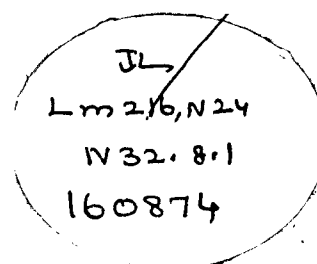


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Artificial Pneumothorax in the Treatment of Pulmonary Tuberculosis

BY

Y. A. BHIDE, M.B., B.S., *Assistant Surgeon,
Osmania Hospital.*

5-AUG-1932

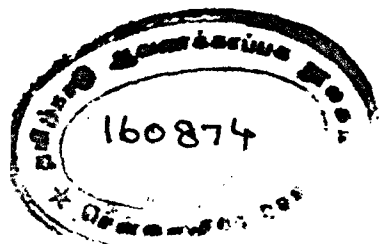
PULMONARY tuberculosis is largely a dis-
ease of city life, but it does occur to some
extent even in villages. Taking the sta-
tistics of our State hospitals for 1340 Fasli we find
that a total of 2,418 cases were treated in the various
hospitals and dispensaries throughout the State, of
which no less than 1,036 are from the city and suburbs
alone. These figures do not disclose the full extent
of the prevalence which must be much larger. The
number of patients from Hyderabad in the sanato-
ria in other provinces is surprisingly large. As the
disease is one of long duration, attacks men and
women in early adult or full prime of life, often the
bread winners of the family, it inflicts a great amount
of suffering not only on the patient himself but on
his family as a whole. One or even more sanatoria
on modern lines in centres easily accessible to pa-
tients in our State are a pressing need, which we

hope will soon be met. In the meantime a beginning has been made and artificial pneumothorax treatment is being given to suitable cases in the Osmania Hospital. The writer commenced work in the Osmania Hospital ten months ago—(July 1931). During this period 75 cases of pulmonary tuberculosis were admitted under my care, of whom 23 were selected on clinical findings for this treatment but five of these were found unfit on actual trial on account of adhesions and in only 18 has it been possible to carry it out. Of these, 8 are still in touch with us and have shown definite improvement as will be seen from the subjoined table, which would help to show that this is a method of treatment which naturally alters our prognosis of this disease in suitable cases and the reason why the writer has chosen this particular method for description is that while it is most effective, it is inexpensive, easy for application and requires a very small amount of skill which can be easily acquired.

Before describing the details of the method it would be of service to indicate the type of case in which it would be serviceable. The ideal case for this form of treatment is no doubt one in whom a part of one lung is affected, the other being absolutely free from disease, in which no pleural adhesions are formed and the constitutional disturbance is very slight. But the method is often of value even where there is a slight amount of disease on the other side.

Selection of the case.

When the patient comes to us, with severe wasting, hectic temperature, almost incessant cough with



2

22
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N 32+8+)

Results of Artificial Pneumothorax Treatment in Pulmonary Tuberculosis.

Patient No.	Side of Artificial Pneumothorax.	Stage*	Nature of Artificial Pneumothorax	Duration of Artificial Pneumothorax	Sputum examination		Temperature		Weight		Adhesions.	Remarks,
					Before Artificial Pneumothorax.	After Artificial Pneumothorax.	Before Artificial Pneumothorax.	After Artificial Pneumothorax.	Before Artificial Pneumothorax.	After Artificial Pneumothorax.		
1	Right side	III A	Partial	14 months	+	+	100-102°	98°-99°	80 lbs.	90 lbs.	..	Left Hospital
2	Right side	III B	Good	8 months	+	+	103°-104°	97°-98.8°	80 lbs.	109 lbs.	Slight.	Has gone home & come for refills
3	Right side	II A	Good	4½ months	+	+	101°	97°-98.5°	120 lbs.	139 lbs.	Nil	Did not come back for refills
4	Right side	I B	Partial	3 months	-	-	100°-101°	97°-98.5°	93 lbs.	98 lbs.	..	Went home after advice
5	Right side	II A	Good	9 months	+	+	100°	97°-99°	88 lbs.	131 lbs.	..	
6	Right side	III A	Partial	4½ months	+	+	101°	98°-99°	120 lbs.	139 lbs.	..	
7	Right side	III A	Partial	34 months	+	+						
8	Right side		Good	2 months	+	+			84½ lbs.	92 lbs.		
9	Left side		Partial	one month	+	-	103°	98.5°	70½ lbs.	76 lbs.		

* The stages are classified as follows:—

Mainly depending on toxæmia which is shown by the fever in a patient and the extent of lung issue that is involved. Temperature (Rectal) up to 100° is classified as stage I, temperature above 100° and up to 101° as stage II and temperature above 101° as stage III. Each stage is again subdivided into 3 parts (A, B, C) depending upon the extent of the lung involved.

+ Tubercle Bacilli present.

" " not present

(To face page 2).

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nummular expectoration and the text-book signs of cavitation in both the lungs, there is little difficulty in diagnosis, but unfortunately very few of these cases are likely to be found suitable for artificial pneumothorax. Our object should be to get the case in hand long before this stage has been reached and it is here that all the aids to the diagnosis of this disease have to be invoked. Patient's temperature should be observed 4 hourly, and any rise of temperature above 99°F., especially in the afternoon otherwise unaccounted for should be carefully noticed; the sputum examined repeatedly for the presence of tubercular bacilli using a concentration method (anti-formin) to find the organisms, when the ordinary methods fail to reveal them. The patient's weight should be taken under identical conditions every week to observe if there is any progressive loss of weight.

As regards the physical signs in the lungs, persistent fine crepitations on ordinary or deep breathing, especially limited to one side, on repeated examinations, taken along with other signs and symptoms are highly suggestive of active disease. At this stage a fluorescent screen examination and a radiogram are of help, though in the absence of these aids the medical man should not be distrustful of his clinical findings.

Principle of Artificial Pneumothorax.

This is to secure rest for the affected lung and no principle could be sounder. When there is a fracture of a bone we attempt to place the fragments at rest in apposition, to allow nature to bring about union and healing. The lung is an organ that is active from birth to death and at first sight it would appear

impossible to secure rest for it. But we have to remember that nature provides a very large amount of reserve in all organs, so that it is possible for a man to live a fairly active life with less than one complete functioning lung. Secondly, while we cannot actually apply a splint to the diseased lung, the natural elasticity of the organ itself with its inherent tendency to collapse comes to our aid. If we make a hole in the pleural cavity communicating with the air outside, the natural elasticity of the lung gets free play and it collapses. But of course it is not advisable owing to the risk of sepsis to adopt this method. What is done therefore is to introduce into the pleural cavity a gas, in ordinary practice the atmospheric air, to allow the lung to collapse. It is evident that so long as a sufficient quantity of air is present in the pleural cavity, the lung will remain collapsed and at rest. But air introduced into the pleural cavity tends to get absorbed, hence the need for refills at intervals.

Apparatus.

It consists essentially of two bottles connected by means of glass and rubber tubing, one of which is filled with water, which on being allowed to flow into the other, displaces the air in it, which is injected into the pleural cavity by means of artificial pneumothorax needle which is like the aspiration trocar and cannula but almost of the same thickness as inoculation needle and provided with stilette to clean it in case it gets blocked. The needle and therefore the interior of the pleural cavity is always kept in communication with a water manometer to indicate the pressure in the pleural cavity.

As is well-known, the intra-pleural pressure in health is negative, but during artificial pneumothorax treatment, it is raised gradually to zero or even a positive figure, the actual extent being judged by the degree of collapse secured.

Procedure of Artificial Pneumothorax.

The patient lies on the unaffected side, the arm being thrown headwards and a pillow given under the body so as to raise the chest and separate out as widely as possible the intercostal places. The skin over the 6th, 7th, or 8th intercostal space in the mid-axillary line is painted with iodine tincture and local anaesthesia is induced right down to pleura by injecting one c.c. of a 0.5% novocaine solution. The pneumothorax needle is then introduced into the anaesthetized area at the upper border of a rib. The entrance of the needle into pleural cavity is shown by a large movement of the fluid in the manometer with every respiration movement. Air is then gradually introduced, beginning with about 300 c.cm. at the first induction and increasing to 500 c.c. or even 1000 c.c. later on, depending upon the intrapleural pressure and the patient's reaction. The refills are given in the beginning at intervals of 2, 3, 4 days progressively increasing the period until after 15 to 20 refills, the interval may be 3 weeks to a month. The treatment has to be continued for more than two or three years to secure good results. The patient rests for about an hour after injection and then can be allowed to go home so that old patients are seen at the time of their refills once every two or three weeks and their general condition noted, they having learnt enough

of the general measures of treatment, during their preliminary stay in the hospital, to follow the routine at their homes.

Effect of Pneumothorax Treatment.

From the mechanism of the action of artificial pneumothorax it will be evident that collapse offers the lung itself a very great, if not complete, measure of rest, prevents the absorption of toxic material from it and bringing the walls of cavities in apposition favours their healing. In the beginning however of the artificial pneumothorax treatment, patients lose in weight for a short period, possibly owing to the action of toxins squeezed out from the collapsed lung. But this loss is very soon made up later in successful cases. The cough is lessened, the fever disappears, the appetite improves and the patient looks and feels a different man. The condition of the lung has to be checked from time to time by the fluorescent screen examination and a radiogram. The period at which to stop the treatment is very difficult to judge, but it is safe to go on a little longer rather than to stop too early. By gradually increasing the interval between refills and reducing the quantity of air injected, the lung may be cautiously allowed to re-expand, carefully watching the general condition of the patient while doing so.

General Measures.

Placing the patient in cheerful surrounding, free from worries, plenty of nutritious food, complete rest while there is pyrexia and careful graduated walking or other exercises as his condition demands; overcoming useless and tiresome cough by encouraging the

patient to suppress it or by administering small doses of codeine ($\frac{1}{4}$ gr. 4 times a day); general attention to the bowels, sleep etc., and treatment if any of co-existing diseases such as malaria, syphilis, which would hamper recovery need not be discussed here at greater length.

Of course the course of this treatment is not always altogether smooth as in some cases pleural effusion occurs which requires to be removed and replaced with air. The operation itself is not altogether free from risks, among which may be mentioned, pleural shock, air embolism, injury to the lung and haemorrhage. But even a hypodermic injection—not to mention intravenous injection—is not free from its own risks and the existence of risks only emphasizes the need for proper method and carefulness.

The object of this article is to dispel in some measure at least, the idea that diagnosis of pulmonary tuberculosis is equivalent to passing the death sentence on a patient and to induce the adoption of this very useful method of treatment at an early stage of the disease. The actual technique can be very easily learnt by a visit or two to the Osmania Hospital. Those interested can obtain further details from Rivere's *Pneumothorax Treatment of Pulmonary Tuberculosis*, 1927.

Eclampsia

BY

MISS M. F. CORREA, M.B., CH.B. (Edin.), L.M.
(Rotunda),

Lady Civil Surgeon, Victoria Zenana Hospital.

