster, over the course of the tenth left intercostal nerve. Pain was severe, but very rapidly relieved by an injection of 12 centigrams Sulfarsenol. A second injection was necessary three days later. Erythema then occurred, with congestion of the mucosae and general malaise. The zoster, however, continued to improve with respect to pain. The vesicles followed their ordinary course and complete cure occurred. (Negative B. G.)

Case 572.

F... (Cath.), aged 78, presented in August, 1930, intercostal zoster affecting the regions of the eleventh and twelfth right intercostal nerves. Pain was violent, but much relieved by an

initial injection of 12 centigrams Sulfarsenol. It was wholly overcome by a second and third injection. (Negative B. G.)

Case 609.

L... (Barbe), aged 35. Intercostal zoster, over region of second and third right intercostal nerves. Sulfarsenol in injections of 12 and 18 centigrams. Improvement was evident after the first injection, which was immediately followed by drying of the vesicles and seeming hastening of their course. Cure was rapid and complete, without persistence of pain. (Negative B. G.)

As taught by a series of 23 cases, we suggest the following plan of treating zoster with Sulfarsenol:

1. Intragluteal injection of 12 centigrams Sulfarsenol.

2. Another similar injection, of 18 centigrams, given 3 or 4 days later. Pain rarely persists after these two injections.

Should pain persist, however, a third injection is indicated, after a second period of 3 or 4 days. Dosage of 18 centigrams should never be exceeded. This method has proved effective in most cases and has always been harmless, with one exception. In case 546, outlined above, intolerance of arsenical medication was evident after the second injection of Sulfarsenol, as shown by diffuse erythematous patches scattered over the body surface, congestion of the mucosae and general malaise. It may be remarked, however, that the zosterian pain disappeared after this injection.

Employment of the intramuscular route should be pointed out, we believe, as an advantage of the treatment of zoster with Sulfarsenol. In the presence of a patient already irritated and fatigued with pain, and often elderly, and whose veins are sclerotic or undiscoverable, it is by no means an indifferent matter to be able to utilise an intragluteal injection, always easy and without danger of accident.

This brief comment is offered only in order to bring to the notice of physicians a simple and effective way of treating or curing the affection known as zoster, whose treatment is otherwise often lacking and unsatisfactory.

(*Concours Medical No. 50, 1930.*)

TECHNICAL OFFICERS IN GOVERNMENT DEPARTMENTS.

The British Science Guild is a voluntary society, non-political in character, whose object is to promote the application of scientific methods and results to social problems and public affairs. It has submitted evidence to the Royal Commission which is now considering the structure and organisation of the Civil Service. The memorandum of this evidence, and the large report on which it is based embody observations and opinions which are of much importance and interest to the medical profession, as to others. They deal with the position of the scientific and professional staffs in the public service, viewing this position, not as a matter of class grievance, but as a national imperfection. The committee of the guild responsible for these documents contained only one medical member, Sir Arthur Newsholme, and there is but little explicit or specific reference to medical matters in them. It may be a fact that the position of the medical staffs of some Government Departments is less unsatisfactory than that of other scientists and technicians. The principles stated, and the suggestions made, by the guild are however, of general application, and with some of them, at least, the medical profession will certainly wish to associate itself.

When the permanent civil service was first established its organization was appropriately such as had reference to the purely administrative, fiscal,

and clerical duties it had to perform. Later it was found that certain specialised scientific and technical matters, as distinguished from simple administrative problems, had to be handled by the departments, and a small number of professional experts, usually acting in the purely consultative capacity, were introduced into the staff organization, where they occupied a subordinate position. Of recent years there has been a great enlargement in the sphere of Governmental activities; the work of the professional, scientific and technical members of the Service has grown in value and importance; the character of this work has largely ceased to be merely advisory; and there have been established separate departments of scientific, industrial, and medical research. Yet with all this the position and status of technical members of the staff relative to that of the purely administrative members has scarcely changed. The Guild points out that "Officers of the administrative class continue to dominate the whole situation in the state departments. The methods of organization are such that the technical experts, instead of occupying positions giving them direct access to ministers, are as a rule, subordinates of the permanent head of the department. Sometimes they are not only to the control of a single administrator, but also to that of clerical officers of the secretariat. This sometimes leads to the usurpation by non-technical officers of the proper functions of the professional technical groups." This often results in the minister being provided only with a layman's interpretation of the expert's advice, or, on occasion, in the suppression of some of technical reports altogether; in view of this position it is essential in the opinion of the British Science Guild, that "the Civil Service should now be organised internally so as to enable those having the best available knowledge in any department to take

a full share in the formation of policy, and to have the right of access on major issues to the controlling administrative, authority and the ministers," and that there should be "a system of Boards on which the experts would serve on equal terms with the administrators." The principle underlying these contentions is one which, in its relations to Public Health Administration and the medical side of other Government services may well support of the medical profession.

With regard to further recommendations that "the essential unity of the professional, scientific, and technical service should be recognised by treating them as a single technical service, "and that" the fullest opportunity should be given to special officers possessing administrative gifts to rise to the highest administrative posts, including the permanent secretaryships of the larger departments there may be less unanimity and greater difficulty. Certainly the classification and systematisation of the profession and technical staffs might well be made simpler and more uniform, and there may be occasions on which the Head of a Technical Department, by reason of great administrative ability, should be appointed a Permanent First Secretary.

It is more than doubtful, however, whether he should continue to exercise the duties of both offices.

In this connection two other points may be mentioned which are not

referred to by the British Science Guild. It has lately been contended that the technical sections of Government Departments should be reduced to a minimum, and that most of their work should be given to private individuals or firms. This does not seem to be a feasible proposition, at any rate as regards matters of Public Health Medicine, but even in that sphere the employment of part-time officers for suitable purposes may well be encouraged, and it is possible that our Government Department sometimes undertake work which might preferably be done elsewhere. The second point is that in association with any professional group in a Government Office it will usually be found advantageous to have a small advisory committee of representatives of the whole profession concerned. Such a committee is established—perhaps it would be more correct to say that such committees are established—at the Ministry of Health in relation to the medical profession; and though there may be periods during which the activities of such committee seem of little importance or effect, yet it continuously serves as a useful means by which the official departments can be kept in touch with the daily work and the organised opinion of the whole profession, of which the official technical group in the Civil Service forms apart. (*British Medical Journal, Saturday, April 14, 1931.*)

SPECIAL CONTRIBUTION TO THE MEDICAL PROFESSION

The discovery of a true reconstructive Tonic.

When we study the chemistry of blood in various diseases, which the human flesh in heir to, we shall have to revise our old opinions as regards the effects of these fevers and infections on the tissues and organs of the body. Recent research has shown that in diseases, specially wasting and chronic ones, that over oxidation takes place in the blood at different stages of the disease. This change also rapidly takes place in those diseases with low fevers and those which develop slowly. Further more, certain salts, particularly the phosphates are constantly present in blood in health and these are considerably reduced in all diseases which continue for long and are accompanied by fever and body wastage. It can therefore be concluded from this that the tissue-waste or its rebuilding depends on the appetities of the tissue-waste or its rebuilding depends on the appetities of the tissue-cells for these salts in the blood. Normally it is from the food, specially the vegetables, that these salts are obtained and utilised by the body. In the vegetables they are present in organic form or in a state of a very fine subdivision and it is in these states that they are assimilated by the human body. If any attempt is made to supply these in a crude form, it will obviously fail if the tissue-cells have no appetite for the salts so introduced, as then the body is not able to utilise them in that form. If we therefore try to increase the efficiency of metabolism only by stimulating it without supplying it with these necessary salts, it will only result in further loss of vitality of the human organism. It is obvious therefore that if we want to treat cases in which there is abnormal tissue-waste and lowered vitality, we must not only supply these salts but also stimulate a cell-appetite for them so that they may be readily assimilated by the body. For this purpose Histogenol is an ideal remedy. Histogenol Naline is so prepared that it surmounts all the difficulties enumerated above and is of great benefit in diseases where the tissue-waste is enormous. It

fulfills all the obligations which are wanting in other Products and Foods. Histogenol is a true tissue-appetizer.

A true reconstructive tonic to be of real value in rebuilding of the human body after ravages of wasting diseases, acute infections etc. must fulfill certain conditions, the chief and the most important of which is that it must supply phosphorus and arsenic in organic form. This necessity has been met with by Histogenol Naline discovered by Dr. Mouneyrat. It is nothing but an elaborate organic combination of Arseno-phosphorus with Nuclein. It is not only non-toxic and harmless but also a powerful reconstructive tonic. It improves the blood, rebuilds the tissues and stimulates the vital functions of the human body and thus improves the general health.

Since the introduction of Histogenol there has been ample evidence of its usefulness in many diseases. It is found valuable in all sorts of cachexias, during the early stages of Tuberculosis, chronic bronchitis, anemias, neurasthenias, convalescence after acute infections and Diabetes.

Whenever a case of cachexia has to be encountered with in practice, Histogenol can safely be prescribed with full confidence of its beneficial results. In early stages of Tuberculosis it will supply much-needed arsenic in those stages and will prevent much loss of strength and vitality. In Bronchitis the cough decreases and there is no fatigue, as Histogenol helps to maintain the strength of the patient. In any type of anæmia Histogenol has proved of value. The salts necessary for aiding the assimilation of Iron to build up Hemoglobin are deficient in anemias and Histogenol supplies these in a very fine form and it is on account of this that it is recommended in these conditions. It is found useful in Neurasthenias as in this affection a general weakness of the whole system is to be met with. Histogenol assists in not only regaining the lost strength and weight, but brings back the tone to the Nervous System. In convalescence either from constitutional diseases or acute infections Histogenol supplies the vital salts needed for the repair of tissues. It can be used in Diabetes owing to its arsenic content.



THE DENVER CHEMICAL MFG. CO., NEW YORK.

**The PERFECT POULTICE
AND DRESSING FOR
INFLAMMATION
AND
CONGESTION**

"Hypercytol is useful in post-operative treatment, tuberculosis, sprue, diabetes and oblorosis."

It has proved of great benefit in this affection after the sugar has been reduced by, e.g., Pancrepatine.

With the record of successful employment of Histogenol in the various diseases enumerated above, the medical practitioner must realise that he has at his disposal a powerful and yet harmless reconstructive tonic. It has great influence on the Hemoglobin content and it is a general cell-tonic which is absolutely non-constipating and produces no gastric disturbances. This preparation besides stimulating the function of the body and the blood-cells quickens metabolism and at the same time increases the physical and vital forces. The Medical Profession therefore will derive great benefits by prescribing Histogenol Naline, wherever a reconstructive tonic is needed.

Furunculosis.

Back into the dim past Furunculosis was considered more within the province of the surgeon than the physician owing to its coccogenic infection and the routine treatment of incisions and dressings. Formerly the treatment mostly centred upon the local application of antiseptic agents, while some relied on the constitutional treatment. This was quite rational when the affection was associated with Diabetes. All these methods, however, were not very successful. In many cases boils to boils succeeded and when at last the troublesome and painful affection had come to an end, this often seemed to have been due more to the process having run its natural course than the result of any treatment. This was also true of vaccine-therapy in which many clinicians had so much faith. All these methods have failed signally to bring about a complete cure within a short period. What was wanted in reality was an agent which would exterminate the boils in situ without any further recurrence. That was the long-felt want of the physicians, which has been fulfilled by the discovery of Stannoxyl.

Stannoxyl is a refined and a scientific product of pure tin and tin oxide and is a specific in all diseases caused by Staphylococci, specially Furunculosis. It is quite harmless, to the

system. Thanks to its being tasteless and odourless, it is taken orally by all without any trouble. This product is unexcelled as a curative agent in all forms of affections that are caused by Staphylococci. It answers to all requirements that can be made on a curative agent for skin affections of microbic origin and suppurations. Amongst concrete cases in which Stannoxyl can be employed with success, only the most essential are enumerated here, viz. Furunculosis, Acne, Carbuncles, Sycosis, Styes and Prickly Heat.

