

The Medical Practitioner

A Monthly Medical Journal

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Editorials :

The All-India Medical Conference ...

Original Articles :

Electrosurgery in Tonsillar Infections, By Dr. T. S. S. Rajan, M. B. C. S.,
L. R. C. P. (London.) ...

Basal Metabolism, By Captain B. T. Krishnan, B. A., M. B., M. Sc. ...

Abstracts : All India Medical Conference

Extracts from the Address of the Chairman, Reception Committee ...

Extracts from the Presidential Address ...

Notes on Treatment of Diseases

Notes on Therapeutics, Diagnosis and other Medical Subjects

Recent views on Puerperal Sepsis ...

News and Comments

Correspondence, Reports, etc.

Reviews

List of postings of Sub-Assistant Surgeons for the month of March 1932

CONTENTS. 4 - MAY 1932

PAGE.

233

236

241

244

247

251

253

255

259

265

266

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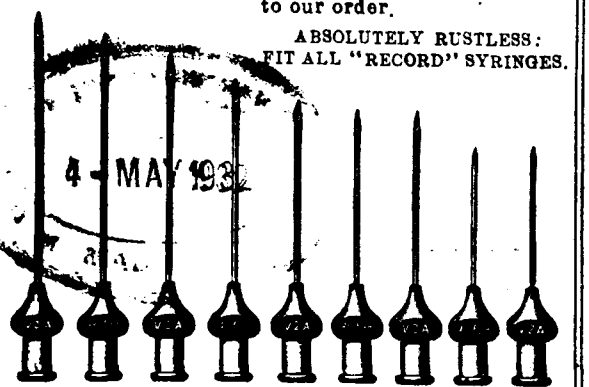
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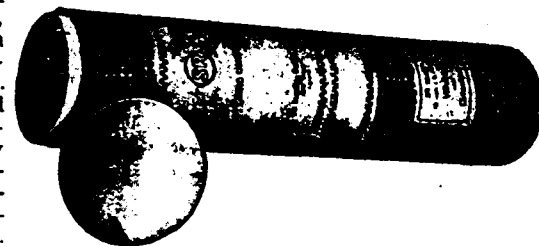
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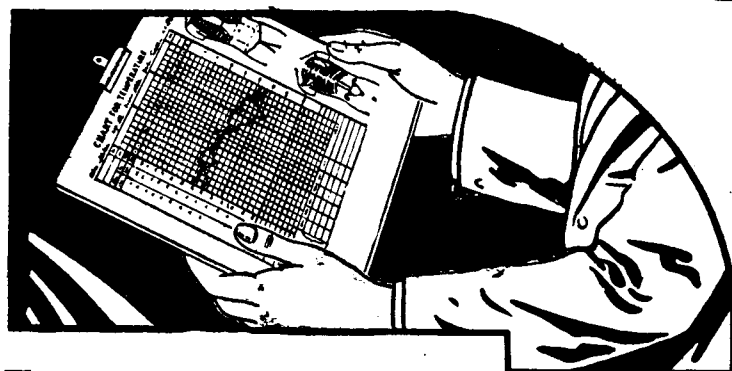
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VOL. III]

APRIL, 1932.

[No. 7.

THE ALL-INDIA MEDICAL CONFERENCE.

The Indian Medical Association which has its head-quarters at Calcutta convened under its auspices the eighth conference of an All-India importance inviting almost all the sections of the medical profession now existing in the country in service and outside. The seventh conference met in Poona last summer and this is the third time that a conference of this nature was summoned at Calcutta since 1917 and on both previous occasions, the medical profession at Calcutta served only as hosts but this time they were the hosts as well as the guests. The extraordinary circumstances under which the conference had to be summoned, were perhaps responsible in converting the hosts as guests. There was a move in Bombay to summon an All-India Conference in that city for the specific purpose of discussing the Indian Medical Council Bill and in spite of a suggestion from the Executive Council of the Indian Medical Association, that it would be detrimental to the interests of the profession to convey different views by the proposed All-India Medical Conference at Bombay when the executive council of an All-India organisation i.e., the Indian Medical Association had forwarded to the Government the views of the profession in India through its executive council, the Bombay Committee which took upon itself the responsibility of inviting an All-India Conference would not yield and wished to have the All-India gathering in Bombay last January and later post-poned the date. In the meanwhile the Indian Medical Association through their energetic Secretaries were

able to summon the All-India Conference and discussed not only the Indian Medical Council Bill but many other problems concerning the growth and prosperity of the medical profession in India. The fact as reported in the Calcutta dailies that as many as 500 delegates from all parts of India including Bombay attended the Conference would, we trust, convince the Bombay committee that no good purpose would be served by calling yet another conference at Bombay when the whole question of Indian Medical Council Bill was thrashed threadbare at Calcutta with an immediate effect (as could be judged from a telegram published in the Free Press) that the idea of appointing a Select Committee to go through the Bill had been given up by the Government during the present session of the Assembly at Delhi.

Though it was a fortunate circumstance that both the Chairman of the Reception Committee, Dr. B. C. Roy and the President, Sir Nil Ratan Sircar were veterans hailing from the Kali Kshetra, they did not lead the profession to the extent they were capable of doing by virtue of the position they occupied in relation to similar gatherings in the past. Dr. B. C. Roy, the Chairman of the Reception Committee was President of the 6th All-India Conference in Lahore and Sir Nil Ratan Sircar had the rare privilege of functioning as the Chairman of the Reception Committee of the very first Conference and later the fifth in Calcutta. Excepting the views on the Indian Medical Council Bill for which the whole profession especially the Licentiates have to be most grateful to both these leaders, all other topics which

were the subject matter of these addresses were nothing more than the treading on the old path with pious wishes later on followed by as pious resolutions which might serve the purpose of only repetition. Dr. B. C. Roy repeated what he said at Lahore in another capacity and Sir Nil Ratan Sircar followed almost a similar course. There was one most important and desirable change in the attitude of Sir Nil Ratan Sircar and that regarding the course of studies of the Licentiates. He along with one or two of his age strongly opposed in 1928 at Calcutta the increase in the course from 4 to 5 years. There was a similar change in the angle of vision of Dr. Jivraj N. Mehta the President of the last year's conference at Poona. A few months before he occupied the Presidential ghadhi at Poona Dr. Mehta gave expression to the view, at a lecture delivered by him at Calcutta, that in the interest of the large population in India there was a need for a lower standard of medical education. He changed this view completely at Poona and strongly advocated a five years' course for the Licentiates as well. As many as 46 resolutions were passed at the Poona Conference which sat on 25th April 1931 and continued its sittings till 28th and on 25th March 1932 the leaders representing the Reception Committee and the profession ought to have reviewed the work of the Indian Medical Association as to what action was taken on the several resolutions passed at Poona and with what results. Almost all the items treated in the addresses and many more were the subject matter of discussion at Poona: Medical Education, Post-graduate training, Public Health, Medical Services including Honorary System, Medical Research, Food and Drug Act, Health, Insurance etc. etc.

Our remarks have been justified by Dr. B. C. Roy who mentioned in his Address:

"You have come, Ladies and Gentlemen, to this great city at considerable sacrifice and trouble. To do what? Is it merely for the purpose of reiterating the grievances we suffer from, under the heels of 'Alien rulers'? Is it only to show them up and convince the world how we are being unjustly maligned as a 'backward primitive' people, weighed down by superstition and ignorance, which accounts for the abnormally high figure for maternal and infant mortality and physical and intellectual degenerates? Is the Indian Medical Conference merely to lodge dignified protest

against the present system of Medical and Sanitary administration in the country and pass resolutions asking for a reform here and a change there? No, No let us give up this whimpering, this habit of protest and protestations."

The Indian Medical Council Bill was one of the most important items discussed in the addresses of Dr. B. C. Roy and Sir Nil Ratan Sircar. The India Government through their mouth piece Sir Fazl-i-Hussain have made it plain that the object of the Bill is:

"To establish a Register of medical practitioners who hold qualifications which are likely to be accepted by other countries as conforming to international standards."

Both Dr. Roy and Sir Nil Ratan Sircar condemned this attitude of the Government and the former said that

"if this be the purpose of the Bill the sooner, the Bill is scrapped."

Apart from the undemocratic outlook of the Bill which has been rightly censured in both the addresses in detail, Sir Nil Ratan Sircar declared that

"the claims of the Licentiates have been unjustly ignored" and concluded by saying

"that the Licentiates should not only have the privilege of recognition in the Central Medical Register but should also have adequate representation."

As pointed out by us elsewhere in the last issue it is rather hard to conceive how and why the inclusion of the Licentiates vitiates the purpose the Government have in view even if it be only to placate the General Medical Council of Great Britain. If the Licentiates are included in the Central Medical Register how could this prevent the Indian Medical Council from exercising the control over the medical education of the graduates in this country? It looks as if there is some hidden hand somewhere which for its own purpose chooses to play the witchcraft secretly. On all points of view the Government will not loose anything at all on the other hand, gain a large amount of money by way of registration fees, if the Licentiates who are just over double the number of graduates in this country are included within the purview of the Bill. We trust the Finance Member of the India Government who on account of financial stringency wants to collect money by all possible means, advise

his colleague Sir Fazl-i-Hussain that the inclusion of the Licentiates in the Central Medical Register is a very sound financial proposition.

Next to the Indian Medical Council Bill the only other new topic discussed in the addresses of both the Chairman of the Reception Committee and the President was the encouragement of Indigenous Systems of Medicine. No patriotic Indian can denounce the Indigenous Systems as "Quackery". But that these systems are now generally practised by quacks in this country, many will not deny. The method advocated by Dr. B. C. Roy in recognising these systems was certainly more rational than the scheme proposed by Sir Nil Ratan Sircar. Dr. B. C. Roy said:

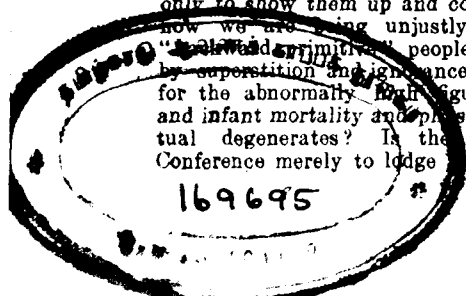
"All-India Medical Council, sooner or later, perhaps sooner than later, shall have to recognise the contributions of these systems in the treatment of diseases and give them their places in the general system. If we are to do that there is no purpose in our arranging our house in conformity with the Western standard."

It is inconceivable, nay most uncharitable, that Sir Nil Ratan Sircar an eminent scientific doctor as he is, should advocate two standards of treatment for human beings differentiating them as a lower and higher grade and keep the rural population under lower grade practitioners. Are the lives of the villagers so cheap? We wish Sir Nil Ratan Sircar realise that cities cannot exist without villages. From the common sense point of view, the village doctor should be better equipped and more resourceful than his more fortunate brethren in the cities as he cannot afford consultation from eminent specialists like Sir Nil Ratan Sircar. The scheme advocated by Sir Nil Ratan Sircar of including courses in Anatomy, Physiology, Pathology, Sanitary Science etc., in schools where Indigenous Systems of medicine are taught in the way it is now done, will certainly make India a country of quacks and not of scientific doctors. We hope it will not be long when Sir Nil Ratan Sircar changes his views on this subject as he has done this year regarding the necessity of increasing the period of training of the Licentiates which he could not countenance in 1929. He has already shown an indication for such a change in the final part of his address. He says:

"It goes without saying that there should be chairs for the study of indigenous therapeutics and pharmacology in our medical colleges and schools."

There was one more new proposal in the address of Sir Nil Ratan Sircar. He said that time had come when the Public Health Department should be under a separate Minister. It is so now, but the fact is not felt on account of the office of Surgeons-General and Inspectors General of Civil Hospitals in the provinces. Sir Nil Ratan Sircar might have as well proposed the abolition of these posts which do not exist in any country either in the West or East. We have mentioned in these columns more than once that these offices should be abolished and the Director of Public Health should be the Secretary to the Public Health Minister in all the provinces in which case all the rest of the reforms in medical profession may dawn earlier than one can expect under the present conditions.

On the whole it is to be said that the eighth All-India Conference at Calcutta was a success taking into consideration the difficulties the organisers had in summoning it with such a short notice. We will be failing in our duty if we do not join with Drs. B. C. Roy and Sir Nil Ratan Sircar in their appeal to the profession in this country to join the Indian Medical Association in large numbers and strengthen the Association year by year. That the activities of the Indian Medical Association were being felt by the Government has been made evident from the fact that the consideration of the Indian Medical Council Bill has been postponed to the next session of the Assembly even without appointing the Select Committee to consider the Bill. It was very fortunate that the All-India Conference met and passed unanimously a resolution that in case the amendments to the Indian Medical Council Bill as approved by the Conference were not adopted by the Government, the medical profession in India would be justified in refusing to accept the Bill. We trust the medical profession in India would rise equal to the occasion and prove their strength by unity.



169695
M. N. S. B. M. P.
N. 32

Original Articles

* ELECTROSURGERY IN TONSILLAR INFECTIONS.

BY

DR. T. S. S. RAJAN, M. R. C. S.,
L. R. C. P. (LONDON)
RAJAN CLINIC, TRICHINOPOLY.

The history of the afflictions of the tonsil must date back from the time when the existence of the tonsil came to be known. It is easy enough to understand the signs and symptoms of an actively functioning organ. The loss of function due to disease from whatever cause is realised by the patient and in fact the latter puts the Doctor on his scent by drawing his attention to the offending organ. In such cases the task of the medical man becomes easy. But disease of an apparently functionless organ is an enigma both to the Doctor and the patient though there is suffering none the less. It often costs the patient his life and it looks as though nature has provided human body with such apparently useless organs like the Appendix, the Thymus and the Tonsil only to get diseased and lead humanity to endless suffering.

Human physiology is yet far from perfect. The why and wherefore of the little cell—the unit of life—is as little understood today as when the first investigator told us that the human body developed from a tiny cell. Physiology has been developing rapidly. It is yet too early to say that the cell as the unit of life is the last word on the subject. Like molecules and atoms which have given place to electrons in Physics, it may yet be possible to find something more fundamental than the cell with its nucleus and nuclei and chromosomes. Perhaps it may then be found that the apparently functionless organs have a function to fulfill. Our knowledge about the function of many of the organs of the body is yet poor though much investigation and knowledge is being added from day to day. How else can we explain the part played by a group of lymphoid cells called tonsils buried in the mucous membrane of

the sides of the Pharynx giving rise to disorders which tell gravely on the development of our body.

The fact is, the function of the tonsil is not yet known. Its removal does not affect life in anyway. In fact it seems to be an advantage not to have one. It has a tendency to atrophy in adolescence and such unknown virtues that it may have possessed may have been useful in childhood. Dr. Portmann of Bordeaux believes the tonsils to function as a breeding place for certain bacteria which produce a toxin that will act as a vaccine and thus develop immunity against various infections. I am afraid this theory will not hold the field against the fact that far from producing immunity against infection, the crypts of the tonsil become breeding grounds for various pathogenic organisms which make the organ a source of trouble to over 70% of children. Whether the tonsil offered battle to the incoming pathogenic organism as a brave and valiant defender and eventually broke down in its efforts and then became the friend and abetter of the foe, thus altering its nature, is more than I could say. It is evident that a chronically enlarged tonsil is a permanent source of misery to the growing child till it is put an end to as a faithless soldier.

But it is a well known fact that fresh mucus has considerable bactericidal power and as the tonsils with their numerous crypts (before being destroyed in later years by acute or chronic inflammation) offer a large mucous surface, there is doubtless during the act of deglutition much mucus forced out and spread over the pharyngeal region thus exerting its bactericidal effect as well as assisting in general lubrication of the throat, besides as all lymphoid tissue is believed to be an effort on the part of nature to protect against infection it is quite likely that the tonsil has some such function when it is healthy.

But to those of you who have had some experience of throat work it is unnecessary for me to explain in detail the troubles that infected tonsils give. The nature of the infection is always bacterial. In many adults tonsils, streptococcus haemolyticus have always been found. Besides these,

other strains of stercococci, various strains of staphylo with pneumococcus, the influenza bacilli, the micrococcus catarrhalis and the Diphtheria bacilli have been found. Such pathogenic organisms finding a safe shelter in the crypts of the tonsils, convert it into a regular culture bed wherefrom ailments direct and indirect have their origin. In investigating the case history of tonsils we may find two sets of pictures. One arising from the local symptoms such as tonsillitis and its acute manifestations and chronic complications and sequelae such as Sore-throat, Quinsy and Catarrh. There is the other set of troubles arising in the neighbouring organs such as Cervical glands, Sinuses, Larynx, Ears, Nose and Eyes.

Of the troubles it produces in other organs it is enough if I were to mention only the prominent few: Arthritis, Neuritis, Lumbago, Frequent colds. Blood pressure above normal, Indigestion, Nervousness, Heart and Kidney troubles, Lack of tone, Foul breath, and all the other group of symptoms that are vaguely included under the term 'Focal infection.'

