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The Medical Practitioner

A Monthly Medical Journal

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THE

Medical Practitioner

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HONORARY MEDICAL OFFICERS.

GOVERNMENT COMMITTEE'S RECOMMENDATIONS.

The committee appointed by the Government to enquire into the system of Honorary Medical Officers in Government Hospitals has sent its report to the Government and its recommendations were published in our last issue. Two meetings were held, each lasting from 3 to 4 hours. The Committee is said to have been benefitted by the discussion of the subject by the District Medical Officers in their Conference held in the interim between the two meetings of the Committee. It is not however stated whether all the members of the Committee attended the Conference and discussed the subject with the District Medical Officers, otherwise the discussion is not of much use as only the official side of the question could have been dealt with by them. The Committee expresses its satisfaction that its findings have been practically unanimous. Much was expected of this Committee both by the profession and the public and the Committee on Retrenchment did not go into the question of replacing paid staff by the honoraries as they thought that the Committee on Honorary Medical Officers would come to its rescue. Consequently the recommendations of the Committee have caused great disappointment to all concerned. The recommendations made, touch only the outermost fringes of the question and do not indicate the lines on which and the extent to which the Honorary system could be extended. They emit the smell of departmentalism and lead one to believe that the Committee contemplates an organisation of a new department of Honorary Medical Officers under the Surgeon-General. The holding of the Conference of the District Medical Officers would have been justified and would not have been a violation of the orders of the Government prohibiting expenditure, if the Committee on Honorary Medical Officers was invited to the District Medical Officers' Conference and the subject been discussed by the official and non official sections of the medical profession. The Committee did not even take evidence to make up for the unrepresentative character of its constitution in which private medical practitioners and the honorary officers of the mofussal had no representation. There cannot be possibly any room for dissention in the proceedings of the Committee where the subject referred to them was treated by them in a general and most nebulous way as seen from the recommendations made; there was evidently no room for disagreement and the self-congratulation in the unanimity of the members means very little.

Coming to the recommendations themselves, it is indeed gratifying that the anomalous and irritating designation of Honorary Sub-Assistant Surgeon is done away with, but the caste system is still allowed to continue. There should be no *grade* among the Honorary Medical Officers. There is no justification in retaining meaningless designations that now exist in the Medical Department, in the case of honoraries. If any Honorary is appointed to work under an officer paid or honorary he is to be designated as Assistant, but if he is appointed as the chief officer he is to be called as Honorary Physician or Surgeon. The designation should connote the place he occupies whether as Assistant or Chief in an institution.

HOUSE SURGEONS AND HOUSE PHYSICIANS.

Every candidate that passes out a Medical College or School should be appointed as a House Surgeon and Physician at least for one year so as to complete his medical education. Training in Schools and Colleges is not sufficient and practical training as House Physician or Surgeon in a hospital is absolutely necessary both in the interest of the candidate and that of the public. It is only after the completion of this course, the candidate should be declared eligible for registration.

CLINICAL ASSISTANTS.

The number to be employed depend upon the number of candidates who are willing to undergo the course and the facilities afforded for them in the State Hospitals. It is desirable that as many as may come forward may be taken and the course extended from two to five years. As these Assistants should spend their whole time in the Hospitals and are not allowed private practice, they should be given an allowance of Rs. 50 in the mofussal and Rs. 75 in the city. The Clinical Assistants should be entrusted with the work now done by the Assistants in the hospitals.

HONORARY ASSISTANTS.

The tenure of appointments should be limited to 5 years so as to make room for new recruits. Ordinarily these should be selected from Clinical Assistants, but provision should also be made for recruiting them from private practitioners who have been in actual practice for at least five years.

HONORARY PHYSICIANS AND SURGEONS.

The tenure for these appointments should be fixed ordinarly for 10 years to make room for others. The selection for Honorary Physicians and Surgeons may be made ordinarily from Honorary Assistants, but provision should be made for recruiting them from amongst private practitioners of not less than 10 years practice and from retired officers as a temporary measure till sufficient number of qualified medical practitioners are available for these appointments on a large scale.

HONORARIES IN TEACHING INSTITUTIONS.

When there is a dawn of independance in the form of Dominion Status in the political horizon, it is not consistent with the existing notions of nationalisation if British registrable qualifications are demanded in our country in the teaching institutions. It is not our intention to lessen the standard of medical education; the aim should be, to get the best material as far as possible from amongst the Indians possessing Indian qualifications. If Indians with high foreign qualifications are available so much the better but our plea is that Indians of merit and having vast experience should not be disqualified, merely because they do not possess British registrable qualifications. As a rule it is customary to fix a minimum qualification for appointments and not the maximum as the committee has recommended.

RECOMMENDING AUTHORITY.

Instead of making the Surgeon-General the recommending authority for these appointments a Committee consisting of the Surgeon-General and 2 Independent Medical Practitioners other than those who are Honoraries should be entrusted with the duty. This Committee should be invested with the duty of ascertaining and recommending to the Government periodically the number of paid appointments that should be replaced by honorary men.

CONFIDENTIAL REPORT.

No confidential report even in a modified form is necessary. If any Honorary officer is found incompetent and his character found unsatisfactory, after proper investigation, he may be removed by the Committee.

ADMINISTRATION WORK.

The Honorary Officers should not be given administrative work. The infection of red tapism must be kept far away from them. As long as dispensaries are not to be maintained by the Government except in special localities and for special work, the question of appointing Honoraries to them does not arise. If the Government medical unit be a hospital with accommodation for in-patients, a paid medical officer either male or female should be appointed as a Resident and in addition, if there be a paid officer over them, a Honorary may be appointed in his place during his absence on leave but the administration work must be done by the paid Resident Medical Officer till such time a committee is appointed for each institution for administrative work and the paid staff replaced entirely by the Honoraries. The Honoraries should be left alone with the professional side of the work.

AGE LIMIT.

That no Honorary Officer should serve after he has completed his 55th year of age or in other words that doctors should not be appointed after they have completed their 55th year is to say the least a slavish imitation of the undesirable service rules. The retirement after the completion of the 55th year of age was first provided in the interest of Europeans serving in India, who after making their fortune in India and with a liberal pension, go home marry and enjoy life giving the benefits of their services to their own country. It is still allowed to continue detrimental to the interest of the economic condition of the country and perhaps taken advantage of for creating opportunities to show favourtism in making appointments which will naturally increase if the retirement is made at the 55th year. When Indians who have completed their 55th year are appointed as High Court Judges, Members of the Cabinet and Ministers and they have been found full of energy, there is no meaning in fixing the age limit to Honoraries. Honoraries do not get any salary, and so, unless they are quite healthy and fit for work, they will never accept the appointments. If however a limit has to be fixed, 60th year may be fixed instead of the 55th. If the post of the Surgeon-General can be held under the rules by men who have completed their 55th year, then, why not Honoraries? The retired Medical Officers particularly those who retire early will make the best Honorary Physicians and Surgeons and at present, in the early stage of the Honorary system they will infuse confidence on the public and make the system popular. The effect of this rule viz. declaring unfit after the 55th year will be to delay the extension of the Honorary System for another ten years more, until the House Surgeons and Physicians evolve into Honorary Surgeons and Physicians by passing through the phases of the Clinical Assistants and Honorary Assistants extending over a period of 10 years.

We have dealt in detail in these columns in the previous issues how and when the Honoraries could replace the paid staff, stage by stage. We will be failing in our duty if we do not appeal to the Government not to loose any opportunity of replacing paid medical staff by the Honoraries without in any way affecting the efficiency in medical relief in this province. We learn that Government has in contemplation of retiring those who have completed 25 years of service. This they could do in the medical department in the higher grade, we mean, in the case of Civil Surgeons and all of them may be appointed as Honoraries, as referred to above. The Civil Surgeoncies not only in Rajamundry but in all other stations such as Tellicherry, Negapatam, Tuticorin could be safely abolished and Asst.-Surgeons or Honoraries appointed in these places. We hope the Government will make necessity a virtue and give a fair trial to Honorary Medical Relief Scheme immediately and save large amounts of money which can be more profitably utilised in improving the present system of medical education and bringing about a state of affairs in the medical profession as obtaining in other civilized countries.

THE INDIAN MEDICAL COUNCIL BILL.

A Bill to constitute an All India Medical Council has after all been drafted and sent to Local Governments to gather the opinions of the Medical Faculties, Provincial Medical Councils and the leading Medical Unions. We went through the preamble and all the 25 Sections of the proposed Bill and failed to see any good purpose that may be served by the proposed legislation. It cannot be said that the framers of the Bill are ignorant of the existence of the provincial Medical Acts, in fact, we find that almost all the Sections are identical. The preamble is as misleading as the purpose which necessitated the drafting of this Bill. Those who have been responsible to frame the Bill would have been more frank if in the preamble they mentioned that the purpose of the Bill was to satisfy the

demands of the General Medical Council, Great Britain, who, for some reason or other of their own, would not approve of the standard of medical education at the Indian Universities. It is really a great humiliation to our national well-being that when the country has been fighting for political emancipation, a piece of legislation is to be enacted to satisfy the whims of a small body of medical men in Great Britain who seem to be more anxious than the sons of the soil regarding the welfare of the people in this country. If the medical education in India is defective to day, the fault is all on the side of those who have been governing India so long. The Allopathic system of medicine was introduced in India by its rulers and vested interests more than anything else have been the cause in fettering the growth of the medical profession in this country. In spite of varieties of handicaps, it is most creditable that there are men and materials in India to-day to look after the medical education to satisfy the needs of the country.

After all, the purpose of the Medical Acts is to enable persons requiring medical aid to distuinguish qualified from unqualified practitioners and regulate the qualifications of such practitioners. The Provincial Medical Councils serve this purpose very well. Consequently the language used in the preamble of the proposed Bill is uncalled for and even mischievous. We quote the preamble so that our readers may judge for themselves the implications made therein. It runs thus :—

"Whereas it is expedient to establish a Medical Council in India and to provide for the maintenance of a register of qualified practitioners of modern scientific medicine in order to establish a uniform minimum standard of qualifications in medicine for all provinces such that persons attaining thereto shall be acceptable as medical practitioners throughout British India, it is hereby enacted as follows."

If in the definition of "Qualified practitioners" were included all practitioners who are now in the provincial registers, the language of the preamble would have been harmless. But we find in the published schedule that for the purpose of this Bill the Licentiates who form the largest section in the medical profession in India have been excluded. So also the L. M. Ss. of the Madras University. Indian Medical College Diploma holders who form a small minority do not also come under the purview of the Bill. This is not all. The preamble says that only those who will be registered in the contemplated All India Register will be "acceptable as medical practitioners throughout British India." In other words it means that all those who are not registered in the All India Register will not be recognised as registered practitioners throughout India. Hitherto the Licentiates and other Diploma holders who were registered in the Provincial Registers were accepted as medical practitioners throughout India. After the passing of the Bill, it looks as if the Licentiates and others like them can practise only in the individual province where they are registered. This is a death-blow to the largest section of the medical profession now existing in India. The sting will be felt the more when it is known that apart from all those in the British Register who get into the All India Register automatically, the practitioners holding registrable qualifications in British possessions and of the foreign countries will be eligible for registration in the Indian Register.

The medical profession and the public are quite familiar with the trend of events which forced the Indian Government to bring forth this special piece of legislation. The Bill merely pacifies the whims of the British Medical Council whose ulterior motive in interfering with the Indian University Medical education seems to be as unjustifiable as it is imaginary. Fortunately the Governor-General did not feel the necessity of passing an Ordinance regarding the proposed Indian Medical Council. The peoples' representatives in the Legislative Assembly are not thus deprived of an opportunity of opposing this contentious and unnecessary Bill. We appeal to them to go through the existing Medical Registration Act in their respective provinces and find out for themselves whether there is a need for special legislation to bring about an uniform standard of Medical Education in India even for the purpose of appeasing the anger of the General

Medical Council. There is a section in the Provincial Acts which runs as follows :—

"The Council shall have power to call on the Governing body or authorities of any University, Medical College or School included in or desirious of being included in the Schedule."

"(*a*) to furnish such reports, returns or other information as the Council may require to enable it to judge of the efficiency of the instruction given there in Medicine and Surgery and Midwifery, and

"(*b*) to provide facilities to enable any member of the Council deputed by the Council in this behalf to be present at the examinations held by such University College or School."

"If the said body or authorities refuse to comply with any such demand, the Governor-in-Council may, upon report by the Council, remove such University, College or School from the Schedule or refuse to include it in the Schedule."

All the Provincial Medical Councils without exception are presided over by a European member of the I.M.S., who is the Surgeon-General in major Provinces and Inspector-General of Civil Hospitals in the minor ones and there are in this Council Government official nominees who are more than the elected members. Is it not possible, we ask, for the General Medical Council to be in communication with all the Provincial Councils and get whatever information they want regarding the standard of medical education in the Universities and in case the General Medical Council found the standard defective could they not suggest improvements in this direction through the Provincial Councils ? If necessary, yearly conferences could be held of representatives of Universities from all the Provincial Councils under the Chairmanship of the Director-General of Medical Services to exchange views and bring about a uniform standard as demanded by the General Medical Council. Why all this unnecessary fuss which, while not serving any good purpose, casts a slur though indirectly on a class of medical men in this country who form the largest group. Those who are in favour of the draft bill may very likely put forth a plea that the Licentiates should patiently wait to claim recognition of equal terms with the University Graduates till the standard of education is raised in medical schools. May we point out to them that in 1858 A.D. when the British Medical Act was passed, there existed in Great Britain medical Universities and other Bodies granting membership and fellowship diplomas and even then the framers of the British Act found it necessary to add a section which run as follows :—

"Any person who was actually practising medicine in England before the first day of August, 1815, shall, on payment of a fee to be fixed by the General Council, be entitled to be registered on producing to the Registrar of the Branch Council for England, Scotland or Ireland a declaration according to the form in Schedule B to this Act signed by him, or upon transmitting to such Registrar information of his name and address, enclosing such declaration as aforesaid."

(This section was in force till 1875).

This declaration referred to ran as follows :

I.....residing at.....in the country of.....hereby declare that I was practising as a medical practitioner at .....in the country of.....

(Signed) (Name)

Dated this.....day.....18.

When such practitioners who did not undergo any course in any institution were allowed to be registered in the British Register, no one, including the General Medical Council can raise any objection to include the medical Licentiates and other non-university diploma holders in the contemplated All India Register. In the British Medical Register even to day all the practitioners do not possess qualifications of the same standard which is insisted upon by the proposed All India Medical Council. If the licentiates of the Society of Apothecaries can find a place in the British Register which contains not only University graduates but also holders of diploma granted by the non-university faculties—the latter being considered to be higher in the matter of educational equipment—why not the licentiates in India who are in no way inferior to the licentiates in England get into the All India Medical Register ?

Having discussed the futile purpose of the Bill let us examine the constitution of

the Indian Council. It is proposed that the Council should consist of (1) President who will be the nominee of the Government of India for the first five years and later elected by the Council, (2) one nominee by the Government of each province, (3) one to be elected to represent the medical faculty of each existing university, (4) one to be elected by the existing universities in India, (5) a representative of the Provincial medical council to be elected by the provincial committee,(6) three to be nominated by the India Government. All the members of the Council whether nominated or elected must be those found in the All India Register and the term of office is five years. It is also contemplated that the elected representatives of the provincial councils must be those employed in the teaching institutions. We shall repeat what we said in these columns in July '30 regarding the proposed constitution of the All India Medical Council, immediately after the special Conference met at Simla in June '30, to discuss about the necessity of an All India Bill.

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

It is evident there is absolutely no need for India to have a Council of the nature and for the purpose contemplated in the Bill and if there should be a medical Act of All India nature it must be on the lines of General Medical Council of Great Britain, all the provincial councils being affiliated to the mother Council establishing relationship between central and branch councils similar to those existing between the General Medical Council and its branches. Certain modifications may be desirable to suit Indian conditions. We do not wish to go into the details of the proposed Bill for there is nothing new in the Sections. As referred to by us above, these Sections are identical with those found in the existing Provincial Medical Acts. The Provincial Medical Councils if made to function efficiently will serve the best interests of the public as well as the profession.

In addition to the above arguments against the advisability of having an All India Medical Council of the nature contemplated in the Bill, the Government will certainly be ill-advised to introduce this Bill during these days of gloomy atmosphere due to financial crisis, as the Bill necessarily will cost the Government a large sum of money with little or no return nor any benefit either to the profession or the general public.

Original Articles

ENDOCRINOLOGY

BY

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

XIX.

SEX.

(Taken chiefly from Berman's "Gland Regulating Personality.")

Over the domain of the body have the endocrine glands a more absolute control than over sex, both as regards the primary reproductive organs and secondary sexual characteristics. It requires therefore a separate and detailed treatment. The sex and its function enter so largely in females that it is held by some authors that the differences between men and women are like those between two different species. Till now we have had no knowledge of sex. But a series of attitudes, the attitude of virtue, of pruriency, of good taste, of the theoretic libertine, the attitude of Satyr's vulgarity all these poses of course have not supplied an iota to an understanding of the foundations of the problems of sex, biologically considered.

Sex Chemistry.

Femininity and masculinity are expressions of the interplay of all the internal secretions. Besides the ovaries and testes the specific glands belonging to sex, other endocrine glands are of equal importance ; there is no absolute feminine nor absolute masculine.

The Cause of Sex.

To all appearances the fertilised ovum starts bisexually double sexed, both masculine and feminine or perhaps neither masculine nor feminine. Then a form develops and within that form a patch of cells arises which are the forerunners of the male or female reproductive cells. At birth, sex is defenitely settled as far as the reproductive organs are concerned. When the germ cell divides, its nuclear material breaks up into what are called cromosomes. There are 22 cromosomes in the male and 24 in females among human beings. In the male cromosomes there are 2 X-cromosomes ; ½ the sperm containing the 12 cells including the X-cromosomes and the other half containing only 10 without the X-cromosomes. If the 12 male cromosomes join with the 12 cromosomes of the female making in all 24 cromosomes females are produced ; but if the 10 cromosomes of the males join the 12 cromosomes of the females making in all 22 cromosomes male is produced. Therefore femaleness is a positive quality dependent upon the action of the X-cromosomes and maleness is an absence of femaleness due to the lack of X-cromosomes. The X-cromosomes are therefore the bearers of sex destiny.

The Secondary Sex Traits.

Though the character of the reproductive organs is determined by the extra cromosomes and though these reproductive organs have great deal to do with the feminine or masculine quality of the organisms as a whole, they are not alone. All other internal secretions have their effect in the final outcome determining the sex quality. Bisexuality preceded monosexuality in the animal pedigree and so exists with it even at the highest points of the genealogical tree. The secondary sex traits are as important to the individual as primary ones and they survive because of their usefulness in external adornment for attracting attention to courtship in the metabolic requirements of a sex combat and sex act and in necessities of caring for the young. The human male has more hemoglobin than the female since he has more red corpuscles in his blood.

The Role of the Ovaries.

While the primary sex characters are present and distinguishable from birth, secondary sex characters are not so. During childhood they are in abeyance. Girls and boys who are permitted to dress alike, to play the same games are indistinguishable from each other. The boys will be boys and most of the girls tom-boys. With puberty, marked changes of attitude towards the other sex appears. It is at puberty the ovaries begin to secrete ova, ripe for fertilisation and the testes begin to secrete sperm ready for fertilising. Before this event there must be a certain atrophy and retrogression of the thymus and pineal glands. Besides, there must be a minimum increase of activity of the thyroid, adrenal and pituitary glands, without them below a certain minimum, the reproductive organs and their secretions will remain infantile

causing a persistant infantalism or a delay of puberty. Formerly ovaries were considered to hold despotism over the specifically feminine functions of menstruation, gestation, parturition and lactation. Now it is seen that they hold equal action with the other endocrine glands. Their true function consists in the production of ova and secretion of hormone or hormones. Over other functions once supposed to be their monopoly all the other ductless glands rule. Spaying or removal of the ovaries is comparable with the menopause *i.e.*, the cessation of the sexual life. It produces certain general constitutional effects and adiposity develops ; there is some disturbance of the lime balance with the increased excitability of the vegetative nervous system. Some women are rendered unstable, others are completely transformed and still other adapt themselves with little or no discomfort to the new situation. For, normally with feminine puberty, there is increased activity of the thyroid, the post pituitary and the adrenal medulla. In the male the ripening of the testes is accompanied or preceded by augmented function of the adrenal cortex and the anterior pituitary. This difference in biochemistry accounts for the contrast between the sexes, in the skin, hair, fat cartillage, voice and bone changes. Ovary, adrenal medulla, posterior pituitary and thyroid constitute the feminine formula, while testes, adrenal cortex, anterior pituitary comprises the masculine endocrine directorate.

The Significance of Puberty and Feminine Precocity.

Before puberty, the ova have lain asleep as it were in a cocoon state. With puberty they awaken and with them develops all those profound mechanisms and inventions that have to do with their nutrition upto ripening. They evolve the cycles that are translated as menstruation, propulsion, fertilisation and implantation of the ova in the uterus, the full development of the fetus, its birth and feeding after birth, all of which are controlled by ductless glands. The uterus becomes gorged with blood periodically to provide an enriched soil for the fertilised ovum to plant itself. The breasts grow and fat is deposited in particular places as reserve material for the manufacture of the milk. The qualities which appeal to the eye, ear and even nostrils of the male appear ; instincts dawn and independence of spirit germinates mixed with a curious shyness, coyness, and desperate loneliness and secrecy. All these happen because, some chemical substance from the endocrine glands have been let loose in the blood. Puberty begins in temperate climates about the 14th year and in hot climates a little earlier. Feeding and environment indirectly and endocrine secretions directly determine this. In females the primary stimulus must originate in the ovary. There are other forms of precocity in the female dependent upon stimulation of other glands, but these forms are masculinisms, a masculinisation of the personality and not a true awakening of the feminine constitution. So, one must distuinguish sharply between a precocity by masculinisation and a precocity of prematured feminisation. When abnormalities of adrenal, pitutitary, thymus or pineal glands occur in girls, it is the masculine streak in hastening of the growth that is made manifest.

Metabolism and Sex.

Since the masculine and feminine are but expressions of certain relative capacities and potentialities some single principle must run through the making of both. Recognising the qualifications inherent in so broad a statement, an important part of the answer is the handling of lime salts. Life originated or at least lived and worked for long ages in sea water. During these eras, the salts of the sea have come to play a dominant role in its being. The lime salts because of their peculiar property of dissolving or precipitating themselves, according to electrical condition in their medium, have come to occupy a central position in all the processes of growth, metabolism and sex differentiation. So it is that masculinity may be described as a stable constant state in the organism of lime salts and the feminine as an unstable variable state of lime salt. The male skeleton contrasts with that of the female as the stronger, longer, larger, heavier and straighter because it is an expression of greater capacity to utilise, store and keep lime in the system. Women throughout their reproductive period are liable to rapid and pendulam-like fluctuations of their lime content. Menstruation

pregnancy and lactation all draw upon stores ol lime, sometimes depleting them to the point of softening the bones and wrecking the whole skeleton. The endocrine glands control the transport, course and permutations and combinations in the history of the lime's progress among the cells and are in turn, themselves affected by it. Man is relatively free of these liabilities and so remains man by his freedom from the recurrent crisis involving the lime salts reserve which constitutes the life story of women.

The Functional Hermaphrodite or Intermediate.

The complete or total hermaphrodite *i. e.* individual who possesses the reproductive organs of the male and female both testes and ovaries, is rare. However undoubted cases are in record ; but the history of these cases shows that at one time the masculine set and at another time the feminine set will hold sway over the sex traits and functions. Blending does not happen. Partial hermaphrodite is relatively common. The mixed ensemble of the directly contrasting type such as the concomitants of the testes with feminine secondary sex traits or of ovaries with masculine sex traits have been described from time immemorial as freaks. Physical features of one sex, tendencies of mental attitute of the other co-exist in the same individual by reason of an excess in one direction or a deficiency in another of the internal secretions. The degrees of masculine trend in women is a crude measure of adrenal cortex domination. The degree of feminine deviation in man is roughly proportional to the amount of the post-pituitary influence in his make-up. Whether one or other sex tendency must dominate depends not only upon the quantity of sex hormone divergence from the ideal normal but also upon environmental conditions provokiug excessive or deficient secretary reactions from the other endocrines involved through the vegetative nervous system. Ordinarily the combative male and the submissive female are differentiated by contrasts of skin, hair, fat and bone structure. The functional hermaphrodites enable us to understand the phenomena of Masochism and Sadism to a certain extent on the chemical side. The masculine personality, the combination of masculine *e. g.*, adrenal, cortex, gonodel and internal secretive predominance is built for aggression. The feminine personality, the union of feminine, *e. g.*, thyroid and ovarian superiority is constructed for submission. In functional hermaphrodite, the attitude becomes reversed or perverted. So a masculoid personality in women will make for Sadism and a femonoid personality in male for Masochism. Variants and refinements of these perversions will often be found in the functional hermaphrodite who must satisfy two streams of visceral pressure within himself. Persistence of the thymus or pineal glands tends to prolongation of the infantile and child types.

THE BACTERIOPHAGE AND PHAGOTHERAPY IN PRACTICE

BY

DR. K. VENKATA RAO, M.B.B.S.,

Modern medicine has advanced by leaps and bounds within the last decade. In the hands of the present day Physician are knowledge, methods of diagnosis, remedies, and means for the prevention of disease, of which 50 years ago none ever dreamed. Very different is the equipment of modern hospitals and operation theatres as compared with those of the sixties and seventies. Pyæmia, septiceæmia, erysipelas and gangrene had been prevalent in most surgical wards. The tropical diseases like, plague, cholera, malaria, dysentry, etc., claimed their death roll in legions.

The researches of Pasteur, the theory of micro-organic origin of disease, paved the way to modern aseptic technique in surgical wards and marked the coming of the laboratory epoch in the prevention and cure of disease. The fight against Bacteria and their toxins has been going on vigorously in all parts of the world since then. Vaccines, antibacterial and antitoxic sera, chemical reagents like salvarson, etc, have been discovered and utilised in the war against the enemies of mankind.

As early as 1909 fighting an insect pest, while working with a locust disease, bacterial in origin, F. D'Herelle in Mexico had observed, while isolating the causal

organism that there were some cultural irregularities noticed. On several occasions while isolating the bacteria from the intestinal tract of the locusts, it was observed that the culture yielded colonies, with irregular indented contours and in the others again in the midst of a part of confluent colonies there were areas entirely free of growth; but this observation was not worked up to a satisfactory explanation.

Hankin in 1896 drew attention to the notable bactericidal properties of certain Indian river waters. He found that the Jumna and the Ganges water possessed an extremely marked antiseptic action for bacteria in general, and for the cholera vibrio in particular. Then he noticed that the water of the Jumna as it left Agra, contained more than 100,000 bacteria per c.c. while some five kilometers further down the bacterial count was reduced to only 90 to 100 organisms. Laboratory experiments with filtered unheated and filtered boiled waters with cholera vibrios established the bactericidal action of the filtered unheated water, but not of the boiled water. Hence he attributed this property to a volatile substance, lost on boiling. This substance he could not isolate.

In 1917 however Professor D'Herelle made the fundamental observation leading to the discovery of the Bacteriophage, while working at the Pasteur Institute of Paris. He obtained sterile (free from bacilli) filterates from the stools of a patient suffering from Shiga dysentery. Each day of the disease about 10 drops of filterate so obtained were planted into some bouillon, previously inoculated with Shiga bacilli and incubated for 24 hours and then cultures were made from these tubes. Throughout the duration of the disease all the tubes thus prepared gave normal cultures of Shiga bacillus. One day however, the tube prepared the previous day remained sterile. This coincided with notable improvement in the patient's condition which was shortly followed by definite convalescence. To the bouillon which had remained sterile a fresh suspension of Shiga bacilli was added to give a terbidity and incubated. After about 10 hours this also cleared. A drop of the dissolved culture from this tube was added to a fresh bouillon culture of Shiga bacilli. After 15 hours this was clear, all the bacilli present had been dissolved. Several successful passages were effected similarly, the disappearance of the bacilli being effected with greater and greater rapidity. This proved that the principle involved became more and more active and this principle was contained in the original fecal filtrate which had first dissolved the dysentery bacilli. On the suggestion that this principle may be a virus pathogenic for Shiga bacillus, further research was conducted, with results which are having wide spread importance in preventive and curative medicine.

The Bacteriophage protobe as D'Herelle names it, was isolated, and its action on bacilli in vitro and vivo studied. The phenomena of Bacteriophagy essentially consists in the dissolution of the bacterial cell by the action of the Bacteriophage. The Bacteriophage is to be found in the intestinal contents of normal men and healthy animals, but particularly in those who are convalescing from a bacterial infection; in their urine, in their blood, in pus, in river water and cultivated soil, in fact in everything which may be contaminated with fæcal matter. It is not present in the fætus or new born, but appears in the infant from the fourth to seventh day after the birth.

Regarding the technic of obtaining this it is sufficient to mention here that this Bacteriophage passes through all filter candles, through ultrafilters which allow the passage of particles with diameters of 30 millimicrons (1/1000 microns). As it possesses the property of colloids, ultrafilters in the form of collodion sacs have been employed for isolating the principle from the body fluids.

The phenomena of bacteriophagy is essentially in the dissolution of the living bacterial cell and takes place well in media where the bacteria themselves thrive well. During the process the bacteriophage multiplies and the dissolving action can be carried on serially for an indefinite period. But a definite concentration of bacteria is necessary. When the bacteria are from 1 to 700 millions per c. c. the action is at its maximum—larger concentration leaving it incomplete. The minimum quantity of a bacteriophage suspension necessary being a ten billionth part of a c. c. This action takes place both acrobically and anacrobically, between a temperature range of 8° to 46°c. As only living and normal bacteria are necessary to bring about bacteriophagy the presence of antiseptics retards this process as these bring about changes in the bacteria. During the process at first an increased multiplication of the bacteria attacked has been noticed before dissolution set in and agglutination of the bacterial emulsion also has been noticed. The bacteriophage is supposed to exist in suspension in liquid media.

The study of the process on solid media has shown the corpuscular nature of the bacteriophage. A culture of susceptible bacteria inoculated with the specific bacteriophage is spread on agar plates. This gives a layer of bacterial growth studded with bare areas—circular spots called plaques—where there is no growth. The number of plaques gives the quantity of the bacteriophage in the suspension, each plaque having been obtained from a single corpuscle in the suspension. This affords a means of counting the bacteriophage corpuscles in the suspension.

This corpuscle fixes itself to a living normal young bacteria and penetrates into the interior of the cell. The bacterium is noticed to swell, turn spherical, and burst into a cloud of particles.

Ordinarily the action of the bacteriophage is non-specific i. e. it is virulent not only for bacteria of a given species but also for bacteria belonging to different species and very distantly related. Though this virulence may be less in degree, it is capable of being increased by adoptation. Being variable, the virulence can be increased by serial passages through suspension of bacteria against which the virulence is desired.

During bacteriophagy the bacteria are not passive. The general biological fact that all living beings react against agents attacking them holds good here also. Where the bacteria meet with a very virulent strain of bacteriophage they usually succumb. But if the virulence is little, the bacteria acquire a resistance such as to afford true immunity on subsequent growth against more virulent strains of bacteriophages. The secondary cultures of resistent forms are capable of destroying the bacteriophage corpuscle or attenuate its virulence. This again is a non-specific action. But when a resistent strain is purified, i. e., separated from any attached bacteriophage and repeatedly sub-cultured this acquired resistance is lost gradually and the organism becomes susceptible again.

So far bacteriophagy has been studied with a large number of bacteria chief among them from a pathogenic point being, Bac. Dysenteria, Bac. Typhosus, Bac. Paratyphosus A and B, Bac. Enteritidis, Bac. Coli, Bacillus Friedlander, Bac. Proteus, Bac. Diphtheria, Vibro Cholera, Staphylococcus, Enterococcus, Streptococcus, Bac. Pestis.

The Physical Properties of the Bacteriophage.

It has been stated already that this exists as a colloid; its size being the same as the serum—globulin Micella i. e. 20 millimicrons. It is formed of protein substances. It is insoluble and exists in suspension in liquid media. Its viability is great, though the number of corpuscles diminish with age or preservation for several years. Its vitality is much the same as that of bacterial spores. It is destroyed by ultra violet rays, but not by radium emanations —here behaving like bacteria. Whatever be the race of bacteriophage, it has been established that temperatures of 75° c. and above destroy it completely. Some impairment in virulence starts at 45° c. If there are multiple virulences in a single race the first to disappear is the weakest and that, at the lowest temperature of 45°c. The virulence of the younger forms is more resistent to cold. The action of chemical agents is difficult to ascertain as these agents act on the bacteria also and render them unfit for bacteriophagy. But considerable resistance is shown being intermediate between that of the vegetative forms of the bacteria and spores of B. Subtillis.

The Nature of the Bacteriophage.

This has been a question of great importance. Several theories are put forward; chief amongst these are :—

1. It is an autolytic ferment brought about by some external agent and this ferment brings on at once the lysis.

2. Bordet's theory is that the bacteria in the cultures, due to nutritional changes

in the metabolism, set free a lytic ferment leading to their autolysis.

3. Lastly D'Herelle's theory is that it is a living organism, an obligatory parasite of the bacteria. In favour of this, he argues that this organism shows all the group characters constituting the criterion of 'Life' if such be conceded. It has powers of assimilation of the bacterial substance, a heterologous medium. It acts on the foreign substance of the bacteria assimilating the same, to grow and multiply. It reproduces itself at their expense and is able to adopt itself to adverse conditions. According to D'Herelle, it possesses only one peculiarity which differentiates it from all living beings whose living nature has been accepted up to the present time. This one distinctive feature is its minute size. Since the experiments demonstrate that its dimensions are approximately the same as those of protein micella this excludes the idea of a cellular being. Knowledge so far has been in favour of the cellular theory of life and so arises the question whether life can exist in any form minuter than a cell. But D'Herelle says that the conception of a cell as a unit of life has been limited, because our idea is based on the visibility limit of the microscopes so far. By this the very conceptions of the cellular theory of life are shaken. But it remains for further research to demonstrate the living nature of such infravisible viruses like those of Rabies, Variola, Vaccinia, Encephalitis lethargica etc. If this were proved one of the oldest theories will have to disappear into the limbo of the past and a new concept that life results from a particular physicochemical state of the protein micella will be born.

Conceding the living nature of the Bacteriophage Protobe as D'Herelle calls it, how does it act on the bacteria? This again is a point for contest and even D'Herelle says it may act in three ways.

1. "It may act by causing the bacteria itself to elaborate autolytic enzynes.
2. It may itself elaborate bacterial enzynes.
3. It may act as an enzyne of which each granule is living. But at present it is impossible to choose between these three"

Its action in man and animals can be taken up next.

Though normally inhabiting the intestinal tract it is able to pass into the circulation and thence to the tissues or places wherever the specific bacteria exist. If it meets with no bacteria it is eliminated quickly from the circulation and is to be last seen in the spleen. As an antigen unlike bacterial antigens its properties vary considerably with different races. It produces a specific antibody. Repeated injections of bacteriophages instead of immunising, produce a sensitisation so as to cause the animal to loose its natural immunity for the bacteria. Antibacterial-sera exhibit an inhibitory action on the bacteriophage but it is not the same as that of an antibacteriophage serum on the protobe.

Coming to the therapeutic uses to which this bacteriophage has been put we find a vast amount of work done on this "Phagotheraphy." If the bacteriophage admitted, finds conditions satisfactory and is highly virulent it gradually multiplies at the expense of the bacteria, gains in virulence and eliminates them before they can develop and cause any pathogenic disturbance. Less favourable conditions bring on a mild disease which finally aborts when the virulence of the bacteriophage is established. But if the conditions are such that the bacteria have acquired or can acquire a resistence to the bacteriophage, the disease gains the upper hand. "The beginning of an Epidemic" according to D'Herelle "is marked by the predominence of the causal bacteria, and the end by the diffusion of the bacteriophage virulent to the bacteria." Hence if a bacteriophage race of such virulance as would act upon all bacteria were obtained, diseases caused by bacteria would come under the immediate control of this Phagotherapy. With this object in view immunisation experiments with bacteriophage suspension have been carried out by a host of workers.

Two kinds of immunity have been noted by D'Herelle and his co-workers. One they call the "Exogenous" lasting for 24 to 48 hours—due to the presence of the virulant bacteriophage in the body of the infected person. Elimination of this bacteriophage rapidly takes place and this exogenous immunity ceases immediately after elimination is complete. The second variety is the Endogenous, brought about by the bacterial products of dissolution resulting from bacteriophagy, these products being particularly suited to bring out immunity by the body of the animal reacting to their presence.

In an epidemic environment the exogenous immunity maintains itself as there are fresh batches of bacteria infecting the host thus providing a nidus for the bacteriophage to thrive. This is lasting so long as these fresh batches of bacteria are available. At the same time an endogenous immunity is also being produced. An antitoxic immunity also develops after the injection of the bacteriophage suspensions and is endogenous in origin.

Phagotherapy has been tried experimentally in Bacillary dysenteries, cholera, plague, typhoid, genito-urinary and other infections by the colon bacillus, in staphylococcus and streptococcus infections. But so far encouraging results are met with only in a few bacillary dysentery and of cholera cases and even here the mass of literature so far accumulated seems to point more towards the preventive use of this bacteriophage than to its curative value in well established infections.

Taking up the work done in connection with these diseases we find the following.

For Bacillary Dysentery.

A mixture of the three, anti Shiga, Hiss, Flexner bacteriophages were used. Treatment by vaccines of Shiga bacilli is known to give rise to violent reactions due to the toxicity of the bacilli. But the injection of the Shiga bacteriophage suspensions which contains the dissolution products of the Shiga bacilli are absolutely innocuous, showing that profound modifications have taken place in the toxic products. Whether injected or given orally the bacteriophage passes into the intestines in a short time in search of its specific feed—the bacteria and there its work begins.

The therapeutic effect as mentioned in reports—the sudden change for the better in the patient's condition has astonished several workers. The signs and symptoms have diminished in 4 to 8 hours after the administration and convalescense sets in in 24 to 48 hours. It should be noted that prescribing of antiseptics, acids, salts, & other drugs which are likely to render the intestinal contents unfit for the bacteriophage action are forbidden. A plain bland diet with plenty of water is recommended.

Patients with other intestinal Disturbances.

Colitis, enteritis without definite cause have been treated with successful results with a mixed race of the bacteriophage including virulence for B. Dysentery groups, B. Paratyphoid group and B. Suipestifer and B. Enteritidis.

In typhoid and paratyphoid infections no remarkable results have been obtained though a solitary instance here and there is cited of a prompt cure and reports say that there is either a prompt cessation of all symptoms or no result at all.

Colon bacillus Infections.

Colon bacillus septicaemia pyelonephritis; pyelitis, chronic cystitis etc have responded. to this form of treatment. But as the colon bacillus is the most heterogenous race a polyvalent bacteriophage not yet being available, the question of an autobacteriophage arises. In some cases resistent to the usual 1 to 2 injections of the phage, instillation of about 20 cc bacteriophage suspension into the bladder has given excellent results.

In staphylococcus infections again cases which have had a series of autogenous vaccine injection without benefit, were given this form of therapy. In furunculosis, 0·5 to 2 cc of the phage suspension was injected as close to the lesion as possible with satisfactory results. Rapid diminution in the induration with disappearance in 24 to 48 hours was noticed. Already suppurated infections opened and dried up quickly. Gratia was the pioneer to try this therapy in staphylococcus infections. He isolated a polyvalent staphylococcus bacteriophage and injected 0·5 to 3 cc in different infections. In some a maximum of 2 injections at 24 hours intervals were given in any part of the body with identical results. In staphylococcus septicaemia the intravenous route was adopted. In furunculosis and folliculitis 1 cc of the suspension was tried at any point preferably under the skin of the abdomen.

The injection may be repeated once but not later than 48 hours in view of anti-bacteriophage sensitisation resulting in loss of even the natural immunity for the bacteria. For local abscess and anthrax he advocates 1 to 2 cc and for septicaemias 2 to 3 cc interavenously in one injection.

In sycosis another chronic and intractable infection, Gougerot and Peyne give a local treatment method where each pustule is opened up with a pippette containing the bacteriophage suspension in such a way as to inoculate each pustule. But great care is needed to go through all pustules and if necessary on a subsequent occasion to attack any left out. Local dressings of the suspension on pads are also recommended and a persistent inoculation of each fresh lesion is important. 24 hours after however there is a reaction, violent in some cases, but this promptly subsides within 48 hours leaving the patient all the better.

Mckinley reports on successful treatment of heavily infected old wounds. In streptococcal infections and bubonic plague no definite results have been obtained. Though an injection of the painful and swollen bubo with a bacteriophage suspension has been noticed to bring about a quick subsidence of the inflammation with benefit to the patient.

In Cholera —D'Herelle and Malone studying 23 cases, found that in 6 patients who died there was no bacteriophage present in three, and in another only a feeble one, a strong one in 2 rapidly recovering cases ; of a fluctuating strength in 15 cases, in whom it became strong with recovery. Roger's saline treatment was used in the early collapse and later on kept up till such time as the natural bacteriophage present acquired virulence. In the Punjab adding the bacteriophage to a well stopped further spread of the infection. There is thus a natural active bacteriophage associated with recovery. D'Herelle and Malone give a death rate of 8·1 % in 74 Punjab village cases treated as against 62·9 per cent in 124 control untreated cases.

Asheshov, Saranjankhan, and Lahiri working in the Patna Medical College Hospital report a death rate of 2·8 per cent in 140 cases treated with bacteriophage suspension and bacteriologically proved as cholera against 25 per cent before they took charge.

They advocate the administration of the bacteriophage by mouth—1 dram every 30 minutes undiluted and sipped directly till 50 cc. of suspension is taken, then 50 cc. in 24 hrs. for 2 days. In bad cases 5 cc of the suspension well diluted in saline is given intravenously or mixed in the Roger's saline itself; for they find undiluted intravenous injection has given rise to transient but quite unpleasant anaphylactic phenomena. They at the same time use the intravenous alkaline saline treatment also to combat collapse. Stools became less frequent and quickly turned fœcal in nature. No other drug or food was given for first 24 to 48 hours keeping in view the danger of unnecessary starving leading to acidosis. Cold water ad lib and ice to suck ; no permanganate, no essential oils, no camphor etc , formed the routine. If progress is satisfactory after 48 hours barley water and whey and fruit juice are given later on only if diarrhoea improves. Stress is laid on the fact that the bacteriophage should be of the highest virulence and capable of meeting all strains come across in an epidemic.

The main role of the choleraphage in future seems to be more on the preventive side. For as observed the cessation of an epidemic coincides with diffusion from convalescence of the bacteriophage adopted to effect bacteriophagy of cholera vibrios. This renders it possible to reproduce this process experimentally by sewing selected cultures of bacteriophage in the water supply of infected places. At the same time as a prophylactic measure inoculation with suspensions of vibrios dissolved by the choleraphage can be carried out.

In conclusion the hopes based on this phagotherapy are still to be realised. "The discovery of the bacteriophage introduces an entirely new chapter into Biology if the bacteriophage be not a living particle, complicates the already difficult matter of defining Life."

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take a liberal diet. The condition improved very much in the third week and the normal appetite returned. After one month his colitis was completely cured and when last seen he was quite all right.

An interesting case of Furunculosis.

There are many cases in which patients suffering from Furunculosis, who are unable to tolerate for some reason or other any kind of injections, have been benefitted by the use of Stannoxyl.

