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THE Medical Practitioner

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ALL INDIA MEDICAL CONFERENCES.

Next month during the Christmas holidays two conferences of All India importance will meet, one the annual gathering of the Licentiates in India, the other a gathering of the medical profession as a whole of all grades both in service and outside. The former meets in Madras and the latter at Lucknow. There are only two medical Associations in this country which could be said to be representing All India interests in their activities. The older of the two which celebrated the Silver Jubilee at Darbhanga last year, is the Association of the Licentiates, a registered association which admits only Medical Licentiates. This was originally started solely for the purpose of redressing the grievances in service of the Hospital-Assistants now called the Sub-Assistant Surgeons but the rules of the Association permitted the admission of the practitioners holding the Hospital-Assistant Diploma. Naturally the destinies of the Association were guided solely by the Licentiates in service, though it has to be said that Licentiates in private practice did not grudge to render any service to the Association. The activities of the All India Medical Licentiates' Association were in direct proportion to the quantity of their grievances in service, some of which have been got over by persistant agitation conducted by the Association. It looks as if there was a lull in the activities of the Association. The Indian Medical Council Bill and the long standing grievance of the Licentiates regarding their Medical Education and such items affecting the life and prosperity and even the very existence of the Licentiates, have been fortunately rekindling the activities of the Association and it is really a sign of the times that the Licentiates in private practice in the city of Madras have been bestirring themselves for about a year to utilise the Association for various purposes affecting the interests of the Licentiates and the Madras Licentiates have invited the Annual Conference to Madras.

It is said that the wheels of the Association are not working smoothly not so much for want of oil or fuel but perhaps due to abundance of them. We eagerly hope that the Licentiates from all provinces of India and especially this province will muster strong at the conference and acquit themselves worthy of the purpose for which the conference is to be held. The Indian Medical Council Bill is still on its anvil, the latest news published in the press makes it clear that the Government of India is adamant and do not wish to swerve an inch from the path they chalked out while introducing the Bill in the Legislative Assembly. It is made plain that the Licentiates cannot find a place in the proposed Council till their educational standard is increased and that the Government cannot at present think of any reform in the Medical Education of the Licentiates on account of economic depression. They have made their betrayal more patent by reitereating that the purpose of the Bill is to get the University degree recognised by the British General Medical Council or in other words placate the G.M.C. The provincial councils have not been functioning satisfactorily and the Licentiates have not been allowed to enjoy

the rights and privileges of registration equally with the other practitioners in the Register especially with regard to the appointments under the Government—paid or honorary. The Provincial Medical Acts instead of levelling up the profession have so far been causing greater cleavage in the profession. The non-recognition of the Licentiates as Medical Examiners for the Insurance companies in India is another blot on the the Licentiates as general practitioners. The invidious distinction made between the Licentiates and the Graduates for School Medical Service is yet another grievance specially affecting this class. There are many other grievances which should find a solution in a gathering of All India importance. Last but not least importance is the question of Medical Education for the Licentiates. It is really a huge question the solution of which requires the serious attention of not only the Licentiates but of the profession as a whole. There is a splendid opportunity for the Licentiates of this Province to make a common cause with their brethren in other provinces, to compare and contrast their hardships both in service and private practice and bring about a solution of their grievances by an All India agitation, to do which, the All India Annual Conference that meets at Madras should be made use of both in individual interest as well as of the class as a whole. We learn that the Reception Committee have made it possible for the Licentiates who are not members of the All India Medical Licentiates' Association to take part in the discussion of the topics concerning the Licentiates' class. It is expected that the Licentiates in this Province will rise to the occasion and will take advantage of this gathering and make it a success.

The task of the Indian Medical Association at the All India Conference at Lucknow is certainly not less onerous, Though only four years old as a registered body the Association has made itself felt by the authorities. Being a non-sectarian Association absorbing in it all the qualified practitioners in the country, the activities of this Association have to be certainly more exacting as they have not only to look to the interests of the profession as a whole but also to the individual grievances of several grades that now exist in this country by virtue of different qualifications as well as different grades in service all such differences now working as water tight barriers preventing the growth of the medical profession as one homogenous entity. The first and foremost problem which should draw the attention of the Indian Medical Association should be the abolition of the castes in the profession. As in politics so also in the medical profession recognition of castes has been a great handicap against reforms. The Association has theoretically acknowledged equality of status of practitioners of different qualifications but unless this principle is practically carried out in actual working there is likely to be dissensions in the Association sooner or later and the very purpose for which this Association has come into existence will be frustrated.

The existence of paid service in this country has greatly hampered the growth of the independent medical profession. In addition to the rights and privileges enjoyed by those in service, they have special facilities for private practice being in charge of Government institutions; consequently state-paid doctors are having unequal and unwholesome competition with the private practitioners with the result that the latter are greatly handicapped. Apart from the unfair competition referred to above some of the state-paid practitioners have been abusing the privileges of private practice enjoyed by them and are running regular business as Chemists, conducting laboratories and even Nursing Homes and the Madras Government have been so far conniving at this if not actually encouraging. Such a development if not checked at once is likely to spread and hamper the growth of the independent medical profession.

Rural Medical Relief which is one of the most essential items in village reconstruction should engage the serious consideration of a gathering of the importance of one that meets at Lucknow. This is an All India problem which should find a solution at the hands of the leaders of the profession. Such and similar subjects which affect the life and prosperity of the rank and file in the profession should be first tackled by the All India Association with the idea of bringing about an uniformity in the working of such schemes throughout India. At present the so called subsidised rural medical relief scheme in the Madras Province is nothing short of indentured labour and

the local bodies who are entrusted with this scheme, run it as if the subsidised practitioners are menials employed under them, the monthly subsidy of Rs. 45 to 50 being reckoned as pay. For paid medical service, the rural area should have certainly the preference. Medical practitioners do not usually settle in villages for private practice as they cannot command practice enough for a bare living. In cities and important towns private practitioners have now settled in large numbers and medical relief may be safely entrusted to them. An organisation of paid medical service should be immediately started in rural areas with adequate pay to the practitioners. Money should be saved by entrusting the work in state hospitals in cities and towns to honoraries from amongst the members of the Independent Medical Profession.

All the agitation should first be directed for the amelioration of the lot of the members of the profession, finding out ways and means by which the practitioners can practice unhampered and be useful members for serving the public. The profession cannot be said to be overcrowded. For want of proper organisation to guard the interests of the members of the profession especially those in the rank and file, the medical profession is suffering from want of work. The elders in the profession work from the top instead of from the bottom. Their eyes are on the plums of office which are always at the top. The existing services have made these plums most attractive. This is why the energies of our leaders are concentrated to get these plums for the sons and daughters of the soil. We appeal to the leaders who meet at Lucknow that they should start agitation in right earnest of All India nature and get equal rights and privileges for all the members of the profession in the matter of the exercise of the profession in whatever capacity so that no invidious distinction is made between the state-paid doctor and a private practitioner or between two private practitioners of different qualifications in exercising the rights and privileges which are conferred on the qualified practitioners by virtue of registration. Regarding the displacing of the I. M. S. and other details of getting medial swaraj—so to say—the cries of the profession will be in wilderness until and unless India gets political freedom.

Before closing, we wish to refer to the Indian Medical Council Bill which is still on the anvil of the Legislative Assembly. This is the third time an All India gathering having an opportunity of discussing the Bill. As referred to above the Government of India do not seem to have taken any notice of the agitation regarding this Bill and we trust that suitable arrangements will be made by the Indian Medical Association to canvass the support of the members of the Assembly to their side so that the Bill is thrown out entirely to be reconsidered after India has a new constitution.

ANNUAL REPORT OF THE HEALTH DEPARTMENT OF THE CORPORATION OF MADRAS FOR 1931.

The Report shows improvement both in the get up and size. It is possible to reduce the latter by including small tables and statements with bigger ones as for instance Table F. may be included in Annual Form 11 by the addition of two more columns and the inclusion of infant mortality in Table D for easy reference. It is hoped that in course of time the report will be so drawn and got up in such a way as to compare favourably with the Public Health Department Reports.

POPULATION.

The last Census showed an increase of 22·8 per cent and the increase is said to be "phenomenal". It is well known that in 1921 non-co-operation movement was very prevalent and acute and that in certain places supervisors and enumerators declined to do the work and the public also refused to supply information. So it is highly probable that in the last census there was under enumeration and if it had been correct the increase in this census will not be high. Coming to the figures in this census, it is stated that the number of infants under one year in the city was 13469. It is well known that when giving the age of a child parents are likely to give one year even though at times it is one year and a few months old. So the number 13469 may include some older children also. According to the vital statistics of the city returns the number of births actually registerd in 1931 was 25738 exclu-

ding still births and the actual number of infants that died during the year was 6391, leaving 19347 cases living. It is assumed as is done always that the number of infants born in a locality is equal to that born outside and brought into the locality. The difference therefore between 19347 and 13469 amounting to 5878 is appalling and gives an idea of the accuracy either of the census or the vital statistics registration in the city.