Over and above this there is the mechanical difficulty in deglutition by enlarged tonsils and interference with respiration. The picture of a tonsil child cannot be easily effaced from ones mind. Its stunted growth, non-expressive stupid looking face, with mouth half open always, with its snoring during sleep, its pigeon chest, the apex beat in the 4th intercostal space: all a tell tale picture of their own. Focal infections have their marked effect on the systemic conditions. It is astonishing to note what an important role focal infection plays in the human economy. Very often the infection is from an unsuspected source. It is perhaps a septic condition of the teeth and gums and more often it is an infected tonsil. Perhaps to one outstanding feature of the treatment of tonsillar infection is the effect it produces on the systemic condition. Such results are more apparent to those that work with the new method of Electrocoagulation of the tonsil than to others. Dr. Leo Doane of Butler County, United States of America, in his work on "Bi-terminal Tonsillar Coagulation" says "while we have for generations removed tonsils, more or less indifferently, by various methods, we

certainly did not have in mind the specific effects of tonsillar and other focal infection that we now so often envisage. We operated tonsils because they were large and because we thought they might interfere with respiration and deglutition or because their possessors were having attacks of Tonsillitis or occasionally Quinsy and perhaps loosing school attendance. Perhaps also, the child was "run down" with loss of appetite and weight and it was thought "might be going into Consumption" especially if there was coughing and so in case the tonsils were red and swollen, the Doctor thought it would be a good plan to have them "clipped" or in later years to have a "Tonsillectomy" done. Surgeons doing much of throat work operate on many more children than adults and in the former the symptoms are more apt to be local, frequently simple hypertrophy with but little infection and little or no systemic reaction. Again when the adults consult the throat Surgeon it is because he has local symptoms or has been referred by his physician. If he comes for operation, by the time he has recovered from shock and loss of blood he has been dismissed by the Surgeon and the subsequent history not usually followed up. On the other hand the Surgeon availing himself of Electrocoagulation, when the work is done in stages and over a period of some weeks and where there is no shock or loss of blood to retard his progress and the improvement being manifest, has an excellent opportunity to note the effects of the treatment as he proceeds. The Author has seen striking improvements in numerous cases within two weeks after the first treatment.

Many of us are only too familiar with the orthodox touching of the throat in the routine out patients work. We expect a pious touch of the swab dipped in some medicated solution rubbed gently inside the throat of a patient just for a second in the twenty four long hours of the day, should be the panacea of all ills that our throats are heir to. It is really a wonder that cases of slight infection do get better with such indifferent medication. A really infected tonsil is never amenable for such kinds of treatment. The crypts are inaccessible for easy manipulation and even

* Lecture delivered at the Chettynad Medical Association on 19-3-1932 and specially contributed to "The Medical Practitioner."

the most patient of us would feel comfortable with a digital manipulation of our tonsil. The lymph drain of the tonsil is as free and ample as that of its blood supply. The tonsillar lymph gland situated behind the angle of the lower jaw is the one that first gets affected and subsequently the infection travels on to the cervical glands along the anterior border of the sterno-mastoid. The indications for tonsil removal are always more than one. Rarely one single symptom calls for such radical procedure. Of the Local indications we may put down:—

- I. 1. Abscess or minute abscesses
2. Pus or other foul secretions
3. Pain on pressure
4. Chronic inflammation
5. Hypertrophy
6. Recurrent attacks of Tonsillitis
7. Frequent attacks of cold
8. Sore throat.

Under General Indications come:—

- II. 1. Cervical adenitis
2. Chronic Otorrhea
3. Early deafness
4. Hoarseness of voice
5. Intractable headaches
6. Toxic Goitre.

Till very recently and even today in many hospitals the routine method for destroying tonsils is by surgical removal. It is not every one that can do a Tonsillectomy well and successfully. The dangers attendant on this operation are many and varied that many Surgeons consider this to be a major operation. I know of a well known Surgeon who laid it down as a dictum that no one who is not prepared to ligature the Carotid artery should undertake tonsil removal. This may sound a frightful precaution but those of us who have done tonsil surgery may not ignore this remark as a mere fancy. The blood supply of the tonsil is profuse. As many as three vessels take part in its blood supply. The lingual, a branch from the external carotid supplies the anterior pillar and corresponding part of the tonsil, the ascending palatine from the facial and the descending palatine from the internal maxillary penetrate the tonsil mainly from the lower and upper portions of the base. Besides the arteries there is

a plexus of veins running along the edge of the palatopharyngeus muscle (the posterior pillar) and another running along the anterior sinus wall in front of the tonsil behind the glosso-pharyngeus (the anterior pillar). Such vascularity is a potent source of danger especially in an unreachable pit as the fauces where the tonsils lie. The dangers and difficulties of Tonsillectomy are many.

1. Most of the subjects of this operation are children below 12 or 14 years of age, with a poor physique, pigeon chested, breathing with their mouths open and often victims of chronic nasal catarrh, bronchitis and cardiac lesions of all sorts. They make very poor subjects for a general anæsthetic and it is well nigh impossible to do the operation without recourse to it.

2. The mechanical inconvenience of doing the operation while the anæsthetic is being admitted through a face mask which adds to the troubles of the operator.

3. Very often even when pupil reflex becomes lost under anæsthesia, the reflex irritation of the throat caused by manipulation with fingers and clamps continues with a result that the general anæsthesia has to be pushed on to a dangerous extent without which a satisfactory removal becomes very difficult. I have known of instances where the cessation of throat reflex was synchronous with cessation of breathing caused by overdose of the anæsthetic.

4. Friable tonsils are very commonly found in chronic cases. You cannot catch them *en masse* by any known instrument. You have to take them piece meal with all the attendant hæmorrhage and imperfect removal.

5. There is the difficulty in controlling the hæmorrhage both from the veins and the arteries. It is often difficult to locate the place of bleeding. The blood simply wells up from the pit wherefrom the tonsil has been removed. Swab after swab is changed and the patient gets out of the anæsthetic and the bleeding becomes fiercer on that account. Such experiences though not common are not rare. I have had three such instances in my series of over two hundred cases though they did not end fatally. They did give me a frightfully anxious hour or two and I

may not welcome such repetition of experiences.

6. There is the prolonged after-treatment. There is difficulty in swallowing, pain and all the after-effects of the general anæsthetic. In a few cases there is bronchitis and occasionally bronchopneumonia. The patient has to be confined to bed for at least four or five days if not longer and finally there is the rare risk of secondary hæmorrhage on the 7th or the 8th day.

Electrocoagulation, the subject matter of this discourse offers perhaps the best solution for these difficulties. The modern advance of Localised Bi-terminal Tonsillar Coagulation seems to have brought Tonsil Surgery to a process of a fine art in Surgical work. Of course it must be taken for granted that the necessary equipment for the work is the first precondition for the performance of this technique. A high frequency generator commonly known as Diathermy apparatus is indispensable. These machines operate on alternating current only and should be fitted with a rotary converter when the supply is a direct current.

The special advantages of Electrocoagulation over the usual cutting methods, which I have personally experienced in my clinic during the past three months are:—

1. Danger of hæmorrhage is practically removed.
2. Mutilation of the pillars common in the usual cutting methods is avoided.
3. General anæsthesia is superfluous except in cases of children.
4. There is no shock from loss of blood, since none is lost.
5. There is very little loss of time, the whole procedure taking not more than two to three minutes all told.
6. There is no hospitalisation necessary, therefore it does not interfere with daily wage earner's work.
7. The capsules and plicas are usually retained.

8. The localised bi-terminal method is superior to the older method of placing the indifferent electrode in some convenient part of the body, since weaker and hence

less dangerous current suffices as no body resistance is interposed.

9. As the terminals are close together, the current passes directly between the two. There is no danger of too deep penetration as with the older monopolar method, and secondary hæmorrhage is thus avoided.

10. There is very much less reaction as to be practically non-existent.

Electrocoagulation, apart from its value of replacing orthodox surgical removal, has perhaps a wider field of application in recurrent and relapsing cases after operation. There are quite a large number of such cases after inefficient or indifferent removal of Tonsils by the knife. In a paper on 'Electro-surgery of the Tonsils' read at the ninth annual meeting of the 'American Congress of Physical Therapy,' St. Louis, Sept. 1930, Dr. Fredrick B. Balmer said. "The recent Government reports estimate that about one third of all operations performed in the United States were for the removal of Tonsils, of these about three fourths of all surgical tonsillectomies are incompletely performed. This percentage as given is too high for efficient operators. It will only be necessary, however to witness some tonsil operations to be convinced that the number stated above is not exaggerated".

The special indications for Electrocoagulation are:—

1. Post operative tonsillar remains, lymphoid hypertrophy or regenerated tonsillar tissue.
2. Lingual hypertrophy and varix.
3. Various fungus affections.
4. Blood dyscrasias such as hemophilia and anæmia.
5. Various general conditions accompanied by serious involvement of the heart, lungs and kidneys and certain diseases such as syphilis, arthritis and sclerotic changes.
6. The aged and the infirm.
7. The vast number of people who emphatically refuse surgical removal.

THE ANÆSTHETIC. The choice of the anæsthetic depends entirely upon the nature of the patient and the amount of intelligent co-operation which one could

expect out of him. The psychology of the patient before the operation is generally the factor that decides the choice of the anæsthetic. As a rule in adults a local anæsthetic must be sufficient. I generally swab the throat with a 1 % solution of Pantocain over the tonsil, fauces and the throat. Generally one or two good and proper applications must suffice. No mouth gag is necessary. The tongue has to be pressed down by the specially insulated tongue forceps and with proper head-light the Electrocoagulation ought not to take more than one or two minutes to each side. I generally do both sides at one sitting. In cases where the patient is unduly nervous and a child under 14 years it is no use trying to do anything without a general anæsthetic. When once the patient is well under, the operation could be finished before the patient comes out. The anæsthesia should not be given while the electrocoagulation is going on. I have also tried infiltration of the tonsil bed in a few cases. It is no doubt very useful and may be used in patients who are not bothered by a fear psychology. For infiltration we use either Novocain 2 % or Pantocain in half percent strengths. About one to two cc. of the fluid will render the field sufficiently anæsthetic for the purpose. As a general rule about 3 to 4 sittings may be necessary for the average case and the minimum interval between each sitting is at least one week.

Very little of after-treatment is necessary. The throat may be swabbed with Mercurochrome or glycerine and iodine or glycerine and Phenol for two or three days.

The whole procedure of extirpation of the tonsil by electrocoagulation sounds very attractive and simple. A thorough knowledge of the orthodox surgical tonsillectomy is an absolute pre-requisite with all that it implies, in the proper and safe performance of electro-surgery. The results obtained will be entirely dependant upon the proper selection of cases, the doctor's skill in the technical application, with due appreciation always of the indications and limitations. A thorough knowledge of the various electrical currents used and their scope is essential for successful results.

Recently two American Doctors, Rhoads and Dick in the routine physical examination of nurses entering training at the

Presbyterian and Cook County hospitals found the tonsils to have been incompletely removed, in 294 out of 403 who have had a tonsillectomy, this working at 73 %. The remaining tissue was found to contain more pathogenic bacteria than the tonsil in its state, prior to removal. Further, the condition did not improve until the recurrent tissue was removed. Herein perhaps the electrocoagulation is undisputedly the best technique. If conditions of tonsil removal leave so much to be desired in a country like America, we need not be surprised if we find similar or worse conditions here. In my experience as a Medical Inspector for over three years from 1918 to 1921 for three big educational institutions, I found enlarged and diseased tonsils in over 70 % of the throats of boys, I examined. You may now understand what an important place a thorough, rational and at the same time a simple technique means in the treatment of such conditions.

To conclude I may tell you that,

1. Electro-surgery is a valuable contribution to the practice of surgery and a new adjuvant in the removal of tonsil.
2. A thorough knowledge of anatomy and surgical principles are pre-requisites to the correct use of electro-surgical technique.
3. Electrocoagulation is the method par excellence for removal of post operative tonsillar tissue and adhesions, lingual hypertrophy and varix and for extirpation of faucial tonsil especially in the presence of certain diseases.
4. There is no method of tonsil removal which is ideal under all circumstances. The combination of surgery and electrosurgery is a means of approaching the ideal.



* BASAL METABOLISM

BY

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The word 'metabolism' in general, indicates the changes, constructive and destructive, which take place in a living organism. The changes by which food materials are used to build up the body and to replace the tissue waste represent the constructive phase or anabolism, while the breaking down processes which result in liberation of energy and formation of certain waste products such as carbon-di-oxide, water, urea, sulphates etc., represent the destructive phase or katabolism.

The essential nature of the breaking down processes or katabolism is one of oxidation i.e. union of certain substances containing carbon, hydrogen sulphur etc. with the oxygen consumed and the splitting up of large molecules into smaller and simpler ones. In this process, the potential energy in the large molecules is converted into kinetic energy which appears as heat and mechanical work. So the essential feature of metabolism is liberation of energy.

The energy requirements of the body when a person is at complete rest i.e. the amount of energy necessary just to maintain the warmth of the body, the action of the heart, the respiratory movements etc. represent what is known as the 'Basal Metabolism.' This is the smallest energy output which is compatible with health. The basal metabolism is fairly constant in an individual and also in individuals of same age, build etc. and so becomes of importance as a physiological measurement along with other measurements such as temperature, pulse rate, blood pressure and so on.

Usually the basal metabolism is measured in the morning 12 to 14 hours after the last meal, with the subject lying motionless. Complete muscular relaxation, by lying down on a cot for 30 to 45 minutes

is insisted on before measurement. Strictly speaking, the metabolism measured under these conditions is not the lowest, because we can obtain lower figures in cases of under-nutrition and during profound sleep. For this reason, Professor Krogh suggested the use of the term 'standard metabolism' but it has not come into general usage.

The basal metabolism is expressed in large calories. A large calorie (C) is a unit of energy and is the amount of heat required to raise the temperature of one kilogram of water through one degree centigrade. The basal heat production can be measured directly as calories by placing the subject in special respiratory chambers called 'Respiration Calorimeters.' In these calorimeters there is provision not only for measuring the heat given out, but also for measuring the carbon-di-oxide and water vapour discharged and the oxygen consumed by the subject. But this direct method requires very costly apparatus and elaborate fittings and an expert to work them. Moreover, for the results to be accurate, observations will have to be made for long periods. The heat production can more easily be measured indirectly by knowing the volume of oxygen consumed and carbon-di-oxide discharged in a unit of time and finding the respiratory quotient which is the ratio of the volume of carbon-di-oxide discharged to the volume of oxygen consumed in a given time. This could be done either by means of the 'Respiration Calorimeter' or by collecting the expired air in a Douglas bag or a spirometer for a definite period and analysing a sample of the air collected. It is found that the respiratory quotient (R.Q.) so calculated varies according to the nature of the food i.e. carbohydrate, fat, or protein that is utilised in the body for energy purposes. If the diet were to be composed entirely of carbohydrate, the R.Q. would be 1 and it has been calculated that for every litre of oxygen consumed there is a liberation of 5.05 calories. If a person is on a mixed diet containing carbohydrate, fat and protein, the R.Q. is found to be 0.82 and the calorific value of a litre of oxygen consumed to be 4.825 C. As generally a mixed diet is taken, if the R.Q. and the

* Contributed to "The Medical Practitioner" at the special request of the Editors.

calorific value of oxygen consumed be taken as fixed data, to determine the basal metabolism of an individual, it would only be necessary to find his oxygen consumption in a given time, under basal conditions, that is, 12 to 14 hours after the last meal and in a condition of complete rest.

Most of the portable machines now in use in laboratories measure the oxygen consumption only and the result calculated is sufficiently accurate for clinical purposes.

When the results thus obtained on a number of individuals of similar age and size are examined, it is found that one calorie per kilogramme (2.2 lbs.) weight per hour is discharged. An average man of 70 kilograms (154 lbs.) weight will thus have a basal metabolism of $70 \times 24 = 1680$ C. per day.

But it is found that small animals give out more energy per unit of body weight than those that are larger. This is because the chief expenditure of energy is for the maintenance of the temperature of the body and the smaller the animal the larger is its surface and therefore its heat loss relatively to its weight. So, other things being equal, it is the surface area and not the body weight which determines the energy production. This is demonstrated by the fact that the calorie output for different animals is constant when calculated per square metre of surface area of the body. The body surface area is calculated from the height and weight of an individual by a formula devised by Du Bois. In man the basal metabolism, according to Du Bois, is about 40.0 calories per square metre of body surface per hour. This, of course, is based on the results obtained in America and other Western countries. In Madras, the writer has found the average basal metabolism, for men of 18 to 25 years of age, to be only about 35.0 calories per sq. m. per hour.

The basal metabolism is affected by several factors such as age, sex, diet, climate, and psychical excitement.

Age, independent of size, is a factor which influences the basal metabolism. The basal metabolism is very low 25 C. per sq.m. at birth and shortly after, reaches maximum 40.0 C. at about 20 years, after which it declines more slowly.

It is about 38.5 C. from 40 to 50 years, 36.5 from 60 to 70 years, and 35.5 from 70 to 80 years. These figures, as pointed out already, are only applicable to men in the West. In India, at any rate in South India, the figures would be lower than the above.

Sex also has an influence on basal metabolism. In women, the basal metabolism is found to be 7 to 10 per cent less than that in men. According to the Western standards, it is 37.0 C. per sq. m. per hour. In Madras the writer found it in women of 18 to 25 years of age to be about 31.0 C. per sq. m. per hour, while in men of similar age it was about 35.0 C. In women there is a rise in basal metabolism just before menstruation and during the second week after menstruation, and a fall during other periods. During pregnancy there is a rise.

Diet plays an important part in maintaining a high or low basal metabolism. Normally when food is taken, there is a rise in heat production to about 10 per cent due to the fact that food, beside being the ultimate source of energy, acts as a direct stimulant of heat production. It is for this reason that precaution is taken to measure the basal metabolism 12 to 14 hrs. after the last meal. This stimulating property is known as the 'specific dynamic action' of food-stuffs and it is greatest for proteins and least for carbohydrates. In cold climates, protein forms a large proportion of the diet as it serves to increase the heat production and thus compensate to a certain extent the heat loss. When people are constantly on a diet rich in protein, the basal metabolism is maintained at a high level. In tropical climates, a low protein diet is obtainable generally and is one of the factors which account for the low basal metabolism.

Another factor which controls the basal heat production is the climate. In cold climates, in order to maintain the normal body temperature, the excessive loss of heat is compensated by increased heat production, which is effected to a large extent by the activity of muscles. The muscles in cold climates possess constantly an increased tonus which at times becomes so pronounced as to give rise to shivering. This increased tonus of muscles, causing

increased heat production, maintains the basal metabolic rate at a high level. In hot climates, on the other hand, there is less tendency for muscular activity and there is constant muscular relaxation which results in a low basal metabolic rate.