Recently I was much surprised at the relief it afforded and at the excellent cure it effected in a severe case or Furunculosis of both the ears. The patient, a school-going girl of 18, had a number of small boils in the ear, which not only gave her a good deal of pain, but her temperature rose to 102° or at times to 103°. The condition used to recur too often, which interfered very much with her daily routine. She was having treatment at the hands of other medical men. One night her temperature rose to 103° and she began to get such unbearable pain that sleep was an impossibility. She began feeling very restless and then I was sent for. I at once gave her Cryogenine tablets, which I had and asked her to take two with hot water. Her temperature was reduced by two degrees after an hour and her pain subsided and she slept well. In the morning I prescribed Stannoxyl, two tablets three times a day after food. At the same time I gave her to instil in the ears the drops of the following :—

Hydrag Per Chlor gr I
Glycerin ounce 1.
M. ft. ear drops

The results were beyond my expectations. After a week of this treatment her boils completely disappeared and she got well. I advised her that when the same trouble threatens again, she should take resort to the same remedy. Fortunately the trouble never recurred.

It may be worth recording here that during the last hot season I have treated nine cases of boils, three of which were of some months' duration. All the cases cleared up completely after a fortnight's treatment with Stannoxyl. It thus appears that in the oral administration of this preparation we have a valuable means of combating any kind of Furunculosis and the advantage is that no strict diet or other restrictions need be observed.

A reconstructive Tonic.

It has been a long-standing practice to employ tonics to stimulate and strengthen the run-down patients in Wasting Diseases. It has recently come to the notice of medical men that this stimulation is inadvisable and inadequate, as it cannot replace the wasted material but it only whips a tired horse, which is thoroughly useless. A tonic in wasting diseases should therefore be such as would provide elements which would restore the depleted tissues. Hemoplase Lumiere is just the tonic which answers all these ends embodying as it does not only Hemoglobin in its natural state but a most assimilable form of Iron also.

It is not of much interest to the busy medical practitioner as to how Hemoplase is prepared, but it will rather interest him to know fully its therapeutic action. In anæmic conditions and wasting diseases there is always a pronounced deficiency in the normal constituents of various body tissues and the natural method to which we look for is the restoration of these by absorption from food. We are all aware, however, that the process of absorption and assimilation in these conditions is very much retarded. It is exactly in such conditions that other tonics, which merely stimulate and strengthen, are of no avail. Hemoplase replaces these deficiencies in a most rapid manner because it is composed of the ingredients viz. Hemoglobin and Iron, which are normally found and which are quite necessary for the maintenance of the organism. These reconstructive elements are so incorporated in Hemoplase that it can be easily assimilated and absorbed by the weakest of the systems. Again when anæmia sets in, the quantity of Hemoglobin in the blood is greatly reduced and as a consequence the oxygen needed for effecting nutritive changes and for metabolism is not supplied in sufficient

quantities. In such cases the administration of Hemoplase can be called a direct method of treating these diseases as it contains Hemoglobin in the natural state and can thus supply directly the organism in sufficient quantities. It is on account of the natural Hemoglobin contained in Hemoplase that it can be stated with confidence that it is an effective remedy in anæmias. It is well known that besides Hemoglobin, Iron plays a very prominent part in maintaining the equilibrium of the blood in body. Therefore the object of including Iron in Hemoplase is that it helps the formation of Hematin and is needed to keep the Hemoglobin supply of the blood to the normal standard. Without Hemoglobin the normal oxygenation of the body-cells cannot be brought about. Besides, Iron in Hemoplase has an identical chemical composition to that found in the body and it is therefore easily assimilated and absorbed and when Iron is administered in such a form, it becomes efficient as a constructive material and a cell cataliser. Hemoplase, as we have seen from the composition, combines the valuable qualities of a blood regenerative agent and of a blood tonic.

We have indicated before that Hemoplase is an excellent tonic. We can state that it is recommended for use in all cases where arsenic is usually indicated viz. in anæmias, specially of the pernicious type. In anæmias the deficiency of Hemoglobin with or without the reduction of red cells is the chief factor which is responsible for the lack of nutrition of the cells in the body. The danger of anæmias is that it lowers the vitality and the body loses its power of resistance against serious infections. A tonic in such conditions gives only temporary relief. Stimulants produce serious after-effects. Hemoplase, on the contrary, is a preparation, which in such cases increases the Hemoglobin content and speeds up the production of red cells. Hemoplase is absorbed immediately in the body and supplies it with the natural blood elements. The normal healthy count of red blood cells is rapidly restored and the content of Hemoglobin is brought to its original level. The whole body is thus re-invigorated and the vitality and the resistance is increased. Hemoplase is used with benefit in Chlorosis, and Malaria, because it, as has already been remarked, rapidly restores to the blood its full normal content of Hemoglobin and increases the vitality. In Chlorosis, on account of the Iron content, it alleviates the distressing symptoms to which highly sensitive women are so prone. Patients who have been exhausted by Hemorrhage and who feel depressed will show signs of rapid improvement if they are administered this preparation. It can be prescribed with confidence in Cachexias and Convalescence, as it is a great restorative. It helps to build up the resistance of the patient in the least possible time. It is certainly superior in this respect to Quinine or Iron tonics. Hemoplase is very useful in the debilitating conditions resulting from acute illnesses. It has been found very valuable after attacks of acute Influenzas. After the frequent attacks of Malaria, Hemoplase strengthens the run-down patient, increases his appetite and improves the general condition. In anæmias resulting from cancerous conditions Hemoplase has a pronounced influence in the treatment. Together with the increase in weight it improves the appetite. In Tuberculosis the results experienced with Hemoplase have been very encouraging. Not only is the appetite restored but the gain in weight and the cessation of night-sweats is very appreciable. This gives the patient a possible chance of recovery. In the early stages of the disease the patient can develop his resistance and vitality by taking Hemoplase together with other remedial agents. It is however effective in persons, who have a tendency to contract Tuberculosis. In such cases recovery of appetite and the increase in weight are the two main results for which Hemoplase is responsible. In this way it modifies the pre-tuberculous as well as the tuberculous soil, so that the bacilli may have very little chance to carry on their ravages. It also completely renovates the tissues on account of its natural Hemoglobin and Iron content and thus brings about a reconstructive action.

We have thus found that as a blood-cell builder and restorer of Hemoglobin, Hemoplase has established a place for itself. Practically every tonic which claims restoration of blood in anæmias contains Iron in some form. We have found that Iron in these tonics is inert as none of it is assimilated owing to the gross form in which it has been incorporated.

This is responsible for the failure of such tonics. On the other hand Hemoplase besides Hemoglobin contains Iron in finely divided assimilable form. The large percentage of this Iron in Hemoplase is taken up by osmosis through the membranes of the cells of the intestinal wall and hence its great therapeutic value Clinical evidence will prove its usefulness in the treatment of Pernicious Anaemias as well as all types of Secondary Anaemias, as also in Wasting Diseases with lowered vitality.

For rapid results two or three injections of 5 c c each can be given per week. This may be supplemented by the oral use of the pills, either during the same period or after a course of injections is completed.

Painless Intramuscular injection of Quinine.

Perhaps it is not possible to make an *absolutely painless* injection of a quinine solution, but it is true that it may be made so nearly painless that no future objections are made against such injections.

A good smooth sharp needle should always be used ; that reduces to a minimum the pain of piercing the skin. The truth is that quinine by itself, does not cause pain nor trouble when injected. The trouble comes from the acid that is used to dissolve the quinine. Next to the caustic alkalies, acids are perhaps the most powerfully traumatic bodies employed in medicine. Fairly strong hydrochloric, hydriodic or hydrobromic acids can dissolve meat without the aid of pepsin. Even weak acids have a hydrolytic effect on muscle, skin, tissue etc.

Necrosis by quinine solutions is undoubtedly due to the alkaloid base. Any basic substance can cause necrosis. Even a very dilute solution of the base *caustic soda* is highly necrotic. Martindale says "The Necrosis caused by quinine salts hypodermically is no doubt due to the deposition of quinine base at the site of injection." Where the solution used is too strongly *acid* the irritation by the acid causes a local reaction, restricting the diffusion of the medicament. This restricted absorption leads to a concentration of the quinine base at the site of injection, with an increase in the Necrotic action.

The first endeavour, in regard to painless injections of Quinine, must be to obtain a solution, the acidity of which is reduced to the least possible. We have that in the "Intramuscular Quinine" A. F. D. ampoules.

Numbers and numbers of doctors have told us that "Intramuscular Quinine" A. F D. ampoules are quite painless. That is not the absolute truth ; there is a *slight* pain, which is negligible for all purposes. These "Intramuscular Quinine" ampoules of A F. D. can even be given hypodermically, if given fairly deeply, without more than negligible pain or inconvenience.

Abstracts

THE PATIENT AND THE CASE

By J. S. LANKFORD.

The average human heart is full of profound trouble and worry. The great understanding physician searches deeply and sympathetically into the very heart of all the troubles of the patient and then knows what is best to advise.

In this day of the modern laboratory with every facility for scientific study and highly skilled technicians, we are too much inclined to lose sight of the *patient* in studying the *case*. The laboratory is alright, an excellent aid, and all of this intensive study of the organs, functions and blood, the physiological and the pathological side of the patient is well, but we should not forget the fact that there appears before us a human creature, full of deep distress, pleading for help.

In recent years there is a strong tendency toward considering the case as a commercial commodity to be measured by the business yard-stick; or as an interesting subject for scientific research without reference to the mind, and spirit and soul of the patient. We pass all too lightly over the very important heart-side of the patient in studying the case scientifically. In fact the profession is too much inclined in recent years to become a trade, a business proposition for profit and we are all too hard and indifferent.

We need to get back to the human creature before us. He is ill; he is mentally impaired; he cannot think straight and place a proper estimate upon things; he is brooding to the point of despair and is incapable of judging his condition from a reasonable standpoint. He is full of serious troubles and problems; possibly a sense of guilt over some secret sin is gnawing at his conscience. The basis of his depression may be hatred, envy, jealousy, animosity or other soul-killing human emotion. Perhaps there is heart-breaking discouragement over failure and the patient is hopeless. Possibly he is possessed by fear which hampers him in every way. More than likely he has a thousand worries and problems that need to be brought to the surface and explained to his great relief. It may be that he has absorbing occupational interests and is under too much brain strain. Or there may be an intoxicating love that is tormenting him. It is possible that he has domestic or social problems that have to be faced.

Search his face, study his mouth, which is more marvellous in its expression than even the eyes. But look into the eyes and into the depths of his soul and read his griefs, fears, pains, morbid forebodings, his anxieties, and all his crushing, burdens and troubles with a deep sympathetic understanding. It will then be possible to give the patient the right kind of guidance and lead him out of the wilderness of despair. When this is done, then his confidence and co-operation will be easily secured in carrying out instructions about diet, exercise, out door life, the shaking off of worries and troubles and he will follow directions about medicine, and there will then be a most happy hope for good recovery if that is possible.

There appears before us a troubled human creature, longing for relief, pleading for assistance. We should look deeply into all these questions and at the same time use the laboratory aids as required and then it will be possible to practice medicine in a satisfactory way, bringing relief, hope, and possibly recovery of health and happiness and a great service will have been rendered.

The history of the medical profession for three thousand years is an entrancing story of personal sacrifice and unselfish human service, and this great profession must not become mercenary and destroy the sublime faith of appreciative people. With a keen sense of the importance of personal human problems and the application of the principles of psychology, and with a continuation of intelligent service the faith of the masses in the profession will be maintained and there will be less likelihood of cults and frauds endangering the health of individual patient.—(*Medical Mentor, April 1931.*)

Notes on Treatmet of Diseases.

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

Dyspepsia : (Atonic) Nitro Muriatric acid dil. mms 10 to 15 with Tinct. Nux. Vomica mms 5 before meals or a pill containing Silver Nitrate gr. 1/6th, Ext. Opium gr. $\frac{1}{4}$th and Ext. Hyoscyami gr. $\frac{1}{2}$ (Modern Medicine).

FERMENTATIVE — 10 to 15 mms of Tinct. Belladona before meals (M. T. T.).

Sodium Bromide, Pot. Bromide and Ammon. Bromide each grs. 40, Liq. Taka Diastos 1 ounce, one dram of this to be taken after meals and if there be fermentation, Resorcin $\frac{1}{2}$ dram, Tinct. Nux. Vomica 2 drams, Cascara Evacuant 1 ounce and Liq. Taka Diastos 2 ounces ; one dram after meals.

WITH PAIN AND NAUSEA, Liq. Taka Diastos 1 dram, Liq. Bismuth et. Ammon Citras 1 dram, Tinct. Nux. Vomica mms. 5 Acid Hydrocyanic dil. mm 1, Spt. Chloroform mms 10, Aqua $\frac{1}{2}$ ounce ; 3 times a day after meals (Therapist).

Pharmasol Bismuth, a teaspoonful 3 or 4 times a day has been found very useful to check pain and nausea.

ATONIC DYSPEPSIA AND GASTRITIS—Pa-Pyta a preparation containing Papain, Pancreatin and Bile extract, one tablet immediately after every meal is useful in atonic Dyspepsia of whatever origin.

WITH LITTLE ACID—Acidone 1 or 2 drams at each meal is good. It contains 5 per cent Hydrochloric acid in loose combination with Pepsin (Kellog).

In cases in which there is increased hunger followed after taking a little food by nausea indicating the irritable condition of the stomach, moist abdominal bandage accompanied by hot pack over the stomach is good (Kellog).

STHENIC—occurring in women during climateric period, Icthyol grs. 5 in pills is the best remedy.

IN ASTHENIC—with a feeling of weight in the stomach immediately after meals but with no pain or tenderness, Pulvis Capsici grs. 10, Ext. Nux Vomica grs. 5, Taka Diastos drams 2, to be made into 20 capsules, one to be taken with each meal.

Homeopathists give Tinct. Bryonia mms 5 to 40 with excellent results (Hare).

Taka Diastos grs. 45, Pancreatine grs. 45, Ext. Nux Vomica grs 4 made into 2 pills one with each meal and a little capsicum may be added.

Instead of Hydrochloric acid, Acedol pastills may be given as they give off Hydrochloric acid slowly ; Soda Bicarb, to be given after meals. In the Sthenic form with excessive acidity the best alkali is magnesium mixed with Bismuth and not with Soda Bicarb as by its decomposition with Co_2 it will irritate the stomach and cause the secretion of more hydrochloric acid. Liq. Bismuth Hydratis dram 1 to 2 with cream of magnesia dram 1 to 2 is good (Leonard Williams).

In the sthenic form salt should be avoided and to relieve constipation Sodium Sulph. grs. 30, Soda Bicarb grs. 10, Tinct. Nux. Vomica mms 5, Essence Menth Pip. mms 2, Infusum Gentian Co. add one ounce, to be taken 3 times a day before meals (Leonard Williams).

In the Asthenic, Acid Hydrochlor, dil mms 25, Liq. Strychnine mms 5, Glycero Pepsin 1 dram, Aqua Mentha $\frac{1}{2}$ ounce to be taken three times a day after meals and to this may be added either Quinine or Liq. Morphia Hydrochlor or Liq. Ferrichlor. or Liq Arsenic Hydrochlor (Leonard Williams).

If due to food allargy, calcium Iodide drams 4, Acid Hydrochloric dil. 4 ounces and Elixir Pepsin 8 ounces, one teaspoonful in a glaseful of water to be sipped slowly after each meal (C. M. S.).

Ammon Chloride in 10 gr. doses given $\frac{1}{2}$ hour before meals is useful in painful dyspepsia due to hyper acidity (Hare).

Excellent results follow the treatment of acute dyspepsia and dysentery in infants with a two days exclusive diet of grated ripe apples followed by two days diet without milk or vegetables. (C. M. S.).

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Extracts from Standard Literature.

REGARDING ACECOLINE.

IN RAYNAUD'S DISEASE : Acecoline greatly improves the true syndrome, treatment of which has hitherto been unsatisfactory. In a typical case, ten to fifteen minutes after an injection of Acecoline the fingers regain their normal colour. This alleviation persists for from twelve hours to three days. Pain is quickly relelved, sometimes after the first injection. Freedom from pain encourages refreshing sleep. Acecoline gave immediate relief from pain in a severe case cited by Villaret and Justin-Besancon, involving the face and all four limbs. Whenever a vascular crisis arose, recovery was prompt after injection of Acecoline. The attacks of pain disappeared entirely after six months of treatment. Quick amelioration of the trophic changes is frequently accomplished by Acecoline. This, however, depends on secondary infection involvement. Severe secondary involvement may seriously retard the efficacy of the product in this direction.

A dosage of 0·05 Gm. subcutaneously is followed by 0·1 Gm. the following day. If results are not sufficient after ten daily doses, 0·2 Gm. may be given as often as twice daily. Complete disappearance of pain, tropic and vasomotor disturbances should result after a typical course of fifteen days' dosage per month for two or three months.

IN DIAGNOSIS OF PERIPHERAL VASOMOTOR DISTURBANCES : Use of Acecoline is of marked efficacy in enabling the physician to determine whether the spasm is anatomical or functional. If due to spasm, the occlusion will be relelved and reappearance of the pulse will ensue.

OBLITERATIVE ENDARTERITIS AND INTERMITTENT CLAUDICATION : (Angina Cruris). The remedial effect of Acecoline is often unusual in dilating the arterioles and diminishing the spasm of affected vessels In the most favourable cases there may be evident increase in the oscillometric index. Acecoline cannot open an obliterated artery. For this reason there is a percentage of failure in conditions complicated by complete arterial obliteration. However, it is of therapeutic interest to note that Acecoline affords much relief even when complete obliteration has taken place. Great relief from pain is experienced, in degree frequently superior to the effect of morphine. After five or six injections intermittent claudication may entirely disapper. Distinct relief is likewise afforded for the tropic disturbances, provided they are not too seriously complicated by secondary infection.

A dosage of 0·1 Gm. morning and evening, immediately increased to 0·2 Gm , has proved efficacious. In mild cases, fifteen injections a month may suffice.

SENILE AND DIABETIC GANGRENE : Acecoline greatly enhances the efficacy of insulin in diabetic arteritis, and in the presence of arteritis after failure of sympathectomy a few injections relieve the pain and hasten the healing of tropic ulcers. Acecoline administered pre-operatively often permits a lower amputation to be made, with less danger of gangrene. It is of value, also, post-operatively.

IN NEUROLOGY : Acecoline has been used with benefit to relieve cerebral artery spasm. It is indicated in accompanying transient syndromes, such as hemiplegias and monoplegias of cerebral origin, aphasia, amaurosis, cerebral thrombosis, and apoplectiform and epileptiform seizures due to vascular spasm. In actual cerebral haemorrhage, in which consciousness is generally lost from the beginning, Acecoline is contraindicated.

IN OPHTHALMOLOGY : Results from use of Acecoline for relief of spasm of the arteria centralis retinae and accompanying syndromes have been marked and immediate. In the experience of Bailiart and Calt, acute macular vision has been reestablished within forty-eight hours.

SEQUEALAE OF VASCULAR HYPERTENSION :—While Acecoline may bring about an uncertain permanent reduction, its value for relief of functional disturbances accompanying hypertension is considerable. Quick disappearance of cramps of the lower limbs, "dead" fingers, giddiness, buzzing in the ears, defective vision, etc., may be expected after Acecoline injection.

In old people with atheromatous arteries, care should be taken to administer Acecoline only in small dosage so as to avoid risk of haemorrhage in the nerve centre.

TUBERCULOUS SWEATS: Marked relief is obtained from samall doses, 0·01 to 0·02 Gm. every day or every other day. A larger dosage may aggravate the condition. Villaret and Justin-Besancon consider acetylcholine the most valuable of the therapeutic agents for profuse tuberculosis sweats.

VAGAL DYSFUNCTION: Acecoline stimulates smooth muscle fibres under vagal innervation. It increases intestinal peristalsis and in certain cases the observation has been made of the relief of habitual constipation. It tones the musculature of the bladder, stomach and intestine. Excellent results have been secured from its use in lead colic. Its value in angina pectoris is being clinically considered, as well as in conditions of scleroderma, especially scleroderma accompanying spasm of the arterioles.

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

"More than 2,000 injections have been given by us personally and nearly 10,000 have been given in the Paris hospitals without one untoward incident, affording ample proof that the therapeutic use of acetylcholine is in no way dangerous, causes neither local nor general reaction, and its effect is wholly maintained even after repeated administration."

VILLARET M. AND JUSTIN-BESANCON, L: THE THERAPEUTIC APPLICATION OF ACETYLCHOLINE, M. J. & RECORD, 129: 343—345 MARCH 20, 1929.

"Our clinical experiments, and those of others, have shown that acetylcholine can be administered to humans without danger, provided that the injections are given subcutaneously or intramuscularly. Intravenously it is dangerous; orally it seems to have no action."

VILLARET, M: THE CLINICAL ALD THERAPEUTIC USE OF ACETYLCHOLINE, MONDE MED. PARIS, 39: 449, APRIL 1—15, 1929.

In a typical case of Raynaud's disease an injection of 0·1 Gm. of acetylcholine gave prompt and striking results. Within fifteen minutes after the injection all the fingers assumed a rosy hue, even those most affected, except for the distal phalanx. This sudden improvement was unaccompanied by any sensation; there was no tingling in the fingers. In this case the treatment was followed with caution for a period of seven months without interruption, 0·05 Gm. of the drug being given every second day, with an occasional interval of one or two weeks. The symptoms disappeared, except that the fingers were sometimes cold for a short time. The oscillometric index registered 1 for the radial artery and 3 for the brachial.

Acetylcholine is of diagnostic value as it shows clearly whether the trophic disturbances are dependent on vascular spasm or on an obliterating arteritis. The effects of the treatment were outstanding: (1) in that life was restored to fingers which were apparently doomed to amputation; (2) in that there was tolerance to the injections over a long period with no untoward incident; (3) in that the results of the treatment were maintained for more than a year.

CASTELLOTTI, F.: CLINICAL STUDY OF ACROCYANOSIS; ACETYLCHOLINE THERAPY, BIOCHIM, E TERAP. SPER, 16; 385, SEPT. 30, 1929.

A patient with typical Raynaud's disease came under observation on April 19, 1929. Under treatment with acetylcholine the discoloration and other manifestations of the disease had practically disappeared by June 20, 1929.

VILLARET, M. AND JUSTIN BESANCON, L.: THE THERAPEUTIC APPLICATION OF ACETYLCHOLINE, M. J. & RECORD, 129: 343—345, MARCH 20, 1929.

Acetylcholine is effective in most cases of true Raynaud's syndrome characterised by syncope of the extremities often passing quickly to local asphyxia, the turning purple or black of the fingers and toes, the presence of pain and the occurrence of severe trophic change in the fingers and toes. It acts by dilating the arterioles of the extremities and it is therefore obvious that, when the disease has produced anatomical obliteratfon of these small vessels, no effect from the medication can be expected. If a patient showing active signs of Raynaud's disease receives an injection of acetylcholine, in ten to fifteen minutes the fingers recover their normal colour. This colouration persists for from twelve hours to three days. Pains disappear rapidly, sometimes even after the first injection. With regard to trophic changes, their amelioration which depends greatly on the extent of the secondary infection, which can affect the action of acetylcholine very seriously.

1 "Acetylcholine for therapeutic purposes is available commercially as Acecoline, which was the preparation used in these studies." Footnote, by Villaret and Justin-Besancon.

News and Comments

Ourselves: The Medical Practitioner completed 2 years of its life. The third year commences with this issue. The profession has been uniformly appreciating its services and there are signs that the official section in the profession who have been rather loath to understand the scope of the activities of the journal, are now realising that The Medical Practitioner does serve them with as much zeal as it does the members of the independent medical profession. After all both sections are concerned with the noblest art of curing human ailments and there cannot exist any difference in the fundamentals concerning the relief of human sufferings. The aim of The Medical Practitioner being the uplift of the medical profession as a whole it has to protect the interests of several sections and grades that now unfortunately exist in the profession and this task cannot be always pleasant either to The Medical Practitioner or to a few who on account of their official and other advantageous positions do not naturally relish the services of The Medical Practitioner rendered to their less fortunate brethren in the profession.

We are satisfied that our fights for the profession as a whole have not been in vain. There is a dawn of reform in the horizon. The necessity for a uniform and minimum standard of medical education has been recognised universally and the principle and utility of Honorary Medical Relief scheme are being approved by the Government. It is for the profession to note the passing events, take advantage of them and foster their growth and prospects. We on our part will not slacken our activities and our propaganda to attain the aims and objects for which The Medical Practitioner was brought into existence.

We express our heart-felt gratitude to the members of the profession who have been co-operating with us in our activities and helping us with valuable contributions.

City Practitioners' Meeting: A public meeting of the Private Medical Practitioners was convened by the Editor of "The Medical Practitioner"—Dr. M. S. Krishnamurthi Ayyar, M. B. C. M.; the meeting was held at 2 p.m. on Sunday the 4th instant at the Ripon Buildings. It is well known that "The Medical Practitioner" which was started chiefly in the interests of the private medical profession, the backbone of the medical relief to the general public, has been, since its birth, advocating in almost every issue of it, the introduction of the system of honorary medical officers in Government Hospitals and has, after the appointment by the Government of a committee of enquiry into the system of Honoraries, published a series of Editorials in the last 4 issues detailing the several stages by which, under the present conditions, the system should be introduced and worked. Further, Dr. M. S. Krishnamurthi Ayyar since his retirement from service in 1924, has been contributing articles on the system of honoraries to lay papers and has dealt with the subject in the books he has published. As the Chairman of the Reception Committee of the first Madras Provincial Conference of Independent Medical Practitioners held in the City of Madras during the congress week in 1927, he dealt with the subject in his address, and elaborated it in the address he delivered as the President of the Third Annual Conference of the Madras Provincial Rural Medical Practitioners' Association held in Madras in December 1930. It is the duty of the Editor of a journal of the nature of 'The Medical Practitioner" to invite the practitioners to a discussion of the Report of the Committee and to express their considered view on it. Merely inviting correspondence and publishing them in the journal can hardly take the place of a free and heart-to-heart discussion in a meeting. It is in realisation of his responsibility as the Editor of the journal that he convened the meeting and if he had not done so, it would have been a grave omission on his part.

Some members of the South Indian Medical Union,—of which it may be stated that Dr. M. S. Krishnamurthi Ayyar has been the Vice-President successively for the last few years—who attended the meeting raised objection to its being held

on the ground that the meeting should have been convened under the auspices of the South Indian Medical Union and not independently of it, more especially as the convener was himself an office-bearer of the Union. As long as Dr. M. S. Krishnamurthi Ayyar is the Editor of "The Medical Practitioner" which is not connected with the South Indian Medical Union, he has acted quite within his rights in convening the meeting independent of the Union, nay it was his duty to do so. If the convening of the meeting independently of the Union is considered objectionable, it may be deemed equally objectionable for him to edit the journal which is independent of the Union. That he was elected more than once, as an office-bearer while he was the Editor, clearly shows that the South Indian Medical Union did not consider it objectionable for a member or even an office-bearer of the union to edit a medical journal independent of the Union. If so, it is difficult to see what objection there could possibly be to his convening the meeting as the Editor of the journal. It may be stated here that the importance of the Private Medical Profession, forming as it does the back-bone of the medical relief to the general public, demands the support not only of the South Indian Medical Union which, by the way, has among its members only a small portion of the Private Medical Profession but of other similar agencies also. Taking into consideration that private medical practitioners are always busy and have practically no time of their own and that for the First Conference of the Private Medical Practitioners held in Madras during Congress week in 1927 only about 50 practitioners attended the conference, the attendance at this meeting must be considered to be fair, usual and what can be expected. The chairman of the meeting would have been within his rights, if he had disallowed the motion for adjournment but he was generous enough to ascertain the sense of the house and when the motion was lost he proceeded with the business of the meeting. If the members of the South Indian Medical Union who attended the meeting, had co-operated and taken part in the discussion at the meeting, they would have secured the approbation of the other practitioners present who are not members of the Union and proved the identity of the interests of both. But by not doing so and walking out when they failed to secure a majority to accept their motion for adjournment, they have shown to the public, the position taken up by the Union in regard to the Private Medical Practitioners as a body and have given just cause for estrangement between the Union and the Practitioners not connected with it. The resolutions passed at the meeting have been published in the Correspondence Columns.

Unwarranted Procedure: Under the caption 'Is it Retrenchment" we brought to the notice of our readers in these columns in August last that to transfer a Civil Surgeon from Anantapur to Vizagapatam Agency as many as 5 transfers were effected covering a distance of not less than 2,000 miles. It now transpires that the Anantapur Civil Surgeon reported ill and was granted 3 months' leave by the Medical Board. Leave having expired the Civil Surgeon was asked to produce certificate of fitness to join duty from a District Surgeon as required by Section 71 of the Fundamental rules. This was produced and the District Surgeon seems to have certified to the effect that the Civil Surgeon was fit to perform the ordinary duties of his profession. The Surgeon-General seems to have been more anxious than the patient himself and got the patient examined by the Government Biochemist regarding sugar content in his blood and this was found less than what it was during the period when the officer was doing duty at Anantapur to the satisfaction of the Surgeon-General. The Departmental Head was still perturbed and ordered the patient to appear before a Special Board consisting of a Surgeon, an Obstetrician and a Pathologist to sit in judgment on the certificate granted by a District Surgeon in the City who had been a Professor of Physiology in the Medical College, Madras, later Professor of Medicine in the Vizagapatam Medical College and a recognised Physician of merit. The Surgeon-General's proceedings savours something more than the duties of an administrator. His extraordinary proceedings in questioning the veracity of the certificate granted by a District-Surgeon who is also in the panel of the members of the Medical Board, would have been less questionable if he without taking the opinion of the Biochemist, separately,

constituted a Special Board consisting of the Biochemist, the District Surgeon concerned and another Physician of merit chosen from amongst the panel of members of the Medical Board. It is not known if the certificate of fitness granted by the District Surgeon was sent to the Special Board. A decision arrived at by a Board so constituted would have been more tolerant and less drastic both in the interest of the patient and the Code of Medical Ethics; and would have cost the Government less money.

Much Ado: We suggested in these columns in one of our previous issues the advisibility of amalgamating the Lady Willingdon Medical School with the Royapuram Medical School. The Government seems to have asked the opinion of the Surgeon-General in the matter, who in his turn must have referred it to the opinion of the Superintendents of the Royapuram and the Lady Willingdon Medical Schools. In the meanwhile an agitation is being led by the lady folk naturally inspired by those who are interested in the shifting of the Lady Willingdon School to Royapuram. With due respect to the feelings of the fair sex we have studiously avoided the word "abolition" and substituted in its place "amalgamation" with the hope that the latter expression will not revolt their feelings. At a Ladies' meeting and in correspondence appearing in local lay press much was made of an imaginary fear that medical education for women would be at stake if the girls were taught along with boys in a medical school. How and why nobody expressed. It is most regrettable that those who advocate equal pertnership between men and women in social, public and political life misconstrue their own ideals in this case. If men and women should mix with each other freely in after life why not in schools and colleges! Regarding the Gosha girls who wish to undergo training as lady doctors, they must be pursuaded to come out of Purda in their own interest. It is inconsistent with the advanced notions of womanhood to encourage Gosha in the matter of medical relief.

Teaching girls separately especially in medical institutions is a luxury and not a necessity. If there be funds available for extravagance nobody can have any objection for separate medical institutions. If, as suggested by us on the previous occasion boys and girls can be taught under the same roof in the medical college why not in schools especially at a time of financial crisis.

There is yet another consideration which we hope will appeal to all concerned. The Surgeon-General has devised a scheme to increase the course of training in medical schools from 4 to 5 years. The money spent on staff and materials for the additional one year's course can certainly be minimised to a great extent by the amalgamation of schools. Apart from the objections from the womenfolk there is likely to be some obstruction from elsewhere. Want of accommodation, in the existing school, hostel for girls, etc., will be arguments against amalgamation. For a couple of years till the school buildings are enlarged or re-built there is bound to be some inconvenience. This has to be gone through in the interest of the medical education. There will be little or no harm in restricting admission till such time the school buildings are improved. Regarding Hostel accommodation for girls, the present building at Egmore is a rented one and the Government can certainly get a building or a couple of buildings for much cheaper rent in Royapuram than that at Egmore. Let not medical education be sacrificed for sentiments. If the Government entrusts medical relief to honoraries on a large scale as advocated by us elsewhere enough and more money could be saved which could be profitably spent on Medical Education.

A Sound Policy: A question was raised in the Bengal Legislative Council during the last sessions regarding the refusal by the Government permission to the Principal, Calcutta Medical College to act as an examiner for any of the medical examinations or to have private practice of any kind. The Minister in charge of the Local Self-Government said that the Government had refused permission to the Principal of the Calcutta Medical College to act as an examiner. The Minister explained that the Government saw the need for such an administrative policy after the defalcation that took place in the College. A new post of Principal of the College and Superintendent of the Hospital was created in 1930 to enable the person holding these two combined posts to devote his entire time to administrative duties. He had no teaching function and was prohibited from private practice of any kind.

Some years ago the duties of the Superintendent of the Government General Hospital and the Principal, Medical College Madras were entrusted to one person who was then called the Senior Medical Officer, General Hospital. In fact his functions were just the same as those now prescribed for the same post in Calcutta. He was also prohibited from private practice and was not an examiner, nor had he any teaching work. The discipline and administration was most exemplary during those days. What Bengal learnt after defalcation Madras had given up, and the Calcutta history of defalcation which forced the Government to adopt the good old Madras policy, is showing signs of repetition in Madras. The Madras Medical College had a slice of defalcation last year. There seems to be something of the nature in yet another teaching institution. Madras will have soon to take a lesson from Calcutta.

The "Axe" in the Centre: We are glad to note that the Retrenchment Sub-committee appointed by Government of India for general purposes, has recommended the abolition of the posts of the Director General of Medical Services and the Public Health Commissioner and the creation of two new appointments. It is proposed that the work so far done by the Director-General on civil side should be entrusted to an officer to be designated as Medical Adviser and the substitute for the Public Health Commissioner should be called Public Health Officer. Both these officers should form part of the Department represented by them and they should be of the grade of the Deputy Secretary. In the absence of the Public Health Officer on deputation etc., his work should be carried on by the Medical Adviser.

Our readers will recollect that we made a similar suggestion in these columns for the amalgamation of the office of the Surgeon-General and the Director of Public Health. The Local Retrenchment Committee did consider the wisdom of such a change but finally gave up the idea. The recommendation at the centre is likely to be carried out. May we appeal to the Government in the interest of economy and efficient administration to give their best consideration to this subject when the recommendations of the Retrenchment Committee go before them for final decision and combine the two offices in one, designating the new officer as Director of Public Health and Hospitals, making him ex-officio Secretary to the Government in the Department of Medical Relief and Public Health; eventually this officer should be designated as the Medical Officer of Health to the Public Health Ministry.

Robbing Peter to pay Paul: It is strongly rumoured that the Government are taking steps for retiring medical officers who have completed 25 years of service. If this step is really intended as a retrenchment measure, the places falling vacant by such retirements should be filled up by honoraries or abolished, otherwise it will lead to extravagance. If it is for the purpose of confirming temporary Civil Assistant Surgeons in the vacancies caused by the retirement of the officers who have completed 25 years of service, it is nothing but robbing Peter to pay Paul. The services of the temporary Civil Assistant Surgeons must be dispensed with as was done some years back when even those who had served for more than seven years, were sent away. They may be appointed as Clinical Assistants or Honorary Assistant Physicians or Surgeons if qualified for those appointments. We have suggested this procedure in more than one of our previous issues and stated that 13 Civil Surgeons, 10 Civil Assistant Surgeons and 55 Sub-Assistant Surgeons who would have completed 25 years of service by July last, would be fit for retirement.

Most Retrograde Suggestion: The Indian Medical World Advocates a scheme "of training a class of village practitioners with adequate, clear, and definite knowledge of measures (including the use of surgical instruments) that are now adopted for the treatment of such diseases as Kala-Azar, Cholera, MalignantMalaria and others that prevail in the country." Such self trained practitioners now exist on a large scale not only in Bengal but in other provinces as well. They are a menace to the advance of medical science. It is really a strange irony that the editorial policy of the journal of the Indian Medical Association, a progressive scientific body should be so retrograde. There is a large

section in Bengal in the medical profession who rightly condemns the system of medical education now imparted in some of the ill-equipped medical schools recognised by the Government and have been warning the Government that students passed out from such schools would do more harm than good. If ill-trained medical men are condemned what about the class of village practitioners of the standard suggested by the official journal of the Indian Medical Association? We trust better counsel will prevail and the Indian Medical Association will not foster ideas of the nature advocated by their organ, which far from being supported by the profession or the public should be condemned in most emphatic terms. Bengal is surely capable of launching a Rural Medical Relief Scheme worthier than that advocated in the editorial columns of The Indian Medical World. We read and re-read the lecture by Dr. Mallick before the Bengal Branch of the Indian Medical Association which was responsible for the elucidation of the comments in The Indian Medical World. The subject dealt with was quite a different one; it was a lecture on "Position of Indigenous system of Medicine in the solution of Indian medical problem." Neither the lecturer Dr. Mallick nor the chairman of the meeting Rai Bahadur Dr. R. N. Ghouse least hinted about a scheme advocated in The Indian Medical World. Both the lecturer and the chairman pleaded for the adoption of Indigenous Medicine on a larger scale than is being done now by qualified practitioners and wished to establish chairs in the Medical Institutions to teach Indian System of Medicine on a scientific basis. There was no need for such comments at all. It is unpatriotic to consider the lives of the villagers to be so cheap as to entrust them to recognised quacks. They are as dear as they are in cities. Diagnosis and treatment of most common diseases such as those mentioned in the editorial comments, at times, baffle, the most scientific physician. It is the patients that are to be treated and not the diseases and unless and until those who treat patients study the human system in all its details, it will be a culpable offence to entrust ignorant ill-trained practitioners to treat human ills even in villages.

Madras Medical Registration Act to be amended: Mr. Daniel Thomas an M.L.C. has been given the required permission to introduce certain amendments to the existing Medical Registration Act. The amending bill will provide for the association of registered allopathic practitioners with the qualified practitioners of several systems of medicine, also with qualified homeopaths and with qualified but unregistered allopathic practitioners. The machinery for testing qualified practitioners belonging to non-allopathic system has not been mentioned in the bill. Perhaps it is conceded that there is a school of Indian Medicine in Madras run by the Government and the students passed out of this school may be said to be qualified, but we are afraid whether this qualification could be recognised by the existing Medical Council. The other difficulty will be about Homeopathy, as the Government have not so far started a school to teach this system. Perhaps the Bengal Government will soon do so. The Minister in charge of Bengal Medical Portfolio is in favour of it. He is only awaiting for an agitation in this direction.

Unless there is a body for registering qualified practitioners belonging to all systems other than allopathic, the amending bill cannot be a practical proposition. Having too many Councils for the purposes of registration will entail lot of expenditure without proportionate benefits. We wish the Legislative Council appoint a committee to go into the matter of registration of qualified practitioners as a whole and if necessary amend the existing Madras Medical Registration Act in a way to suit the Indian conditions.

Proposed amendment to the Indian Medical Degrees Act: This seems to be a season for amendments of acts concerning medicine. While at Madras the Local Medical Registration Act is to be amended, the Government of India contemplates to amend the Medical Degrees Act on a suggestion from the Government of Bombay. We trust our readers are aware of the existence of the latter Act passed in 1916. This Act is an all India one and prevents quacks from making use of bogus degrees on pain of criminal prosecution. The quacks have proved themselves shrewder than the framers of the Act and are now using titles such as L.M.S.H., M.D.H. etc., indicating

that is an L.M.S. or M.D. of the Homeopathic system. The crime of deceiving the public by the adding of the word Homeopathy or a similar word after the medical qualifications is not cognisable under the existing Act. The Bombay Government have proposed that the existing Act is to be so amended that the above mentioned titles shoul not be made use of by the quacks even with the additional letter or word to denote the particular system to which the quack belongs. The Government of India consulted the Surgeons-General and Inspectors-General on the subject in June 1930 and these officers submitted that the Bombay Government was too drastic and recommended that instead of using the abbreviation of degrees and diplomas granted at present by statutory bodies such as University etc., the quacks should describe themselves in full for example they should not style themselvee as D.M.H. but instead, describe themselves in full as "Doctor of Medicine in Homeopathy."

Treatment of ailments by quacks being certainly dangerous to the public it should be the policy of the Government to prevent quacks by all possible means. The principle of copy-right has not caused any hardship and the law protects such rights in Trade and Commerce. Why should not the Government come to the relief of the public who are today falling easy victims to the quacks? These quacks can use any language and any term to advertise themselves. Registered practitioners are prohibited from advertising. Hence the danger from the quack is all the more. The degrees and diplomas granted by recognised bodies can certainly be treated as a right, not to be used by anybody else, either in full or in abbreviation even with additional qualifying words. The recommendations submitted by the conference of the advisors of the Government cannot certainly serve the purpose of the proposed amendment.

Unholy Crusade: Some time ago, an M.L.C. published a letter in "The Hindu" condemning Honorary System of Medical Relief. Dr. M. S. Krishnamurthi Aiyar wrote a reply in the same paper. We expected that the M. L. C. will be wiser after reading this reply. But—no—he perhaps feels inwardly that his cause is dear and is now trying to get help from out side. He does not mind how and where he gets such help. A labour representative was invited for tea by the Central labour Board of which this M. L. C. was the president and a resolution was passed against the Honorary System of Medical Relief. This subject was quite out of taste on an occasion when a guest is invited for a social function. We wish the M.L.C. reads and re-reads Dr. M. S. Krishnamurthy Aiyar's letter and be more responsible in his utterances though there is no need for it regarding himself as he happens to be a nominated member of the Legislative Council.

South Kanara District Medical Association: The annual gathering of the above Association was held at the Wenlock Hospital, Mangalore on 19-9-31, at 3 p.m. The late Dr. B. Iswarayya, the District Medical Officer and the President of the Association occupied the chair.

This Association came into existence in 1930 early in the month of June at the instance of the late Lt.-Col. D. G. Rai, I. M. S., the then District Medical Officer South Kanara. Registered Medical Practitioners both in service and outside are eligible for membership and may be residential or moffusal throughout South Kanara District. The total number of members on the rolls on 30—6—31, were 23 resident and 18 non-resident. There were 14 meetings held till 30—6—31, for the year, of these two were ordinary business meetings, two special and the rest clinical meetings.

Associations are started and exist for individual and collective benefit of a society. But if the members of the Association are of different feathers their flocking usually does not look homogenous: sooner or later disharmony prevails quite consistent with the laws of nature and consequently such Associations have a mushroom growth. There are signs in the activities of this District Medical Association of valuing the utility of feathers and not the colour in the feathers as was evidenced in the annual gathering when the mantle of the President was thrown over the shoulders of a non-official. We wish that equality of status will not

be in the matter of collection of subscriptions only but would extend to the rights and privileges enjoyed by all members. Then only there will be unity in diversity. We trust the Association will keep up high ideals of equality and progress onwards with speed and zeal evinced by its energetic Secretary who has been unanimously selected for the 2nd term.

Medical Certificates by Honoraries : It was reported in the local nowspapers that the Government had passed orders permitting only Asst. Physicians and Surgeons holding M. B., B. S. qualification to issue medical certificates while on duty in the hospitals. We very much doubt whether the Surgeon-General was consulted before the Government passed this order. There is naturally a strong resentment amongst the non-M. B., B. S. honoraries. If what is reported in newspapers is correct, the action of the Government is as unjustifiable as it is unreasonable. We trust the Head of the Medical Department will soon advise the Government that no distinction should be made in the rights and privileges of honoraries. We may also mention that the Committee on Honorary Medical Officers have recommended to the Government to do away with the designation of Sub-Asst. Surgeon in the honorary system so as to minimise the invidious distinction now prevailing in the profession. Just at this juncture when honorary system is about to be put on trial on a larger scale it is desirable that the Government should forget caste system in the medical relief though it is their own making.

Reduction of Diet in Hospitals : It is most unfortunate that the Government of Madras and Bombay have decided in making a reduction in the diets now allowed in the hospitals. Diet forms part of treatment and those who are entrusted with the lives of the patients should have unlimited discretion in prescribing diet or drugs. Any restrictions in this direction will be detrimental to the well-being of the patients. The largest item of wasteful expenditure is the pay of the officers and we are not tired of expressing our opinion that the only and the best method of effecting retrenchment in the medical department is the substitution of paid officers by the Honoraries both at the top and at the bottom. Vested interests are perhaps more precious than the lives of the patients in Government hospitals!