It is stated that the transference of such a vast population into the city was possible by the enlightened policy of the Corporation in launching the Mambalam extension. The census figures given for each division works out the variation in the population from a decrease of 9% in Muthialpet division to an increase of 53% in Thondiarpet and Korukupet. The Royapettah division in which the Mambalam extension is included gives only an increase of 45 per cent, while Mirsapat 46 and Perambur 49 per cent, show an increase more than that of Royapettah. The increase in Royapettah for 10 years is 45 per cent and the population of Mambalam in 1927 was 1880 and the later could not have been increased by 45 per cent in the last 4 years. Any body seeing the place will be convinced that it presents a deserted appearence and almost every day sale advertisements of sites, half built buildings are published in the papers. The site is low and during rainy season except the roads and the houses, the rest are filled with water. The question for consideration is whether the Corporation is justified in lavishly spending such a large amount of money in the making and maintaining of roads and lighting to serve such a small population while streets and lanes in other parts of the city with a larger population are neglected.

The increase of population in the different castes and races works out as follows: Europeans 22 per cent, Anglo Indians, 18 per cent, Indian Christians 24 per cent, Mohammadans 32 per cent, Hindus 21 per cent and others 53 per cent. Among Hindus, Brahmins show an increase of 29 per cent. Chetties 4, Vellalas 24, Balijahs 21, Vannia 38, Adi Dravida 25, Patnavars 8, Yadhavas 11 and Kammalas 14. The most interesting point worthy of note is that while the total number of deaths was in Balijah 14126 and in Vannia 19613 during the last seven years for which figures are available and exceeded the total births 12107 and 19516 respectively, that in the census year 1931, the Balijah community shows an increase of 21 per cent and Vannia 38 per cent. Does it mean that these two communities had largely migrated into the city, when the census was taken? This is hardly believable. Either the vital statistics returns or Census figures or both are unreliable.

GENERAL BIRTH, DEATH AND INFANT AND MATERNAL MORTALITY.

The general birth rate for the year was 39·8. It was the highest among the Mohammadans 41·6 followed by the Hindus 40·4, Anglo Indians 35·8, Indian Christians 34·2 Europeans 13·4 and "others" 0·3. Among "Others" whose population is 2901 there was only one birth during the whole year while among Europeans whose population is 3581 a little over that of "others" there were 58 births, seems unreliable and requires investigation.

The general death rate was 35·8 and the Mohammadans top the list with 39·9 followed by Hindus 36·5, Indian Christians 26·8, Anglo Indians 25·0, Europeans 6·7 and others 1·0. Even in the matter of death that only 3 persons died among "others" is hardly believable and also requires investigation. Among the Hindus the highest was among the Patnavars 47·3 and the lowest among Brahmins 20·4. The death rate among Adi Dravidas, Patnavars have exceeded their birth rates and it is very striking in the case of the latter and demands enquiry.

The infant mortality among the general population was 24·8. In other words nearly one fourth of the number of infants born die before they complete their first year of life. There does not seem to have been any appreciable decrease in the rate in the preceding decade and the small variations shown in several years of the decade may be accounted for by the efficiency or otherwise with which the vital statistics had been collected. That the operations of the Child and Maternity Welfare Scheme have had very little effect in this matter is now clear. It is stated by an eminent authority that "Go where we will and examine what statistics may be available, what we find invariably is that a high birth rate and a high infantile mortality rate go together. More children's cradles imply more children's coffins. This is the case all over the world. An enormous unchecked number of births and a correspondingly high number of infants destined never to emerge from infancy." Any measure adopted, therefore, to bring down the infant death rate which does not also reduce the birth rate will ont only fail but involves a waste of money. The truth of the above statement is borne out by the birth rate and infant death rate of the different castes in the city. The Europeans whose birth rate is the lowest have the lowest infant death rate while the Mohammadans whose birth rate is the highest have also the highest infant death rate. The infant mortality of Patnavars is given as 120 for the year under review and their death rate is highest 473. The figure 120 seems therefore unreliable and demands enquiry.

The Maternal mortality rate for the year is 11·4 per 1000 births. Before making comparison it must be known whether all deaths occurring after child birth are returned under "child birth." Some time back all deaths occurring within a month of child birth were returned under that heading. Unless each death occuring among women after child birth is seen and examined by medical men, no correct inference can be made on the fall or rise of the deaths returned each year.

CHILD WELFARE SCHEME.

This department was under the direct control of the Health Officer till October when it was placed under the independent charge of the Lady Superintendent. Sometime back the Conservancy department also was removed from the control of the Health Officer and placed under an independent officer—afterwards brought back and placed under the Health Officer. This reminds one about parasites which, in order to complete their cycle of life, pass some portion of their existence outside their hosts. Not only the Child welfare scheme was separated from the Health Officer but the report of the Lady Superintendent is removed to the end of the report of the Health Department.

The incorrect and insinuating statement given in the last report and which were criticised in these columns, exhibiting lower incidence of Maternal mortality among the cases attended under the Scheme, than that obtained in hospital cases without mentioning that all the cases attended by the C.W.S. were normal cases while most of the cases admitted into the hospitals including the cases sent by the C. W. S. were difficult cases, are happily absent in this report. We pointed out in reviewing the last Administration Report that the bathing of infants and supplying free milk to them are not important duties and we are glad to note that the Director of Public Health also pointed their uselessness. The Lady Superintendent however states that without bathing and free supply of milk the Child Welfare Scheme will be incomplete.

It is stated that of 13514 cases of labour that came under the care of the scheme only 10449 normal labour were actually conducted by the scheme and 1244 difficult cases were sent to hospitals. The number of deaths that occurred among the normal cases actually conducted by the scheme was 8 and the rate works at 0·78 and not 0·61 as given in the report. The same mistake was made in the last report also. The maternal mortality of 0·78 in normal labour conducted by the trained and carefully supervised midwives compared with the rate of 1·1 obtained in all cases—normal and difficult and unattended by any midwives in the city, cannot be said to be satisfactory and does not reflect any credit on the Scheme. It is for difficult cases that skilled assistance is required. If the C.W.S. is intended only as a clearing house to select difficult cases and send them to hospitals, the utility of spending money on this scheme and the existence of a large number of lady doctors—13 in the staff—are not clear. Poor patients cannot afford to secure the services of private doctors and the accommodation in the maternity hospitals is limited. As long as private doctors attend cases in the houses of even poor patients why not the lady doctors attached to the scheme do the same? Not only do the lady doctors not attend and assist the scheme midwives, but the latter do not remain or assist the private doctors when called in to conduct labour. There is no meaning in the lady doctors and Health Visitors making visits. They are absolutely useless. In the place of Health Visitors of whom there are 30, qualified midwives may be

appointed and if the lady doctors cannot attend difficult labour cases in the houses of poor patients their services are of no use and may be dispensed with. The treatment of puerperal and other diseases as out-patients may very well be done at the several maternity hospital dispensaries in the city.

The same mistake committed in the last report of calculating infant mortality and comparing it with the city mortality rates calculated on a different basis, is persisted this year also. We think if the corporation authorities or the Director of Public Health would not look into matter and bring home the mistake of the C.W.S. the figures will continue to vitiate the report.

The intimate connection of Birth control with Public Health and Maternity welfare Scheme is not yet recognised. The following observation of Dr. August Forel, M.D. is worth quoting in this connection. "To build an ever increasing number of hospitals, asylums for lunatics, idiots and incurables, reformatories etc., to provide them with every comfort and manage them scientifically, is undoubtedly a very fine thing, and speaks well for the progress and development of human sympathy. But what is forgotten is, that by concerning ourselves almost exclusively with human ruins, the results of our social abuses, we gradually weaken the force of the healthy part of our population. By attacking the roots of the evils, and limiting the procreation of the unfit, we shall be performing a work which is much more humanitarian, if less striking in effect."

Original Articles

RECENT ADVANCES IN OPHTHLMOLOGY.

THERAPEUTIC AND OPERATIVE.

By

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(Continued from the previous issue)

Next, I pass on to the subject of improvement of vision by glasses, and the latest developments in that branch of our work. The outstanding new piece of work in that field is the use of contact glasses.

CONTACT GLASSES.