ECLAMPSIA is the occurrence of fits in a woman who is pregnant or who is in puerperium, and who would not have had the fits had she not been pregnant. This condition usually occurs between the seventh and ninth month of pregnancy, i.e. at a time when the foetus has become viable.

The etiology of the condition is not certain, but for all practical purposes we are satisfied that it is due to certain toxins and it must be our endeavour to eliminate the toxins by every possible channel i.e. the bowel, the skin, and the kidneys. The last however in these cases are generally hydraemic and therefore should not be forced to work with strong diuretics, for it would be very much like whipping a tired horse; our best plan here would be to limit ourselves

to fomentations to the loins to relieve congestion; linseed poultices four hourly work well.

The routine practice of the Victoria Zenana Hospital is outlined below;

1. As soon as we admit an eclamptic or pre-eclamptic, we draw off the urine and examine it for albumin; its significance according to the quantity present is as follows:—

A trace only—a sign of danger.

Present—danger.

Abundant—great danger.

Solid on heating and remaining so on the addition of dil. acetic acid—grave condition.

2. The systolic and diastolic blood pressures are taken; these range usually between 140—160 mm. Hg. systolic and 100—110 mm. Hg. diastolic. The former is not as important as the latter, for, from the diastolic pressure we can gather the state of the kidneys. If they are inefficient, we can do nothing better than let them rest by:

(a) starving the patient for 48 hours in severe cases, fluid in the shape of barley water, four to six pints in 24 hours being allowed, and

(b) by eliminating toxins by other channels i.e. skin and the bowels.

3. If the patient has had morphia before admission, and still has a fit, we refrain giving her any

more of it till two hours have elapsed since the last injection. If she has had morphia and is drowsy, or if she becomes boisterous we give a few whiffs of chloroform and start colon lavage with several gallons of soap and water. This is continued until the water, after doing a good result of evacuation, returns clear. We leave in a pint of the following solution:

Soda bicarb—one dram.

Water—one pint.

4. Stomach Wash:—We give a stomach wash if the patient is vomiting or is unconscious. In the latter case it is easier also to administer the purgative with the stomach tube. During the procedure if the patient gets a fit, the funnel is lowered and manipulations stopped leaving the gag in her mouth; washing is continued when the fit is over.

Technique:—The patient is placed on her side with her head right over the edge of the bed on which a mackintosh is spread leading to a container for wash water. A wooden gag is placed between the teeth of the patient and the stomach tube is glided along a finger into the oesophagus and pushed up to the mark on it. A solution of bicarbonate of soda, a dram to a pint of water, is used for washing out the stomach, and washing is continued until the fluid returns clear; sometimes this takes several pints of fluid. After this we leave in the stomach:

Mag Sulph.—dr. ii.

Pulv. Jalap. Co.—dr. i.

Glucose sol. (5%)—oz. iv.

Fits:—We detail a *Dai* to stay continuously by the bedside of the patient. As soon as the signs are shown of a coming fit, the attendant puts the gag between the patient's teeth and turns her to a side lest the mucus secreted in the mouth be aspirated and lead to pneumonia. If a fit comes on after the injection of morphia, we give her:

Chloral Hydras—grs. xxx.

Glucose—dr. i.

Aqua ad—oz. iv.

per rectum six hourly.

If she has fit after fit in spite of this, an injection of morphia gr. $\frac{1}{4}$ with Atropine Sulphate gr. 1/100 is given provided two hours have elapsed since the last injection, and not more than $2\frac{1}{2}$ to 3 grains of morphia are given in 24 hours.

The occurrence of eclamptic or even pre-eclamptic stage practically always leads to a natural termination of the pregnancy.

Under the plan of treatment described here we have in the Victoria Zenana Hospital a maternal mortality of 3 per cent and a foetal mortality of 28 percent in the pre-eclamptic cases, while in the eclamptic ones the mortality figures are, maternal 21 percent and foetal 32 per cent, as will be seen from the following table.

Table showing the results of the Pre-eclamptic cases treated in the Victoria Zenana Hospital during the year 1340 Fasli.

Pre-eclamptic cases	Number admitted	Cured	Relieved	Discharged otherwise	Died	Remarks
Delivered	28	27	...	1	...	
Undelivered	2	...	...	1*	...	*Taken home in a dying condition.
Delivered before admission	1	1	...	...	...	
Total	31	28	1	2	...	

Table showing the results of Eclamptic cases treated in the Victoria Zenana Hospital during the year 1340 F.

Eclamptic cases	Number admitted	Cured	Relieved	Discharged otherwise	Died	Remarks
Delivered	30	25	...	2*	3	*One removed home in a dying condition
Undelivered	7	2	...	1	4	
Delivered before admission	1	1	...	...	...	
Total	38	28	...	3	7	

Table showing the foetal mortality in the eclamptic and Pre-eclamptic cases treated in the Victoria Zenana Hospital during the year 1340 Fasli.

Children	Born	Alive	Dead	Remarks
Of pre-eclamptic cases	29	21	8	One case of twin birth.
Of eclamptic cases	31	21	10	
Total	60	42	18	

In the pre-eclamptic cases albumin is almost always present in the urine which is scanty, and the patient's subjective symptoms are severe headache, giddiness, and dimness of vision. The two undelivered cases shown in the table were blind for days; they were kept for four days on barley water 3—4 pints for 24 hours, and Pulv. Jalap. Co., Mag. Sulph. and glucose solution daily. Milk, rice and vegetables were then gradually added to the dietary. The blindness gradually wore off.

The eclamptic cases have fits in addition to the above mentioned symptoms. The blood pressure, especially the diastolic, is high, but comes down by almost 20 mm. Hg. under treatment.

The questions of importance for the practitioner to decide are:—

1. The degree of risk to the life of the mother.
2. Is recovery possible? and if so is the evacuation of the uterus a condition of it; and

3. The risk to the child.

The risk to the mother is greatest when the fits begin during pregnancy or labour; it is least when they begin during the puerperium after the fifth day. The greater the number of fits, the more the risk, and eight to ten fits constitute a grave case. The prognosis is still worse if in addition to the fits, the patient has a high temperature. The less the amount of urine passed, and the more the albumin in it the worse the prognosis for the mother.

The early signs of recovery are:

1. Increase in the amount of urine passed, with a diminution in the amount of albumin.
2. Decrease in the number of fits.
3. Gradual return of consciousness.

Recovery is possible if the patient is taken early in hand and efficiently treated. We find it better to leave the emptying of the uterus to nature, helping if necessary with a hypodermic injection of Pitocin 0.5 c.c. (this acts like pituitrin but without raising the blood pressure) or with the application of forceps. The toxin in these cases often kills the foetus, the death of which improves the prospects of the mother.

The patient is advised not to incur the risk of pregnancy for a couple of years.

I have to thank Dr. Miss K. S. Kanga, Superintendent, Victoria Zenana Hospital, for permission to publish the statistics, and for helpful suggestions.

The Tragedy of Glaucoma

BY

B. K. PHATAK, M.B., B.S. (Bom), D.O. (Oxon).

A patient generally led by his relative, seemingly blind, is brought in the Clinic. He stares at you like a blind man, which he really is, and very hopefully tells you that he is suffering from "Cataract" and after waiting for over 2 years and going nearly blind he has come to you for the operation about which he has so much heard which will give him back his sight and enable him to live his daily useful and independent life.

You have a nice look at him. He has no doubt the grayish look in the pupil associated with cataract. But you notice also that his pupils are dilated and they do not react to light. You have every grave suspicions about the diagnosis given by the patient himself viz. "Cataract". You ask him therefore as to why he waited so long before approaching you.

Very often the answer is that the poor man had approached a doctor long before who had diagnosed his condition as "Cataract" and had asked the patient to wait till he nearly went blind when the "Ca-

taract" would be mature and the operation undertaken. The patient had acted up to the advice and now demands back his sight and is ready for any operation.

You then take the patient into the dark room and on examining the fundus you find the glaucomatous cupping and the diagnosis is quite clear. To make it more certain you take the tension of his eye with a tonometer and it is found very high. The patient is suffering from "Glaucoma" and any operation as far as his sight is concerned is of no use to him whatsoever.

You tell your frank opinion to the patient. The patient goes back with a heavy load on his mind cursing outwardly his bad kismet. If however somebody could fathom his innermost feelings he would be cursing his doctor for his wrong diagnosis and advice and thus leading him on to what is worse than death to many of us—blindness.

This is the experience of the various Ophthalmic Clinics I have worked in and there is none more heart-rending than to find that you could do nothing at all for the poor man's eyes and but for the mistaken diagnosis the poor man would have enjoyed good use of his eyes for years to come.

The busy general practitioner notes the failing eyesight and the grayish look of the lens and gives the diagnosis as "Cataract". He looks for the textbook description of the disease which like that of other diseases is of late of very late stages. Early glaucoma is very difficult, nearly impossible, for the general practitioner to diagnose. But it is on these

general practitioners that the onus of rightly diagnosing the disease lies and they thus hold the destinies of many of their patients in their hands.

Glaucoma is not always an acute disease. Circumcorneal injection, shallowness of the anterior chamber and headaches may not be present to any marked degree in what is called the Glaucoma Simplex. Tonometry and Perimetry locate the disease when it is just beginning to develop.

In Glaucoma there is rise of intraocular pressure. The actual causation is still under dispute. Nervous shock leading to vasomotor disturbances is one of the main causes. The sclerocorneal junction is the place where the sclera and the cornea and the iris meet. It is through this angle that the aqueous humour escapes into the canal of Schlemm, a circular canal, and thus reaches the general circulation. This keeps the intraocular tension within normal limits. In glaucoma due to some yet unknown reasons the iris is pushed forwards and the angle gets more acute and thus draining of the aqueous humour is prevented which leads to rise of tension in the eye. When the intraocular tension rises, all the structures of the eye are put on stretch. The optic disc where the Sclera is thinned out and is in the form of a sieve to allow the nerve bundles to enter the eye is the most delicate part of the eye and is very susceptible to pressure. It is here that damage is done first. The nerve fibres are pressed on and pressure atrophy of the nerve fibres takes place. The sieve-like sclera is pushed outwards and a bulging is produced which is called the "glaucomatous cupping." The nerve fibres, at least of the eye, do not regenerate and hence

the advisability of operating on the glaucomatous eye as soon as possible and relieving the tension before the nerve fibres of the optic nerve are completely destroyed.