Patients' Gift : A recreation hall was opened by the Hon. Dewan Bahadur S. K. Kumaraswami Reddiar, Minister for education at the city Tuberculosis Hospital, Royapettah. This, as previously arranged would have been done by the Chief Minister who is in charge of the medical port folio and who could not be present on account of the sad bereavement occasioned by the death of his mother. Opening ceremonies are usually doing direct or indirect educative propaganda and the opening by the Minister for education, of the recreation hall which is intended for a variety of purposes in addition to the purpose indicated by its name, such as, for dining, exercise, to serve as a resting room and a lecture hall for students and practitioners, was most appropriate. The newspaper reading public are certainly benefitted by such opening ceremonies which gives them a graphic description of the prevention of Tuberculosis apart from curing. The public get a guiding as to whom and where to go for advice and treatment.

It has always been a convention that in all such and similar ceremonies the minister in charge of the department and the head of the department are made most conspicuous, and the occasions are such that one has to say about the other and of those who have been responsible to bring about these ceremonies. Dr. Kesava Pai the Superintendent of Tuberculosis hospital has been able to demostrate that grateful patients rich or poor do appreciate the benefits of medical relief and do come forward with their quota towards schemes of public utility if approached in the proper way. If the hospital benefits are not appreciated by the public and if the public do not come forward with donations, contributions and endowments for the purpose of medical relief, the fault lies in the present system of medical relief which is so officialised as to keep away the non-official interests out of reckoning.

Whatever might have been the reasons for the increase of expenditure in other departments which have necessitated the Government to have recourse to the "axe" the heavy expenditure incurred by the Government in the Medical Department

was mainly due to lack of imagination on the part of the Government in not handing over the management of hospitals to non-official agencies.

As is mentioned elsewhere in these columns if the idea of retiring those who have completed 25 years of service, is considered to be practicable, we would suggest to the Government to appoint Dr. Kesava Pai as the First Honorary Medical Officer in the very institution where he has been working so that he can devote the rest of his active life for the anti-tuberculosis work which is so dear to his heart and bring about several institutions to combat Tuberculosis in the city under non-official control.

Ante-natal Clinics : About two years ago Lt. Col. Hingston, the Superintendent of Women and Children Hospital convened a meeting of the practitioners in the City of Madras to impress on them the importance of Ante-natal work which was then about to be commenced both in the hospital at Egmore and Gosha Hospital at Triplicane. He said that a male and a female doctor were specially deputed by the Government for specialisation in this subject in England. He made his audience to understand that facilities will be afforded to the private practitioners to attend these clinics and get their patients treated. Later Dr. Lakshmanaswamy Mudaliar, the 2nd Obsteteric Surgeon of Women and Children Hospital, Egmore conveyed the idea on more than one occasion that it should be made possible for the private practitioners to treat their private patients in the Government hospitals. We have so far no information as to how far these ideas have been given effect to both by Col. Hingston and Dr. Mudaliar. We now learn that at the instance of the Red Cross Society batches of three lady doctors in service are to be posted for training at the Gosha Hospital Ante-natal Clinic which is under the charge of Dr. Mrs. M. John M. B., F. R C. S. It is said that the cost of this training is being met by the Red Cross Society. We welcome the idea and appreciate the services of the society in this direction. But it is not known so far if private lady doctors have any place in this special training. The Government in this country have not realised the fact that the official and non-official section of the medical profession should be treated alike in the medical relief work which must have only one standard and one aim to cure or relieve human sufferings.

The importance of Ante-natal work in the prevention of maternal as well as infant mortality needs no comments. We trust that those who are interested in this work should press upon the Government the necessity of associating members of the independent medical profession with the existing Ante-natal clinics so that in course of time every practitioner male or female are encouraged to do Ante-natal work in their consultation rooms and bring the mortality of the mothers and infants to the lowest minimum possible.

Honorary Medical Officers : We wish to point out the necessity of discussing about the Report of the Committee on Honorary Medical Officers by the various Associations now existing in this province and convey to the Government their considered opinion in time before the Government pass their final orders. The Tanuku Medical Association has been the 1st to consider this report and we have been informed that the Chetty Nad Medical Association meets on the 17th instant, for this purpose. It is also desirable that the medical profession should know the views of the various Associations on this important subject. May we therefore suggest that such of the Associations who pass any resolutions on the report will please send the same to us for publication in these columns There are some Associations in the moffusal consisting of official and non official practitioners and it is feared by some that the official element in such Associations is not likely to favour the idea of the discussion on the report. This difficulty if real may be got over by the non officials alone taking part in the deliberations. The officials cannot have any objection for this course.

ERRATA : In September issue on page 424, line 29, 'male' to be read as female ; page 451, line 20, '6' to be read as '4'.

Correspondence, Reports, etc.

Dentistry in Madras.

Though many of us may be anxious to read something about "Dentistry" it is very unfortunate that medical journals do not contain articles on this important subject. As far as I know there are only three persons who possess British qualification L. D. S., R. C. S. (Eng.) in the whole presidency. In the whole of India there is not even one recognised college that gives a full course and diploma in dentistry. I find several medical men are not aware of the fact that they can get dental training in the Government Dental Hospital, Madras in accordance with G. O. No. 2221 P. H., dated 2nd November 19_5. This course is open to registered medical practitioners only just like L. O. and L. T. M. Though this is in existence for several years it seems there are not even a dozen men who have finished this training. It is to be regretted that only two or three District Hospitals are provided with dental clinics though the fact is universally recognised that a large bulk of human ailments are due to oral sepsis.

There are several reasons why qualified medical men do not take up dentistry. When one takes up dentistry he has no time for general practice. One or two cases a day will absorb much of his time and energy. He has to bend down, according to the position of the patient in spite of all the conveniences in a dental chair, which all dentists cannot afford to have, drive his engine with his legs and use his hands in adjusting the patient and the hand piece of the engine. All this time the eyes of the operator are to be fixed to the bar of the hand piece that is playing over the teeth the slightest miss of which will do immense harm to the patient. If a case of tartar of the teeth requires scaling and it is to be finished in one sitting it will take about two hours and by the time the operation is finished, the operator gets completely tired. The remuneration for such a tiresome job is not worth mentioning. The operation of extraction is a destructive one and that is not generally liked by the patient unless there is unbearable pain and he is convinced that it cannot be relieved by anything less. Here again the fee is a pittance when compared with the fees earned in general practice. To add to this the registered medical practitioner with dental training has to compete with the so called dental-surgeons who are neither qualified to practice medicine or dentistry nor have spent any money or years to learn the science but are capable of cheating the public in all possible ways. These attract the public by huge glittering signboards calling themselvesDental-Surgeons. When Patients and their friends see the shining brass signboard with all its majestic appearance in an attractive building of a busy street they naturally feel they have a reliable qualified dentist and enter in to see a young man well dressed in the most up-to-date western fashion. The patient will not dare to ask him anything regarding his qualification and by chance if some such talk arises the 'Dr' is able to tell any amout of lies in his polished ways in trying to convince them that he has taken a course in some non-existing dental college in the upper north or the far east.

These cheats boldly use the prefix 'Dr,' and they call themselves Dental-Surgeons. They use several varieties of titles behind their names. The chief among them is C. D. S. to mean Certified Dental Surgeon. Wherefrom this certificate comes no one knows I have known servant boys working under such self-made Dental-Surgeons become independent practitioners just after a few months with C. D. S. in their signboards. Another such diploma is L.H.D.S.to mean Licentiate in Homeopathic Dental Surgery.

Bogus diplomas are awarded in Dentistry as in Medicine and Surgery by persons who run bogus institutions, the tuition being usually by post. The Government unfortunately have not as yet come forward with measures to prevent cruelty to human beings though a department called S. P. C. A. has been brought into existence by social workers at the instance of the Government to prevent cruelty to animals. Quacks and charlatans have taken advantage of the callousness of the Government and are multiplying every day.

If proper steps are taken by the Government to put an end to quacks in dentistry as well as in medicine and surgery, there will be a stimulus to young men to take to the profession of healing art in larger numbers. A diploma in Dentist is a desideratum and the Government will be well advised, if they bring into existence a Dental School to award Diploma in Dentistry. Suitable fees may be charged and collected from students to make such an Institution self supporting.

Govt. H. Qrs. Hospital, Madura. D. NAINAR, Hony. Dental Surgeon.

Honorary Medical Officers

A MADRAS MEETING.

(REPORT OF THE PROCEEDINGS.)

A meeting of the private medical practitioners of the city of Madras was convened by Dr. M. S. Krishnamurthi Aiyar, Editor, The Medical Practitioner, on Sunday 4th instant, at 2 P.M. The meeting was held in the Council Chambers, Ripon Buildings; the attendance was fairly good.

Before the proceedings commenced Dr. Nimbkar questioned the authority of the convener for holding the meeting which he said could be done only under the auspices of the South Indian Medical Union. For sometime great anxiety was felt whether Dr. Nimbkar and a few others who were with him, all members of the South Indian Medical Union would allow the gathering to go on peacefully with the proceedings. The convener who was heckled with all sort of questions by the few obstructionists remained calm in spite of grave provocation and proposed Dr. T.V. Ranganath Rao to the chair.

Proceedings having commenced Dr. Nimbkar proposed that the meeting be dissolved and that the South Indian Medical Union be requested to hold a meeting of the private practitioners for the purpose of discussing about the Report of the Committee on Honorary Medical Officers. This resolution was seconded by Dr. U. K. L. Narayana Rao and supported by Dr. U. Krishna Rau. The resolution being put to vote and lost Dr Nimbkar, left the hall followed by Drs. U. Rama Rau, U. Krishna Rau, U. K. L. Narayana Rau, Sanjeeva Rau and one or two more. Then the proceedings went on most peacefully and the following resolutions were passed:—

1. The meeting while approving the suggestion of the Committee to do away with the designation of Sub-Assistant Surgeon in the honorary system of medical relief scheme, wish to point out to the Government that the honoraries should be so designated as to connote the nature of work they do in a particular institution, whether as Assistant or Chief.

2. The meeting is of opinion that medicoes including those trained by the Government for Civil or Military duty passing from medical schools and colleges should undergo training as house surgeons and house physicians for one year before they are eligible for registration.

3. The meeting is of opinion that clinical assistants should be paid a monthly honorarium of Rs. 50 in the moffussal and Rs. 75 in the city and should be debarred from private practice.

4. That in the opinion of the meeting honorary assistant surgeons and physicians should have a fixed tenure for a period of 5 years to make room for other recruits and ordinarily these assistants should be selected from clinical assistants, but provision should be made for recruiting honorary assistants from private registered practitioners who should have been in actual practice for at least 5 years and these should be given a carriage allowance of Rs. 30 in the moffussal and Rs. 50 in the city.

5. The tenure of office of honorary physicians and surgeons should be ordinarily for 10 years, so as to make room for honorary assistants; and honorary assistant surgeons and physicians who have put in five years' service should be eligible for these appointments and also private medical practitioners of not less than 10 years practice.

6. The meeting suggests to the Government that the recommending authority for honorary appointments should be a committee consisting of the Surgeon-General and two independent medical practitioners other than honoraries.

7. Regarding the Committee's recommendation XIV(2) concerning the appointment of honoraries for administrative work the meeting is of opinion that no honorarium should be paid but in case they are entrusted with the teaching work they should be given suitable allowance for such work.

8. The meeting is of opinion that there is no need for the provision of the confidential report even in a modified form and reports against or in favour of the honoraries should be made openly to the recommending authority.

The meeting discussed about the advisability of passing their opinion regarding the Indian Medical Council Bill. But as the whole Bill was not before them they passed the following resolution :

9. The meeting understands that a large section of medical practitioners registered in the provincial registers will not be treated as recognised medical practitioners for the purpose of Indian Medical Council Bill and considers that this omission is unjust and detrimental to the interest and unity of the medical profession and will be definitely against the very aims and objects of the contemplated special legislation.

10. The meeting thanks the Corporation authorities for permitting the use of the Council Chambers for conducting the proceedings of the meeting.

A vote of thanks to the chair was also passed unanimously.

A MEETING AT TANUKU.

The non-official section of the Tanuku Medical Association passed the following resolutions at their meeting held on 27—9—31.

(1) This association thanks the committee for recommending equal facilities and opportunities for all grades of medical qualifications.

(2) This association is of opinion that unless the duties of the three grades of Honorary Medical Officers, Clinical Assistant, Assistant Surgeon, Physician, or Surgeon are clearly defined it is not possible for the would-be applicants to take advantage of the scheme. Therefore this association requests the Committee to define the various duties before further action is contemplated.

(3) This association is of opinion that all Honorary House Surgeons and Physicians should be paid an honorarium of not less than Rs. 50/- per month.

(4) (a) To make the Honorary system workable and attractive this association is of opinion that Government should declare it as their policy that the paid medical staff will be replaced entirely (in a certain minimum period) as vacancies occur by the honorary medical staff and further recruitment to paid services will be stopped hereafter.

(b) This association further is of opinion that as a token of the above policy the Government should appoint Honorary Medical Officers permanently in such of the posts as have fallen vacant, and for this purpose should invite applications from would-be candidates from among Private Medical Practitioners.

(5) This association recommends that a small representative Committee of the Honorary Medical Staff of the Presidency be formed with the Surgeon-General as Chairman (for the present) to deal with matters concerning this side of the profession. The decision of the Committee be binding on the Chairman. In cases of difference of opinion the Minister-in-charge should be appealed to who should have the final say in the matter

(6) The association is of opinion as regards the report in The Hindu of 22nd September 1931 that Honorary Assistant Surgeons who hold M. B., B. S. degree have been empowered to grant medical certificates, that it is contrary to the spirit of clause I of recommendations of the committee on Honorary system and as such recommends that all Honorary Officers eligible to hold appointments to grades of at least 2 and 3 (i. e.) Honorary Assistant Surgeon and Honorary Physician and Surgeon irrespective of their qualifications, be empowered to issue Certificates.

Retrenchment.

Colonel Bhola Nauth, I. M, S. (Retd) writes from Lahore :—

My view is this, that for retrenchment to be genuine and effective a few preliminary considerations are necessary. It must be recognised that India is a poor country which cannot afford the luxury of a costly administration. This fact however would be recognised if the interests of the Government and the governed were identical, which unfortunately is not the case. It is unnecessary to point out that foreign labour, whether hand or mental is always more

expensive than home labour. The employment of foreigners in the Indian services will continue sq long as the tax-payer has only to pay the piper but cannot call the tune.

It has been amply proved that Indian medical men whether trained in India or in England, are just as good and in several respects preferable to Englishmen. For the economical working of a department it is necessary that its administration should not be top heavy and that the employees do not receive wages out of proportion to the amount of work they are called upon to do If the considerations noted above are not conceded then all talk of retrenchment is a sham and hypocrisy. That the Government do not admit these considerations is evident from the way in which they have approached the subject.

Is any retrenchment possible when you are up against the dead wall of parliamentary statutes, and other such obligations? Is any retrenchment possible when the devolution rules thrust down your provincial throat a fixed number of officers with fixed emoluments for whom you have to find jobs whether you can afford it or not ? You may shift them from place to place if you like, but their number you cannot reduce and their emoluments you cannot touch. Is any retrenchment possible when the bogy of efficiency is staring you in the face whichever way you turn?

Can you expect a service man to make proposals for the reduction of his own income, and offer his neck to the axe ? Retrenchment means the relinquishment of a portion of one's income to enable the country to live within its means and be able to balance its budget. It involves self sacrifice. Harikari may be a laudable cult with the Japanese but it is not so with the matter of fact Britain.

They don't mean to retrench and they don't intend to retrench. Do you imagine it requires a Retrenchment Committee to tell the Government of India that medicine is a transferred subject therefore the retention of the D.G.I M.S. is a white elephant, that the provincial Surgeon-Generals and I.G.C.Hs. are a superfluity, that it is a waste of public money to employ a chain of highly paid I.M.S. men in the medical stores department, that it is cheaper to amalgamate the chemical examiners with the pathologist and bacteriologists, that scores of experienced and well qualified medical men both retired I.M.S. and non service men are available for honorary work? But no one is more blind than the one who will not see.

With these remarks I give you briefly my views on the proposals. Postponement of repairs and additions to the existing buildings etc., temporary stoppage of grants and reduction in the purchase of stores are items of expenditure presumably budgetted for in the interest of the patient. If this is disallowed it means that savings is being made at the expense of the patient.

Abolition of a civil surgeoncy, abolition of a medical school, cutting down travelling allowances, etc., I am afraid, I do not know the local condition to be to give opinion. If in the opinion of the Committee an office can be run better with fewer clerks or no clerks if patients could be looked after without a compounder or nurses or if latrines can be kept clean without sweepers, do away with not one menial servant but with all of them. But one may be pardoned to enquire as to how many lakhs of rupees do they hope to save by further starving these semi-starved devils.

Abolition of assistants to some of the professors in the college, substitution of non-medical professors for medical professors in Chemistry and Biology, reduction of the grade of Anæsthetist and Pharmacologist from civil surgeon to assistant surgeon grade, postponement of study leave and periodical training etc., are in my opinion items of retrenchment that should be given effect to.

Regarding enhancement of college fees it would mean shutting the door of education and after all how many millions will these bring to the coffers of the Government ?

Regarding extention of honorary system you may add not one but 20 honorary surgeons and physicians to the fixed number of I.M.S. men and it will not make the slightest difference as far the expenditure is concerned.

When all is said and done how much revenue will be saved by these wonderful

proposals and what will be its value against the loss of efficiency which must follow in their wake, is it worthy? In my opinion the recommendation of the retrenchment committee as a whole are not only futile but puerile. If Government had men of business they would not have packed this committee with men who have no service experience and knew nothing about the administration of a department on the technical working of which they were made to sit in judgment. Could one expect any other kind of report from such a committee?

A new successful treatment for Pneumonia.

Some doctors may consider this treatment for Pneumonia peculiar, but its success seems to merit further attention.

A young man of thirty sought my treatment for fever, dyspnea and a certain amount of toxemia. He had cough and was expectorating profusely. On examining the lungs, I found out that in the right lung in front and behind there were bronchial breathing and crepitations. Heart was quite normal. It was on the third day that the patient came under my care. I gave him the routine expectorant mixture with diaphoretics and some counter-irritants for the lung inflammation. In addition to this usual treatment I injected 5 c. c. of Iodaseptine. With another injection on the third day of my treatment, the temperature came down by crisis, quite a desirable effect in Pneumonia. The fever did not rise after that and the process of inflammation in the lungs was cut short much before its usual period and the lungs rapidly began to resolve.

In this case it is important to note that no harmful effect was observed on the cardio-vascular system, neither was there any rash due to iodism or any unpleasant by-effects.

G. M. DHURANDHAR,
M. B. B. S.

M.B.B.S., Course for L.M.P's.

Sir,

With reference to the welcome and valuable information published in The Medical Practitioner from time to time with regard to the opportunities for L.M.Ps to qualify themselver for M B.B.S. may I request you to kindly enlighten your readers on the following.

Many institutions have been publishing that they would give postal tuition for L.M.Ps to appear for the Cambridge Senior Examination which is the preliminary test to be undergone by an L.M.P., to qualify himself for M.B.B.S.

Can you kindly ascertain and publish in your journal the courses of study and curriculum for the said examination so that candidates can study without the necessity of approaching the institutions to give them postal tuition.

Another thing that worries the L.M Ps in Government service is, regarding the possibility of their getting leave for two years to enable them to join a medical college and undergo the necessary courses.

Unless the Government is kind enough to devise means to enable the L.M Ps under service to get two years leave, the concession granted by the Madras University cannot be availed of. The Sub-Assistant Surgeons in service will be obliged to you if you kindly suggest a solution to enable them to take advantage of the concession.

M. V. HANUMANTHA RAU, L.M.P.

[*We hope to deal with this subject in the next issue.—Ed.*]

The Malabar District Medical Association.

A meeting of the Malabar District Medical Association was held on 22nd August, '31' in the Paran Hall, Calicut, under the Presidency of Dr. A. P. Balram, the Vice-Presidnt of the Association.

Dr. (Miss) V. Janaki, who had promised to read a paper on "Child Welfare" was unavoidably absent. Her letter was read and recorded.

Dr. V. Krishna Menon next moved the following resolution :—

This Association while thanking Dr. M. R. Guruswamy Mudaliar for opening a new avenue for the L.M.Ps to qualify themselves for the M.B.B.S. is emphatically of opinion that the regulation passed by the Academic Council of the University of Madras at its meeting held on 14th March '31 is highly impracticable and nullifies its object in as much as the passing of the Intermediate Examination is an unnecessary proviso and insuperable impediment, and requests the Board of Studies and the Academic Council of the University of Madras to reconsider its resolution and allow the L.M.Ps who have undergone the full course in Medicine, Surgery and Midwifery and acquired a general proficiency in these subjects to undergo two years course in a recognized Medical College and to appear for the M.B.B,S. Examination."

Dr. C. V. Narayana Iyer seconded the resolution. After full discussion the resolution was put to vote and passed unanimously.

The following resolution wasi then moved from the chair:

"This association records with extreme regret the sudden and untimely demise of Major Khandwalla, I.M.S. a sympathetic Officer of Cannanore Central Jail and very popular figure in the District and desires to convey to his family the extreme sorrow felt by this Association."

The resolution was passed unanimously all members standing.

Dr. C. V. Narayana Iyer then moved the following resolution, which was seconded by Dr. J. Herbert and passed unanimously all members standing.

"This Association learns with deep sorrow the loss that Rao Saheb Dr. A. Gopalan has sustained by the passing away of his wife and desires to convey to him and his two sons, who are members of this Association, their deep condolence."

Honorary Medical Officers.

Under the auspices of the All-India Licentiates Association a meeting was convened by Dr. D. V. Venkappa, Provincial Secretary on 11—10—'31 at 98, Godown Street, Madras to protest against the exclusion of the Licentiates in the purview of the proposed Indian Medical Council Bill. Dr. U. Rama Rau presided. The following resolutions were unanimously passed.

(1) The meeting strongly protests against the exclusion of the Licentiates and other medical diploma holders from Indian schools and colleges in the purview of the Indian Medical Council Bill and wishes to point out to the Government that the proposed legislation will not only not serve the interest of the medical profession in India and disorganize the same still further but also defeat the very aims and objects of the bill in the matter of establishing "a uniform minimum standard of qualifications in medicine from all provinces such that persons attaining thereto shall be acceptable as medical practitioners throughout British India."

(2) The meeting appeals to all the branches of the association in the country to organize protest meetings and carry on intensive propaganda

(3) The meeting appeals to the Madras Medical Council to recommend to the

Government to include in the proposed Indian Medical Registrar all registered practitioners in the provincial register.

That a deputation consisting of Drs. U. Rama Rau, D. V. Venkappa, V. Rama Kamath, K. B Bhujanga Rau, R. Ramanujalu Naidu, K. S. Sivaramakrishna Iyer do wait on the Government to press the claims of the Licentiate in the proposed Indian Medical Council Bill.

Printer's Omission: In page 22 current issue, line 8, after the word 'Board' read as "who seem to have recommended eight months' leave."

Reviews.

THE PSYCHIATRIC STUDY OF PROBLEM CHILDREN.

BY

SANGER BROWN, II, M. D. ASSISTANT COMMISSIONER, DEPARTMENT OF MENTAL HYGIENE, STATE OF NEW YORK AND HOWARD W. POTTOR, M. D., ASSISTANT DIRECTOR, PSYCHIATRIC INSTITUTE AND HOSPITAL AND CLINICAL PROFESSOR OF PSYCHIATRY, COLUMBIA UNIVERSITY, NEW YORK,—PUBLISHED BY THE NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE, ALBANY, N. Y.

Psychiatric problems are not dealt with in India to the extent they deserve in spite of the fact that admissions in Mental Hospitals are ever on the increase. Child being the father of man it is essential that the general outlines of the methods of examination of school-children should be improved in such a manner that the school Medical Inspector should have clear instructions as to how to go about a case regarding the mental development, apart from other physical, clinical and laboratory methods employed in the routine examination of school-children. Examination of school-children in India is still in a primitive stage and unless and until the public, the Government and the medical profession co-operate heartily in this work, it is bound to be very unsatisfactory. For this and similar work those interested should have inspiration from countries like America where progress in these problems has been as quick as it is rational and scientific. The book under review on Psychiartic Study of children by the New York State Department of Mental Hygiene deals in a concise way the psychiatric problems in children and will be very useful to the members of the medical profession and others who are interested in the bringing up of healthy children who form the future nation. The book is written in elegant style and though technical in nature could easily be understood even by the laity. This will be a valuable addition to the library of every medical man especially of those engaged in school hygiene.

V. R. K.

A PSYCHIATRIC WORD BOOK.

BY

RICHARD H. HUTCHINGS, M.D., FELLOW OF THE AMERICAN PSYCHIATRIC ASSOCIATION, MEMBER OF THE AMERICAN PSYCHOANALYTIC ASSOCIATION ETC.—PUBLISHED BY THE STATE HOSPITAL PRESS; UTISA, N. Y.

This book is a lexicon of terms employed in Phychiatry, and other allied mental science. The branch of medicine dealing with mental conditions is rapidly advancing and developing in a way that it is not possible for the medical profession in all its branches to loose sight of the rapid strides in Psychiatry. Whether in infancy, childhood, adolescence, at home, school or factory problems of inefficiency and maladjustment are confronting the profession. So, it is essential for students and practitioners to have with them a book for easy reference regarding the terminology of neurological words employed is Psychiatry. For this purpose we recommend the above book which is neat, handy, useful and can be easily carried in the coat-pockets without any discomfort.

V. R. K.

THE TREATMENT OF FRACTURES.

BY

LORENZ BOHLER, M.D., CHIEF SURGEON AND DIRECTOR OF THE VIENNA ACCIDENT HOSPITAL—AUTHORISED ENGLISH TRANSLATION BY M. E. STEINBURG, M. S., M. D., OF PORTLAND, OREGON—SECOND EDITION WITH 234 ILLUSTRATIONS—PUBLISHED BY MESSERS. WILHELM MAUDRICH, VIENNA.

The author has in the course of his 19 years experience, treated more than 10,000 cases of fractures, studied about 17,000, dissected more than 300 fractures on the post mortem table, chiefly during the Great War and has also taught a large number of post-graduates. Evidently he must have come across every variety of fracture from the simplest to the most complicated, from every point of view. These facts themselves are sufficient to recommend the book which has been written in a lucid and an impressive style and which leaves no room for any hesitancy as regards adoption of treatment advocated in this volume. The author lays great stress on some of the points which are many a time, missed by the general practitioner, such as a sound knowledge of Anatomy, attention to minute details in the reduction and immobilization, proper assistance, want of due regard to many points such as action of muscles function of adjoining joints, time of solid and strong union etc. Non-compliance of these details has ended many a time in disastrous results to the patients. The author does not bind himself down to any particular creed of treatment, but demonstrates in the most convincing manner the utility of a particular treatment in any particular case. There is no doubt, as the author himself says that some of the treatments may not be possible in private houses and can only be adopted in well organised Clinics This book is a sound exposition of the latest treatment of fractures by one whose aim is not merely to have union of the fragments, but to have all the normal functions of the bones and joints restored. We strongly recommend this book to the general practitioners as well as to specialists interested in Orthopaedics.

W. J. F.

JOURNAL OF INTRAVENOUS MEDICATION.

The Editor Dr. D. M. Vasavada, L.M.S. has made out a case for bringing out a journal specially devoted to Intravenous Medication It is for the Profession to decide and prove the necessity of the existence of a journal which should run its life as a seperate entity. As in this and other spheres of activities of journalism, the scope and usefulness of a particular organ mainly depends upon those who conduct such journals We congratulate Dr. Vasavada for his zeal and earnestness to serve the profession in an unique yet useful way by narrating and compiling his own experience in intravenous medication and those of other medical men in the form of a journal. We wish him success.

V. R. K.

No.	Names of Sub-Asst. Surgeons	From	To
1.	Dr. V. Sundaresan.	Govt. Hd. Qrs. Hl., Coconada.	Govt. Royapuram Hl., Madras.
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The Medical Practitioner

A Monthly Medical Journal

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AND
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CONTENTS.

Business Notice.

Scientific articles and notes of interest to the profession are solicited. Contributors of original articles will receive a copy of the journal in which they are published.

Communications on all matters connected with the journal, literary and business should be addressed to the Managing Editor, 147, Purasawalkam High Road, Vepery Madras, as he alone is responsible for the conduct of the journal. Annual subscription to the journal is Rs. 1—8—0 including postage, payable in advance. Papers and articles forwarded for publication should be either typed or written legibly on only one side of the paper. They are understood to be offered to "The Medical Practitioner" alone and any breach of this rule will be followed by non-publication. When any such of the article appears in "The Medical Practitioner" the copyright automatically becomes the joint property of the author or authors and of the publishers. Paper and articles sent will be sent back to the contributors, if so desired, and postage sent for the purpose. The Editors of "The Medical Practitioner" cannot advise correspondents with regard to prescriptions, diagnosis, etc., nor can they recommend individual practitioner by name as such action would constitute a breach of professional etiquette.

In response to this agitation, the Government raised the starting pay of the Assistant Surgeons from Rs. 100 to Rs. 200 and of the Sub-Assistant Surgeons from Rs. 25 to Rs. 75 and now the former can aspire to get Rs. 1,200 and the latter Rs. 200 a month. Some of the Govern ment medical officers instead of restricting private practice within the strictest limits of consultation or treatment are now making a business of such consultations and treatment in the way in which private practitioners carry on medical practice. The following are a few examples of the misuse of the term of private practice by state-paid officers :—

(1) Running dispensaries at their residences for the use of their patients without calling this business by any name.

(2) Having some understanding with Chemists and getting commission on the sale proceeds of their prescriptions without any room for consultation in such shops.

(3) Attaching themselves to Chemists' shops and soliciting work by putting in boards with their names and official designations.

(4) Owning Chemist shops, Laboratories and doing business in the premises.

(5) Running Nursing Homes, Surgical or Medical or both.

On 19-3-28, Hon'ble Mr. A. B. Shetty, M.L.C. asked the then Minister:

(*a*) Why the Government allows the right of private practice to its medical officers alone, while the men in other departments like that of Engineering are denied any such privilege and,

(*b*) Whether there are instances of medical men in the service of the Government being consultants of particular chemists' shops or the owners of such shops and whether these officers could run any business of a remunerative nature.

The then Minister answered saying that the Government consider that until the independent medical profession in this Presidency was in a position to satisfy the medical needs of the people, the latter should not be deprived of the services of the Government Medical Officers. These answers though vague show as was mentioned by us a little while ago that the government medical men were allowed private practice not with the idea of supplementing their income but to afford treatment to the public as the Government thought there were not sufficient number of medical practitioners in this country. Regarding the 2nd question the Minister answered that he had no information. The diarchial system of Government has necessarily been responsible to give a second body and soul to the popular Ministers apart from those they own by birth and consequently they cannot see or hear as ordinary human beings do. We have questioned the correctness of such statements in these columns more than once by quoting the figures collected by Lt. Col. Bradfield in his lecture delivered some time back before the Madras Branch of the British Medical Association. According to the statistics collected by him in Madras in 1928, there was roughly one Doctor for every 840 of the population which is a higher figure than that in British Isles where there was one Doctor for every 920 of the population. The Government cannot deny the fact that specific instances of the medical officers having private business of their own, referred to above, have been brought to their notice. The explanation Government got from these officers must have afforded sufficient justification to prove what was referred to in the second para of the answer from the Minister to Mr. A. B. Shetty.

From the nature of interpellations and answers elicited so far one could easily see that the Government are conscious that there is abuse of the privilege of private practice, yet they do not feel bold to admit the same. The answers given by the Minister to Mr. A. B. Shetty's interpellations on 19-3-28 and recently by the present Minister during the last legislative session will bear testimony to the weakness displayed by the Government in handling this vicious situation in the medical department. The facts that the Government issued orders in 1928 through the Surgeon-General warning some of the Assistant surgeons who were openly running business of the nature referred to above and the Minister's

statement on 28-2-31 that the running of nursing homes was against the existing rules of service and his last statement on 29-10-31, indicate how matters are shifted and drifted when medical officers at the top of medical services are concerned in the infringement of public service rules,

The policy of "drift" in the matter of discipline will merely lead on to demoralisation. The "humbler folk" in the medical services who were warned against the infringement of rules have not and would not respect the Surgeon-General's orders warning them against misusing the right of practice as the principle involved in the running of private nursing homes, conducting pharmacies and associating with chemists were identical. Consequently it has not been possible for the head of the department to take any disciplinary action against medical officers who are directly or indirectly conducting pharmacies or associating with chemists. The answers given by the Minister on 26-3-31 on the floor of the Legislative Council to a question from Mr. A. B. Shetty that neither the Government nor the Surgeon-General had any information regarding the continuation of the misuse of the private practice, is not altogether correct. We have information that the Surgeon-General did receive at least one complaint wherein specific instances were brought to his notice. But no serious notice was taken about it. Perhaps under existing circumstances when the prominent members of service who are engaged in the training of medical students in medical College and when one of them did even act for the Surgeon-General, it has not been found possible or expedient to treat such complaints with any seriousness.

The fact there is misuse of the privileges of private practice by the government medical officers, cannot now be denied. But it is feared that the Government do not wish to take serious notice of what is going on. We ask the Government with all seriousness whether it is not detrimental to public interest if this state of affairs in Medical Department is allowed to continue. Is it not a strange irony that majority of the medical officers who are now engaged in running private business, at least in the city, are amongst the higher and the provincial service, all of them having the double responsibility of hospital and teaching work. It can never be possible for these to devote as much attention to the work they are expected to do and for which the Government pays them handsomely. This apart, the discipline in the institutions will suffer seriously. On 26-2-31 the Government got information on the floor of the Legislative Council that some time ago the Superintendent, Government General Hospital had the necessity of warning the staff against late attendance. We are sure that the particular Superintendent of the Hospital who was debarred from private practice except of a consulting nature but who could not be said to be free from blame in this respect, was not able to command any discipline as he did almost the same work as the other members did with regard to private practice though perhaps he kept up his time regarding hospital attendance.

The members of the "humbler folk" who are running chemists shops or are the associates of chemists usually have the services of those above them in the Medical College or General Hospital for consultation and it is but human that the "humbler folk" not only escape any notice regarding indiscipline but have been able to remain in the city for more than 5 years, a concession which is denied by the service rules to others in the same position. Consequently they have been able to continue their private business uninterruptedly. Some of the students passed out from medical college after being employed under the Government, have copied what their teachers do and the Government cannot say that they are unaware of these allegations. There are complaints from moffusal that some of the medical officers are utilising hospitals as private Nursing Homes. If the Government do not condemn these baneful practices, the consequences will be most disastrous especially as those concerned in these practices happen to be in

charge of medical education and medical examinations and there are signs for a tendency on the part of the students to take advantage of the business run by their Professors and their Assistants.

Apart from loss of discipline and money on the part of the Government on account of the misuse of the private practice, the Government should know that such practices are thwarting the healthy growth of the independent medical profession on account of the unequal and unwholesome competition between them and the state-paid officers. The Government have now under its employ only about 900 doctors of all grades and on a rough basis it is calculated that at the rate of 6 for rural and 12 for urban areas for every 10,000 unit of the population, there should be 25,000 medical practitioners to satisfy the needs of the medical relief in this province. The proceedings of the Retrenchment Committee have indicated that the Government find it difficult to pay even these 900 doctors, now under their employ. It will never be possible at any time for the Government to employ 25,000 doctors. So, it is on the independent medical profession that the Government and the public have to depend for medical relief. It is therefore imperative that the Government should encourage the growth of the independent medical profession by all possible ways.

The principle of honorary system of medical relief has been acknowledged by the Government and it is expected eventually that the honoraries should replace the paid staff. The honoraries who spend part of their earning hours in hospital service, will certainly be handicapped if the state-paid practitioners are allowed to infringe their rights of private practice. Consequently first-rate medical practitioners will never offer their services for honorary work. So, as suggested by us once before in the interest of the public and the profession it is essential that the Government appoint a Committee of officials and non-officials from the medical profession and outside to go into the question of prohibition and restriction of private practice by state-paid-officers and in the meanwhile the Government should lose no time in defining the terms private practice and consulting practice and their limits, for the guidance of all concerned. In the Federated Malay States and Strait Settlements medical men under Government employ are prohibited from private practice and such a system has been working quite smoothly ever since the British landed in that country. There need not be any cause for anxiety or hesitation on the part of the Government to try here what has been tried and found successful in a colony under their rule.

THE INDIAN MEDICAL COUNCIL.

An appeal.

We learn on good authority that the Government made it clear before the Conference at Simla which met in June 1930 to consider about the desirability of constituting an All India Medical Council, that the proposed Council had nothing to do with the decision of the Medical Council and that the object of the proposed Bill was entirely for the purpose of improving the medical education in this country. We are surprised that quite contrary to this understanding the Government of India have addressed letters to the Provincial Governments asking their opinion on the proposed Indian Medical Council Bill wherein the necessity for having an All India Medical Council is mentioned in the following words.

"If Indian medical students were to be relieved of the hardships to which the decision of the General Medical Council exposed them, it was imperative to resume consideration of the proposal for the establishment of an All India Medical Council, as the creation of such a Council, offers the best, if not the only, prospect of again securing the General Medical Council's recognition of Indian degrees."

When the Legislative Assembly vetoed the appointment of a Commissioner, the General Medical Council hurled upon the Indian Universities a thunderbolt refusing recognition of medical degress conferred by these bodies. Soon after, from the opinions expressed in this country both by the profession and the lay public one could judge that the thunderbolt

instead of enervating the profession would innerve them and it was then said that a prominent member of the medical profession in Bombay, an M.L.C., would move an amending Bill at the Bombay Legislative Council with a view to rescind all the privileges which are conferred by the Bombay Medical Act on the holders of the British Medical qualifications in that Presidency. Similar action was thought about in other Provincial Councils. Eminent members of the profession gave expression to the views that the establishment of an Indian Medical Council should be proceeded with as early as possible and the provisions for the permission of the foreign nationals to practise in India should be modelled on the lines of the Egyptian Medical Act which made it compulsory for foreign nationals who wanted to practise in Egypt to pass an examination to be held by a special board of examiners. It was also then mentioned that out of about 450 medical students undergoing medical studies in England, about 360 students had their medical education in India and there were only about 40 or 50 under graduates who were studying in British Medical Schools and it was therefore rightly urged that a special provision should be made in the All India Act on the Egyptian model referred to above and with a clause that the Indian nationals with English qualifications would be admitted in the Indian Register till 1935. Regarding post-graduates study in England, it was said that there could be no difficulty at all so long the required fees were paid and the practitioners were registered in their own country. Opinions were also expressed that Practitioners from America, Portugal and other countries whose qualifications were not recognised in the United Kingdom were now freely admitted for post-graduate course in any part of the British Isles and that Indians likewise could enjoy the same privileges. These were the reciprocal feelings expressed in India in 1930 soon after the ban was placed by the General Medical Council on Indian University Medical degrees. Now instead of a Commission the Government of India wishes to constitute a more costly machinery of a Medical Council for the same purpose, which will on a meagre scale cost the Government a recurring expenditure of Rs. 90,000 a year and such an Indian Council indirectly puts a ban on nearly 75 per cent of the existing qualified and registered practitioners. If the ban on Indian graduates who are only about 1/4th strength of the profession in this country was felt so keen because they were not recognised to practise in foreign countries what should be the measure of indignation and with it the humiliation felt by the largest section if the medical profession in this country if this legislative measure were to exclude them from the Indian Register? It is very painful to read in the letter addressed by India Government to the provincial Governments the following sentences:—

"The question of bringing licentiates within the scope of the All India Council was raised in this Department letter No. 903-H, dated the 23rd, May 1928; the opinions then expressed were, with very few exceptions, in favour of confining the Council to dealing with graduate qualifications. The Conference of June 1930, was also of opinion, that the Council should, at any rate at the start, deal only with such qualifications, and the Government of India think that in the present state of medical education in the country there is much to be said for that view."

Fortunately the Government of India are still keeping an open mind on this subject and they have asked the local Governments to communicate their opinion for bringing the Licentiates within the purview of the proposed Council. We are glad to say that as far as Madras Presidency is concerned the concensus of opinion, excepting a few at the top, is in favour of not excluding the Licentiates. It is a very pleasant irony that Madras though nicknamed, the benighted, has always been more progressive in its ideals. So long the leaders play their part well, Madras always had been in the forefront regarding reforms. The present struggle for Home Rule or call it by any name began first in right earnest in Madras. Medical Associations in the city as well as in the moffussal, have whenever opportunities arose expressed themselves in favour of the inclusion of the Licentiates within the purview of the proposed

Council and it is said that the Madras Medical Council, at their last sessions have also recommended the inclusion of the Licentiates in the proposed Council. Representatives of the Licentiates in Madras will soon wait on the member of the Cabinet, in-charge of the Medical Registration, to press the claims of the Licentiates and their work has been made easy by the opinions expressed in favour of their inclusion throughout the Province by the profession and we hope that the Madras Government will voice the true feelings in this Province when they send a reply to the Government of India. A representative Conference of all grades of practitioners in India which met in Poona last April, did recommend to the Government the desirability of including the Licentiates within the scope of the Bill. We appeal to the members of the profession both in their individual as well as collective capacities, in other parts of the country not to lag behind in showing their hands to their Licentiate brethren and lift them up and bring about harmony and content in the profession. The British members of the profession need no direction. As was pointed out in these columns more than once as early as 1858, their fore-fathers in the profession had no objection to include in the British Register, practitioners of the Allopathic system of medicine though they had no training in any school or hospital. A time was fixed when the Medical Registration Act was passed within which time the unqualified practitioners could make a declaration that they had been practising Allopathy and were included in the Medical Register. In the case of the Licentiates the qualms of conscience need not be disturbed at all for allowing them within the purview of the proposed Bill. They are as good qualified and registered practitioners as anybody else and in spite of various handicaps in their training for which they are not responsible, they have shown to the world that they are second to none in their capacity to serve as medical practitioners, given the same opportunities. There is an agitation all through the country for the raising of the period of training of the Licentiates from 4 to 5 years. If anybody was obstructing this reform, it was the Government. The inclusion of the Licentiates in the All India Register—with a provision restricting time till five years after passing of the Act—will surely act as an incentive to the Government to improve the course of their training if the Government and the public feel that there is a need for the non-university diplomas also.

The purpose and very object of the Act will be frustrated if the Licentiates and other diploma holders are excluded from the scope of the Bill, as the object of any Medical Act ought to be to improve the medical profession as a whole and not only one particular section as contemplated in the proposed Bill. It will be a culpable neglect on the part of the Government to exclude the largest section of practitioners from the purview of the Bill as the educational standard of this class more than that of the graduates that requires immediate attention of the government. We wish to repeat what we said on this subject in February 1930.

"The institution of an All India Medical Council which ignores the comparatively large number of non-degree-holders trained out by the several Provincial Governments and who form the rank and file of the medical profession in India, will not function and advance properly the interest of medical relief in India. University degrees are at the best mainly passports for admission to public service, in the absence of any other means of assessing the merits of the candidates seeking entrance to the service. Even the General Medical Council in Great Britain does not show any difference in the registration between the University and Non-university Diploma-holders and in the matter of appointments in the public service no distinction is made between them. Not only in medical but other sciences, the non-university men have done a great deal and risen to high eminence as much, if not more, than university degree-holders. We are, therefore, of opinion that for the real advance of medical science and uplift of the medical profession and mutual improvement, of both the university and non-university men and women, they should stand united. If the education imparted to non-university diploma holders is found defective, it is open to the proposed All India Medical Council to rectify the defect."