These are thin transparent glass shells, which are worn by the patients in their conjunctival sacs, over the eyeballs. They are made by Zeiss (who grind the glasses) and by Muller of Weisbaden (who blow the glasses). Zeiss supplies two trial sets of test contact glasses, varying in their scleral measurements and corneal radii; the inner corneal surface radius is the same; the outer surface is ground with a + or — sphere worked into it. Muller's glasses resemble the shell artificial eyes, with a central transparent portion. In the Zeiss variety, when worn, there is a fluid meniscus between the cornea and the glass, but in the Muller glass, there is no fluid meniscus. No air bubble should be present in either case. They are very useful in cases of conical cornea, high myopia and irregular astigmatism. In some cases, vision is improved from 6/60 to 6/6 or 6/9 by the use of these glasses. They have been used also for protecting the eyes in cases of lagophthalmos and spastic entropion, when they are worn at night, and also as tinted glasses in cases of photophobia.

DUOCHROME TEST.

A new apparatus for the subjective test of the patients' visual acuity, known as the duochrome, has been put on the market. The principle underlying this is that in the normal eye, red rays will be focussed behind the retina and green rays in front of the retina. On this apparatus are illuminated test types of red and green; a myope sees the red clearer and a hyperope the green clearer; glasses are put in front of the patient's eye till the red and green types are either both clear or equally blurred. There is also an astigmatic chart worked on the same principle on this apparatus. With this apparatus it is possible to correct one's error of refraction to within 0·12 D whereas a retinoscopy can correct to within 0.25 D only. It is very useful for checking up the final results obtained by the usual method, and is certainly much appreciated by intelligent patients.

TRIFOCAL GLASSES.

Trifocal glasses have been used in America for some years and are being used more and more now in England. With ordinary bifocal lenses, the patient gets clear distant vision and clear near vision, but he feels unhappy for the intermediate distance—say from 5 meters to within the limits of his usual near working distance. A third correction for this intermediate distance is certainly an advantage in many cases; this can be inserted at the top or at the centre of the glasses according to the purpose for which the correction is required. The usual bifocals have another disadvantage—the patient when using them finds it very difficult to go up or come down a staircase for which he has to make use of the reading portion of his bifocal glasses. This difficulty is obviated by using "a bifocal lens with a raised reading segment," leaving a narrow strip of 2 or 3 mm. of the distance correction lens below it. Multifocal lenses (Ultifo) introduced by Gowland of Montreal (1922) has a variable reading curve.

TELESCOPIC OR GALILEAN SPECTACLES.

Where a combination of lenses is arranged as in an opera glass, it is found useful in cases of retinal diseases and high myopia. The glasses magnify the retinal image and increase the impaired power of vision. Spherical and cylindrical corrections can be incorporated into this. The disadvantages are that the clear field of vision is reduced and that the spectacles are very expensive and heavy for constant use. Zeiss has made a trial case of these telescopic lenses.

In lenses for aphakic eyes, there is found to be a considerable amount of astigmatism when the patient looks obliquely through them. This is obviated by the "aspherical lenses suggested by Gullstrand in which the periphery of the lens has a different curvature". Another improvement in the glasses for these patients is the "lenticular glasses" in which only the central portion has the high power lens ground into it. This reduces the size and weight of the lens.

RECENT ADVANCES IN OPERATIVE TECHNIQUE AND OPERATIVE METHODS.

Local anæsthesia has always been to the ophthalmologist of greater use than general anæsthesia in his operative work. During recent years, we have been using local anæsthesia in a much larger number of operations, and general anæsthesia is now reserved for children and for cases of large tumours and inflammatory conditions of the orbit, and major plastic operations of the lids involving the face also. Novocaine has always been our choice for infiltration anæsthesia. There have been two important and valuable aids to our operative work during recent years i.e., the blocking of the facial nerve and the blocking of the ciliary ganglion. The facial nerve is easily blocked by a novocaine injection given over the lower jaw just below the condyle (O'Brien's method); this paralyses the orbicularis palpebrarum and prevents the patient from squeezing the lids over the eye during operations. The blocking of the ciliary ganglion makes operations on the eye absolutely painless and enables us to do iridectomies in glaucomatous and iridocyclitic eyes without giving the patient any pain. For these cases we had to use general anæsthesia formerly. Now enucleations and eviscerations are ordinarily done under local anæsthesia.

Among ophthalmic operations, perhaps the only new operation is Gonin's ignipuncture for detached retina. In these cases, the tear in the retina is located first and then puncture of the sclera over the site of the tear is made with a cautery, the cautery point being pushed into the eye so as to sear the edges of the tear and make the tear close up. Thermocautery is preferred for this purpose. Ignipuncture may have to be repeated in some

cases; sometimes failure is due to there being more than one tear or probably another unrecognised tear. Location of the retinal tear is very difficult. If the vitreous is thick, coaptation of edges of the tear is difficult. Elschnig says that in cases occurring in myopia of high degree, as the vitreous is very fluid, there are better chances of success. In large detachments, a preliminary puncture is done, the subretinal fluid evacuated and then the proper ignipuncture is performed. Prof. Gonin got a definite cure in about 60% of the recent cases (7). Early cases are more hopeful and the younger the patient, the better the prognosis. Prognosis is less favourable in detachments at the macular region. Lindner gets 24 to 64% of success; he says that 12% of old detachments are capable of improvement. At Moorfields Hospital, out of a total of 75 cases, nearly 50% improved and over 30% were definitely cured. This operation has certainly revolutionised the treatment of detached retina.

OPERATIONS FOR SENILE CATARACT.

Removal of the lens in its capsule is certainly the ideal operation but, especially for the average operator, many serious complications are often met with during and after the operation, the chief ones being an escape of the vitreous or its prolapse or impaction in the wound, with their subsequent after-effects. Smith's method is good in the hands of experts but the tendency for complication is greater than in either the Barraquer's or Stanculeanu-Torok method. In Barraquer's procedure with the erisiphake, one has to remember that the instrument, when carelessly applied, can bring on disaster; the iris may be caught in the suction cup or the suction cup may slip and, the zonule giving way, may suck out vitreous. In some cases the capsule may burst and one is not often successful in cataracts with very soft cortex or friable capsules. In young people, the zonule offers great resistance, and delivery by this method may be very difficult. In Stanculeanu-Torok method, where the lens is delivered in capsule by holding on to it with a pair of blunt pointed forceps, very little harm is done even if the portion of the capsule happens to come away (without the lens) in the grip of the instrument; this method is largely advocated in the continent of Europe by Elschnig and in America by Knapp, and deserves extended trial in this country; very little pressure is exerted on the eyeball; thus it is the safest of the three methods of removing the lens in its capsule.

The "capsulotomy" method is the safest and most popular of the operations for senile cataract; the disadvantage of retained cortex and capsule, with their sequelae, is the only point against it. New procedures advocated, and very usefully too, in these operations are additional control of the eye by blocking the facial and ciliary nerves by injections of novocain. Conjunctival bridge flaps made during the section give added security; the section can also be secured, with some additional trouble, by stitches either conjunctival or corneo-scleral.

OPERATIONS FOR GLAUCOMA.

A broad based *iridectomy* is still considered to be the best operation in all acute and inflammatory cases. The aim of the operator in cases of chronic glaucoma is to produce a filtering channel just outside the limbus, subconjunctivally, without having a large bleb or a thin conjunctival covering over the sclerectomy opening.

Sclero-corneal trephining still holds the field in all English-speaking countries as the operation of choice for chronic primary glaucoma. The two drawbacks of this operation are said to be hypotony and late infection; these are met with very rarely. A thin bleb over the trephine hole can be prevented either by dissecting out a thick conjunctival flap or in cases where the subconjunctival tissue is very scanty by putting over the trephine hole a graft of tissue taken from the capsule of Tenon.

Cyclodialysis (Heine) is largely practised on the continent of Europe, and is said to be good in simple glaucoma, glaucoma secondary to cataract extraction etc. Holth gives a warning about the possibility of cataract formation after this operation, due to atrophy of the ciliary body.

Iridencleisish as been advocated largely by Herbert, (8) from his observation that iris inclusion in a corneoscleral wound produced a filtering cicatrix. This operation is not recommended in cases associated with present or past iritis or iridocyclitis. The one objection that is put forward against this operation is the possibility of risk of sympathetic ophthalmia. Holth advocates an iridencleisis with a meridional iridotomy as a better procedure giving more satisfactory results.

ALCOHOL INJECTIONS.