FURUNCULOSIS:—This is by far the most common complaint treated by Stannoxyl with very successful results. The most refractory cases respond to this treatment with surprising rapidity. Stannoxyl is considered a specific for this affection.

ACNE:—Many physicians have talked highly of the satisfactory results following on the administration of Stannoxyl in acne both suppurative and Vulgaris. This product has replaced the autogenous vaccines, which have been used in a number of instances with disappointing results. The oral treatment of Stannoxyl has proved very efficacious almost immediately. In addition to arresting acne, Stannoxyl has at times a hemopoietic property on account of which it also combats anæmia, which is frequently associated with this affection, successfully. The patient, therefore, at the end of the treatment invariably feels better in general health. All this cannot be said of vaccine treatment.

CARBUNCLES: Under Stannoxyl treatment Carbuncles dry up, shrink and scale over in a remarkable manner and of all the methods of treatment tried so far, whether local or general, this alone has been effective. Incisions and dressings no doubt cure the affection, but it cannot be denied that the trouble, the duration, pain and also the expense is so great that the patient always prefers this treatment.

Sycosis, Styes and Prickly Heat—all yielded to Stannoxyl rapidly and effectively.

The advantages of the treatment by Stannoxyl are:—

- (a) Prompt relief of pain.
- (b) No incisions.
- (c) No injections (if they are not liked).
- (d) No recurrence.

Stannoxyl is available in tablet form as well as in ampoules. Tablets are generally preferred and there are cases in which patients suffering from boils or acne are unable to tolerate for some reason or other injections of any kind. For them oral treatment is the best.

The results in all cases which needed Stannoxyl were remarkable, but I give the following as they are of special interest:—

1. The patient, a young man of twenty-eight, came to me with deep-seated boils on the hairy part of his face. He was treated with autogenous vaccines. This had absolutely no effect. One of the boils had enlarged very much and as a result he had oedema of the face and eye-lids and he complained of severe pain. The pus was discharged and the pain relieved but boils continued to appear at intervals on both sides of the face and also on the neck. Injections of vaccines were given and antiseptic lotions applied without any good resulting from it. Then at last I thought of Stannoxyl. Improvement commenced on the third day and continued onwards. Subsequent boils which continued to appear were of very small size and were aborted rapidly and the most remarkable thing was that they were not so painful. He used to take about eight tablets per day. The patient's health began to improve and he was completely free from trouble after three weeks.

2. The patient, a boy of about twenty years, came under my treatment for big boils near the axilla and the buttocks. I at once started giving him Stannoxyl tablets eight per day. After three days the boils were seen subsiding and the pain was less severe. After four more days there was further improvement. All the boils had been aborted and a large indurated mass was felt in the axilla which was not very tender. Although the boils used to appear in other places besides the axilla and the buttocks, they soon subsided and gave very little pain. The trouble completely disappeared after two weeks.

3. A young lady of about 23, sought my advice for acne vulgaris on her face. I immediately kept her on Stannoxyl treatment. Previous to this she was having acne vaccines from some other medical man. She had been given also various face lotions. All these proved unavailing. After about five days of Stannoxyl treatment, her face began to show signs of improvement. She had to finish one bottle before her face completely cleared up. I advised her however, to take a bottle more, about two tablets per day after about a fortnight's interval in order to prevent recurrence.

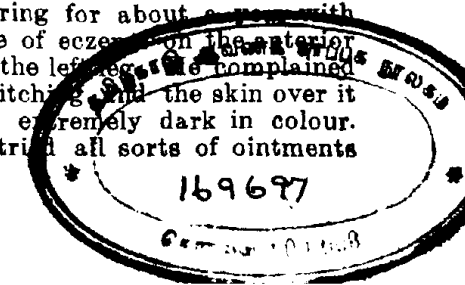
The results of this treatment, even in the most obdurate cases speak for themselves. It must be emphasised that the patient has absolutely to undergo no trouble during the treatment either of injections or incisions and dressings. The patient's general health also improves. This might be due to the diminished pain and the prospects of early recovery. Stannoxyl therefore is a most elegant, clean, odourless and tasteless preparation, which can be easily taken without any harm to the system.

Successful treatment of two cases of Eczema.

It is very difficult to estimate accurately the therapeutic value of a certain Product, unless it is tried on numerous cases. This method of trying is usually a slow one and in private medical practice, as many patients in Bombay at least, do not stick on and the physician is therefore much handicapped in following the cases and noting the results and efficacy of a particular product that he must have employed. I was however, fortunate in following two cases of eczema, wherein I tried Pharmasol Trimine, which has shown itself quite satisfactory in my hands.

1. Mr. G. thirty years old with no specific history but of gouty diathesis, was suffering for about a year with a dry type of eczema on the anterior aspect of the left leg. He complained of severe itching and the skin over it had gone extremely dark in colour. He had tried all sorts of ointments

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which gave him some temporary relief and freedom from itching, but the trouble used to recur. I started with 1 cc of Pharmasol Trimine Injections intramuscularly and repeated it every third day. With the first injection there was no perceptible change. After the third injection the itching sensation gradually lessened and the acne that he had on the face increased probably the result of reaction. After the fifth injection, the dark colour began fading until it cleared eventually after the full course. The acne, which had much developed after the second injection also disappeared and his face became clear of all blotches and eruptions. Locally he was given an ointment containing Salicylic acid, Liq. Picia Carbonia, with white vaseline as the base. He was a subject of all sorts of skin-disease such as acne, seborrhoea, etc. but after the exhibition of Pharmasol Trimine his skin became much clearer than before.

2. A young lady of about 25, came to consult me for dry and weeping type of eczema on her fingers and the lateral aspect of her left leg. She gave no specific history. The itching, she said, would not allow her to rest well at night. She had taken all sorts of medicines for her ailment from quacks as well as qualified men without any improvement. I put her on a course of Pharmasol Trimine 1 cc every third day. Locally she was given oil of cade together with zinc oxide ointment. After the third injection the eczema began to show marked progress for the better. The effect showed itself plainly by a decrease in the discharge and by the comfortable sleep that she enjoyed owing to the disappearance of the itching sensation. After the course of six injections her trouble improved considerably and it disappeared completely after some days of local treatment.

Pharmasol Trimine in my experience is quite an efficacious product which offers properties for therapeutic control in eczematous conditions. No harmful by-effects were observed and no pain is felt by the patient after injection except a slight sensation of

numbness, which disappears immediately.

Combining Symptomatic and Curative Treatments for Tuberculosis.

The curative treatment of Tuberculosis by means of Aminobiase possesses one disadvantage especially against old lesions, in that in some cases it may take some weeks before the improvement becomes obvious. This is necessarily so, wherever we depend for the action of a drug on its direct healing effect on a localized septis process, because absorption of toxins may continue till the healing is nearly completed.

It is fortunate therefore to be able to confirm the advantages of combining Biocholine treatment with Aminobiase.

While the Biocholine attacks the problem from a physiological point, increasing the natural resistance to the disease, enabling larger quantities of detoxicating products to be formed and sent into circulation, and restoring the natural degree of Cholesteremia which is required for the "healing by first intention" of tuberculous processes, the Aminobiase proceeds to build up sclerosed tissue around the wound and to squeeze out the bacillus.

The cough may be relieved by the use of oral remedies such as Syrup Creosal. Indeed such palliative measures should never be forgotten, since the cough may irritate the lungs and so delay the restoration of health.

Common Colds.

The risks which one runs when one suffers from a "Common Cold" are really great, when one considers its prevalence, its contagious nature and its possibility of spreading onwards through the trachea down to the lungs. These colds are caused by bacteria and ultra-microscopic viruses and this bacterial infection of the upper respiratory tract may be comparatively trifling as in acute coryzas or mild nasal catarrhs or they may be of utmost gravity if the infection travels onwards and influences the pathogenicity of such organisms as pneumococcus, streptococcus or Pfeiffer's bacillus, etc. which are in some individuals the normal inhabitants of the

respiratory tract. In order to avoid these severe sequelae, micrococcus catarrhalis or bacillus septus, the bacilli, which cause common colds, and which light up these severe infections, must be attacked. The prevention of these colds would therefore enormously reduce the incidence of these severe infections which find an entrance into the organism. In order to do away with this menace constituted by these colds and their concomitants, Kinectine is the remedy which has proved efficacious. In this product we have an agent, which maintains the alkaline balance of the body, which is disturbed in these affections owing to the predominance of acidosis. Colds, nasal catarrhs and influenza in its initial stages can frequently be aborted if Kinectine is administered, as soon as the symptoms are observed. The administration of three tablets per day is usually beneficial and if this dose is repeated for 3 consecutive days, the attack can be cut short and the severity of the secondary infections either avoided or minimised. As a prophylactic in epidemic Influenza and in local infections of the nasal mucus membranes, etc. Kinectine acts in a most gratifying manner. It is evidently an absolute preventive if employed at the very first appearance of symptoms of a cold in the head. In Hay fever it is as much a specific as Quinine is in the cure of Malaria. In acute Coryza, Kinectine has proved in the hands of many physicians more efficacious than any other combination of drugs, shortening the duration of the attack by several days. In influenza, in its primary stages its value has been proved beyond doubt. In this affection as also in colds, Kinectine acts in such a way that there is immediate shrinking of the congested and engorged mucus membranes, which is usually the condition in these troubles. In paroxysms and fits of asthma, Kinectine has been prescribed with splendid results. The attacks and the dyspnoea have been relieved. One merit of this product is that it is palatable, that it has a prolonged effect and that there is seldom any need of repeatedly administering

it for a long time. The remarkable result that is obtained by giving Kinectine in Hay fever can scarcely be exaggerated. This is an allergic disease, where there is often the disturbance of the acid-base balance. Kinectine acts almost as a specific in this disease and lachrymation, sneezing, etc. which generally accompany this affection yield to it without the least difficulty.

Thus we find that Dr. Mouneyrat, when he discovered Kinectine and placed it at the disposal of the medical practitioners, has done a distinct service to humanity.

Now the advantages of Kinectine over Catarrhal vaccines can scarcely be overrated. The first and the foremost is that the product can be given orally and no injections are necessary. In the case of vaccine it is really difficult to estimate the proper amount of dosage either as a prophylactic or a curative in cases of common colds. In case a full dose is given there is an exacerbation of the symptoms and this makes a very bad impression on the lay patients. With Kinectine we ran no such risks and we are always safe when we give the proper doses given in the literature. Apart from the fact that the majority of medical men are against inoculation of any kind, still it must not be expected, so far at least as Micrococcus Catarrhalis and Bacillus Septus are concerned, that the immunity offered by the vaccines is not useful. But it is always possible that the patient may meet with rather a severe infection, which may establish itself. Kinectine, though it does not presume to confer immunity, at least cures the condition thoroughly at the time.

To summarise, Kinectine has proved to be a most useful addition to the general practitioner's armamentarium, as with its help, specially when used early, Common Colds, Sneezing, Coryza, etc. met with in every day practice, can be cut short and complications, which are generally severe, avoided. The product is in most elegant form and at the same time economical and no unpleasant effect has been experienced by any body with it so far.

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Notes on Treatment of Diseases.

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

Diabetes Mellitus: 1. In the matter of diet the caloric requirements are calculated from the surface area of the body of the patient and his weight. Banting takes the basal caloric requirements at 25 times the weight of the patient in kilogrammes and the glucose and fat rates as 1 : 3. A man weighing 50 kilogrammes and who is not obese, requires 1,500 caloric made up of 50 grams of protein (205. c.) 125 grams of fat (1137. c.) and carbohydrate, 38. (Ed. Survey.)