Apart from the exclusion of the Licentiates in the proposed Bill there are many other inherent defects of a non-democratic nature regarding the constitution of the Council, election procedure etc. and we have pointed out these in general terms in these columns last month. We have also expressed our opinion that just at this juncture when political constitution of our country is in a melting pot, this measure of a doubtful utility ought not to have been introduced at all. Excepting a very few number of the Indian graduates who wish either to practise in the United Kingdom or enter the I. M. S. Cadre, the Bill will not materially benefit the other larger section of the graduates. The Indian Government expects a fee of not less than Rs. 75 from the graduates for registration in the Indian Register and an additional contribution of a voluntary nature so as to enable them to meet the recurring expenditure of Rs. 90,000 a year; the proposed fee is certainly too large a price for the imaginary status which the graduates might get on account of this measure. Those for whom this special piece of legislation has been proposed should seriously consider all points of view in the interest of the country and the profession and not at all for the purpose of getting recognised by the General Medical Council. The only effective remedy for this and other ills is to have Dominion Status for our country and till then we can get along with the existing Provintial Medical Councils and utilise them for what they are worth.

Original Articles

ENDOCRINOLOGY

BY

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XX

THE RHYTHMS OF SEX.

(Taken from Berman's "Gland Regulating Personality.")

The forces of sex, particularly, the forces of internal secretions moult and sculpt and mould again the women out of the flesh and blood. Adolescence—puberty menstruation ; the maid—pregnancy—labour—lactation—the matron, 30 years ups and downs of these processes around the idea of love or suppressed love against an esthetic back-ground of some sort ; and finally the loss of the stress and strain of sex—the menopause. All the landmarks of the life of women in their entirety are erected and dominated by the tides and currents, the phases of concentration and dilution of the different internal secretions in the endocrine mixture which is the blood. Innumerable varieties and combinations of inter-glandular action supply us with the limitless types of adolescent girls. Some endocrine co-operatives that make up one girl, stable and settled will make others unstable and unsettled. Environments, habit-formation, training and education serve only to bring out the internal secretion make up of the girl or to suppress and distort and so spoil her. Adolescence will be peaceful, calm, semi-conscious or disturbing, revolutionary and obsessive according to the reaction of the other endocrines to the rise of the ovaries. The kind of adolescence provides the clue to the kind of maturity for both are the effects of some endocrine factors.

The Sex Gland Chain.

The activities of a normal woman involves a series of sex glands since these function, in addition to the ovaries, the glands of the uterus, the mammary glands and placental glands. Each of these contributes directly to the reproductive life of the individual. To call the ova, the sex glands, is to confer upon them a name which really belongs to a chain of glands. All the members of the sex chain including those of the thyroid, adrenal, pituitary are necessary to the functions of menstruation, impregnation, settlement of the fertilised ovum in the wall of the uterus, labour and lactation. A disturbance of one of them will set up disturbance all along the line and the resonance of distress or compensation upon the part of all of them. As an inter-locking directorate over the sexual functions of the females, they are members of one or the other ; so what helps or hurts one helps or hurts all.

The Cycle of Menstruation.

It seems as if once successful impregnation has been achieved, the feminine organism adrenalises itself, makes itself more masculine and less feminine inhabiting the posterior pituitary and the adrenal medulla as well as the ovaries. Besides, the corpus luteum stimulates the thyroid to prepare for the heavy demands to be made upon it during pregnancy. It is recognised that a slight enlargement of the thyroid is a sign of pregnancy and among the ordinary people who use collars the inadequacy of the usual size owing to the increase in the thickness of the neck caused by the enlargement of the thyroid is taken as a sign of pregnancy. Before menstruation there is a stage of preparation, a stir and twittering of the endocrine at the premenstrual stage. Currents of communications flow between the different glands; messages and replies pass to and fro when these are properly balanced, so that all goes well, the consciousness of the women will be disturbed by no knowledge of them. In some women abnormal sensation appears, a sense of fullness in the breasts or of weight in the back of pelvis or pain in the head. The last is due to the swelling of the pituitary beyond the capacity of its bony container. In a good many women nervous and mental phenomena herald the expected menstruation because of the complete upset of the balance between the internal secretions with the resulting disturbances of the emotional nervous system. Irritability, depression, excitability, malancholia, exaltations, restlessness, hysteria, loss of self-control or even more marked mental aberrations may appear. Following them or roughly paralleling them may come various abnormalities of

menstruation itself. The character, extent and duration of these, furnish the best clues to the endocrine stability or instability of the particular feminine organism. Six to ten days before menstruation, sex high tide is beginning, for, it is the time when the blood pressure goes up. As this rise of blood pressure is probably controlled by the posterior pituitary, we have a clue to the reason of the rhythmic variations in the rate of production of its secretion. For some, menstruation is so closely connected with the phases of the moon and tides. The rhythmicity of the posterior pituitary may possibly be traced to the days when the pineal was an eye at the top of the head and in direct relation with the pituitary. The four phases of women's 28-days' cycle succeeds each other as the pre-menstrual — menstrual — post-menstrual and inter-menstrual, with the precision of the pistons moving in a motor when no interfering factor as disease, profound emotion or climatic disturbance, are present affecting the endocrines. The sequence of events appear to be as follows. The amount of post-pituitary secretion reaches a certain concentration. This in turn activates the ovarian cells which congest the uterine glands and lining membrane. The follicle bursts, the ovum is discharged and wanders, the uterus waits and wonders ; nothing happens, the curtain is lowered, the scenaries removed and actors revert to civilian clothes.

Pre-menstrual Molima.

The pre-menstrual molima is the traditional title given to symptoms, sensations, feelings and observations of women in the pre-menstrual phase. In the light of endocrine analysis they become exceedingly important indicators of the underlying constitution of the individual concerned. The pre-menstrual period furnishes a direct clue to the dominating internal secretion in a woman. Moreover these pre-menstrual phenomena are the shadow cast by coming events, for, they mimic and prophesy the events of the last crisis of feminine sex life, the menopause. There is the sub-pituitary insufficient type in whom the excessive swelling of the gland causes headache and a dull heavy timid feeling and definite depression. Drowsiness, sleepishness, indifference to surroundings, general sluggishness of thought, feeling and reaction and phlagmatic frivility all go with it. The hyper-thyroid type of woman reacts with an exaggeration of her tendency. When the posterior pituitary begins to secrete more in her its stimulation of the thyroid is enough to tip it over the normal line. Such a woman in her pre-menstrual phase becomes irritable, restless and does not know what to do with herself, cannot concentrate in conversation or occupation or any single activity, may become excited to the point of mania. Hot, tremulous, sleepless, she has a much harder time of it than her pituitary sister. Evidence exists that in man too there is some cyclic rhythmicity of his endocrine which sets up a fluctuation in his physical and mental efficiency. The reproductive mechanisms of women have rendered their whole internal secretary systems, nervous systems, all their organs, their minds definitely and sharply more tidal in their ups and downs of functions and so less predicable, reliable and dependable.

The Masculoid Women.

The masculoid woman as a functional hermaphrodite exists first as a congenital entity with an inborn distribution of endocrine predominances that make up for masculinity. There are also numerous acquired forms. The infections of childhood, measles, scarlet fever and diphtheria and above all mumps may so damage the hormone system that an inversion of sex type follows. However, these stimulating and depressive effects of environment are even more significant. A cold climate which necessitates a more volumnous hair covering for an animal will evoke hypertrophy of the adrenal cortex. The adrenal cortex makes for pugnacity, temper, animal courage, irritability and anger reactions. So a hairy animal will be more pugnacious, courageous, irritable and combative. The same applies to women. The presence or absence of sterility natural or enforced always present or appearing after the birth of a child, must be given a prominent place in studying the endocrine make up of women. When there is not enough ovarian secretion, the ovum may not be able to burst through the ovary. Next the propulsive action of

the genital ducts may be insufficient on account of defective corpus luteum; the uterus may not have received enough post-pituitary or thyroid to make it a fit soil for the ovum to plant itself, or there may be too much of these which cause the uterus massage itself daily by gentle contractions and so to keep it well-toned. Excessive massage will throw out the ovum.

The Maternal Instinct.

The maternal instinct is the instinct to create, provide and care for off-spring. It is different from sex instinct. A distinct difference in the quality and amount of the two instincts may be observed in the same person. A strong maternal instinct may be seen again and again to dominate a woman with but little or no sex urge. Numerous physiologically frigid women lead happy and successful married life because of contended maternity, while other women with normal or exaggerated sex instincts who welcome and stimulate the sexual life, may have no wish for children, no functioning maternal instinct at all and if sterilised will accept their fate with indifference or even exultation. These variations probably occur because of a difference in chemical source and determination of two instincts. While ovaries stimulated by the thyroid and adrenal medulla are the chief determinant of the sex instinct, to the posterior pituitary may be credited the hormone mostly involved in the maternal instinct. The inter action of the two glands the ovary and the posterior pituitary modified by the accessory influences determine the relative intensity of the two instincts. In a sense the two glands may be said to be antagnostic and yet one stimulates and compliments the other.

The Transfigurations of Child-bearing.

Though what happens at puberty and what happens all through life through the agencies of endocrine, is amazing enough, what happens during the period of child-bearing is perhaps the most amazing of all. Pregnancy is the time among its internal secretions of great uprooting and stirring of fundamental and cataclysmic changes in the most intimate chemistry of the cells. During pregnancy the integrity of every structure of the body is tested. Different endocrine types react characterstically towards the situation of pregnancy. The adrenal type may not be able to respond with the necessary enlargement of its cortex which is the normal for the needs of gestation. So, pigmentations, darkening and discolouration of the skin especially of the face, the traditional cholasma develop. The hyper-thyroid may become strongly exaggerated almost to the point of mania and psychosis. The sub-thyroid will suffer an emphasis of sex defect and passion because of the pregnancy to the truly diseased state of myxedema, the state of dull, slow, stupid, semi-animal and semi-idiocy. The pituitary type becomes more masculanised; the face becomes more triangular and coarser; the chin and cheek bones are pronounced and there is growth of all bones, so that she seems to grow visibly in height and breadth and even in the size of hands and feet. Concomitantly there is a change, a more matured outlook upon life, all due to stimulation of the anterior pituitary, controller of growth physical and mental.

Critical Ages.

The climatric is called the dangerous age. As a matter of fact the age of adolescence is just as much a dangerous age as the age of deliquescence. The only difference between them is that the dangers of the one have been hushed while those of the other well-boomed and advertised. Both are dangerous to the individual. Because both are periods of instability and readjustment of the cells particularly the brain cells, to a deranged endocrine system or blood chemistry. Moral attitudes differ at the two ages not so much as an effect or experience as expressions of different visceral pressures produced by the newly dominant internal secretions. The chain of events at the menopause, the acme and then the ebb of sex tide may be summed up as follows: The ovaries an important member in the endocrine directorate cease producing their eggs and so shrivel as a storage battery atrophies when it dries up and a new arrangement of gland activities becomes necessary. If a balance of power is established quickly and equitably very little happens. But

if some endocrines prove recalcitrant and take advantage of the situation to make itself dominant, trouble and maladjustments and then psychic echœs come. Prepitrictary control will mean a relative masculinisation with hairs on the face and aggressive attitudes. Posterior pituitary most often refuses to settle and expressing its ambition as headache, flushes, obeseity and hysteria, may cause excessive misery and unhappiness to its possessor. With the waning of the ovarian function the thyroid type will also exhibit its peculiar flare. If there is thyroid excess the woman will be excitable and irritable; the thyroid defecient will be depressed and dull; the thyroid unstable will have a cyclic up and down alteration of mood and temperament. The adrenal centred will have a high blood pressure and suffer from constant weakness and fatigue. Man has critical ages of sex deterioration as well as woman. This age is between 55 and 65. Here enters upon the scene, that organ of internal and external secretion—the prostate—the most important of the accessory sex glands in the male. It is the hemologue or representative of the uterus, small and undeveloped during childhood, its growth at puberty parallels that of the other reproductive organs. Its secretion has been shown to be necessary to the vitality of the sperm cells. Accompanying its shrinking, causing climatric, come on irritable weakness, despondency and melancholia.

Sex Crisis.

Even before puberty cyclic variation of health and conduct may be observed in boys and girls which undoubtedly depend upon currents of internal secretions. In a certain percentage, sext racks appear pretty early. At puberty arise the most exquisite cases of life crisis dependent upon hormone crisis. The boy becomes restless, irritable and quick tempered when his thyroid and adrenal respond to the call of the interstial cells; if they do not, he will become dull and lustless. The girl correspondly is transformed into vivacious, gay, nervous and apprehensive butterfly or a sedate, dreamy, bashful or even morose, moth. Poise seems to be controlled by the prepituitary and the growth of the long bones is also dominated by it. It would seem as if its secretion dedicated to the one function could not be available for the other. So it happens that those on whom growth ceases early, develop mental maturity more rapidly and possess more of it than those on whom growth continues. The acuteness and sagacity of certain dwarfs is proverbial.

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* HUMAN BRAIN—ITS STRUCTURE AND FUNCTIONS

BY

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I am thankful to the Andhra University for having asked me to deliver these lectures and equally am I grateful to Lt. Col. F. J. Anderson, M. C., F. R. C. S., I. M. S., Principal, Medical College, Vizagapatam for kindly permitting me to do the same.

Biological Introduction.

The living body is a little world in the midst of a larger world. It does not lead an independent existence but its welfare on the other hand is dependent on its own activities adjusted to those of surrounding nature. The body is composed of organs and tissues, the organs with definite functions to perform and the tissues forming the cellular fabric. The tissues, the details of which should be studied microscopically are classified as Nervous, Muscular, Fibrous and Adipose, etc.

All living substances possess in some measure the distinctive functions of excitability and conductivity, i. e., they respond in a characteristic fashion to certain external forces called stimuli. When stimulated at one point the movement or other response may be effected at some other remote part. This implies that some form of energy is created and

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Of course the weight may vary from 800-2000 grams. The maximum weight is reached at about 20 years, remains stationery between 20 and 50 years and later gradually diminishes in size and weight. Heavier individuals possess a heavier brain though not necessarily intellectual. Weight for weight man possesses a heavier brain than animals. This is well illustrated in the case of elephants who possess a very small cranial cavity and a comparatively small brain. The remaining spaces in the elephant's skull are full of air sinuses. At the sametime it must be remembered that some birds such as nightingale possess a relatively heavier brain when compared to that of man. The weights of the brain differ in races :

ORIENTALS : Caucasian race 1335 grams ; Chinese 1332 grams ; Malay and Indian 1266 grams ; Negro 1244 grams; Australians (natives) 1185 grams.

OCCIDENTALS : German 1485 grams ; English 1346 grams; French 1286 grams.

Culture greatly influences brain weight. It has definitely been proved that with the growth of civilisation, brain weight of races has also increased.

It is very difficult to establish a definite relation between brain weight and intelligence. A highly intelligent person need not necessarily possess a relatively heavy brain, though a certain minimum weight, 935 grams is absolutely essential for the proper performance of psychic functions. There are records of notable brain weight as 2028 grams among individuals of insignificant mentality. Remarkably low brain weights as 300 grams occur among idiots and degenerates. The following figures of brain weights of some illustrious persons will be interesting :

Dante — Italian Poet — 1420 grams ; Dupuytren—French Surgeon — 1437 grams ; Broca—French Surgeon and Anthropologist—1484 grams ; Byron —English Poet—1807 grams.

The above are instances where the brain weights are decidedly above the average. The following figures represent the brain weight of equally eminent people but whose brain weights are decidedly below the average, notwithstanding their fame and name.

Liebeg—German Chemist—1352 grams ; Tiedeman—German Anatomist and Physiologist—1254 grams ; Dollinger —German Theologian—1207 grams.

Malaria. Quinarsine is specially useful in those resistant types of Subtertian Malaria, which is refractory to ordinary Quinine, as it possesses a specific action on the sexual forms of the malarial parasites. Again, the Splenic enlargement recedes much more speedily under the influence of Quinarsine. It is the best treatment for removing gametocytes from children, as they tolerate this product remarkably well. They easily take the pills, as they are almost tasteless. Quinarsine is specially valuable in the treatment of those cases of Malaria, which are resistant to Quinine. Its use is very beneficial in Blackwater fever, Malaria of gravid women and also in Malarial diarrhœa in children as well as adults. The attack of Blackwater fever lasts at the most for three days, when the patient is prescribed Quinarsine and his urine clears up completely either on the fifth or the sixth day. Pregnant women can safely be administered Quinarsine, as they tolerate it without any trouble and without any danger to either mother or the child. Malarial diarrhœa is very common and it is frequently impossible to check it with Euquinine in children and Quinine in adults. Experience has shown that with Quinarsine physicians have succeeded in curing cases. It is very useful particularly in cases of Quinine idiosyncrasy. In any labour force if Quinarsine ampoules are injected or if the pills are administered as an after-treatment, the number of gametocyte carriers will be considerably reduced. Antigametocyte campaigns can be easily carried out with Quinarsine successfully on tea-estates or in rice-growing districts. In short, this new combination is the most effective non-toxic therapeutic agent in all the three forms of Malarial infection. It has been proved beyond doubt that it frees the peripheral circulation of the sexual as well as the asexual forms of the three species of Plasmodia. Lastly this product can be employed with success in mass treatment owing to its cheapness. Further, cases of anemia and general debility consequent on attacks of malaria can be successfully treated with Quinarsine ampoules and pills.

The advantages that Quinarsine offers over other preparations of Quinine are too numerous. To commence with, the combination of Quinine with Arsenic acts more rapidly than any salt of Quinine. It affords continuous treatment without any symptoms of Quininism and hence the effects are permanent. Tinnitus Aurium, intolerable headache, dizziness and the bitter taste of Quinine—all these are eliminated when the patient is under Quinarsine regime. In this treatment toxic symptoms are conspicuous by their absence and the relapses are almost nil. Idiosyncrasy to this preparation is not so far met with. The patients therefore prefer Quinarsine to any other product. The unique advantage is that it can be prescribed without any harm to pregnant women. This is an important feature of Quinarsine, as marked secondary blood-changes as a result of chronic malaria in these women which would otherwise prove fatal, are avoided. The compound of Arsenic in Quinarsine was never observed to cause arsenical poisoning and is certainly well-tolerated. No after-effects such as arsenical dermatitis or psoriasis were noticed. Harmful action on the kidneys or the liver was never detected even after prolonged administration of Quinarsine. With it therefore protracted treatment can be carried on in chronic cases with impunity.

This product has become during recent years the routine after-treatment of all cases of Malaria and its ravages, owing to its being the safest and harmless combination that the Medical Profession has at its disposal.

Experiences with Pharmasol Manganese.

Employment of Pharmasols has been greatly extended during recent years in skin-troubles and in other directions on account of the fact that these products possess greater advantages over their molecular substitutes. In dermatology, particularly in those conditions which are rebellious to other treatments, these Pharmasols, specially Pharmasol Manganese, have been found of great service. Pharmasol Manganese is an example of the rationale of colloidal therapy in skin-diseases and suppurative processes. A certain amount of immunity, which is always present in an individual is increased by the injection of Manganese Salts.

The advantage of Pharmasol Manganese lies in this that it liberates Manganese ions and the supply of these is gradual and prolonged. In dealing with suppurative processes and in combating slight persistent infections, Pharmasol Manganese has been a valuable addition to the equipment of not only the skin-specialist but the general practitioner also.

Pharmasol Manganese holds in suspension particles of Colloidal Manganese dioxide. It is due to the power of these particles to act as catalytic agents and of oxidising enzymes that this product acts. When Pharmasol Manganese comes in contact with the tissues, it is gradually absorbed and the requisite ions which increase the protective powers of the serum proteins are liberated and thus the invading organisms are effectively dealt with. When Pharmasol Manganese is injected intramuscularly, it spreads into the tissues in three ways:—

(a) It may diffuse into the intra-cellular spaces.

(b) It may be ingested by the neighbouring cells or leuococytes.

(c) The ions may be released and may be dispersed either by diffusion with the help of the Circulatory system.

After spreading in the intra-cellular spaces Pharmasol Manganese is ingested, as that is the usual mechanism when foreign bodies are introduced in the tissues. Finally ionization takes place and then the active principle in the product does its work. It is only through ionization that the therapeutic colloid acts with a marked accelerating effect. On account of the ionic solubility of the colloid and the moderate size of the particles in Pharmosol Manganese it is most effectively absorbed.

Pharmasol Manganese has become at present the approved line of treatment in a variety of indications. The results following the admistration of Pharmasol Manganese both intromuscularly and orally in Acene have been found satisfactory by many clinicians. Auto-vacciness in these cases have been successfully replaced by Pharmasol Manganese. Improvement has been effected by a course of six injections. In the suppurative phase of this trouble, Pharmasol Manganese has been very useful. Besides arresting suppuration it efficiently combats anemia owing to its hemopoietic properties. General health after the full course of injections is much improved. In *Boils* and *Carbuncles*, Pharmasol Manganese has been extensively applied with remarkable results. The great feature of this treatment is that new boils do not develop and the existing ones heal rapidly. To these patients who are unable to tolerate injections and in children the oral form of the Pharmasol should be prescribed. Besides curing the condition, Pharmasol Manganese has a stimulating and tonic effect on the general health. Carbuncles also dry up and scab over by this treatment. This product in addition to shortening the treatment, relieves the pain, improves the general health and prevents recurrences. *Seborrhic Eczema, Dermatitis Herpetiformis* have been found to yield to Pharmasol Manganese. In the former, weekly injections of 0.5 c.c. increased to 1 c.c. have given very good results. The latter has been found cleared up in about three weeks' time by means of these jnjections. This preparation has its uses in some forms of Gonorrhœa. An intramuscular injection of Pharmasol Manganese may clear up chronic or subacute urethritis which has resisted other forms of treatments. In some cases of strictures it should also be injected, as it causes the disappearance of fibrous tissue and thus enables dilatation to be taken up. In acute cases of Epididymitis it is of great benefit. Pharmasol Manganese has been given with success in cases of *Impetigo Contagiosa*. Intramuscular injections of this product helps to control suppuration due to *Staphylococcic* and *Streptococcic infections*. It increases the resistance of the tissues and improves the anemia commonly associated. It is therefore a valuable adjunct to the surgical treatment of suppuration. In some cases of *Psoriasis* this Pharmasol has been employed with success. A large percentage of intractable cases of *Urticaria* have been successfully dealt with by Pharmasol Manganese. In many obscure cases of Urticaria, where no definite cause can be traced, this product has been tried with excellent results. When this colloidal product is used in

these cases, it increases the oxidation and the protein colloidal particles in the serum are stimulated. The result is the dispersion of the particles, so that the surface exposed to the invading particles becomes greater. The increased action therefore of the protein particles in the tissues and the fluid completely destroys the invading protein or the toxin. This is how Pharmasol Manganese acts in Urticaria where no cause can be assigned.

Frequently Pharmasol Manganese is given by the intramuscular route. The injection is painless and the complete absence of reaction, local or general, is a great advantage. There is also oral form of this product, which can be given to those patients who are unable to take or who cannot tolerate the injections. It can be administered to children affected with Furunculosis. The dosage varies according io the requirements of cases. As regards the injections the routine that is followed is to start with 0.5 c.c. and gradually increase it to 2 c.c. The injections should be given twice weekly. The dose of the oral preparation is one tea-spoonful in water three times a day after food. The only precaution to be observed is that in pregnancy this product should be prescribed with great caution.

The following cases bear ample testimony to the value of Pharmasol Manganese.

1. This a striking case of a girl of school-going age who had her face, eyebrows and ears affected with Seborrhic Eczema. The patches on the face were covered with masses of crust and when these were removed pitted and inflamed surfaces were exposed. She stated that the condition had lasted for more than six months. Though she gets temporary amelioration at times by means of topical applications, the trouble recurs. Pharmasol Manganese was injected at first 0.5 c.c. and the same dose was repeated at the end of the week. There was distinct improvement of the patches, which began to fade after this. Next week the initial dose was increased to 1 c. c. and again it was repeated after four days. The patches are clearly on the way to improvement. In the third week she was injected twice leaving an interval of three days. After six injections the face, ears and eyebrows completely cleared up, though the skin was a little red. She told me that this sort of appearance of her face was seen for the first time after six months. The skin has remained quite clear upto the present time. It would be interesting to know that no external treatment was given.

2. A woman aged 42, had Urticarial attacks, which she used to get off and on for over eight months. Her general condition is pretty good. The face, arms and legs were covered with thick swellings of varying sizes. There was intolerable itching and burning. In the first week she was given two injections of 0.5 c. c. of Pharmosol Manganese at an interval of three days. At the beginning of the next week she reported that the rash had been much better and the itching sensation had much diminished. The injections were repeated twice weekly gradually increasing the dose every time until she had six injections. She was entirely free from her trouble after this and it has not recurred so far. It may be added here that she was having Salines and Calcium Lactate internally.

The treatment of sexual disorders in men.

During the last decade it was customary for medical men to treat sexual disorders mostly by general curative methods. Recently these methods have been abandoned and are replaced by glandular products. This does not mean that general therapeutic methods employed formerly to combat physical and particularly nervous debility associated with these disorders are futile and useless, for really they are valuable auxiliaries in dealing with those maladies. These latter are at present on the increase but fortunately recent researches have clearly shown that the actual cause is not to be found in any superficial functional defects, but is due to internal secretory disorders. Other causes may be acting but the decisive factor is the deficiency in internal secretions.

Organo-therapy, specially in the field of sexual deficiencies has had sufficient clinical trial to warrant its continued use in these cases. For the majority of these disorders Homovir is by far superior to

any other preparation of the same kind in the market, as it is prepared in accordance with the most recent research in Organo-therapeutics and internal secretions. This is a pluriglandular preparation, which in addition to its proper basis of the hormones of the male generative gland also contains the extracts of the Thyroid, Pituitary and Suprarenal. The synergetic action of these several extracts is most suitable for combating sexual troubles resulting from a variety of causes. The efficacy of this preparation is further enhanced by the addition of the alkaloid Yohimbine, a substance which exercises a favourable or almost a specific influence on the Spinal cord as well as the Corpora Cavernosa. Besides, this last substance also possesses the property of stimulating the internal secretions of the glands.

From this composition we see that Homovir is a clinically effective association of the glands which are normally active in the body. It is a scientific and physiologically effective therapy for mental and physical exhaustions generally known as the "Fatigue Syndrome." It is a rational and effective treatment of sexual functional imbalance, sexual inefficiency, sexual neurasthenia etc. Homovir may be considered as a physiologic tonic, a restorer of mental, physical and sexual vigour. It supplies the enfeebled organism of man with Endocrine substances which are essential to the repair and maintainence of normal functions. It is a common knowledge that sexual functional inadequacy is due to the Endocrine imbalance and therefore the administration of Homovir, in which proper qualitative and quantitative association of different glands is present, is not only a rational therapy but is the best possible remedy to restore glandular energy and the normal Endocrine balance. Owing to the suitably selected combination of these extracts with Yohimbine and in view of the clinical experience so far obtained, we can safely assert that Homovir can be used with excellent results not only to restore diminished sexual activity but also as a remedy for curing varies sexual and general disorders.

Let us now deal with the constituents of Homovir separately:—

Hormones of the male generative glands: The genital glands send a specific harmone in the blood which circulating in the organism ensures the development and the preservation of the sexual apparatus. Between the genital glands and the rest of the Endocrine system an intimate relation exists. The activity of the Pituitary or the Thyroid depends on the internal secretions of the genital glands. The aim of the Manufacturers of Homovir is to provide a substance which will stimulate the activity of the whole complex of the Endocrine glands by the internal secretions of the genitals and thus bring about general rejuvenation. Besides, the Testicular Extracts raise metabolism and definite effects of this on the organism are clearly noted.

The next constituent is the *Extract of Pituitary*, which exercises a remarkable stimulating action on the male genital tract. As the extract is prepared by the alkaline method, a definite development is surely obtained when small doses are used. The hormone of the Pituitary supplements the internal secretions of the Genital glands. In fact the Pituitary supplements the internal secretions of the Genital glands. The Pituitary is so to say the Supernumerary organ of the sex glands. It is found after experiments that the Anterior lobe of the Pituitary is deficient in its internal secretions in cases of subfunction or premature involution of the Genitals. This extract therefore, is ingeniously included in Homovir. It was observed that after the administration of this Hormone, the development and the internal secretion of the Testes Improved much. There is also a pronounced enlargement and improvement of Seminal Vesiculae when the Pituitary hormone is administered.

A close connection exists between the *Thyroid* and the Genitals. It is noticed that many cases of Sterility, Infantalism and sexual Neurasthenia are largely due to Thyroid insufficiency and it is therefore one of the constituents of Homovir.

The Extract of Suprarenal gland is also included in Homovir. Experimental evidence shows that this is concerned in the growth and development of the body, particularly of the sexual system. It is considered as the chief factor in the

physiologic mechanism of Reproduction. It also helps general metabolism and the heat-production of the body.

Yohimbine, the alkaloid present in Homovir, adds to its efficacy, as it has a specific action on the centre in the Spinal Cord and besides it exerts a stimulating action on the internal secretions of the Glandular Extracts in Homovir.

Owing to these suitably selected ingredients we can assert that Homovir supplies those Endocrine substances which are lacking in cases of general debility and sex-neurosis. It not only assists the development of the body and the appearance of sexual characteristics but increases the physical and mental vigour and maintains quite a well-balanced state of health and all this enables the person to lead an active life. This product is considered as a proved specific for the insufficiency of Hormones, as it directly supplies the missing Hormones of Reproductive Glands and renews vitality and restores the lost strength. It exerts a stimulating and a powerful tonic effect in men suffering from a chronic state of nervous and mental weakness. In exhaustive and organic impotence it restores the genital tone and regulates the nervous and mental balance.

The early signs of the actions of Homovir are that the patient's general condition is much improved. Normal sleep is restituted and an increase in appetite is noted. As a result the weight also is increased. A beneficial effect is observed on constipation. The effects produced on sexual function enfeebled either by age or prematurely are remarkable. In cases of prolonged and resistant impotence treated unsuccessfully by other methods Homovir succeeds in raising or even restoring in ioto the lost function.

Homovir as a wide field of application, as can be seen from the variety of troubles in which it has proved valuable. To begin with, it has a pronounced action of re-juvenation on the ageing organism as well as in cases of presenility. The chief indication for Homovir is Impotency. By the fact that Homovir brings forth general restoration of the sexual apparatus, it is greatly effective in all manifestations of impotence due either to age or other influences. If the Impotence is due to organic causes, Homovir is a specific as it organically invigorates and strengthens the sexual apparatus. In these cases it is the organically faulty functions of the glands which are corrected by the administration of Homovir. The supply of Hormones in Homovir strengthens the entire Nervous System,increase the desire for coition and thus in the majority of cases curse Impotence completely. There is a possibility of helping patients in cases of Sterility by means of Homovir. The normal functioning of the Sexual tract by this simple treatment of Hormone-therapy by the mouth may prove effective in such cases. Similarly all those ailments which are the result of either injury or diseases of the Testes can be successfully treated by Homovir, as it provides the Hormones, which are deficient in such cases. When sexual Neurasthenia is due to Endocrine derangement, Homovir acts as a specific on account of the combination of the various Hormones in it. The different Hormones are in such quantities and such strength that a uniform and general action can be achieved with it. The Pituitary, the Thyroid and the Suprarenal stand in such regulative relation to one another that not only the function of the Sexual Glands is made normal, but the general condition is also improved. By the application of Homovir, the secondary appearances of diseases which are the result of degeneration of the sexual organs, can be frequently dealt with successfully. In Asthenia this product acts well, as it does not directly act on the separate functions but regenerates the organism itself by stimulating the internal secretary apparatus and the Central Nervous System.

A special advantage of this preparation is that it can be taken orally and can also be injected hypodermically. The assimilation is very easy and no undesirable effects are observed. The improvement in sexual respects makes itself felt in a comparitively short time and sexual weakness etc. diminishes rapidly.

As Homovir is available in the form either of tablets or injections, recourse can be had to any of these methods. If it is necessary that the patient should be kept constantly under observation of the physician, the method of injection should be preferred, as these patients are sexual neurasthenics, sensitive and unstable and usually complain of gastric disorders. Where there are no such complaints, tablets should be prescribed. Tablets should also be administered to aid the injection treatment. It may be noted here that no unpleasant effects are produced after injection nor are soreness or infiltration noticed at the site of injection.

An interesting case of Dyspepsia and weak digestion.

A young man of 27 working in a Government Office, subject to sciatic attacks, came to me for treatment of his dyspepsia and inability to digest food. On examination it was found that his gastric trouble was due to anaemia which was marked. He complained of various uneasy and painful sensations with weight at the epigastrium and heart-burn. He was not able to digest what little he ate and substances were brought off the stomach even after four and six hours after food. There was no vomiting but all these symptoms increased his sciatic attacks, specially in the left lower extremity. As a result of all this he contracted what can be termed as a chronic form of dyspepsia and indigestion. As this disorder continued, the general debility increased, sleep began to get disturbed and appetite became much impaired. Furred tongue, relaxed sore throat, irregularity of the bowels and lowness of spirits were much more evident. He had tried all sorts of remedies and diets but the complaint resisted to all these. As he came to me merely for his gastric complaint, I prescribed Papyta Tablets, 1 tablet after each meal. He began to feel much better after a week and found that digestion was much easier. After twenty days' treatment he was quite free from the trouble. Not only was he able to take in his daily diet, but his general condition distinctly improved, his insomnia disappeared and he began to feel energetic. The patient became very enthusiastic about the Papyta treatment, which he considered by far superior to any other digestive mixtures. His pains in the lower limb also became much less. In this case ,the efficacy of Papyta was not only immediate but persistent as the patient, after he had finished two bottles, had not taken anything by way of drugs for his gastric disorder and his digestive system is up to the present day working quite all right.

Conference on Hereditary Syphilis

Extracts from Reports

"TREATMENT OF HEREDITARY SYPHILIS IN THE NEW BORN CHILD AND INFANT."

BY DOCTOR HENRI LEMAIRE, PHYSICIAN TO THE PARIS HOSPITALS.

Page 116.—"Sulfarsenol and Eparseno may be injected subcutaneously in solutions made extemporaneously in distilled water. Sulfarsenol is much the more commonly employed and its initial dosage is one-third centigram per kilogram body weight. This dosage is progressively increased until the dosage of the final injections reaches 1.5 centigrams per kilogram body weight. Three injections are given weekly, and 12 injections constitute a series."

"PROPHYLAXIS OF HEREDITARY SYPHILIS."

BY DOCTOR G. MILIAN, PHYSICIAN AT THE SAINT-LOUIS HOSPITAL, PARIS.

"Post partum Prophylaxis and Treatment."

Page 189."....if the application of arsenical medication appear to certain physicians difficult or embarrassing because of the delicacy of the veins of the patient, which may be endangered by use of arsenobenzols, this difficulty may be overcome by using Sulfarsenol intramuscularly, the latter being an arsenobenzolic compound which is admirably tolerated by the tissues as long as doses extending from 60 to 72 centigrams, or more, are not employed...."

"THE PREVENTIVE TREATMENT OF HEREDITARY SYPHILIS."

BY DOCTOR G. PETGES, PROFESSOR AT THE FACULTS DE MEDECINE, BORDEAUX.

Page 241.—"For this method of application I have thus given the preference to Sulfarsenol which, when properly managed, is well borne subcutaneously, at the cost of slight pain, in doses whose range extends over 6 to 60 and 72 centigrams, a dosage permitting fully sufficient treatment. With these doses, the results obtained equal those obtained by intravenous injections. Even in cases of Syphilis treated very late, or in cases in which the Wasserman reaction remains persistently positive, the effect produced appears more active and durable ..."

Notes on Treatment of Diseases.

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

Dysentery : AMEBIC ; Emetine Hydrochlor. ½ to ⅓ gr. intravenously once a day or full doses of Bismuth Sub. Carbonate ; large rectal injections of Quinine solution 1 : 1000 ; if the motions are sanious 1/2000 gr. of Bichloride of Mercury every hour or 2 hours by mouth ; the following to be gently introduced into the bowels. Soda Boracis 1 dram, Tinct. Benzoin 1 dram, Spt. Camphor 1 dram, Aqua 2 pints may be gently given as an Enema. Stoversol is said to be good ; it is supplied in a tablet form for oral administration (I. M. G.).

In majority of chronic cases a twelve days' course of Emetine 1 gr. by mouth and ½ gr. hypodermically every day. Bismuth Emetine Iodide grs. 3 in Salol-coated capsules daily. The patient should be kept in bed at least for sometime after taking the medicine. In intractable cases, Neo-Salvarson 0.3 to 0.4 gram to be given intravenously once a week. Enema of Quinine 1 : 1000 to 5000 is good. In hepatic abscess aspiration is better than operation and into the cavity Emetine may be injected 4 to 5 grs. in solution (M. T. T.).

Bismuth Sub. Nitras in large doses about 2 drams to be given suspended in milk or water every 4 hours to make the contents of the intestines alkaline in order that Emetine may work well. The Bismuth Sub. Nitras should be pure as otherwise toxic symptoms may arise. 1 gr. of Emetine every 12 hours should be given hypodermically. In place of Bismuth Sub. Nitras, Kaolin may be given suspended in milk or water ; Emetine should be continued for six days. In place of Emetine, Stoversol may be given, but is not so effective as Emetine. Kurchibine a preparation of Indian Kurchi bark containing Bismuth Iodide in addition has been found very effective. Ipecac and its derivatives should not be given for a long time as the ameba may become Emetine-fast. It may be given however alternately with Stoversol, Yatrin and Kurchibin. Yatrin to be given 3 pills T. D. for a fortnight and 2 pills T. D. for a week and 1 pill T. D. for a week (I. M. J.).

Parathyroid with Calcium Lactate is found to be beneficial after Emetine has failed.

Revonal both orally and as an enema ; may also be tried.

Yatrin may also be given as enema first give a cleaning enema with 2 per cent of Soda Bicarb, then an enema with intestinal tube containing Yatrin 1 : 200. The Yatrin should be dissolved in hot water and then cooled ; the enema should be retained for 6 hours (international Medical Digest).

In children for amebic dysentery Revanol by enema is good (I. M. J.).

If the pulse rate rises 100 to 110, Emetine should be stopped. (Journal of Chemo Therapy.)

Kharophen tabloids is good (I.M.J.).

BACILLARY DYSENTRY : First give Calomel grs. 2 followed within 4 hours by a saturated solution of Sodium Sulphate ½ to 1 ounce. During the next 2 days give Sodium Sulphate saturated solution 1 to 2 drams every 4 hours and 1 dram every 6 hours afterwards and then sufficient quantity of Sodium Sulphate every day to have the bowels moved (M.M.). In mild cases, two days' treatment and in severe cases four days' treatment is necessary. Betanaphthol grs. 5, Olive oil dram 1, Olium Cinnamon mm 1, Mucilag Q. S. Aqua Menth Pip. 1 ounce three times a day, may also be tried after.

3. In chronic cases, Stoversol grs. 4, twice a day for a fortnight and then 1 gr. every night for a fortnight ; Tinct, Ferri Perchloride mms 20, Liq. Hydrarg Perchloide ½ dram in ½ ounce of water well diluted 3 times a day after meals. If evacuations are broad and there is much diarrhoea Betanephthol grs. 5 in cachets or Bismuth Salicyles grs. 20, 4 times a day (M. T. T.).

In acute form Shiga infection is more common and severe then Flexner infection and causes Arthritis as a complication. Albumen water, whey, beef tea, chicken broth are better than milk diet. Salines as Mag. Sulph. Soda Sulph. or Soda Phosphate may be given in 1 dram doses every two hours in the day. In the night Liq. Opii. Sedativa or Morphine by injection may be given to produce sleep. Anti-dysenteric serum should be given before the 6th day 2nd not afterwards. 60 to 100 CC may be injected into the abdominal wall subcutaneously and may be ropeated every alternate day. If the symptoms are severe, Shiga serum should be given and if mild combined Shiga and Flexner serum. Before giving the serum as a preventive to anaphylaxis, subcutaneous injection of 1 c, c. should first be given (M.T.T.).

Charcoal may also be tried and given 10 to 15 grs. a day. If it causes nausea it may be given with Kaoline. Kaoline 100 grams should be given twice within an hour suspended in water or tea ; less than 100 grams is useless and this treatment should be repeated on the following day.

For hæmorrhage occurring in the disease, lead Acetate 0.6 grams, Gum Arabic 30 grams, white of 5 eggs and 1000 c.c. water one teaspoonful to be given every 2 hours.

The three important medicines in bacillary dysentery are **Mag. Sulph.** in concentrated solution, Aromat. Sulphuric Acid and Calomel. (Hare.)

Turkey Rhubarb in ½ teaspoonful doses every 1 to 3 hours until the drug appears in the stools and in children 5 gr. doses every 2 hours for 3 doses (Rogers.)

Bacte—Dysentery—Phage, the bacteriophage adapted to the bacteria of Bacillary Dysentery of Shiga, Hiss or Flexener type has been found very effective in all forms of Bacillary Dysentery acute or chronic.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

HYPOTENSYL.

THE ACTIVE PRINCIPLES OF VISCUM (GUI) WITH GLAND EXTRACTS FOR THE TREATMENT OF ALL CONDITIONS ASSOCIATED WITH HIGH BLOOD PRESSURE.

THE SIGNIFICANCE OF HYPERPIESIA : Some of the pathological conditions with which high blood pressure is associated are fairly well understood, others are quite obscure. It may indicate such serious states as arterial or renal disease, but on the other hand it may not be definitely indicative of morbid conditions as many subjects with a systolic arterial pressure of 180 m.m. Hg. and over have lived to old age. A systolic pressure in any individual above the normal maximum for his or her age, is, however, to-day generally considered of primary importance by the diagnostician. That hyperpiesia is becoming more and more common is undoubtedly true, due, perhaps, to modern conditions, excess in alimentation, abuse of tobacco, the increase in longevity, etc., and there are few men above fifty or women past the menopause, who do not to some extent suffer from the troubles of high blood pressure.

THE OLD REMEDIES : Most of the classic remedies for hypertension are gradually being abandoned for various reasons : Nitrite of soda, Trinitrin and other Nitrites because their action is temporary and ill-defined (and therefore of little real use). The same may be said of Benzyl Benzoate and Garlic extracts which are inconstant in action and difficult to control therapeutically. Strophanthus and Squill have their uses in special cases when their action on the heart is an asset.

Only to Chloral and Mistletoe extract can a real specific action be attributed. The first, however, has certain inconveniences because of its secondary action on the nervous system.

Mistletoe alone amongst the older remedies has withstood critical test and is accepted as the medicament of choice in the treatment of the hypertension syndrome. The diuretic and antispasmodic properties of Mistletoe were known to the ancients, but not until the publication of the work by Chevalier (C. R. Academie des Sciences, Nov., 1907) followed by that of Fabini and Antonini (C. R. Academie de Medicine, Turin, May 1911) was positive evidence available of its hypotensive qualities. Later, the investigations of O'Hart and Hoyt (Prog. Med., Dec., 1928) and of Mattei and Cavaroni (Presse Medicale, Aug., 1926) did much to renew interest in and increase the use of this vegetable product. The hypotensive action of Mistletoe is characterised by the rapidity and constancy of its action, manifested particularly on the systolic pressure. It has, at the same time, a secondary diuretic action on the kidneys equal to that of Squill.

NEW REMEDIES : During the last few years attention has been drawn by various workers to the presence in certain organs of substances having a hypotensive action. Harrower and Glendale were the first to show that the liver contains a substance which reduces hypertension, systolic and diastolic. Their findings were later independently confirmed by Major (Journal Amer. Med. Assoc,, July, 1926), by Langton and Macallum and by Lantmann (Med. Journal and Record, June, 1926).