Hughes (9) recommends an injection of 0·2 to 0·3 cc. of 95% alcohol into the outer portion of the orbicularis palpebrarum of the lower lid to correct a spasmodic entropion. A preliminary injection of novocaine is necessary to obviate pain. (Novocaine added to the usual cyanide of mercury injections is also very useful.) Retrobulbar injections of alcohol, after a preliminary novocaine injection, have been recommended for painful blind eyes.

SHALLOW SOCKET, after removal of an eye, which does not retain an artificial eye is fairly common; the lower fornix being especially shallow. These are satisfactorily treated by anchoring, with stitches, the lower conjunctival fornix to the periosteum of the rim of the orbit (Greeves.)

ENTROPION is very satisfactorily treated by Webster's operation of splitting the tarsus from the conjunctival surface along the line of cicatricial contraction, spreading it out and filling the gap thus produced with a mucous membrane graft from the mouth.

CICATRICIAL ECTROPION is dealt with by freeing the lid, dissecting away cicatricial tissues, doing a preliminary temporary tarsorrhaphy and filling the bare area with a "whole skin" graft; or a buried graft according to Gillies's method may be used.

CORNEAL FISTULAE. Different methods of putting conjunctival ribbon flaps to cover the fistula after a preliminary cauterisation of the edges of the fistula have been successfully adopted. Of course it is a difficult procedure but often a good result can be obtained.

TATTOOING OF THE CORNEA for leucoma has been tried successfully (with better results than with Indian ink) by gold or platinum chloride solutions. The epithelium over the leucomatous patch is scraped after anæsthetisation, and the eye washed with distilled water. A 2% solution of platinum chloride is applied over the raw surface with a swab for 2 minutes; this is fixed by the application for 25 seconds of a freshly prepared 2% solution of hydrazine hydrate. The eye is then irrigated with sterile water and finally with normal saline for 2 minutes. This procedure is said to give a very good result. In our experience, the result though good to start with, the colour began to fade after a week or so in most cases. This procedure is certainly worth an extended trial.

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10. Practice of Refraction by Duke Elder.

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*THE NUTRITION OF THE SCHOOL CHILD.

By

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Newer knowledge of nutrition tends to emphasise the growing importance of proper nutrition in the maintenance of health, prevention and cure of a large amount of ill-health aud crippling foreshadowing great possibilities of savings in health and money to the nation. The school child abroad has improved considerably in stature and weight on account of the increasing attention to nutrition, such as the introduction of supplementary meals or school lunches, school canteens, milk clubs, nutrition classes, etc.

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This paper is based on the results of routine medical inspection and additional personal investigations carried out during the period 1925-1930 in the district of Nellore. Impressed with the possibilities of preventing a good deal of poor health by slight alterations in diet, the writer collected data regarding the types of diets, the common foodstuffs in use, the timing of meals, etc. Attention was then concentrated on three important features: (1) the consumption of milk and buttermilk, (2) use of lentils, legumes, nuts, etc., and (3) the place of fruits in the diet. The interesting fact was revealed that nearly 80-90% of boys use buttermilk daily or very frequently. Attempts may be made to improve the modes of preparation, the quality, etc., and to supply it in schools or in their homes. Legumes, nuts, etc. may be brought into fashion. For the poorer people, bananas, or even the country fruits are quite as nutritious as the costly oranges and batavias.

Application of recent advances to practical dietetics are discussed in detail. The calorific needs of children, the minimum and optimum requirements of protein, carbohydrates, and fats, the neglected but cheap sources of these in South India, the necessity of a well-balanced diet to health, the importance of mineral and vitamin requirements to the proper functioning of the body and mind, the composition of milled and unmilled rice in relation to its vitamin and mineral content, the value of using the whole cereal grains particularly of the grain embryos (like Atukulu) as possible sources of nutrition, the desirability of increasing the availability and quality of milk and buttermilk to children, are some of the points discussed. Under the heading of nutritional factors of lesser importance of cooking as an aid to digestion, the satiety value, the roughage value, etc. of diets, and the great role played by phychic influences preceding and accompanying the act of eating are emphasised. The paper concludes with an appeal to the Health Propaganda Board to popularise these physiological principles of nutrition among the teachers, the pupils and the parents.

NEWER KNOWLEDGE OF NUTRITION: Nutrition has been defined as "the sum total of those processes by which the living organism receives and utilises the materials necessary for the maintenance of life." In few departments of Medicine are such rapid studies being made as in the Science of Nutrition. Apart from the special diets prescribed as an aid to Medical treatment from the days of Hippocrates, investigators have developed elaborate schemes or regimens of diets, which are said to form, by themselves, the complete treatment of certain diseases, (i.e., Gerson diet for Lupus, diabetic diets). Over and above all these, are the modern conceptions of the importance of nutrition In relation to health, prevention and cure of disease. Water metabolism and mineral requirements of the organism have all been assigned considerable importance in the normal functioning of the body. The great discoveries of our own century are the Vitamins, whose absence in diets for long periods, causes not only the well recognised types of deficiency diseases, but also produces in the organism and in the major section of a community a complex, though mild and unnoticed, series of changes, causing or later predisposing to ill-health, and an ever increasing list of maladies. Macleod quotes an old adage. "Horses work best when they are well fed and feed best when they are well worked." Need it be emphasised that the statement applies with equal force to boys?

Great possibilities of national savings in health and money are foreshadowed by the latest advances in nutrition; health may be insured; efficiency doubled or trebled; minor ailments almost wiped out and constitutional diseases or crippling reduced to the lowest level.

THE SCHOOLCHILD: Sir George Newman's valuable annual reports on the "Health of the Schoolchild" form fascinating studies concerning the health of the future citizens of the Empire. "The more we are able to nourish our children from infancy upwards by foods, fresh air and exercise, the greater will be our contribution to the prevention of rheumatic fever." Comparing the appearances of school children of 1894 and of 1924, Sir George affirms that there has been "an advance in the nutrition of the schoolchild and that consequently the child is growing in stature and weight."

The value of regular weighing of children either at two or three monthly intervals (instead of an annual stock-taking) has been brought into prominence recently. Those who do not gain weight in three months are thereafter considered as "Specials" for the purpose of subsequent examinations.

Careful enquiries have also revealed that "more often it is careless mothering than actual shortage of food which results in malnourished children." The need is qualitative and not only quantitative. To recompense for any defect in the diets served at home, supplementary meals have been given in schools. 4½ million milk meals and 700,000 cod liver oil meals were supplied to London school children in the course of the year 1928. It is interesting to remember that school lunches for children were established by Count Rumford (1792), were revived in "Case des ecoles" of a French Battalion in Paris in 1849 and became permanent by law in 1882. Victor Hugo started a school luncheon movement at Geurnsy in 1866. England took up the movement in 1902, while New York commenced the School luncheons in 1908.

Another simple but efficient method was the introduction of school canteen, the motto of which has been "wise buying, good planning of menus and attractive cooking". These are run by specially trained nutrition workers, under the auspices of the parent-teachers' associations.

Milk clubs are rapidly becoming popular. To extend the advantage of milk to all children, a scheme has been devised in Birmingham and Liverpool, whereby a milk club is formed in the school. Every member brings one penny per diem and gets 1/3 pint of pure milk in the schools. Nutritional clinics have also been started in schools. Nutrition workers visit the homes and get the parents and children interested in nutritional problems in a practical manner.

The writer was one of the few who started life as medical inspectors in the year 1925, when medical inspection was made compulsory. In the course of the first two years, as a result of inspection, compilation of data, forwarding of cards to parents, re-examination of children, and of investigations how far the children had adopted and benefited by the advice given on the previous occasion, a general impression was created that most of the minor ailments disappear with or without the medicines suggested, but recur frequently, that most of the parents find it impossible or dislike to place the boy under the observation and treatment of a qualified medical practitioner, and that food tonics like cod-liver oil, bemax, etc. are too costly for the average householder to continue their use over the long period of growth of the child. A fool-proof, universal and permanent means of preventing or curing most of the diseases of the children appeared to be the ideal, the nearest approach to which was achieved by concentrating all the attention on the state of nutrition of the child, as a simple measure towards the ideal of the maintenance of health and cure of disease, instead of simply suggesting some palliative or symptomatic treatment (even that not often carried out) for dental caries, tonsils and adenoids, enlarged glands in the neck, mild chronic infections of the respiratory tract, anaemias, functional disturbances of the heart, chest deformities due to rickets or appearances predisposing to tuberculosis, etc.

Animal experiments and clinical investigations have also indicated how by attention to details, such as the deficiency in the qualitative character of the food, the body is helped in the harmonious regulation of normal health and much minor or severe illness can be easily avoided.