The first signs of early glaucoma are redness of the eye confined to the circumcorneal zone, slight headaches, blurring of the eyesight, seeing haloes and all these may be put down by the unwary to slight irritation of the eye due to something. A very important aid to diagnosis in this very early stage of the disease is Perimetry when a nasal contraction of the field of vision is observed. There are other important and field defects also too minute to be described in detail here. The nasal contraction of the field is due to the pressure inside the eye acting first on the temporal side nerve fibres of the retina. Another important instrument is Tonometer. If the tension of the eye, which varies normally between 15 and 25 mm., is above 35 the case may be safely diagnosed as "Glaucoma". Thus the general practitioner can understand how difficult it is to diagnose in his general everyday practice early cases of glaucoma. A specialist with the aid of these instruments can alone diagnose it. If the general practitioner finds a case with failing vision, redness of the eye, and slight headaches he should remember glaucoma and unless he can definitely diagnose cataract he should send the case on to some specialist. This he should do in the interest of himself and his patient. For early diagnosis means early treatment and thus preservation of whatever sight the patient is left with or in some cases actual recovery of some of the lost sight.

Regarding the prognosis we should bear in mind that the nerve fibres that have atrophied due to pressure will never regenerate whatever the treatment adopted. The nerve fibres which are however not completely atrophied will to some extent recover. Therefore whatever sight the patient has already lost in a chronic case will not be recovered from but the further progress will be stopped by an operation. In an acute case however where the nerves have only been pressed on and not yet actually been destroyed the sight will in some early cases improve remarkably from "3 feet" to "6|9" even.

The treatment is primarily operative. The medicinal treatment in the form of eserine $\frac{1}{4}\%$ drops is only a very good accessory line of treatment. Though cases of chronic glaucoma simplex may be kept on these drops for months together still any day the eye may flare up necessitating immediate surgical interference. It is always therefore a safe and good thing to operate on the glaucomatous eye as soon as possible.

The operative line of treatment aims at either reopening the closed channel through which the aqueous humour is absorbed into the system of making another artificial channel through which the aqueous humour may escape into the system and thus keep the intraocular tension within normal limits. The operations are many but the chief are i. Iridectomy, ii. Elliot's Trephing, iii. Lagrange's Sclereto-Iridectomy. In iridectomy the closed channel is reopened. In both trephining and sclereto-iridectomy a filterable scar is produced

through which the aqueous humour escapes under the conjunctiva from where it is absorbed into the general circulation. Regarding choice of the operation each has its strong advocates and if done well all these serve the purpose very well. Personally I prefer Iridectomy in acute cases and trephining in chronic cases.

Other measures in the form of tracing and irradiating any focal sepsis and improving general and mental health are important necessary factors in the treatment.

Two Case Reports.

1. A male admitted to the K. E. M. Hospital Ophthalmic Section, Indore C.I. in August 1931 at 9 p.m. He came from Mhow a distance of 13 miles from Indore in a motor suffering from excruciating pain in the eye. His vision was 2 feet and the condition was diagnosed as "Acute Glaucoma". He was put on the table at 10 at night within an hour of admission and under chloroform an iridectomy was performed. The patient passed a very nice night and was completely relieved of the pain next morning. The patient recovered his eyesight every day and by the 15th day vision came to about 6|9 in the operated eye. A prophylactic trephining was performed in the other eye and the patient went home completely happy with the full use of his eyes and very grateful.

2. A Male turned up in the Outdoor Ophthalmic Clinic of the Osmania General Hospital, Hyderabad in May 1932. Was diagnosed as "Cataract" by his doctor 2 years back and was advised to wait till

he nearly went blind. I found that he had Glaucoma in both eyes with typical glaucomatous cupping and a tension of 60 m.m. in both eyes. I told him that no operation could give him back his sight and I advised him trephining for relieving him of the pain he was suffering from now and then. This was refused and the patient went back a picture of misery for he had built up all his hopes on getting back his sight after the "Cataract" operation.

These two typical cases show the enormous difference made to the patient by the early diagnosis and early operative treatment. In one case the patient is quite all right, with full use of his eyes, enjoying life, doing his usual work, dependent on nobody, living the life of a useful citizen. In vivid contrast to this there is the tragedy of the wrong diagnosis where the patient is completely blind, with no solace but God, completely dependent for everything on the tender mercies of others, in fact, a drag on himself, his people, his society and his country.

A Case of Stone in kidney with Pyonephrosis

BY

KHURSHEED HUSSAIN, M.B., Ch.B. (Edin.),
*Professor of Surgery, Osmania Medical
College.*

STONES in kidney are found more generally in the female and in adult cases. They are more frequent in certain localities.

A patient, Rahiman Bee aged 25 years came from Raichur and was admitted as inpatient in F.S.W.I. on date 29—2—32, for renal colic and Raichur, the district in H.E.H. the Nizam's Dominions from where she arrived is noted for the stone cases.

Personal and Family History:

The patient has been married 8 years; menses regular; had no issue; she drinks toddy occasionally. Her ordinary diet consists of bread, rice, and meat. She herself does her domestic work at home and she is from a poor family; her husband is a chaprassi at Raichur.

Present and Previous Illness:

She gave no history of previous illness except a vague history of attacks of convulsions in her childhood. The present complaint is typical of Renal Colic; duration 3 years; dull aching pain in loin, more in left Lumbar region radiating to the pelvis and towards the bladder; the pain was always constant and sometimes spasmodic. She had a number of severe attacks during the last 3 years. The attacks were of characteristic nature with shivering, vomiting, cold perspirations, blood in urine and passage of large quantities of white discharge in urine—to put it in her words “Sudda”.

The Medical Officer of Raichur sent a letter informing that the patient had to be kept under Morphine several times to relieve her from these attacks of renal colic.

Examination:

Patient is strong and healthy. Abdominal wall was rigid due to constant pain. Tenderness was noted opposite the left 12th Rib. Bimanual examination to feel the kidney was not possible due to tenderness and rigidity. P. V. examination revealed nothing important. Urine was highly acid with albumin and R. B. C. and plenty of pus cells. Skia-gram gave the characteristic and distinct shadow of a large, irregular, pearshaped stone in front of the 12th rib opposite the 1st and 2nd Lumbar Vertebrae (Fig. 1).

Methylene blue was injected to test the functional capacity of the kidneys in the patient and the result with that of a healthy woman.

KHURSHED HUSSAIN:—A CASE OF STONE IN KIDNEY WITH PYONEPHROSIS

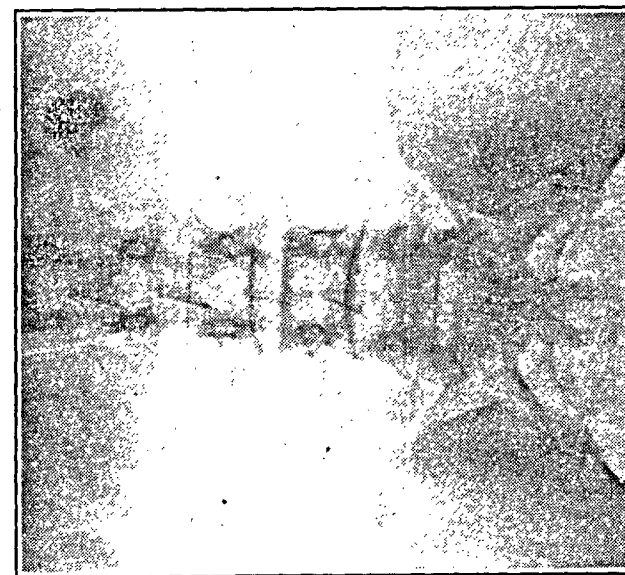


Fig. 1—Position of stone on admission.

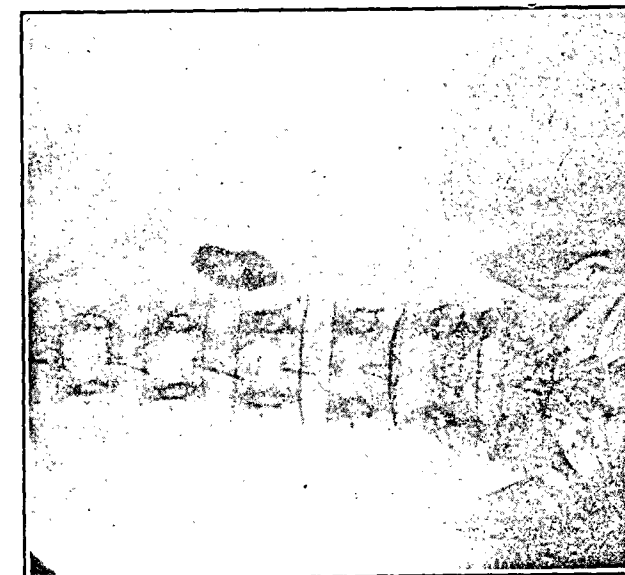


Fig. 2—Position of stone 11 days later.
| To face page 24.

The time of excretion of coloured urine in the patient and in healthy woman was same; the methylene blue was excreted in urine in $2\frac{1}{2}$ hours after the injection. Injection was given on 16th March 1932 at 5-30 a.m. and the colour of urine became normal in both on 20th March 1932 at about 9-30 a.m. (i.e. 3 days after).

(This test does not of course show whether the affected kidney is still functioning. All one may reasonably conclude from it is that the patient had enough functioning renal tissue to maintain health).

On the eleventh day of admission i.e. on 11-3-32 patient had suddenly a severe attack of renal colic with 105° temperature and agonising pain. Morphia and Atropine was given to give relief to the patient. A Skiagram was taken again during the attack and showed that the stone was displaced slightly against 2nd and 3rd vertebrae (Fig. 2). The kidney shadow in the skiagram was very large as compared with the Previous one. More blood and pus was found in urine. The attack and the temperature subsided in 5 days and then the patient was submitted to the operation.

Operative treatment:

Six hours previous to operation Morphia $\frac{1}{4}$ gr. and Atropine 1|150 gr. was given subcutaneously. On 22nd March 1932 Nephro-lithotomy was performed by lumbar route under Chloroform anaesthesia.

The time taken to complete the operation was 55 min., and the total duration of anaesthesia was 65 minutes.

Details of the Operation:

A large quantity of pus about 6 ozs. escaped from Perinephric region. Kidney was opened from its convex border and on exploring the pelvis of the kidney the stone was felt and extracted.

Description of stone:

The stone was impacted in the calyces. It is irregular and triangular in shape and well notched in centre. Its weight is 94 grains. It is hard, brownish in colour and is composed of uric acid and phosphates.

After extracting the stone the wound was closed keeping one small drainage tube in the pelvis of the kidney and another in the perinephric region, the latter to drain the pus from the big pouchlike cavity of the region.

After-treatment was uneventful throughout. The patient remained very comfortable. Temperature came down to normal on 3rd evening. Even the post-operative temperature on next day remained 101° only. There was no suppression of urine and there were no secondary complications. The 2nd kidney compensated and worked well.

Besides the escape of urine through drainage tubing into the dressings which were freely soaked, the following quantities of urine were collected every day.

6 hours after operation 5 ozs of urine was drawn by catheter. Again on the same day of operation 10 ozs. of urine was drawn.

On the 1st day of operation the patient herself passed 25 Ozs.