Since then many clinicians have testified to the value of liver extracts in hypertension due to toxemias and not resulting from sclerotic conditions, the beneficial effects being frequently of considerable duration. This hypotensive action of hepatic extracts induced other workers to experiment with extracts of other organs. Gley and Kisthinois (C. R. Soc. Biol. No. 12, 1929, and Presse Medicale, Oct. 2nd, 1929) report the isolation from the pancreas of a hypotensive substance, independent of Insulin, a substance capable of neutralising the hypertensive action of Adrenalin.

HYPOTENSYL : Until there is found a particular substance which will reduce high blood pressure as effectively as Insulin reduces blood sugar content in diabetes, the only rational prescription is a combination of the older medication, such as Mistletoe, which has given proof of its efficacy with organotherapeutic extracts which have also proved their utility. Hypotensyl is such a combination, combining the immediate and certain action of Mistletoe with the re-educative and lasting action of organotherapeutic extracts. Its use assures both an immediate relief of symptoms and a lasting effect. Its action is easy to control by the sphygmomanometer. If the arterial pressure is taken before and about 4 hours after a dose of Hypotensyl, the reduction will generally be found to be from 20 to 30 m. m. Hg. It suppresses the arterial spasm which is harmful to the normal action of the heart, forestalls arterio-sclerosis and albuminuria, decongests many of the organs (heart, kidneys, uterus) and has also an important antispasmodic action on the nervous system.

There are no undesirable effects of Hypotensyl administration so that treatment can be continued over long periods. In those cases which respond well to treatment it will be found that the same dose of Hypotensyl will be as effective after several months treatment as at the commencement.

After a course of treatment. patients who have benefitted should be examined weekly when the treatment is discontinued to observe a recurrence of the high blood pressure or symptoms. Frequently there is a return of high blood pressure before the symptoms reappear.

While Hypotensyl accomplishes more in the symptomatic treatment of hypertension than any other method, it must still be understood that the effects can only extend so far, as long as the underlying cause of hypertension is not removed ; for this reason, patients with a long history of hypertension respond much less readily the treatment than those who have only suffered for a short time prior to treatment.

HYPOTENSYL is available in tablet form, each tablet representing :

Viscum Album Extract	... 0.075 Gm,
Hepatic Extract	... 0.10 Gm.
Pancreatic Extract	... 0.05 Gm.

Dosage : The average dose is 3 to 6 tablets daily, a dosage that can be increased or diminished according to the necessities of the case. The tablets are best taken half-an-hour before meals. Treatment should be continuous for periods of 15 to 20 days and a week's interval allowed between these courses.

Bacteriophage Therapy in Naso-Pharyngial Infections.

The introduction of Bacte Phages by Professor D'Herelle marks an advance in modern medicine because of their high therapeutic value and their absolute freedom from producing any general reaction. The investigations carried on by various clinicians during the treatment indicate that Bacte Phages can be administered safely, as they are well-tolerated. The possibilities therefore presented by these Bacte Phages as therapeutic agents are many. It may be said that Bacte Rhino Phage has become the favourite with a number of Practitioners, who have em ployed it in cases where the Pharynx- and the Respiratory Tract are infected.

The utility of Bacte Rhino Phage can be realised when we consider the various points of view in diseases of the Pharynx, Naso-Pharynx and the Respiratory Tract. In these cases Bacte Rhino Phage being used topically (it is sprayed into the nose and mouth), not only soothes the affected part but also favours the reparative processes in these tissues. Besides, this kind of topical treatment, spraying etc. appeals to the mentality of the patient; for he wonders that when his throat or nose is inflammed, how taking in of mixtures is going to relieve him or injections of different vaccines in a distant part of the body is going to do him any good. The psychic effect of this treatment is therefore of great value. Bacte Rhino Phage has a psycho-therapeutic potency which a physician cannot afford to ignore. This local treatment in the cases mentioned above is not only appropriate but justifiable.

So far as the affections of the Respiratory Tract are concerned we notice that the mouth and the fauces are generally the starting point from which the bacilli penetrate into the body and attack the various internal organs. Recent investigations have testified to this, as the bacteria causing Corvza. Colds. Bronchitis etc. have been found harboured by the mouth, throat and fauces. It is much more easy to destroy these bacteria in these regions than when they spread into other parts of the body. Bacte Rhino Phage is the appropriate and effective method of doing this and the Profession is indebted to Professor

D'Herelle for its introduction as a local therapeutic agent of no mean value. The importance of the local treatment with this Phage can only be understood when we take into consideration the subsequent sequelae resulting from the infection of the Upper Respiratory Tract with this bacteria. These cocci are mostly Pneumo-Cocci, Strepto and Staphylo cocci and Pfeiffers' bacilli and these have the power of inciting their activity in the lower portion of the Respiratory Tract and the lungs. The clinical evidence has proved that if these cocci are destroyed by the timely and regular spraying of the Bacte Rhino Phage, these dangerous sequelæ can surely be avoided.

Bacte Rhino Phage is a judicious combination of Staphylo and Strepto cocci, Entero cocci, Pneumo-cocci, Bacilli Proteins and Bacilli Pyocyneous. All these are suspended in 2 cc of sterile broth in one ampoule. This Rhino Phage retains its germicidal efficiency for several years. It not only destroys the infection but depletes the turgid mucous membranes and the nasal and frontal sinuses are properly and effectively drained. If it is used by spraying locally on the appearance of symptoms of cold In the head, it acts as a very good prophylactic. For the common cold it is a good curative agent also. Rhino Phage brings about shrinking of the engorged mucous membranes and owing to this, it cuts short the acute inflammatory processes. After spraying this Phage there is no irrigation or burning nor is there any metallic or acrid taste, as is the case with Iron or Tannic Acid. Compared to other antiseptics which are generally used for the nose and throat, Bacte Rhino Phage possesses a higher bactericidal activity and it is well borne by mucous membranes. It, by markedly diminishing the bacterial growth brings about general improvement in the oral hygiene and the effects thus produced are pronounced and permanent.

The results obtained by many practitioners with the Bacte Rhino Phage sufficiently warrant its extensive application in many diseases. To begin with, as a cure for common cold Bacte Rhino Phage has proved more efficacious than any combination of local antiseptics and it shortens the course of the attack by several days. It is one of the best forms of topical application in Sore Throat, Coryza and Rhinitis. It has the great merit of cleanliness and asepticity. This Phage has a prompt satisfactory action in Sinusitis. Whatever the cause of infection, spraying once or twice a day the contents of one ampoule has given relief to the patients in these cases. Naso Pharyngitis has been cleared up within three or four days by the spraying of about half a dozen ampoules of Bacte Rhino Phage, In cases of Rhinits relief has been obtained bp this Phage within twenty four hours. Its use has been found very beneficial in acute Coryza. It is much more efficacious than Silver preparations and at the same time far more pleasant for use. It is frequently very difficult to get rid of the various bacilli harbouring in the Naso-Pharynx of carriers, specially when the acute infection has just disappeared. In these cases experience has shown that spraying with Bacte Rhino Phage has cleared the region completely even in persistent cases. It has been highly recommended by those who have used it in acute inflammatory conditions of the nasal mucous membranes. It is extremely effective in Chronic Hypertrophic Rhinits with profuse discharge.

Bacte-Rhino-Phage is therefore an effective prophylactic and at the same time a strong therapeutic remedy. It is as already stated one of the best forms of local applications. It is clean as well as aseptic. The great point in its favour is that reactions of an undesirable kind are absent after the use of this Phage and thus it has a great advantage over Vaccines. Furthermore, its administration is not only indicated in acute stages of the disease, but also in the subacute and chronic ones. Another advantage presented by this remedy is that the effect of its beneficial contact with the diseased parts lasts for a longer time than those of gargling. The contents of the ampoules of this Phage gain access to the deeper parts of the tissues and also the crypts of the tonsils. Again other antiseptics only check the growth of the bacilli, while Bacte Rhino Phage destroys them entirely. No toxic phenomena are seen after spraying and even two ampoules per day are well-tolerated.

This Rhino Phage therefore is not only a useful remedy in the hands of the Rhinologist for combating the various diseases he has to deal with but also in the hands of the general practitioner.

News and Comments

Interpellations : Important questions asked by the members of the Local Legislative Council regarding the medical department and the replies of the Government at the last sessions have been published elsewhere in this issue. The most important interpellations were regarding private practice by Government Medical officers, which subject included the nursing home run by the Second Surgeon, General Hospital. As the answers given by the Hon'ble Minister are likely to affect the morale of the whole medical service we have dealt with this subject in our Editorial columns. Though the answers from the Minister did not elicit as much information as the occasion demanded, those who have read the answers can judge for themselves whether the private practice allowed to the Second Surgeon is actually affecting the work and results of treatment in the General Hospital. The members who interpellated being non-medical men, there cannot be any room for jealousy, though hard facts are at times most distasteful. The Government knows more than the interpellating members that the Second Surgeon is not the only person who runs a nursing home. If the Second Surgeon attracted the attention of some of the members of the legislative council, it is perhaps due to their surprise how it was possible for a whole time officer of the Government to be a Surgeon in the General Hospital and at the same time run a nursing home of the magnitude in no way smaller than the wards of the General Hospital under the charge of the same Surgeon and yet without affecting "the official work of this officer".

The post of the Honorary Cardiologist was another subject for interpellations. The anxiety shown regarding this subject was towards the qualifications possessed by the person dealing with cardiology. The medical profession who are familiar with this subject are only concerned to know if special subjects are to be taught in the Medical College, Madras, only when persons come forward to teach them and the curriculam of studies to be changed or enlarged depending upon available teachers and not on the necessity or importance of subjects. The Medical examinations for Andhra and Madras Universities being common, it is desirable that in both the institutions, the courses of study and facility of training medical students should be uniform or else the students will be at a disadvantage, as the standard of questions and answers will necessarily vary especially if those teaching these special subjects were to be examiners. It is unfortunate that those who are responsible in creating new appointments in the teaching institutions do not consider all sides of the question. They should mind the interests of the students more than those of the candidates who wish to be in charge of special lines. The science of healing art is as big as an ocean and the aims of those who are in charge of medical educational institutions should be to give the students a good grinding in the general principles of medical science, specialisation being allowed to individual taste after college course. The students will certainly find it hard to devote the required attention for the study of special subjects in several branches of Medicine and Surgery. When specialists are available or made available arrangements should be made for post-graduate training and this will benefit both the teachers as well as those who are taught.

Regarding the appointment of honorary medical officers the Minister replied that the Government have acknowledged the policy and was also of opinion that honorary men could run a whole medical institution, but he was not in favour of replacing salaried men by honoraries though that would help retrenchment. We do not wish the Minister to go so far, but as suggested by us repeatedly can he not stop further recruitment? There seems to be no signs in this direction and the honorary system will certainly continue to be supernumerary benefitting

neither the Government nor the honoraries. We trust the Minister will soon make practical demonstration of his belief in honorary system of medical service by putting stop to further recruitment.

One of the members elicited information regarding the cost of the D. M. Os Conference. It was stated by the Minister that it was about Rs. 3,880. Our readers might remember that we questioned in these columns about the usefulness of such a Conference especially during the days of financial stringency. The Government will be well advised to know the programme of such conferences before they are convened. The Surgeon-General is a touring officer and he can during his visists discuss with the D. M. Os and Civil Surgeons and settle important questions connected with the medical department and issue orders for the guidance of the officers in the department instead of spending large amounts of money on conferences causing in addition inconvenience to the public on account of the absence of the medical officers from their stations.

No test for paying House Surgeons and Physicians : A couple of months ago selection was made by the special committee for the posts of House Surgeons and House Physicians. As usual some are paid : majority are to work as honoraries. It is not known why this invidious distinction is made regarding payments. How these two classes paying and non-paying are determined, is beyond all reasonable thinking. It does not seem to depend on any known fixed principle. Candidates who had bright career do not get the allowance while those who had to stumble more than once before passing have been-fortunate to get it. Pecuniary conditions would have been a better test. If, of one test the candidates are sure it is, they say, favourtism. We have dealt with this subject last August soon after the House Surgeons and House Physicians were selected that year and were amazed then, as we are now, that those who are responsible to recommend candidates for allowances do not seem to have any sound and fixed policy. The course of House Physicians and Surgeon is necessary before a young doctor enters life either as a paid officer of the Government or as a private practitioner and as has been pointed out by us repeatedly, it is desirable in public as well as professional interest that all those who pass out from schools and colleges should have compulsory course of House Surgeons and House Physicians before they are registered and for this purpose the Government should provide facilities for their training in all hospitals in the city as well as in the mofussal.

Seniority not counted : We have been repeatedly pointing out in these columns the several instances in the medical department where seniority and merit were discarded when new appointments were created and in some cases even when routine promotions in the department are given effect to. Whatever causes that might have been at work we, observe with satisfaction that at least in one or two recent appointments in the teaching cadre, the old dictum that who so ever teaches in a college should be first transformed into a Civil Surgeon, has been given up and it has been now made possible that a teacher could remain in the same cadre without superseding anybody in rank. So far so good. With regard to administrative appointments such as that of Assistants to District Medical Officers, the Government have been of late appointing raw juniors in service and in some cases even those who have not been confirmed as Assistant Surgeons. Almost every District has one or two taluk headquarters hospitals invariably under the charge of an Assistant Surgeon and when the D. M. O. goes on short leave the Assistant D. M. O. has to act for him and do the administrative duties of the D. M. O. So, it is necessary to appoint a Senior at least to all other Assistant Surgeons in a District as an Assistant D. M. O. There are several paras devoted in Civil Medical Code where the D. M. O. has been given direction to train his Assistants in Police, Jail and other administrative duties of the D. M. O. so that his Assistant should have efficient training to be fit to do the duties of the D. M. O. in his absence. There may be occasions when a D. M. O. may seriously fall ill when, to treat the D. M. O. and other members of the public who require the benefit of advice of a senior medical man in the station

there should be one ready at hand, who has had the required experience in the healing art to take the place of the D.M.O. So, for administrative and medical relief alike the Assistant of a D. M. O. should be a senior Asst. Surgeon who is expected to do the work of a D. M. O. satisfactorily. It may be said that there have not been many complaints from seniors in service when juniors are posted as Assistant D. M. Os. Reasons are not far to seek. In stations where the Assistant D. M. O. can expect lucrative private practice there have been always grumbling. There are many taluk stations where Assistant Surgeons could command more practice than in some District Headquarters and Assistant Surgeons in these stations might mind money more than prestige. At times a particular D. M. O. is a hard master to serve under and a few Assistant Surgeons might forego both money and prestige to escape this master. Consideration of these excuses by the head of a department denotes a weak and faltering administration. Public service exists for the people. It cannot be otherwise in medical service. If the words "exigencies of service" cannot be made applicable in medical department, it looks as if this service exists, to serve those who should serve.

Provincialisation of Local Fund Medical Services : The system of transfers is a necessary evil in the paid medical services and to effect these satisfactority, giving every one a turn in good or bad stations, does not seem to be possible in the existing state of affairs especially in subordinate medical service. Majority of the dispenseries under the taluk boards are now in charge of Government Sub. Assistant Surgeons and a few are under the charge of Sub. Assistant Surgeons in taluk board service itself. There are healthy and unhealthy places in every district and good or bad paying stations and necessarily transfers have to be effected in the interests of service. Those in Government service having a wider field are naturally in an advantageous position. The pucca taluk board Sub. Assistant Surgeons feel that they are not having the same facilities. There seems to be a Government order reserving stations in a particular district for Government Sub. Assistant Surgeons and so the District Surgeon who is the advising authority to effect transfers in local board service cannot dislocate the Government Sub. Assistant Surgeons to give these stations to local fund Sub. Assistant Surgeons though both the class of Sub. Assistant Surgeons are under the direct control of the District Medical Officer. As could be seen from a letter addressed to us appearing in the correspondence columns of this issue, there seems to be no chance of transfers at all to local fund Sub. Assistant Surgeons under the present conditions of service. The rational remedy for all these ills is the abolition of paid service and creation of the honorary system of medical relief, and till such time we would suggest that the administrative control over medical services be entirely entrusted to the Government, in other words provincialising the medical services or vesting the administrative authority of the district medical institutions to the District Boards. Such an arrangement has been working satisfactorily in the Engineering Department. Why should not this be tried in the Medical?

Never ending Hardships : We cannot afford to be tired of voicing the grievances of the rural medical practitioners till they are redressed. Almost every day we receive letters complaining against the tyranny of some taluk board president or the other almost all of whom wish that subsidised practitioners should treat even the rich (himself and his collegues not being excluded) free, though it is specifically stipulated in the agreement that the practitioner may charge fee for his services to all those whose income exceeds Rs. 30 a month. Apart from the treatment at the dispensary, they have to supply drugs like Tinct. Iodine and Boric Acid free to some of those in authority. How could they do all this with the meagre subsidy that is given to them? It can't be said that the Government is unaware of these happenings. On 21-12-30, the Hon'ble Minister while answering to the Address presented to him by the Tiruppur Taluk Board referred to the Rural Medical Relief Scheme in the following words :

"The Government did not anticipate

such a difficulty, as it was then thought that a small pay would be sufficient to the Doctors taking into consideration that Doctors would be able to get decent private income to boot. The question of examining and reorganising and eliminating the various evils in the present system, was being considered by the Government and the entire scheme would be re-examined at no distant date."

We trust the Hon'ble Chief Minister would soon find time to meet the deputation of the Rural Medical Practitioners and devise better ways and means to run the scheme satisfactorily.

The Indian Medical Association's Responsibility: Our readers are aware that at the instance of the Indian Medical Association, an All India Medical Conference was convened at Poona last April and 46 resolutions were passed, out of which the following two referred to the Indian Medical Council Bill.

(1) While this Conference is in favour of the creation of the Indian Medical Council, it is emphatically of opinion; (a) that it should be, if and when started, an independent and predominently a non-official body with an adequate representation of the independent medical practitioners, both graduates and licentiates and should have a non-official elected President from the beginning; (b) that its functions should be among others, to maintain an uniform and minimum high standard of medical education in India; and (c) that when the Bill for the establishment of the Indian Medical Council is published, the Central Council of the Indian Medical Association should submit a representation to the Government in consultation with the following six members specially elected for the purpose:—Dr. E. S. Bharucha (Poona), Dr. Tendulkar (Poona), Dr. Rochiram Amesur (Karachi), Dr. Jethalal Vora (Bombay), Dr. Hyderali Khan (Patna) and Dr. M. A. Cholkar (Nagpur).

(2) This conference is of opinion that no one who is not on the Indian Medical Register, should be entertained in the Civil, Military, Naval or Air services of the country or be permitted to act as a Ship's Surgeon or in such other services.

We wish to point out an error in No. 1 part (c) of the resolution. This particular portion of the resolution was proposed by Dr. Rochiram Amesur of Karachi and it is said that the mover actually expressed that the Central Council of the Indian Medical Association should meet to discuss about the proposed Bill and that the Central Council should for this purpose co-opt six additional members mentioned in the resolution. We hear that the individual members of the Central Council have been addressed to by the General Secretary and requested to send their personal views. The object of the resolution can never be served by adopting this procedure. It is incumbent that a meeting of the Central Committee should be convened as early as possible at a central place and we have information that Nagpur was suggested at the time.

We feel it desirable to point out that the wording of the resolution referred to above and as reported after the Conference had undergone material changes. We have the authority of the mover Dr. Rochiram Amesur to make this statement.

We trust that those who run the Indian Medical Association will realise their responsibilities not only to themselves but to the profession at large and lead a campaign to carry out the principles enunciated in the resolutions passed at the Poona Conference regarding the Indian Medical Council Bill.

Healthy Examples: Elsewhere in our correspondence columns we have published a circular issued by the Bombay Medical Council which deserves the notice of the other Medical Councils in this country. Conditions of medical relief and medical service in India are quite different from those obtaining in other countries and many a time practitioners in Government service get undue professional prominence especially when semi-official medical associations do propaganda in the prevention of diseases. But so far nobody has questioned such prominence. It is usual in this city that notices of meetings where professional subjects are to be discussed, are being published in lay newspapers and sometimes even the lectures delivered are so published. Complaints in these matters being very unpleasant, members of the profession do not take any initiative. Unlike as in Bombay the Registrar, Medical Council

in Madras being himself a medical man and a private practitioner to boot, it may be perhaps too much to expect him to take notice of unethical conduct either of Associations or individuals, yet we have published the Bombay circular to apprise the profession of the evils of unethical conduct with the hope of fostering latent ideals at least which may at any future date evolve practicable results with regard to the condut of the profession in matters like this.

So far to our knowledge the Bombay or Burma Medical Councils do not object to the publication of the proceedings of their meetings and the press representatives are allowed to attend the sessions. The publication of the proceedings of the Medical Councils will certainly be a means to let the public and the profession know the nature of work transacted by these Councils and will be productive of good results. Even the profession is now not aware to the extent they should of the nature of work turned out by the Medical Councils. We wish the Bombay and Burma example is followed in other provinces also.

Better late than never: We are second to none though late, in appreciating the meritorius work of Dr. Mathuradas of Moghal (the Punjab) one of the most eminent Eye-Surgeons, who has been recently appointed as Civil Surgeon, Ferozepore District and also as an Hony. Assistant Surgeon to His Excellency the Viceroy. He began his life in Government service as a Hospital Assistant. the old designation for a Sub-Assistant Surgeon, and by dint of his excellent work as an Eye-Surgeon and without passing any extra examination, has been able to attain the highest position which an Indian could aspire in the Medical services. His career is worthy of the attention of the Government as well as the medical profession, demonstrating as it does that the humblest in the medical profession could, if given opportunities, be at the top and that without futher ordeals of professional examinations. We wish other Governments also to follow the example of the Punjab and encourage medical men to follow the foot-steps of Mathuradas. The life of Mathuradas will, we hope, be taken as an example by the members of the profession also, especially the Licentiate section of it.

Nearer in Madras we are glad to report that another Licentiate in the person of Dr. P. Rama Rao who is now in Vienna undergoing post-graduate training has been able to be recognised by the American Medical Association who have elected Dr. Rama Rao to serve in their executive committee, an unique honour so far given to an Indian. We congratulate Dr. P. Rama Rao and wish him a speedy return to Madras after finishing the post-praduate training.

Artificiality cannot last long: The present tendency in some who wish to lead seems to be more for an artificial existence. It is their belief that business meetings are not well attended unless there be tea and that the attendance at such gatherings will depend upon the items that are served on the table with the tea than the interest in the subject for which the meeting is called. This will necessarily imply that those who could afford to be generous hosts can only talk and be heard. We cannot quarrel with such leaders or their associates for their way of thinking but for these to belittle the work of others by misrepresenting the facts after unsuccessful attempts of breaking such work cannot be anything more than an after-math of a heavy feast. Associations are run for public good and not for the good of the few individuals who may run such associations and any amount of artificiality will not count much in the long run. There is certainly less harm done to the public by individual leadership even taking it for granted for the matter of argument that the particular individual is misguided, but the harm done by a few individuals in the name of Associations will have a far reaching effect on a society, making public life impossible.

A Correction: Under the Caption "Ante-Natal Clinics" we mentioned in these columns that at the instance of the Red Cross Society batches of three lady-doctors in service were to be trained at the Gosha Hospital Ante-Natal clinic and that the cost of training was to be met by the Red Cross Society. We very much regret that our information was not

correct. We now learn authoritatively that the Surgeon-General thought it was necessary that some of the lady doctors in service belonging to Apothecary and Sub-Assistant Surgeon grades should have post-collegiate training and has ordered that such lady doctors should be posted at the Gosha Hospital for training in all subjects including Ante-Natal Work and the cost of such training is being met from the Dufferin Fund which is under the control of the Surgeon-General. Individual applications from private lady doctors who wish to undergo training in Ante-Natal work may be made to the Surgeon-General through the Superintendent, Gosha Hospital, Triplicane.

M. B. B. S. Course for L. M. Ps : Many of our readers have been writing to us seeking advice regarding the Senior Cambridge course which has been laid down as one of the entrance preliminary qualifications for the L. M, Ps. of 5 years standing. They wish us to publish the curriculum of the Senior Cambridge Examination. A few more ask our opinion about the existing private institutions who are advertising about postal tuition for this course. While a good many in Government service want us to inform them whether there is any liklihood of their getting the required leave to attend the course. One or two request us to canvass candidates who wish to have Telugu as their 2nd language.

For the details about the curriculum the candidates may apply direct to the Inspector of European Schools, Old College Road, Nungumbakkam, Madras who is the officer conducting the Senior Cambridge examination in this Presidency. The regulations are in the form of a book of 40 pages of printed matter, demy 1 to 8 size, and we regret we are unable to undertake reprinting them. Regarding the private institutions who are advertising postal tuition, we cannot take the responsibility of saying one way or the other. The Principal, City College, Broadway is advertising about postal tuition course in this journal. Beyond the fact that the Managing Editor knows him personally more than anybody else running such private institutions being one of his clients in the advertising department, we are not in a position to say more. But we can through the Managing Editor, easily approach him for any information the candidate may require. Regarding leave for L. M. Ps in Government Service it is likely that 3 or 4 a year may be given the required leave and perhaps not more due to financial stringency. There is no liklihood of their getting Study leave allowances as the Retrenchment Committee have expressed strong views against such a procedure as a routine. In Madras Presidency the oriental languages recognised so far by the Cambridge University are Sanskrit and Tamil. But they are prepared to include Telugu or any other oriental language not mentioned on page 38 of the regulations, in case a special fee of Rs. 60 is borne collectively by all the candidates desiring to include other oriental languages such as Telugu etc. Dr. R. David, L. M. P. Victoria Memorial Mission Hospital, Hanumakonda, Hyderabad State desires us to inform the candidates wishing to take up Telugu as second language to communicate with him so that a Telugu group may be formed for the Senior Cambridge Examination.

All India Medical Licentiates Association : We learn that the Silver Jubilee Conference of the above Association will meet at Darbhanga on or about the 30th December 1931 and that Diwan Bahadur T. Rangachariar, M. L. A., C. I. E., has kindly consented to preside on the occasion. We congratulate the General Secretary on his choice of the President at this momentous juncture when the destinies of Licentiates to be recognised practitioners for the purpose of the proposed Indian Council Bill are in the hands of the representatives of the people in the Legislative Assembly. We are sure that if the Association convince Mr. Rangachariar about the injustice likely to be done to this class of practitioners by the proposed Bill, he will use his influence with his collegues in the Assembly and have the Licentiates included within the purview of the Bill or not have a council at all for the purpose for which it is proposed.

Honoraries in Govt. Hospitals : We can do no better in expressing our views regarding the employment of honoraries in State Hospitals than by quoting the words of Lt.-Col. Fraser,

I. M. S., Superintendent, Head Quarters Hospital, Coimbatore on the occasion of the opening of the new buildings at the Government Hospital, Coimbatore by H. E. The Governor of Madras on 13-10-'31 :—

"I would like to place it on record that we have been a very happy family here ; my staff, official and unofficial, have worked together with the greatest harmony and I foresee in this a happy augury for the future when most state hospitals will be largely staffed by voluntary physicians and surgeons. Such an arrangement is of mutual benefit to the State and to the doctor, for, it relieves the former of much expense and assists the local doctors in building up a practice." His Excellency naturally hoped for "the date when hospitals will be largely staffed by honorary medical workers."

We trust that His Excellency knows that a large number of State Hospitals have been "staffed by honorary medical workers" and these at present serve only in releiving the official staff of their responsibilities of work in the hospital so much so that some of them at least, have been able to run private business and that with the permission of the Head of the Department. It is well that His Excellency will consider whether this sort of relief to the full-time officers in the hospitals will not only be detrimental to the interests of the Department but also to the healthy growth of independant medical profession in this country who as expected by His Excellency will never be able to take up honorary work in the hospitals so long their rights of private practice are infringed by state-paid practitioners who in addition to what they earn as fat salaries are to-day having private practice as a business. It is certainly a strange and most unfortunate irony that with the introduction of honorary medical officers scheme that the head of the Medical Department should have considered it justifiable to permit the subordinates to do private business, and did not consider how the honoraries could command practice and with it a decent living. As the Minister in charge of the Medical Department had expressed the other day on the floor of the Local Legislative Council that he did not interfering with the orders of the Surgeon-General in permitting a Government medical officer to run private business, it is worth while for the honoraries to know from His Excellency, his views on the subject basing on his experience of voluntary system of medical relief in his own country.

Correspondence, Reports, etc.

Interpellations.

PRIVATE PRACTICE BY A GOVERNMENT MEDICAL OFFICER.

In reply to Mr. V. T. Arasu the Government stated that they considered it unnecessary to place on the table the several Government orders regarding private practice by Government Medical Officers and that the rules relating to the subject were contained in paragraphs 279 to 288 of the Madras Civil Medical Code which is available in the library for reference.

In reply to Mr. V. T. Arasu, the Minister for Local Self-Government stated that the Second Surgeon of the Madras General Hospital had been permitted by the Surgeon-General to maintain a nursing home for his own private patients and that the Government did not propose to take any disciplinary action.

Mr. Arasu asked how the Chief Minister was justifying this answer in view of the emphatic and definite answer to a question on a previous occasion that Medical officers were not allowed to run nursing homes.

The Minister replied that this matter was not before him at the time he gave the previous answer.

The same member put it to the Minister whether the morale of the whole

service was not undermined by such permission being given by the Surgeon-General to Surgeons in the General Hospital to run nursing homes.

Mr. Sami Venkatachalam Chetti enquired if the permission to the Second Surgeon to carry on private practice was granted at the instance of the Government.

The answer was in the negative.

Q. Were the Government previously informed ?

A. Notice.

Mr. R.N. Arokiaswami Mudaliar wished to know whether the Government will be prepared to grant similar permission to others.

The Chief Minister stated that it was the Surgeon-General who sanctioned such arrangement and not the Government.

Mr. Sami Venkatachalam Chetti : Have not the Government power to rescind the sanction ?

A. Yes : but they do not see any reason for interference.

Mr. C. S. Ratnasabapathi Mudaliar : Has not the exercise of this power been made conditional ?

The answer of the Minister was not heard in the gallery.

CASES OPERATED IN THE GENERAL HOSPITAL.

Q. Mr. V. T. Arasu : Will the hon. the Minister for Local Self-Government be pleased to state, (a) the number of cases that were operated on by (1) the First Surgeon, and (2) the Second Surgeon, in the Madras General Hospital during the months of January, February, March and April 1931 ; (b) the number of cases that healed on first intention out of their respective operations ; and (c) the number of cases that went septic out of their respective operations ?

A. (a) The number of cases operated on by the First and Second Surgeons in the Government General Hospital, Madras, during the months of January February, March and April 1931, is as follows:—

	Surgeon First	Surgeon Second
January 1931	141	97
February 1931	130	84
March 1931	139	92
April 1931	105	92

(b) and (c) Of the operations performed by the First and Second Surgeons during the months of January to March 1931, 474 cases healed by the first intention and 82 by the second. The cases referred to here are those operated on and discharged during the three months. Information about other cases and those for April 1931 are not at present available. Government do not consider it desirable to furnish information showing the result of the operations performed by each of the Surgeons separately.

Q. Mr. V. T. Arasu : It it the practice of the Surgeons to leave operations in the hands of their raw assistants ?

The hon. Mr. B. Muniswamy Naidu : I want notice.

Q. Is the Minister aware that Sepsis is more common in the wards in charge of the second surgeon than in other wards, and if not will he call for the information?

A. I do not think it is necessary to call for the information.

Mr. C. Basudev: Is not the hon. member pursuing a personal vendetta against the second surgeon of the General Hospital ?

The President : Order, order.

Mr. Arasu : Will the Minister call for the information ?

A. I do not think it necessary.

Mr. K. P. Raman Menon : Is the Minister aware that there is a good deal of personal jealousy against the second surgeon of the General Hospital ?

There was no answer.

QUALIFICATIONS OF CARDIOLOGIST IN THE GENERAL HOSPITAL,

Mr. C. Basu Dev : Will the hon. the Minister for Local Self-Government be pleased to state—(a) whether the Government have appointed an Honorary Cardiologist to the Madras Government General Hospital and whether he is in independent and sole charge of that department ; (b) if the answer is in the affirmative, what are his special qualifications to fill the post ; (c) whether the Honorary Cardiologist has had any opportunity of studying the science recently either in England or on the continent ; and (d) when did this gentleman visit the Westeren countries ; if any, and in what capacity ?

A.—(a) The hon. Member has apparently in view the appointment of Mr. T. Krishna Menon, M. B. C. M., (Mad.) M. R., C. S., (Eng.), L. R. C. P. (Lond.). Honorary Physician, Government General Hospital, Madras. as Honorary Lecturer in Cardiology and Hæmotology, in the Madras Medical College. This Lecturer is not, however, in charge of any special department for Cardiology in the Government General Hospital, Madras. (b) His special qualifications are that he has undergone post-graduate study in England in the following hospitals: (1) Charing Cross Hospital, London, (2) Brompton Hospital for diseases of chest. (3) West London (Post-Graduate) Hospital. (4) Mount Vernon Hospital, London. Since appointment as Honorary Physician, Government General Hospital, Madras, he has been working in the special subject under the directions of the Professor of Medicine, Medical College, Madras, as there are facilities for the study of the subjects at the General Hospital. (c) He has had no occasion to visit England or Continent recently. (d) He visited England in 1913 and was then a post-graduate student there.

HONORARY MEDICAL OFFICERS.

Q.—Mr. Abdul Hameed Khan : Will the hon. the Minister for Local Self-Government be pleased to state—(a) whether as a result of the appointment of honorary officers to Government hospitals there has been any saving in expenditure on the department ; and (b) how many paid officers in the department have been replaced by honorary officers ?

A.—(a) and (b) Honorary medical officers are generally appointed as supernumerary to the paid staff. One assistant surgeon has been temporarily replaced by an honorary medical officer assisted by a sub-assistant surgeon. This has resulted in a small saving to Government. Further proposals for the replacement of paid medical staff by honorary staff are under consideration by Government.

Mr. Hameed Khan : Have not Government found this system financially beneficial and if they have, what further steps have they taken to replace the paid staff by honorary surgeons ?

The hon. Mr. B. Muniswami Naidu : The system is on its trial and Government would give effect to them where they are found to work well.

Mr. V. M. Ramaswami Mudaliar : Is there any obstacle to replacing paid officers by honorary officers ?

A : Honorary officers are being appointed and when suitable opportunity arises the salaried officers are replaced. As I have stated in the answer, one Assistant Surgeon has already been replaced.

Mr. V. T. Arasu : From the experience that has been gained so far, will the Minister say whether honorary officers are not capable of running an institution by themselves without the aid of a paid officer ?

A : They are capable men but the question is whether they should replace the paid salaried men.

Q : When we have men capable of running an institution by themselves, where is the objection to entirely manning Government institutions by such men ?

A : Honorary men can run a whole institution no doubt but whether they should replace salaried men in Government institutions is the question to be considered.

Mr. Hameed Khan : Is not Government anxious to retrench in this direction ?

A : They are.

Q : Then why should they not adopt this policy and save money ?

A : Government have accepted the policy.

Q : Then do Government consider that honorary men cannot run Goverment institutions by themselves ?

A : I will not go to that extent.

Q : Then what is the opinion of the Minister ?

A : I have already answered the question.

The Leprosy Campaign with Special Reference to Malabar District.

No campaign against any disease will meet with any success unless the strength of the afflicted population is roughly estimated, the commonest contributory causes are inquired into, and the measures

are adapted according to the local conditions. The 1921 and 1931 censuses show 15,598 and 33,049 cases of leprosy respectively for the Madras Presidency. The decennial censuses from 1871 to 1921 have never exceeded 16,663 (1911 census) but the figure for 1931 shows an increase of over cent per cent. Could there be an error on the part of the Census enumerators or does the figure indicate that the disease is spreading very rapidly? The census figures can be greatly relied upon as the Census Officers do not detect cases but depend on the information generally given to them by the principal members of a house who will be cautious enough to state the obvious cases only. Moreover, the health survey of 1930 has recorded about 35,500 cases, though the survey is still incomplete in a few heavily infected districts.

If the census figures are correct it then follows that the virulence of the disease had doubled itself during the past decade. One should bear in mind that the intensive leprosy propaganda work begun in 1929 has educated several people to identify leprosy in its early stages. This can be illustrated by the fact that the Revenue Officers who surveyed South Arcot and East Godaveri Districts in 1929 detected 3,800 and 3,000 cases respectively while the census figures for 1921 for these Districts were 1650 and 840 respectively, and the 1931 figures were 4,129 and 2,273 respectively. This does not exclude the possibility of the disease being on the increase, for the out-patient leprosy clinics show that the number of cases at recent origin is far greater than the number that have died. In brief it may be stated that the sudden increase in the last decennial census is due to the propaganda work as well as to the spread of the disease. Though these census figures could be relied upon for comparative study, the actual incidence in the Madras Presidency could be estimated at a figure no less than a lakh, a figure which equals the census figure of 1921 for the whole of India. Many have expressed that a special survey party should be appointed to estimate the actual incidence in the Presidency. As such a party of six members would take about forty years to complete its work, the money, time and energy spent on it, could be more profitably utilised in some other direction.

With reference to the Malabar District the 1921 census gives a figure of 1109, and the 1931 census a figure of 1668. The same two reasons that accounts for the increase in the whole Presidency, hold good for Malabar District also where there has been a fifty per cent increase. Till the end of 1930, the activities of leprosy work were wholly confined to the Leper Asylum at Chevayur. This institution was unable to cater to the needs of all the affected individuals as its accommodation was limited to 160 and its wards were always full. A visit to this asylum would show very encouraging results obtained through the earnest efforts of the energetic medical officer. Moreover, the prolonged course of treatment in leper asylums, the curse of caste and creed pre-judices so strong in South India, the sentiments of domesticity among those who have the means of maintenance or the semblance of a home, the absence of pain, discomforts and deformities in the infective cases, and the desire to labour to support one's family till incapacitated, have prevented, severa. patients from resorting to treatments in in-patients' institutions.

In the Malabar District the taluqs which have been heavily infected are Ponani, Palghat, Walluvanad, Ernaad, Calicut and Kurumbranad, the heaviest infection being in Ponani Taluq. This disease is no respector of castes or creeds ages or sexes, and has paved its way among Rajahs, Government servants of all grades, students, teachers, labourers and beggars. Some of the factors which could possibly account for the infection are :—

(1) The semi-clad body of most of the people. This favours direct contact of the skin with any infective material on or outside the body.

(2) The insanitary condition in many houses and the promiscuous use of clothes, beds and furniture by relations and friends.

(3) The nauseating habits of depositing or rubbing anywhere the discharges from the nose and ulcerated lesions.

(4) The commonest skin diseases, such as scabies, the mosquito bites and the abrasions which lower the local resistance of the nude skin which is favourably prepared to harbour these infective organisms, and

(5) The ignorance of the public of the early manifestations of this disease.

The temple at Guruvayur no doubt serves as a nucleus of infection but that does not account for the heavy infection among the moplahs at Ponani Taluq. A perusal of the registers at any leprosy Clinic will show that the cases among the moplahs out-number those among any other community.

For infection to take place, prolonged close and continuous contact is very necessary and it is this only that accounts for the incidence among children of leprous parents. A family history is not necessary but the constant handling of a child by a leprous servant or relative, or the prolonged close association with an infective individual will suffice to cause infection, especially when one is semi-clad. Children are very susceptible to the disease owing to the delicate structure of the skin, and the skin diseases they are subject to, but the disease may not mainfest itself for some years. Moreover, the virulence of the disease is low as is evident from the fact that several infective cases move in the public, with little or no inconvenience, dissiminating the disease, a few contacts being affected. One does not fail to find that some persons living in the same house as an infective leper have escaped infection.

In the light of the above remarks the problem of leprosy in the Malabar District is a grave one and attempts, for the present, should be directed towards arresting the spread of the disease and reducing the incidence ; with this end in view and to meet the patients' difficulties mentioned before, the new policy of opening out-patient Leprosy Clinics has been introduced in the Malabar District. Since the beginning of this year, along the same lines as those adopted in the other parts of the Madras Presidency, in the other Provinces of India, and in the Far East, all the Medical Officers in the Malabar District have been trained in Leprosy, most of them having undergone a special course of training at the Headquarters Hospital, Calicut. A leprosy Officer under the District Board has been appointed to co-ordinate the work and to do special propaganda work. Bi-weekly out-patient Clinics have been opened at Calicut, Quilandy, Taliparamba, Cannanore, Kuttuparamba, Tirurangadi, Tirur, Chowghat, Palghat Alathur and Cochin and four more have been proposed at Tellicherry, Ponani, Angadipuram and Ottapalam. The Clinic attached to the Headquarters Hospital, Calicut, is very popular, several cases having improved markedly and a few being fit to be discharged. The attendance on treatment days is between 90 and 100. The Municipality will do well to open a Clinic attached to its dispensary at Kuttichera or Kallayi as many cases are found in those vicinities. The Municipality will thus be a great boon to the public of Calicut and will be participating in the Leprosy Campaign in the Madras Presidency where about 75 treatment centres are now in existence, and 50 more will be opened within a year.

The day has at last dawned bringing hope of recovery to these unfortunate victims and we can hopefully look forward for a day in the near future when the period of treatment can be considerably curtailed. Attempts are being made to bring treatment within easy access of every affected individual so that they may avail themselves of the opportunities afforded. The price paid for ignorance is the contraction of the disease and penalty paid for neglect is a painful, miserable, crippled, lingering existence. Ignorance can be tolerated but neglect is inexcusable. The spread of the disease must be checked the incidence must be reduced and the country must be rid of leprosy. If the public, the local bodies and the Government would co-operate in this great cause, the campaign would be successful in a short period. Therefore India "Expects every man to do his duty."

Provincilisation of Local Fund Medical Services.

Sir,

I request you will kindly publish the following lines in your esteemed journal.

Under the New Local Board Amending Act each Taluk Board is likely to split into smaller Taluk Boards. Till now each

of gonorhoeal origin and if that be the cause of his septic knee I would suggest to the doctor to carefully investigate if he had any epidydimitis or vesiculitis or vasitis. It is worth while taking a careful history and examine his urethra for posterior urethritis with a urethroscope. The discovery of impotence after the earth-quake and presumably the first attempt at coitus after the recovery from septic knee is a mere accident. There is also another possibility. It may be a case hypopituitirism a defficiency of pars anterior. The remedy then is the administration of the anterior lobe of the pituitary body. In any case the impotence is not a calamity in a man of 40 in these days of economic depression and over population and when birth control is so much advocated.

Malappuram, 22—8—31. | P. P. Chandu Nambiar, F.R.C.S. (I) M.R.C.S, (Eng.) L.R.C.P. (Lond.) Civil Assistant Surgeon.

Foreign Body in the Nose.

A girl aged about 3 years was brought to me for the removal of a foreign body in her right nostril at 2 p.m. It appeared to be a green glass bead. All my attempts having failed to remove it with the aid of instruments even after applying local anaesthetic and using a 4 oz. syringe without its nozzle to help out the bead by suction, I gave a hypnotic dose to the child and advised the mother to make the child sleep on the left side resting its head raised and slanting on a pillow.

I advised this posture basing on a phenomenon in the case of obstructed nostril getting relieved when the patient suffering from nasal obstruction due to Catarrh lies down on the side opposite to the nostril which is obstructed. To my great relief and satisfaction the child was brought to me at 7 p.m. with the history that the bead came out of her right nostril, of its own accord.

My theory is that when a patient with an obstructed nostril lies down on the side opposite to the obstructed nostril the lung on that side being pressed makes the upper lung more expanded and consequently the preasure of air coming out of the lung on the upper side necessarily is increased with the result that any obstruction in the upper nostril is forced out.

I don't know whether I am correct in explaining the phenomenon. Whatever be the physiological action concerned in obstruction in the nose in cases similar to the one reported by me, a general practitioner may try postural treatment adopted by me.

I have brught this case to the notice of the general practitioners with the hope that postural treatments advocated by me in nasal obstructions are worth their trial especially in far off places where specialists are not available as this treatment does not cost anything and is in no way risky.

Girgaum Back Road, Bombay. | G. L. Deshmukh, L.C. P.S; M.B.B.S.,

Errata

Page 39, 2nd column, line 27, read "keept" as "kept."