The writer had the opportunity of observing the work of the school medical officers in Edinburgh and Glasgow, in 1928-29. The campaign for more milk to the child was gathering force. The reports on the marvellous growth-stimulating properties of milk, the investigations into the composition of the diet of the school child, the feeding experiments in progress in Britain, stimulated the writer to think of similar work of ascertaining the existing conditions and investigating the possibilities of improvements, according to the needs and available sources in South India. As buttermilk and ghee were consumed in large quantities an investigation at the Usher Institute of Public Health, Edinburgh, was contemplated to assess the nutritional value of buttermilk and ghee. But, on account of the practical difficulties of securing

reliable and representative samples, the work could not be proceeded with.

Accordingly, during the subsequent medical inspections, the pupils were specially examined with reference to their state of nutrition and questioned about the details of the diets, with a view to find out the common factors and to make up for the deficiencies.

An examination of the percentages of malnutrition reveal the following :- (1) The percentage of malnutrition in the higher forms (IV, V and VI) appears to be higher in bigger towns like Nellore than in smaller towns like Kavali, where the diet savours more of the homely rural type than of the town type. (2) Figures for Forms I, II and III showed wide differences in some schools, and these could be roughly correlated with the variations in the relative strength of different communities, of varying social and economical status. (3). The boys in the lower classes, containing lower age-groups, being quite young, perhaps neglected at home or requiring more food for their rapid growth, showed a greater incidence of malnutrition as compared with the boys of the III Form and classes above, who are also becoming vigorous fighters for more and better food at home.

It is evident that the groups showing higher percentage of malnutrition, also have a comparatively higher incidence of dental disease, enlarged tonsils, glands in the neck, etc.

May I be permitted to add that in estimating the percentages of malnutrition, as done at present, the personal equation may be responsible for a wide range of variations and that the figures of various observers cannot justly be regarded as averages or representative for purposes of comparison.

More detailed investigations regarding the quality and arrangement of diet brought out the following information. The vegetarian diet invariably consisted of rice, pepper-water, with a vegetable curry. Less frequently but commonly, dholl in varying amounts, chutneys, leafy vegetables, tubers, are taken. With regard to the vegetables, apart from the seasonal limitations, there are also social and economic considerations rendering the field of choice very limited. There is great scope for private or co-operative effort to supply towns with a variety of vegetables, instead of leaving the population at the mercy of a few ignorant agriculturists. The non-vegetarian diet, had in addition to rice, meat or fish usually once in a day, supplemented with a vegetable or rasam. Fish vary from the small cheap types in poorer houses to the large-sized ones in middle-class families. The poorest labouring classes lived on ragi porridge, rice conjee and cheap leafy stuff like "gongura." On the whole, the non-vegetarian diet was less varied, less in amounts, than the vegetarian types. The arrangement of meals was roughly as follows: The child takes something before coming to the school in the mornings, (tiffin and coffee in well-to-do houses, rice and conjee or butter milk in the middle classes, and practically conjee alone in the lowest classes). At about 12 or 1 in the midday he hurries home walking varying distances, gulps down what is placed before him often without relishing it, and rushes back to school. This midday meal may be a sumptuous dinner of the rich, the frugal meal of the lower middle-class, or the rice and conjee or rasam or ragi and chutney only in poor homes. In the evening, very few children get anything comparable to "evening tea." At night, the same type of diets are taken. The quantities consumed vary considerably according to the appetite, the boldness of the child, on the one hand, the economic condition, size of the family and the intelligence of the parents on the other.

As these variable factors cannot be easily altered by the recommendations of the medical officers, it was considered that the easiest way to attack the problem was to get an idea of the use of milk and milk products, legumes, fruits, etc. in the ordinary dietaries of the children.

MILK AND MILK PRODUCTS. There was a small group of children who used milk as a drink or mixed with rice daily and regularly. There was a second group who took coffee daily once or twice and thus had some quantity of milk. A third group took milk frequently but not daily or

regularly. The last group never took milk at all and this was the largest.

Those who come from the upper middle classes took ghee always, with every meal. The lower middle classes took ghee sparingly. The poorer classes never could afford it. There was a small percentage of boys who took butter or cream.

With reference to buttermilk, many interesting points were revealed. In the well-to-do classes, curd was more popular, though butter-milk was also used. All the middle classes invariably had buttermilk almost daily as an item of diet. But what was most surprising was the revelation that even the humblest, the poorest, lowest class boy was taking buttermilk, daily and regularly. There were some who took it frequently not daily. The number of those who do not take buttermilk at any time was inconsiderable.

The state of the nutrition of the children was correlated to these findings. All children were divided into three classes for this purpose, those showing evidences of fair nutrition (Class A), those showing less satisfactory but average nutrition (Class B), and those whose nutrition was distinctly below par or very poor indeed (Class C). Boys taking milk and buttermilk always showed the highest percentage of Class A boys. The group taking milk only or coffee showed the same percentage of Class A and Class B boys as the groups taking only buttermilk regularly. The group taking neither buttermilk nor milk showed a small percentage of Class A boys, but showed a large percentage of Class B. A curious feature was that the percentage of Class C boys was practically the same in all groups. Much more detailed and individual study is required before all these can be explained, but one principle may be accepted that, since buttermilk is used by a large section, efforts may be made to improve its quality and purity and to institute buttermilk drinks in the schools, instead of allowing the boys to buy sweets and sodas.

Similar data regarding the use of dholl suggested that there is need of increasing the quantity of dholl used. Legumes, so common and cheap in India, are taken advantage of only by the poorest and lowest classes, while the well-to-do classes, except in rural parts, look down upon these very useful sources of proteins. Nuts are also very much neglected and the public are still to be taught that nuts, though not fashionable here, are all the same, very nutritious and that the biological value of nut-protein is equal to that of meat. Fruits and fruit juice are considered necessary only to invalids or infants. Oranges are in fashion. The ordinary boy could, and ought to, eat bananas daily, as they are always available and cheap. It is an irony of fate that the Americans should point out to us that banana has not been accorded the place in the diet to which it belongs and that it is the fruit particularly good for children, desiring weight, apart from its vitamin values. Country fruits and country nuts are all cheap and easily available and the boys should loose no opportunity of eating these, provided they do so in moderation and take only ripe fruit.

(To be continued).

Abstracts

THE DIAGNOSTIC VALUE OF THE VON PIRQUET TEST.

BY

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The skin test for the detection of active tuberculosis, perfected by von Pirquet, of Vienna, in 1907, has been used so little, by the large proportion of practitioners, that its value as a diagnostic procedure is little or not all understood. In view of the recent activities of the state departments of health in this field, it would seem desirable to have at hand a concise statement of the why's and wherefores of that test, in order that the practitioner may use it with intelligence.

TUBERCULIN.

The test, in its present form, is the result of a discovery, by von Pirquet, that the skin reacts in characteristic manner after vaccination with Koch's tuberculin. In 1890, Koch prepared what he called tuberculin and erroneously attributed to it curative properties. It is an extract of a glycerin-bouillon culture of the tubercle bacillus, at least six weeks old, which has been sterilized in the autoclave and then concentrated in a water bath to one tenth its volume. So prepared, tuberculin is a syrupy liquid, containing many dead tubercle bacilli.

When this fluid is injected into a healthy person or animal, it produces no reaction, either general or local. However, when it is injected hypodermically, even in small doses, in a patient having tuberculosis in any of its forms, there appears, within 48 hours, a marked elevation of temperature, which continues for about 12 hours. Moreover, there is a very lively reaction at the tuberculous focus. Thus, if there was a tuberculous nodule at the apex of a lung, one would observe an exacerbation of the cough, increased expectoration and more numerous rales—Koch interpreted this reaction as a necessary method of eliminating a tuberculous focus, preparatory to subsequent cicatrization. It is really the beginning of an aggravation of the disease.

As a means of treatment, tuberculin was soon abandoned, but continued to be used by veterinarians as a means of diagnosis. The subcutaneous injection of tuberculin in man, for diagnostic purposes, was also tried, but there were so many disadvantages that it was discontinued. It is manifest that, if the test is to be of any value, the patient must be free from fever at the time of the injection. Moreover, it is necessary to use doses large enough to provoke a reaction that is not doubtful. Such doses often light up a disease that was in a quiescent stage. For these reasons, the use of tuberculin has been almost entirely abandoned in medical practice.

In 1907, von Pirquet, in the light of what he had observed in his researches on anaphylaxis, conceived the idea of testing the effect of a drop of tuberculin on a denuded surface, as suggested by what he observed in the use of smallpox vaccine, and in this way perfected the test which bears his name.