„ 2nd day	Do.	26 Ozs.
„ 5th day	Do.	31 Ozs.
„ 7th day	Do.	45 Ozs.
„ 8th day	Do.	50 Ozs.

The drainage tube from the pelvis of the kidney was removed on the 5th day, and the other tube from the perinephric region was removed on the 13th day after operation. The discharge from the wound gradually became less and it was very slight and watery on the 20th day of operation and completely stopped on the 29th day; the wound was completely healed and the patient cured in one month. But she was kept for one more week under observation and then discharged on the 30th April 1932 quite healthy and happy.

How the Goddess Pochamma Yielded to a dose of Santonin and an Injection of Morphia

BY

U. R. PARGAONKER, L.M. & S. (Hyd.)

*Medical Officer, Travelling Dispensary,
Bhir District.*

A medical man in his every day practice comes across a variety of symptoms produced by the infection of system with *Ascaris lumbricoides* simulating a good number of diseases.

Symptoms vary in each case and depend on:—

1. Local pressure.
2. Toxins circulating in blood, and thus creating symptoms according to organs affected.

Hence I would like to bring to the notice of my friends a very interesting case.

On 20th of October 1930 I was asked to see a patient in the village Versuni of Hadgaon Taluk where I had been on epidemic duty. A very virulent type of cholera, after having its heavy toll, had

just ceased a week back. Plague epidemic was prevalent in the two adjoining villages and a warning was given to this village also by the dying rats.

The patient whom I saw was a Hindoo female of about 22 years. She was complaining of severe abdominal pain and was very restless. On enquiry I was given to understand that she had two loose fluid motions and vomitted twice. There was no history about the patient having taken a heavy meal the previous night, which possibly could have upset her digestion.

After examining the patient, I gave one injection of morphine and atropine subcutaneously, followed by a dose of Carminative mixture with chlorodyne. Hot fomentations to the abdomen were continued till the patient came under the influence of morphia.

At 4 p.m. on the same day the condition of the patient was much better; but at 10 p.m. in the night, the brother of the patient came and told me that the patient was having high fever. (This was preceded by rigors).

I again went and visited the patient.

Temperature—102°F.

Pulse—99 per minute.

Respiration—21 Do.

All the other accompaniments of fever were present. The patient complained of tenderness in the right inguinal region and on palpation a slight enlargement of the gland was noticed. There was every reason for me to think of plague as there was rat-fall actually in the same and the other two adjacent houses.

To be on the safe side I started with a dose of calomel and soda and the following mixture.

Tr. Iodine—m.9

Acid Carbolie—m.6

Saline mixture—ozs. 3

Oz.1. t.d.s.

The bubo was painted with liquor Iodine. On the next day at 9 a.m. in the morning I visited the patient and found the temperature to be normal, though the slight glandular enlargement still persisted. The general outlook of the patient was very good.

At 10 p.m. the brother of the patient came to tell me that the abdominal pain had recurred with more intensity, and requested me to give another injection. By the time I went there the patient became violent and delirious. She was quite uncontrollable to six persons even.

Her eyes prominent and staring, face flushed, she was shrieking loudly. She was still more upset by my presence. She herself declared that the Goddess Pochamma was having the influence on her and no allopathic treatment should be carried out. All were in dilemma as to what should be done next; every-body there was against my treatment except the father and the brother who by this time were having confidence in me. The further treatment was left to my choice after all.

The general condition of the patient on the whole was not bad. I was thinking about the cause. I took some sort of toxæmia to be at the root of the mischief—naturally round worm attracted my attention.

Any how I gave another injection of morphia and the following powder was given early in the morning:—

Santonine—gr. 4

Calomel—gr. 5

Sod. bicarb.—gr. 5

1 powder.

Followed by castor oil.

At about 4 p.m. about 37 round worms were passed.

The patient is enjoying sound health. ed and a bunch of nine worms matted together.

In my case book I have a few more cases of this type where round worms play the mischief. I would request my readers also to give a fair chance to round worms, specially in children, when the illiterate people are trying to run to this and that God.

A Case of Caesarian Total Hysterectomy

BY

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(Eng.), L.R.C.P., (Lon.)

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A Muhammadan woman, 4th Para, was admitted into the Maternity Section of the Osmania Hospital at 12 noon on the 4th of August 1931, complaining of severe pain in the abdomen for the past 6 hours.

On examination:—The uterus corresponded to full term, was soft and not acting,—head presenting and moveable above brim—foetal heart audible. On the left side between umbilicus and the anterior superior iliac spine a swelling of the size of an orange was distinctly palpable and very tender to touch, and pain was severe. Diagnosis of twisted ovarian pedicle or a long stalked sub-serous fibroid was made. A large soap water enema was given with a good re-

sult. The pain subsided to a slight extent. At 4 p.m. oleum recini 1 oz. was given and a diet of glucose water and albumen water ordered. Patient kept in Fowler's position. During the night pain was more severe—Morphia $\frac{1}{4}$ gr. with Atropine 1|150 gr. was given hypodermically—this had little or no effect. At 7 a.m. the day following it was decided to open the abdomen under CHCl_3 . On opening the abdomen in the mid-line about 5 ounces of rice water coloured fluid scaped. The uterus was gently delivered out of the wound and its place taken by a large towel wrung out of warm saline which kept the intestines out of the way, the edges of the wound protected with saline gauze. The growth proved to be of a gangrenous stalked sub-serous fibroid. The pedicle was ligatured and tumour removed. The fundus of uterus was found studded with multiple fibroids varying in size to that of a walnut. The uterus was then opened and a living male child weighing $6\frac{1}{2}$ lbs. was delivered. The Placenta was adherent and while separating it, 4 interstitial fibroids of the size of the palm of an average hand were detected two at the fundus and two at the area of the lower uterine segment. Instead of wasting time by peeling off the placenta, it was decided to remove the uterus and this was accordingly done. On attempting to suture the stump it was found that the whole cervix was occupied by a fibroid which practically filled the pelvic cavity and this necessitated the whole cervix being removed. The vaginal flaps were then sewn together and the area peritonised. Two pints of normal saline left in the abdomen and closed with through and through silk worm gut sutures.

Progress:—During the 24 hours following the operation, 4 pints of saline were given submammary and glucose and water given by mouth. Pulse improved. On the 5th, 6th and 7th days she ran a temperature of 103°, and was treated with polyvalent Anti-Streptococci Serum 20 c.c. and Quinine bihydrochlor 10 gr. intramuscular for 3 days. No malarial parasites were found in the blood. Temperature was normal on the 8th day. Beyond this recovery was uneventful. Sutures removed on the 10th day—union by first intention. Patient was discharged on 5—9—31 i.e. 31 days after delivery. On vaginal examination before discharge the pelvis was found free.

There is an axiom that a woman who grows fibroids rarely grows foetuses. This patient has grown both simultaneously. It is likely that the fibroids existed before the birth of the 3rd child 4 years ago or even earlier. It is quite possible for a woman with a fibroid tumour to bear not only one child but several. These fibroids are usually sub-serous or at the fundus if sub-mucous. In this case the fibroids were of all three varieties. i.e. sub-serous at the fundus interstitial in the body and submucous in the cervix, the latter practically blocking the pelvis and yet not offering a hindrance to conception.

It is interesting to note how one operation leads to another under normal conditions, all, a 4th para with a vertex presentation and previous labours natural at term, would need, is helping with the forceps in case of relative uterine inertia. It was the acute pain and tenderness and swelling that led to the ab-

domen being opened. The presence of multiple sub-serous fibroids at the fundus made one suspicious of interstitial growths which would have certainly stood in the way of perfect retraction. This induced one to do a Caesarian and the existence of four large interstitial growths led to the removal of the uterus and finally the presence of the large sub-mucous cervical fibroid gave one no choice but to do a total hysterectomy.

There was no history of menorrhagia nor metrorrhagia between the pregnancies. The eldest child is now 17 years of age.

Breech Presentations.

BY

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I have read with interest in the B.M.J. of 29th August 1931.

1. The remarks on Breech Presentations by Mr. Gibberd.
2. Ante-natal treatment of Breech Presentations by Dr. Gertrude Darnley.
3. The management of Breech Labour by Mr. Alec Bourne.

Regarding the classification of Breech Cases—any breech labour with an average or large child in a primipara at full term is a “complicated” Breech, particularly when the legs are extended. Let us ask ourselves the question what the complications are one

has most likely to face in a full term primipara with breech presentation.

1. Early rupture of membranes.
2. Slow dilatation of the os.
3. Draining away of Liq. Amnii.
4. Flat pelvis or slight general contraction: this condition is present in such cases.
5. Intra-uterine manipulations to bring down a leg and extended arms.
6. Intra-pelvic manipulations to flex the chin.
7. Strong fundal pressure.
8. Exhaustion of the mother—most often CHCl_3 is given twice, once to bring down a leg and again to release the arms and deliver the head.
9. Laceration of the cervix, vagina, perinaeum—the latter often complete.
10. Prolonged convalescence.
11. Sepsis.
12. P.P.H.
13. Dead foetus or one nearly dead from intra-cranial haemorrhage and asphyxia pallida.

In each case, with most of these complications staring one in the face, the classification of “Complicated” is quite justifiable. In case of placenta previa, the ideal classification is Labour Complex Ante Partum Haemorrhage, Placenta Previa. The case is primarily one of Placenta Previa and not of extended breech. If an extended breech should co-exist, then nature has come to the rescue, as in most cases, the treatment adopted in placenta previa is to bring down a foot. Further, cases of placenta

previa rarely go to full term and more rarely occur in primipara. The picture presented in placenta previa is one of multiparity and prematurity.

Treatment:—I agree with Dr. Gertrude Dar-
nley that if external version is done to rectify the
position it ought to be done about the 35th or 36th
week. At the Osmania, all cases of breech in primi-
para are allowed to go full term and if the child is
anywhere near the average size or large, a Caesarian
Section is performed. The advantages claimed for
this method are:—

1. Live mother.
2. No exhaustion.
3. Avoidance of a long labour.
4. No sepsis.
5. No tearing of cervix, vagina or perinaeum.
6. Live, full term child without intra-cranial
haemorrhage and asphyxia pallida.
7. Mother and child leave hospital perfectly
well on the 21st day.
8. The second pregnancy in these women is
in nearly all cases a vertex—the child is
smaller and all that may be necessary is
helping with forceps for relative uterine
inertia.

In deliveries per Vaginum it is well to bring
down the arms before the head gets into the Pelvic
cavity—then get the Occipito Frontal or if possible
the S.O.B. diameter to engage one or other oblique
diameter of the pelvis, the assistant applying fundal
pressure should be instructed to apply the bulk of
the pressure on the frontal part of the head in order

to promote and maintain flexion and prevent exten-
sion. The child's back should be turned to the front
under the symphysis pubis only when the head is
well in the pelvic cavity. The face then rotates into
the hollow of the sacrum when there is more room
than elsewhere in the cavity for the operator's hand
in case further manipulations are called for, the final
delivery of the face and the head being completed
between pains in order that the perinaeum may
escape with as little laceration as possible.