The basal metabolism is also influenced by certain diseases. In thyroid disease, the change in basal metabolism is of real

value for purposes of diagnosis. In conditions of lowered function of the gland, the basal metabolism is 15 to 20 per cent or more below normal, while in conditions of increased secretion it may be 15 to 20 per cent above normal and may increase up to double the normal. In certain anæmias the basal metabolism is usually increased and a decided increase is noticed in fevers.

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BOMBAY.

Abstracts

ALL INDIA MEDICAL CONFERENCE

(EIGHTH SESSION)

EXTRACTS FROM THE ADDRESS OF
DR. B. C. ROY, B.A., M.D., (CAL.), F.R.C.S., (ENG.),
M.B.C.P., (LOND.) (MAYOR OF CALCUTTA)
CHAIRMAN, RECEPTION COMMITTEE.

Fellow Delegates and Friends:

I welcome you to this "City of Palaces" on the occasion of the eighth session of the All-India Medical Conference. The popular idea is that this city is a creation of the British. But the name "Calcutta" is derived from the word "Kali Kshetra" which means literally "the field of Kali". According to Pauranic legend, one of the fifty-one pieces of the sacred body of Sati fell on a spot to the south of Calcutta and the spirit of Sati is said to have manifested itself in the form of Kali. The Hindu Mythology has it that—"during the churning of the ocean, Kurma (the tortoise) too heavily pressed by the Mandara Mountain on his back and by Ananta (the infinite), gasped out a deep breath in order to stupefy the Daityas, and the country of "Kilkila" was formed, and it extended over the whole tract that was covered by his breath" and this tract is Calcutta and its neighbourhood. We find in history that the present site of Calcutta was in the 12th century A. D. in the form of a triangle about 2 square miles in extent. This island is stated to have been given by King Vallala Sen of Gaur as a royal gift to a Brahmin family and the fame of Kalighat spread far and wide towards the latter part of the Sixteenth century.

In 1645 Gabriel Broughton acquired considerable influence at the Imperial Court at Agra, where he had, it is said, restored Princess Jahanara, the eldest and pet daughter of Emperor Shah Jahan to life, after she had been given up by the Court Physician. He came and resided with Prince Shah Shuja, Governor of Bengal at Rajmahal and used his influence so well that, in 1652, he procured the English letters-patent granting them permission of trade in Bengal without payment of customs or dues. In 1658 English factories were established at Hooghly, Balasore, Cossimbazar and Patna and it

was at Cossimbazar that Job Charnock was appointed a fourth factor and from there he ultimately migrated to Chuttanuttee and laid the foundation of the present town of Calcutta. Chuttanuttee had provisions and advantages which the other parts of Bengal lacked and was connected with the interior by broad roads. On the 24th of August, 1690 Job Charnock found himself at Chuttanuttee and laid the foundation of the "City of Palaces."

The city has grown to enormous extent as will be evident from the fact that in the year 1704, the population of Calcutta was 45,000 and to-day it is a little over a million. Calcutta was formed of three villages—Chuttanuttee, Govindpur and Kali Kshetra. At the site now occupied by St. Andrew's Church in Dalhousie Square, was erected in 1727 a Court House for the Mayor of Calcutta and the Supreme Court sittings were first held in this house and it was used then also as a Town Hall. The present Town Hall, where we meet to-day, was built in the year 1894 at a cost of Rs. 70,000. This City of Palaces contains numerous famous buildings—one of the most picturesque of which is the Government House, the erection of which was begun in 1797 by the Marquis of Wellesley, because he maintained that "India should be governed from a palace, not from a counting-house; with the ideas of a prince and not with those of a retailer in muslin and indigo." This sentiment probably, was the beginning of the foundation of this great "City of Palaces," which for a long period formed the capital of British India.

"You have come, Ladies and Gentlemen, to this great city, at considerable sacrifice and trouble. To do what? Is it merely for the purpose of re-iterating the grievances we suffer from, under the heels of "alien rulers?" Is it only to show them up and convince the world how we are being unjustly maligned as a "backward primitive" people, weighed down by superstition and ignorance, which accounts for the abnormally high figure for maternal and infant mortality and physical and intellectual degenerates? Is the Indian Medical Conference merely to lodge a dignified protest against the present system of medical and sanitary administration in this country and pass resolutions asking for a

reform here and a change there? No, No, let us give up this whimpering, this habit of protests and protestations. I suggest that we should get out of this "Pupa" stage of our existence and emerge as responsible "Imagos" prepared to take upon our shoulders the responsibilities of our adult life, realise our duties, develop ourselves and fulfil our destinies as men devoted to the noble task of healing, in the rapidly changing state of things in this ancient land of ours. The question is how to do this? What constructive suggestion can this Conference make to achieve this? We who, are on the wrong side of fifty naturally look fondly to the young ones to take up the task, to put their shoulders to the wheel and succeed. If that be our desire, have we equipped them properly for it? Those of us who have been trained under the old system have been obsessed with the idea that all that was required of a medical practitioner in India was to be a "good assistant." He should talk in his 'Master's voice.' He should act as he has been told to act. He should be able to correctly reproduce in his own professional life the ideas he has been brought up in. Fortunately however, we have now a different vision of the medical profession. Medicine is not merely knowledge capable of quantitative expression and utilisation but is a developing conception, a mixture of empiricism and rationality, a mixture of research and practice. It is both a science and an art. Therefore, we should train our boys to make accurate observations and draw correct inferences on the one hand and on the other get them to test the same in a scientific spirit, with scientific methods, check such results and deduce conclusions for future guidance. Unfortunately, with the ever-increasing and perplexing methods of clinical examinations in the laboratory, there has grown in the students, to-day, a tendency to neglect the use of the senses, to rush to conclusion based upon examinations of dead materials in a lifeless laboratory. He is apt to forget that science resides in intellect and not in instruments. Therefore, the future training of our students should be in the intellectual technique of inductive science.

In order to be able to give this instruction, we should decide first of all, what should be the minimum qualification of a candidate about to enter the medical school? Secondly, what should be the minimum period of instruction in medical subjects which will give him the requisite knowledge in the practice of medicine, midwifery, and surgery, and thirdly, what provision should be made for giving him post-graduate instruction?

You are aware that in the olden days, the pick amongst the "failures" in the family was destined for the medical line, the most "rowdy" among the boys was sent to study medicine to "steady" him. Things have changed now and we find to-day a large number of applicants, possessed of the requisite intelligence and training to take full advantage of the medical course. But in the selection of students for this career, no attempt is yet made to find out whether he possesses those qualities which are essential in a making of a good medical practitioner; to test whether, he possesses self-confidence, initiative, judgment, common sense, and a spirit of optimism which is prepared to meet critical situations with faith and courage?

There is an opinion abroad that in view of the poverty of this country, a type of medical practitioners should be always available who would be prepared to give medical aid at a very cheap cost and it is argued that he could only do so, if his period of medical studies does not exceed four years so that the cost of education is less. This is not the proper way of arriving at the decision regarding this point. What we want to determine is the period which should be sufficient for a student to obtain knowledge in the scientific subjects and the period which he must spend in the wards of a hospital, before he can be considered to be fully equipped as a practitioner in the healing art. From this point of view let us decide if the period is to be 4 years or 5 years. My experience as a teacher for a quarter of a century has led me to this conviction that it is impossible, particularly, in these days when rapid advances have been made in all the

departments of medicine, to give to a student, sufficient insight in the medical subjects in a period of four years. It appears that the College of Physicians and Surgeons of Bombay and the Bengal Council of Medical Registration have resolved recently to introduce in their schools a course of five years. To my mind, it is the correct thing to do. But there is another side to this question. The introduction of a four years' course has led to the creation of a class of medical practitioners who, however capable they may be, have been relegated, under the present system, to an inferior position in professional life. It has led to a great deal of heart-burning and the gentlemen belonging to the "depressed" classes have felt the ignominy of the situation. And to-day, the All-India Medical Council Bill, about which I will say something later, has refused to recognise the position and influence of this class of what we call "Sub-Assistant Surgeons." The name is an anachronism under the present circumstances and the sooner they disappear from our vocabulary, the better for all of us.

But even when a student has obtained his instruction, he has learnt the technique of science, he has yet to learn the art of practice of medicine. He is to be taught by an oft-repeated mental process to observe, to sort, to combine, to infer and to apply the results in practice. He should be taught by precept and example the importance of tact and fine feeling. He should be taught that the art of noble behaviour is not inconsistent to the practice of the scientific methods, that humanity and science are not contradictory, that whether he adopts Allopathy, Homeopathy, Osteopathy, or any other "pathy," in actual practice, the only system which will stand in his stead is "sympathy" with the sufferers. Even medical research can be only truly fruitful when it is prompted by sympathy for the pain and distress of the sufferers. Therefore, there should be for every student a provision for post-graduate studies before he is to embark on his only mission in life—"the conquest of human pain." It is clear that the instructions given in the schools and colleges form only the foundation on which to build the future superstructure of the physician's armatorium. For this purpose, a training

in an institution or under a tutor is essential. In fact, if I were given the choice, I would suggest that instead of getting the ordinary didactic lectures, a student should get attached to a teacher and should gain knowledge by the example and precept of a living teacher rather than commit to memory barren pages of dead books.

Associated with this provision for post-graduate training there must be provision of opportunities for research. It is unfortunate that in this country all provisions and facilities for research have hitherto been under the control of the State and were guided by the members of a Military Service. It is an irony of fate that under such circumstances, the Indian medical practitioners should be blamed for not taking up research seriously and contributing their quota in extending the bounds of knowledge in medicine, when no facilities were open to them to undertake research.

MEDICAL SERVICE.

Regarding medical and sanitary services in India Dr. B. C. Roy said that they are virtually controlled at present by military medical service. Whatever claims put forward by the members of the Indian medical services be, he wished that the Indian Medical Conference should declare that no posts in the medical and the sanitary departments should be the "preserve" to any "service" and that for the purpose of medical and sanitary service in the country candidates must be recruited by open competition in India. It was possible that in bigger towns, hospitals might be manned by honorary workers. Regarding prevention of diseases he said that the notion that only a "sircari doctor" could be looked upon as an authority and the private doctor was a back number was fast falling down and in case Indian Medical Officers in service joined hands with their bretheren in private practice and lift up the screen of misapprehension and illusion as a result of the false fear of "politics" the work, of the medical profession and the public with regard to prevention of diseases would have been much more satisfactory than it was now.

INDIAN MEDICAL COUNCIL BILL.

The Universities and the Councils of the medical registration in different provinces

being primarily concerned in imparting medical education, Dr. B. C. Roy was of opinion that these bodies should have a predominant voice in the proposed All India Council. The Government as such had nothing to do with a bill whose work was to initiate proposals for developing medical institutions and maintaining them at a high level, and not for the side purpose of establishing conformity with the "International Standards." He wished that the conference would make it clear to all concerned that "Reciprocity" was not and could not be the object and aim of Indian Medical Council Bill. It was to be treated merely as a side issue and if the purpose of the Bill was as explained by Sir Fazl-i-Hussain to establish a register of medical practitioners who hold qualifications which were likely to be accepted by other countries as "conforming to International Standards," he wished that the Bill be scrapped.

AYURVEDIC AND UNANI SYSTEMS.

In the development of medical education and medical practice in India Dr. B. C. Roy wished the conference not to ignore the Ayurvedic and Unani systems which remarkably were holding their own for centuries. It must be the concern of the conference to give these systems their legitimate places in the general system.

FOODS AND DRUGS ACT.

He said that it ought to be the concern of the profession to provide for plentiful supply of health-giving food and efficacious medicines prepared and manufactured in their own country. He pointed out that Bengal had taken the lead in this direction and there were signs that other parts of India were following suit. He appealed to the Indian Medical Conference that "Buy Indian Goods" should be their slogan.

MEDICAL RESEARCH.

Regarding medical research he was very sorry that it was now a sole monopoly of the I. M. S. officers. He wished that medical research be nationalised and developed in the lines most suitable for India and for this purpose it was not enough that researches were conducted to find out the nature and causes of diseases but they should also concern about Indian drugs

in curing the diseases and that vigorous steps should be taken to find out physiological effects and pharmaceutical action of Indian drugs in the treatment of diseases.

He made an appeal to the profession in India to muster strong as members of the Indian Medical Association and with the united strength solve the problems brought to their serious attention during the conference sessions and come to conclusions worthy of themselves and the country to which they belonged.

Extracts from the Presidential Address

BY

SIR NIL RATAN SIRCAR Kt.

LADIES AND GENTLEMEN,

I consider it a great privilege and honour to perform the function which you have so kindly offered to me. I only wish I were fully worthy of your choice.

Your attention has already been drawn to some of the most prominent questions bearing on the position of the Indian Medical profession in relation to the State, to the organisation of Research, to Medical Education in its various grades, to Public Health and Sanitary Organisation, and to scientific movements affecting the well-being and progress of the Indian nation. The foremost among these at the present moment is the legislative measure for which the Government has introduced a Bill to establish a Medical Council in India and to provide for the maintenance of a British Indian Medical Register. One should have expected that in view of the impending changes in the Indian Government, this measure should have been postponed to a more suitable time, but the Government of India is in haste on the plea that immediate creation of an All-India Medical Council has become imperative in order to afford relief to the Indian medical graduates whose claims to recognition have been rejected by the General Medical Council of Great Britain. To placate the General Medical Council appears to be the only underlying motive of the Bill and Indian sentiments and Indian interests are freely ignored in order

to achieve this object. In a country like India where there are at least 12 universities and many more schools outside them, founded in widely different environments, for imparting medical education, it would be expected that a legislative measure of this nature should have offered a guidance to these institutions by suggesting co-ordination and co-operation and, where possible, combination and common effort for the improvement of the educational standard. Unfortunately there is nothing in the Bill to suggest such a purpose. Again, wherever similar legislation exists, it is noticed, that corresponding to the heavy responsibility imposed upon registered practitioners, wider rights and higher privileges, *e. g.* reservation of appointments in the superior services in all department, the right of granting certificates, the exclusive right of practising in their own country etc., are secured to them; but the Bill is ominously silent on the question of such fundamental rights and privileges and after the enactment there will be nothing to prevent even a Non-Indian Non-Britisher to practise or hold higher appointment here without directly conforming to the discipline imposed by the Indian Medical Council. The only privilege which has been considered to be very attractive to Indian practitioners and which has been highly extolled in a press communication recently by Sir Fazli Hussain is that this measure if successful in achieving its end (of placating the General Medical Council) will enable them to practise in Great Britain where at the present moment there are about 300* Indians practising. This temptation, however, does not appeal to the vast masses of our graduates. On the other hand the Bill seeks to place the destinies of over 12000 graduates and many more licentiates in the hands of a practically official Council. For, out of a total of 28 members, the nominees of the Central and Provincial Governments including the President (numbering 12) most of the representatives of the University Medical Faculties (numbering five or six) and also many of the so called representatives of the independent practitioners (who must be teachers and, therefore, mostly official) will be, thus, Government officers.

Then again according to the Bill, the qualifications recognised by the General Medical Council will have to be recognised by the Indian Medical Council without the guarantee of any automatic reciprocity in Great Britain in favour of the Indian graduates. I do not wish to anticipate subsequent speakers by discussing in detail the various omissions and objectionable features of the Bill but there are certain omissions which particularly call for our protest. One of these is that Andhra, Patna and Rangoon Universities have not been recognised in the first Schedule. From personal knowledge I am in a position to state that the Patna Medical College is a thoroughly well-equipped and well-staffed institution and I do not know how its claims to recognition could be ignored by the Government. I believe that the other two Universities also are equally well-equipped and staffed.

The claims of the Licentiates have been most unjustly ignored. They possess adequate qualifications and are actually registered in the provincial medical Registers. Many of them hold important offices in medical schools and hospitals involving very heavy responsibility. Hundreds of them are highly efficient and responsible practitioners throughout the country, whose services to the community and to the profession can not be over-estimated. Many of them have attained very high distinctions both in the professional and scientific lines. Further they are thoroughly organised in well-developed associations which are doing most useful work. Some of these associations run medical journals, of undoubted importance and wide circulation. We should think that the Licentiates should not only have the privilege of recognition in the Central Medical Register but should also have adequate representation on the Council.

There are one or two other points to which I should draw your attention before concluding my remarks on the Bill. The very elastic power to be conferred upon the Governor-General to make the first regulations and to appoint the President and, possibly, also the Registrar even before the formation of the Council is really

unique and deserves strong condemnation. Last of all we can never agree to the proposal of having a nominated President in the Medical Council. Such a provision will inflict a severe injustice on the profession and it can never reconcile itself to such flouting of its sentiments and feelings. The Registrar also should be appointed after very careful selection.

MEDICAL EDUCATION.

Sir Nil Ratan Sircar said that Medical Education in the higher grades was in the hands of the Universities in this country. He attributed want of inspiration and a want of spirit of enquiry to the Universities neglecting post-graduate training of students. He was for associating research work from the very start of the career of the Medical students.

Regarding medical schools which were progressively going up year by year and where medical education was imparted to next lower grade students who eventually passed out of the schools as Licentiates, there was a strong public opinion for the raising of the status of the schools. He had every sympathy with this object and earnestly wished that the status of the Licentiates was improved. He roughly calculated that for a population of 350,000,000 at least 150,000 practitioners were needed to minister to the medical needs and such a need in his opinion could only be satisfied by the creation of a grade of practitioners lower than the Licentiates and for this purpose he advocated that in the schools where indigenous systems were taught the curricula of studies should include Chemistry, Physics, Anatomy, Physiology, Pathology, Sanitary Science and Surgery. He trusted that the future holders of qualifications from such schools would be considered quite fit to deserve recognition as medical practitioners. He believed that introduction of this modified form of medical education would help India materially in the matter of solving one of the difficult problems namely, the supply of medical practitioners for the vast population in the rural areas. He was glad that research concerning the physiological and therapeutic actions of Indian drugs were being conducted by eminent scientists. This process he said would eventually lead to the assimilation of the ancient systems

with modern medical science and concluded. "It goes without saying that there should be chairs for the study of indigenous therapeutics and pharmacology in our medical colleges and schools."