TECHNIC OF TEST.

The technic of the test is very easy. A skin area is chosen (preferably over the deltoid muscle) which is clear and free from any dermatologic lesions whatsoever. After cleansing with some mild antiseptic, two small scarifications are performed, about one-quarter inch in length, one above the other and about three-quarters inch apart. As in smallpox vaccinations, the epidermis should be eroded just sufficiently to reach the dermis. On the lower scarification a drop of tuberculin is deposited ; the upper one serves as a control. After drying, the arm is bandaged and the patient is advised to return in forty-eight hours for examination.

If the patient harbors no live tubercle bacilli, the two scarifications will be exactly alike when seen again. Both have healed, with a small scab much like an ordinary scratch. However, if the patient has, anywhere in his body, a live tubercle bacillus, even though it may not be active, a series of events will occur at the site of the tuberculin deposit. The day after the vaccination, the scarification has become a red papule, surrounded by an area of erythema and

(See page 43.)

give rise to sinuses it is very useful to give these injections together with other local and general treatment. The treatment of Tuberculosis of the Bones and articulations comes within the province of the surgeon, but we can definitely say here that the surgical treatment can well be substantiated by Biocholine injections as is evidenced by clinical observations. The results have shown that under proper hygienic conditions even under adverse circumstances Biocholine is able to prevent and cure Tuberculosis.

Biocholine, as above mentioned when introduced in the body is very energetic and is rapidly absorbed by the tissues. It is because of this that even the debilitated patients are able to avail themselves of the active principles of this product. That the product is absolutely harmless has been seen even in most serious cases. After repeated injections not the least disturbance has ever been experienced. An additional advantage in favour of Biocholine is that the kidneys are not in the least affected after its long-continued use, which means that the renal affections do not constitute any contra-indication to the treatment. The phenomena of reaction is rarely seen after Biocholine injections, but if at all it does occur it is of no importance since no damage results from it nor is the curative effect in any way diminished. Another advantage is that this treatment may be given at any age, at any stage and in any form of the disease.

Biocholine is regarded by the profession as a valuable remedy for increasing the resistance of the organism in Tuberculosis as well as other debilitating and wasting diseases.

The following cases under my observation in which Biocholine was resorted to are mentioned below :—

1. A young student of 21 who was suffering from bad hacking cough for several months was brought to me for treatment sometime in August last. On thorough examination I found that he was suffering from Pulmonary Tuberculosis. Family history when elicited showed that his mother had died of this disease. He had lost weight and used to get very often night sweats. His expectoration on microscopic examination revealed the presence of Koch Bacilli. Fever which was normal or even subnormal in the morning varied from 99^0 to 101^0 in the evening. His general condition was bad. On ausculation it was discovered that the apex of the left lung was in a caseating state. He told me that at times there was hemoptysis. I started at once Biocholine injections every other day. He had besides this Cod Liver Oil, Pharmasol Collo Calcium and other supplementary treatment commonly given in this disease. Condition improved to an appreciable degree after a course of 10 injections. Fever never rose after this above 99^0. Night-sweats lessened. There was perceptible diminution of expectoration and hacking cough. His weight after six more injections rose by 2 lbs. He was able to eat and digest well. In fact the treatment enabled him to resist the disease wonderfully. He is now in a much better condition, though he is not quite free from the disease. He proposes to go for a change shortly.

2. This was a case of a young girl of 14 who was suffering for the last three months with suppurating adenitis in the posterior cervical region. The history that I could get from her was that at the outset there was swelling of the glands in the area, which afterwards became painful. Later she began to have a little temperature, specially in the evening. After two months the swollen glands formed into a mass which was giving her lot of pain. Some days later the mass burst of itself and here she was now with suppurating sinuses. In this state she was brought to me. The local and the general symptoms had aggravated. I put her on Cod Liver Oil and gave an injection of Biocholine. The local treatment of scraping the sinuses and dressing with iodoform gauze was done. The injections of Biocholine were repeated every alternate day until 10 injections were given. They had a great influence on the course of the disease. The glands began to diminish in size and the temperature after some days never rose above 98^0. The tenderness and pain also disappeared. After some days she was taken to the hospital for surgical treatment. Although Biocholine did not completely cure the patient, it cannot be doubted that it had a favourable influence on the course of the disease. The patient was much more comfortable after 10 injections and she was able to enjoy the ordinary amenities of life.

this syrup, because of its calcium content, acts as an effective antispasmodic. Combined with this there is also the tonic influence on the heart-muscles. Coughs due to exposures and colds soon abate with Syrup Creosal. It soothes the local irritation of the upper air-passages and the patient is promptly relieved of the complaint. In coughs of whatever origin Syrup Creosal treatment is indicated on account of its valuable disinfecting action. This syrup can be used with success in children who suffer from chronic catarrh of the respiratory tract with troublesome dry cough. In pulmonary tuberculosis this preparation is very serviceable. The sputum is diminished, deodorised and disinfected. Tubercle Bacilli are at times destroyed. The expectoration is easier and the hacking cough is relieved and the patient gets the necessary rest. It improves nutrition so that the patient is able to eat well and thus gains in weight. With better rest and improved digestion, time for the cure or the arrest of the disease may be greatly shortened.

Syrup Creosal presents definite advantages over other cough remedies. It does not contain any narcotic ingredient and it is well-liked and perfectly tolerated. The non-irritant and non-toxic character of this syrup is a great advantage specially in cases where its use is to be continued for long. It never disturbs the appetite, in fact an increase in appetite is noticed. No gastro-intestinal trouble has ever been caused even after its continued use. The absorption of the syrup is rapid and perfect. The heart and the circulation are left undisturbed after its use. Disturbance of the kidneys is also unknown. All these points require special emphasis as this is a creosote preparation. The syrup, as can be gathered from these advantages, has absolutely no contra-indication.

It will be recognised, therefore, that in Syrup Creosal the profession has got a valuable medicament for alleviating coughs of whatever origin. On account of its certain action as a sedative and an expectorant, its application in all inflammatory catarrhal affections of the respiratory organs has a favourable influence. The tonic and stomachic action of this preparation raises its value in the treatment of these diseases, specially in pulmonary tuberculosis. The absence of any disturbance of the kidneys or the heart and the circulation allows its wide and long-continued use with perfect toleration.

Two cases are mentioned here in which remarkable results were obtained with Syrup Creosal :—

1. A lady of about 40 was suffering from influenza accompanied by bronchitis. Her temperature ranged from 101° to 103°. On auscultation were found copious rales and rhonci. The expectoration was difficult. The usual expectorant mixtures failed to produce any effect. Under Syrup Creosal rapid reduction of the physical signs in the lungs were observed. Fever came to normal after four days' use of this syrup and demonstrable improvement in the bronchial catarrh was noticed one day after this. A feeling of being quite at right set in after this and she was completely free from everything after seven days. Her health has remained unimpaired to this day.

2. Another typical case was of a lady who was suffering from Tuberculosis of the lungs. Caseation of the right lung had just started. There was extreme emaciation and constant remittent fever. She suffered from exhausting cough which did not allow her proper rest at night. No amount of antiseptics and stimulant expectorants could do her any good. Under Syrup Creosal administration the flow of sputum was much easier and the hacking cough troubled her very little which enabled her to enjoy a good rest every night. The troublesome chest pains and the spasmodic coughing were much less than before and the anorexia also disappeared. Appetite was better and the general feeling of well-being soon set in. Although we cannot claim any specific effect of this Syrup, we can safely assert that the patient was far more comfortable on account of the facility of expectoration, freedom from hacking cough and anorexia and further she was able to cope with the disease in a much better way.

Pluriglandular therapy.

It is an established fact that in the human organism there is a close and intimate inter-connection between the different endocrine glands, which constitutes a very delicate and intricate mechanism. If there is any disturbance or alteration in one or more of these endocrine glands, the whole of this mechanism gets out of order. If one endocrine gland is mainly at fault, one is mostly certain that other glands of the whole apparatus are involved. In such cases if we employ only the gland, that is chiefly responsible for the trouble, for the treatment, we are bound to fail while the combination of several other glands will answer the purpose well. It therefore follows that pluriglandular therapy is a rational and logical treatment for remedying these defects. This treatment is sure to succeed firstly because these gland substances have definite synergistic action between them and secondly because if one gland is at fault, it practically involves the whole of the Endocrine System. Experience has convinced us that treatment with the combination of these various glandular extracts brings about rapid improvement and eliminates many of the contra-indications. The effective product of such a nature is Opocrin Gland Complex (Masculine). Clinical reports have shown that it is reliable and of proved accuracy.