Page 40, 2nd column, line 20, read "Medical Council" as "General Medical Council."

Page 41, 2nd column, line 13, read "if" as "of."

Page 43, 2nd column, line 19, read "Provintial" as "Provincial."

Page 44, 1st column, line 34, read "of some" as "of the same."

Page 45, 1st column, 2nd para headline, read "Molima" as "Molimina."

Page 45, 1st column, 2nd para last but one line, read "timid" as "tired."

Page 46, 2nd column, line 15, read "sex" as "her" and "passion" as "pass on."

Page 47, 1st column, 2nd para, 5th line, read "sext racks" as "sex traits."

Page 49, 1st column, line 22, read "flexus" as "plexus."

Page 49, 1st column, line 32, read "bulci" as "Sulci."

Page 49, 2nd column, line 22, read "meduliary" as "medullary."

Page 49, 2nd column, line 29, read "flexus" as "plexus."

Page 53, 1st column, line 4, read "2nd" as "and."

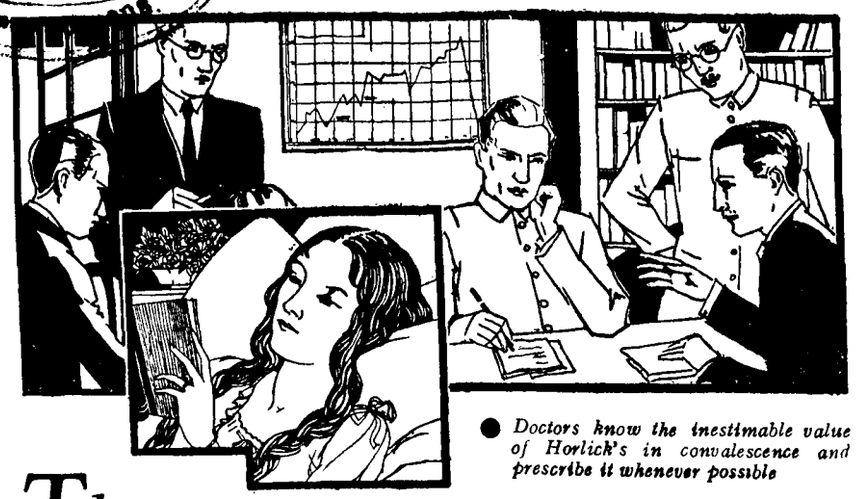
Page 53, 1st column, line 7, read "ropeated" as "repeated."

Page 55, 2nd column, line 47, read "corvza" as "coryza."

Page 56, 2nd column, line 14, read "bp" as "by."

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

No.	Names of Sub-Asst. Surgeons.	From	To
1.	Dr. G. Srinivasa Rao,	Govt. Hd. Qrs. Hl., Guntur.	Govt. Dy. Gurzala (Guntur Dt.)
2.	„ M. Subba Rao,	Govt. Dy. Gurzala.	Govt. Hd. Qrs. Hl., Guntur.
3.	„ K. Simhachalam,	Govt. Hd. Qrs. Hl. Chittoor	L. F. Dy. Puttur (Chittoor Dt.)
4.	„ K. Narayanan Nair,	Vizagapatam Agency.	Govt. Mental Hl., Calicut.
5.	„ A. Gopalan Nambiar,	Govt. Hd. Qrs. Hl., Calicut.	Govt. Hd. Qrs. Hl., Coimbatore.
6.	„ T. R. Venkatraman,	Govt. Hd. Qrs. Hospital, Coimbatore.	C/o Principal Madras Forest College, Coimbatore.
7.	„ M. Gopalan	L. F. Dy. Kaveripatnam Leave	Hd. Qrs. Hl., Salem.
8.	„ G. Gopalan,		Govt. Mental Hl., Madras.
9.	„ P. K. Gopalan,	L. F. Dy. Denkanikota.	C/o Civil Surgeon, Vizagapatam
10.	„ R. Narasimham,	Kolab Bridge Works Dy. Vizag Agency.	C/o P. D. B. Salem.
11.	„ T. D. Ramaseshan,	L. F. Hl., Polavaram.	Govt. Hd. Qrs. Hl. Calicut.
12.	„ M. Dattatriya,	Govt. Hd. Qrs. Hl., Vellore.	C/o P. D. B. North Arcot.
13.	„ V. Venkataramanjulu,	L. F. Dy. Maharattipalayam.	Lady Willingdon Leper Settlement, Tirumani (Chingleput Dt.)
14.	„ P. M. Sreedharan,	Govt. Hd. Qrs. Hospital. Coimbatore.	Lawley Rd. Dy. Coimbatore.
15.	„ K. Narasimham,	King George Hl., Vizagapatam.	Govt. Hospital, Rajahmundry.
16.	„ C. Krishnamurthy,	Govt. Hl., Rajahmundry.	L. F. Dy. Siddhout.
17.	„ K. Rajamannar,	Govt. Hd. Qrs. Hl., Chittoor	Govt. Hd. Qrs. Hl., Chingleput.
18.	„ P. K. Narayana Nambiar,	Mental Hl., Calicut.	Govt Hd. Qrs. Hl, Coimbatore.
19.	„ S. Sesha Reddi,	Govt. Hl., Palmaner.	Hd. Qrs. Hl., Chingleput.
20.	„ M. Jacob,	Leave	C/o P. D B., Salem.
21.	„ M. V. Srinivasan,	L. F. Dy. Uttangarai.	L. F. Dy. Palakodu.
22.	„ N. S. Sundaram.	Govt. Hd. Qrs. Hl., Tanjore.	C/o C. M. C. Negapatam.
23.	„ K V. Venkataram Ayyar,	Leave	Govt. Dy. Tiruvallur.
24.	„ S. T. Thiagaraja Pillai,	Leave	L. F. Dy. Thiruvadanai.
25.	„ M. Goparaju,	King George Hl., Vizagapatam.	C/o P. D. B., Chittoor.
26.	„ Ch. Swamy,	L. F. Dy. Pallipat.	L. F. Dy. Puttur (Chittoor Dt.)
27.	„ C. Krishnamurthy,	Govt. Hl., Rajahmundry.	L. F. Dy. Siddhout.
28.	„ E. I. Devapriam,	Govt. Hl., Penukonda.	Govt. Hl., Kadiri.
29.	„ M. V. Ganesan,	Govt. Hospital, Kadiri.	Govt Hl., Penukonda.
30.	„ M. Subba Rao,	Hd. Qrs. Hl., Guntur.	C/o I. G. of Prisons, Ootacamund.
31.	„ V. Swaminathan, M.R.C.S. L.R.C.P.,	Leave	Govt. Hd, Qrs. Hl., Bellary.
32.	„ L. V. Jaganadha Rao,	Hd, Qrs. Hl., Bellary.	L. F. Dy. Nandikotkur.
33.	„ M. A. Parthasarathy, Ayyangar, F.R.C.S.I.,	Govt, Hd. Qrs. Hl., Madura	Municipal Hl., Udumalpet.
34.	„ P. V. Subba Rao,	L. F. Dy. Pamur.	C/o Civil Surgeon, Vizagapatam
35.	„ K. Srinivasamurthy,	Govt. Dy. Krishnadevipeta.	C/o P. D. B. Nellore.
36.	„ T. Sitaramayya,	King George Hospital, Vizagapatam.	C/o Civil Surgeon Vizagapatam
37.	„ I. V. Narasimham,	Executive Engineers Establishment, Koraput	Hd. Qrs. Hl., Bellary.
38.	„ V. Syed Ahamed Saheb,	Leave	Hd. Qrs. Hl., Chittoor.
39.	„ Mohamed Ayoob Khan Saheb,	Govt. Dy. Minicoy Island.	Hd. Qrs. Hl., Calicut.



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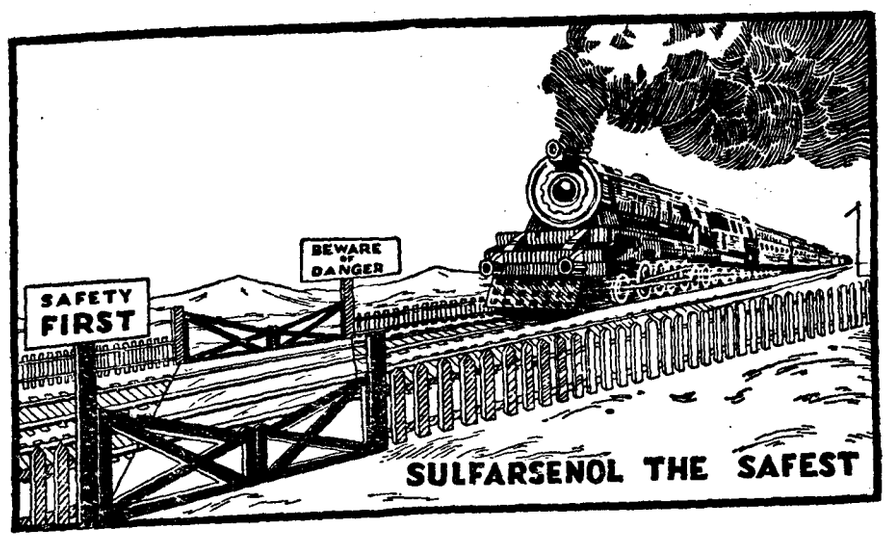

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VOL. 3. No. 3. DECEMBER 1931.

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A Monthly Medical Journal

EDITED BY
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Business Notice.

Scientific articles and notes of interest to the profession are solicited. Contributors of original articles will receive a copy of the journal in which they are published.

Communications on all matters connected with the journal, literary and business should be addressed to the Managing Editor, 147, Purasawalkam High Road, Vepery, Madras, as he alone is responsible for the conduct of the journal. Annual subscription to the journal is Rs. 1—8—0 including postage, payable in advance. Papers and articles forwarded for publication should be either typed or written legibly on only one side of the paper. They are understood to be offered to "The Medical Practitioner" alone and any breach of this rule will be followed by non-publication. When any such of the article appears in "The Medical Practitioner" the copyright automatically becomes the joint property of the author or authors and of the publishers. Paper and articles sent will be sent back to the contributors, if so desired, and postage sent for the purpose. The Editors of "The Medical Practitioner" cannot advise correspondents with regard to prescriptions, diagnosis, etc., nor can they recommend individual practitioner by name as such action would constitute a breach of professional etiquette.

THE

Medical Practitioner

Annual Subscription Rs. 1-8-0. Single Copy As. 4.

VOL. III] DECEMBER. 1931. [NO. 3.

NEW YEAR GREETINGS

We offer our hearty greetings to our readers for the New Year which in a few days will be ushered into the world. The year will be a momentous one in the history of India, far reaching changes are expected to be made bringing the people in closer contact with the administration of the country. The people should equip themselves to take up the duty and discharge it satisfactorily to all concerned.

The medical profession has now overflown its narrow groove of affording medical relief to the sick and permeated into the physical, social economic and even political spheres of life. Before a child is born ante-natal care of the mother is to be taken by the physician. The child has to be brought into the world with due care and the family physician has to advise proper diet and correct dysfunction of any organ which may pre-dispose to diseases. The school physician next comes in and by means of "*intelligence test*" regulates the course and kind of study best suited to the pupil. When puberty sets in, instruction on sex matter and advice as to marriages have to be given by the physician. At the reproductive age regulation of birth, both as to the number and the interval between births have to be considered and decided by the physician. During climacteric, on account of the disturbance of the equilibrium of the functions among the different ductless glands and other organs, suitable adjustment on the mode of living, etc., has to be prescribed by the physician. All these cannot be attended to individually or by private organisation. Public Health, School Medical Service, Child-welfare, etc., have to be organised and maintained by Government and medical men should be given a large share in the working and administration of these departments. After the late World War, "a few advanced countries are beginning to discover that medical men make the best statesmen because their knowledge of life is very real and their mental outlook genuinely a wide one." In the new era which is to dawn in the ensuing year the responsibilities of the medical profession will become great and it should realise the fact and equip itself to discharge them. The people look to the independent medical practitioners largely to undertake the onerous duties.

"The Medical Practitioner" was started chiefly with a view to protect the interests of the independent medical profession and to advance it to the position which is its right to occupy and has been following rigorously these principles in all their aspects ever since it came to existence. That its activities

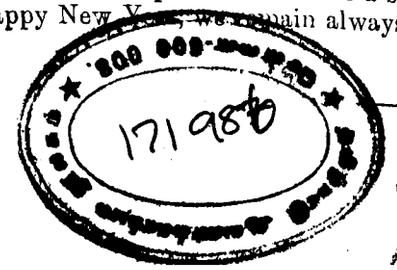
have not been in vain, will be evident from the fact that the Government has recognised the principle of replacing paid-medical officers by honoraries, though they have not given effect to it to the extent it is possible to advance this scheme. The Government or at least the Hon'ble the Minister-in-charge of Medical Department did express that the Rural Medical Relief Scheme useful as it was, had been found very defective in its working though it is regretted that the Minister has not as yet found time to improve the scheme. There is tangible evidence that the voice of "The Medical Practitioner" regarding the grievances in the Medical Department had been heard. Appointments in teaching institutions are now made without raising the rank of the officers so appointed. This has directly put down supersession.

It is not to be thought that these advancements have been brought about only by "The Medical Practitioner," but it cannot be denied that it had some share in it. The Medical Practitioner has no party spirit and is not a party journal and has been always keeping in view the advancement of the independent medical profession and the unity of the medical profession as a whole. It had occasions to criticise some paid-medical officers and the medical service but had not spared the private medical profession individually or in a body when occasion demanded such treatment. There are several ways to reach the goal of the independent medical profession and it is not desirable nay, sometimes objectionable to follow only one way. All resources should be tried and all different ways and means adopted to reach the goal. The fact that one of the means is tried by one agency, does not mean that it is hostile to others.

There are still many things to be done and among others the most important are the unification of the medical profession by doing away with the different classes or grades of medical men, the extension of the honorary system throughout the Province, the improvement and extension of study of the L.M.Ps. and bring their standard of education to that of the medical graduates, improvement of medical inspection of schools by appointing medical men as teachers for Hygiene and Physiology and entrusting them not only with the medical inspection but also with the work of school medical clinics, and last but not least importance, is the improvement to be brought about in the proposed Indian Medical Council Bill to make it serve the purpose of similar Medical Acts existing in other civilised countries.

We are glad to state that the number of subscribers to "The Medical Practitioner" has appreciably increased and we are highly grateful to the members of the profession who have been showing their appreciation of the services of "The Medical Practitioner" by enlisting themselves as subscribers.

Though the bulk of the journal has considerably increased we have not increased the subscription with a view to enable even the humblest member of the medical profession to be a subscriber. Wishing you all once more a happy New Year, we remain always at your service.



THE ANNUAL REPORT OF THE CIVIL HOSPITALS AND DISPENSARIES.

IN THE PRESIDENCY OF MADRAS FOR THE YEAR 1930.

THE NUMBER OF MEDICAL INSTITUTIONS.

At the end of the year there were 1188 medical institutions, 948 in rural areas and 240 in urban areas, or in other words one institution for 22,000 persons in urban areas and one in 39,000 in rural areas. Of these 1,188 institutions 190 are State-Public, 33 State-Special, 482 Municipal and Local Fund, 72 Private Unaided, 52 Railway dispensaries and 359 Rural subsidised. We have been frequently pointing out that for the present, Hospitals with provision for in-patients should be the unit of medical institutions maintained by Government and that at the Headquarters of almost every Taluq there should be a well equipped hospital with provision for at least 20 in-patients. The dispensaries where out-patients are only treated should be left to Private Practitioners or private agencies. Neither the Government nor the municipal or local fund should maintain them at public expense. Only the rural dispensaries under the Scheme of Rural medical relief should be subsidised, and special dispensaries such as for the treatment of malaria, may be maintained from public funds and not others.

PATIENTS TREATED.

The number of out-patients treated in all the institutions was 12,602,532 of whom 1,692,705 were treated at the Rural subsidised dispensaries and the average number treated in each rural subsidised dispensary was 4,714 *i.e.*, about 400 each month. The total number of beds available for in-patients was 1,464 for a population of about 45 millions which works at the rate of one bed for every 4,737 persons, while in the United States of America where the people are rich enough to get themselves treated at their own houses and where the number of practitioners are sufficient to attend to the needs of the public, the number of beds available is one for every 270 persons. Even in the Phillippine Islands with a population of 10 millions the number of beds available is about 8000 and at that rate the number of beds required in Madras is 36,000, *i.e.*, 4 times the existing number. Instead of frittering away the little money available in paying high salaries for medical men and opening dispensaries for the treatment of out-patients, replacing paid-officers by honoraries and closing all dispensaries for the treatment of out-patients and leaving them for private agencies, the number of beds may be increased and medical work carried on satisfactorily both to the patients and to the advancement of medical science. The diagnosis of diseases and treatment given to the out-patients cannot be expected to be satisfactory at all.

OPERATIONS PERFORMED.

The number of "selected surgical operations"—the designation used in the year under report, for that of "real major surgical operations" used in former years—show a decided fall and in the mortality an appreciable rise. The necessity or the advantage and meaning of the change is not clear except perhaps to serve as an explanation for the fall in number and rise in mortality of the operations. The fear entertained, that the fall in the number of operations and the rise in the rate of mortality must be due to the neglect of patients admitted in the State Hospitals officered by the highly paid-medical officers, consequent on their resorting largely to private practice including opening of nursing homes, as evidenced by the interpellations made at the last session of the Legislative Council, cannot be said to be without foundation.

VISITED DISPENSARY SYSTEM.

The roaming system of affording medical relief can never succeed. It will serve only as an excuse for not doing satisfactory work either at Headquarters or at the out-stations. No dispensaries should be opened at those places, and the subsidised rural medical scheme should have been introduced there. Why the poorly paid-medical officers at those stations are required to go out to villages to treat cases and the highly paid-officers in the city and big towns are permitted to have

recourse to private practice and open nursing homes are not known.

NURSES AND MIDWIVES.

Taking the social conditions as existing at present in the Province, female nurses are not much in demand for attending the sick inpatient's own houses—particularly on attending male patients. Male nurses are needed more and also midwives capable of undertaking sick nursing for female patients in their own houses. Arrangements should therefore be made for training male nurses and female (Indian) midwives in large numbers. The fact that only 169,289 births out of more than 2,000,000 that occur annually were attended by midwives, indicates the urgent necessity for training more midwives.

APPOINTMENTS FOR I. M. S. AND MADRAS MEDICAL SERVICE OFFICERS.

It is said that a Civil Surgeon for the Ante-natal and Pediatrics department of the Government Hospital for Women and Children Madras was sanctioned and one is actually appointed. The Government deputed to England, at its cost, the 2nd Obstetric Surgeon of the Government Hospital for Women and Children, Madras to undergo training in Ante-natal work and Pediatrics—but the officer now appointed for the post, is not the one specially trained for the purpose.

If a non-medical officer is appointed as professor of Biology at Vizag why not the same procedure followed in Madras, if by so doing some savings can be effected.

HONORARY MEDICAL OFFICERS.

On the occasion of the opening of an additional block to the hospital at Coimbatore, H. E. the Governor of Madras expressed his concurrence with the hope of the Superintendent of the Coimbatore hospital, regarding the future of the honorary medical relief scheme and His Excellency looked forward to the day when hospitals will be largely staffed by honorary medical workers. The wish of an ordinary person is quite different from that of the Administrator of the Province. While in the former case, it is left to the free will of the department concerned to accede to the wish or not, in the latter case it is an order clothed in smooth words which has to be carried out. That the Surgeon-General did not show any enthusiasm for the extension of the honorary system when only one officer was appointed and that, temporarily in the place of a paid-officer, is indicated in the statement he made in the report that "in a few instances honorary officers are actually replacing Govt. Medical Officers." We entirely concur with "The Swarajya" that this statement "is neither conducive to an expression of veracity nor indicative of exactness in regard to the particular policy it is claimed to be followed." It is hoped that the Surgeon-General will take the hint given by His Excellency and make early arrangements for the replacing of paid-officers by honoraries as far as possible.

ADVISORY COMMITTEES.

The Advisory Committees now appointed do not seem to function properly. Formulation of rules for the conduct of the committees by themselves, would not make the committees work. The members constituting the committee must be properly selected. The Madras Mail hits the nail correctly when it says that "the improvement would be more speedily forthcoming if the committee received more definite encouragement from the medical authorities than they have done. The rarity of the meetings is due the lack of business for "the committee to transact" and recommends "the appointment of a non-official as a secretary." It will be necessary that such committees should be appointed for all Government Medical Institutions when honorary system is extended.

SUBSIDISED RURAL MEDICAL SERVICE.

The work done in the subsidised rural dispensaries is considered by the Surgeon-General to be satisfactory. There were 312 such dispensaries in 1929 and 65 were added in the year under report and 14 closed and 4 converted into permanent dispensaries. Out of existing 359, eight are in urban areas. There is no necessity for opening rural dispensaries in urban areas as private medical practitioners are available to meet the demand there. The ultimate goal of subsidised rural medical scheme is that when people acquainted with and appreciate the medical service rendered by the subsidised staff, the subsidised rural medical dispensary should be withdrawn and shifted to other villages and its place taken by private practitioners and not by opening of permanent dispensaries with public funds.

ANNUAL REPORT OF THE HEALTH DEPARTMENT OF THE CORPORATION OF MADRAS FOR THE YEAR 1930.

THE PRINTING AND GET UP OF THE REPORT.

There is an appreciable improvement in the printing and get-up of the Report and it is satisfactory to note that our comments about them as regards previous reports have not been in vain. Still there is room for improvement. The graphs are badly drawn and they are too many in number and do not in any way contribute towards the better understanding of the figures more than the tables. The number may at least be reduced if it is not convenient to do away with them altogether. Some of the small statements may with advantage be published as insets at the side of the report or two or more of them may be published on a page instead of separately, as done at present. In cases of those printed across the pages or on opposite pages, the serial numbers should be given at each end for easy reference. Attention to these details will not only make the report compact and handy but reduce the cost of the publication.

BIRTH, DEATH AND INFANT MORTALITY.

The number of births has increased and so also the deaths but the infant mortality has fallen a little. This is rather peculiar as birth rate, general death rate and infant mortality rate ordinarily vary directly with one another. This peculiarity becomes more evident in the figures given for each community. Among Musalmans whose birth rate 54.6 and general death rate 51.6 are by far higher than those of other communities, the infant death rate is 249.7 about the same as that of the Hindus 249.3. In the sub-castes of the Hindus, the birth and general death rates of the Chetties 54.0 and 45.8 respectively are higher than those of the Brahmins 36.3 and 28.7 ; but the infant death rate of the Chetties (187.6) is lower than that of the Brahmin (196.0). Similarly the birth and general death rates of Kammalas 45.5 and 41.0 are higher than those of Brahmins while the infant mortality rate 197.1 of the former is more or less equal to that of the latter. These and similar such variations indicate that vital statistics registration is not correct and needs looking into. In a City like Madras where qualified persons are appointed as Registrars, information regarding death of infants as per order of birth, i. e, 1st born, 2nd born, etc. and death of mothers from child-birth as per the number of child given birth to, i.e. Primipara, Secundipara or birth of first child, birth of 2nd child, etc., will be highly valuable and useful.

CHILD AND MATERNITY WELFARE.

The number of labours actually attended by the 82 midwives attached to the C. W. S. deducting the number of difficult cases sent to hospitals was 11,471 and each midwife has attended on an average less than 12 cases a month. It is within our knowledge that unless actual labour commences immediately after or within a short time of the arrival of the midwives, they go away and before they return the deliveries are completed but the cases go to the credit of the midwives as having been attended by them. A few out of the 12 cases should be deducted as belonging to the above category and the remaining number cannot be considered to be adequte work for a midwife for a month, when in mofussal stations, midwives employed by municipalities or attached to hospitals or even private midwives attend sometimes more cases. For the arresting difference in the percentage of cases attended in the several divisions of the city excluding Choolai centre (which is said to have been opened in the course of the year) varying from 8.3% in the 11th Division (Sowcarpet) to 74.4 in the 7th Division (Katchaleswaram) the explanation given in the report is incomplete and unsatisfactory. An enquiry into the matter by an independent agency of the Corporation is desirable. Out of the 12,600 cases seen by C. W. S. 1,129 were sent to hospitals as they were difficult cases—leaving 11,471 natural cases and as the maternal mortality occurring

among the cases sent to the hospitals will be included in the hospital returns, the rate of mortality (62 deaths) should be calculated on 11,471 cases and not on 12,600. On such calculation the rate works at .54% and not .49% as given in the report. There is nothing highly creditable in this rate for natural labours with all the ante-natal and post-natal care, even in India where such results are obtained even without ante-natal and post-natal care, not only in cases attended by private qualified midwives but in those not attended by any—even barber midwives. From the statement made in the report that difficult cases are sent to hospitals and the absence of any operation such as application of forceps, version, etc., seen in the tables given in the report, it is clear that only natural labour cases are attended by the C. W. S. If so, the necessity for 13 lady-doctors is not apparent. Difficult cases requiring application of forceps, version, etc., are being attended to in the houses of the patients themselves by doctors and so there can be no difficulty for the C. W. S. lady-doctors to do so. It is only for difficult cases skilled assistance is required and if the C. W. S. with all the midwives and lady-doctors cannot give it, the utility of the C. W. S. maintained at a high cost, is not appreciable. The treatment of infants and pregnant women can certainly be attended to in the several hospitals and dispensaries in the city. The supervision of milk supply and bathing of infants are not so important as to necessitate the maintenance of such a costly staff. Great pains have been taken to collect statistics of maternal mortality from the several hospitals in the city for comparison with those of the C. W. S. evidently to show the superiority of the work done in the latter. It is very well known to all that only difficult cases—not only sent by the C.W.S. itself but others—seek admission in hospitals and the maternal mortality must be obviously high and sometimes higher than that obtaining even among the cases occurring in private houses unattended by midwives. The institution of comparison between the figures obtained from hospitals and outside, and those of the C. W. S. under the circumstances stated above indicates either complete ignorance of statistical methods if not wilful misrepresentation of facts.

MORTALITY AMONG INFANTS KEPT UNDER OBSERVATION BY THE C. W. S.

The ideal method of exhibiting infant mortality is by calculating the number of deaths of infants of one year and below, in a year on the number of live births in the same year. With the trained staff now working in the city it is possible to collect such figures and compile such a statement. The practice at present followed in the city and elsewhere in India, is to take the number of deaths that occurs in a year of infants born in or brought into the place not only in the year under report but in the previous year also and work out the ratio on the number of births occurring in the place in the year under report. Thus the death of infants registered in 1930 pertain to infants born in or brought into in 1930 and 1929, while the births relate to infants born in the city in 1930 only. Therefore the rate as per the ideal method referred to above cannot admit of comparison with that obtained in the usual way. The Superintendent, C. W. S. in collecting the figures, for calculating as per the ideal method on the cases that were under observation, has included the number of infants that left the city (the number of deaths among whom is not known). Deducting those cases the infant mortality rate works 176 per 1000 live births instead of 157.2 as given in the report. The rate 176 is comparatively high and cannot be considered even in India for the infants under the care of the C. W. S. to be satisfactory. On the whole neither the work done by the C. W. S. nor the way in which the report is prepared can be viewed with satisfaction.

Original Articles

ENDOCRINOLOGY

BY

DR. M. S. KRISHNAMURTHI AYYAR,
M. B. C. M.

Glands and Mind.

(Taken from L. Berman's "The Gland Regulating Personality.")

The internal secretions influence all the processes of mind, intellectual and emotional. Reflexes, instincts, habits, tendencies and emotions are involved in their machinery. The development and normal functioning of the intellectual and emotional functions are controlled by them. Acuteness of perception, memory, logical thought, imagination, conception, emotional expresssion or inhibition and the entire content of consciousness are influenced by the internal secretions. The nerve cells and tissues are dominated by them. The speed of their chemistry and their associations and thus the speed of thought are regulated by them. Iodine has been shown to increase the electric conductivity of the brain, that is the rate at which electrons will fly through it. The Thyroid may be regarded as adjusting the amount of iodine brought to play upon the brain cells at a particular moment of danger or exaltation. Adrenalin increases the electric conductivity of the brain. Nerve impulses and with them sensations and ideas travel faster and flow more quickly through iodinised or adrenalised brain cells.

THE BODY—MIND COMPLEX.

Mind, still regarded as something distinct and apart from the body, is thus exhibited as but part and parcel of it. The sense organs of the body mediate the primary mind stuff. Without internal secretions and a vegetative nervous system, there can be no soul in the sense of complex emotion. Nor these combinations of thought and emotion which synthisize attitudes, sentiments and character. The internal secretions and vegetative nervous system mediate the primary soul stuff. Mind is thus emulsified with body as a matter of cold literal fact. The soul was once a subtlety of metaphysics. Now when mind appears soaked in matter saturated with chemicals like the harmones, therefore woven out of material threads, the independent entity created out of intangible spirit flies like a ghost at dawn. Mind, the slippery phantom, now becomes controllable for the purpose of every day life, because we can put our fingers upon, touch, handle and change these material factors, the internal secretions and the vegetative nervous system. The future of the race and the future of human nature depends upon the knowledge to be born of the researches into the vast possibilities of this idea. Man, the adventurer, the prey of chance and luck, will then become, indeed now becomes, the Captain of Fate and Destiny. It is of itself a revolution in the intellect to conceive of instincts and emotions, suggestibility and contra-suggestibility, initiative and imitation, volitions and inhibitions as chemical matters. In all their relations, mutually reacting affects and defects, excesses and deficiencies, the internal secretions set up psychic echoes and reflections. When morbid and their equilibrium dislocated, we may even have phobias and neuroses. A man's nature is chemically his endocrine nature. Primarily when he is born he represents a particular inherited combination of different glands of internal secretions. They, constituting the inventory of his vital stock in trade, start his life. Afterwards food, the routine of his existence the accidents of experience, education, disease and misfortune in short environment modify him, because, they modify his ductless glands and his vegetative nervous system as well as his brain, depressing some parts and stimulating others and so re-arranging the system. In particular will he be transformed as the gland is affected which is the centre of the system to which the others adopt and accommodate themselves. If he has children he hands on his constellation of endocrines in spite of mishaps, not at all or only slightly transformed.

THE SEX INSTINCTS.

Hormone reactions initiate the complicated forces, processes and expressions of sex. The diction of Vorchow that woman was in effect an appendix to the ovaries, had long been taken to apply to her psychical traits as well as somatic.

Her mind like her skin, her hair and her pelvis is a product of the sexual endocrines. But these determinations are by no means her monopoly. Man is likewise a creation of the chemical action of his glands. That he is not so obviously an appendix to his testes is due to two reasons. First, the male sex hormones have not the instability nor cyclic rhythmicity of the female. Secondly his sex instincts have become over-layered with other more labile instincts, with habits and customs and necessities that appear to oust the sex instinct into an altogether decentralised position. Moreover it is the function of the female to be the excitor in the sex process, her unconscious thoroughly aware of the fact, sees to it that the sex instinct stands starkly central and dominating her life. The moods of life like the more stereotyped manifestations of sex, are dependent upon proper supply to the blood of internal secretions of the reproductive organs, the gonoidal endocrines. All through the animal world in the springtime when the pituitary awakens or increases its secretion and so stimulates the sex glands to augmented activity, emotions of sex and their expressions are provoked by the inner stirring.

EXPRESSIONISM AND EXHIBITIONISM.

We need a detailed examination of the various forms of expression that art has differentiated, in its relation to exhibitionism and an effort of the circulating libido-producing substance of the glands. Sex exhibition differs in man and woman because of the differently combined internal secretions that are their substrates. The male's attitude, aggressive pursuit is instigated by the compound adrenal and gonad endocrines. The female's various emulsions of coyness and display, seem to be generated by post pituitary and gonad hormones in alliance. At puberty when the sex glands bloom and the complex of sex instinct is activated, exhibitionism manifests itself in a host of guises and disguises. Femininity in a woman, the womanly woman or the external feminine, may indeed be defined by the degree of somatic and psychic exhibitionism she presents. A woman who has a delicate skin, lovely complexion, well formed breasts and menstruates freely will be found to have the typical feminine outlook on life, aspirations and reactions to stimuli which do constitute the biological feminine mind. Large, vascular balanced ovaries are the well springs of her life and personality. On the other hand, the woman who menstruates poorly or not at all is coarse featured, flat breasted heavily built, angular in her outline, will also be often aggressive dominating, even enterprising and pioneering, in short masculoid. She is what she is because she possesses small, shrivelled, poorly functioning ovaries. Between these two types, all sorts of transition exist, according as the other endocrines participate in the constitutional make-up.

INSTINCT AND BEHAVIOUR.

The sex instinct analysed as an endocrine mechanism perhaps provides the clue to the understanding of all instinct behaviour. If we assume post-pituitary regulates the maternal instinct, then its co-relates—sympathy, social impulses, and human feeling—must also be influenced and so is furnished another example of a chemical control of instinctive behaviour. McDougall analyses instinct into three elements—a specific stimulus—situation—an emotion following—ending in a particular course of muscular reaction. Translated into endocrine terms, what happens may be pictured as a series of chemical events. When the activity of a ductless gland rises above a certain minimum its hormone in the blood sensitize as a photographic plate is sensitised—a group of brain cells to respond to a message from the outside world with a definite line of conduct. There is registration by the brain cells of the presence of the specific stimulus. Then there is communication by them with the endocrine organs and as a result, some of them are moved to further secretion and others are paralysed or weakened. In consequence of changes of concentration in the blood of various internal secretions, tensions, movements and tumescences as well as relaxations, inhibitions and detumescences occur throughout the vegetative system—the blood vessels, the viscera, the nerves and the muscles. In their final fusion the commingling vegetative sensations constitute the emotion evolved in the functioning of the instinct. The play of an

instinct may be analysed into four processes. They succeed one another as existing situation—endocrine stimulation—tension within the vegetative system—conduct to releive tension. The equation of an instinct based upon an analysis of the working of the sex instinct is the model for the analysis of all instincts, and therefore of all the compounded instincts that all human behaviour may be resolved into. Conduct—normal and abnormal, social and asocial in all their complexities even into the third and fourth generation, is governed by the same laws that determine the movements of the stars and eruptions of volcanoes. The most interesting factor in the instinct equation is the endocrine, because that is the one that is most purely chemical.

ENDOCRINE CHARGING OF WISHES.

It is the distinction of modern medical psychology that it has established the wish (craving, need, desire, libido) as the moving force in any psychic process. The position of the wish in psychology as the force within and behind the instinct may be compared to that of the energy in physics, when it was elevated to a central position in the explanation of the physical processes in the 19th century. The concept of the charged wish has illuminated all the hidden recesses and rendered audible all the subdued murmurings of the mind. The truely novel in the content of the idea is the recognition of the fact that the wish is charged. Now it could never be charged in a vacuum. That means that a wish could never be born in the brain alone, for the brain has no power to charge itself with energy—it can only store and transmit. If a wish is a potential energy that must be transformed into kinetic and it must have a source. That source is the vegetative system and without it the great complex of viscera in the abdomen and the chest, blood and its vessels, endocrines, muscles and nerves, the brain would remain but an intricate cold storage plant of memories, associations of part experiences. It would need no change and initiate no effort. But when the wish enters upon the scene it is as if a dead storage battery, has been refreshed with new current. Enriched with billions of electrons there is a stir and a movement, dynamic mind. But the dynamo is the more ancient possession of the animal, the vegetative apparatus. In short, what must always be remembered is that a wish is never cerebral but always sub-cerebral, visceral in its origins. The sub-cerebral makes the cerebral. Activities in the nervous system below the brain and in the vegetative system force upon it its functions. A physics of human behaviour becomes possible with the aid of these concepts of endocrine regulation of intravisceral pressure and equilibrium and an intramuscular pressure and equilibrium, with the brain as the shifting fulcrum of the system. The associated reflex, aborginal ancestor of the involved train of associations that constitute the highest thought, conduct and character is the unit of the system.

A stimulus originally indifferent to the endocrine may by association, the laws of which are many, come to act like a spark to the endocrine-instinct mechanism. Hence we can account for the subtle play of instinct throughout all thinking. Even objects resembling the specific excitant of an instinct only remotely or in some one quality, may start its mechanism and a host of associations bound up with it. Thus the maternal instinct may be excited by the sight of a baby. The doctrine of association of instinctive and so of endocrine reactions, enables us to understand the feeling tone that at any moment prevades consciousness as well as its content. Choices, the psychology of selection of food, color, friends, mates, amusements also become explicable rationally. For, conflicts among the different components of the vegetative system are continuous and inevitable. If the pressure within a viscus has been heightened and persists *i.e.* is not disturbed by some associated factor or instinct, conduct results to lower the pressure to what it was before the instigation of the tension appeared. But if another instinct is sparked, or another association factor comes, into play,

another focus of increased pressure within the vegetative system is created with another stream of energy flowing to the brain and demanding an outlet. This clash of instincts, the struggle between different foci of the vegetative nervous system competing for the possession of the brain is a common every day process in conduct. Which will win means which will will. And so we have an energetic basis for volition. Which will win appears to depend primarily upon the kind of endocrines that predominate in the make up of the individual, secondarily with his education. For, it is the endocrines that are really in conflict when there is a struggle between two instincts. And if one endocrine system conquers, it must be either because it is inherently stronger, its secretion potential, that is, the amount of secretion it can put forth as a maximum is greater because a past experience has conditioned it to respond although the opposing endocrine does not. The response of the ductless glands to the situations varies with their congenital capacity and acquired susceptibility. Capacity is a question of internal chemistry modified by injury, disease and accident, shock or exhaustion. Susceptibility depends upon the play of forces focussing upon them what may be summed up as associations. In the ability of one endocrine system to inhibit another, we have the germ of the unconscious. Hence the *modus operandi* of the repressions and suppressions, compensations and dissociations which may unite to integrate or refuse to intergrate and so disintegrate or deteriorate a personality. As the personality develops, the vegetative nervous system becomes susceptible to the manifold associates of family, school, church and society, art, science and religion and last but not least, sex. All the different nuances of personality are expressions of particular relationship, transitory or permanent between the endocrines and the viscera and muscles. Conversely behaviour shows what a person actually is chemically: that is, what endocrine and vegetative factors predominate in his make up.

THE MADRAS MEDICAL COUNCIL.

Review of work.

(From October 1929 to March 1931)

BY

DR. V. RAMA KAMATH.

MEMBER, MADRAS MEDICAL COUNCIL.

"The Medical Practitioner" came into existence on account of one of the pledges given by me to the electorate when I stood for election to one of the seats in the local Medical Council early in 1929, as I then promised the electorate that if I was returned to the Council I would start a journal specially to guard the interests of the medical profession. The profession needs no special account of the nature of the service rendered to them through the columns of "The Medical Practitioner." But this account will not be complete unless the profession knows what the Medical Council has been doing to foster the growth of the profession by guarding the rights and privileges bestowed upon the profession by the Statute (The Medical Registration Act) and by having a control over the profession so that these rights and privileges are not misused. The Medical Council meets only twice in a year in March and October and the proceedings of the March meeting remain confidential till they are confirmed at the next meeting i. e. in October and the proceedings of October remain confidential till March in the following year. So far the Medical Council has been a conclave and not a public body. Consequently it has not been possible for me to give an account of the work of the Council, the record of work of one particular meeting being too little to be noted as a special article in this journal. The Medical Registration Act was passed in 1914 and the first council came into existence in 1915. From the perusal of the records of the proceedings of the Council, no member of the Council seems to have given notice of any resolution on his own accord though there was provision for such a procedure in the Act. Matters that were referred to the Medical Council by the Government or other bodies or individuals outside the Council were only the subjects of discussion till 1929 and any

member proposed resolutions on the subject matter of such reference. Defective as the Medical Council now is, there are possibilities for the elected representatives to do something at least in guarding the interests of the profession as could be evidenced by the proceedings of the Council.

The duties of the Medical Council are: (1) to provide for the registration of the medical practitioners and maintain a register for the purpose. (2) to confer certain rights and privileges by virtue of such registration, (3) to exercise disciplinary control over the medical practitioners when they misuse the rights and privileges conferred upon them by the Act, (4) to control the medical education both in colleges and schools and (5) to conduct elections to the Council. I shall take up the above items in the order they have been mentioned.

MEDICAL REGISTER.

Section 11 of the Medical Registration Act deals with this subject and makes it obligatory on the part of the Registrar to prepare the Medical Register in the month of January correcting the same upto 31st December preceding; yet the present Registrar was not doing his duty in this direction ever since he came to office. All possible constitutional methods were tried by me to rectify this omission but in vain and the Register for 1930 has not as yet seen the light of the day. Early in 1929 when I stood for election, I brought this irregularity to the notice of the Government; the Government having not directed the Council to do its statutory duties, Mr. A. B. Shetty, M.L.C. interpellated the Government in the year 1930 at the March session of the Legislative Council and the reply was that on account of the elections, the Registrar did not find time to compile the Register. This subject has been discussed in the columns of "The Medical Practitioner" sufficiently on more than one occasion and it was pointed out that the excuses were lame, the elections must have been an incentive to get the Medical Register up-to-date as Medical Register was also the electoral roll and consequently the election could not be an excuse. It was expected that the President of the Council who reads the "The Medical Practitioner" is being sent regularly would take the initiation and direct the Registrar to keep the Register up-to-date. But no, at last I thought of moving a resolution regarding this subject and moved the same in the March 1930 Session of the Council, the resolution ran thus:

"The Council regrets that the Medical Register is not being compiled and published in time and in the way contemplated in Section 11 of the Madras Medical Registration Act and the rules framed thereunder and calls upon the Registrar to explain the delay so far in compiling and publishing the Medical Register for the last several years."

There was no discussion on this subject for want of a seconder, the Registrar having given out the excuse later through the mouth of the President that the cause of the delay was on the part of the Government Press. Having no discussion on the subject, it was not possible for me to refer to the reply given by the Government on the floor of the Legislative Council and referred to above. For aught I know the cause of delay cannot be the election of 1930 nor the Government Press as the Registers, 6 years prior to 1930 were not published in time, there being a delay of more than a year than the prescribed time. If press gave trouble there was nothing to prevent the President who is one of the biggest and responsible officers of the Government to report about the negligence on the part of the Government Press to the Government. Nothing has been done in this direction so far, The Council and the Goverument having failed in their responsibilities, I must appeal to the profession to agitate and make their voice felt by the authorities. It will not be out of place if I were to mention here the inordinate delay caused by the Registrar in registering the names of the practitioners in the Medical Register. In some cases it has taken a year for the practitioners to get their registration certificates after they have paid the registration fees. Though the number of such cases is large, vouchers regarding payments made to the Registrar could be produced only by two. I reported about these cases to the Registrar on or about the 12th August 1931 and having no reply from him addressed a letter to the

President on 1-9-31 requesting him to find out the cause of such delay in the matter of registration. I got a reply from the President, dated 16-9-31 that he was looking into the instances of my complaints. I wrote to the President on 19-9-31 reminding him again. Evidently the President was not able to attend to this work himself and on 2nd October 1931, the Registrar wrote to me to say that he was enquiring into the matter and later on 21st October 1931, he wrote to say that he had a primary explanation from the clerk and that he did not complete the enquiry and till this day nothing is heard about the final disposal of the case by the Registrar.

RIGHTS AND PRIVILEGES CONFERRED BY THE REGISTRATION.