ORGANISATION OF PUBLIC HEALTH AND SANITATION.

The appalling death rate of preventable diseases in this country due to adverse climatic, educational and economic conditions demanded the urgent constitution of a Ministry of Public Health with large funds at its disposal. He wished that the list of notifiable diseases should be enlarged and advocated that even the inspectors in this department should be medical men who would be in a better position to advise the public regarding diseases and to take efficient preventive measures against the spread of infective diseases.

ORGANISATION OF MEDICAL RESEARCH IN INDIA.

He said that medical research in a regular organised basis was first started with the establishment of the Haffkin Institute in Bombay in 1896. Since then a number of state laboratories and research institutes had come into existence all of which being controlled by the members of the Indian Medical Service only. It was a wrong and uneconomic policy to reserve these posts for the members of the Indian Medical Service who were given fabulously high salaries with the result that over 70% of the total expenditure of the research institute was spent on the services alone. He considered for a poor country like India, these reservations were as unnecessary as they were detrimental to the interests of the medical men born and bred up in this country who, if given equal opportunities, would enhance the reputation of India for scientific research, before the world. He found that Indian Research Fund Association was stingy in the matter of grants for Indian workers.

He said, the fact that there was huge amount of unutilised talent among the members of the non-official medical men who form 80 per cent of the total strength of the medical profession in India should not be lost sight of, to rectify these defects. He advocated urgent reform for the introduction of the system of voluntary

research workers. As there was a vast amount of valuable clinical material available in large hospitals, he desired that the Research Institutes should be attached to such hospitals and scholarships given to post-graduates so as to stimulate research work. He was glad that the idea of establishing a Central Research Institute in a place away from big hospitals had been permanently dropped and hoped that such mistakes would never be committed in future.

MEDICAL SERVICES.

Sir Nil Ratan Sircar said that this was one of the most perplexing questions under the consideration of the profession for over 40 years and that the Indian public were unable to reconcile themselves to the idea of having a military service dominating over the Civil Department. In 1928 the Government came to the conclusion that out of 268 posts in the higher grades only 178 should be reserved to the I.M.S. thus releasing 90 posts to the provincial medical service men. But it was provided that the existing arrangement to the proposed arrangement should be gradual so that those occupying the surplus posts were to hold their appointments till their retirement. So, practically the new scheme would not come into operation for another 20 years. Out of 15 professional appointments, 12 were reserved for Europeans, 1 for Indians and 2 open to the members of both communities. Of the 105 posts of Civil Surgeons, 90 were reserved for Europeans, none for Indians and 15 open for Indians and Europeans in the I.M.S. service. It would thus be seen that the contest which was till now between I.M.S. and non I.M.S. men, had taken a communal turn most regrettably. Moreover, India cannot stand such an expensive luxury of services.

There was yet another regrettable incident which he brought to the notice of the Conference and that was the suggestion of the R.T.C. that an adequate number of European doctors to Civil Medical Services should be recruited to satisfy the needs of the European population in the provinces, a fact which could not be reconciled to the proposal of Provincial Autonomy. He advocated competition for recruitment

of candidates for medical services and heartily endorsed the opinion of Dr. Jivraj N. Mehta that "time has now arrived to cease altogether recruiting officers in the Civil Medical Services excepting for services like the Public Health Service and School Medical Service etc. which should be manned by adequately paid medical officers with no right of private practice. The honorary system of work in the civil hospitals and dispensaries should be encouraged more and more." He would add to this that honorary services should be extended as far as possible to the department of medical education also.

He concluded his address by saying "There are some other important problems, as for instance, that of National Health Insurance against accident or disease, training of Indian nurses of both sexes, the extension of medical education amongst women that require immediate solution but time does not permit me to deal with these matters to-day.

We all know that in every one of the fields of Medical education, Research, Public Health organisation and Medical Relief there is a huge possibility of further work that has remained undone. Past experience does not encourage us to expect much from Government. In spite of difficulties therefore we must depend upon self-help. But no tangible result can be achieved by isolated efforts, individual or sectional. Efficiency demands organisation which means combination. In the first place we must combine and organise this Association thoroughly in order to make it an efficient instrument, not only of Medical public opinion but also of National effort and action in the Medical and allied departments.

In the name of the welfare of the Nation all the professional men in India should be invited to join this Association. No time should be lost to have branches in every province and also in most of the important towns and cities in India. We must not forget for a moment that union is strength. This Association should organise itself so thoroughly that it may be universally recognised as the competent exponent of

the views of the whole medical profession in India regarding any important question.

The ambition of the profession should be to feel, to think, to speak and to act like one man in a spirit of loving service to the nation.

India is the land of poverty and poverty coupled with ignorance stands as the root cause of all our miseries such as starvation, bad sanitation, disease, untimely and heavy mortality etc. But the task of ameliorating the condition of the sufferers has been entrusted to the medical man. In this great task the scientifically trained medical man will be the guide, friend and philosopher.

Blessed are we, the members of this noble profession of India, who have the privilege of being entrusted with the heavy burden of so many duties and responsibilities on our shoulders, and blessed be this Association in whose bosom we all unite with renewed Faith, Love and Strength.

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.

Emuresis: Monobromiated camphor 0.1 gram and Calcium Lactate 1 gram, twice daily.

In children Ext. Hyoscyami $\frac{1}{2}$ dram, Sodium Bromide 1 dram, Syrup Simplex 1 ounce and Aqua Anesi to add 2 ounces, one teaspoonful, in water three times a day for a child of 8 years old. (T. Therapy)

Orchitic Extract. (J.O.T)

Sodium Bromide 3 drams, Ext. Ergot Liq. 3 drams, Tinct. Belladonna 3 drams Aqua add 4 ounces, one teaspoonful at bed time.

Strychnine Sulphate gr. $\frac{1}{2}$, Acid Phosphoric dil. 1 dram, Ext. Cocae fluidum 3 ounces, one teaspoonful three times a day after meals. (P.M.)

Pot. Chlorate with Liq. Strychnine is useful and also Luminol. (M.T.T)

Pituitrin is given hypodermically. (J.O.T)

Tinct. Belladonna mms. 3, three times a day to a child of two years to be gradually increased to m. 10; Liq. Ext. Ergot m. 20 three times a day; if the quantity of urine is large Tinct. Valereina mms. 10 to 15 in water for a child of 4 years.

Adrenaline m. 5 (1:1000) to be dropped under the tongue and retained there as long as possible or Ephredine $\frac{1}{2}$ gr. at bed time.

Epididymitis: (Gonorrhoeal) Sodium Iodide 2 gms of pure salt in 20 cc of distilled water to be given intravenously and repeated every other day for 4 doses. (C.M.S)

To combat the agonising pain saturated solution of Mag. Sulph or 5 % Guaiacol ointment and if necessary to be supplemented by hypodermic injection of morphia.

Sulfarsenol from 18 ctgr to 36 ctgr doses is being used with good results. Milk injection is recommended to relieve pain and is very effective; to be given intramuscularly (10 cc) and to be repeated after 2 days. (C.M.S)

Intravenous injection of 5 % solution of Calcium Chloride 5 cc to be given on alternate days. (C.M.S)

Trimine a colloidal preparation containing Manganese, Zinc and Iron in 1 cc doses intramuscularly every three days hastens resolution.

Epithelial Growth of Breasts:

Thyroid and Mammary gland, Thyroid powdered 2 centigram and Mammary powdered 1 gram, before meal. (J.O.T)

Epistaxis: Adrenaline chloride 1:1000 in salt solution to be applied to the nasal chambers on a piece of cotton; Tinct. Benzoin Co. to be applied in the same way as above; a spray of Mendle's solution 5 mms. in 1 ounce of water; local application of Vinegar and water or Lemon juice. (Hare)

If Haemophilia is the cause Horse serum to be given hypodermically particularly for persons addicted to drink.

Extra Systole: Quinidin 2 grams a day is the best remedy if the myocardium is not diseased. (M.C.N.A)

Epilepsy: (Diagnosis) Large amount of Sodium chloride 5 grams will bring on

convulsions and also hypodermic injection of Adrenaline or Cocaine.

Babinsky sign is nearly positive normally during the first year of age and occasionally until the third year; but it is positive in Epileptics and negative in Hysteria.

In Hysteria, the pupils are not dilated and eyes are not open and turned but closed.

In Hysteria there is no absolute unconsciousness.

Epileptic seizures disappear during inter-current diseases and after Etherisation.

The Epileptics usually overeat.

If the convulsion does not appear for 3 years then it has to be presumed that the disease has been cured.

Treatment: Luminol Sodium $1\frac{1}{2}$ to 3 grs. is the best drug to be given three times a day at first; but gradually reduced. The treatment to be continued for 3 years with remission of a day or two in a week. Sudden withdrawal will bring on the fits. In Petit mall, Potas Iodide in large doses is very satisfactory.

When there is an aura, the fit may be aborted by the inhalation of Amyl Nitras. Potassium Bromide and Sodium Bromide and better still Strontium Bromide may be given.

Elixir Bromo Valerianate A.F.D. has a maximum sedative effect with minimum of Bromisim and consequently may be used for indefenite period without untoward effects.

As there is deficiency of calcium in Epileptics, Calcium and Parathyroid are useful.

Acetanilidum is sometimes useful in aborting the attack.

In old cases Opium is good and also Digitalis and Belladonna.

In severe attacks, Luminol may be given by injection.

For Status Epileptics, Hypodermic injections of Sodium Bromide 30 grs. in one ounce of water to be given on the back below the angle of the scapula repeatedly or Luminol may be given intravenously. (P.M)

Ovarian or Testicular Extracts combined with Parathyroid, Thymus, Thyroid and Ante-pituitary are given with good results. (Harrower)

Paraldehyde is good in children. (M.T.T)

As there is deficiency of Phosphoric acid, Sodium Phosphate either by the mouth or intravenously is useful. (Sajous)

Chloral Hydras dram 1 per rectum or Hyoscine Hydrobromide 1/150 to 1/50 grain hypodermically. (Rudolf)

Boric Potas Tartrata from 45 to 75 grams a day is good. (L.W)

Pot. Permanganate, 1 grain in $1\frac{1}{2}$ pints of water by rectum every day (C.M.S) For constipation salts are better than any other medicine. Sometimes rebreathing of expired air which contains large quantity of Co., controls the fits. (Talbot)

Ketogenic diet is highly recommended. In normal persons the proportion of Ketogenic to Anti-Ketogenic diet is as 1 to 4. In Epileptics the proportion should be changed gradually: $1\frac{1}{2}$ to 1, 2 to 1, $2\frac{1}{2}$ to 1, 3 to 1, and up to 4 to 1 (Fat is the Ketogenic diet, while Carbohydrate and Protein are Anti-Ketogenic). The proportion represents Fat: Carbohydrate and Protein. The practice of withholding Protein is condemned. It should be given at the rate of $1\frac{1}{2}$ grams per Kilogram of body weight.

In Epilepsy as there is water detention probably in the brain or in the nervous system, dehydration is highly recommended. This may be resorted to periodically giving concentrated solution of Mag. Sulph. Dehydration is more useful in adults than the Ketogenic diet, while the Ketogenic diet is better than the dehydration in children.

MYCOL

FOR A.F.D. CONSTIPATION

INTESTINAL STASIS AND
ALIMENTARY TOXEMIAS

Where Typhoid cases need a laxative Mycol is suitable and safe.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Common Errors in Diagnosis of Heart Disease.

In New York St. J. Med., Aug. 1, 1931, Dr. L. H. Sigler, of Brooklyn, dwells on certain errors common in cardiac diagnosis. Errors arise from a misunderstanding of the normal, in regard to both size and shape and in rate and rhythm of the heart beat. But there is no normal, and the heart that agrees with so-called normal standards may be the seat of grave myocardial disease. Other clinical manifestations of cardiac disease should be searched for. The heart murmur is, by far, the greatest source of error in cardiac diagnosis, and many a false conception is formed on account of its presence. But in a great many cases the murmur has no pathologic significance. The author feels that any murmur not associated with any cardiac enlargement or definite change in the configuration of the heart is to be considered to be of no pathologic significance and should be disregarded. Exceptions to this rule are murmurs heard in some forms of congenital abnormalities of the heart, where there may not be any enlargement. Another common cause or error is the improper correlation of disease elsewhere with heart reaction, especially conditions arising from reflex, toxic and infectious states. Errors arise also from an improper conception of cardiac pathology and the too frequently used and misapplied terms; chronic myocarditis and angina pectoris. The author remarks that, if all the cases so diagnosed should come to autopsy, probably 80 per cent would not show any evidence for the syndromes mentioned. The term angina pectoris should be entirely discarded from medical literature as meaning nothing. At most it should be only a part of the cardiac diagnosis. (C. M. & S.)

The Present Treatment of Diabetes.

Summing up the present-day position and prospects of the diabetic patient, Dr. E. P. Joslin, of Boston, states, in J. A. M. A., Aug. 29, 1931, that a growing percentage of diabetic patients now outlive

their life expectancy; diabetic mortality has decreased in the young; and its rise in the old is largely to be explained, not by an increase in the disease, but rather because of an increase in the number of known diabetic patients, due to the general lengthening of life in the whole population. The total number of people aged 50 and over is today much greater than formerly. The use of insulin has permitted physicians steadily to increase the amount of carbohydrates in the diet. Visiting diabetic nurses should be available for the general practitioner, because they will, not only save his time but also carry into the homes of the patients ideas about insulin and diet and the avoidance of come and gangrene. The treatment of diabetes fails largely because of remediable faults. When the blood sugar percentage is known, treatment can go ahead boldly and scientifically. If the physician in the country is expected to treat his patients as well the physician in the city, he must be given the same advantages which are given to the city physician. He must have a laboratory within reach and available day and night. Too great notice should not be taken of a blood-sugar level a trifle above normal, if the urine is sugar-free. Ten years ago a diabetic patient was regarded as a grave surgical risk, but to-day it is a graver medical risk to avoid surgery. Co-operation between physician and surgeon, close observation of the urine and of the blood for the first few days after operation, provision for from 50 to 100 Gm. of carbohydrate to maintain nutrition and, along with it, insulin, if necessary to promote its utilisation and thus avoid acidosis, are factors that make surgery safe in diabetic patients. (C. M. & S.)

Recent views on Puerperal Sepsis

BY JAGDISH RAI, M.B.B.S.,
NANDI, ROHTAK.

In spite of advance in modern medicine the rate of maternal mortality from puerperal sepsis is very high. It is a great cause of chronic invalidism in women as well. The recognition of the value of early treatment is the only means of reducing mortality in this disease. There is a false belief that puerperal sepsis is a febrile disease and it is on

account of this misconception that cases are treated late with the result that either the case ends in death or passes into a state of chronic ill health and invalidism. At the outset it is quite exceptional for cases of puerperal sepsis to develop pyrexia. The only criterion of sepsis which can be relied upon is increased pulse rate which is often present several days before the onset of fever. Other signs may be offensive lochia, red or purulent lochia even several days before, fever. Briefly speaking the chief signs and symptoms of early puerperal sepsis are:—

1. Increased pulse rate over 90.
2. Increased temperature over 99°
This should not be relied much.
3. After pains. It is strange that lay men as well as medical men still labour under the delusion that it is natural for a woman to suffer from after-pains for the first few days after the delivery. These indicate an obstruction to the escape of fluid from the uterus and are danger signal. If not relieved after twelve hours effective drainage of the uterus must be arranged.
4. Abnormal lochial discharge. The presence of offensive lochia is another indication for early treatment. Profuse lochial discharge means inflammation of the uterine wall. In some cases it is diminished or even suppressed. If red lochia persists 6-7 days after delivery the case must be regarded as septic and treated as such.

TREATMENT: Prophylactic Diet. It has become an established fact that vitamins A and D have anti-infective action, and therefore either diet rich in natural sources of vitamin A like milk, egg yolk, green vegetables, butter should be given in plenty during the last 2-4 weeks of pregnancy or market preparation of vitamins A and D given.

2. Anti-streptococcal serum. In cases in which a vaginal examination has been made or in which trouble is anticipated

an intramuscular injection of anti-streptococcal serum polyvalent 10-70 cc must be given during labour or few days prior to it.

3. Regular instillation of pure glycerine within the cervix (one inch) throughout the pregnancy is very useful. Dose 10-200 cc once or thrice a day.

4. Use of suitable antiseptic for midwifery practice. The only suitable antiseptic is brilliant green. It is active in 1 m. 10000 dilution in the presence of blood. Safety margin is 1 in 200 lysol and Peruplavina are more or less useless.

CURATIVE TREATMENT: 1. Drainage of the Uterus. This may become obstructed by intra-uterine and extra-uterine causes. Interference may occur in the uterus itself. This may be due to unhealthy condition of uterine wall or caused by trauma from instruments or intra uterine douche. Cervical canal may become obstructed by fragments of blood clot and placenta tissue or swelling of cervical walls. At the end of first week of puerperium when the uterus is again returning to the pelvis there is danger of retroversion and so it is necessary to correct this tendency by placing the patient in the prone position at frequent intervals in addition to adopting the semifowler position. A loaded rectum and over distended bladder and oedematous vaginal wall must be attended to.

2. Injection of pure glycerine one inch within the cervical canal is very useful procedure and must be adopted in every case. It is perfectly harmless and safe but very efficient. It disinfects and drains the uterine cavity 10 cc-200 cc. may be injected once or thrice a day for several days.

3. In severe cases 4% glucose in normal saline 1½ litre in 24 hours given slowly intravenously and repeated several times is the most useful procedure. Copious fluid by mouth subcutaneously or rectally with alkali and glucose are useful. Diet rich in vitamin A and D or large doses of Vitamins A should be given.