This Opocrin Gland Complex (Masculine) is a natural combination of the gland substances, Cerebral, Gastric, Hepatic, Pituitary, Pancreas, Kidney, Suprarenal, Orchitic and Thyroid. The extracts of all these are grouped together physiologically. These are preserved in such a way that they are not affected so far as their biological potency and structure are concerned. The Gland Complex is always in a state of immediate activity and has acceleratory and tonic action. It stimulates metobolism, brings about normal cell-function and effects such profound physiological changes that the whole activity of the organism is increased. This Gland Complex is therefore indicated in those conditions where the metabolic rate is lowered and where there is sub-oxidation and under activity of the organism. We shall take each extract in this Gland Complex separately and then see how it supplies all the elements necessary in cases of derangement of the internal secretary apparatus.

EXT. CEREBRIN : As this extract acts as a good sedative to the nerves and as its administration is followed by good results in functional nerve-troubles and various other mental conditions it forms one of the constituents of the Gland Complex.

EXT. GASTRIC : This is included in the Gland Complex to stimulate proper digestion of the proteins. This extract contains the active substances of the gastric mucosa which have proved very valuable in all cases where the stomach's secretion has been lowered or is defective.

EXT. HEPATIC : This extract is a highly powerful derivative from the liver and it contains haematopoietic principles which are very useful in the treatment of anaemias. This extract helps also to prevent or overcome alimentary toxemia due to the accumulation of waste products as this extract is able to neutralise the toxins. This is met with in insufficient functions of the liver. It is incorporated in the Gland Complex to overcome these defects which are associated along with other troubles.

EXT. PITUITARY : This extract contains hormones of both the anterior and the posterior Pituitary body and is therefore very useful. While the anterior lobe helps to maintain and stimulate growth and may be regarded as the principal factor in the actuation of the sexual functions, the posterior lobe regulates the urinary system, the peristalsis of the bowels and the tone of the muscle-fibres specially of the capillaries. It is thus useful in the treatment of conditions of more or less definite insufficiencies of the Pituitary.

EXT. PANCREAS : The purpose of inclusion of this extract in this Gland Complex is to set right any digestive disorders which follow the deficiency or diminution of the pancreatic function. The enzymes present in this extract break up the proteid, fat and sugar bodies. The extract promotes flow of the pancreatic juice, the bile and also the succus entericus. Digestion is thus favourably influenced and constipation is overcome. This latter aspect is due to the secretion of a peristaltic hormone in the intestines.

EXT. KIDNEY : There is still some doubt as to the internal secretion of the kidney, but it is certain that the extract of this gland is valuable mainly in the senile conditions of the kidney and its insufficiencies. Its action is to increase the anti-toxic power of the renal apparatus. This extract is found

in the Gland Complex because patients with run-down conditions and general debility have faulty or granular kidney. By overcoming this renal insufficiency, the general condition may be improved.

EXT. SUPRA-RENAL: The toxicity of the sympathetic nervous system depends on the adrenalin of this extract. It is therefore necessary in this Gland Complex as it would aid to maintain the intensity of all the vegetative functions as well as the toxicity of the muscles. There is another important function of this extract in that it directs the growth of the undeveloped organism and helps the formation of secondary sexual characters. Its function as regards prevention of pathological pigment formation is not important so far as the Gland Complex is concerned.

EXT. ORCHITIC: This extract effectively meets the necessities in cases where there is not only deficient development of the secondary sexual characters, but also where the normal sexual activity is deficient. This extract substitutes the missing hormones in these genital deficiencies and thus establishes the equilibrium of the whole genital apparatus, which is so very inter-related with other Endocrine Glands. On account of this as also its general tonic and restorative action its inclusion in the gland complex is highly necessary.

EXT. THYROID: As this extract plays a predominant part in the development of the organism, formation of the bones and regulation of metabolism, its inclusion is quite essential in such a product as the Gland Complex. Again the relationship of the Thyroid and the genital glands is very close and as it has lot to do with the maintenance of the intellectual functions its incorporation in this tonic preparation has become all the more necessary.

THE GLAND COMPLEX (MASCULINE) is a natural association of all these extracts of the Glands which act synergestically with one another and the therapeutic effect of the product is based on this. Its administration restores and maintains the hormone balance, which has been upset by the disordered function of one or more of the Endocrine Glands. As it is not likely to be always accurate as regards the faulty gland in the organism or as to what extent the whole endocrine system is involved, the application of this preparation in such cases provides the necessary endocrine supply in a balance manner and brings about gradual improvement. The active endocrine extracts in this Gland Complex exert a definite and regular action in the treatment of conditions in which there is general debility and in which the metabolism and energy is below par. The extracts here produce remarkable increase in physical strength and mental vigour. The addition of the suprarenal, Thyroid and Pituitary Extracts to the Orchitic makes the results more positive and discernible. On account of the marked reciprocal action of these gland-extracts this Opocrin can be used in the treatment of low functional capacity of the sexual system in men. The Gland Complex by directly stimulating cell-metabolism increases the general metabolism of the organism, which means that the organism frees itself from accumulated toxic fatigue products. Thus there is increased output of energy and the patient feels himself normal. The Gland complex can therefore be considered as a tonic with a definite therapeutic action. The positive effects of this Gland Complex are that it increases metabolism and physiological oxidations, that it develops energy, helps in the elimination of toxic waste-products, and improves the vitality and the strength of the patient.

From the action of the several components of this Gland Complex (Masculine) we can infer that it is devised to meet various requirements which the general practitioner is called upon to treat daily. It is meant for use in male patients on account of its containing the orchic extract and is indicated in Asthenia, General Debility, run-down conditions, Neurasthenia, lowered metabolism, premature senility, genital disorders and fatigue syndromes. Experiments and clinical experience have amply proved the efficacy of this Gland Complex (Masculine) in *Asthenia* and *General Debility*. This is due because of the increase in metabolism, correction of suboxidation and toning of the muscular system brought about by this pluriglandular product. The extracts in this product directly stimulate cell-metabolism, in other words they bring energy and strength to the organism and hence the product does benefit in *run-down* conditions. Good results follow the exhibition of this Gland Complex in *Neurasthenia*, which is considered of late to be a disturbance of the several glands of internal secretion. The extracts of Suprarenal, Thyroid, Pituitary, and the Testes compensate for the deficiencies as suggested by the pathology of the disease. The main defect of Neurasthenia is Suprarenal deficiency and this is corrected by the increased activity of both the Thyroid and Suprarenal extracts. The therapeutic effect of this product in conditions of *lowered metabolism* is quite obvious from the preceding remarks. The mild stimulation of the various Endocrine Glands, the increase of energy output and a general sense of well-being brought on by this Gland Complex are of great use in *Premature Senility* and *Old Age* in which there is usually lowering of metabolism and deterioration of the vital processes. The Gland Complex has been found therapeutically effective in the treatment of *Sexual Neurosis* and *Impotence* in *Males*. This effect is due to its containing the active testicular extract as also the Thyroid and the Pituitary which regulate the functional activity of the genital system. Further, the product assists in the rebuilding of the normal physical as well as the mental condition by exercising its specific effects on the functional and the endocrine activity of the reproductive system. Its action in cases of *Fatigue Syndromes* is really tonic. These conditions, in which usually no symptoms can be demonstrated are the result of lowered metabolism and also of the functional depression of several groups of the Endocrine Glands. It therefore requires glandular therapy and the Gland Complex is the product of choice which enhances the metabolic rate in a definite manner and fulfills the various glandular deficiencies.

From the above it can be deduced that this pluriglandular preparation containing the various gland extracts is really suitable for combating various conditions mentioned. The efficacy of the product is moreover due to the synergistic agents that are contained in it. The Opocrin Gland Complex represents a real endocrine product which is prepared in such a way that the different glands are included in one and the same treatment and that it can be given in doses just suitable to the human organism obviating any pronounced stimulating action. Again it is available in such a form that its proper preservation and rapid assimilation is ensured. It therefore enables the general practitioner to institute pluriglandular therapy according to the latest developments of Organo therapeutics.

Experiences with Boldine.

It is not uncommon in general practice to come across affections of the Liver and the Gall-Bladder. They vary from ordinary congestion to Cirrhosis of the liver and Gall-Stones. In the latter cases the majority of the physicians advise surgical operation of which the patients are in perpetual dread. Any preparation therefore which can cure this latter affection without any surgical intervention is welcome both to the physician and the patient. Boldine is one such preparation which besides being effective and stable has an elective action on the biliary secretion. In fact this product is based on the normal physiological action of bile. It mildly stimulates the functional activity of the liver. A mild cholagogue without any depressing cathartic action it lessens the tendency to biliary stasis. It increases the flow of bile and renders it less viscid and less ropy in character.