2. The disease is said to be very common among the Jews on account of the large quantity of garlic and onions they use. Physiological Iodine in the form of nitroids before meals, high colon irrigation every night, massage to the liver are recommended. When there is gangrin glucose may be given. (Graham.)

3. In the sthenic variety Bromide of Arsenic, Clement's solution, Codeine sulphate (not phosphate) and common salt and Soda Bi-carbonate to be given. In the Asthenic variety, Thyroid gland gr. 1, Adrenalin gland gr. 2, Strychnine 1/40 of a grain made into a capsule to be taken in the middle of each meal. (Sajous.)

4. In Ketosis the following mixture is useful. Soda Bicarb. 1 dram, Pot. Citras, gr. 30, Calcium carb. gr. 3, Magnesium carb. gr. 3, in one ounce of water, ½ an ounce of this to be taken 3 times a day. (Maclean.)

5. The extract of oats has the effect of Insulin and Nitrogen metabolism is also increased by Insulin. (J. O. T.)

6. All glucose is not assimilable but only one form of it, namely gamma glucose is utilisable. Insulin converts

glucose into gamma glucose. (Leonard Williams.)

7. The acidosis formed by the conversion of proteids into fats cannot be reduced by giving alkalis, but only by giving either fat or carbohydrate. (Burg.)

8. The testes in the males and ovaries in females are said to cause the disappearance of sugar in the urine and glycerine may be given in place of carbohydrate. (Ed. Survey.)

9. All vegetables should be thrice boiled in a large quantity of water and Soda Bicarb. added to remove all the carbohydrates from them, and the following vegetables prepared in such a way may be given.

Turnip, Parsnip, Cabbage, Beets, Summer Squash, Carrots, Vegetable Oysters, French Arti-choke, Onions and Egg-plant. If only a small quantity of carbohydrate is taken one hour before break-fast, there will be no sugar in the urine. (Kellog.)

10. Iodide of Calcium in 5 gr. doses thrice a day has been found very effectual. (The Practitioner.)

11. One ounce of powdered leaves of gymnema sylvestre (செஞ்சிஞ்சு) natural order Asclepiadaceae boiled with 10 ounces of water till the quantity is reduced to 4 ounces; half of this for a dose 3 times a day. (I. M. G.)

12. The insulin sometimes causes shock. Manganese per-hydroxyl is good.

13. Caramose 100 to 200 grams divided into 4 doses and given with coffee, pudding and alcoholic drinks. Glucose is also good.

14. Strontium Nitrate 0.012 to 0.02 grams per day is good.

15. The action of insulin is augmented by the administration either orally or by hypodermic injections of Nickel and cobalt in small doses. The pancreas contains these salts. (J. A. M. A.)

16. Insulin may be given by inunction over the skin in nervous diabetes. (Ed. Survey.)

17. Diabetes complicated with Exophthalmic goitre is best treated with compound solution of Iodine from 20 to 60 mms. daily. (Internal Medicine.)

18. Synthalin, a synthetic guaridine preparation, is used orally. Sometimes it produces nausea, loss of appetite, epogastric pain and albuminuria and sometimes jaundice. The new preparation synthalin B. has not got these disadvantages.

19. Glukhormint is said to be effective and may be given orally.

20. Myrtillin which is found in blue-berry and oats is useful as it acts like insulin. (I. M. D.)

21. Glycerine is recommended as it has a low carbohydrate co-efficient and is an anti-ketogenic substance. (Modern Medicine.)

22. As the disease is supposed to be a deficiency disease the administration of Vitamin B is said to be effective. (I. M. D.)

23. For renal glycosuria parathyroid 1/10 gr. cal. chloride gr. 5 is good. (I. M. G.)

24. In diabetes of hepatic origin liver substance acts like insulin. (J. A. M. A.)

25. Sulphur internally has the action similar to that of insulin. (J. A. M. A.)

26. In diabetic polyneuritis, orchitic substance is good. (J. O. T.)

27. Calcium lactate is sometimes useful. (Barker.)

28. Phyto-chinin and the Factor A. of Funk is useful. (I. O. G.)

29. Oral administration of certain aqueous liver extracts contain a blood-sugar-reducing substance and active when taken by the mouth.

Pancrepatin, an extract of the Pancreas, activated by the addition of

Hepatic Juice has been found to answer the requirements both regarding deficiency of digestive enzymes as well as internal secretion. The aim in the treatment of Diabetes should be to supply a substance to enable the patient to metabolise a sufficient quantity of Carbo-hydrate and to abolish completely not only glycosuria but even an excess of blood sugar, avoiding hypoglycemia. Pancrepatin satisfies the rational of scientific treatment.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Treatment of Bacillary Dysentery.

Treatment of dysenteries is not so simple as is generally supposed. To begin the treatment of dysenteries without the proper bacteriological examination of the stools is hardly scientific. The diagnosis of these diseases merely on the clinical syndrome is faulty and never pays as the treatment depends on the bacilli that are the causation of the particular type of dysentery. In the two principal varieties of Dysenteries, the Amoebic and the Bacillary, although there are many points of differentiation, still in actual practice the medical man is led astray on account of the manifestations of the symptoms being less obvious. An acute case of Bacillary Dysentery is at times mistaken either for Cholera, food-poisoning or epidemic diarrhoea and of the amoebic type for indigestion, progressive anaemia or sub-acute diarrhoea. Unless therefore a correct diagnosis of the type of dysentery is made, its proper treatment cannot be instituted.

Now the difficulties in the way of Bacteriological examinations are many. Firstly, very few patients can afford the Bacteriological examination. Secondly, it is quite out of the question in mofussil practice, where there is

hardly any good laboratory and even if the specimen is despatched for examination at a large town, it cannot reach there in a state proper for cultural study.

Diagnosis is therefore made in the majority of cases from the obvious clinical signs. The following points will be of great help in determining the type of dysentery:—

(1) In bacillary dysentery the stools are many in number, while in amoebic they are far less.

(2) There is more of toxemia and prostration in Bacillary Dysentery than in the Amoebic one.

(3) In Bacillary type the stools consist of very little fecal material, but more of mucus and blood as compared with those in the Amoebic one, where the major portion of feces only.

(4) Fever is invariably present in Bacillary Dysentery while the Amoebic type is mostly free from it.

It is common knowledge that Bacillary Dysentery is due to the infection in the majority of cases by *Bacillus Flexner* and in some by *Bacillus Shiga*, while the parasite responsible for Amoebic Dysentery is *Entamoeba Histolytica*. These being the two principal types which the medical man meets with in his general practice, he has practically to diagnose and treat either a case of Bacillary or Amoebic Dysentery. Accurate diagnosis is absolutely essential as the lines of treatment in the two types is quite different. If a Bacillary infection is treated with Emetine and the Amoebic one by Saline purgatives, no benefits will accrue to anybody. The confusion therefore is so great that it is better that our knowledge about the causation should be definite and exact.

The treatment of Bacillary Dysentery was not at all satisfactory until Dr. D'Herelle discovered Bacte Dysenteric Phage, which is almost a specific for Bacillary Dysentery. No sera,

vaccines or chemo-therapeutic agents are reliable, as is found out after their use in a large number of cases. Formerly, in spite of the fact that these sera and vaccines may be of same effect in a certain number of cases, still the difficulties in the treatment of Bacillary Dysentery were many. To begin with, the elimination of toxins could not be properly done owing to the difficulty of giving Salines to the patient who simply is in awe of purgation, as according to him, he is already purging too much, which has weakened him to a considerable extent. Next, it was very difficult to find out when we should stop elimination and start astringents. Besides, tenesmus and pain were the symptoms which were most refractory to any treatment. In the treatment with Emetine it was not easy to find out whether 2 or 3 grs. of it has worked or not. When the specific serum treatment was given, it was difficult to find out the exact dosage, as too much of it may strain the kidney, which has already been overtaxed by dysenteric toxins. The subsequent complications were far more difficult to treat than the malady itself. The old method of treating these affections with astringents used to interfere with the appetite of the patient and on the top of it cause constipation, which means considerable harm to the constitution. In order to overcome all these difficulties, D'Herelle has given to the profession Bacte Dysenteric Phage, which has made the treatment of Bacillary Dysentery very simple indeed. If once the dysentery is found to be of a Bacillary type, all that one has got to do is to break open the ampoule which contains the exact dosage and pour it in half a glassful of cold water and give to the patient, repeating the dose every four hours. If at the end of 40 hours, the dysentery still persists, we should at once conclude that it is not Bacillary and the treatment for the other type should be soon commenced.

As progress is being made almost everyday in the investigations of diseases of bacterial origin and in the production of serums and vaccines as curative agents, it would not be out of place to know what these Bacte Phages are. These represent a new class of organisms which attack bacteria, developed and elaborated by Professor D'Herelle. These possess many advantages which were not found in the vaccines and sera and they therefore constitute a great advance in Bacterial therapy.

In the preparation of these Phages the organisms are taken from the culture medium on which they have grown and kept in contact with the Physiological Saline Solution for a very short time and this prevents the formation of autolysates which are more or less toxic. It is therefore on account of this that the Phages are non-toxic. These do not lose their virulence or activity for several years. Clinical investigation has shown that they can safely be administered and are well borne. They have a great advantage over vaccines and serums in that they can be given by the mouth and are absolutely innocuous even when there are errors in diagnosis. The only precaution that one ought to observe is that the ampoules should not be heated, nor should they be poured in hot or even in warm liquids, and no antiseptics should be used. Care should be taken that the contents of the ampoules should be utilised within three hours after being opened.

A few typical cases of Bacillary Dysentery which have been successfully treated by Bacte Dysenteric Phage are cited below:—

1. A young boy, aged about 15, came to me for treatment for frequency of loose motions, about fifty per day, with severe tenesmus and temperature. He was treated before, according to the history he gave me, with Castor Oil Emulsion and about 2 or 3 injections

of Emetine, the dose of which he was not able to tell. He came to me on the fourth day of his illness and the toxemia appeared to me very intense. That it was a case of Bacillary Dysentery was found out after considering the following points.

1. The great number of stools without much fecal matter but more of mucus and blood.
2. Severe prostration and toxemia.
3. Presence of temperature.
4. Failure of Emetine treatment.

He was at once given one ampoule of Bacte Dysenteric Phage in cold water and the dose was repeated after four hours. He was kept in the beginning on water, infusions of tea and fruit-juice. Later he was allowed milk. No improvement was noticed during the first twenty hours, but after that gradual change for the better set in. Tenesmus had disappeared and the number of stools had come down to about seven or eight. He got almost all right after forty hours. He persisted in taking the treatment for two days until he was completely all right. He however, continued the light diet and the liquid food for some days.

2. This was a remarkable case of Bacillary Dysentery contracted about a fortnight before he came to me for treatment. The stools were very frequent containing more of mucus than blood. Tenesmus and toxemia were very great. The patient had received various treatments including injections of Emetine, Auto vaccines and irrigations of Potassium Permanganate, Boric Acid, etc. None of these measures were effective, the disease continuing its course and the patient being much debilitated and weakened. Microscopical examination of the feces revealed the presence of bacilli, probably Flexner's and the treatment with Bacte Dysenteric Phage was at once instituted. After treating it for about 48 hours with this Phage there was

distinct improvement and the patient was much better. Pain and tenesmus disappeared and the number of stools fell on successive days, until it was reduced to one per day. This case shows in a very striking manner the efficacy of Bacte Dysenteric Phage in Bacillary Dysentery, which had proved refractory to every form of treatment.