SPECIAL CONTRIBUTION TO THE MEDICAL PROFESSION.

OPINIONS GATHERED FROM

PRACTITIONERS.

Antisymphilitic Therapy.

It is an admitted fact that Bismuth is less toxic than Mercury and more effective as a Spirochæticide. It is also easier to administer than Mercury or Arsenic. In order to cope with the symptoms of Tertiary Syphilis, lightening pains of Locomotor Ataxy, Bismuth possesses qualities which are far superior to those of Arsenic and which carry with it the least danger of therapeutic shock. One of the best Bismuth preparations that we have for the treatment of Syphilis is Benzo Bismuth. A decided and a very strong reason for the wide use of Bismuth therapy is that it can be injected easily and painlessly in the gluteal muscles. The effectiveness of anti-symphilitic products can only be assessed by the disappearance of the Spirochetes not only from the skin-efflorescences, but also from the blood. Benzo Bismuth has often a slow but sure effect. Although on the first injection some Pallida can still be demonstrated, still, lasting and complete freedom from them can be effected by long-continued injections and that too without any undesirable by-effects. After the third or fourth injection skinning over of ulcers and reduction of infiltrations can in most cases be discerned. The glands are considerably reduced. Secondary rash begins to fade after the third injection. Hypertrophic anal papules considerably improve after three injections and have completely disappeared after a course of seven injections. It would be interesting to note that run-down and anæmic patients with symptoms of secondary syphilis have shown a marked rise in their Hemoglobin percentage after a complete course of Benzo Bismuth injections. This might be attributed to the remarkable amelioration of the subjective and objective symptoms of the patients.

With regard to the serum reaction it was ascertained that after five injections the Wassermann begins to show a weak

positive reaction. After six to eight injections the sero-positive reaction becomes almost negative.

Benzo Bismuth is a sovereign remedy both for children and adults. In long-standing cases and in those where arsenical preparations are not tolerated injections of Benzo Bismuth can be given with advantage. In cases where high fever, vomiting, diarrhoea and heart-trouble follow injections of Neo-Salvarsan, the practitioner is compelled to resort to these injections. Benzo Bismuth is in the majority of cases well-borne. So far the writer has only once seen blue line on the gums and foul breath after the injections of Benzo Bismuth. With this exception no untoward by-effects were ever observed. In Tertiary Syphilis where several courses of Neo-Salvarsan have been given patients feel an aversion for them. Again these injections do not reach the Nervous System on which the effect is most essential. In such cases Benzo Bismuth acts better. Here the writer would like to refer to a particular case of Locomotor Ataxy in his charge. The patient had a couple of Salvarsan and Mercury injections. His gait was characteristic and no improvement was seen after these injections. Benzo Bismuth was injected and after nine injections he was at least able to walk without any support.

The remarkable results obtained with Benzo Bismuth convincing as can be gathered from the following case which the writer had the chance to treat.

A young man of twenty-eight came for pain in all the joints, which he said were specially worse at night. He gave history of a hard chancre about a year back. He had undergone treatment before, which appeared to have done him no good. The diagnosis of course, was Syphilis and Benzo Bismuth treatment was instituted. He was injected twice weekly. After nine injections not only was he free from his symptoms but his Wassermann showed a weak positive reaction. After this he had complete rest for two weeks and then six more injections were given. Then the serum reaction was absolutely negative and the patient was entirely free from the infection.

Boldine A.F.D. exhibits a curative action in Hepatitis, alcoholic and tropical liver diseases.

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These noteworthy therapeutic effects are solely due to Benzo Bismuth as no Salvarsan preparations were given in this case afterwards. In the beginning it was not known what he was prescribed. Again, on account of absolute freedom from pain the patient had no aversion for this line of treatment. The practitioners can therefore inject this product with confidence because of its efficacy and painlessness and for the following consideration:—

(1) In cases where the technique of injection would be difficult on account of deep layers of fat and deep lying veins, Benzo Bismuth can be easily injected intramuscularly without any harm.

(2) It can be injected in children who are refractory and restless. Here intravenous injection would be an ordeal and hence the utility of Benzo Bismuth because of its easy administration.

(3) In cases where unpleasant by-effects of intravenous injection such as vomiting, angio-neurotic oedema, dermatitis etc., usually trouble the patient this preparation can be given with advantage.

(4) The absence of idiosyncrasy and undesirable reactions make its use very wide.

Bromo-Valerianate Therapy.

The choice of sedative and hypnotic preparations offered for the use of the medical practitioner has greatly increased during recent years. At one extremity we find our usual Bromides of the Pharmacopia with their simple sedative effects and at the other a variety of hypnotic drugs with their strong and powerful action. Elixir-Bromo-Valerianate is the via media between these two, because though it has sedative and hypnotic properties, it is harmless and non-toxic. To-day Elixir-Bromo-Valerianate has been accepted by several physicians as the most presentable and the most harmless form of Bromide therapy.

a long period, a maximum sedative and hypnotic effects with minimum of Bromism. This should be evident from the characteristics of the ingredients contained in it. Strontium Bromide is the least toxic and the most powerful hypnotic of the Bromides, which acts energetically on the circulation. It is more efficient than other salts in controlling the convulsive affections. Valerian included in this formula is tasteless and helps the action of the Bromide by diminishing the irritability of the termination of the sensory nerves. It possesses antispasmodic, antihysterical, and antiperiodic properties. The syrup of orange disguises the taste of these two and being a flavouring agent makes the preparation very palatable.

In the field of therapeutics it is almost a platitude to say that detection and removal of the cause of disease should be the first and foremost aim of the physician. Frequently, however, the physician has to give symptomatic treatment and herein the use of this Elixir comes in. This preparation occupies a very high position with regard to its pharmacological action. The Elixir being an efficient sedative eliminates worry, anxiety and restlessness. It allays abnormal nervous excitability, checks convulsive seizures, relieves neuralgia. In short, it brings about amelioration of those conditions which come within the sphere of Bromide therapy.

When one considers the therapeutic application of this preparation, the first indication that naturally occurs to one is Epilepsy, for, Bromides from time immemorial are associated with the control of epileptic seizures. The Elixir when continued for a long time gives uniformly satisfactory results. The happy combination in this preparation and the purity and efficacy of each constituent, have earned for it a very high place in the therapeutics of this disease. The treatment of this affection has always been a stumbling-block to physicians. Water-metabolism is mainly responsible for the production of Epilepsy. Provided the restriction of fluid intake of the patient is enforced and those articles of food which excite thirst are strictly forbidden this product would surely work wonders. If this dehydration treatment is combined with Elixir-Bromo-Valerianate therapy, improvement is obtained in the

reduction of fits, diminishing the duration and severity of each attack and freedom from headache and vomiting after each fit.

In treating Hysteria one has noticed that favourable surrounding is much better than seclusion. This together with the medical treatment with Elixir-Bromo-Valerianate would certainly have beneficial influence on patients with hysterical psychosis. The Elixir will allay restlessness and anxiety of the patients and if the treatment is continued for a long period, the fits will gradually disappear.

In the treatment of cases suffering from a variety of neurosis, two factors should be borne in mind. First, one must discriminate between nervous symptoms due to hyperexcitability and those due to depression, because in the latter case this treatment is contraindicated. Treatment in the former cases is more or less symptomatic and Elixir Bromo-Valerianate is a safe and reliable remedy when a sedative action is desired. For those reasons the Bromo-Valerianate treatment is successfully used in Infantile convulsions and Laryngismus Stridulus. In fact this treatment occupies a valuable position in cases of abnormal nervous irritability where no specific contraindication exists.

In troublesome insomnias, this Elixir has been found very valuable. It, as might generally be believed, does not produce sleep per se but frees the nervous system from hypersensitiveness and irritability or any mental strain and thus permits normal sleep. At the same time there is no risk of toxic after-effects and habituation.

In dysmenorrhoea in young and nervous women and in nervous hyper-excitability of the menopause, the Elixir-Bromo-Valerianate treatment is advocated. It acts as an antispasmodic in former cases and in the latter, it reduces the nervous irritability, as it is considered the best sedative at this critical period of a woman's life.

This preparation has been found efficient and is far less irritating to the stomach in cases of chronic alcoholism. The Bromo-Valerianate relieves also the periodical headache and vomiting of Migraine with gratifying rapidity.

Other indications for this preparation are facial tic and other similar spasms

where the intensity of the spasms can be much reduced by the careful administration of this Elixir.

This product has at times been used with success in the series of untowards symptoms of Quinism, particularly tinnitus aurium. The latter can easily be overcome by the administration of this Elixir.

The advantages that this product offers over similar preparations of Bromides and Valerian are many. It is a good combination and has been successfully prescribed by several physicians. This is due to the fact that therapeutically it is very potent. The great tolerance to this product is a factor in its favour. Bromism is absent even after long-continued use. The purity of the product is an additional advantage. Another point in favour of this Elixir is its safety and harmlessness even when given for long stretches of time.

To sum up, Elixir-Bromo-Valerianate is a safe sedative and hypnotic and it can be prescribed without any damage to the organism or without producing any by-effects for years. The necessity of increasing the dosage does not arise as prolonged use of it does not in any way diminish its therapeutic effects.

StannoxyL.

EXTRACTS FROM STANDARD LITERATURE.

Effective Non-surgical Relief for Boils and Styes.

A compendium of reports from the scientific literature.

STANNOXYL: A potent anti-staphylococcal preparation of metallic tin and tin oxide for use in cases of boils, styes and other staphylococcal infections.

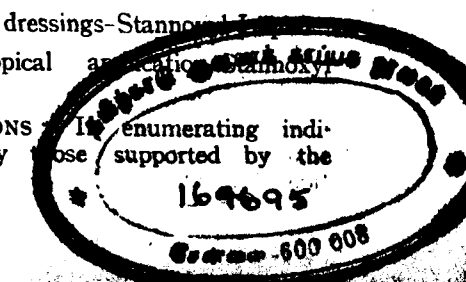
HOW FURNISHED: For oral administration-StannoxyL Tablets (80 in a vial).

For intramuscular injection-StannoxyL Ampoules.

For wet dressings-StannoxyL Lint.

For topical application-StannoxyL Ointment.

INDICATIONS: In enumerating indications, only those supported by the



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medical literature are offered. Stannoxyl is of benefit in most staphylococcal infections; and, specifically, in conditions such as the following, when they are due to the staphylococcus.

Boils	Sycosis
Styes	Suppurating wounds
Generalized furunculosis	Chronic osteomyelitis
Crops of boils	Purulent osteitis
Furuncle of the ear	Purulent periostitis
Pustular acne	Mixed infection of tuberculosis
Axillary abscess	Prophylaxis against staphylococcal infection in diabetes mellitus and other cachectic conditions
Carbuncles	
Abscess of the breast	
Lymphangitis of nursing women	
Infective dermatitis	

TIN AND TIN OXIDE IN STAPHYLOCOCCAL INFECTION: Powder tin was used empirically in France as a popular remedy for boils before experimental investigation presented definite clinical claims to the medical profession.

To the laboratory and clinical research of Dr. Raymond Gregoire and Albert Frouin, a chemist of the Pasteur Institute, are we indebted for our knowledge of the role of tin and tin oxide as specifically anti-staphylococcal agents.

Interested in the popular use of powdered tin for boils by the tin-workers of Beauce, to the southwest of Paris and also in the immunity which tin-workers acquire against furunculosis, Gregoire and Frouin resorted to laboratory experimentation.

The results of their findings were first presented to the medical profession in the *Compt. rend. Acad. d. sc.*, 164: 794 May 4, 1917, and in the *Bull. de l'Acad. d. med.*, 77: 704 May 29 1917. Their investigations have since been supported by the clinical observations of various other workers in all parts of the world.

THE EXPERIMENTS OF GREGOIRE AND FROUIN: Gregoire and Frouin studied the effects of tin and tin oxide on the staphylococcus, the most prevalent pyogenic microorganism in suppurating affections. In ordinary bouillon culture media, tin and tin oxide strongly inhibited the growth of staphylococci under anaerobic conditions. When transplanted to fresh media at intervals of forty-eight hours, only a few colonies remained after the third or fourth passage. Even under aerobic conditions, tin and tin oxide, while not hindering

the growth of staphylococci, definitely diminished their virulence.

Animal experimentation likewise demonstrated the anti-staphylococcal nature of tin. Rabbits were experimentally infected with staphylococcal bacteriemia. Twelve hours later tin salts were injected intraperitoneally. After a single injection of tin the injected rabbits lived from four to eight days longer than the controls. Since the rabbit is extremely sensitive to the staphylococcus, this series of tests demonstrated most favourably the protective value of tin salts.

Experimentation on dogs proved that the organism may remain under the influence of tin for four or more weeks after medication has been discontinued. The investigators administered daily doses of 2 Gm. of metallic tin or tin oxide over a period of twenty days. They found that tin is very rapidly absorbed from the digestive system and eliminated very slowly in the urine. The therapeutic effect would therefore appear to be well prolonged after the medicament is discontinued.

STANNOXYL, AN EFFECTIVE STAPHYLOCOCCAL DETERRENT AND BACTERICIDE: Clinically, Gregoire and Frouin were able to secure remarkably favourable results with the use of tin and tin oxide for both general and localized staphylococcal infection.

Following closely the research of Dr. Gregoire and A. Frouin, the Robert and Cerrere Laboratoires of Paris, made available to the medical profession a product which they called Stannoxyl. Stannoxyl is a mixture of pure metallic tin and tin oxide. It is prepared under rigid laboratory conditions and may be depended upon for freedom from lead and other impurities. It follows closely the formula which Gregoire and Frouin utilized with such success in hospital practice.

FREEDOM FROM TOXICITY: The many clinicians who are familiar with the use of Stannoxyl, corroborate the findings of Gregoire and Frouin, that the treatment is without gastric or intestinal disturbances and exhibits no untoward actions, either general or local.

WHAT RESULTS MAY BE EXPECTED: Under Stannoxyl medication local improvement, in furunculosis hordeolum and other local or general staphylococcal involvements starts almost immediately. The most outstanding early therapeutic manifestation is relief from pain. Pain and itching may cease as early as the second day and inflammation disappears by the fourth. The walls and base of the furuncle become softened. Suppuration ceases and the core is rapidly absorbed. From the eighth to the tenth day the scab drops off, leaving a healthy base. Gregoire and Frouin found Stannoxyl distinctly remedial in furunculosis after vaccines and all other measure had failed. In suppurating wounds with staphylococcal involvement, Stannoxyl, in conjunction with general surgical treatment, appears to hasten healing. Stannoxyl acts as a deterrent in chronic staphylococcal bone infections. It abates the symptoms of fever, high pulse, expectoration and loss of weight in the mixed infections of tuberculosis. The literature confirms the remarkable efficacy of Stannoxyl in obstinate axillary abscess, abscess of the breast and lymphangitis of nursing women. It is especially indicated as a prophylactic against staphylococcal invasion in diabetic and cachectic conditions.

PREVALENCE OF STAPHYLOCOCCAL INFECTION OFFERS STANNOXYL A WIDE THERAPEUTIC SCOPE: Pasteur in 1878 first demonstrated the presence of staphylococci in pus. It is now known that the staphylococcus is the most common pathogenic organism causing suppuration. It is the organism most frequently concerned in the production of pyogenic inflammations of the skin, the mucous and serous surfaces, cavities connected with them, and of bones.

The staphylococcus is found in pustules, furuncles, carbuncles, abscesses, eczema, impetigo, sycosis, mastitis, felons, purulent osteitis, osteomyelitis, periostitis, and abscesses of the joints, as well as purulent conjunctivitis, dacryocystitis, tonsillitis, suppurative lymphadenitis, parotitis, arthritis, ulcerative endocarditis, pyelonephritis, phlebitis, meningitis, liver abscess and pyemia. New-born children, the aged, the diabetic, the debilitated and the cachectic exhibit a decided lack of resistance to staphylococcal infection. While

the claims for Stannoxyl are limited to conditions in which there is definite clinical evidence of its efficacy, the wide range of staphylococcal infection in the human organism may suggest to investigating physicians remedial uses other than those mentioned here.

THE DANGERS OF LANCING A BOIL: Seventy per cent of general staphylococcal infections are fatal according to Babcock, *Text-Book of Surgery*, 1928. Physicians have welcomed the use of Stannoxyl, for it relieves them of the complicating dangers of lancing and spreading of the infection. Hasty incision in the treatment of a boil is to be avoided. It involves extension of the infection and possible formation of a dangerous carbuncle. It may cause septicemia through pollution of the blood stream. Malignant boils on the face and upper lip, if interfered by a surgeon may give rise to thrombosis of the cerebral sinuses, septicemia and terminate in death. Mortality is higher after surgical interference than with conservative treatment. In any event, lancing a boil causes unnecessary pain, requires an irksome dressing, prolongs the inflammation, and leaves a disfiguring scar. Use of Stannoxyl is especially welcomed in threatened boils or staphylococcal infection of diabetics, whose surgical wounds and infections are so difficult to control.

MODE OF APPLICATION OF STANNOXYL: Under ordinary circumstances, treatment by mouth is sufficient. The daily dose is 4 to 8 tablets, or from 0.5 to 1 Gm. There need be no change of diet or of mode of life. Ordinarily the treatment does not even demand the wearing of a local dressing. If the case is exceedingly urgent, Stannoxyl may be administered by intramuscular injection, one or two ampoules daily. A wet dressing made with a 1 or 2 per cent solution of Stannoxyl Liquid reinforces the systemic action.

Treatment of Whooping Cough.