Section 4 deals with the rights and privileges conferred by registration. The medical certificates issued by registered practitioners are valid and no appointment could be held by qualified practitioners unless they are registered. At present this section applies only to Allopathic practitioners. Except in the matter of issuing medical certificates unregistered practitioners belonging to other systems of medicine can hold office under the Government and other Bodies. The practitioners are familiar that their statutary right in the matter of issuing medical certificates has been done away with by the executive orders of the heads of the Government departments and the certificates issued by private practitioners have been till recently countersigned by Government medical officers. In 1930, at the March Session of the Medical Council, I proposed the following resolution :

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

This was passed by the Council though, one of the nominated Indian member and an European member also nominated both, Government servants opposed this resolution. The resolution was referred to the Government and the G.O. on this subject 2746, P.H., dated 30th October 1931 was published on page 100 of the December 1930 issue of "The Medical Practitioner". This G.O. put an end to the practice of countersignature but another equally objectionable procedure of taking a second opinion from the Government Medical Officer has been introduced. So, when the Council recorded the above G.O. I proposed the following resolution :

"While thanking the Government for abolishing the practice of countersignature on medical certificates which they did in accordance with the resolution passed unanimously by this Council on 10th March 1930, the Council respectfully suggests to the Government that the remedy suggested in G.O. No. 2746 P.H., dated 30th October 1930, is inconsistent with the principles and spirit of medical ethics recognized by this Council, and therefore the Council prays that the Government Order under reference be reconsidered, making it obligatory on the heads of the Government departments to accept the certificates granted by registered medical practitioners to the patients actually under their care and treatment, as such certificates are issued as part of the treatment, and further wish to point out to the Government that the Medical Council and not any individual member of Government or his nominee is the proper authority to sit in judgment against the conduct or the proficiency of the members of the medical profession."

But the resolution was lost Dr. U. Rama Rau and myself voting for and Major Anderson, Lieut-Col. Pandalai, Major Cruickshank, Dr. Frimodt-Meller, Dr. Azizulla Sahib and Dr. N. Venkataswami Chetty voting against, Drs. S. Rangachari and Krishna Menon remaining neutral.

(To be continued.)

Abstracts

THE HARD OF HEARING PATIENT.

FACTS THE FAMILY PHYSICIAN SHOULD KNOW

BY

HAROLD HAYS, M.D., F.A.C.S.,
NEW YORK CITY.

Startling as it may seem, we are now getting to the stage where we know something about deafened people—how to prevent deafness; how to make wholesale tests of the hearing of school children; how to treat the ears of these children so that many of them will not become hopelessly deafened adults; how to study and investigate deafness in adults so that there is a possibility of improving their hearing; and finally how to reconstruct the lives of very hard of hearing individuals so that they may get out of the despondent state in which one often finds them.

It has frequently been the custom in the past for the general practitioner to shrug his shoulders and intimate (to put it mildly) that there was very little to be done for a class of people who lead a hopeless social and economic existence. He recalls that the specialist, in the past, has been content to run a catheter into the eustachian tubes, blow in some air and say, "That's that, let us hope for the best." And, after his patient has gone the rounds of the quacks, because no reputable man seemed to be able to do anything, he has come back to him as bad as ever.

But times have changed and many a serious-minded otologist is dreaming of a not-far-distant future when he will be able to do something for his deafened patient. These men would rather improve hearing than perform a good mastoid operation. But, if one is to do anything for such patients, one must have the co-operation of the general practitioner, for he is the man who brings his patient into the world, takes him over life's seas of trouble and frequently follows him to his final resting place.

THE DEAFENED CHILD: How many general practitioners know that there are over three million deafened children in the schools of our country who are sufficiently hard of hearing to retard them in their studies? Ernest Elmo Calkins, a deaf man, wrote a very interesting book called "Louder, please," a few years ago. When he was a child he was unable to get along well in school. He was considered stupid by his teacher. He was punished at home and his parents considered him a hopeless proposition. Being a child, of course he didn't realize that he was hard of hearing and that his deafness was growing worse. When he was about ten years old someone suspected the trouble, but by that time it was too late to do anything. To-day, he is a very deaf man but he has fought his handicap, is a brilliant writer and a most successful advertising man. Now, if he had been taken in hand by a wide-awake family physician, when the trouble first started, I have no doubt that a great deal of his hearing might have been saved. Many a time, a similar child is considered stupid in school and is placed in the "dunce" class when his mental co-efficient is above normal.

While visiting the Detroit School for the Deaf a few years ago, Miss Van Iderstine pointed out to me a little girl who had been sent to her from one of the public schools because she could not keep up with the other pupils. Tests of her hearing showed that she was quite deficient. Her mental co-efficient was above one hundred per cent. While in Miss Van Iderstine's School, she was taught lip-reading and was placed under the care of Dr. Emil Amberg, one of Detroit's most capable otologists. At the end of a year her hearing had greatly improved, she had become a good lip-reader and she had lost her inferiority complex. She was returned to her regular school, where, in a short time, she excelled the other pupils.

Certain studious and earnest otologists are keenly interested in the study of the hard of hearing child, and clinics for the prevention of deafness will spring into being in various parts of the country. Deafness can be prevented in many cases. Hearing can be improved in childhood and often hearing can be restored to normal. It is a painstaking task and the family physician, the one in most inti-

mate contact with the patient, is the one who can start the child in the right direction. Dr. Edmund Prince Fowler has such a clinic at the Manhattan Eye, Ear and Throat Hospital in New York City and is definitely proving certain facts which I promulgated a number of years ago when maintaining a private clinic for hard of hearing children. Among these facts, so valuable to the family physician are the following.

1. Hard of hearing children often go undiscovered until proper hearing tests are made to establish the fact that their stupidity in school is due to impaired hearing.

2. Deafness is preventable, provided the ears and the general condition of the patient are taken care of at the proper time.

3. Many of these children are suffering from repeated colds in the head (sinus trouble), repeated ear-aches, running ears, tonsils and adenoids and impaired vitality.

4. The hearing acuity cannot be improved unless one is able to overcome the impaired resistance of the child.

5. Most of these children are lacking in vitamins and should be fed on cod-liver-oil, butter and unskimmed milk.

6. Many of such children live in poor hygienic surroundings and do not take sufficient exercise.

THE DEAFENED ADULT: But what are we going to do for older people who are hard of hearing? Theirs has been a hopeless state. Does one realize how many of them there are in the United States? The best way to answer the question is to imaginatively get at the files of one of the companies selling electric hearing devices. Most of the larger ones are doing a thriving business. They have the names of hundreds of thousands of deafened people who are so hard of hearing that they seek a hearing aid. Add to this the names of the hundreds of thousands who, although deaf, do not wish to use a hearing aid and one arrives at a figure which ascends to the millions. The otologist sees very few of these people who in many instances, are told that medical science can offer them nothing.

It is very unfortunate that the mental attitude of the public tends that way. In these modern times much can be done, not only by the otologist, but by the family physician.

Practical facts will best illustrate my point. Let us inquire into the physiology of hearing. We are dealing with a complex mechanism which no one but God Himself would place in a human body. Unlike the eye, into which direct impulses are sent, the ear mechanism is a clumsy arrangement which, praise be to the Lord, works efficiently for most of us. A sound wave strikes the ear drum which vibrates, sets in motion three little bones which no mechanic could imitate, transmits the wave to the internal ear where fluid is set in motion and finally, by playing on the organ of Corti, the wave is transmitted to the auditory nerve and brain, where it is interpreted.

It is my belief (yet to be proved) that there is an amplifying apparatus in this mechanism somewhere. But the important fact (already proved) is that nerve impulses create carbon dioxide in the fatigue phase and that oxygen stimulation must take place before the nerve can function properly again. It can, therefore be readily understood that, regardless of mechanical perfection of the hearing apparatus, it will not be able to bring about desired effects if the function of the auditory nerve is interfered with, either because of local disease or general body indisposition. One must add to this that mental or emotional states have their direct effect upon nerve impulses and may aggravate a hearing defect as much as a physical abnormality.

Let me deal with a few concrete illustrations.

1. A patient of mine, a school teacher, who for many years has been quite hard of hearing, went to Yellowstone Park for the summer and spent most of her time on horseback. She returned to New York at the end of three months. Hearing tests showed an improvement of thirty percent and the hearing has remained improved for five years without treatment.

2. A prominent physician in a near-by city consulted me because he has an almost total deafness, with tinnitus in his left ear. Examination with the naso-pharyngoscope showed an edematous condition of his left eustachian tube. Recalling a series of carbuncles he had had a few years previously, I suggested a blood chemistry study, which showed increased sugar. This condition was corrected, whereupon his tinnitus disappeared and his hearing returned to almost normal.

3. A young girl, a college student, was found to have a sixty per-cent loss of hearing in both ears. Physical examination was practically negative, except for a slight thyroid disturbance. This patient had a definite complex against her mother, who was a very difficult woman to get along with. Every time she had an argument with her mother, a definite emotional explosion took place and her hearing became decidedly worse. By taking her away from the family influence and working on her psychologically, her hearing was restored to normal.

These are only a few of thousands of cases.

I am eager to impress upon the family physician the fact that abnormal physical and mental states influence hearing acuity and, if one wishes to obtain any worthwhile result, one must study each case as a separate entity and eliminate every factor which diminishes the patient's resistance. Seeing a patient twice a week to inflate his ears is useless, in the majority of cases. I am so convinced that this is a wrong procedure that, to-day, I insist on all hard of hearing patients going to my private hospital for at least four weeks. They are not kept in bed, but they are fully occupied with one treatment or another all day long and, what is as much to the point, their time is mine and, when they come into the office for local treatment, they are in a completely relaxed condition. At first they undergo a complete physical examination, basal metabolism test, blood chemistry and X-ray studies, etc. Definite types of head massage are given them. Also hypodermic injections of iron and arsenic and high colonic irrigations are given.

The type of local treatment they receive depends on the condition found. X-ray treatments to the naso-pharynx, diathermy, dilation and treatment to the eustachian tubes, pneumomassage, etc. The results have been most gratifying and I am hoping that, in the course of time, I can analyze a sufficient number of cases to come to definite conclusions.

Very few family physicians know that accurate measurements of hearing may now be made with an instrument called an audiometer. This electric device will allow one to test hearing from 156 to 8,000 double vibrations, corresponding to tuning forks of the same range. The test is charted on a card, called an audiogram, and from these charts a definite percentage of hearing loss can be worked out. By comparing tests, best made by an assistant, at repeated intervals, one is able to visualize any changes. The up-to-date otologist to-day makes use of his tuning forks only in making a differential diagnosis.

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APPLYING COLLOID CHEMISTRY TO MEDICINE.

EXTRACTS FROM STANDARD LITERATURE.

"The world of neglected dimensions" is the picturesque term which Professor Wolfgang Ostwald of Leipzig, recently applied to colloid chemistry. And, when we consider that the marvellous uses of colloid chemistry in medicine have only been recognised during the last few years, we may well paraphrase this expression to read "the world of neglected therapeutic opportunities."

When Leonardo da Vinci, who painted the famous Mona Lisa about 1500, explained why the sky is blue, he was really elucidating a problem in colloid chemistry. He showed that the blueness is an illusion produced in the void by the scattering of sunlight by finely dispersed particles in the atmosphere against a background of infinite space. The great artist knew not only his colours but also how to explain them.

DISCOVERY OF COLLOIDS: Physics took up the study where art left off, and Thomas Graham about fifty years ago "discovered" the colloids. The word "discovered" is used in the same sense as Benjamin Franklin discovered electricity; for, while every housewife knew something about the properties of those typical colloids, gelatin and starch, it was Graham who gave to the world the tremendous possibilities of the scientific applications of colloid chemistry.

Literally colloid means glue-like or gelatinous, but Graham proved that the colloid represents a new state of matter and that it possesses distinctive physical properties. If a solution of salt or sugar is separated from clear water by a membrane of parchment paper, these substances diffuse through the membrane and tend to equalize the two solutions; but, if starch or gelatin is used instead of salt or sugar, no dialysis takes place. Failure to diffuse through a parchment membrane is one of the characteristic properties of colloids,

NATURE OF COLLOIDS: The colloids are of great importance in medicine; therefore, we are naturally interested in their nature. The modern conception of the colloid is that it is intermediate between an emulsion and a solution of crystals. In an emulsion, the tiny globules may be seen with the aid of the microscope; in the solution of crystals, the matter is dispersed into its molecules. But the colloid is neither one nor the other. It is half way between the two.

Colloids are of great importance to the human body; so much so that Sir William Bayliss, the great psychologist, has written a book on the subject. The blood, in addition to the red and white cells and the salts and other crystalloids dissolved in it, is rich in colloid particles.

COLLOID BALANCE: Equilibrium of the colloids of the body—or colloid balance, as it is called—is essential to normal physiology. When the colloid balance is upset, symptoms resembling those of anaphylaxis supervene. Widal, the father of the Widal test for typhoid fever and many other important scientific discoveries, has invented the term colloidoclasis to designate destruction of the colloid balance.

Colloidoclasis, or impairment of the colloid balance, is now believed to have much to do with the development of immunity to infectious diseases. Clinically it closely resembles the crisis marking the termination of pneumonia.

The question naturally arises, can we influence the processes of natural immunity by injecting colloidal substances? And the answer is that we can.

Colloidal metals have been used with much success for therapeutic purposes. Martinet in his Clinical Therapeutics describes their great value in the treatment of infections as follows:

"The colloidal metals were introduced in therapeutics in relatively recent times. Their study is both of practical and of theoretic interest; practical, because they now constitute one of the most useful agents in anti-infectious medication; theoretic, because they are capable of evoking reactions similar to those of the ferments—which are likewise colloidal—and pharmacologic effects very comparable to those observed with the antitoxic serums, such as diphtheria antitoxin.

"This interest has markedly increased in late years by reason of the increasing importance of the study of colloidal statics and the disturbance of colloid equilibrium, both in medical diseases and their treatment.

"The colloidal metals exert on the system an action very similar to that exerted by certain therapeutic serums.

"There exists, on the whole, a very great similarity between the artificial crisis induced by the use of the colloidal metals of antitoxic serums and the spontaneous crisis which marks the termination of infectious diseases, such as pneumonia.

"To summarize the indications from the colloidal metals, it may be stated that, aside from the cases of infection in relation to which an accredited specific serum is available (diptheria), they are the most potent and most reliable antiinfectious agents now known, and that it is proper to use them systematically in any infection, of whatever nature and location, if such infection be serious, refractory or attended with some complication."

The stamp of authority has been placed on the use of colloidal metals for the purpose of inducing artificial immunity in infectious diseases.

THERAPEUTIC REPORTS AS TO COLLOIDAL METALS.

Although the application of colloid chemistry to medicine is a new field, the large number of publications on the subject reflects its general importance. Colloidal silver and gold in particular have been found to yield brilliant therapeutic results in the hands of many careful investigators.

Schade, in an article published in 1927, states that the practical application of colloid chemistry to medicine is just beginning. He believes that the most frequent pathologic change in inflammatory conditions is an abnormal state of the cellular colloids and that the use of colloids in the treatment is designed to correct this abnormal condition.

Neergaard (1926) writes that the therapeutic effect of colloidal metals is two-fold: The preparations have a certain bactericidal action and they also increase the bodily resistances in the same way as non-specific protein therapy. In his opinion, the latter factor is the more important.

By injecting colloidal metals, Bechhold (1922) saved the lives of mice inoculated with the bacillus of swine plague in doses that would otherwise have killed in two to four days. Siegmund (1923) demonstrated that injections of colloidal substances markedly increase the resistance of mice to subsequent infection and that they act by stimulating the reticulo-endothelial cells to greater activity. After injections of colloids he found that these substances were stored in the reticulo-endothelial cells for future use.

SAFE ANTI-INFECTIOUS ACTION: Koeller-Aeby (1924) states that almost all infections with the exception of tuberculosis show more or less response to colloidal silver therapy, yet the drug is well tolerated and may be given in any case without ill effect. He, too, regards its non-specific effect on cell metabolism as of prime importance.

Plehn (1921) regards colloidal silver as of especial value in septicemia when the blood culture is positive. In his experience, it has also proved serviceable in other infectious diseases, particularly in rheumatic fever when salicylates fail.

Saxl and Donath (1924) obtained promising therapeutic results with colloidal silver in infections. They attributed their success in part to functional blocking of the reticulo-endothelial apparatus and to prolongation of the pressor action of epinephrin. Dunger (1907) found that injections of colloidal silver lead to pronounced leucocytosis. It is also claimed that colloidal silver acts as a catalytic agent and thereby aids in the destruction of toxins. Vanderkleed and Heidelberg (1914) state that colloidal silver influences the leucocytes directly and increases the opsonic strength of the leucocytes in the presence of serum.

With regard to the treatment of gonorrheal septicemia, Tice's Practice of Medicine makes the following statement:

"Satisfactory results have been reported with the intravenous injection of colloidal silver given in doses of 10 c. c. every three or four days."

COLLOIDAL SILVER THERAPY: Biochenski (1922) found colloidal silver together with protein injections of value in obstetric and gynecologic conditions, particularly puerperal infections, perimetritis and parametritis, and acute, subacute and chronic conditions of the adnexa.

Stevens (1927) cites the use of colloidal silver in ointment form for the treatment of various localized infections, such as erysipelas, lymphadenitis, septic phlebitis and gonorrheal arthritis. Waller (1919) advises colloidal silver for the treatment of purulent conjunctivitis. Roe (1922) believes that, if it were adopted in every case of purulent ophthalmia in infants, "there would be no such thing as impaired sight or blindness from this cause."

While therapeutic results with colloidal silver have been most gratifying, there is equal authority for the use of colloidal gold in treatment.

Guyot and Jeanneney (1922) found injections of colloidal gold of great value in the treatment of surgical infections and infected war wounds. When it was given intravenously, they observed a reaction similar to that of protein shock. The more marked the reaction, the more rapidly the patient recovered.

COLLOIDAL GOLD THERAPY: Weinberg (1923) reported eleven cases of epidemic encephalitis treated with colloidal gold by intravenous or intramuscular injection. In all but one case, this treatment resulted in cure or arrest of the disease with marked improvement.

Tice's Practice of Medicine (1920) makes the following statement:

"Septet and Manet used intravenous injections of colloidal gold in five cases of variola confluens and succeeded in obtaining a reduction of the fever during the suppurative stage which, in spite of the serious condition, never rose above 104 °F."

In a group of cases successfully treated by intravenous injections of 1 to 5 c.c. of colloidal gold (0.1 per cent gold), Conterno (1925) observed an immediate reduction in the white blood cells, which was soon followed by an increase above the normal figures.

Since colloidal gold and silver have both proved so efficacious in the treatment of infections, it was logical to combine them. And experience has confirmed the wisdom of this procedure.

Rosenthal (1925) notes that he has found colloidal silver of great value in generalized or septicemic rather than localized infections and his practice is to follow this treatment by intravenous injections of colloidal gold. In this way the temperature is gradually reduced without severe shock.

Nelsons's Loose-Leaf Medicine (1920) mentions the use of solutions of gold and silver in the treatment of influenza.

COMBINED COLLOIDAL GOLD AND SILVER: Fuller (1926) reported an extremely severe case of epidemic encephalitis treated successfully by injections of electro-colloidal gold and silver. The patient was in coma and apparently close to death. On the seventh day, there appeared little chance of recovery. Then an intravenous injection of 0.05 per cent. of the gold-silver colloid suspension was given. Within an hour the patient became conscious and there was general improvement in the symptoms. Likewise the temperature, pulse and respiration fell. The injections were therefore continued and the patient made a complete recovery. Five months later, examination showed her to be normal and she was able to resume her usual social life.

Alexander (1924) states that, while colloidal silver is an excellent germicide and a preventive of ophthalmia neotatorum in many cases, combination with colloidal gold enhances its therapeutic effectiveness.

From this brief resume of colloid therapy, it is obvious that much may be expected from a combination of colloidal gold and silver, particularly in the treatment of influenza and septicemic infections.

WHAT IS ORARGOL?

Orargol combines colloidal gold and silver therapy. It is a colloidal suspension of gold and silver, prepared electrically from an alloy composed of 10 per cent. gold and 90 per cent. silver, stabilized and sterilized by tyndallization. Since gold and silver have proved the two most efficacious metals in the treatment of infections by colloidal injections, the logic of their combination is apparent.

Three preparations of Orargol are available:

(1) Orargol "Injectable," in doses of 5 c.c. is administered intravenously or intramuscularly. This preparation is of greatest value in influenza, pneumonia, sepsis, typhoid fever, epidemic encephalitis and other infectious fevers; also as a prophylactic against infection before and after operations.

(2) Orargol "Non-Injectable," is a concentrated and slightly glycerinated but non-isotonic solution for oral medication in influenza, measles and other febrile conditions in infants, septicemia and other infections; also for use as a wet dressing.

(3) Orargol O. R. L. (oto-rhino-laryngology), is used for the treatment of coryza, rhinitis, hay fever, tonsilitis and naso-pharyngal inflammations. It is also useful as a collyrium in ophthalmologic conditions.

Orargol, being a combination of the colloidal suspensions of both gold and silver, possesses marked advantages over preparations that use either of these metallic colloids alone. Because of the fine state of sub-divisions of the colloidal particles of gold in Orargol, it is possible to obtain a very powerful anti-infectious action without causing violent reactions. Orargol is prepared so that it is isotonic in the ampoule, a fact which enables the physician to employ it without any special preparation at the time of injection. It may be mixed with artificial sera, combined with glucose or saccharose. In fact, the addition of 5 to 10 c.c. of Orargol to a massive injection of such serum is recommended for pre-operative and post operative treatment.

INDICATIONS FOR ORARGOL "INJECTABLE."

REDUCTION OF FEVER: The most pronounced clinical effect of Orargol is that it lowers temperature in cases of fever due to infection. This result is accomplished by the same mechanism that normally brings about the crisis in lobar pneumonia. As Martinet has stated, "the colloid metals exert on the system an action very similar to that exerted by certain therapeutic serum." Therefore, the fall of temperature in febrile states after Orargol injections may be compared with that following the injection of large doses of antitoxin in diphtheria.

INFLUENZA: Influenza, or la grippe, is notoriously a disease in which Nature frequently fails to elaborate immunity to the virus. For this reason, it is important to institute artificial immunity by injections of Orargol. In some cases, this treatment promptly aborts the infection; in others, the fever is lowered and the course of the disease considerably shortened. By using Orargol in influenza, physicians have been obtaining gratifying results in a disease the treatment of which has hitherto been admittedly unsatisfactory.

PNEUMONIA AND BRONCHO-PNEUMONIA: Since Martinet has compared the artificial crisis induced by injections of colloidal metals with the spontaneous crisis of pneumonia, the logic of using Orargol in pneumococcus infections is apparent. Clinical experience has proved that the remedy has a favourable influence on the course of the disease. In addition to stimulating the development of the immune processes, it reduces the temperature and is a strong safeguard against hyperpyrexia.

SEPSIS: The body's defence against sepsis depends on the development of immune substances in the tissues and blood. Should the infecting organism be too virulent, the patient succumbs before the body has had time to elaborate these substances. Therefore, Orargol is extremely useful to stimulate the formation of protective substances in the early stages of septic infections. It should be given early.

TYPHOID FEVER, EPIDEMIC ENCEPHALITIS AND OTHER INFECTIONS: Excellent results have been obtained in these conditions. Since Orargol is a general anti-infectious agent, it may be used with good hopes of success in a wide range of diseases of microbic origin, either alone or in association with other remedies. When Orargol is given at the beginning of an infectious disease, it mobilizes the body's defences and helps them to react more favourably to the introduction of sera, vaccines and other specific forms of treatment.

NO CONTRA-INDICATIONS: There are no contra-indications to the use of Orargol. The remedy should be employed as early as possible in the treatment of acute infectious diseases.

INDICATIONS FOR ORARGOL "NON-INJECTABLE."

INFLUENZA: When it is undesirable to give intravenous or intramuscular injections in cases of influenza, Orargol "Non-injectable" should be administered by mouth. It is absorbed from the mucous membrane of the digestive tract and plays the same antifebrile role as the injectable form, but less quickly and to a less degree.

MEASLES AND INFANTILE FEVERS: In infants and young children the injections are not advisable and oral medication with Orargol "Non-Injectable" is to be preferred. For this reason this preparation is adapted to the treatment of measles, infantile diarrohea and other infectious fevers occurring in very young subjects.

PNEUMONIA SEPSIS AND OTHER INFECTIONS: In these conditions oral medication with Orargol "Non-Injectable" should be used to supplement treatment with one or more injections. As Orargol has a general anti-infectious value, it may be given by mouth as a prophylactic against and treatment for a great many diseases of infectious origin.

AS A DRESSING : Since it stimulates the development of local immunity, Orargol " Non-injectable " is a valuable agent for use as a local dressing for infected wounds.

INDICATIONS FOR ORARGOL O. R. L.

COMMON COLD : Used early, instillations of Orargol O. R. L. may abort the cold by reason of their immunizing effect on local tissues.

HAY FEVER : As Orargol is of pronounced value as an anti-anaphylactic, it should always be employed in cases of hay fever, whether of the spring or autumnal variety.

TONSILLITIS AND NASO-PHARYNGEAL INFECTIONS : Local applications of Orargol O. R. L. have an antiseptic value and also stimulate the development of local immunity in the affected tissues.

AS AN EYE WASH : In conjunctivitis and other eye affections, Orargol O.R.L. may be employed as an antiseptic collyrium.

DOSAGE AND MANNER OF USING.

Orargol " Injectable " is given intravenously or intramuscularly in a dosage of 5 to 20 c.c. ; for children, 1 c.c. for each year of the age. The injections may be given every day or every other day.

ORARGOL "NON-INJECTABLE" is given by mouth in a dosage of 20 to 100 drops a day, taken in divided doses in any beverage. If necessary, this dosage may be doubled. A tea-spoonful morning and night is commonly administered to adults.

The general practice is to begin the treatment of infectious diseases with an intravenous or intramuscular injection of 5 to 20 c. c. of Orargol " Injectable " ; then the systemic effect is continued by administering a tea-spoonful of Orargol " Non-injectable " morning and night in a lukewarm beverage. For infants and young children, from 2 to 4 c. c. may be injected ; orally, one-half tea-spoonful.

The dosage of Orargol O. R. L. is 4 to 5 drops, inhaled through the instillator specially supplied by the manufacturers. Before use the instillator and the medicine dropper are boiled. Then 4 to 5 drops of Orargol are poured into the curved portion. After the olive-shaped extremity of the instillator has been inserted into the nostril and while the nostrills are compressed by the fingers, the patient inhales forcibly. By this means the Orargol is carried into the nose and disseminated over the nasal mucous membrane.

The Orargol preparations may be used in conjunction with any other form of treatment.

Notes on Treatment of Diseases.

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

Duodenal Ulcer : A light meal is followed by pain more quickly than a heavy meal. While in Gastric Ulcer substantial meal causes more pain than a light meal. Tinct. Belladona in 5 mms. dose to be given ¼ hour before every alternate food or it may be given in conjunction with emulsion of Morphia (B.P.C.) 1 or ½ dram. Alternately with Belladona and at an interval of ½ an hour before meals a table-spoonful of Olive Oil may be given. Midway between the meals when the acidity is expected to be at the highest and at bed time Bismuth oxycarbonate gr. 15 may be given ; and for relieving constipation Liquid Paraffin (L.W.).

Feeding frequently every 2 hours gives much relief.

Tinct. Belladona mms. 10 before meals and Bismuth subcarbonate a level teaspoonful after meals and at bed time (J.A.M.A.).

Dysmenorrhœa : Ovarian substance or ovarian residue may be given.

2. Corpus Luteum by injection to be commenced 4 days previous to the menses.

3. Small doses of Contramine with Iodine, Thyroid and Sulphur (McDonagh).

4. Eumenol.

5. Placenta.

6. Yohimbin under the name of Menolysin 3 times a day.

7. Pituitary and Mammary Extracts.

8. With scanty discharge—Ammenol in 10 grs. doses 4 times a day and Ante-Kamnia in large doses ; with profuse discharge—Atopine 1/100 in tablets thrice daily to be commenced a few days before the menses (Hare).

9. Benzyl Benzoate grs. 15, mucilage acacia 1 ounce, Aromatic Elixir 1 ounce, ½ a teaspoonful every two hours (M.T.T.)

10. Cannabis Indica and Gelsmium are of great use also Antipyrine and Antifebrin (Hare and M.A.).

11. Goodal's mixture containing Ammon Bromide 2 drs. Pot. Bromide 3 drs. Spt. Ammon Aromat 4 drs. Aqua Camphor ounces 6 ; 2 to 4 drams every 4 hours.

12. A mixture of Placenta, Corpus Luteum, Pituitary and Ovary with Atropine and a small quantity of Scopalmin, Quinine and Salipyrin (J. O. T.).

Ear ache : To relieve the acute pain in the ear whether in meatus or tympanic membrane, the best application is a solution of Cocaine 10% and Carbolic Acid 10% in water (Practitioner).

2. Carbolic Acid gr. 25 and Glycerine 1 ounce a few drops to be poured into the ear in acute cases (M.T.T.).

3. Boric acid grs. 15, Spts. Recti. ounce 1 ; this may be diluted with equal quantity of distilled water before putting into the ear (M.T.T.).

4. Equal parts of Tinct. Belladona and Tinct. Opii to be dropped into the ear after washing ; irrigation with hot normal saline solution every 2 hours (Hare).

5. The practice of stuffing the ear with cotton wool is condemned as it would predispose to ear ache.

6. Octalgen may be dropped into the ear (I.M.G.) also Liquid Iodex.

7. A preparation consisting of equal parts of 'Cocaine, Menthol and pure Carbolic acid to be applied and then incision made in the tympanic membrane. Warm application to be made with hot water leather bottle (M.T.T.).

8. In children drops of Glycerine and Carbolic acid 10% ; for Naso-pharynx Camphor gr. ½, Menthol gr. ½, Iodum gr. ¼ and Liquid paraffin 1 ounce to be dropped into the nares with the patient lying on the back (M.A.).

9. After cleaning dry the external meatus cotton wool saturated with a solution of 10% formaline is introduced and left for a few minutes and then removed, the formaline left in the ear should be wiped dry and then sterilised Kaolin insufflated.

10. Warm Iodex with Methyl Salicylas, dip a piece of cotton into the fluid and place it into the ear.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Gonorrhœa and its Modern Treatment.

Gonorrhœa is as old as the hills and if we look at its past history, we find its reference not only in the Bible but in other Scriptures also. This disease was attributed to various causes and was treated not on rational lines until in the year 1879 Neisser discovered the Gonococcus which was the causal organism of the disease. This was confirmed by researches of various scientists like Bakei, Watson and Finkelstein and others who succeeded in the preparation of different cultures and in the invention of various methods of cultivating them. It was Desormeaux who is called the 'Father of Endoscopy' who based the treatment of this disease by the exact knowledge of the pathology of Urethritis which he could see by the Urethroscope, of which he was the inventor. It really marked the first step in the truly scientific treatment of this disease.

Despite the dangers, immediate and remote, Gonorrhœa is not regarded by the laity as a serious malady. It is therefore the duty of every medical man to bring home to every patient suffering from this disease the risks which he runs both to himself and to Society. The man who acquires this disease, instead of going to a physician and getting it properly treated, runs to a chemist or reads an advertisement in the daily papers and tries to treat it himself. As soon as the discharge stops and his pain disappears, he thinks that he is cured and he may then infect either his wife or the prostitute as the case may be. The duty of the physician, when he is consulted is quite clear in these cases. He should acquaint his patient with the general idea of Venereal Diseases, their mode of dissemination and he should warn him against the neglect of the elementary precautions which should be observed.

Gonorrhœa, as we have seen above, is due to the Gonococcus of Neisser and is frequently the result of contaminated sexual intercourse, though occasionally it may be contracted by infected towels, hands, etc. At times urethral inflammation may be set up by irritating chemicals. Besides Neisser's Gonococcus, there may be other organisms capable of producing urethral discharges, but these are rare.

The disease generally manifests itself as a urethritis in the beginning. In about a week's time the Gonococcus is definitely established in the anterior urethra and a thick yellow discharge begins to ooze out. There is redness of the meatal lips which are found stuck together. These phenomena appear within twenty-four to forty-eight hours after infection. The discharge becomes thicker, creamy, yellow and purulent as time passes.

At this stage the pain during micturition is characteristic and it becomes much pronounced as days pass on. The pain is sharp, shooting and burning. The patients dread the act of micturition and try to delay it as much as possible. The seat of pain is at times in the penile portion of the urethra and at times in the perineum, where the patients usually feel a sort of heaviness. Sometimes difficulty is experienced in passing water owing to the swelling of the urethral mucous membrane which narrows the lumen of the urethra. The erections are accompanied by pains because the mucous membrane loses its elasticity and dilatability during the inflammation. Ejaculations or wet dreams also give rise to intense pain which may lead further to fissuring of the mucosa. This might cause slight hæmorrhages.

As the elasticity of the mucosa gets diminished more and more, the penis becomes distorted as the mucous membrane does not follow the expansion of the Corpora Cavernosa during erection. This condition is known as Chordee. The pain of Chordee is intense. All these symptoms are accompanied by general disturbances such as lassitude, depression, loss of appetite and exhaustion. There might be a slight rise of temperature. After a fortnight these symptoms become less marked. The inflammation of the glans and the meatus subsides. There is no pain during micturition or erection. Pus-cells and Gonococci become less and less and the urine becomes clear. This phase of the decline of the symptoms depends more or less on the observance of the necessary hygienic measures and on the treatment.

If the anterior urethritis remains untreated or if the urethral irrigations are not given with proper care and correct technique, the Gonococcal infection spreads backwards and the condition known as Posterior Urethritis is set up. If this condition is diagnosed early, it can be cured with proper treatment, otherwise troublesome sequelæ, such as Epididymitis, Prostatitis, Vesiculitis, etc., may follow. Posterior Urethritis may start in the second or third week of acute infection. The amount of discharge is very small. The patient at this time thinks that he is improving but the medical man should keep a careful watch on the posterior urethra. The urine is turbid and the micturition is very frequent. The pain is generally intense at the end of micturition. The Posterior Urethritis may go on to the chronic stage if not properly cared for. Filaments may appear in the urine. The patient may complain of vague pains and unpleasant sensations in the Urogenital region. There might appear later sexual neurasthenia, which usually ends in sexual impotence. Ejaculatory troubles, such as loss of semen, pain during ejaculation and blood-stained spermatic fluid, may make their appearances. Repeated attacks of Epididymitis may trouble the patient at variable intervals.

In order to treat Gonorrhœa successfully one must make an accurate diagnosis. It is therefore essential to make every effort to arrive at a correct diagnosis and for this purpose the physician should not only examine the urethral discharge but examine the walls of the urethra and the glands connected with it. As regards the discharge, if it is continuous, one can take it that the infection is acute but if there is only a drop, the infection is of a chronic nature. If the discharge is only present in the morning, one has to deal with the condition known as Gleet. After examining the discharge a general survey of the patient should be made, which should consist of the history of the attack, the exact time of infection and inquiry into previous attacks of the same disease. An examination of the urine is absolutely necessary as we can conclude from it whether the infection is limited to the anterior urethra or has spread backwards and affected the posterior urethra or the bladder. The two methods that are commonly employed are, the one is known as Thomson's two-glass test and the other more exact and elaborate is that of Jadassohn's.

THOMSON'S METHOD: This is otherwise known as two-glass test. Though it is very simple, it is not accurate. It is meant only to find out whether the disease is restricted to the anterior or posterior urethra. If the anterior urethra is affected, the first glass is turbid and the second one is clear. If both glasses are turbid, there is diffuse urethritis. If there are filaments in both glasses but the urine is clear it means that it is a case of chronic urethritis. This method is quite useless for accurate work as there are many loop holes in it.

JADASSOHN'S METHOD: The anterior urethra is washed carefully with a syringe until the washings return quite clear. These are necessarily from the anterior urethra. The patient then passes urine in a glass and pus or debris that comes out is necessarily from the posterior urethra. This method enables one to distinguish the secretions of the anterior and posterior urethra and to arrive at an accurate diagnosis.

Next comes the microscopic examination of the discharge. The Gonococci can be recognised from a fresh discharge at once. They are diplococci grouped together in clumps either inside the pus-cells or in their apposition to the epithelium cells. It would not be out of place if we briefly describe several methods of staining.

METHYLENE BLUE METHOD: Take a drop of discharge from the urethra with a platinum loop. Spread it in a thin layer and dry it by moving about in the air. Fix it by passing through a flame about three times. Pour a few drops of Loeffler's Methylene Blue. Leave it for roughly ten seconds and then pour off. Wash the slide with water and dry it wiping the

excess of water with a blotting paper. Put it under the microscope and the Gonococci can be recognised by their dark colour and diplococcal form.

GRAM'S METHOD : After spreading the discharge from the urethra in a thin layer, dry it in the air and pass it through the flame three times without overheating. Pour over the slide Gentian Violet Stain (freshly made) and keep it for five minutes and pour it off. After this, washing with water is avoided and Lugol's Iodine solution should be poured, and kept for one minute. This is then poured off and absolute alcohol should be poured drop by drop for about half to one minute. The blue diffusion which appears stops after a few minutes and then wash it with water. Counter-stain now with very dilute solution of Carbol-fuchsine until a light rose colour is seen. The Gonococci appear red because they have given up the Gram-Violet stain to alcohol. In other words this method shows that Gonococci are gram-negative.

These two methods are the most important from the standpoint of the general practitioner. There are others viz., staining with Giemsa's stain and Carbol-Methylene, etc., but they are not suitable to the clinician on account of the time and the trouble that they take. The determination of the blood-picture, the cultivation of the Gonococcus and the Complement Fixation test do not give very satisfactory results and besides they come within the region of the Bacteriologist.

THE PATHOLOGY : The Gonococcus when it enters the urethral mucous membrane remains on the surface for twenty-four to thirty-six hours. This is the incubation period and after that it enters the epithelium. In the cylindrical type of epithelium it penetrates readily while in the flat pavement type there is a good deal of resistance. This penetration causes a severe inflammation of the urethra. This reaction is the attempt on the part of the body to combat the pathogenic irritant and hence is accompanied by diapedesis of the leucocytes. Then the struggle ensues between the leucocytes and the Gonococci. In the struggle the Gonococci are surrounded by the leucocytes which are killed and then they together with the organisms are first brought to the surface of the mucous membrane and then discharged into the lumen of the urethra giving rise to flow of pus from the meatus. The urethral mucous membrane is much damaged in the struggle not only by the Gonococci but by the leucocytes as they pass from within outwards. The epithelium is thus injured undergoes mucus degeneration and is even destroyed in certain places.

The infiltration of the urethra is at times limited to the superficial layers and at times it involves the entire thickness. As a consequence the urethra becomes rough and inelastic. The inflammation later may even spread into the connective tissue and may affect the Corpora Cavernosa, the net-work of which is swollen and undergoes infiltration. There is inflammation not only of the surrounding veins and arteries, but the capillaries are full of polymorphonuclear leucocytes. The lymphatics are involved and the lymphatic glands are enlarged, become painful and may suppurate.

The urethral glands are also affected and this plays an important role in Chronic Gonorrhœa. The Gonococ although not actually on the epithel of the Glandular Lacunæ, are surrounded by leucocytes which cover it. The inner surfaces of the Gland-ducts after desquamation, are invaded by the leucocytes and due to cell-proliferation the duct-walls become thickened and infiltrated. The inflammation ends either by sclerosis or by the ducts becoming obliterated and by their being transformed into cysts.

The infection has a tendency of spreading backwards. If the virulence of the Gonococci is not intense, or if the constitution of the patient is strong enough and if timely and adequate treatment is given the infection does not pass beyond the membranous sphincter. It is then called Anterior Urethritis. If it spreads beyond this sphincter the condition is known as Posterior Urithritis. This occurs in about 60 to 70 per cent of cases and it is more serious on account of the complications, such as Prostatitis, Vesiculitis, Pyelo-nephritis, etc. which ensue.

The process of repair sets in about three weeks. Gonococci diminish in number, leucocytes become less active, infiltrations are resorbed and regeneration

of the epithelium starts. Pavement epithelium is formed and the cylindrical epithelium is destroyed for ever. Thus the urethra may lose its elasticity. Gonococci disappear from the deep tissues in about six weeks. If this happy result does not take place, the organisms remain somewhere in the tissues or glands of the urethra and may keep up the inflammation. Then the urethritis becomes chronic. Strictures are the invariable result of Chronic Gonorrhœa.

In chronic urethritis there is stratification of the epithelium which later on keratinizes. The mucous membrane thus loses its permeability and hence drugs and antispetics cannot reach its deeper layers. The Lacunæ of Morgagni and the Litre's glands are involved at later stage.

The former are sometimes sclerosed or at times retract and atrophy. Occasionally their orifices become abstracted and cysts are formed which are likely to suppurate. Thus peri-urethral abscesses are the result. It is around Litre's Glands, as is remarked above, that the infiltration is most marked. Many changes may take place, either the glands may swell or they may be converted into cysts filled with colloid material or with epithelial debris on account of the cell-proliferation.

The Gonococci lodge in these glandular sacs and maintain the urethritis. Thus it is that recrudescences of this disease take place. The glandular secretions sometimes increase and then the Gonococci come once more to the surface of mucous membrane of the urethra.

The inflammatory process in the peri-urethral erectile tissue and the Corpora Cavernosa undergo similar changes. After the proliferation of the round cells connective-tissue fibres and retractile bands appear, which go to form the beginning of a stricture.

In Posterior Urethritis we meet with the same changes. After cell-proliferation the cylindrical epithelium desquamates and then regenerates or may be converted into pavement-epithelium.

In the membranous urethra, strictures are more liable to be formed because in this region the mucosa are likely to fissure due to contractions and because the ulcerations that result heal by cicatrizations.

The fibrous tissue that is formed in the prostatic region obliterates the orifices of the Ejaculatory ducts, the walls of which lose their elasticity. Occasionally owing to the sclerosing and narrowing of the orifices of these ducts the patient feels pain during ejaculation. At times on account of the rigidity of these ducts the Seminal Vesicles close incompletely and thus Spermatorrhœa is the result.

The Prostate also undergœs certain changes. Either Prostatorrhœa may take place due to the filling of the gland with atrophied or desquamated epithelium or Prostatitis may occur when the gland is filled with polymorphonuclear leucocytes.

We are thus able to see that the Gonococcus spreads deeply into the mucous membrane of the urethra and extends upwards to the posterior urethra and then further infects the Prostate, Vesiculæ Seminalis and later enters the blood-stream.

COMPLICATIONS : The complications of Gonorrhœa are varied and numerous, local and general. In this resume only the most important will be touched.

PHIMOSIS AND PARAPHIMOSIS : These are very frequent and can be diagnosed easily.

Another complication commonly present in this disease is Adenitis in the Inguinal region. The lymphatic glands enlarge and cause intense pain and discomfort to the patient. The cause should receive more attention of the medical man than the complication.

LITRITIS : that is, inflammation of the glands of the Anterior Urethra is by far the most common complication due perhaps to faulty technique of irrigation. The glands later on are felt as hard nodules in the penile portion of the Urethra. They may suppurate. If the inflammation extends into the periglandular tissue, the condition known as *Folliculitis* may occur, which is rather serious. Proper prevention of such complications is therefore highly desirable.

COWPERITIS : is not quite a common complication, but is very important as the Gonococci are lodged in Cowper's Glands and then the disease may last indefinitely.

PROSTATITIS : In the majority of cases where the disease has lasted for more than four weeks and has not received

slowly and without any undue pressure. At the most 3 c.c. of the solution is quite sufficient for one sitting. After withdrawing the speculum a Bismuth suppository should be inserted not only to prevent adhesions of the rectal walls but also to protect the rectal mucosa from being soiled. The latter effect is due to the fact that Bismuth does ensure constipation. The injections should be repeated weekly and it is advisable afterwards to administer liquid paraffin to keep the motions soft. Usually five to eight injections are sufficient to treat the whole of the rectal lumen. The most important point that should not be neglected is that the patient should rest after each injection for at least half an hour to prevent any subsequent rectal pain.

If at all any complications do occur, it would be sloughing and hæmorrhage. The first one may result from lack of strict asepsis and correct technique. As the part is highly septic, every precaution should be taken to ensure asepsis. The second complication may be due to the vein being transfixed. If one is careful enough, this can easily be avoided. Besides these no accidents or harmful effects have so far been experienced.