Since Emetine, given hypodermically, does not interfere with the activity of the Bactephage in the intestines, there is no harm, where the diagnosis is in doubt, of giving both treatments simultaneously.

How does Nature do it?

Although constipation is the most prevalent ailment, due perhaps to modern civilization, no effort has really been made to treat it on rational lines. Mostly cathartics, purgatives and salines are administered which relieve the condition for the time being only, to recur once again much to the annoyance of the patient and the physician. The rational therapy of constipation consists in not only relieving it, but also educating the bowels in such a way that they move and act regularly without any further trouble. To accomplish this there is no product which will relieve not only constipation but also its many attendant evils, more satisfactorily than Mycol. If we carefully consider the character and the composition of this preparation (bile extract, lactic ferments and beer yeast) we will come to the conclusion that its effects are much more certain and far-reaching than other laxatives. Mycol is quite an efficient product which is at the disposal of the Medical Profession. Besides stimulating peristaltic movements of the intestines, it modifies the activity of the pathogenic bacteria in the presence of bile with the help of Beer Yeast and Lactic Ferments. It acts as a very good antitoxin and being entirely harmless can be given for a

prolonged period until the toxins in the bowels are removed and the entire digestive tract is thoroughly disinfected. It is mild in action and induces complete evacuation of the bowels without causing any griping pains or weakness. The great advantage of Mycol is the discreet and reliable manner in which it attains the laxative effect. There is no lassitude and no griping, nor nausea, which accompany the usual cathartics and saline purgatives. It is on account of the sustained action of Mycol that it is recommended by physicians to patients who have chronic constipation.

By far the most useful laxative is Mycol and this is due to the fact that unlike paraffin oils it does not form a coating on the mucous membrane of the bowels, nor does it so mix with food particles as to prevent their absorption. The prevention of absorption of food naturally leads to the interference of nutrition. Mycol therefore is to be preferred to any elaborate preparation of liquid paraffin. Add to all this, Mycol has not got the dehydrating properties of the salines, which take away large quantities of serum from the blood by their habitual use. Besides this, the sulphates e.g., magnesium sulphates are reduced to sulphides, which prevent proper absorption of iron and other metallic substances in the food.

Mycol is so prepared that it passes through the stomach unchanged as the gastric juice has no action on it, and only when it reaches the small intestine, does it begin to act. In the bowels it begins to act in such a way that it picks up those bacterial toxins, which are harmful and removes them from the system leaving alone those products of digestion which are essential to the growth as well as the proper working of the digestive tract. This it does with the help of lactic ferments and Beer Yeast in the presence of bile. Mycol, as we have seen, does not possess any harmful

chemical physical properties and unlike paraffin oils does not interfere with the normal process of digestion but on the contrary helps it to a great extent.

Mycol has been found by a number of physicians to meet numerous indications. Constipation, intestinal toxemias and stasis, boils, acne, rheumatism, piles, head-aches and liver troubles are some of them, which can be treated in a most effective manner by this product. Constipation, which is due to a variety of causes, yields speedily to Mycol. In intestinal toxemias, Mycol has a very effective action on the bacterial toxins and toxalbumins. It acts with speed and certainty. The toxemia is rapidly abated and the intestinal tract, if the patient is kept on Mycol for a sufficient period, is thoroughly detoxicated. In pregnancy it has a very helpful effect on nausea and morning sickness and relieves constipation, which is generally present in this condition, and thus lessens the chances of intestinal toxemias, which may result from it. In cases of intestinal stasis, efficacy of Mycol has been universally recognised, as it has the capacity of not only bringing about propulsion and evacuation of the bowels before the feces are dried and hardened, but it also disinfects the bowels thoroughly on account of lactic acid ferments. The volume and the plasticity of the mass in the intestine, specially the large one, is maintained and this acts as a mechanical stimulus, which is quite essential to keep up the normal bowel action. As a result the muscles of the intestines are gradually trained to the point of their normal physiological habit of evacuation without any further aid. Thus it is that Mycol is a great bowel-educator and corrector. There are numerous cases of Acne and also Boils, which are refractory to any local treatment. In such cases the trouble is presumably due to auto-intoxication and Mycol has been employed in such cases with great

success. The Beer Yeast increases leucocytosis which is needed in these cases and the lactic acid ferments are good disinfectants. Many such cases have been treated with Mycol and not only were these cured, but hardly every any recurrence of the trouble ensued. The vague limb-pains, generally called rheumatic pains, as well as Rheumatoid Arthritis due to intestinal auto-intoxication, rapidly yield to vigorous Mycol treatment. Here, in the latter case specially, Mycol carries out intestinal detoxication and thus overcomes the chronic infection of the joints and other septic foci. The use of Mycol in Piles is of course evident, as it ensures certain action of the bowels regularly. Its employment in Liver diseases is obvious, as it contains Bile, which is deficient in such cases, and acts as a cholagogue purgative acting gently and without harshness or concomitant disturbances. In indigestion, colitis or where there is least suspicion of intestinal inflammation, as everybody knows irritant purgation is to be strictly avoided, complete and easy evacuation can be effected without the least irritation by Mycol, the action of which can be hastened by taking one or two tablets with the diet prescribed three or four times a day.

Mycol in short, besides being a harmless and efficacious evacuant, is a powerful detoxicating agent. It restores normal absorption of the intestinal mucosa, where it is unhealthy and the intestinal flora is rendered absolutely free from pathogenic bacteria and it induces a habit of regular defecation.

Notes and Extracts from Standard Literature.

TUBERCULOUS SWEATS.—VILLARET M. AND EVEN, R: ACETYLCHOLINE IN THE SWEATS OF TUBERCULOSIS, PRESSE MED., 37: 1561, DECEMBER 8, 1928.

The authors' experience included twenty-eight cases. All had profuse

sweats for at least five days, which resisted the usual treatment. The sweating ceased after the first injection of acetylcholine in eight cases; after the second injection, in five cases (in three of these cases there was a diminution of the sweating after the first injection); after the third injection, in one case; and after the fourth injection in one case. In several cases there was a transitory cessation of the sweating, which became lasting in from two to fourteen days. In twenty-two cases the relief from sweating was maintained; in one case there was a perceptible diminution. There were five failures.

Where the usual hygienic measures fail to control the sweating of tuberculosis we have the choice of three remedies—atropine, calcium chloride intravenously, and acetylcholine. The authors prefer the last for two reasons:

1. The results are more constant than with calcium chloride.
2. They are more lasting than with atropine. Moreover, atropine may have toxic effects, and calcium chloride is attended with the inconvenience of intravenous injection.

Employed correctly, we have in acetylcholine the most potent remedy yet found for the treatment of persistent sweating in tuberculosis.

LEAD COLIC.—LAIGNEAU LAVASTINE AND FOUQUET, J: LEAD COLIC RELIEVED BY ACETYLCHOLINE, BULL. ET MEM. SOC. MED. HOP. DE PARIS, 53: 360 MARCH 8, 1929.

The patient, a young man of 24 years, was suddenly seized with severe abdominal colic and vomiting. Several days later he was admitted to the hospital and was given 0.1 Gm. of Acetylcholine. The pain was markedly relieved, but recurred in a short time. A second injection of the same amount was then administered, after which the relief was somewhat more prolonged. After five daily injections his condition was practically normal; the arterial pressure was 125, the pulse 68, and pain had disappeared. Some days later another crisis occurred, and the acetylcholine injection was repeated. Within forty minutes after the injection, pain was relieved and the patient stated that he experienced a sense of general well-being.

Acetylcholine exerts both a sedative and

an orthosympathetic action. One can be confident on this point. Under its influence all the acute phenomena are corrected and the vasomotor reactions, absent during the crisis, reappear. Acetylcholine seems to possess a therapeutic efficacy in lead colic, superior in its action to that of morphine, and it is free from the inconveniences of the latter. The effect of the first injection may be ephemeral, but it is easy to repeat the injection every three or four hours and thus prevent the recurrence of the colic, always carefully watching the pulse.

VALLARET, M. AND JUSTIN-BESANCON, L: THE THERAPEUTIC APPLICATION OF ACETYLCHOLINE, LANCET, 1: 493 MARCH 9, 1929.

"In lead colic, although only a few cases have come under observation, strong doses of Acetylcholine (two or three injections of 0.2 Gm. every ten minutes) seem to give splendid results."

TABETIC GASTRIC CRISIS.—GUTMANN, R.A.: THE ACTION OF ACETYLCHOLINE IN A CASE OF GASTRIC CRISIS OF TABES, HOPITAL, 17: 167, MARCH, 1929.

This case is of interest because of the new application we have found for a product still under investigation. A woman, aged 35, had suffered from severe attacks of gastric and abdominal pain since 1924. Suddenly one morning she had an extremely violent attack of pain in the epigastric region, with vomiting, which did not relieve the pain. The attacks were repeated from twenty to thirty times during the day and lasted from four to six days. These attacks continued to recur at irregular intervals and finally a cholecystectomy was performed. No relief was afforded. When the patient came under observation, it was found that she had been treated for syphilis and was suffering from a typical tabes.

While suffering a very severe tabetic crisis, she was given two injections of acetylcholine hydrochloride at an interval of five minutes in dosage of 0.05 Gm. In fifteen minutes the pain and vomiting ceased and did not recur. The patient has since been receiving intensive specific treatment. Though this must be taken into consideration, the effect of acetylcholine was remarkable and is deserving of further investigation.

Sterile Intestines Unnatural.

Bacteria are everywhere in nature. Wherever life of any kind is possible, bacteria gain an entrance and thrive. In the intestines as on the skin, saprophytes of various kinds find a suitable soil in which to grow.

In cases of some saprophytes of the intestines "Symbiophytes" might be a better description, for certain strain of bacteria appear to assist digestion.

In the case of yeast cells growing in the intestines Symbiosis is surely the more applicable term since not only do yeasts tend to suppress the putrefactive bacteria of vital rivalry, but they are proved to generate vitamins which are important adjunctives to nutrition.

In cases where pathogenic bacteria gain an ascendancy and where sterilizing processes are adopted, it may often be advantageous to substitute yeasts for the eliminated bacteria. An excellent strain of yeast for such purposes is found in "Proliferase." Yeasts are not destroyed by the Bactephages, so that Proliferase may be used without contraindication after Bacte Intesti Phage or Bacte Dysentery Phage.

Yeasts against Cancer.

In support of a theory that an excess of saccharine substances in the tissues predisposes to cancer, yeasts have been

used, apparently with some success, in treating various malignant growths.

As to whether this theory about glucose is correct or not, it is hard to say definitely, because no matter how much confirmation we have regarding the curative influence of yeasts in cancer, this need not be due to the fermentative action of the yeasts on the sugar. It may be due to some form of suppression by vital rivalry. It may be due to the influence of Vitamin B on the nervous system. The connection between "repeated irritation" and "Cancer" is quite well established. The connection between irritation and cancer presumes an "irritability," which is a nervous function and one greatly influenced by a paucity of Vitamin B.

Lately it has been pointed out that according to occupational statistics, workers in breweries are immune to Cancer. Has this got anything to do with the yeasts employed in the brewing process?

That also is hard to tell. It may be so, or again it may be due to the sedative (anti-irritative) influence of the hops, or to some other cause.

Perhaps, better results from yeast therapy in cancer can be got if a viable-at-body-temperature yeast like Proliferase were to be tried.