So far no definite specific therapy for Whooping Cough has been found out. Vaccines prepared from Bordet-Gengou bacillus, which is considered responsible for this affection, have been largely used without any success and many pediatricians are sceptic about its value. The

large number of remedies suggested by different physicians is a clear indication of the refractory nature of the affection. Again it is very difficult to find out the exact remedy out of the innumerable drugs recommended that would suit an individual. In this malady it is only a guesswork with physicians and they go on trying different drugs if one or the other fails. Treatment however by Syrup Pertussis Gabail is a great step forward in the campaign against Whooping Cough. This treatment if commenced early when the diagnosis is established by means of a leucocyte count, goes a long way in controlling the fits which are so troublesome and annoying to the child. However no claim to speedy cure is made with this syrup but the disease can certainly be shortened and the number and severity of the coughing paroxysms can be much reduced. Syrup Pertussis is a rational combination of sedative, antispasmodic and expectorant drugs. The formula is as under:—

Ext. Valerian	...	2.40 gm.
Ammonii Valerianae	...	2.0 gm.
Pot. Bromide	...	2.25 gm.
Chloral Hydrate	...	2.25 gm.
Ext. Grindelia Liq	...	1.25 gm.
Ext. Polygala Liq	...	1.25 gm.
Syr Rubus Iodeus	...	60 c.c.
Aq Destillata ad	...	125 c.c.

This combination has proved itself of great service as can be recognised from the properties of the different constituents in it. Both the Extract and the Ammonium salt of Valerian have been deodorised and are freed of their disagreeable taste in this formula. As these salts have the property of lessening the irritability of the terminations of the sensory nerves, they have been very useful in controlling the paroxysms.

The Bromide diminishes the sensibility and the reflex excitability of the fauces and hence is very valuable as a sedative in this affection.

Chloral Hydrate acts as a good antispasmodic as it depresses the motor tracts and paralyses the reflex excitability.

Ext. Grindelia Liquidum is of great service in Whooping Cough as it is an effective stimulant expectorant and a bronchial antispasmodic.

Ext. Polygala Liquidum is another ingredient which by facilitating expectoration supplements the action of Ext. Grindelia Liquidum.

The Syrup Rubus Iodeus makes the mixture very palatable by disguising the taste of all the ingredients.

This combination has yielded particularly happy results in Pertussis. A favourable effect on the attacks is soon obtained. After taking this syrup no very marked desire for sleep is evident nor is there the least sign of stupor in spite of the Bromide and the Chloral Hydrate. In the second week after commencing the treatment the paroxysms of whooping are diminished in number and their severity is much lessened. The general condition of the patient improves and the child is better able to take the nourishment, as the vomiting which usually follows a paroxysm, is stopped. Moreover, the syrup by acting as an efficient sedative controls the nutritional disturbances so that patients under its regime can have suitable carbohydrate diet and they are greatly benefitted by it. The general view of the physicians who have prescribed this syrup is that it renders the course of the disease milder and prevents a number of lung complications. The advantage of this preparation is that no cases of idiosyncrasy have so far been observed with it and it can be administered even to infants despite the fact that it contains Chloral Hydrate. It is a medication which is extremely well tolerated even by sensitive children and readily taken by them on account of its palatability. No unpleasant by-effects are ever caused by this syrup. The plentiful addition of Syrup Rubus Iodeus successfully disguises the taste of other nauseous drugs in the formula. A great advantage is that it is especially suitable for prolonged administration.

1. A young boy about four years old was brought to me for Whooping Cough. It was the second week of the disease. Previous to this he was treated by another

physician, who thought it to be a case of pharyngitis and septic tonsils. I could see this from the prescription that the child's mother gave me. The tonsils were no doubt much enlarged and the pharynx was much inflamed. Of course during the first two weeks the typical whoop might not have been developed and this might have led the physician astray. When the boy entered my room he got the whooping fit and it was therefore not at all difficult for me to diagnose the case. I prescribed at once Syrup Pertussis Gabail and asked the mother to give him Cod-Liver-Oil Emulsion. After three days' treatment the severity of the paroxysms was considerably reduced and the number of fits was greatly lessened. The paroxysms that troubled him at night and disturbed his sleep became less and less until after a week's treatment he could sleep the whole night without getting a single paroxysm. Before this treatment was instituted the child used to get sudden whooping fits when he was having his food. He used then to vomit out what he had taken and he was unable to take anything more. The syrup controlled these fits remarkably well and he was able to take his nourishment without any disturbance. Though this syrup cannot be called a specific for Whooping Cough, yet, the fact that it relieves the paroxysms of coughing and prevents complications should be considered as no small achievements.

Experiences with Urogenine.

1. M. T., a male aged 40 was seen by me sometime last month. He complained of pain in the dorso-lumbar region which he said was occasionally so violent as to make him cry out. On movements of the body such as bending etc. the pain was intense. There was anorexia and slight hepatic congestion. The temperature was normal but the tongue was heavily coated and the urine scanty. The examination of the urine showed nothing abnormal except a few phosphates and urates. The diagnosis arrived at was Lumbago presumably due to uric acid diathesis. Violent pain in the lumbar region on the left side did not show any signs of amelioration even after the prolonged use of Salicylates, Iodides and Diuretics. Even after giving

Aspirin, Guaiacol Carb. and Sulphur the pain did not disappear but it became less acute and more diffuse. When the complaint had become sub-acute, I prescribed Urogenine and stopped all other drugs. He was advised to take light but nourishing diet. After Urogenine regime for about a week improvement manifested itself. Pain became much less, his digestion which was faulty due to the sluggishness of the liver, improved and he began to pass urine freely which on examination was found free of urates. After a month of this treatment the patient felt better, began to get good appetite and no longer experienced pain. He is still continuing the treatment and the complaint has not recurred so far.

2. C. L., a young man aged about 35 working in a bank gets frequent attacks of Gout in the knee and wrist joints. The stiffness at times became so pronounced and painful that walking or even passive movements were impossible. The general condition was very bad, anorexia was present and the patient was unable to sleep well at night. The examination of the urine revealed the presence of urates. Albumen was absent but there were some epithelial casts. The acute condition was treated on the usual lines i.e. Salicylates, Colchicine, Iodides etc. but when this had passed off, I placed the patient on Urogenine. The result was most gratifying in that the patient had no further relapses for a long time. He finished one bottle of Urogenine and for a long time he had no arthritic attack of Gout, which used to trouble and incapacitate him off and on. He still continues taking Urogenine.

3. I was called one night on a case of Renal Colic in a young man of about 30. The patient was in terrible agony and badly wanted something to relieve his pain. I injected Morphine at once and prescribed an alkaline diuretic mixture. I found out on enquiry that this was his fourth attack the family seemed to be worried on account of the frequency of these attacks. The relatives informed me that the patient was very strict in his diet, did not touch meat, pulses etc. and he was not in the habit of taking any sort of alcoholic beverages. Next day when I called, I found the patient quite well. I prescribed Urogenine to him to be taken regularly two teaspoonsful

thrice a day before food. The patient is doing that for the last three months. It was very gratifying to find that during the course of this period there was no recurrence of the colic and the patient was feeling generally better. Being fully satisfied with the result of this treatment the patient continuously taking Urogenine. The cure has persisted so far.

Seborrhœa of the Face and Scalp.

Seborrhœic condition of the scalp is, I find, a frequent occurrence among those patients who are not very scrupulous in observing the hygiene of the hair and the scalp. The contagious nature of this skin trouble is not so well appreciated as it is not very uncommon to find many members of the same family being infected, specially in those cases where the same bed is occupied or if the same pillows are used. Again the use of the common hair-brush and comb is also responsible for the spread of this infection. Before instituting the right treatment for this affection all these points must be impressed very strongly on the patients who seek our advice.

The diagnosis in these cases is generally easy as can be seen from the tiny, soft and brick-coloured papules on the face. Sometimes they occur in irregular, ovoid patches slightly raised with sloping margins. This condition might be mistaken for ringworm as the centres of these patches at times heal up leaving a ringed eruption. The scalp is at first affected and from there the infection spreads to the forehead and the face and if untreated may affect the neck and the shoulders. The opinions are divided as to the cause of the infection, some saying that *Bottle Bacillus* is the responsible agent, others ascribe it to *Staphylococcus Griseus*, while there are some who say that both the bacilli act in conjunction.

A typical case fresh in my mind which was brought to me for consultation will serve to illustrate the points that I wish to stress. A young man of about 25 came to me with typical appearance of Seborrhœa of the face. On examination of the scalp I noticed round erythematous patches and the hairs surrounding them dry and lustreless. In one or two places there was slight excoriation which was probably due to scratching, as there was clear evidence of itching.

The treatment in these cases is tedious and long and unless it is carried out faithfully, the trouble tends to recur. Any small trace of the disease may be a source from which the infection may restart. X-rays and such other elaborate treatments are all right in the Specialist's hand but these can be hardly considered the right methods for the general practitioner. The following method, which I have adopted, is the one which gives excellent results. After cleaning the hair and the scalp with a good antiseptic soap at bed-time apply Sarcopitol well on those parts rubbing it vigorously and allowing the product to act on the whole night. In the morning again clean the whole face and the scalp with a good soap. Apply after this aqueous solution of Sarcopitol (one of the solution to two of water to start with) several times in the day, care being taken not to allow the solution to drop in the eyes. In my hands this treatment has proved quite successful. In fact I consider this preparation far superior to any other Sulphur lotion and far cleaner than other ointments and creams. It effectively destroys the parasites and it penetrates to the roots of the hair where it kills the micro-organisms which lie embedded. It must however, be persistently used and thoroughly rubbed in until the minutest vestige of the disease is wiped out.



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

THE DENVER CHEMICAL MFG. CO., NEW YORK.

News and Comments.

The Bickerings of a Bombay Knight: If India has not come to the level of other progressive countries in all matters affecting the growth and prosperity of her teeming millions, it is due to the misguided zeal of a few like Dr. Nasarvanji Choksy, who were later knighted and who, on account of their knighthood have been able though unwittingly to mar the otherwise bright prospects of India growing as one Nation. The "Times of India" publishes in its columns the views of Sir Nasarvanji Choksy, who wrote that "Licentiatees can under no circumstances be placed upon the same plane as graduates. The former stand apart as a class with lower qualifications and as a cheaper agency suited to Indian conditions."

To justify his statement the Knight contributes a series of three articles to the "Times of India" on three consecutive days, commencing from 29-3-'32. The trend of arguments put forth by Sir Choksy are as faulty as they are quite beside the subject. He objects to the inclusion of the Licentiatees within the purview of the proposed Indian Medical Council Bill, because their preliminary educational qualifications and medical training are not equal to those possessed by the graduates. It is very unfortunate that this Medical Knight, who claims to have been in charge of medical institutions in Bombay and who owes his knighthood perhaps for services rendered in his capacity as a medical man betrays his ignorance regarding the purpose of Medical Acts and Medical Councils. The Medical Act of 1858 passed by the British Parliament begins with a preamble, which runs as follows:—

"Whereas it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners"

It is common knowledge that the medical register compiled under the authority of that Act consists of Graduates of Universities; Fellows, Members and Licentiatees of several faculties; and also Licentiatees of the Society of Apothecaries. It can never be said that the standard of training of all these are mathematically equal as enunciated by the Bombay Knight with regard to Licentiatees and Graduates in India. According to the theory promul-

gated by him, Dr. Nasarvanji Choksy, L.M.S., (Bombay University) 1884, M. D. (Hon. Causa University Freiburg), 1900, cannot be in Part I of the Bombay Medical Register along with M.B.B.S. graduates of later date as there is almost as much difference between an L.M.S. of Bombay University of 1884 and an M.B.B.S. of the same University of later date, both with regard to preliminary qualification and the training as there is at present between the Licentiatees and Graduates. To be consistent with his own theory, the profession would expect the Knight to bring about one more part in the Bombay Register as he did sometime ago, for grouping L.M.Ss. apart from M.B.B.Ss. There is a gulf of difference between an Hon. M. D. and an ordinary M. D., of whatever University and it will never be justifiable according to the new theory of Sir Choksy to group medical men of different qualifications in the same register. In Great Britain there exists to-day as in 1858 variety of qualifications with as different standards. Yet neither the House of Parliament nor the medical profession have thought it desirable to divide the Medical Register in parts denoting different qualifications. The object of Medical Acts being quite different from what the Bombay Knight wishes to proclaim, the House of Parliament in Great Britain included a section in the Medical Act of 1858 Section 17, which empowered all persons practising in England before 1st August 1815 to be registered and these persons had no training in any Medical School or hospital, and it was enough they declared that they were practising as medical practitioners. It is clear from this section and the preamble of the Medical Act of 1858 that the purpose of the Medical Acts in other civilised countries is to help the public to distinguish qualified from unqualified practitioners and to bring the qualified practitioners under disciplinary control of a council.

Sir Choksy is obsessed and perplexed with a complex of lower standard and goes beyond the bounds of the purpose for which he wrote three articles in "The Times of India" and condemns the Licentiatees as a class and wishes that they should practise only in rural areas. None so far in all other civilised countries did

advocate a lower standard of medical men to treat the village folk, yet in India we have veteran Knights like Sir Choksy who value the lives of villagers cheaper than those of their fortunate brethren in the cities. The fact that as a result of investigation, it was found in 1931 that only 160 Licentiatees were practising as private practitioners in the rural areas of Bombay Presidency while 1510 were practising in the towns and cities, has been used by Sir Choksy as an argument for condemning the Licentiatees as medical men instead of using the same as a valid reason that in spite of all sorts of handicaps in their way, the Licentiatees have been able to hold their own and get themselves recognised as efficient medical practitioners. That the Licentiatees are "an agency to suit Indian conditions" is the slogan of Sir Choksy but he wants to add to his war-cry that they are "a class with lower qualifications." The value of a stuff depends more on quality than the qualifications of quality, all that "glitters" not always being "gold." The ideal test of a want is that it should suit the purpose for which it is wanted. The assessment of value of an opinion certainly depends upon the person and his position in life. A Viceroy and Governor-General of India who initiates a Knight can surely claim a higher value for his opinions than a Knight of a Province and what did Lord Chelmsford say of the Licentiatees as early as 1920? His Excellency said:

"Ever since I have been in India, I have been hearing of the good though unobtrusive work done by the Sub-Assistant Surgeons. Though your cadre consists of the largest number of medical men in India the value of your services to your country and fellow countrymen is perhaps not as widely known as it ought to be. Your work lies largely in remote parts of this vast country and is performed chiefly among the voiceless masses. And it is no doubt chiefly for these reasons that the high character of your services is principally known only to those among whom you work and to your immediate superiors. But those in authority, you may rest assured, are in no way unmindful of what the administration and the country owe to you. I cannot think of any report of plague, famine or any other epidemic which I have read without coming on reference to the good work done by Sub-Assistant Surgeons, and your praises are continually sung to by those responsible for the medical administration of the country."

During the Great War you volunteered in large numbers and acquitted yourselves always with credit and often with distinction. Gentlemen, you have a fine record behind you and I can only exhort you to go forward and add to it."

Sir Nil Ratan Sircar a Knight of no mean order, who was once a Licentiate of Bengal and then a Doctor of Medicine of the Calcutta University and who acted as the Principal of a Medical College in Calcutta concluded his opinion regarding the inclusion of the Licentiatees within the purview of the Indian Medical Council Bill, in his Presidential Address at the Eighth All India Medical Conference held at Calcutta recently by saying:

"The claims of the Licentiatees have been most unjustly ignored. They possess adequate qualifications and are actually registered in the Provincial Medical Registers. Many of them hold important offices in medical schools and hospitals involving very heavy responsibility. Hundreds of them are highly efficient and responsible practitioners throughout the country, whose services to the community and to the profession cannot be over estimated. Many of them have attained very high distinctions both in the professional and scientific lines. Further they are thoroughly organised in well developed associations which are doing most useful work. Some of these associations run medical journals of undoubted importance and wide circulation. We should think that the Licentiatees should not only have the privilege of recognition in the Central Medical Register but should also have adequate representation on the council."

The institutions quoted by Sir Choksy which did not recommend the inclusion of the Licentiatees within the purview of the Bill such as the Bombay Medical Council, have a predominant element of the nominees of the Government and it is no wonder that they should dance to the tune of Sir Fazl-i-Hussain who has made it plain on behalf of the Government of India that the Bill was only for placating the General Medical Council of Great Britain. Yet Sir Choksy should know that the Medical Councils of Madras and Bihar and Orissa did recommend to the India Government the inclusion of the Licentiatees within the purview of the Bill so also did almost all the Medical Associations in this country and the latest opinion of the whole medical profession in India as expressed at the last All-India Medical Conference in Calcutta, is to the same effect. Even the Bombay

Medical Union quoted by Sir Choksy seems to have changed their opinion as is evidenced by the statement made by Dr. Dadachanji, the President of the Union in the "Times of India" in its issue of 29-3-32. In the interest of the public more than the interests of the Licentiatees themselves it is desirable that they should be included within the purview of the proposed Bill, then only there will be greater chances of bringing about a uniformly high standard of medical education for the treatment of rural as well as urban population.

An Ayurvedic Medical Council:

At the instance of the present Minister of Local Self-Government, a scheme to get the status of Ayurvedic Medical Practitioners recognised, is under the contemplation of the Bengal Government. It is said that the Bengal Government would proceed with the necessary legislation to register the Kabirajas if private donations could be raised to defray the expenses, and a prominent Marwari merchant has come forward with a donation of Rs. 15,000. It has been proposed that the Council should consist of 25 members consisting of Kabirajas, representatives of Universities, Sanskrit Associations, the Calcutta Corporation and other vested interests. This is a move certainly in the wrong direction, and would perpetuate heterogeneity in the medical profession, where the principle of homogeneity ought to be the ideal. For the latter purpose the leaders of the different systems of medicine should strive to bring about institutions where Chemistry, Physics, Anatomy, Physiology, Pathology, Sanitary Science, etc., are being taught maintaining a standard in no way inferior to that in the Universities, and later the student allowed to take up any particular system, for which he has the aptitude, making it compulsory that he should also have a comprehensive knowledge of all the systems. Sir Nil Ratan Sircar gave expression to such a scheme at the recent All-India Medical Conference but the lower standard advocated by him cannot be accepted. It is desirable that members of all the systems of medicine should consider this question seriously and prevent multiplicity of Medical Councils and Medical Acts which would otherwise come into existence

following one after another under the ministerial regimes when the popular Ministers have to demonstrate their sympathies for movements when they make public speeches on the occasions of gatherings concerning such movements. The Bengal Minister did demonstrate his sympathy for Homeopathy also, sometime ago when he opened a ward of a Homeopathic Hospital at Calcutta and it will not be a surprise if a Homeopathic Medical Act will be on the anvil of the Bengal Legislative Council following the Ayurvedic Council if another philanthropist offers a donation.