The Deccan Medical Journal

July 1932

A WORD TO OUR READERS.

While offering our apologies for the belated appearance of the Journal, we would request our readers to bestow some serious thought upon its position and that of the Managing Committee of the Association. At the last annual meeting of the Association the question had come up for consideration whether it was worth while continuing the publication of the Journal at all and it was ultimately decided to make one more attempt to keep it going. It was evident that many members attached a fairly high sentimental value to it, and would feel genuinely sorry if this activity of the Association were to cease. It is the only medical journal in our State and there surely is room for one periodical and that a quarterly to deal with medical and sanitation matters in the State. The Journal again is the only medium for exchange of experiences and interchange of ideas between the medical men scattered over the State, particularly those in the mofussil who have not the chance of attending the clinical meet-

ings, held periodically under the auspices of the Association, to profit by the experience of others and brush up their knowledge. It thus does not require much pleading to make out a case for continuing the publication of the Journal.

But experience has shown that the activity has meant a deal of strain on the editor out of proportion to the apparent value of the Journal, and rendered it difficult for him to cope with it, owing it would appear, to the lack of sufficient active interest and co-operation on the part of members. Contributions for publication of a high standard cannot be made without some hard work and thinking; but one of the objects of the journal—if not the main-object—is to encourage among the members of the Association, the habit of properly studying and working up the clinical material at their disposal and of recording noteworthy observations, thus helping to raise the general standard of medical work. It is obvious that unless a sufficient quantity of suitable material is forthcoming the editor is sure to find himself unable to keep the Journal going or obliged to lower the standard of the articles accepted—which is worse than ceasing publication out-right.

We therefore earnestly appeal to the profession to look upon it as a duty and strive to have something worth publishing by which others could profit even a little and send the material to us. Merely subscribing to the Journal is not enough.

Our endeavour will be to include in the Journal such material as will be of help and appeal more particularly to the medical man in the mofussil, working single-handed and away from the labora-

tories. With this end in view we are making arrangements to ensure that our readers shall be provided regularly with the reports of recent advances in the different branches of medicine, of practical value, published in medical literature. We would also solicit the contribution of articles embodying the results of personal observations and experiments substantiated by actual facts and figures.

Medical Practice in Hyderabad State

Hyderabad State covers an area of more than 82,000 sq. miles and has a population of 12 millions. It is about the size of France. It is situated on the Deccan plateau at a moderately high altitude with an average rainfall of about 30 inches and a comparatively dry climate. As far as the natural conditions are concerned it should be a very healthy area. Though we are free from virulent epidemics of diseases such as kala-azar and beri-beri, which prevail in the neighbouring provinces of British India situated at a lower altitude, we do have widely prevalent in the State diseases like malaria, leprosy and occasional epidemics of plague and cholera which account for a good deal of loss of life annually besides much ill health and economic loss. A study of medical literature from the other countries—not much larger in extent but more advanced in matters medical—shows variations in the incidence and virulence of diseases in their different parts, which are of sufficient importance to repay a careful study. A cursory look at the statistics from the dispensaries in our different districts also gives the impression that the incidence of common diseases varies to some

extent from district to district. But systematic intensive studies have not as yet been undertaken, to determine the extent of this variation and discover the causes which may account for it. A beginning of course has been made in this direction by the Malaria and Plague Departments. Their activities are however for the most part, limited to the City and the materials and epidemiological data collected by them both in the city proper and in some of the districts, though published partly may take some more time to be available in complete form. Such systematic studies will be possible when the proposed Public Health Department will come into existence, which we believe will not be ere long.

Some years ago while reading the report of the Hookworm Enquiry in the Madras Presidency conducted with the aid of the Rockefeller foundation, a fact which struck us very forcibly was that while hookworm infection was shown in the maps as being fairly common in the districts bordering on our State, the State itself was shown blank—probably for want of usable data. The statistics of our hospitals and dispensaries also give very little indication of the prevalence of this condition. But it seems hard to believe that this condition which is so common in the adjoining British territory, is a respecter of political boundaries, when we further take into consideration the similarity of physical conditions and the fact of migration of a considerable amount of labour population from those districts in connection with some of our large engineering projects. We further learn though accurate figures are not available to us, that a considerable proportion of the inmates of the Leper

Asylum at Dichpalli have shown the presence of this infection. Similarly with regard to leprosy, the statistics from the dispensaries and hospitals cannot be expected to reflect the real extent of prevalence of this disease in the state as very few of these patients attend the dispensaries. The recently inaugurated programme of training the Medical Officers in the state in batches in the methods of diagnosis and treatment of leprosy has improved the condition a great deal and may be hoped to induce the early cases to come out and seek treatment at a stage when cure or at least prevention of further mischief can be safely expected. Special lectures by the workers in leprosy are also being given to our University students.

Taking group of fevers, one can say that while malaria forms no doubt the majority of these cases, other fevers like sand-fly and typhus group of fevers which we hardly find mentioned are prevalent in the state and will be recognized when they are looked for. If reported from the areas where they are observed, medical men in other parts of the State will at least have a definite knowledge of their existence in those parts.

The standard of Medical education in Hyderabad has been definitely raised in recent years since the inauguration of the University Medical Faculty. The standard of general practice will however take a considerable time to reach the standard of the Western countries. Outside our main teaching hospitals, special institutions and some of the district hospitals, the microscope is not as frequently in use as we should like it to be. Laboratory facilities which

are available in the Hyderabad city and to a limited extent in some of the district hospitals are beyond the reach of the mofussil dispensaries. The importance of the microscopical examination of blood, faeces etc., in the practice of medicine in the tropics can never be overestimated. In fact practice on scientific lines is almost impossible without their aid, and in the absence of proper diagnosis, we grope about in the dark and fail to take advantage of even those advances in the treatment of these conditions which have been definitely established.

We would plead that survey work to study the prevalence of some of the important tropical diseases such as hookworm infection, leprosy, dracon-tiasis etc. be systematically undertaken by the Government as no other agency could do it.

But the medical practitioner in charge of an outlying mofussil dispensary or a private practitioner in a village also have very important contributions to make to remedy this condition. Even in the absence of laboratory facilities investigations into a disease can be conducted by keeping record of careful and accurate clinical observations and such contributions to knowledge have been made in earlier times when the microscope was not so generally in use. To make one positive suggestion we will take the case of malaria. It is well known that the percentage of children with enlarged spleens may be very large in a given locality, but in the same locality the proportion of adults with enlarged spleens is very much smaller. Is this due to the regression of the enlarged spleens of childhood with growth or is it due rather to the succumbing of the heavily infected chil-

dren so that only those whose spleens had not enlarged very much reach the adult age? The general impression from what we have been taught is that the children acquire a certain amount of immunity as they grow up and that at some indefinite time the spleens regress. But it is worth while to have these statements corroborated by first hand observations on a stationary population in an endemic area, keeping the records of each individual, year after year. Evidently this requires the presence of the same medical man in a locality for a number of years or the continuity of the work must be maintained by a succession of medical men, who may happen to be there each for a short period. As such, private medical practitioners or those in charge of mission hospitals and dispensaries have a greater chance of doing this sort of investigation.

Other problems for investigation will occur to our readers and we would urge them not to let their ideas die off, but try to work them out.

Abstracts from Current Medical Literature

MEDICINE

Treatment of Diabetes Mellitus by Synthalin.

Todd, Brinkman, and Sansom report favourably on the treatment of cases of diabetes mellitus by Synthalin. From 1927 Synthalin has been continuously used in the Diabetes Clinic of the Bristol Royal Infirmary. It has been increasingly in use on the Continent also. They attribute the unfavourable results from other English clinics to the dieting of the patients on the system elaborated chiefly by Allen. In the Bristol Royal infirmary the diabetic patient's diet was relatively rich in carbohydrates. Synthalin is harmful when given to a patient who is on a diet which is poor in carbohydrate.

Diet is calculated on the basal requirement of the patient. Twice the basal amount is given for light and thrice for medium-heavy work. Carbohydrate is allowed fairly liberally.

The patient is kept on the following phosphate mixture.

Sod. acid phosphat—Gr. xv.

Tr. nucis vom—m. viii.

Spt. vini rect.—m. xxv.

Inf. gent. co ad—oz. i.

The mixture is taken t.d.s. An adult patient is started with 10 mgs. or two pellets of beta-synthalin (Schering, London), morning and evening. With every two pellets of synthalin one tablet of decholin (Medical Laboratories, London) is also given. Treatment is continued for two days, rest being given on the third day to prevent cumulation. Phosphate mixture is not stopped on the day of rest. Urine should be tested daily for qualitative sugar, specific gravity and diacetic acid. Probably no urinary change will be noted for ten days, but the patient often feels some relief before changes in the urine are noted. If there is euphoria but no urinary change, synthalin is increased by two pellets daily for five days or so, until either intolerance or diminution of the glycosuria and ketosis is observed. With each increase of two pellets of synthalin one tablet of decholin is also administered. When good clinical and urinary results have been obtained for some weeks, attempt is made to diminish synthalin by one pellet daily until the dose which stabilizes euphoria with sugar-free urine is found. Decholin is diminished pro rata. Liver and sweet breads are gradually added to the diet later on. A heaped dessertspoonful of bemax or a teaspoonful of marmite is taken once daily.

Transfer from insulin to synthalin is usually easy in a case of slight or moderate severity. For a 30 to 40 unit case, insulin is diminished by half, and synthalin is instituted as above. When urine is sugar-free, insulin is again reduced by half increasing the synthalin if necessary. Insulin is thus gradually cut out.

Diabetic coma should not be treated with synthalin as it is much too slow in becoming effective. Severe cases of diabetes especially in young subjects, are better treated with insulin first, but when stabilized, a cautious attempt to wean on to synthalin may be made.

Finally authors conclude that synthalin is a perfectly safe treatment if sensibly administered and that it gives as good results as insulin in about 70 per cent of cases but with much less trouble to the patient (as it is administered orally and no injections are required) with same cost as insulin treatment. (*The Practitioner*, May, 1932, Vol. cxviii, No. 5).

THE SERUM TREATMENT OF PNEUMONIA.

R. L. Cecil and N. Plummer discuss the treatment of type II pneumonia with Felton's concentrated serum. Type II pneumonia has a mortality rate of 48.8 percent, almost twice that of type I variety; the death rate in septic type II cases is extremely high being 87.5 per cent. In a series of 252 cases of type II pneumonia treated with Felton's concentrated serum the mortality rate was 40.5 per cent, as compared with a death rate of 45.8 percent in 253 alternate controls. During last year of this investigation, only early cases of type II pneumonia where

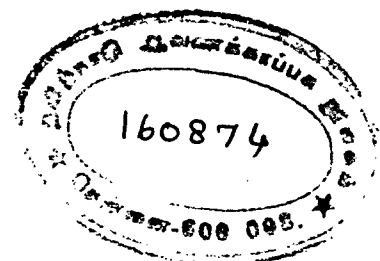
included in the therapeutic study; death rate of 14.3 per cent, was met with in 21 cases treated with intensive serotherapy as against 65 percent in 20 controls. The results indicate that Felton's type I concentrated serum has a definite though not striking clinical value, and must be looked upon as a promising therapeutic agent in the treatment of pneumonia.