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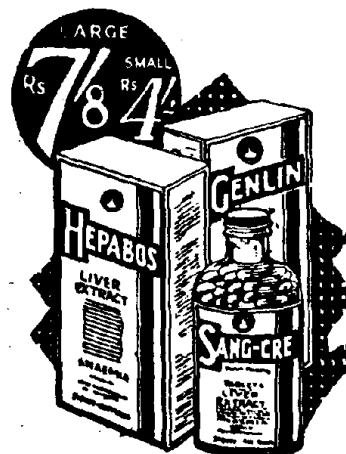
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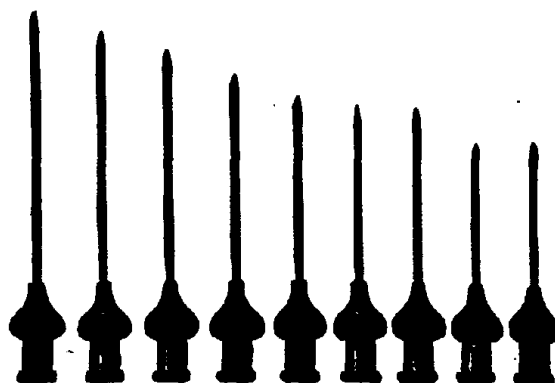
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News and Comments

Anti-Leprosy Campaign: We understand that the Government have inaugurated a Scheme for combating Leprosy in this province and for this purpose divided the Presidency into six groups. Six Medical Officers who had training at the Calcutta Tropical School of Medicine have been deputed for this work under the guidance of a Leprosy Officer who is at present holding his Office at Calicut and who may eventually have his head-quarters at Madras or there-about. Every head-quarter's hospital will have a Leprosy Clinic and in addition there will be centres for treatment in Taluks which are endemic areas regarding the prevalence of this disease. Apart from treatment at the clinic and other centres the Medical Officers are expected to do survey and propaganda which are likely to be of intensive nature in schools. Nilgiris and Ceded Districts will not have Leprosy clinic at head-quarters as the incidence of the prevalence of Leprosy in these districts seems to be very low.

It is inconceivable why the city of Madras has been excluded from the field of activities of propaganda against Leprosy. Though we have not got with us the actual figures we can without fear of contradiction mention that the incidence of this fell disease in the city is certainly high. Apart from street beggars whom one is horrified to see in the worst stages roaming about near the tram-cars, railway stations and places of worship, leprosy is seen in all forms both amongst the middle and high class people in the city. The work turned out regarding leprosy at the skin department of the Government General Hospital and also at the Out-patient Dispensary of Royapuram Hospital can never be said enough to combat leprosy in the city. This apart, it can never be said that the Government have done well regarding the campaign which to be popular and effective should be divested of its official column and entrusted to private agencies under official control and guidance in the matter of finance alone. If the Officer at the head of these campaigns could be one outside

the official cadre why not other medical men who may be entrusted with this work? It is unfortunate that those who are responsible for medical relief in this country are devoid of imagination even at this juncture when every pie of public funds should be saved and could not conceive of plans of doing extensive, efficient campaign for combating leprosy in which the lay public and the medical profession must interest themselves.

M.B.B.S. Course for L.M.Ps:

The regulation passed by the Madras University without any definite rules regarding the course of studies and the unsettled equivalent for Intermediate standard as a preliminary qualification, have been the cause of disappointment to a large number of L.M.Ps., and our office is flooded with letters of enquiries of all sorts. In a matter like this which should have the final consent of the Senate of the Madras University, there is bound to be a certain amount of delay which is unavoidable though it has to be said that it would have been possible for the Board of Studies to frame definite rules regarding the successful working of the Regulation and place them before the Academic Council and finally before the Senate along with the Regulation. What can't be helped must be endured. The L.M.Ps. about whom nobody thought of regarding the feasibility of their qualifying themselves for a higher degree or diploma in their own native land for some decades when they could qualify themselves for the same in foreign countries, can certainly afford to have patience for a few months more till the next meeting of the Senate. We understand that the Board of Studies has met and approved to recognise the Senior Cambridge Certificate as a substitute for the Intermediate qualification. Any other standard equivalent to Intermediate will be considered by the Academic Council on individual applications. Regarding the two years' additional course prescribed in the regulation, which the candidate have to put in at the Madras or Vizag. Medical College, the first year course may consist in any subject or subjects

amongst Physiology, Anatomy and Pathology. For the purpose of the new regulation it is enough that the student attends for a period of one year the college classes choosing any subject or subjects he wishes and at the end of this year he should appear for the 2nd M. B. B. S. Examination. After this course, he should have another one year course in any subject or subjects amongst Medicine, Surgery and Midwifery and at the end of this course appear for the final M. B. B. S. examination. As mentioned above necessary rules and preliminaries have been arrived at by the Board of Studies whose recommendations have to be approved by the Academic Council which meets in August and then finally passed by the Senate at their next meeting. From what we could judge from the sympathetic attitude of the members of the Senate on the last occasion when the Regulation was passed, we do not think there will be any controversy on the details regarding rules considered and recommended by the Board of Studies.

Wolf and Lamb Story: We hear that a Taluk Board President is threatening a subsidised medical practitioner why his services should not be terminated as it had come to the knowledge of the President that this practitioner is visiting an adjoining village and treating patients.

The President wished to provide for another practitioner by starting another subsidised dispensary in this village and had finally to give up the idea on account of the Government refusing sanction for the same as this village could easily get the services of the already existing rural practitioner, in the neighbouring village. The President does not want that this practitioner should leave the village and have private practice elsewhere though without prejudice to his work at the subsidised dispensary. He could not frame charges against this practitioner for any neglect of work at the subsidised dispensary. The President is angry that he was deprived of yet another opportunity of patronising. He does not seem to think that starting another subsidised

dispensary close to the one now existing is not necessary and it will cost some money to the Taluk Board. The story is clear and the actors could be easily identified by their action. Yet who knows how the authorities would decide as the Rural Medical Relief Scheme seems to have a special unwritten code of reasoning.

Principle versus Convenience: The private practitioner at Kaup, Udipi Taluk (S. Kanara Dt.) who protested against the starting of a subsidised dispensary in the locality where the services of a qualified practitioner were available to the public and who got a reply from the Government to the effect that the Government had advised the Taluk Board not to start a subsidised dispensary and if for any reason the subsidised dispensary was to be started the practitioner at Kaup should be appointed as its medical officer has, we understand, appealed to His Excellency against the action of the Minister who subsequently permitted the starting of subsidised dispensary at Kaup which he seems to have done on account of special reasons as referred to in our last issue. Though the person concerned is a rural practitioner the principle involved deserves the attention of the authorities and hence the result of the appeal will be watched with keen interest. It is unfortunate that the special reasons now put forward were not considered by those who were responsible to change the order once passed.

Retrenchment to the Rescue: As was anticipated by us, the comments appearing in these columns in the month of May about the probable appointments to the Professors of Pathology and Anatomy, Medical College, seem to have stirred up those who were likely to be affected by those appointments. The letter from one of our esteemed correspondents appearing in the same issue did indicate the view points of those now in service who had the necessary qualifications for the posts. We are glad to learn that better reasons prevailed and though the plea put forward against the bringing of outsiders was not heeded to ostensibly, retrenchment seems to have come to the rescue of the Government to change their policy as advocated by their adviser.

Professional men as Secretaries: Under the "Abstracts" columns in this issue is published an abstract headed, "Technical officers in Government Departments." It was Sir Ray Lancaster that said as follows: "While departments in Government in which scientific knowledge is the one thing needed are carried on by Ministers, Secretaries, Assistant Secretaries etc. who are wholly ignorant of science and naturally dislike it, since it cannot be used by them and is in many instances the condemnation of their official employment" and as remedy he suggested "that probably an enquiry into the discussions of neglect of Science and questionable treatment of Scientific men by administrative departments of Government might with advantage be undertaken by a Committee appointed by our great Scientific Societies for the purpose." These observations were made some decades ago with reference to conditions then obtaining in England where the education imparted to lay men was all-round and they were capable of understanding and appreciating scientific knowledge. In India even at present the Ministers who had had their education in India where the general education is lamentably one-sided and purely literary in character and where it is not rare to come across with B.As and M.As whose knowledge of Elementary Science almost nil. In England the administration of the Public Health Department including hospitals is conducted by a Minister who has under him as chief Adviser the Medical Officer of Health. In India the Public Health Minister is assisted by a lay Secretary who is as ignorant of the scientific knowledge as the Minister himself. This looks like a blind man leading the blind. To remedy this defect we have been pointing out in these columns the advisability of doing away with the posts of the Surgeon General and the Director of Public Health and appointing an officer designated as the Chief Medical Officer of Health in their places to work immediately under and assist the Minister of Health as is the case in England. In our April issue we have pointed out when the appointment

of the Director of Public Health falls permanently vacant to put the Surgeon General in charge of the department and designate him as the Director of Public Health and Hospitals and make him work immediately under the Minister in place of the Secretary.

There are several scientific departments in the province, Medical, Public Health, Public Works, Agriculture and Industries etc. Instead of appointing lay men as Secretaries to the Minister in any of these departments the heads of the departments may be made Ex-officio Secretaries as was the case sometime back in the Public Works Department when the Chief Engineer was the Ex-officio Secretary to the Government. This arrangement will prevent duplication of work and delay and expenditure on establishment. We recommend this to the attention of the Retrenchment Officer.

Government Policy—Accident or Design? Communal representation in services is bad enough. To think of it in Medical Service especially in the appointment of a head of a department will be nothing short of folly. We mean no offence to the nominated or elected members in the legislature who cannot but use communalism as a plank—certainly not in public interest. The claims of Major Hesterlow ought not to have been pressed by those concerned on communal lines at all. He has all the necessary qualifications required for the office of the Director of Public Health even otherwise. The new policy of five years' lease given expression to by His Excellency in reply to the Anglo-Indian deputation that waited on him to press the claims of Major Hesterlow, is as unreal as it is impracticable. The new nominee of the Government is only 43 years old while Major Hesterlow is 44. The Government nominee cannot retire at his 48th year unless he gets a higher appointment. If Lt.-Col. Russell could serve as a Director of Public Health for nearly 10 years why not others? The new policy is more an accident than a well-thought-of proposition in the interest of the department. A few years ago when the only available senior-most I.M.S. Officer in this province was an Indian, the Government

made the appointment of Surgeon-General an All India concern and brought an L.M.S. Officer from outside this province for the 1st time in the annals of the history of this appointment. Bringing an outsider for the post of the Director of Public Health is certainly more unjustifiable than the importation of the Surgeon-General. The Public Health Minister made a statement on the floor of the Legislative Council during the last Budget session that in the event of the post of the Director of Public Health falling permanently vacant he would give it to a member of the Provincial Service. The appointment of an L.M.S. Officer from outside is certainly against the assurance given by the Minister and even against the recommendations of the Lee Commission. If no suitable person was available in the provincial cadre, the acting L.M.S. Officer who happens to be a native of this province might have been confirmed or as a last resource the post might have been abolished as mentioned by us elsewhere and put under the charge of the Surgeon-General giving him a suitable designation as suggested by us a little while ago in these columns.

Is it indifference or secrecy : We understand that the committee recently appointed by the Government to consider the extension of the scheme of honorary medical relief will begin its sitting early next month. The public or the members of the medical profession who should co-operate with the Government to make this scheme really popular and useful have not as yet been informed anything more than the names of the members who form the committee. A few days

after the announcement of the names, we wrote to the Deputy Secretary, Local Self-Government Department suggesting to him the necessity of the profession knowing the terms of reference to this committee. Having neither an acknowledgment nor a reply from him, we wrote to him again and had no reply till now. It looks as if the Deputy Secretary is indifferent or perhaps wishes not to disclose the terms of reference and other details. We had occasions of writing to Deputy Secretary of the Local Self-Government Department or others in the Secretariat and elsewhere including the Government House and we had no cause for feeling sorry for our action. We had always replies for our letters and the replies from those at Government House being always most courteous and prompt. In matters like this, it has always been the policy of the Government to get much co-operation from outside. We are at a loss to understand why the present Deputy Secretary does not wish to give publicity about the programme of work of this committee. We wish to inform him that "The Medical Practitioner" which reaches almost all the qualified and registered practitioners both in Government Service and outside has the largest circulation in South India. The Government will gain more and have nothing to lose if they give publicity to a subject of the nature and importance under reference. We trust the Government will take note of what we have expressed in these columns and will not lag behind in giving publicity to the programme and activities of the committee.