Misdirected Retrenchment: There is a hue and cry in Bombay against the methods employed by the Bombay Government in the medical department by closing a large number of beds in the hospitals and by restricting dietary. We have been pointing out repeatedly that if there was any department under the Government which could be entrusted safely to non-official agency, it was the "Medical" and that there was less risk and more gain to the Government if the honorary system of medical relief was extended on a large scale. It is most unfortunate that in Bombay where any amount of talent is available among the members of the independent medical profession and where under the very nose of the Government, hospitals like the King Edward Memorial Hospital are efficiently run by honoraries, that the Government did not make use of the services of Honoraries for the purpose of curtailing expenditure but adopted too drastic and inhuman methods. It is inconceivable that the Bombay Government should have appointed a paid Venercal Specialist which costs the Government Rs. 19,000 per annum which would have served to pay honoraria for 31 members of the independent medical profession at the rate now fixed by the Government for paying the honorary staff. Government have instituted a small charge in all Government hospitals from those who are not indigent. It is an irony that the Government should allow complete discretion in assessing fees to patients to their medical officers when the experiment of a Lay Secretary to administer hospitals has resulted in tangible saving to the Government. It would have been wiser to

entrust the Lay Secretary to collect fees from the patients, and the medical officers to do only their legitimate duty of treating the patients as is the case in hospitals in Great Britain.

There seems to be no uniform policy or methods conducive towards curtailing expenses in hospital administration in India which has resulted in wasteful expenditure towards fabulous salaries paid to the medical officers under the Government. The rights and privileges of unrestricted private practice allowed to the state paid medical officers has in some instances been the cause of indiscipline and corruption in Government Hospitals. The abuse of these privileges has also hampered materially the growth of the independent medical profession.

Startling Transformations: The Medical Department of the Government of Madras has unique versatile methods in the matter of making appointments. Those responsible in making the appointments seem to have no faith in past service and experience. The theory of individual "like and dislike" more than the qualification and merit must have been at work in the making of a few recent appointments. A Civil Assistant Surgeon who served as such for the first five years after his entering the provincial service, was transferred to the Public Health Department where he served in different capacities and though he was not in touch with the curative side of the profession for over 16 years, has been suddenly transformed as a Civil Surgeon and made to do the duties of a Surgeon and Physician as a District Officer. It has been possible for another person who was confirmed as Civil Assistant Surgeon in 1924 to be a Civil Surgeon in 1926 after only two year's service as he was appointed as a professor of chemistry in a medical college; and after 6 years' service as a chemistry professor he has been suddenly transformed as a District Medical Officer who has to cut and treat human beings for their ailments. Both these officers could have been provided with posts which they could fill in with less risk. The Civil Assistant Surgeon with 16 years' meritorious service in Public Health Department as the Health Officer of the Corporation of Madras and

special Malarial officer and who had all the necessary qualifications, might have been appointed as the Professor of Hygiene, Medical College instead of another who cannot be said to have British Registrable qualifications to be in charge of teaching in a medical college. It would have been less objectionable if the other young Civil Surgeon was posted as the 1st Assistant Chemical Examiner which post would soon fall vacant after the retirement of Khan Bahadur Muhammad Azizulla Sahib Bahadur. Both the above officers would not have been Civil Surgeons in 1932 but for their extraordinary luck in the earlier part of their life; one was transferred to Public Health Department and the other was made a professor of a college. Justice, equity and fairplay required that these two ought not to have been brought back to administrative offices in the capacity of D. M. Os. superseding their less fortunate brethren even though they cannot be said to be more qualified to serve as physicians and surgeons than those who have been working as such ever since they entered service.

The third appointment that would surprise the profession most is the Honorary Physician of the Government Royapettah Hospital. The Registrar Madras Medical Council has been found to be the most fitted for the post.

It was reported in these columns last month that the clerk of the Madras Medical Council had been handed over to the police by the President for the alleged defalcation and for alleged tampering with the manuscript Medical Register and cash book. It is also common knowledge that there have been inordinate delays in registering a large number of medical practitioners and that the Medical Registers were never published in time ever since 1925. The President Medical Council is the Surgeon-General with the Government of Madras who initiates appointments honorary or paid and he should know more than anybody else if the Registrar, Madras Medical Council can continue to function as such and at the same time be the Honorary Physician of the Government Royapettah Hospital?

Correspondence, Reports etc.

Darbhangha Conference.

Joint statement issued by the ten delegates of the Punjab and Delhi Provinces explaining the circumstances which led to their walk-out from the meeting of the subject committee held on the night of the 4th January and from the conference on the 5th January, 1932.

1. At the meeting of the subjects committee when the question of the election of the officer-bearers for the ensuing year came up for consideration and the president had been elected, the names of Rai Sahib Dr. Ram Narain Lal, and Dr. Mohammad Farid were nominated for the Vice-Presidentship. (several other names were informally discussed). After a time the Chairman applied the closure and the only names duly nominated were the two mentioned above. Of the two Dr. Mohammad Farid's name was ruled out on the ground that he was not a bonafide member of the Association. Thereupon the names of Rai Sahib Dr. Sen Gupta of Bihar and Dr. Desai of Ahmedabad were proposed. But there was opposition to these names from some sections of the house. The Chairman was called upon to give a ruling on the point whether fresh nominations were in order after the chair had declared the nominations to be closed. The Chairman gave his ruling that no more names can be nominated for the Vice-Presidentship. Dr. Ram Narain Lal being the only name for the office, he must have been declared duly elected to the office of Vice-President.

2. At this stage there was confusion in the house and more names were being proposed for the Vice-presidentship. The Chairman thereupon went back on his previous ruling and consequently upon the decision of the house with regard to Dr. Ram Narain Lal's election to the office of Vice-President and accepted the nominations of Drs. Sen Gupta and Desai. On this the Punjab and Delhi delegates including Dr. Gian Chand Blaggana the finance Secretary and Dr. Amar Nath Khosla the Treasurer walked out in a body in protest owing to the disrespect shown to the Chair in making nominations when even the elections should have been deemed

concluded and also owing to the chairman himself going back on his previous ruling on the point.

3. A joint statement of protest was then addressed to the Chair which was signed in addition by Doctor Chhabil Das, the joint General Secretary with regard to this point. On the 5th January, the Chairman had an informal talk with some of us and subsequently took Dr. Gian Chand to his room where they were closetted for over an hour. This conversation resulted in the Chairman agreeing to annul all proceedings after the election of the Vice-President and start with the election of the General Secretary in the subjects committee. On this understanding we agreed to attend the conference. To our surprise and disappointment, however, when we arrived at the conference, we were told, (as we were late), the previous decisions were confirmed and the old office bearers were re-appointed for the year.

4. The Chairman thereupon took some of us aside and said that in order to ease the situation he would prevail upon Rai Sahib Dr. Ram Narain Lal to resign and in fact that the latter had agreed to do so. But we pointed out that we had no quarrel with individuals and that our only difficulty was the unconstitutional manner in which they had been allowed to be carried on. The Chairman admitted his helplessness in the matter. Under the circumstances we had no option but to walk out of the conference altogether. Three of the office bearers of the Previous year are among those that walked out with us and we were informed that those three had been re-appointed to their office without even consulting them and making sure of their willingness to accept office. It must also be remembered that Rai Sahib Dr. Ram Narain Lal who wanted to be excused from the office of Vice-President on the ground of health, did now consent to take up the more and exacting office of General Secretary.

5. As we have stated already, we have no special predilection or prejudice in connection with one or other of the office holders. The three of them who walked out with us were not at all anxious that they should be reappointed. In fact they are surprised that in spite of their protest they

had been re-elected. But what we do feel is that there ought to be definite constitutional rules to be followed in the Conference, elections etc. We suggest that the standing committee should suggest to the already appointed Rules-Sub Committee to frame the necessary rules regulating the work at the conference on the basis of other registered bodies. In the meantime the standing committee may at its discretion re-appoint the same office bearers to carry on the work of the Association pending the formal election which should be held in such manner as may seem to them constitutional and proper.

6. We take this occasion to bring to your notice the following which indicate how the absence of definite rules, has led to doubtful and questionable results.

(a) The Chairman of the Reception Committee of the Darbhanga Conference was not a *bonafide* member of the Association.

(b) Dr. Venkappa who claimed at the Darbhanga Conference to be the Provincial Secretary for Madras and to whom Rs. 100/- has been advanced for propaganda in August last rejoined the Association only in October last. In 1929 he had refused his V. P. nor did he pay his subscription for 1930. It is strange that a non-member should have been advanced money from the Association and that he should call himself Provincial Secretary.

(c) Dr. Ahmad Hussain, President of the Jhansi Branch attended the Conference as a delegate though he has not paid his subscriptions for 1931. On the 27th ultimo he paid Rs. 4/ for his subscription for 1932.

(d) Certain "Delegates" seem to have elected themselves as delegates to the Conference. One of them is reported to have been elected from a centre where there is no branch at all. Others are stated to have come from Centres where there were less than five members.

7. Irregularities of this description might be condoned in an infant institution. But after celebrating our Jubilee it is

hardly creditable that we should allow things to continue like this. Especially in view of the forthcoming Medical Council Bill and the status that we claim under it, it is essential that we should begin to set our house in order.

AMRITSAR, }

SAMUELS RAMSINGH,
SOM RAJ ISSAR,

For Punjab and Delhi Delegates.

Subsidised Medical Relief Scheme.

A deputation of the subsidised medical practitioners of this Presidency waited on the Honourable The Chief Minister at the Secretariat, on the 4th and 5th instant for the purpose of discussing the defects in the working of the scheme and rectify the same. The deputation consisted of Dr. S. Ramasubbu, L.M. & S. Provincial Secretary of the subsidised practitioners' Association, Dr. K. Vittaldas Pai, M.B. B.S. of Pallavaram and Dr. B. K. Shenai, L.M.P. of Acharapakkam, and was led by Dr. V. Rama Kamath, in the unavoidable absence of Dr. U. Rama Rau who was the first nominee appointed by the President of the Third Provincial Conference of the Association, to lead the deputation. The Surgeon-General, The Director of Public Health and the Deputy Secretary Local Self Government Department were also present.

A memorandum was presented by the Association on the occasion, but the honourable the Chief Minister desired that for the purpose of initiating discussion, it would be advisable to take up first, the resolutions passed at the third Provincial Conference held in Madras on 31-12-30. The first item of discussion was about the increase in the subsidy, which the Honourable Minister said, was not possible under the present stringent financial condition. Regarding the transfer of control of the scheme to a District Medical Council, it was the opinion of the Honourable Minister that the Taluk Boards might not contribute their share of the expenses of the scheme, especially when they would not have any share in the management thereof; all the

same, the question of payment of the subsidy to the practitioners would be examined in making the D.M.Os. the agency responsible for payment, the Taluk Board Presidents sending the bills to them, as this change would very likely lessen the complaints of the practitioners against the Presidents and ensure better supervision by the Government. It was the considered view of the Minister that the Taluk Boards should provide uniform and suitable buildings for the running of the subsidised dispensaries, and also quarters along side, if possible, for the residence of the practitioners with or without rent for the latter, depending upon the view taken by the individual Taluk Boards. The Honourable Minister accepted the principle that the Taluk Boards should invariably give preference to a practitioner of the same village, Taluk or District in the matter of paying the subsidy, and said that Government had already passed orders that they would not allow any subsidy in respect of a place where a qualified practitioner already existed. Regarding the appointment of the midwife by the subsidised practitioner, the Honourable Minister said that he would not accept the proposal of the Association, but would agree that the midwife should co-ordinate with the practitioner in his professional work whenever she had the time to do so. It looked as if the proposal that the drugs and other requisites necessary for the midwife should be supplied separately by the Taluk Boards was acceded to. In respect of the supply of drugs to the subsidised practitioners, the proposal that an amount more than Rs. 360, a year—which is now reckoned on an average of 30 patients a day—should be made proportionate to the attendance when it exceeds 30 was not acceptable to the Minister but he was almost sure that in special cases where there was a large attendance of poor patients, the concerned Taluk Board was likely to help the practitioner with the supply of additional drugs.

Regarding Public Health duties, which the subsidised practitioners were called upon to do, it was agreed that in cases of fairs and festivals they should get a daily allowance of Rs. 5, plus the usual travelling allowance if they were to be on duty in any place

beyond 5 miles from their villages. With regard to inoculation duty, the Honourable Minister said that in addition to the travelling allowance, practitioners should be paid at the rate of 9 pies per inoculation subject to a minimum of Rs. 2, and a maximum of Rs. 5, a day and that in either case the subsidy should not be deducted for the days they were so engaged.

As regards the leave, the Honourable Minister said that he would examine this question and showed an inclination as if 30 days of absence from duty in a year with full subsidy might be reasonable though the Surgeon-General expressed it as his view that 15 days would be enough for the purpose. The Honourable Minister added that whatever decision regarding absence from duty with full subsidy was arrived at, a practitioner could absent himself from duty for the maximum period allowed without any restriction as to the period of such absence at a time, and that the subsidy might be cut down only when the total period in a year exceeded the number of days allowed therefor. It was also agreed that the Taluk Boards might be given the option of terminating the agreement of the subsidised practitioners for continued absence from duty for over three months at a time, and that within that time the old arrangement of the practitioner putting in his substitute might continue.

Regarding the resolution that the subsidised practitioners should be paid batta and travelling allowances at a uniform scale for attending Law Courts, the Honourable Minister said that this question was beyond the purview of his Department and that the Association might approach the concerned authorities in the matter.

Regarding medical inspection of school children and the appointment of the subsidised practitioners to teach Hygiene and Physiology in the Elementary Schools, the Surgeon-General gave it as his view that it would be a legitimate duty of the practitioners; this subject however was not gone through as the Government have given up the scheme of compulsory medical inspection of school children.

Regarding the supply of Government orders, circulars, etc., connected with the subsidised medical relief scheme to the Provincial Secretary the Honourable Minister said that the G. Os. and circulars concerning the subsidised schemes as a whole would be supplied but not those concerning the individual cases.

Dr. Kamath thanked the Honourable Minister for his patient and sympathetic hearing and trusted that with the help of the Surgeon-General and the Director of Public Health the Honourable Minister would be able to bring about the necessary reforms in the scheme so that real village reconstruction of a substantial nature could be brought about in the villages with the help and co-ordination of the subsidised practitioners whose scope of service was such that they could be usefully taken advantage of for any reconstruction work in rural areas.

School Hygiene.

Very often we read suggestions from various quarters to institute Elementary Hygiene and Physiology as compulsory subjects in the schools to be taught by medical men. Though the suggestion is to be welcomed it is very unfortunate that the authorities pay little heed to these suggestions. It is a step in the right direction that Elementary Science has been included in the 'A' group subjects of the Revised Regulations for S. S. L. C. It is satisfactory to note that schools teach Elementary Physiology under Elementary Science. A school boy should know all about his body and how to keep the same clean and healthy. Such a knowledge is certainly of greater importance than the knowledge of electricity. So the idea of teaching Elementary Hygiene and Physiology to one and all students cannot fail to get support from the heads of the Educational Department or from the public when it is known that India pays the highest toll in the death rate by preventable diseases. Major Webb, the Director of Public Health had said rightly that students are the best material among whom effective propaganda could be

conducted with good and tangible results. There cannot be a better agent to convince the Government about the importance of teaching Physiology and Hygiene in schools than the Director of Public Health who it is hoped will take the initiative in this matter. This reform may be introduced without any delay and with no additional financial commitment in case private practitioners are employed as part time teachers in all schools where the teaching of Physiology and Hygiene should be made compulsory and the medical practitioner is entrusted with the teaching of these subjects. The same practitioner should be in charge of School Hygiene as well.

The present system of the medical examination of school children cannot and will not achieve the purpose expected of this scheme. Neither the local bodies nor the Government seem to have realised their responsibilities in this matter of vital importance. As the scheme works at present it serves only one purpose and that is of finding temporary employment to a few medical practitioners here and there and that too not to the full extent. No care is bestowed in the choice of the medical practitioners and it some time happens that medical men who reside far away from the schools are appointed as medical inspectors. The work is not also satisfactorily divided. There are instances where one has too many schools and others have no work worth the name. The fact that many a time the Government is partial to their own medical officers and appoint them as medical inspectors in localities where there is no dearth of private practitioners qualified to do this work, is another factor which has a baneful effect in the present scheme. Exigencies of government service are such that it is not possible for a particular medical man in government service to continue to work in a particular school for more than 3 or 4 years at the most. In some cases they are transferred even in the course of a year. Consequently continuity of work with the accompanying interest in it has not been possible even in the perfunctory work that is now being conducted. So; if a private practitioner is

appointed as a teacher he could not only teach school boys Physiology and Hygiene but also be in close touch with the students and study their defects and deficiencies and rectify the same.

It is reported that the Government is contemplating, as an economy measure, to modify the present scheme and that in future the children will be examined once in two years instead of once a year as it is being done now. If the Government have faith in the medical inspection of school children as a measure to build up a strong healthy nation in India they should at all cost improve the present scheme instead of retarding its progress. It is want of faith in men and material outside Government departments which are tied down with red tapes, that is the cause of the failures of many schemes of public utility. It is expected that the Government will not stop or retard the good work of medical inspection of schools but improve it with the help of private agencies and by combining the work of a teacher and medical inspector in the way suggested above.