(*Journal of the American Medical Association*, March 5, 1932, xviii, 779).

BRUCELLA INFECTION OF BRIEF DURATION

Undulant or Malta fever is generally considered to be a prolonged recurring disease. H. R. Leavell, M. Poston and H. L. Amoss report a case of exceptionally short duration, namely seven days. Although the origin of infection, in this case was not definitely determined, it is thought that the disease was contracted in the laboratory since no contact with animals could be traced nor did the patient at any time consume unpasteurized dairy products. It is not improbable that many cases of this type pass unrecognized, and owing to the difficulty of diagnosis by ordinary clinical methods, is mistaken for other conditions. The possible significance of such cases of short duration is discussed both with regard to the possibility of such patients becoming carriers and with regard to the development of cutaneous hypersensitiveness to Brucella and of agglutinins for Brucella organisms. (*Arc. Intern. Med.*, December, 1931).

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ENDEMIC TYPHUS FEVER; RAT FLEA AS A POSSIBLE VECTOR.

H. A. Kemp collected a number of fleas, both *Ceratophyllus fasciatus* and *Xenopsylla cheopis*, from rats trapped at a typhus focus, and ground up in 6 c.c. of physiological saline solution. Three c.c. doses of the emulsion were then injected intraperitoneally into guinea-pigs. Within six days of inoculation lesions characteristic of endemic typhus (New World) developed. On the seventh day of experiment the animals were killed and transfers of brain and spleen emulsion were made into fresh guinea pigs. With one exception, all animals receiving the passage virus reacted positively within six days. Post-mortem examination, both macroscopical and microscopical, differed in no essential features from those observed in the original test animals. Animals recovered from the attack produced by the virus were subsequently found to be immune to a strain of typhus virus established from the blood of a human patient with endemic typhus. (*Journal of American Medical Association, Sept. 1931*).

MALARIA TREATED WITH ATEBRIN

Richard Green M.D. Melb., D. T. M. Liverp., Malaria Research Officer, I.F.M.S. reports the results of treatment of fifty cases of malaria with this new synthetic drug. Forty six cases treated with quinine bihydrochloride were used as controls. He concludes that Atebrin compares favourably with quinine in ridding the blood of malarial parasites and in relieving symptoms. So far it seems superior to

quinine in preventing relapses. It is not unpleasant to take, but in a small proportion of cases gives rise to abdominal pains and in large doses, where excretion of the drug is delayed, a yellowish discolouration of the skin appears. Unlike plasmochin it has no effect on gametocytes of *P. vivax* and *P. falciparum*. The optimum dosage of atebirin for all forms of malaria is probably 0.1 gramme per 15 kg. of body-weight. In the series of cases 13 relapses were noted among 34 quinine treated cases, while among a total of 19 cases treated with atebirin and observed for a longer period than quinine cases, no relapses occurred. The author concludes that if the cost of treatment with atebirin compares favourably with that of quinine, this new drug assumes an added importance, particularly if it is shown definitely to be more effective than quinine in preventing relapses when used for short courses of treatment. (*Lancet, April 16, 1932*).

Surgery

REACTION OF THE FLUID ESCAPING INTO THE PERITONEAL CAVITY THROUGH PER- FORATED GASTRIC AND DUODENAL ULCERS

D. J. Harries, D.Sc., M.D., F.R.C.S., investigated during the last eighteen months sixteen cases of which seven were gastric, eight duodenal and one with a perforation on each side of the pylorus. He found in every case the free fluid in the peritoneal cavity alkaline in reaction. The fluid squeezed out of the gastric perforation was acid in reaction but in the duodenal cases six were alkaline and one was neutral. In the case with double perforation the fluid was acid in gastric and alkaline in duodenal perforation. The fluid secreted by the peritoneum during the operation was alkaline. Reflex contraction of the pylorus is produced by the irritation of the peritoneum by the fluid escaping through a perforation in the stomach or duodenum. Some of the gastric cases were operated upon within four hours of perforation, but in each case at the operation the free fluid in the peritoneal cavity was alkaline. This

result could only be obtained by the secretion of an alkaline fluid by the peritoneum. In gastric perforations alkaline fluid continues to be secreted by the peritoneum after the operation is completed, but that the fluid is afterwards absorbed. It is well known that draining the abdomen after operation raises the mortality rate and the author thinks that it is reasonable to suppose that the continued loss of the alkaline peritoneal secretion through the drainage tube may be responsible for this. (*The Practitioner*, May 1932 Vol. CXXVIII, No. 5).

TREATMENT OF CONGENITAL HYPERTRO- PHIC PYLORIC STENOSIS.

E. J. Donovan observes that congenital hypertrophic pyloric stenosis is one of the most important surgical conditions encountered in early infancy, and if treated after proper preparation by the Fredet-Rammstedt operation, it can be permanently and easily cured. The author has not been successful in treating the cases with any form of medical treatment. He analyses 119 consecutive cases. Vomiting is always the first symptom, and the average age of onset in these cases was three weeks. Pre-operative preparation is the most important factor in lowering the operative mortality in these patients; if the baby is in particularly bad condition, he receives one or two pre-operative blood transfusions, using 20 c.cm. of whole blood for each kilogram of body weight. All patients receive from 1 to 4 hypodermoclyses of 100 c.cm. of 3% glucose before operation. (*Annals of Surgery*, February, 1932, XCV, 174).

Ophthalmology

RELATIONSHIP OF INTRA-OCULAR PRESSURE TO AGE.

H. K. Muller of the University Ophthalmological Clinic in Basle conducted several experiments on the eyes of the cadavers to determine the relationship between age and intraocular pressure. He calibrated the eyes of the cadavers of various ages by means of a cannula attached to a Schoitz tonometer. After full consideration having been given to various factors such as temperature, the period which elapsed between the death and experiment, and so forth, he came to the conclusion that the child's eye has an average intra-ocular pressure of 29.5 mm.Hg., while in the adult the pressure averages 26.5mm. Hg. Over the age of 45 the average pressure is 25 mm. Hg. (*Archiv. fur. Augenheilkunde January 1932*, cv, 504).

OPHTHALMIC SIGNS IN ANAESTHESIA ADMINISTRATION.

K. F. Madan, M.D., D.O.M.S., Lecturer in anaesthetics, University of Punjab' Lahore, writes that from his experience as an instructor in anaesthetics,

he finds that some knowledge of eye diseases is a great help to the anaesthetists. There are patients in whose eyes abnormalities or variations are present in the size and reactions of the pupils, in corneal sensitiveness, etc., which are apt to puzzle or mislead the anaesthetist, resulting in serious accidents. Hence before administering the anaesthetics, just as the heart, lungs and urine are examined, so should certain points about the eyes be noted, such as the size, shape, reactions, and colour of the pupil and corneal sensitiveness of both eyes, and it must be ascertained if any morphia or atropine has been injected and if the patient has had any eye trouble in the past. It should be remembered that the cornea is insensitive in certain diseases e.g., keratitis neuro-paralytica, herpes zoster and absolute glaucoma; contracted and fixed pupils are found in cases of iritis, and iridocyclitis and pupil will not dilate however deep the anaesthesia; in high myopia, glaucoma, optic atrophy, contusions of eye, after diphtheria and herpes, and in genuine amblyopia, the pupils may be dilated; the pupillary light reaction in cases of iritis is absent particularly in cases with synechiae, absolute glaucoma, lesions of the reflex path and, the Argyll-Robertson pupil. (*The Practitioner May 1932 Vol. CXXVIII, No. 5*).

Obstetrics & Gynaecology

PLASMOQUINE IN PREGNANCY.

Philip Manson-Bahr records five cases of malaria in pregnant women suffering from all three species of malaria infection, from third to the eighth month of pregnancy. The result has been most satisfactory and there was no relapse either during pregnancy or postpartum. He states that the combination of plasmoquine and quinine appears to be well tolerated by pregnant women, and is unattended by danger either to the mother or to the child in all three clinical varieties of malaria. Appropriate therapeutic dose of plasmoquine compound in this condition is considered to be four tablets of standardised product daily (0.04 g. of plasmoquine plus 0.5 g. of quinine sulphate) for five separate weeks with a pause of three days interval between each weekly course. (*Lancet*, April 23, 1932).

TREATMENT OF VERTEX OCCIPITO POSTERIOR POSITION.

Arthur H. Bill thinks that too early interference in the first stage of labour as well as too long waiting for spontaneous rotation after full dilatation of the

os are both faulty methods of procedure. Waiting policy is believed to be safer but only during the first stage of labour. High foetal mortality in this condition, in the author's opinion is due to the general teaching that in most of the cases head will rotate spontaneously and therefore treatment should only be expectant. Persistent posterior position is a distinct abnormality to be treated by proper interference early in the second stage of labour. To expect the natural forces such as that of uterus and abdominal muscles directed towards the pelvis and in a line with the child's body to produce a rotatory movement of the foetal head sufficient to turn it to 135 degrees is scientifically unsound. The line of treatment advocated by him and followed strictly at the Cleveland Maternity Hospital is that of extreme conservatism and watchful waiting in the first stage of labour combined with active interference at the beginning of the second stage. The first stage is managed in primipara under morphine and scopolamine supplemented later by ether anaesthesia and in multipara by sodium amytal followed either by colonic ether or inhalation anaesthesia.

An hour of the second stage of labour should be sufficient to test whether spontaneous rotation will take place or not.

His method of delivery is influenced by two factors.

1. Not to use high forceps.
2. Never to deliver the head in the posterior position with the idea of bringing it down to the lower pelvic plane.

The rotation is thus corrected first before attempt at delivery is made. The procedure is reduced to two main methods.

1. Internal podalic version followed by immediate extraction.
2. Rotation of the head by forceps according to modified Scanzone method followed by forceps extraction.

Version is performed whenever the largest diameter of the foetal head has not passed the pelvic brim. If the head is in the pelvic cavity, the head is first rotated with forceps and then delivered with the of high head, even if the membranes are intact, ver-same. Manual rotation is never performed. He advocates the cephalic application of forceps. In case of high head even if the membranes are intact, version is advocated as soon as os is fully dilated. Caesarian section is advocated only in rare cases due to dystocia of rigid cervix or contracted pelvis.

Out of 514 cases treated on this principle, the foetal mortality was 4.47 per cent and if prematurity and maccrated babies are excluded the percentage falls down to 3.1. In his own series of 500 cases which he himself delivered the foetal mortality is only one per cent. The good results are attributed to his not waiting for spontaneous rotation and interfering early in the second stage. (*American Journal of Obstetrics and Gynaecology*, October, 1931).