There are however, several contra-indications, which one must strictly bear in mind. These methods should only be employed in uncomplicated internal piles. If there are sloughing, strangulated or external piles, they are contra-indicated. Pregnancy and Phlebitis are conditions in which also they should not be made use of. Some consider this method of injection harmful in Furunculosis and skin-diseases of Staphylococcal origin. Again in cases where there is no adequate compensation due to diseases of the heart or kidney it is not advisable to employ either of these methods.

Extracts from Standard Literature.

ABDOMINAL SURGERY.

ABEL, A. LAWRENCE: ACETYLCHOLINE IN RELATION TO ABDOMINAL SURGERY, LANCET, 1:459, MARCH 1, 1930. REPORT OF ADDRESS READ BEFORE THE SECTION ON SURGERY, ROYAL SOCIETY OF MEDICINE.

Hunt and Taveau, testing acetylcholine in 1906, found that it lowers arterial pressure. Choline seems to be a breakdown product which is formed during the normal metabolism of the central nervous system. Excreted into the wall of the alimentary canal, it exerts a hormonic action on Auerbach's plexus.

Work in Magnus' laboratory in Utrecht showed that paralysis of the bowel produced by chloroform poisoning was quickly relieved by intravenous injections of choline hydrochloride. Acetylcholine produced in human beings a lowering of arterial blood pressure; it had an anti-coagulant action on the blood in vitro, and also an anti-anaphylactic power.

For a very severe abdominal case, when, on being seen for the first time, the patient was in extremis, Abel gave 0.6 Gm. of acetylcholine, intramuscularly; for a less severe case, 0.2 Gm. at one, two, or three-hourly intervals.

ATROPHIC RHINITIS.

GUNS, P. AND COENE, R.: NEW TREATMENT FOR ATROPHIC RHINITIS, ANN. D. MAL. DE L'OREILLE, DU LARYNX, 48:414, MAY, 1929.

Theories of the etiology of atrophic rhinitis suggest a definite relationship with the parasympathetic nervous system We have in acetylcholine a substance more powerfully vagotonic than pilocarpine. It is more active in acid than in alkaline medium. We have studied the nasal secretions and find them to be alkaline. This suggests the advisability of acidifying the nasal fossæ before employing acetylcholine, and then applying this medicament directly to the mucosa.

In seven cases of ozena or atrophic rhinitis we have made applications of acetylcholine every other day or twice a week, as the case required, with correction of local lesion in every case and an improvement in the patient's general condition.

As to the reason for making a local application of the acetylcholine, instead of injecting it subcutaneously, acetylcholine decomposes readily in an alkaline medium (blood, lymph), it seems advisable to stimulate locally the parasympathetic nerves by high dosage of acetylcholine which thus acts locally on the arterioles and capillaries without causing a general disturbance of the parasympathetic system.

We have employed 10 per cent, 5 per cent and 1 per cent solutions of acetylcholine but cannot say that we have noted any difference in the local activity of these different concentrations.

CONSTIPATION.

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

"In different cases we have noticed that the injection of large doses produces an increase of intestinal peristalsis, resulting in disappearance of habitual constipation."

ABEL, A. LAWRENCE: ACETYLCHOLINE IN RELATION TO ABDOMINAL SURGERY, LANCET, 1:459, MARCH 1, 1930. REPORT OF ADDRESS READ BEFORE THE SECTION ON SURGERY, ROYAL SOCIETY OF MEDICINE.

A. Lawrence Abel sent a communication regarding acetylcholine to the Society, which was read by Mr. G. Parker. Acetylcholine was of value, too, he said, in cases of acute and chronic constipation, as well as in a wide range of other conditions (which are reported elsewhere in these abstracts).

DIABETIC ARTERITIS.

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

When arteritis is presenile, senile, or diabetic with gangrene, the effect of acetylcholine is often remarkable. Before every operation it is useful to give the patient a series of injections of acetylcholine, as this often limits the extent of the operation; so that, for example, section below the knee may suffice instead of amputation at the thigh. In diabetic arteritis, acetylcholine plus insulin treatment is superior to insulin treatment alone.

DIAGNOSIS OF PERIPHERAL VASCULAR AFFECTIONS.

VILLART, M. AND JUSTIN-BESANCON L.: PERIPHERAL VASCULAR AFFECTIONS, PRESSE MED, 36:673, MAY 30, 1928.

In addition to its value in the exploration of arterial trunks acetylcholine is indispensable in all peripheral vascular affections to verify the condition of the arterioles, capillaries and venous system. To this end the tests with histamine and acetylcholine employed conjointly for diagnosis and prognosis contribute most important information.

HEITZ, J.: CRITICAL REVIEW OF THE DIAGNOSTIC AND THERAPEUTIC USES OF ACETYLCHOLINE, ARCH, D. MAL. DU COEUR. 22:383 JUNE, 1929. AS REPORTED IN THE BRITISH MEDICAL JOURNAL, OCTOBER 12, 1929, p. 56.

Acetylcholine differs pharmacologically from histamine in that the latter dilates the capillaries while constricting the arterioles. Administered in moderate doses subcutaneously, no modification of the cardiac rhythm is produced; but by retinoscopy a dilation of the retinal vessels, lasting about ten minutes, is observed.

Acetylcholine can be employed in the diagnosis of arterial spasm. The latter has hitherto been investigated by noting whether or not the oscillations of a sphygmomanometer applied to the limb increase when the extremity is placed in a hot bath. These oscillations are augmented according to the degree to which the reduction of blood supply is due to spasm. It has been found that the subcutaneous injection of 0.1 to 0.2 gm. of acetylcholine will stimulate the effect of a hot bath and cause the return or increase of oscillations which had been absent or reduced, owing to spasm of the vessels supplying the limb. These investigations have shown that even in a diseased blood vessel there is frequently superadded spasm, causing still further impairment of the blood supply.

HEMIPLEGIC STROKE.

FILIPO, M.: HEMIPLEGIC ICTUS. TREATMENT WITH ACETYLCHOLINE HYDROCHLORIDE, Presse med., 37: 1169, September 7, 1929.

Filipo reports the results in six cases and concludes that early treatment by subcutaneous injection of acetylcholine gives the most favourable results. The preparation used was synthetic acetylcholine hydrochloride, stabilized by the addition of dextrose and kept in sealed amp[illegible] For use it is dissolved in

twice distilled water. The injection of 0.1 gm. in one case and of 0.2 gm. in four others was sufficient to cause recovery from the stroke within from twenty minutes to several hours. On one patient no effect was observed.

The drug should not be used in patients presenting symptoms of cerebral hemorrhage, because its vasodilator action would in these cases be harmful. The fact that restoration was not effected in one case may be due to tardy administration of the drug after the stroke.

Lipocerebrine.

COMPOSITION : Lipocerebrine is an etheral extract obtained from the cerebral substance of sheep, containing the phosphorized and non-phosphorized lipoids.

The former embrace cephalin and the myelic compounds, substance of a similar nature to lecethin ; the latter, cholesterol and sulphatides, that is to say, substances in which the phosphorus is replaced by sulphur.

The role of the phosphorized lipoids is well known ; it is of great importance in regulating the internal exchange of the nervous system, particularly those of the brain where the interchange is intensive. According to recent works, the sulphatides are active in a similar and not less important manner.

Cholesterol has a marked counteraction on a whole series of lipo-soluble toxins, it reinforces the anti-toxic action of the liver and has considerable influence on the general condition. It also stabilises the phosphatides and the sulphatides.

LIPOCEREBRINE constitutes a natural synergy with an activity not to be found in any of its isolated constituents, e. g., egg lecethin, cholesterin.

THERAPEUTIC INDICATIONS : Cases of neurosis and nervous depression all show a notable diminution of lipoids. Further, all these conditions coincide with metabolic disturbance, and consequently also with humoral surcharges from toxic or badly assimilated products, resulting from functional deficiencies in general and from a slowing-up of oxydation.

LIPOCEREBRINE obviates this lack of phosphorus and sulphur, by providing these elements in the physiological state in which they are most likely to fulfil the roles for which they are destined. It also regulates nervous activity and interchange, stimulating cell life and the calcium content of the cells is increased and stabilised.

INDICATIONS : Asthenia, Neurasthenia. Cerebral Anaemia, Nervous Insomnia. Hysteria, Psychosis and all nervous conditions, Convalescences, Anaemias, Chlorosis, Diabetes, Pretubercular conditions,

FORMS AND DIRECTIONS FOR USE : LIPOCEREBRINE is put up in two forms.

(1) An oily solution for injection in boxes of 12 ampoules of 2 c. c. each.

(2) Tubes of 60 dragees each containing 10 centigrams. Dose : One or two ampoules daily, or four to eight dragees.

News and Comments

Darbhanga Conference : The All India Medical Licentiates' Association will celebrate the Silver Jubilee early in January next and for this purpose have arranged for an All India Conference which will meet on 3rd January 1932 and continue sitting till the 5th. As announced in these columns last month Dewan Bahadur T. Rangachariar C.I.E., M.L.A., Advocate, Madras will preside over the Conference. The scientific section of the Conference will meet under the chairmanship of Col. L. Cook, C.I.E., I.M.S., Inspector-General of Civil Hospitals Behar and Orissa. Hon'ble Sir Ganesh Dutt Singh Kt. Minister-in-charge of Medical Department, Bihar and Orissa Government is expected to open the exhibition.

We congratulate the organisers of the Conference in advance, and hope that the Conference will be conducted in a manner worthy of the occasion. The times are momentous. India's destinies are in a melting pot and just at this juncture the Government of India, knowing as they do, the disharmony and discontent prevailing in the country due to communal and political causes, have chosen to introduce the Indian Medical Council Bill with the ostensible purpose of "establishing a uniform minimum standard of qualifications in medicine for all provinces such that persons attaining thereto, shall be acceptable as medical practitioners throughout British India" but really to appease the anger of the General Medical Council, Great Britain. The Bill if passed by the Legislative Assembly in the form it is now presented for public opinion, will certainly bring out cleavage in the medical profession and add to the disharmony and discontent in the other spheres of public life. The Association has been lucky in getting the kind services of Mr. T. Rangachariar, a gentleman having a good record of public work. We trust Mr. T. Rangachariar, shrewd and wise as he is, will guide the destinies of the Conference and show ways, means and methods by which the licentiates who form the largest bulk of the medical profession in this country may succeed in their agitation in persuading all concerned to bring the licentiates within the purview of the proposed Indian Medical Council Bill. The interests of the country more than the interests of the licentiates themselves demand the necessity of recognizing the licentiates as "recognized practitioners" for the purpose of the proposed Indian Medical Council Bill.

All-round Protests : From the reports we have received and perused in the dailies both here and other provinces, the Indian Medical Council Bill has not been well received by the medical profession. It is noteworthy that the Burma Government were wise in forwarding this Bill for the opinion of the lay public and the Burma Indian Chamber of Commerce to whom the Bill was referred for opinion "protested at the outset against the exclusion of licentiates from the scope of the Bill. The Committee pointed out that the effect of such a step would be to divide the medical profession in India into sections antagonistic to each other and to undermine the prestige and status of the licentiates who would naturally be looked down upon as medical practitioners without proper qualification. The Committee expressed their firm opinion that no steps should be taken which would have such an undesirable effect and urged, therefore, that licentiates should be qualified for registration from the very commencement. In this connection the Committee pointed out that when the General Medical Council of Great Britain was created, not only qualified but even unqualified men who were practising before the 1st August 1815 were given an opportunity to be registered.

As regards the Constitution of the Council, it appeared to the Committee that the constitution proposed in the Bill was likely to make the Council a purely official body. The Committee expressed the opinion that in order to achieve the real object in view, the Council should be composed of non-official independent persons and suggested that :—(a) **The** block of members to be nominated by the

Local Government of the province as proposed in the Bill should be entirely eliminated and instead provision should be made for the election of one licentiate from each such province. (b) Unofficial element should be introduced by providing for a certain number of seats for private practitioners. (c) Election by private medical practitioners should not be confined to graduates only. (d) As regards election by provincial Medical Councils, all medical practitioners registered in the provincial registers should be eligible for election.

As regards the President, the Committee suggested that he should, after the first term, be elected and not nominated by the Governor-General in Council.

Regarding the mode of election of members from the Provincial Committee of the Council, the Committee suggested that such election should be conducted by the President of the Council and not by the Medical Registrar as proposed.

Lastly, the Committee suggested that all disputes regarding election be decided by an independent tribunal and not by the Governor-General in Council as proposed."

The medical practitioners are to serve the lay public and their opinion should be counted more than that of the members of the medical profession for obvious reasons, especially when there exist in this country several castes in the medical profession. We trust the medical graduates and others with foreign qualifications who have been so far shrugging up their shoulders or sitting on the fence with an indecisive mood and especially those who have been openly protesting against the inclusion of the licentiates within the purview of the proposed Bill would realise that the word "Reciprocity" which has been very freely used by them in connection with the recognition of foreign qualifications by the proposed Indian Medical Council might also be used by the licentiates in their dealings in matters professional.

A Youth's Wise Example : The expression "misguided" has been usually or rather was familiarly used in relation with the word "Youth". Times have changed and with it the mentality of the youth. Everywhere one hears of activities of "the youth movement" and there is overwhelming evidence that the youth movement has been productive of very good results in all public activities. It is a happy augury that there is a dawn of this movement in the medical profession. Dr. K. Rama Rao a young house Surgeon working at the Government Royapuram Hospital has shown a splendid example that it is possible for a single youth which elders could not do either individually or collectively. He was able to organise a very successful meeting (proceedings published in correspondence columns) of the licentiates working in the neighbouring institutions at Royapuram to discuss about the Indian Medical Council Bill. It is not always possible to get as many as 40 members of the profession to attend a meeting convened even by well organised Associations of some standing. We congratulate this young medico on his prudence in convening a meeting in the manner he has done and hope others like him will follow his example and do effective propaganda regarding matters concerning not only the welfare of the profession but also the welfare of those whose lives are entrusted to the profession.

A Wise Experiment : The Government of Madras have at last decided to try an experiment at the Government Royapettah Hospital, Madras by replacing one Civil Asst. Surgeon, three Sub-Asst. Surgeons, one lady Sub-Asst. Surgeon by one Hon. Surgeon, one Hon. physician, one Hon. Asst. Surgeon, one anaesthetist and one Hon. Sub. Asst. Surgeon. Evidently the work turned out by one Civil Asst. Surgeon is to be done by one or the other honorary under the title of Hon. Surgeon or Physician and the work turned out so far by 3 paid Sub-Asst. Surgeons is to be divided amongst two Hon. Asst. Surgeons and a Sub-Asst. Surgeon; the title of the anaesthetist whether he is to be an Asst. or a Sub-Asst. has not been so far fixed. It is also not known under whom the only Sub-Asst. Surgeon has to work. It looks as if he is to work under all the Hon. Asst. Surgeons as his title indicates. The Government would either have waited to appoint a Sub-Asst. honorary pending their final decision on the report of the Committee on honorary medical officers which Committee have unanimously recommended to the Government to do away with the title of Sub Asst. Surgeon in the honorary medical relief scheme. In the interest of the class to which they belong we would suggest to all L.M.Ps not to apply for the post of honorary Sub-Asst. Surgeon now advertised for, by the Surgeon-General. They will gain and not loose by not accepting the posts of Hon. Sub-Asst. Surgeons.

The experiment as reported does not seem to be complete as nothing is known about the Superintendent of the hospital nor about the Resident Medical Officer. It looks as if these posts will not be offered to honararies but the persons holding these posts at present are likely to change.

A Sub-Magistrate Betrays His Temper : Law seems to protect those who administer it from punishment of offences which if committed by others are punished for; or else, it would not have been possible for a Sub-Magistrate at Vellore to burst into a temper on reading a medical certificate granted to one of the accused who was summoned to appear before the Magistrate. The medical practitioner certified to the effect that he required a fortnight to observe the accused before he certified about the mental condition of the accused. The Magistrate is alleged to have given expression to the following words:

"I cannot believe this certificate; did you pay half a rupee or one rupee and got the certificate? Why did you bring it? Do you want to cheat me ...."

The fact that the accused was later on sent to the District Medical Officer for observation and that this officer also certified that the mental condition of the accused necessitated an observation for a fortnight, makes the utterances of the Magistrate more heinous. We learn that the practitioner concerned has complained to the District Magistrate about the Sub-Magistrate's unwarranted and unjustifiable behaviour. The President, Madras Medical Council has also been informed about this incident. We trust that the District Magistrate will take notice of this complaint and protect the honour of the position of those who administer justice for the Crown. It is incumbent on the part of the President, Medical Council to report this case to the Government who have administrative jurisdiction over the judiciary not only in North Arcot district but also in other districts, for such action as necessary to protect the prestige of the medical profession. We do not for a moment urge that the judiciary should not pass remarks over the medical certificates which form part of the evidence in cases that they have to try. But an ex-parte judgment before trial with regard to opinions expressed by medical men cannot be passed off or passed over lightly.

Provincial Medical Councils' views on the Indian Medical Council Bill : The official ridden provincial medical councils, to whom the proposed Indian Medical Council Bill is sent for opinion are likely to favour the official views. The fact that at least two medical councils so far have recommended the inclusion of the Licentiates within the purview of the Bill should open the eyes of the Government of India. Madras and Bihar & Orissa medical councils are the two referred to above. The Medical Councils in Bombay and United Provinces have not recommended the inclusion of the Licentiates. The representatives of the Licentiates in the Bombay Council must have felt keenly the absence of Dr. Jivaraj N. Mehta in the council. In United Provinces the two representatives of the L.M.Ps Drs. Rai Sahib Ram Narain Lal and Kunj Behari Lal Varma left the Council chambers under protest when the Council voted against the inclusion of the L.M.Ps within the purview of the Bill and have submitted their opinion to the President of the Council requesting him to forward their views to the local Government. These two representatives have done well. Their example may with advantage and wisely be followed by those in the same plight in other provinces.

In Rangoon the Council had no representatives of the L.M.Ps, while discussing this Bill as the election of the L.M.P. representatives to this Council was declared invalid on the same day just before the subject came for discussion. The Bengal Council has not met so far. We expect that the Bengal Council will very likely recommend the inclusion of the Licentiates.

About the other defects in the Bill of an undemocratic nature, we are almost sure that the members of the Assembly will see to them and get them rectified.

Medical Council Election in Burma : As referred to a little while ago, the recent election to the Burma Medical Council of the representatives of the L.M.Ps. have been declared invalid on account of some irregularities in the conduct of the election and a fresh election is to take place soon. There are three vacancies and five are contesting for the seats and the contest seems to be very keen. We trust that the Licentiates in Burma will take into their consideration merit and past services rendered by the candidates. Vote is a sacred trust and the final choice should be the best three.

Dr. Balaram's Research : Cancer has been so far considered as an incurable disease as Leprosy was till quite recently. As was pointed out by Dr. Balaram in his announcement in the columns of "The Hindu" last month the cure for Leprosy or at least relief very near a cure, has been now found by the administration of the derivatives of Chaulmugra Oil which was known as a remedy for Leprosy in India from time immemorial. It is quite possible there may be useful indigenous drugs for curing cancer. Dr. Balaram is a qualified and registered medical practitioner of some standing and must have realised his responsibilities in making an announcement of the nature read by the public in the columns of a news paper. It is desirable in public interest more than in the interest of Dr. Balaram that all possible facilities should be provided for by the Government to enable the doctor to prove to the scientific world the results of his research in the cure of cancer. As the remedies found out by the doctor have passed the stages of experiments as is evidenced by the cures demonstrated by him before an audience of qualified doctors, members of Malabar District Medical Association, the cost involved for further demonstrations, will be only for the treatment of patients; and if the patients already admitted in any state hospital for the treatment of cancer are to be treated by Dr. Balaram, the additional expense to be incurred by the Government will be a negligible amount. Consequently, callousness on the part of the Government in not inviting Dr. Balaram to treat cases of Cancer in a state hospital where there are facilities for the correct diagnosis of Cancer, will certainly be culpable.

Resurrection : Nearly a year ago we brought to the notice of the General Secretary, All India Medical Licentiates' Association the necessity of reviving the activities of the Association especially in the city of Madras at a time when we foresaw danger ahead. We have evidence that the General Secretary did what he could in this direction and at last the proposed Indian Medical Council Bill, which does not recognise the existence of the Licentiates as medical practitioners, served as a blessing in disguise whipping all concerned to their sense of responsibility and the result has been a fairly successful meeting of the Association which met at No. 98, Godown Street, Madras with a happy augury of a bright future. Recent events which took place in another place of a Union of Licentiates and non-Licentiates where the Licentiates pressed their claims on equal terms with the latter regarding honorary appointments in state hospitals and were indirectly receipients of a gratuitous insult having to stand the comparison of skilful attendars claiming the posts of Professors because of their practical knowledge, must have goaded some at least to their higher sense of dignity and made them realise where they were with an unhappy association with those of different feathers. It is quite natural that birds of the same feather should flock together and make a common cause when others do not tolerate their existence. We do not mean that birds of different feathers cannot meet and should not meet. "The Medical Practitioner" exists to bring about happy and healthy unity in diversity. But this is only possible if the spirit of tolerance and goodwill prevails.

We are most happy that on the eve of the New year the Licentiates have revived their Association and we trust that under proper leadership they will continue to exist as good and useful a body as they have been otherwise.

Correspondence, Reports, etc.

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

BY DR. D. NAINAR, DENTAL SURGEON, MADURA.

While feeling grateful to the Madras University authorities for allowing L.M.Ps to qualify themselves for M.B.B.S. degree I wish they realise the practical difficulties in the way of the L.M.Ps. to take advantage of the concession.

Sometime ago it was mentioned in the columns of "The Medical Practitioner" that the purpose of the university authorities in compelling the L.M.Ps. to possess a preliminary educational qualification approved by the General Medical Council, Great Britain, was to avoid any objection on the part of the G. M. C. to refuse recognition of the M.B.B.S. degree in case the preliminary educational qualification was not to the standard demanded by them. I wish to point out that there need not be any cause for such fears. The G. M. C. is more particular about the standard of medical education and not the preliminary general education for the matter of registering the M.B.B.S. in the British Register. The Indian university medical degrees have been refused recognition on this score. When a Madras Matriculate with M.R.C.S., L.R.C.P. qualification could be in the British Register, there can be absolutely no difficulty for the Madras Matriculate with the M.B.B.S. degree to be recognised by the G. M. C. This argument apart, there is no cause for alarm if the Indian M.B.B.S. degree is not recognised by the G. M. C. It is enough that the L.M.Ps after passing the M.B.B.S., are recognised by their own countrymen. If the university are really sincere to help the L.M.Ps to qualify themselves for the M.B.B.S. degree they should relax the regulation passed by them, making it possible for the L.M.Ps. to appear for M.B.B.S. degree with the preliminary educational qualification now possessed by them.

When the Madras University does not recognise the Senior Cambridge Examination as equivalent to the Intermediate standard what is the purpose in forcing the former standard on the L.M.Ps? Moreover the efficiency of medical men should be in medical science more than in anything else and for this purpose the general education of an L.M.P. of 5 years' standing is more than the university can demand.

A Legitimate Grievance.

The cut of the "Axe" of retrenchment would be felt more keenly by the medical officers in Government service especially those belonging to Provincial service, as there seems to be no fairplay in the application of the axe. Some are cut hard, some left off with pin pricks, while others are given more than they deserve. Quite recently a special post of an anæsthetist was created in the General Hospital, Madras and an Assistant Surgeon who went to England on study leave was recalled from the midst of his studies, the Surgeon-General promising him a lift in cadre of Civil Surgeons; the Government have since passed orders pulling him down to his old rank as Assistant Surgeon. Another Assistant Surgeon with high foreign qualifications has been made a lecturer in the Vizagapatam Medical College in the place, till recently occupied by a Civil Surgeon who a few years ago was also lifted to the Civil Surgeon grade from the rank of Assistant Surgeon superseding many seniors above him. None can afford to quarrel with the Government in the change of their policy but any policy must be consistent and the principles enunciated in such a change should be adhered to in the case of all. The Government have now approved of the policy of reverting acting Civil Surgeons to their previous position as Assistant Surgeons. We trust that this new policy should be made applicable to all who are now acting as Civil Surgeons, or are on probation as such or have been confirmed as Civil Surgeons quite recently. The Government should also note one instance where a temporary Assistant Surgeon was transformed into a Civil Surgeon.

The terms Assistant Surgeon and Civil Surgeon connote particular grades in the provincial service and it was wrong on the part of the Government in promoting

junior Assistant Surgeons as Civil Surgeons on the plea of posting them for teaching work in a Medical College. It is inconceivable how a Military officer in the position of the Surgeon-General, could, in the past recommend to the Government the transformation of Assistant Surgeons into Civil Surgeons on whatever plea. Is it possible, I ask, for a Lieutenant, or even a Major to be a Major-General unless he puts in the required service, though such juniors had educational qualifications higher than those possessed by their immediate seniors? As was pointed out in the columns of this journal times without number, the Government might have posted specially qualified junior Assistant Surgeons for teaching work retaining their cadre as they have now done at least in two cases referred to above. The fact that almost all such junior Assistant Surgeons who are made Civil Surgeons to do special work, got their higher qualifications at the cost of the Government and that applications were not invited by the Government from all the Assistant Surgeons for such posts, makes such supersession most unjustifiable. If the Government wish fairplay and desire to put an end to discontent now prevailing in the department, they should make a review of the appointments of Civil Surgeons for at least a period of five years and revert all juniors to the cadre of Assistant Surgeons, if necessary, without disturbing the work they are now doing. It is most opportune now to make such a review especially during the period of financial stringency and the Government could certainly save large amounts of money apart from putting an end to the heartburning and discontent now prevailing in the medical department.

An Assistant Surgeon
Senior to Civil Surgeons.

The Indian Medical Council Bill.

PROTEST MEETING IN RANGOON.

A meeting of the Medical Licentiates of Rangoon comprising of Government and Railway Servants, Medical Registrars and Private Practitioners, was held in the Burma Medical School on Thursday the 5th November at 6 p.m. to protest against the proposed All India Medical Council Bill. The attendance was a record one. In addition to the doctors, many medical students were also present.

Dr. Maung Glay, Private Practitioner, was voted to the chair.

Dr. P. A. Nair acted as Secretary of the meeting.

The President after a short introductory speech, requested Dr. R. S. Dugal to explain to the audience about the object of the meeting. Dr. Dugal in a lucid speech, clearly explained about the proposed All India Medical Council and as to how it would affect the Licentiates of India and Burma if it were formed as proposed in the Bill. In the end the following resolutions were passed unanimously:—

(I) That this meeting of the Medical Licentiates of Rangoon lodges its protest against their exclusion from the proposed All India Medical Council and is of opinion that (a) the Bill is neither based on tradition or conventions on which such bodies are formed nor democratic in principle, (b) that the preamble of the Bill is highly misleading in so far as, on the one hand, it seeks to establish a common register for all qualified practitioners and a uniform minimum standard of education, on the otherhand, it excludes 80 to 85 per cent of qualified practitioners holding independent and responsible appointments in the state from the proposed Council thereby declaring them as unqualified medical men. (c) That the creation of this caste system in Medical profession in India which is unheard of in any other country, is opposed to all canons of democracy and is bound to create bad blood and antagonistic feeling in the profession. (d) That this meeting demands, that the proposed All India Medical Council should be formed on the lines similar to those on which the General Medical Council of Great Britain was formed, viz., that all medical men practising in India should be put on the common register when the proposed council comes into existence and thereafter a uniform minimum standard of medical education prescribed which would entitle registration in the Council.

(II) That this meeting of the Medical Licentiates resolves to bring to the notice of the I. G. C. H., Burma, that the exclusion of Licentiates from the proposed All India Medical Council is a deliberate slur and stigma on the self-respect and dignity of the sub-assistant surgeons and those Assistant and Civil Surgeons, whose qualifications fall short of those required by the Bill. In the opinion of the meeting they are being classified as unqualified medical men in the sense of the word "qualified practitioners" as used in the preamble of the Bill.

This meeting urges the I. G. C. H., Burma, to strongly support and uphold the cause of men under him and represent their case to the Local Government and also to the Government of India and thus save them from the humiliation contemplated in the Bill.

(III) That this meeting resolves that a deputation consisting of 5 members, viz., Dr. Dugal, Dr. Mg. Glay and Dr. Nallappa and two of the Government servants should wait on the Inspector-General of Civil Hospitals, Burma, and place before him the position of the Licentiates in Government service in the event of the Bill as it stands, coming into force.

(IV) That this meeting strongly disapproves of the action of Burma Medical Council in lending support to the Bill as it stands and protests against its taking decision on matters vitally affecting the interest of Licentiates in the enforced absence of the representatives of the Licentiate class, thereby depriving them of their right of offering criticism and registering their protest against the Bill through the Council. That this meeting further declares that the opinion expressed by the Burma Medical Council does not represent the real views of the vast majority of the registered practitioners.

(V) that this meeting resolves that the following members, viz., Dr. Dugal, Mg. Glay and Dr. P. A. Nair do form a deputation to interview the members of the Legislative Assembly from Burma and place before them their case and enlist their support in the Assembly when the Bill comes there for discussion.

Dr. Nair was requested to make necessary arrangements for interviews and arrange other matters connected therewith.

With a vote of thanks to the chair the meeting terminated.

Royapuram Medical Licentiates' Meeting.

A meeting of all the Licentiates attached to the Government Royapuram Hospital and Raja Sir Ramaswami Mudaliar's Lying-in-Hospital was held in Bryson School on Sunday the 15th November at the Government Royapuram Hospital at 11 a.m. under the Presidency of Dr. D. V. Venkappa, Provincial Secretary of the Madras Branch of the All India Medical Licentiates' Association. It was a fairly big gathering of about 40 doctors who assembled and discussed the proposed All India Medical Council Bill.

Dr. Kolagatla Rama Rao, House Surgeon and organiser of the Meeting in proposing the President touched briefly about the Bill and impressed upon the necessity of those present by enlisting themselves as members of the Madras Branch of the All India Medical Licentiates' Association. Doctors, C. Ramachandra Iyengar and K. S. Sivarama Krishna Iyer and others spoke at length about the desirability of the inclusion of the L.M.Ps. in the proposed All India Medical Register and detailed to the meeting about the services rendered by the Sub-Assistant Surgeons. The following resolution was then unanimously passed:—

"This meeting of the Licentiates attached to the Government Royapuram Hospital and Royapuram Medical School views with great concern and anxiety the proposed All India Medical Council Bill in which it is contemplated to exclude Licensed Medical Practitioners in the purview of the All India Medical Register and hence earnestly appeal to the Government to remove the obstacle in view of the fact that they are qualified Medical Practitioners recognised by the Provincial Medical Council."

The President whilst thanking the organisers of the meeting gave a brief history of the origin and growth of the Association ever since its birth at Bangalore in 1906. It was an organisation about a quarter of a century old and the Association was on the eve of celebrating its Silver Jubilee at Dharbanga next month. He traced the origin of the class ever since up to the present moment when the denomination of the L.M.P. took different names and how the

different heads of the Medical Department including the Directors General of Indian Medical Service and Governors of the different provinces presided over their conferences and how they spoke of the invaluable services rendered by the class as a whole. He gave extracts from the speeches of Lord Chelmsford, Sir Pardey Lukes, General Gifford and Major General Megaw and other important personages and pointed that there were the everlasting testimonials given to the class which well neigh befitted them for recognition in the All India Medical Council. He pointed out that the Association was carrying on a vigorous campaign all over India and hence wished that more should join the rank and file of the Association at this juncture.

With a vote of thanks to the Chair and the authorities of the Hospital, the meeting terminated at 12-30 p.m.

A Case-Report.

On 25-3-'31 Miss B. F. an Anglo-Indian girl, aged 14 years came with the complaint of cough and fever which gradually rose high in the evenings to 103° or 104°. The patient was lean and emaciated and could not attend the school for 4 terms due to cough and fever. On examination the patient had signs of consolidation in the right lung.

As the patient was very weak and had harassing cough, I put her on a sedative cough mixture for a few days. With careful attention to diet and regimen the patient showed signs of improvement in the general condition. I decided to try Aminobiase of which I gave 2 c.c. hypodermically on the evening of morning 3rd September. On 28th there was no slight reaction and the patient had a rash all over the body, more marked on the chest and arms. The next day the patient felt better. Two days later the injection was repeated and the patient became more cheerful. A series of 10 injections, were then given and the patient improved remarkably. The weight of the patient rose from 96 lbs. before treatment to 120 lbs. at the end of treatment. She was put on Cod-liver Oil with Malt Extract and in a few weeks, she was able to attend the school. The whole treatment lasted for two months. Though the patient was willing to take another course of injections, the guardian was disinclined.

This case clearly shows how beneficial Aminobiase injections are in old standing cases of Tuberculosis (2 years in the present case). This drug is easily tolerated and free from any unpleasant reactions such that of the old tuberculin injections.

174, Greek Street, RANGOON. — G. Ramaswami, L.M. & S.

The South Kanara District Medical Association.

PROCEEDINGS OF THE GENERAL BODY MEETING, 21ST NOVEMBER 1931.

24 members were present. The proceedings began with an "At Home". The President occupied the chair.

The President congratulated the new Chairman Dr. K. Vittal Shetty and members of the Municipal Council Drs. S. S. Hegade, H. V. Adappa, U. P. Mallayya and A. F. Cœlho, and Dr. K. G. Rao on his becoming an Honorary Magistrate.

Dr. L. P. Fernandez spoke congratulating the new Councillors. Dr. K. Vittal Shetty suitably replied to the felicitations.

Dr. U. P. Mallayya also spoke thanking those who honoured him.

The resolution regarding the journals to be ordered for 1932, as decided by the Executive was approved by the General Body.

The General Body approved the resolutions of the Executive Committee on the Report of the Government Committee on Honorary Medical Officers which were to the following effect:

1. A Committee consisting of the District Medical Officer and two senior independent practitioners of the district should be nominated by the Government to recommend names for the various appointments.

2. The Government be requested to stop further recruitment in the medical department, pending definite conclusions as to the exact number of hospitals to be run by honoraries, which question to be decided by a Committee appointed by the Government.

3. The Government may be requested to pay conveyance allowance to Honorary Medical Officers.

The following resolutions suggested by the Executive Committee regarding Indian Medical Council Bill were also passed unanimously:

(1) Though this Association welcomes the idea of establishing an All-India Medical Council, it is of opinion that the time is most inopportune in these days of financial stringency and in view of the fact that the constitution of the Government of India itself, is in the melting pot to forge a new constitution and as such requests the Government to postpone the measure either to be dealt with by the newly constituted Legislature under the reforms or at least for a period of three years.

(2) This Association feels that the Preamble of the Bill is defective and requires redrafting on liberal and definite lines.

(3) This Association strongly disapproves the proposed constitution of the Council, contemplated by the Bill as it is far from being democratic, is most inadequate in its representation of the Independant Medical Practitioners who constitute 99 per cent of the Profession and requests the Government to provide for not less than 50 per cent representation to the Independent Profession in the proposed Council.

(4) This Association strongly disapproves the proposal of excluding the Licentiates who form about 75 per cent of the Profession both in and out of Government service and who have done meritorious service during war and are now doing yeomen service in civil practice and who would be banned as outcastes by the proposed legislation. This Association strongly recommends the Government to provide for the inclusion of this class in the proposed Bill.

(5) This Association is strongly of opinion that the reciprocity clause in the Bill is onesided. The Association therefore recommends that reciprocal Registration of Practitioners be allowed only to such countries that allow Practitioners on the Indian Medical Register the privilege of Registration and Practice. The entrants to service, civil or military, should be only from countries who reciprocate in the above manner.

After a vote of thanks to the members and the chair, the meeting terminated.

Treatment of Tuberculosis.

The literature published on page VI of "The Medical Practitioner" July 1931 suggesting the combined treatment of Tuberculosis by Biocholine and Aminobiase has proved a most happy one. I had previously observed good results from Aminobiase alone, but not in every case. The failures may very likely have been due to the fact that the patient got tired of the injections before results were sufficiently apparent.

Since reading literature I have tried the combined treatment and find so far that the improvement is noticed after a few injections.

My method for a patient who has had no Aminobiase before is as follows:—

1st day: Aminobiase—half ampoule
Biocholine—one ampoule
Mixed immediately before injecting.

3rd day: Biocholine—one ampoule.

5th day: Aminobiase—one ampoule
Biocholine—one ampoule
Mixed immediately before injecting.

7th day: Biocholine—one ampoule.

This treatment can be continued without any interruptions.

It is too early yet to say that any of my cases are cured, but at least there is a steady improvement in both the cases under my care, and so far there has been no cause to interrupt the treatment.

Amba Pharmacy, Katha—Bazaar, BOMBAY — G. M. Durandhar, M.B.B.S.

All India Medical Licentiates' Association

MADRAS BRANCH.

The Provincial Secretary, Dr. D. V. Venkappa organised a meeting of the local branch of the All India Medical Licentiates' Association at No. 98, Godown Street, Georgetown, Madras on 10th December '31 at 5 P.M. About 30 Licentiates were present. Dr. U. Rama Rau the President of the Branch presided. The following office bearers were elected unanimously : Dr. U. Rama Rau, President, Dr. R. Ramanujalu Naidu, Vice-President, Dr. U. D. Gopal Rao and Dr. D. Subrayadu joint secretaries ; Drs. V. A. Muthia Thevar, V. Rama Kamath, T. Gopal Rao, T. V. Ranganatha Rao, Balasundaram, A. C. K. Hebbar, K. Rama Rao, Ramachandra Ayyangar and Viswanathan as members of the Managing Committee.

Dr. U. Rama Rau was unanimously elected as the delegate to the ensuing Conference at Darbhanga. Dr. Rama Rau having expressed some doubts on account of other engagements at the time in the city, three other names, Drs. V. Rama Kamath, Antoniswami Pillai and Viswanathan were mentioned to act for Dr. Rama Rau in case he did not attend the conference. Dr. Rama Kamath did not relish the idea of a contest for such an honour especially when the travelling allowance of the delegate is met by the Association and said he would prefer attending the Conference as a free man and that it was quite possible for him to serve his brethren as such and wished to be excused in declining the honour. Dr. Antoniswami Pillai having also withdrawn, Dr. Viswanathan was elected to act for Dr. U. Rama Rau. Advantage was taken of the gathering for passing some urgent resolutions which were to the following effect : (1) the Government be requested to set apart 50 per cent. of the posts of Clinical Assistants for Licentiates in the city of Madras who should serve as such for a period extending from 2 to 4 years and that a deputation consisting of Drs. U. Rama Rau, D.V. Venkappa, V. Rama Kamath, T.V. Ranganatha Rao and V.A. Muthia Thevar do wait on the Surgeon-General to represent the grievances of the Licentiates in connection with the report of the Committee on honorary medical officers. (mover. Dr. K. Venkata Rao.)

2. The meeting protests against the exclusion of the Licentiates as honoraries in hospitals attached to teaching institutions. (mover : Dr. U. D. Gopal Rao.)

3. It is the opinion of this meeting that Licentiates should not apply for the post of honorary Sub-Assistant Surgeons at the Government Royapettah Hospital now advertised in the newspapers unless the designation is altered suitably to indicate the routine of work entrusted to the particular honorary. (mover : Dr. V. Rama Kamath.)

4. The meeting recommends the name of Dr. D. V. Venkappa to the post of Provincial Secretary in recognition of his past services to the Association. (mover : Dr. U. D. Gopal Rao.)

Reviews.

RONALD ROSS.

DISCOVERER AND CREATOR.

BY R. L. MEGROZ WITH A PREFACE BY OBSERT SITWELL: GEORGE ALLEN AND UNWIN LTD. LONDON : PRICE 10s. 6d.

Mr. Megroz, has by his book placed the public particularly the members of the medical profession under great obligation to him, by enabling the readers to get a clear and deep insight into the life and many-sided activities of Ross. It is generally believed that a genius is an eccentric person dwelling on the extremity of the border line which separates the sane from the insane and a scientist is a morose misanthrope, living amidst, test tubes, microscopes, guinea-pigs. All these prepossessions are removed by reading the life of Ross and there is much truth and force when (Ross) says "that science, the differential calculus which separates, subdivides and analyses ; and poetry the integral calculus which sums up. The poet should begin by being the man of science and the man of science by being a poet." In the preface, Osbert Sitwell says and says rightly that Sir Ronald Ross's life must remain for ever a cause of pleasure and pride to all Englishmen. We Indians in general, have our own share of pleasure and pride in that Dr. Ross was born in India and the Madrasees in particular that his first appointment in the Indian Medical service which led to the discovery of the causation and spread of malaria, was in Madras. That Ross is a genius is beyond all doubt and if genius is properly understood, should be all embracing and versatile. But opportunities for the development of all the faculties do not occur in all cases and in some when they occur in a particular direction, all the energy of the individuals is directed towards it. In the case of Ross, however, the stimulation was from several directions partly accounted for by the embarassing nature of his environment. His mathematical insight contributed to the rigorously logical methods of his experiments and the invention of a microscope suited for his purpose—and his poetry gave vent to his feelings, caused by his troubles and insult poured on him by his official superiors in service and thus relieved the tension to enable him to continue his research. His dramatic faculties extended his field of observation and sympathy and his intution which goes beyond the realms of rigorous reasoning opened up new vistas for his gaze and scrutiny. Shakespear in his Macbeth, speaks of lady Macbeth washing her hands frequently and it was given to psychologists, particularly to psycho-analysts to trace up the cause of this obsession to the murder committed by her. Had it not been for these various qualifications, Ross would have been strangled to death by the redtapism of the service to which he belonged. It is said that when Ross told his Adjutant that the mess house would be free from mosquitoes if the garden tubs and tins under the dining tables and flower vases were removed, the latter became angry and refused to remove them. Even now in Madras, the practice of growing of flowering plants in tubs and of ever greens over the windows in European and Indian bungalows in imitation of the practice obtaining in England, contributes not a little for the breeding of mosquitoes, not to speak of sheltering of reptiles in those bungalows and it is noteworthy that while mosquitoes are found in bungalows they are not to be seen in small houses constructed in streets. It is extremely doubtful whether Ross would have retained his appointment till he completed his full service, as he was considered a nuisance to the officer in authority over him. In the case of Dr. Georges also during the construction of the Panama Canal when the work was entrusted to a committee presided over by an Engineer with Dr. Georges as one of the members of the committee, the President addressed the American Government to remove Dr. Georges from the committee as his presence was a nuisance, but the American Government having the interest of the people at heart, wisely removed the Engineer President and replaced him by Dr. Georges. Will any other Government particularly that guided by precedent, prestige, and mamool ever do likewise ? It is said that Ross knew poetry, prose, drama, mathematics, etc., in fact every thing except money-making. Certainly in those days I.M.S. officers attended to their legitimate work in the hospitals, rarely

resorted to private practice and were never allowed to open nursing homes. Now everything is changed even the hours of working in the hospitals, to afford facilities for private practice. There is now study leave to enable officers to visit foreign countries and improve their knowledge. However, the study leave is not invariably given to officers who really want to improve their knowledge but to the favoured few, whose salaries are raised on their return. At times they were not even appointed to the posts for which the knowledge obtained during study leave is needed and they were given any appointment which gave them more pay. From the list of books written by Ross given in the appendix to the book, a large number pertains to subjects other than medicine. If Ross had followed literature or mathematics, he would have become famous but not a world benefactor as he is now by his devotion to medicine.

The book is an unique production wherein the extraordinary achievements of Ronald Ross, have been compiled in a manner which is bound to interest not only the members of the medical profession but also others in various spheres of public life, be they lovers of science, poetry or prose or even politicians and as such, this book will be a valuable addition to any public or private library.

SENIOR CAMBRIDGE EXAMINATION.

TELUGU AS A SECOND LANGUAGE.

Such of the L. M. Ps who wish to take up Telugu as the Second language, will please communicate with the undersigned,

Dr. R. DAVID,
Victoria Memorial Mission Hospital,
Hanumakonda, Hyderabad (Deccan.)