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Mysore Medical Registration Act : At the last session of the Mysore Legislative Council, Dr. Mylvaganam put before the house the following amendments:—

(1) "No person other than a registered practitioner shall be entitled to practise Allopathy in Mysore and to demand and recover reasonable charges for medical or surgical aid rendered by such person, and the costs of medicines and surgical appliances supplied by him."

(2) "No person other than a registered practitioner shall be entitled to recover any charge in any court of law for any medical or surgical advice, attendance, or for the performance of any operation as a registered practitioner, or for any medicine which he shall have prescribed and supplied."

(3) "Every person who contravenes this Ordinance or any Regulation shall be guilty of an offence against this Ordinance and shall, unless otherwise expressly provided, be liable on summary conviction by a Police-Magistrate for each offence to a fine not exceeding Rs. 200/-."

(4) "Every person who attempts to commit or abets the commission of an offence against this Ordinance shall himself be guilty of the same offence."

It is to be regretted that the Dewan President ruled the amendments out of order instead of allowing a discussion on them. Dr. Mylvaganam, an eminent member of the medical profession having to his credit the knowledge and

experience of the objects and needs of the Medical Registration Act both in this country and in the West, and who had put in 23 years of service under the Mysore State, having served last as Senior Surgeon, is certainly a better authority on this piece of legislation than the lay Dewan President, in spite of his position, as the head of the Mysore Administration. Dr. Mylvaganam's experience of the working of the Medical Registration Act in Madras and in other presidencies in India is,—what we have been expressing in these columns time and again,—that the Medical Registration Act, as it is now worked, is certainly incapable of serving any useful purpose either to the general public or to the medical profession itself. Dr. Mylvaganam brought to the notice of the Council that a legislative measure which does not protect the public from the unqualified practitioners, was quite useless and the only so called advantage which medical men derive in the matter of issuing Medical Certificates, was certainly of minor importance. We would say that even this so called privilege is a myth on account of the counter-signature or a "Second Opinion" which is now demanded. Dr. Mylvaganam's argument, that the Bill did not insist on the registration of every qualified medical practitioner and that it did not prohibit unqualified men from practising, fell on deaf ears.

The purpose of Medical Registration Act in other civilised countries is not

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mainly to secure for a qualified practitioner the privilege of issuing Medical Certificates. In Madras and in sister provinces these acts have not so far proved to function in the way they do in Great Britain and elsewhere in the matter of protecting the rights and privileges of the profession, the only purpose these acts now serve is to bring the independent medical profession under the disciplinary control of the Surgeons-General or the Inspectors General, as the present medical councils have an overwhelming majority of the subordinates directly working under these officers. State of affairs cannot be otherwise in Mysore.

Alleged disobedience of a G. O.: We have been hearing complaints from medical practitioners that some of the Medical Officers under Government have not been taking notice of a recent order of the Government which put an end to the procedure of counter-signature of the medical certificates. We are now in possession of the facts of one such case. A practitioner issued a certificate to his patient employed in Government Telegraphic Department and his certificate was sent to a District Surgeon for counter-signature. The practitioner wrote to the Superintendent, Central Telegraph Office, and to the District Surgeon who counter-signed the certificate apprising them of the fact that counter-signature of medical certificates had been put an end to by the Government. The reply from the Government Central Telegraph Office was, that his office

was not subject to the orders of the Local Government. The District Surgeon would not himself reply and makes his clerk write to the practitioner that his master would not reveal anything from the official correspondence and in case the practitioner wanted any information on the subject he might go over to the office. We are not interested in other details except the principle involved. It is preposterous that the Superintendent, Government Central Telegraph Office, would not respect a local G. O. which had been discussed threadbare by the Financial Experts representing all provinces in India and as such had the sanction of the Government of India. Worse still that a Presidency District Surgeon working directly under this Government would not heed the G. O. for private reasons.

What was the difficulty for this officer to return the certificate informing the party that he would give a "Second Opinion" if necessary. Ignorance of law is no excuse in law courts. A person in the position of a Dist. Surgeon cannot and will not plead ignorance of a G. O. What else then is the cause for counter-signing, no body can know and the Surgeon General who is also the President of the Madras Medical Council and who has been written to about this matter seems to be so far silent and the fact that the complaint has not been acknowledged as yet makes us doubt if the complaint has reached the concerned officer at all.

AN INDIAN MATERIA MEDICA.

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THROAT SURGEON, DIPLOMATE AND
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In response to a request from Dr. V. Rama Kamath, the Managing Editor of "The Medical Practitioner," I have narrated hereunder as briefly as possible, all about the Post-Graduate study in Vienna and the special opportunities available for a foreigner to improve his knowledge in all branches of Medical Science.

Vienna is a beautiful city, being the Capital of Austria. The people are pleasure-loving, very courteous, helpful and kind to the foreigners. One especially from the East feels quite at home, as there is absolutely no colour distinction. German language is spoken throughout. Vienna boasts of possessing three "M"s, and in my opinion, rightly too. They are Music, Medicine and Madchen. Average cost of living is not very much. One can live a decent life with Rs. 150/- to Rs. 200/- a month and an economic life, with Rs. 100/- to Rs. 150/-.

MEDICAL SCHOOLS: There is only one Degree, the M. D., to obtain which one must study five years. The curriculum of studies is more or less the same as obtaining in Indian Universities, there being nothing very special about Medical Schools there. Hence, I would not advise any student to go there to start medical studies. The chief importance of Vienna is its Post-Graduate Work.

HOSPITALS: Hospitals are run by paid and honorary staff. In fact, the pay even is very small compared with the salaries in India. For instance, Prof. Hajek, who is a living international authority in "Nose and Throat" gets a monthly salary of Rs. 400, with his forty years' service and reputation. This is the highest pay and the other professors of equal international reputation draw only Rs. 300/- to Rs. 400/- a month. The argument of the State for these low salaries is this: "We give you opportunities to learn and all facilities to practise and to improve your knowledge;

you can perfect your knowledge and earn in private practice, and for the opportunities we give, you should be prepared to serve the poor even without remuneration." Thus we see service in Hospitals is practically free and in fact, all eminent men are attached to some hospital or other, as honorary workers; and every facility is given to them not only to treat the sick but also to work out experiments to advance the science of medicine. There are various titles for which the doctors in Vienna aspire. The way in which these titles are conferred is as interesting as it is the real test of one's merit and work. The highest title is Professor, next Dozent, next Assistant and last, Medical Doctor. A Medical Doctor after passing out, chooses his special subject and attaches himself to that department of a hospital as an honorary doctor. His ambition is to become an Assistant. To be entertained as an Assistant, one must work in the hospital morning and evening and must do some research work; he should contribute original articles to magazines; and must be able to take part in the discussions of the meetings of the medical men. These meetings take place regularly every week and are open to the profession whose members discuss about various cases they come across in the hospitals. All the leading professors take part and guide the young in their enthusiastic work. After four years of such training if a doctor satisfies his professor with his work, he will be recommended for 'Assistant' title, to the University. The University will then confer the title, if it is satisfied. As an Assistant, the doctor will be entitled to a small remuneration of about Rs. 80. Then he has to work up the same way for another five years before he becomes a 'Dozent.' A Dozent gets about Rs. 100 to 150 per month. The highest ambition for a medical man in Vienna is to become a Professor. This is really a difficult job. Not only has he to do research work of a higher standard, but he should also produce an original book on some subject—to achieve this one should work roughly from 5 to 10 years. These titles are really worth their name and cannot be got by mugging up books. In fact, it is such a system which is the real foundation of Vienna's greatness in Medical Science.

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Every one of them from Doctor to Professor, is endowed with a zeal to learn more and more. Each spends half his time in laboratory and post-mortem rooms, and there is always the ever-ready superior to discuss with him and to guide him. They make themselves first thorough with their knowledge of Anatomy and Pathology; they study Bacteriology and then they go to Diagnosis and Therapeutics. It is evident that unless one knows the Anatomy and Pathology well, one cannot dare to write or speak in the weekly meetings, before the learned Professors, who are usually merciless in their cross examinations.

Thus it is that their knowledge is sound and perfect. One will be astonished to see to what a minute extent even a medical doctor knows his Anatomy and Pathology. This system of routine research work naturally gives scope for the talented to come out with their discoveries which later become a boon to the suffering and a pride to the profession. Such a system of study and research has naturally produced the greatest authorities in Medicine in Vienna and this is why Vienna is recognised by the whole world as the centre for medical knowledge.

WORK AND TRAINING IN THE HOSPITALS: At the head of each department, there is one Professor, under whom there are two or more Dozents, as the case may be. Each Dozent is in charge of certain wards. Two or three Assistants are attached to each Dozent, who, in turn, divide the wards between themselves. Under each Assistant, there are two or more Medical Doctors, who are practically honorary workers, doing post-graduate work. The Assistant will be in charge of Medical Doctors and post-graduates whom he trains in the work and routine of the hospital and gradually gives them chances to do the responsible work of treating the patients. The Assistants are in their turn, helped and guided by the Dozents, who gradually allow them to do major operations. The Dozents practically do all the major operations etc., and in very difficult cases, the Professors interfere to guide them. The Professor regularly attends the hospital and inspects every case, corrects the mistakes, of his

subordinates solves their difficulties and argues with them and gives them the necessary guidance and help. Thus from the medical doctor or post-graduate to the Dozent, all have equal chances of improving their knowledge and facilities to get practical work in their own spheres, provided they show the zeal to learn and work, and provided they infuse confidence in their superiors that they can be trusted. The length of period one works in the hospital does not entitle him to a higher title. The quality of work and zeal to learn more count much. There are ever so many ways to improve one's knowledge and there are as many opportunities and facilities for recognition of good work which is the index of getting responsible major work in the hospital. The work turned out by juniors is closely watched by seniors who never fail to encourage a hard working and earnest doctor.

OTHER OPPORTUNITIES: Every department of a hospital is thoroughly fitted with up-to-date apparatus, laboratory, preserved specimens, coloured diagrams etc. Any doctor working in the department has full access to all these. As a matter of fact, in the afternoons or leisure time, a doctor studies these diagrams, examines the specimens and if there is any ward work to be done in laboratory, does it personally. At other times, he reads books in the library. This is not all. There are always lectures to post-graduates given by Professors and Dozents arranged by the University. One never misses these lectures and these lectures cover the whole subject and if one wants any special lectures, he can arrange with the lecturer privately. In addition, operation classes are held for one or two doctors at a time. In these classes, operations are shown and are practised under their guidance on dead bodies. One can have any number of hours for the operation classes and there are ever so many able men willing to give the training. If one attends all the theoretical lectures, and practises under guidance, operations on dead bodies, side by side working in a hospital, he can easily grasp the practical aspect of the subject and be quite confident in his work. Unless one has taken these courses previously, especially in operative surgery he has little chance of getting operation work in the hospital.

To crown all this, there are weekly meetings of medical men where all difficult cases or new discoveries or unsolved problems of the various hospitals and individual doctors are fully discussed by junior as well as senior doctors and the renowned professors.