Medico-legal

It is only on rare occasions that patients in India sue their medical attendants for damages and as such the following case recently heard in the Allahabad High Court will not be without interest to our readers.

A prescription for a petty ear complaint has cost a Civil Surgeon in U.P. Rs. 4,000 by way of damages to be paid to the plaintiff in a suit heard at the High Court.

It was alleged that Mr. Benarasidas Kankan, District Munsiff of Tilhar in U.P., suffered from ear trouble and sought the advice of Mr. Shyambehari Lal, Civil Surgeon of the locality, who prescribed ear drops containing $15\frac{1}{2}$ minims of carbolic acid and a mixture of paraffin to be used whenever there was dryness in the ear or pain. The Munsiff did not use the prescription for a year after its being prescribed, and later when he found his trouble recurring, he asked a chemist at Aligarh to dispense it for him. When the drops were used, it was found that the ear drum of the unfortunate officer was damaged and made his hearing defective, upon which he filed a suit against the Civil

Surgeon claiming damages for negligence and lack of instructions on the part of the Civil Surgeon.

Their Lordships came to the conclusion that the Civil Surgeon's prescription was a novel one, that the mixture was risky as an ear drop and was likely to do harm if the mixture was not vigorously shaken before use and that pure carbolic acid which was at the bottom would injure the ear drum. Their Lordships observed that the doctor had no justification for prescribing such a novel and dangerous mixture for a petty complaint. They also found that the doctor did not give any clear warning as to the necessity of shaking the mixture before use and that he did not enter necessary directions in the prescription itself.

Their Lordships held that the chemist who had dispensed the prescription was not to be blamed.

The defendant was ordered to pay Rs. 4,000 damages to the Munsiff.

(From the 'Hindu' of 28th May 1932).

Association Notes

The Annual General Meeting of the Association was held in the Osmania Hospital on 4th May 1932 at 5.30 p.m. Col. J. Norman Walker, President of the Association was in the chair.

The Annual report and the audited balance sheet as submitted by the Honorary Secretary and Treasurer was adopted by the General Body. The following Office-bearers were elected for the ensuing year.

President:—Col. J. Norman Walker, M.R.C.P., D.T.M. & H., I.M.S. (Retd.)

Vice-President:—Major Md. Ashraff, M.B., Ch.B. (Edin.)

Hon. Secretary & Treasurer:—C. F. Chenoy, M.B., B.S., D.T.M., D.P.H. (Lond)

Editor of the Journal:—S. W. Hardikar, M.D., M.R.C.P. (Edin.)

Members of the Managing Committee:—

Khursheed Hussain, M.B.Ch.B. (Edin.)

Major Farhat Ali, B.A., M.B., C.M.

Miss M. F. Correa, M.B., Ch.B. (Edin.)

S. A. Jabbar, M.B., B.S., D.M.R.E.

Tasadduq Hussain, L.M. & S. (Hyd.)

S. Raghavender Rao, L.M. & S. (Hyd.), D.T.M. (Cal.)

The Hyderbad Medical Association
Financial Statement for 1931-32.

Receipts				Payments.			
	Rs.	a.	p.		Rs.	a.	p.
Balance brought forward	576	5	1	Printing charges	42	9	4
Subscriptions collected from members	462	0	0	Postages	16	0	0
Advertisement charge in the Deccan Medical Journal	33	13	4	Stationery	2	0	0
Bank interest on Savings Bank Deposit in the Imperial Bank of India	36	0	0	Journal publication to the Editor	307	12	11
				Bill collector's allowance	27	0	0
				Misellaneous	1	8	0
				Closing balance	*711	4	2
Total Rs.	1,108	2	5	Total Rs.	1,108	2	5

N.B.—Opening Balance as shown in the last Balance sheet is Rs. 588-13-1. The ex-Secretary has spent Rs. 12-8-0 for the Association. Receipts for which attached.

*Cash in deposit with the Imperial Bank of India	Rs. 706	6	5
Cash with Hon. Secretary	4	13	9
	Rs. 711	4	2

J. NORMAN WALKER, President. C. F. CHENOY, Hon. Secretary & Treasurer.

Verified the Bank Pass Book and other supporting vouchers and found correct.

S. A. RAHIM, Hon. Auditor. M. F. CORREA, Hon. Auditor.

THE HYDERABAD MEDICAL ASSOCIATION

During the year under report the following meetings of the Association were held.

General	2
Managing Committee	2
Clinical	6

Clinical demonstrations and papers were read by the following members of the Association.

Lecturer.	Subject.
1. Dr. R. N. Coorlawalla, F. R. C. S. (Eng.)	Demonstration of some interesting surgical cases
2. Dr. S. W. Hardikar, M. D., M. R. C. P. (Edin.)	1. Continued pyrexia with lung symptoms simulating tuberculosis 2. Pneumothorax treatment of pulmonary tuberculosis 3. Locomotor ataxia
3. Dr. Khursheed Hussain, M. B., Ch. B. (Edin.)	Fibro-sarcoma of scapula, Moulded vesical stones, Burn, Pyloric stenosis Intestinal obstruction and multiple carbuncles,
4. Dr. J. Low of Leper Asylum	Clinical manifestations of Leprosy
5. Major M. R. W. Hart, M.B.E. L. R. C. P. M. R. C. S.	Percaine Spinal Analgesia,
6. Dr. S. A. Jabbar M. B., B. S., D. M. R. E.	Some aspects of the Radiological diagnosis and treatment of Surgical Tuberculosis by Heliot heraphy.

MEMBERSHIP.

The number of members on the roll at the close of the year was 93, as against 70 at the beginning of the year.

C. F. CHENOY,
Hon. Secretary.

Osmania Medical College Old Students' Association

The first Annual Prize Essay Competition for 1340 Fasli (1931 A.D.) was held as announced previously. Essays were submitted by the following members:

A. C. Abraham, L.M. & S. (Hyd.), D.T.M.
(Bengal).

Abdul Hai, L.M. & S.

Y. Williams, L.M. & S.

The essays were judged by a committee consisting of the following:

1. Major M. G. Naidu, M.B., C.M., late Professor of Medicine, Osmania Medical College.
2. Dr. S. A. Rahman, M.B., Ch.B., Professor of Physiology, Osmania Medical College.
3. Dr. H. J. Chinoy, L.R.C.P. & S., D.P.H., Professor of Hygiene, Osmania Medical College.

The essay "*Anopheline Fauna of Hyderabad City and their Control*" by A. C. Abraham, was considered the best and was awarded the Gold Medal

kindly presented to the Association by Dr. H. J. Chinoy. The essay will be published in the "Records of The Malarial Survey of India" December 1932, and arrangements have been made for the reprints of the same to be supplied to all the members.

The second annual "Old Students' Day" was celebrated on 18th December 1931 and the function, besides being a great success by itself, afforded an opportunity for the city and mofussil members to meet together. Sports were conducted by Lieut. M. Verghese and Abdul Hai. The function came to a close with the dramatic performance "Scenes from Arabian Nights" staged by some of the 'Old Boys'.

The second prize Essay Competition for (1341 F) 1932 will be held again as usual and essays for the same from the intending competitors must reach the Hon. Secretary (Dr. S. W. Hardikar, M.D., M.R.C.P.E., Professor of Pharmacology, Osmania Medical College, Hyderabad Deccan), before 6th October, 1932 (1st of Azoor 1342 F.).

News

Col. J. Norman Walker, M.R.C.P., D.T.M. & H., I.M.S. (Retd.), Director, Medical and Sanitation Department, H. E. H. The Nizam's Government proceeded to England on four months' leave.

Major Md. Ashraff, M.B.Ch.B., Deputy Director, Medical and Sanitation Department will officiate as Director and C. F. Chenoy, M.B., B.S., D.T.M., D.P.H., as Deputy Director during the above period.

M. K. Pundit, M.B., B.S., M.R.C.P.E., D.T.M., Civil Surgeon Aurangabad, has been posted to the Osmania Hospital vice Hassan Alikhan M.B., Ch.B., on leave.

V. M. Joshi, L.M. & S., has been posted to Aurangabad to officiate as Civil Surgeon Vice M. K. Pundit.

S. K. Jatar, L.R.C.P., M.R.C.S., D.L.O., Civil Surgeon Raichur, has been posted to Osmania Hospital, vice S. A. Rahim B.A., M.B., B.S., D.O., on leave.

G. A. Yemani, L.M. & S., has been posted to Raichur to officiate as Civil Surgeon vice S. K. Jatar.

B. F. Leevin, M.R.C.P.E., D.T.M., L.M., Civil Surgeon, Warangal, has been posted to Osmania Hospital, vice V. R. Gorakshakar, M.B., Ch.B., on leave.

Md. Ahsan Siddiqui, L.M. & S., has been transferred from the Travelling Dispensary, Warangal to Travelling Dispensary, Raichur.

Hari Gopal Modaliar, L.M. & S., has been posted to the Travelling Dispensary, Warangal, *vice* Md. Ahsan Siddiqui.

Md. Iftexharuddeen Hussain, L.M. & S., has been transferred from Bidar to Jalna.

C. V. Subramanyam, L.M.P., has been posted as a Sub-assistant Surgeon at Bidar.

P. N. Bindoo, L.M.P., Reserve S.A.S., Osmania Hospital has been posted to Alampur, Raichur District.

Md. Sultan Sahib, has been transferred from Parkal to Sultanabad in Kareemnagar District.

K. Subbarayudu, has been transferred from Sultanabad to the District Hospital at Kareemnagar.

P. Veeraju, L.M.P., in charge of Travelling Dispensary, Kareemnagar, is transferred to Pakal.

M. G. Chincholikar, L.M.P., in charge of Samasthan Dispensary at Gurugunta has been posted to Osmanabad to be in charge of Travelling Dispensary.

B. N. Siddapurkar, L.M.P., has been transferred from Samasthan Wanparti, to Samasthan Gurugunta.

L. G. Gurulingam, L.M.P., has been posted to Khammamet Dispensary.

P. Sunder Raj, L.M. & S., has been posted to Narsampet Dispensary, *vice* L. G. Gurulingam.

I. G. Parvatikar, L.M.P., has been transferred from Travelling Dispensary, Asifabad to Civil Dispensary at Parendla.

A. B. S. Modaliar, L. M. & S., has been posted to Travelling Dispensary at Asifabad *vice* I. G. Parvatikar.

F. Seshadri, L.M.P., has been posted from Aliabad Dispensary to Devarkonda.

B. S. Venkatavardhan, L.M.P., has been posted to Aliabad Dispensary *vice* F. Seshadri.

K. Lakshmikanta Rao, L.M.P., has been posted to the Civil Dispensary at Amerabad.
the District Hospital at Mahbubnagar.

R. M. Puranik, L. M. & S., has been posted to

The following are the further postings of the Medical Officers during the last quarter.