Madura. } D. Nainar,
Dental Surgeon.

Tomatoes.

Henry C. Sherman, Ph.D., Professor of Food Chemistry at Columbia University, says in his 'Food Product':—"Weight for weight, tomatoes, raw or steamed, rank with lettuce or string beans as a source of Vitamin A and B and with oranges and lemons as a source of Vitamin C. The dry matter of tomatoes and of spinach contains even a higher concentration of Vitamin A than does butter-fat."

Tomato juice contains Vitamin A, B and also Vitamin C. The contents are unchanged in cooking. Tomato juice has been recognised as one of the most successful remedies for Rickets and Scurvy, and for malnutrition for children and invalids. The patients of Children's Memorial Hospital at Chicago are fed on tomato juice. The doctor in charge of the Hospital reports: The Vitamin content of tomatoes is accomplishing the "undreamed of" in the feeding of infants and children, and is doing marvellous things in cleansing the system." Tomato juice is recognized as

being one of the most thirst-quenching beverages, having the important acids, citric and phosphoric. It stimulates the secretion of saliva and increases the appetite. The juice is tried also in cases of obesity and anaemia. Dr. P. G. Cammidge of London reports:—"Tomatoes rank first among all vegetables and fruits as a food treatment for Diabetes."

Tomatoes contain proteins, phosphates, potash lime, magnesium, sodium, sulphur, chlorine and iron. Dr. G. W. Wagner of Chicago states that tomatoes are the richest of all foods in Vitamins.

Palliput, M. GOPARAJU, L.M.P.

Malabar District Medical Association, Calicut.

A meeting of the Malabar District Medical Association was held in the Paran Hall, Calicut on 20th February '32 Major Cox, I. M. S., (D. M. O.) presided. The meeting was largely attended.

After the minutes of the previous meeting were read and adopted, the letter of resignation of Dr. S. K. Pillay of his presidency and membership of the Association, on account of his transfer out of the station, was read and accepted. It was proposed by Dr. A. P. Balaram that the association's thanks for his valuable services be recorded. Dr. V. I. Raman seconded this resolution and it was passed unanimously.

Dr. V. Krishna Menon proposed that in the vacancy caused by the resignation of Capt. Pillay, Major Cox I. M. S. be elected as the president of the association. This was seconded by Dr. Balaram. Major Cox accepted the post with pleasure and it was passed with acclamations.

Dr. N. Achuthan, M.B., B.S. was then called upon to deliver his lecture on "Eclampsia". From a statistical review of cases, the lecturer said that the disease is much more frequent among Indians than other races. He dealt the subject at great length and spoke on the incidence, period of onset, pathology, differential diagnosis, etiology, pathogenesis, prognosis and treatment of the disease. In dealing with the pathogenesis, he spoke in detail about

Strognoff's ovular and neural theories and in the treatment of the disease he compared the Dublin and the Petersburg methods. An interesting discussion ensued in which several members took part.

The meeting terminated with votes of thanks to the lecturer and the president.

Notification.

REGULATIONS REGARDING THE ADMISSION OF L.M.P. DIPLOMA HOLDERS TO THE M.B. & B.S. DEGREE EXAMINATIONS.

A candidate who holds the Diploma of L.M.P. or any other qualification accepted by the Syndicate as equivalent thereto, will be admitted to the Degree of M.B. & B.S. provided—

(a) he has passed the Diploma Examination at least five years before the date of application for the Final M.B. & B.S. Degree Examination;

(b) he has passed the Intermediate Examination in Arts and Science of this University, or an examination accepted by the Syndicate as equivalent thereto, or an examination accepted by the General Medical Council for entrance to the Medical Course;

(c) he has attended a course of study for not less than one academic year in a College of Medicine recognized by or affiliated to this University before appearing for the Second M.B. & B.S. Examination; and not less than one academic year subsequent to passing the Second M.B. & B.S. Examination and before appearing for the Final M.B. & B.S. Degree Examination, during which year the candidate shall be required to produce evidence of having attended clinical course in a Medical College recognized by or affiliated to this University; and

(d) he passes Part II of the First and the whole of the Second and Final M.B. & B.S. Examinations of this University.

EXPLANATORY NOTE.

(a) Diploma holders may begin the special course three years after passing the Diploma Examination.

(b) It is not necessary that Diploma holders should have passed the Intermediate Examination with Physics and Chemistry as two of the three optional subjects prescribed for the Examination.

(c) The courses, prescribed for the subjects comprising Part II of the First M.B. Examination and Parts I and II of the Second M.B. Examination, may be taken concurrently but candidates will not be permitted to sit for the Second M.B. Examination before they pass Part II of the First M.B. Examination. So also they will not be permitted to commence the course prescribed for the Final M.B. Examination nor will they be allowed to sit for the Final M.B. Examination, before they pass the Second M.B. Examination. Before they appear for the Final M.B. Examination, they should also produce evidence of having attended the required clinical courses.

The fees for the courses are as shown below:—

I. Each of the subjects other than the final year subjects, e.g., Anatomy, Physiology, Pharmacology, Hygiene, Pathology and Ophthalmology—Rs. 50.

II. Each of the final year subjects of Medicine, Surgery and Midwifery—Rs. 30.

Medical Jurisprudence—Rs. 15.

Students who do not belong to the Madras Presidency should pay fees at twice the above rate.

The courses will commence in July 1932, but no separate classes will be held for these candidates and they will have to take their courses along with M.B. & B.S. students.

ANNOUNCEMENT.

As published in previous issues The Oriental Research Laboratory has introduced a Specific for Eczema and allied skin lesions called ZAMA. The specific has been tried and found very effective in Eczema occurring at all stages, specially in infants and elderly people where the disease is usually obstinate and baffles the usual medication. The cost of ZAMA is 12 annas a cup; 20 per cent. discount will be allowed to the readers of "The Medical Practitioner" if they book their orders through **The Medical Practitioners' Service Bureau, Vepery, Madras.**

Reviews

THE ADMINISTRATION REPORT, STATISTICS AND PROFESSIONAL REPORT OF THE GOVERNMENT OPHTHALMIC HOSPITAL, MADRAS FOR 1931.

The Professional Report, unlike that of General Hospital, Madras is highly interesting and instructive and can serve as a clinic useful for the medical practitioners and particularly for specialists in Ophthalmology. The language and style of the report are highly commendable. Col. Wright the talented Superintendent possesses evidently a broad outlook of the profession and appears to be one among the very few who recognise that the ultimate goal of medicine is the prevention of diseases. He deplores that much energy, time and intelligence are spent in refining the technique of cataract operation, or to use his own words "human carpentry" and that no adequate endeavour is made to find out the cause of the disease nor steps taken to prevent its onset. Prevention does not so much appeal to the imagination of ordinary persons as surgical operations even though they may be unnecessary. The fact that the Government Maternity and Ophthalmic Hospitals in Madras are considered to be the best in the East, may be a matter for congratulation to the Government, but in humanistic point of view, must be looked up with some anxiety, as it indicates a large extent of poverty and sickness among the people. In the report the origin of the hospital is traced to the East India Company and it is noteworthy that this hospital was the first one opened in India. One of the Superintendents Dr. Lane was in addition, the Private Secretary to the then Governor of Fort St. George. In the absence of medical men among the Secretaries and members of the Council and Ministers, the appointment of a medical man like Col. Wright as the Private Secretary to His Excellency the Governor, to advise him on matters of Public Health and Hospitals, will be of immense benefit to the people. Col. Wright is in favour of staffing Government Hospitals with honoraries in general, but doubts whether the multifarious duties of the Superintendents of the hospitals, as the Ophthalmic, Maternity etc. can be performed by honorary officers. He need not have any such misgivings as it is quite sufficient, to entrust the administration of the institutions to paid officers as the Resident Medical officers, and the professional work given to the honoraries. There is nothing bizarre in the suggestion, for, as a matter of fact important institutions in Bombay such as the Nowrosjee Wadia Maternity Hospital and Seth Gordhandas Sunderdas Medical College and Hospital are run very efficiently by honoraries. Perhaps it may not be possible at present, to get a medical practitioner with sufficient experience and ability to be appointed as Hon. Superintendent of the Ophthalmic Hospital. If, however, Col. Wright on his retirement settles down in Madras and is willing to be appointed as Honorary Superintendent, he will be doing better service to this country than he did while he was the paid Superintendent, and advance the cause of and

enhance the dignity of Honorary System in this province. The appointment of foreigners, if considered to be a drain on this country, such officers leaving India after retirement with a large experience gained in the course of their service, which they later use in their native country, is a serious loss which should be prevented as far as possible. M. S. K.

THE NINTH ANNUAL REPORT OF THE NOWROSJEE WADIA MATERNITY HOSPITAL BOMBAY FOR 1931.

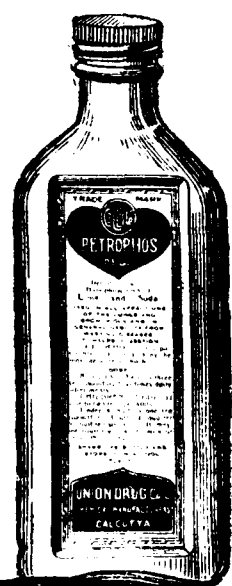
The Report under review is very instructive and interesting. The fact that in this Hospital all the medical officers excepting the Resident Staff are honoraries including the Principal Medical Officer, should be noted by the Bombay and other Provincial Governments as an example which, without a shadow of doubt proves, that important medical institutions could be run efficiently and with less cost by honoraries. The number of deliveries attended in the Nowrosjee Hospital for the year 1931 was 4467 and the number of patients admitted was 5869 and the average number of beds occupied was 117 per day, and the rate of mortality was 1.5 per cent; out of the number of 94 deaths 16 were ante-natal deaths and 78 post-natal. Research work was carried on in the hospital and short notes on each case of death are given. The report is highly interesting and shows that satisfactory work is done in the hospital. We offer our congratulations to Dr. M. V. Mehta, Principal Medical Officer and his colleagues who helped him and co-operated with him in making the work of the Hospital a success. It is culpable callousness on the part of the Bombay Government that in spite of the satisfactory administration of the institutions of the nature under review where excellent work is turned out by members of the independent medical profession, that they have not been able to realise it would be a sound financial proposition during these days of stringency to entrust Government hospital administration to the members of the independent medical profession. M. S. K.

THE ANNUAL REPORT OF RAJAH SIR RAMASWAMI MUDALIAR LYING-IN-HOSPITAL, MADRAS FOR 1930.

The Annual Clinical Report though described on the wrapper as such, has not a single line on Clinics inside it. It is simply a dismal display of figures and looks like an appendix to a report. If the report is intended to be read by persons other than those on the staff of the hospital, it is useless and cannot serve the purpose. If it is intended only for the use of the hospital staff it need not have been printed. The report is issued by the Corporation of Madras and it is inferred therefore that the hospital is maintained by the Corporation. Why should this special institution be maintained by the corporation is not known? Being a small hospital with 50 beds, it may be staffed by honoraries, and the Corporation, administered by the elected members, can show to the Government that a special hospital can also be run by honoraries. The number of deliveries attended to was 2137 and the mortality rate 1.7 per cent. M. S. K.

List of postings of Sub-Asst. Surgeons for the month of March 1932.

No.	Names of Sub-Asst. Surgeon.	From	To
1	Dr. N. A. Abraham	Leave	C/o P. D. B. Tanjore.
2	" S. Ramaswami Ayyangar	Cholera duty Coimbatore	Govt. Hd. Qrs. Hl. Trichinopoly.
3	" M. Lakshminarayana	Leave	Govt. Hd. Qrs. Hl. Nellore.
4	" M. Subba Rao	Government Hd. Qrs. Hl. Bellary	C/o P. D. B. Bellary.
5	" O. Krishnan Nambiar	Govt. Hd. Qrs. Hl. Salem	C/o P. D. B. Salem.
6	" P. Chokkalingam Pillai	Kaveripatnam	Leprosy Officer, Group VI
7	" P. K. Narayanan Nambiar	Group Leprosy Officer, Coimbatore	Govt. Hl. Attur. [district.
8	" K. Simbachalam	Government Hd. Qrs. Hl. Masulipatam	L. F. Dy. Sarungavarapukota (Vizag. Dt.)
9	" R. Someswara Rao	L. F. Dy. Sarungavarapukota	C/o Civil Surgeon, Vizag. Agency.
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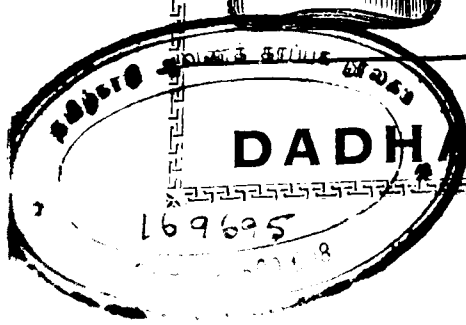
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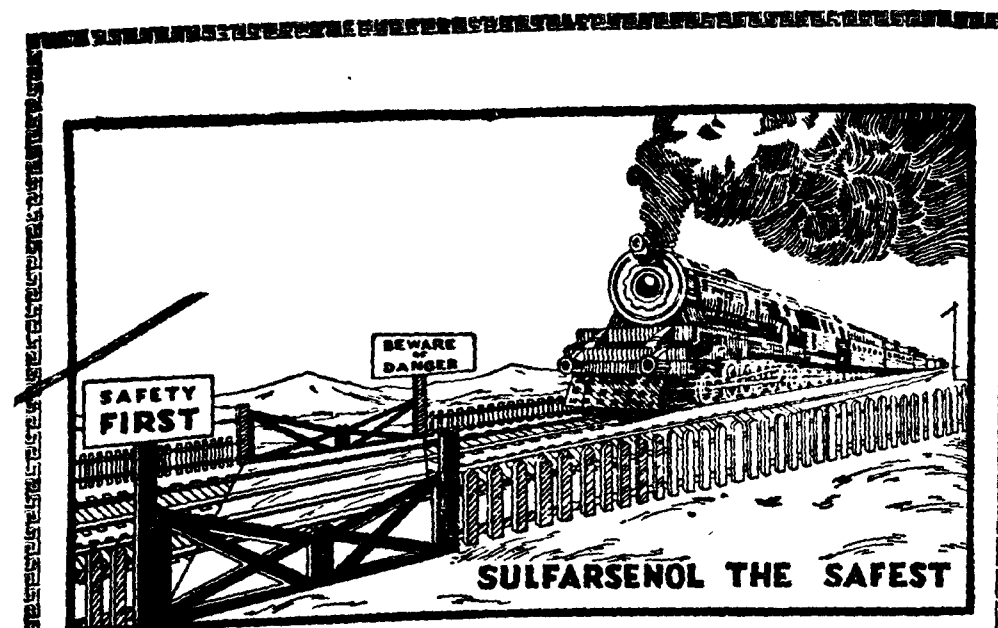
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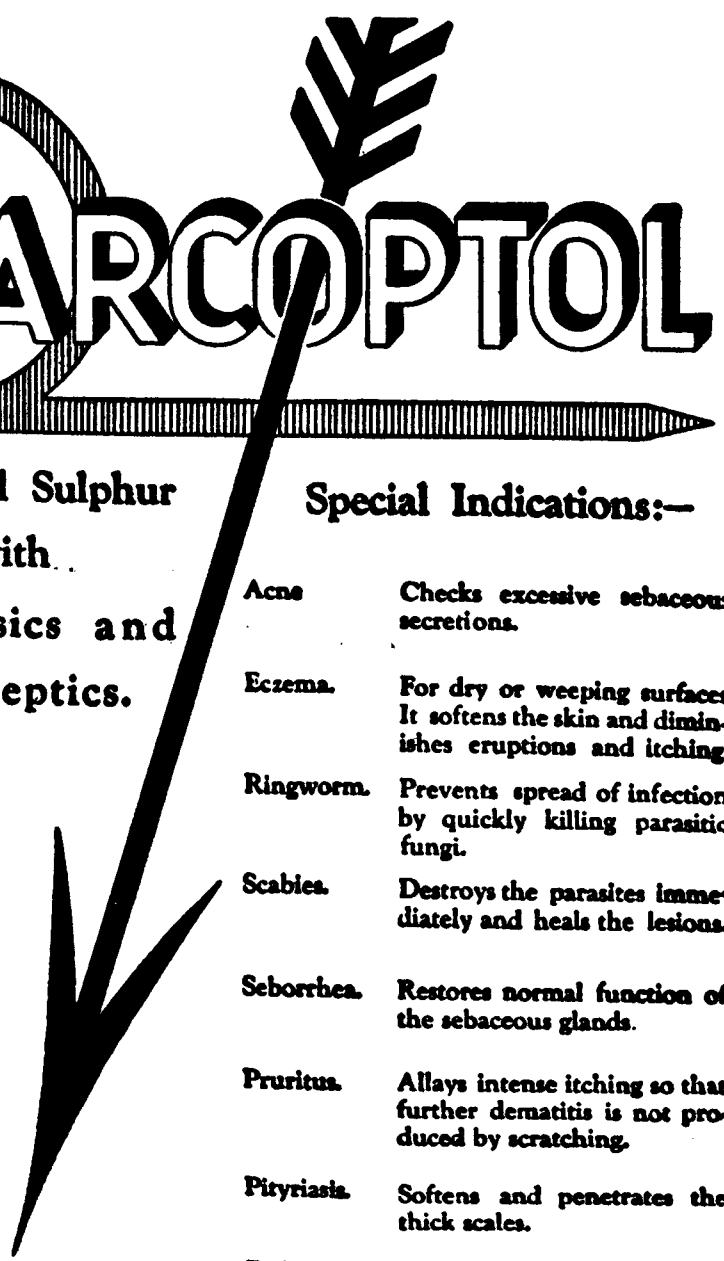


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