POST-GRADUATE STUDIES BY AMERICAN MEDICAL ASSOCIATION: These are arranged by the University on an extensive and exhaustive scale and will be going on throughout the year. These cover up theoretical lectures, clinical examination, diagnosis, demonstrations and treatment, operative work on dead bodies etc. for a very cheap amount. But invaluable though these are, it is very essential that one should have a good knowledge of German language. Hence, for a foreigner without any knowledge of German, who cannot be benefitted by these lectures, these are valueless. Hence, let me pass on to the more valuable subject for an Indian Medical Practitioner.

There is an Association started by the Americans in Vienna, for the benefit of the English-speaking doctors of the world. This is called The American Medical Association. They have entered into an arrangement with the Vienna Universities and their professors for the courses of post-graduate studies to be given exclusively in English. The membership for the association is about £3 entrance fee and about 10 shillings monthly subscription, and all registered medical practitioners from whatever country, are eligible for admission. This Association is very popular among American Doctors, there being at any time, at least two hundred American post-graduates in Vienna. The Association arranges lectures, clinical classes, operative classes etc., for the various special subjects, only for its members. The details of the lectures with their cost and other details together with the cost of living etc., is published in a detailed form by the Association in a book called "Blue Book," which can be obtained by remitting four shillings to the Secretary, American Medical Association, Alser Strassae, Vienna (Wien.)

The University also grants diplomas for the post-Graduates of this Association, on their completing the required courses (Details in the Blue Book). Any post-graduate going to Vienna will be quite at

home if he walks straight up to this Association. The Secretary and other officers are very kind and courteous and obliging. Every information and assistance and guidance will be gladly given, regarding lodging, boarding and studies.

OPPORTUNITIES FOR POST-GRADUATES: Briefly, the opportunities are:—

(1) **HOSPITAL WORK.** One can attach himself to a hospital, examine the patients, can do refraction etc., and if sufficiently long in one department, will be gradually given minor operations etc. Can use hospital laboratories, instruments and library.

(2) **THEORETICAL LECTURES.** These are mostly in the afternoons. One can select the subjects he is interested in.

(3) **CLINICAL CLASSES.** Clinical classes are held where a number of patients are brought in. Post-graduates examine them all. The professor in charge discusses with them, case by case, diagnosis, prognosis, treatment etc.

(4) **PRACTICAL CLASSES.** Bronchoscopy, Oesophagoscopy, Urethroscopy, etc., are practised on patients by post-graduates under guidance.

(5) **OPERATIVE CLASSES.** This is a very important item though a costly affair. Two at a time only can take these classes. One is given a fresh dead body every day, and with his teacher's guidance he is allowed to do all the operations on the dead body. The teacher by his side will be describing and guiding every step he takes. This work is practically equal to operations on living. At any rate, if one does perform operations half a dozen times on dead bodies with expert guidance, he can feel quite confident to operate on a living body. Operations on eye-balls are practised on pigs' eyes while muscle operations on eye, are practised on dead bodies.

(6) Minor operations are done in Nose and Throat hospitals, as Tonsils, Adenoids, Septum, Turbinatectomy Antrum punctures, poly-laryngeal insufflations etc., and the post graduate can assist in major operations. Ear cases can be examined and treated, drum punctures, catheter inflation etc., can be done and he can assist in Mastoid operations. If the post-graduate wants to do this work, he has got to pay eight pounds a month and attach himself

to an Assistant in a hospital. The Assistant trains the post-graduate very thoroughly in examination, diagnosis, non-operative and operative treatment. It is necessary that one should work at least three months in Nose, Throat department and two months in Ear Department, if he wants to do the work himself confidently.

The above description can easily convince any one that Vienna is the place for post-graduate study on special subjects, and that study is so thorough, systematic and organised. The doctors in Vienna from the Professors down to the Medical Doctors and the other staff, are extremely kind, courteous and hospitable to the foreigners and the sincerity of the doctors to teach the students and amicability of the Professors in discussing with any doctor any difficulties and their readiness to enlighten the students on any information, are highly commendable and praise-worthy, and it is this high standard of social life not only in professional men but in lay men even in the streets, that is chiefly responsible for the high esteem and love with which Vienna is viewed by the whole world.

Madras Public Health Department.

(By an esteemed correspondent.)

The Madras Public Health Department in the present form was brought into existence actually in 1922 by appointing Health Officers in the first instance for 5 of the Districts. But the commencement for the present scheme can be said to date with the Government order issued in May of 1921. In issuing the order, the Government realising the necessity to start a Public Health scheme and finding that suitable candidates would not come forward to perform the duties of health officers, and as they knew very well that any number of candidates would be available if they were to form the proposed health scheme as a part of the existing medical service, laid down a scale of pay and allowance for the Assistant Surgeons or the Sub-Assistant Surgeons when they acted as Health Officers. This scale, in the case of Assistant Surgeons who were to be styled as First Class Health Officers, was grade pay of the Assistant Surgeon plus an allowance ranging from Rs. 100 to Rs. 300 increasing by Rs. 50 very five

years as compensation for loss of private practice; and in the case of Sub-Ast. Surgeons who were to be styled as Second Class Health Officers, grade pay of the Sub-Assistant Surgeon plus an allowance ranging from Rs. 50—Rs. 150 increasing by Rs. 25 every five years. At this rate an Assistant Surgeon would draw a maximum pay of Rs. 750 and Sub-Assistant Surgeon Rs. 350 as his maximum before he retired from the service. The scale of pay above mentioned, the chance of reverting to the Medical at any time, and the chance of getting the post of Assistant Director of Public Health were quite attractive enough to make 17 Officers to join the Health Officers' Class introduced in 1921. The Government had doubts whether even these terms would attract the right type of candidates and so in the case of Government Officers who joined the class they sanctioned the pay and allowances of these officers on the scale they were drawing prior to the joining the class. In the following year they found that they were able to attract more candidates and so instead of the pay and allowances a subsistence allowance of Rs. 100 was paid to officers who joined the class subsequently when it was proposed to put the Health Scheme on a permanent basis and when the Government found that they had attracted sufficient number of candidates to serve their purpose, the scale of pay was revised as follows:—

First Class Health Officers, 250-20-450-25-600 (efficiency bar at 450).

Second Class Health Officers, 100-10-300 (efficiency bar at 200).

Thus the pay was actually reduced under the plea that enough candidates were available and was also consolidated removing allowances. The cadre was also separated from the Medical. The scale of pay is far less than fixed for some of the other services and does not compare favourably with the scale of pay prescribed for the Anatomy and Physiology Cadres, Rs. 350-800 where no additional qualification is expected from these; but in the case of Health Officers in addition to the medical qualification a Public Health Qualification is expected.

As regards the position of the officers in the cadre it is also uncertain. The Government in their original G.O. mentioned above, in recruiting candidates for the

health work, said that the service was provincialised and this was again stressed in subsequent G.Os. They even went to the extent of telling the local bodies when there were differences of opinion regarding the appointment of any Health Officer that as the Government paid the entire pay of the District Health Officers and $\frac{1}{2}$ of the pay of the Municipal Health Officers they had the right of transfer and appointment. Doubts have been raised regarding the provincialisation of Health Officers as there were no provisions in the old act, and it is the same in the new amended act. The Government now want to consult local bodies to form a cadre of Local Board and Municipal Health Officers. The Health Officers in service are quite against this procedure for they joined the service with the distinct understanding that they are being offered a Government service and in the case of the First Class Health Officers the status of Gazetted Officers and not Local Board Service; and any change in the constitution is likely to disappoint the Health Officers.

Because of this muddle between the local bodies and the Government quite a large number of Health Officers recruited since 1925 have been kept either on a probationary or acting list with the result that they are not able to enjoy any leave which is to their credit without at the same time putting on the dates of their increments. This has deterred quite a number of officers from taking leave which is specially necessary in the case of officers who have to be in camp for at least 21 days in the month; and it is not possible for any officer to do justice to his work without taking rest at some intervals. Other officers have taken leave on account of sickness and the result is their increments have been put off and this will continue to the remaining period of service.

There is nobody to look into these matters and help the cause of the Health Officers. The members of the local bodies have not so far helped them and a few are not in favour of these disappointments, and naturally the M. L. Cs. do not make this an important subject for discussion. In every country the state is concerned more with the preventive aspect of the

disease leaving the curative to philanthropic and honorary workers to carry on. If the Government is anxious to enlist a body of workers in the preventive line they should try to get the best possible in the field who look only to prevention of disease rather than any gain to themselves. It is not too much to say that if opportunity is available all graduates will rather become medical men either in Government service or in private practice and only those who are not successful in either of these will enter Public Health Service and hence it is all the more important that sufficient attraction must be made available to get the best hands possible consistent with decent living. A definite Government service should be decided upon and officers lent to local bodies for some time to come till the Public Health Departments in the various districts and municipalities are on a more firm foundation;—when the local bodies themselves can take charge of this Department as in other countries.

Medical Retrenchment.

How true it is that repetition is the cheapest form of innervation! When one wants to expend the minimum amount of energy either in thought or action, one resorts perhaps to repetition.

The press communiqué on Medical Retrenchment affords an interesting illustration. Talk of retrenchment! At once, one must get into a committee; must call for the so-called expert, expert in turn expects details from abroad—he is asked to get more information—then, there is the usual cutting from below—the very usual neglect of beams in the open eyes—and the indiscreet wild chase after shadowy specks!! It does not require any stretch of virile imagination to grasp, that, when one wants to keep alive and within proper bounds a useful tree, one should begin by trimming and pruning. World styles him, foolish who begins meddling with the trunk or main branches. Yet it is the rule with all advising officers to fiddle about the trunk leaving alone all weary out-growths.

The retrenchment committee allowed itself to be veiled as regards the real

"Papyta tablets are composed of Papain pancreatin and other digestive assistants. They give relief in gastric and intestinal dyspepsias, correct digestive disturbances and overcome constipation".

items of growing expenditure in the medical department; and instead availed themselves of a flash-light, to look at the foundations of the medical department—the poor sub-assistant surgeon! There is an oppressive cry of 'top heaviness' all round. They chose to be deaf. Of late the medical department, has been the beneficent recipient of perennial freshes, on the top hills, and indiscriminate blocking of all the channels down below. The craze for civil surgeoncies has long ago passed the limits of decency, and the less said about the methods pursued for obtaining these, the better. It is a pity that some old Civil Surgeons are kept in service to see the outcropping of some specialist civil surgeoncies. The sooner their groanings are heard, the better. So in a right scheme of retrenchment one should begin by allowing to retire, and not grant supernumerary doles to these overworked officers and the corresponding places to be given to capable Assistant Surgeons on comparatively smaller salaries, stopping at the same time the pernicious system of flooding at the top. It is of the utmost importance that some more civil surgeoncies now in an embryonic state, should not be borne out precipitately till the economic stress is over. A second line of action is to stop all recruitment into civil assistant surgeon cadre for a couple of years and the places falling vacant may be filled from among the experienced sub-assistant surgeons.

III. A third line of encounter will be to requisition more extensively on the ever-ready help of the independent medical practitioner in mofussil stations.

IV. The necessity of all extra hands brought in within the last five years in all cadres, from civil surgeon downwards must be thoroughly enquired into.

V. The advisability of giving collateral charges in certain well-selected cases must be considered.

VI. The heads of the department must be clearly impressed with the necessity of observing strict economy in travelling allowances. Lots of money are wasted in needless transfers. Poor ill-paid officers are shunted from the pillar to post, even after 15 years of service without the least consideration

to the education of their children and dependents. There is no meaning in the transfer of an officer, say from Parlakimidi to Pamban or Palni or from Adoni to Addanki. Scant attention is paid to the languages known by the officer, all taking place under "exigencies" of service,—an expression covering a multitude of sins.

VII. As expressed in "The Medical Practitioner" the Vizag. Medical College has become a luxury. She labours hard every year under the weight of lakhs of rupees and bears the proverbial mouse. There were more Andhras in medical department when there was only a school at Vizagapatam. This college has outlived its utility to the very people whose needs it was fondly hoped it would cater for in an hour of diplomatic need.