Medical Officer.	From	To
V. G. Gopalaswamy, L.M. & S.	Doodbavi	Yakootpura.
M. Naseeruddeen, L.M. & S.	Kotwali Balda	Doodbavli.
P. B. Kanade, L.M. & S.	Osmania Hospital	Kotwali Balda.
Md. Ahmed	T. D., Bidar	Osmania Hospital.
V. D. Paramasivam, L.M. & S.	Huzurabad	Purna.
B. S. Naidu, M.C.P.S.	Nizambad	Narayenpet.
Munavvar Hussain, L.M. & S.	Seram	Karayajat Dispensary.
M. Amarendra, L.M. & S.	Osmania Hospital	Seram.
V. V. Hardikar, L.M. & S.	Kamatipura	Osmania Hospital.
V. H. Atrey, L.M.P.	T. D., Purbhani	Osmania Hospital.
S. Ramdas, L.M. & S.	Lingal	Osmania Hospital.
A. Khaliq Shareef, L.M. & S.	Nalgonda	Lingal.
J. Ramshastry, L.M. & S.	Khandhar	Nalgonda.
Anwar Hussain, L.M. & S.	Osmania Hospital	Khandhar.

The following persons were newly appointed and posted at the places mentioned against their names.

C. V. Subramanyam L.M.P.,—Bidar.

G. Venkataswamy L.M.P.,—Huzurabad.

B. H. Joshi L.M. & S.—Chincholi.

B.A. Phatak, L.M.P.—Nalgonda.

S. Vasudev, M.B., B.S.—Miryalguda.

M. Gulam Ahmed, M.B., B.S.—Sangareddy.

OSMANIA UNIVERSITY.

(Medical Faculty).

The following are the results of the various examinations held in April 1932.

Final M.B., B.S. Examination—

1. Md. Munawwar Ali—Second class.
2. Shanker Rao Jadhav—Second class.
3. S. Vasudev—Second class.
4. Syed Arifulla Khadri—Second class.
5. Syed Nizamuddeen Ahmed—Second class.
6. Hakim Md. Abdul Rahman—Second class.
7. Gulam Ahmed—Second class.

Third Professional Examination (M.B., B.S.)—

1. Ahmed Hussain—Second class.
2. A. K. M. Badruddeen—Second class.
3. D. Tulsi Das—Second class.
4. Syed Ali—Second class.
5. Ahmed Abdul Wahid Khan—Second class.

Second Professional Examination (M.B., B.S.)—

1. Md. Hussain—Second class.
2. Md. Ghouse—Second class.
3. Mir Mustafa Ali Zaidi—Second class.
4. Ahmed Abdul Aleem—Second class.
5. Md. Abdul Rab—Second class.
6. N. Gurachari—Second class.

First Professional Examination (M.B., B.S.)—

1. Md. Hasanuddin Khan—First class.
2. Md. Akbar Ali—First class.
3. Abu Md. Gyasuddin—Second class.
4. Md. Munirul Rahman—Second class.
5. Md. Nazeer Mohinuddin—Second class.
6. Md. Masiuddin Ahmed—Second class.

CALCUTTA SCHOOL OF TROPICAL MEDICINE AND HYGIENE.

S. Raghavender Rao, L.M. & S. (Hyd.) qualified for the Diploma in Tropical Medicine of the above school at the examination held by the Faculty of Tropical Medicine Bengal in April 1932.

H.E.H. THE NIZAM'S MEDICAL AND SANITATION DEPARTMENT.

The following Medical Officers have passed the Departmental Urdu Zabandani Examination.

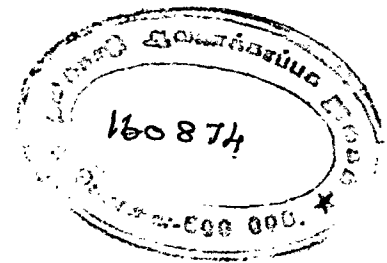
- V. D. Paramasivam, L.M. & S.
Vishanatham Pillay, L.M.P.
B. H. Joshi, L.M.P.

The following Medical Officers have passed the Grade Examinations held during March 1932.

- A. C. Abraham, L.M. & S.
Govind Triambak Rao, L.M. & S.
E. C. Raodeo, L.M.P.
C. P. Prabhune, L.M.P.
Ram Rao Ghanekar, L.M.P.
C. Venkataratnam, L.M.P.
W. D. Silas, L.M.P.
M. C. Masihcharan, L.M.P.
B. Dikshachary, L.M.P.
V. H. Atrey, L.M.P.
G. K. Kulkarni, L.M.P.
V. T. Bilgi, L.M.P.
V. V. Kulkarni, L.M.P.
Md. Farooq, L.M.P.
G. M. Kulkarni, L.M.P.

Passed in Medicine, Midwifery, Jurisprudence and Hygiene only—

- B. R. Jatkar, L.M.P.



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The Deccan Medical Journal

Published quarterly by the Hyderabad Medical Association and is issued free to Members. For non-members the annual subscription is B.G. Rs. 5 or O.S. Rs. 6.

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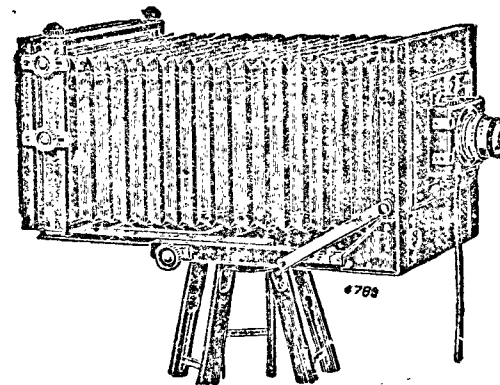
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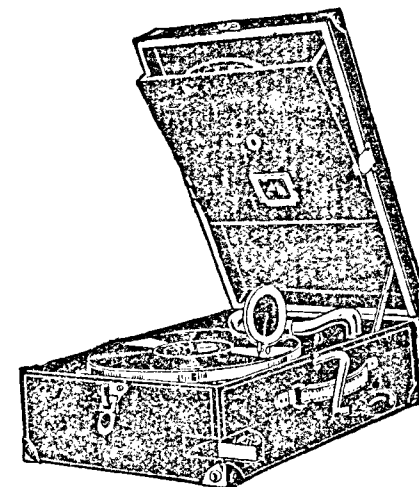


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The oil as its name suggests prevents and cures pus. It is a specific remedy for Sinuses particularly T. B. Sinuses, Carbuncles, Fistulas, Burns. Pus due to Nacrose bones Septic Ulcers, Eczema, Impetigo, Herpes, Sycosis, Ringworm, Scabies, urticaria, wounds, in short all skin eruptions whatever their origin be.

MODE OF ADMINISTRATION.

As a preventive it should be used immediately a wound or injury is received.

In cases of Sinuses, Fistulas, Carbuncles or deep seated Cavity due to Necrosis of the bone the oil should be syringed by an ordinary glass ear syringe and bandage applied Twice Daily. For skin eruptions and small-pox, oil should be applied locally twice daily. In latter case it will stop itching and scarring.

In case of burns of the 1st, 2nd or 3rd degree, it should be applied immediately by immersing a piece of lint in the oil and placed on the burnt surface and an ordinary bandage applied daily once. Before applying the oil parts should be cleaned with ordinary warm water.

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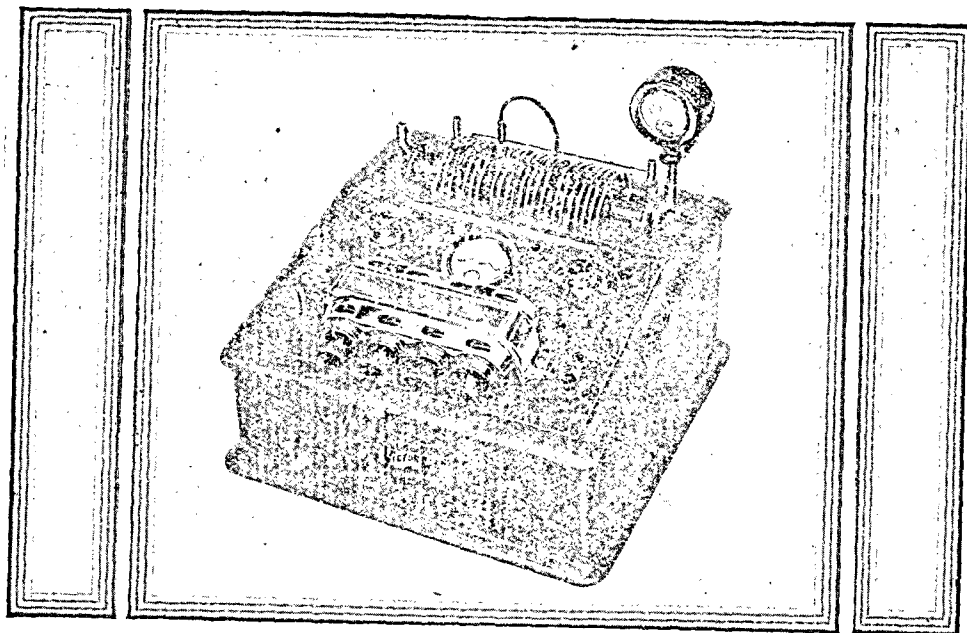
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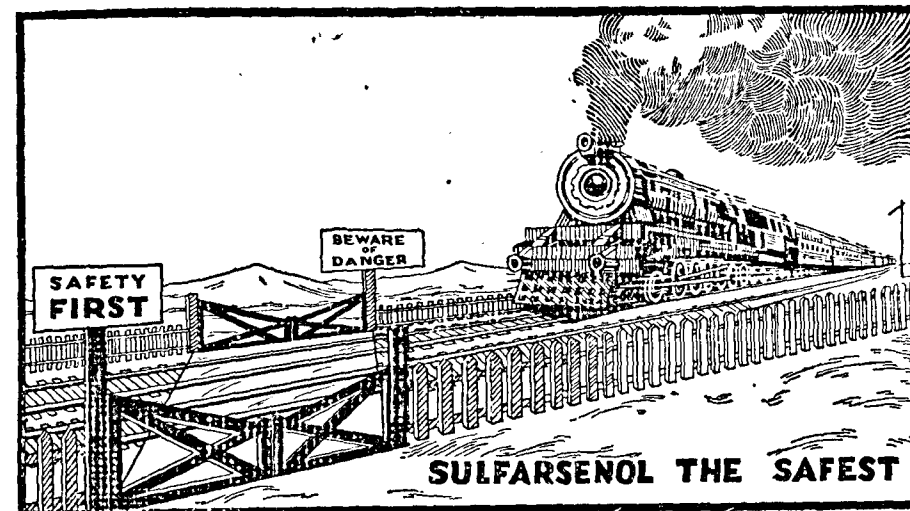
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