VIII. The pay of the I.M.D. Officers may be debited to imperial funds till the financial stress is over.

IX. A system of Honorary District Medical Officers with a fixed travelling allowance may also be tried, by recruitment from amongst those Civil Surgeons who prefer to retire early.

These non-official recommendations may smack of Soveit; but to a disinterested lay economist they represent the base truth. If the expert advisors only call for the co-operation of the independent medical profession, we are sure they endorse us without dissent. It is only when the Red Tape is made to change its hue by a judicious admixture of non-officials that any real retrenchment could be effected. Lastly I am pained and humiliated at the thought of stringency to be employed in granting study leave and deputation. These are granted every year with a view to enable the medical officers getting more light in recent advances in medical subjects. To think of shutting off avenues of light and chances of equipping with better methods of treatment is barbarous in conception and will be inhuman in action.

Reviews.

Clinical Methods in Tropical Medicine

By LT.-COL. G. T. BIRDWOOD, I.M.S.,
Publishers: MESSRS. THACKER,
SPINK & CO., P.O. Box 54, Calcutta.
4th Edition Price Rs. 8-8-0.

Lt.-Col. G. T. Birdwood has done real service to the profession by bringing about this hand-book which is really useful to the final year students and to the general practitioner for not only studying cases by the bedside but also for treating them successfully. Col Birdwood as the Principal of the Agra Medical School seems to have had exceptional opportunities of knowing the needs of the students and also of the junior practitioners as is evidenced by the unique way the book has been got up. The book is a small encyclopædia of clinical medicine and bacteriology in the field of special diseases in Tropics. Contributions by Research Workers of eminence such as Megaw, Harvey, Christophers, Acton and Walton is a special feature in this hand-book. The popularity of the book could be judged by the brisk sale of the three editions and the author has made every effort to bring the fourth edition up-to-date by rewriting several sections and by the addition of a few more, on such

important subjects as Vitamins, the Essentials of a good diet, on Renal Efficiency Test, Urea Concentration, Benedict's Test, Insulin and Diabetes, Acidosis, the Schick Test and an additional note on Leprosy treatment, and Spahlinger's Treatment for Phthisis, also a chapter on the cause and prevention of Goitre. New sections have also been added on Preservation of Pathological Material, Preservation of Poisonous Snakes, Larvae and Worms. The get-up of the book is very neat and attractive. We have no hesitation in recommending this useful all absorbing handbook to the students and the practitioners.

The Stolen Trash

By

DR. GOPAL LAKSHMAN DESHMUKH.
Price As. 8.

Dr. Deshmukh, has described the seven periods of human life,—Birth, Infancy, Childhood, Youth, Middle Age, Old Age and Death—in lucid verse which appeals to some more than terse prose. The description given of each period is philosophical but none the less true. Philosophy sometimes opens and shows glimpses of truth, which ordinary science and reason do not disclose. We recommend the book to lay and medical men and women alike, to while away their leisure hours profitably.

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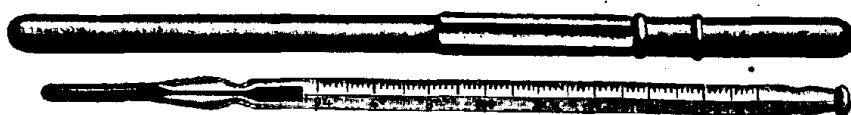
The Secretary-in-Charge, 6-A, Corporation Street, CALCUTTA.

List of postings of Sub-Asst. Surgeons for the month of May 1931

No.	Names of Sub-Asst. Surgeons	From	To
1.	Dr. A. Bhagyanatham Pillai	Govt. Hd. Qrs. Hl. Ramnad	c/o P. D. B. Ramnad
2.	" K. N. Kesava Pillai	Govt. Hl. Pollachi	P. D. B. Coimbatore
3.	" A. M. Govindarajulu Naidu	Govt. Hl. Peddapuram	Gr. I. Dts. (Leprosy Campaign)
4.	" V. Jagannatha Rao	L. F. Dy., Vetapalem	Gr. II Dts. do.
5.	" S. Sankara Rao	L. F. Dy., Vayalpad	Gr. III Dts. do.
6.	" R. Shampugam Pillai	Govt. Hl., Villupuram	Gr. IV Dts. do.
7.	" A. M. Krishnan Nambiar	Hd. Qrs. Hl., Coimbatore	Gr. V Dts. do.
8.	" B. Satyanarayana Naidu	Hd. Qrs. Hl. Guntur	Tk. Hd. Qrs. (L.F.) Dy., Chandragiri
9.	" G. K. Kuppaswamayya	Tk. Hd. Qrs. L. F. Dy., Chandragiri	Govt. Hl., Tirupathi
10.	" M. Jagga Rao Naidu	L. F. Dy. Naidupet	c/o I.G. of Prisons Ootacamund
11.	" K. V. Rajagopalan	Govt. Hl. Tuticorin	Do
12.	" J. Suryaprakasa Rao	Govt. Hd. Qrs. Hl., Vellore	c/o P. D. B. North Arcot
13.	" K. Narasimham	Govt. Hd. Qrs. Hl., Berhampur	Govt. Hl. Parvatipur
14.	" M. V. Suryaprakasa Rao	Leave	Govt. Hd. Qrs. Hl., Chittoor
15.	" M. V. Ramanamurthi	Govt. Hl. Palmaner	Govt. Hl., Peddapuram
16.	" B. K. Thathachary	Special Duty	Tk. Hd. Qrs. L.F.Dy., Kuppam
17.	" S. Sessa Reddi	Tk. Hd. Qrs. Hl., L. F. Dy., Kuppam	Govt. Hl., Palmaner
18.	" M. V. Ramanayya Chetti	Leave	K. G. Hl., Vizagpatam.
19.	" N. O. V. Raghavacharyulu	Leave	Tk. Hd. Qrs. Hl. Sidhout
20.	" T. Ramadoss	Tk. Hd. Qrs. L. F. Dy., Sidhout	Tk. Hd. Qrs., L. F. Dy., Rayachoti
21.	" S. Krishnayya	Gl. Hl., Madras	Govt. W. & C. Hl., Madras
22.	" A. Apparameswaram	Leave	Police Hl., Salem
23.	" V. N. Narayana Aiyar	Leave	c/o P. D. B. N., Arcot
24.	" M. H. Dorai Raj	Govt. Hd. Qrs. Hl., Trichy. (Res.)	Govt. Hd. Qrs. Hl., Trichy. (Sanc.)
25.	" A. P. Joseph	Govt. Hd. Qrs. Hl. Trichy	c/o P. D. B., Tanjore
26.	" S. N. Sankaralingam	L. F. Dy. Rajapalayam	Govt. Hl., Usilampatti
27.	" O. S. Venkataraman	Camp Duty	Govt. Hd. Qrs. H. Calicut (Res.)
28.	" M. Pichu nani Iyer	Leave	c/o P. D. B., Tinnevely
29.	" Gopala Menon	Leave	Govt. Mental Hl., Calicut
30.	" H. M. Hande	Govt. Ment. Hl. Calicut	Govt. Hl., Chidambaram
31.	" V. Visvanathan	Govt. Hl., Chidambaram	Tk. Hl. Qrs. L.F. Dy., Gingee
32.	" B. Manjunatha Baliga	L. F. Dy. Mannarghat	Govt. Hd. Qrs. Hl. Palamcottah
33.	" S. Natarajan	L. F. Dy., Battagundu	c/o P. D. B., Tinnevely
34.	" S. P. Srinivasagam Nadar	Res. Duty, Madura	c/o P. D. B., Madura
35.	" A. Pichukuppu Sastri	Leave	c/o P. D. B., Ramnad
36.	" S. V. Krishna Rao	Res. Duty Berhampur	Hd. Qrs. L. F. Dy., Kaikalur
37.	" V. Venkataramaswami Pantulu	Govt. Hl. Kalahasti	K. G. Hl., Vizagpatam
38.	" Muhammad Yusuf Khan Sahab Bahadur	L. F. Dy., Thammanpatti	c/o P. D. B., Salem
39.	" P. Balasundaram	L. F. Dy., Yercaud	Police Hl. Salem
40.	" A. Apparameswaram	Police Hl., Salem	Hd. Qrs. Hl., Salem (Res.)
41.	" P. S. Sankaranarayana Aiyar	Leave	Tk. Hd. Qrs. L. F. Dy., Tiruvottiyur
42.	" N. Gopalan	Tk. Hd. Qrs. L. F. Dy., Tiruvottiyur	c/o P. D. B., Trichy
43.	" P. S. Kalyanasundaram	L. F. Dy., Thathiangarpatti	Govt. Hd. Qrs. Hl., Trichy
44.	" M. H. Dorai Raj	Hd. Qrs. Hl., Trichy	c/o P. D. B., Trichy
45.	" S. P. Thiruvalluvar Pillai	L. F. Dy., Jayankondacholapuram	c/o Civil Surgeon, Vizag. Agency
46.	" V. Muthuswamy Ayyar	Leave	c/o P. D. B., Tanjore
47.	" P. K. Gopala Panikkar	L. F. Hl., Kodavasal	Govt. Hl., Tuticorin
48.	" P. Suryanarayana	Govt. Hd. Qrs. Hl., Guntur	Tk. Hd. Qrs. L. F. Dy., Repalle

List of postings of Sub-Asst. Surgeons for the month of May 1931

No.	Names of Sub-Asst. Surgeons	From	To
49.	Dr. R. Sivaramamurthy	Tk. Hd. Qrs. L. F. Dy., Repalle	Tk. Hd. Qrs. L. F. Dy., Vinukonda
50.	" K. Seshacharya	Tk. Hd. Qrs. L. F. Hl., Vinukonda	Hd. Qrs. Hl., Guntur
51.	" U. N. Shama Rao	L. F. Dy., Pedappampatti	c/o P. D. B., Coimbatore
52.	" T. R. Manikkam Pillai	L. F. Dy., Kangayam	c/o Civil Surgeon, Vizag. Agency
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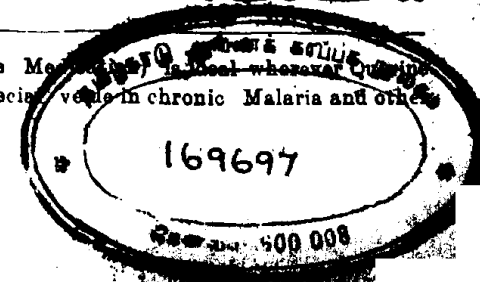
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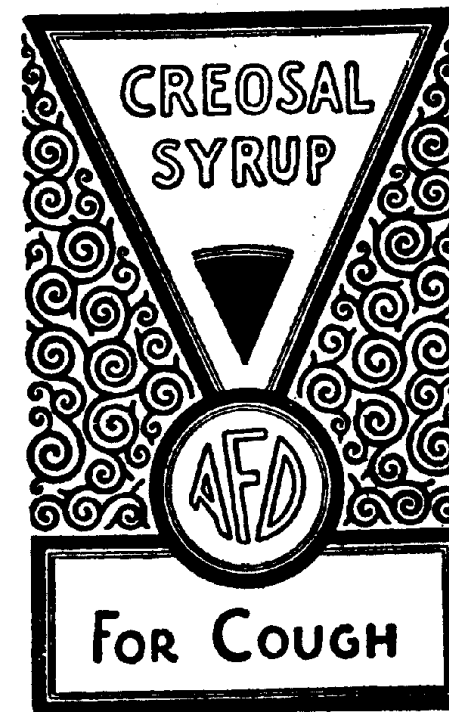
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