Because Boldine combines in it all these properties it is indicated in hepatic congestion, lithiasis, all kinds of icterus, cholecystitis etc. In jaundice which precedes lithiasis and which resembles simple acute catarrhal jaundice Boldine acts not only as a curative, but also as a prophylactic against future development of biliary lithiasis. In jaundice which is transitory and in which biliary canaliculi and hepatic cells are involved Boldine is very useful as it stimulates the liver cells and clears the canaliculi and restores the normal flow of bile in the intestines. In cases where a partial or complete obstruction of the Common Duct has been caused by stone, Boldine helps the dissolution of the stone in a safe and sure way. In Cholecystitis Boldine should always be given preference as it produces an effective drainage of the gall-bladder. It ensures gradual and gentle evacuation of the bile and alleviates pain both in the region of the gall-bladder and the stomach. Gall stones are found more often in women than in men. Therefore any tendency of bile stasis or history of frequent bilious attacks should be cut short by a course of Boldine treatment. More serious complications can thus be prevented. In many such cases even of serious nature, reports of several clinicians have clearly

shown that, Boldine has rendered surgical operation absolutely unnecessary. This it does by promoting the flow of bile and facilitating the expulsion of the concretions. Similarly in chronic hepatitis and hepatic hypertrophy the administration of Boldine is beneficial. Being an efficient cholagogue it allays inflammation and irritation.

In conclusion we can state in general that:—

1. Boldine treatment can be given with safety in all classes of patients suffering from Liver and Gall-bladder diseases.

2. It can be used on the slightest suspicion of any disturbance of the biliary secretion.

3. If given for a long time and in adequate doses it is effective in preventing further serious complications. Hence it is a good prophylactic.

4. Boldine is a great advance on the ordinary hepatic stimulant treatment.

(*Continued from page 42.*)

edema. The papule endures during the next day, but after that the edema and the erythema begin to subside, the papule pales and is less salient and, in subsequent days, only a small red spot is left, which disappears without traces during the next week.

This local reaction is all that a positive von Pirquet test gives. There is no fever nor any focal reaction. Occasionally the lymph glands in the region of the vaccination are slightly congested, but this is very infrequent and, at best, transitory.

SIGNIFICANCE OF THE TEST.

Everyone agrees, nowadays, that a positive von Pirquet test is proof that the patient harbors live tubercle bacilli within his body —in his lungs, in some lymphatic gland, or at the center of a tuberculous nodule, that is clinically healed. It, alone, does not argue for an active tuberculous process.

In infancy there is no such thing as quiescent tuberculosis, and a positive von Pirquet test, in infants, is practically positive proof of active tuberculosis. After the second year, cases of quiescent tuberculosis begin to appear, and thereafter a positive test loses its clinical importance, in proportion to the age of the patient. When the patient has reached adolescence, it has no clinical significance whatsoever and many statistics have been published to show that from 90 to 98 percent of an adult, urban population will show a positive von Pirquet test, even in subjects who have never had clinical symptoms of tuberculosis.

In this connection it is interesting to understand the mechanism of the tuberculin skin reaction. If a von Pirquet test is performed with a tuberculin from which all the dead tubercle bacilli have been filtered out, the test is negative, even in subjects whose clinical symptoms leave no doubt that they have active tuberculosis. There is not even a formation of anti-bodies, as so often occurs with the vaccines. This necessity of the tubercle bacilli, even though dead, is explained by Erlich's theory. The tubercle bacillus plays the part of an antigen and causes the creation of antibodies ; that is, of substances which can neutralize or modify the effect of the bacillus or its toxins.

It appears that, in cases of tuberculosis, more than one kind of anti-bodies results from the presence of the antigen. Some of these actually kill the antigen (tubercle bacillus or its toxins) and so are healing agents. However, there are other antibodies, called lysins, which convert the toxin of the tubercle bacillus into a toxin of a different nature. They act by dissolving the body of the dead tubercle bacilli, and so liberate endotoxins. It is held that, when tuberculin containing dead bacilli is deposited on a scarification, the lysins circulating in the patient's blood or lymph dissolve these, with the liberation of endotoxins, and it is to these that the local reaction is due.

This theory has been invoked to explain variation in the intensity of the von Pirquet reactions. It has been held, for instance, that a strong von Pirquet reaction argues a plentiful supply of lysins, hence active tuberculosis. This view has not received unanimous assent. However, many hold that there is truth in it.

A negative von Pirquet reaction has very great significance, providing one can eliminate certain factors. The absence of a reaction to tuberculin means either that the patient carries no live tubercle bacilli within his body or has not the power to react to tuberculin—a status called anergy.

ANERGY.

There are several circumstances which are known to produce a state of anergy. During the incubation stage of tuberculosis —a period which varies in duration between wide limits—there is a state of anergy. This so-called "anti-allergic" period has been found to be as short as 6 days in some cases, and to endure for 4 months in others. However, in the vast majority of cases, the incubation period varies from 20 to 30 days. Hence, if one suspects that an infant has been recently infected with tuberculosis, one should repeat the von Pirquet test after 4 weeks. If the second test is also negative, one may be fairly assured that the suspicion is unfounded.

A state of anergy appears also in various other circumstances. A previously positive von Pirquet test becomes negative in advanced tuberculosis with marked malnutrition;

during menstruation, pregnancy and lactation; and during the progress of certain acute infections, such as measles, scarlet fever, pneumonia, influenza, etc. However, as the von Pirquet test has significance in the first two years only, most of these causes for a state of anergy may be disregarded and one may conclude that the negative von Pirquet's reaction, at four week intervals, gives very great assurance that the patient is free from tuberculosis.

CONCLUSIONS.

In conclusion, the von Pirquet test should be applied only in the first two years of life as a diagnostic procedure, for after that age it loses its value. In older patients we have many ways of diagnosing active tuberculosis. The microscope, x-rays and the clinical history will all concur in establishing a diagnosis that leaves no doubts.

In infancy, however, tuberculosis nearly always begins in the mediastinal lymph glands, which are grouped at the hilus of the bronchus, and as this condition very often has no definite symptoms, it is unsuspected. A retardation in growth, a slight anemia or a slight elevation in temperature should suggest a von Pirquet test. A positive result would amply testify to the nature of the ailment.

A marked hypertrophy of the glands of the hilus occasionally causes a compression of the trachea or bronchus, and so gives rise to respiratory stridor and a croupy cough. In such cases the x-rays will fully reveal the nature of the condition. Except for these occasional cases, only von Pirquet's test can do us service.

It may be remarked that the x-ray diagnosis of hypertrophied glands of the hilus has led to many errors. The shadows seen are not always hypertrophied glands. Safety requires that the x-ray diagnosis be supplemented by a von Pirquet test.

European hospitals for the care of infants have adopted the von Pirquet test as a routine procedure. It is their publications which have inspired what is written here.

(*Clinical Medicine and Surgery, August 32.*)

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.

Haemorrhage: To prevent haemorrhage in persons who are prone to it, Calcium Chloride grs. 20, Tinct. Auranti drs. 2, Aqua ad 1 oz. to be given three times a day. Thrombosin 5 cc may be given hypodermically (L. W.). In haemorrhage from the bowels, morphia hypodermically and ice bag to the abdomen are good. If more than 1000 cc. of blood is lost, give intravenously 500 cc, of 6 per cent. aqueous solution of Gum Arabic. Transfusion method is best. Saline injection is not so good as Gum Arabic. In haemorrhage of the new born, injection of human serum or horse serum or haemostatic serum have been tried with satisfactory results. In haemorrhagic diathesis of the new born, 3 to 10 cc. of blood to be drawn from the mother or a healthy adult and injected in the buttock of the child. (Armitage). Ceanothus Americanus is good as it decreases the coagulation time. In haemorrhage from wounds, the best haemostatic is blood plasma made under the name of 'Vincoll'. In the new born Gelatin Alba grs. 30, Sodium Chloride grs. 2, Aqua Distillata, ozs. 2, one dr. every hour. Adrenalin Chloride 1 in 1000 solution 1 to 2 mms. with little water every hour.

Calcium Chloride grs. 2, dissolved in water, every 2 hours. (I. M. J.) After Tonsillectomy Hæmoplastin both orally and by injection.

Haematemesis: Adrenalin 1 in 1000 one dr. may be given by mouth and Morphia hypodermically. Morphia and Atropine to be given by injection, followed by, if the bleeding is persistent, 15 grs. of Adrenalin 1 in 1000 in one ounce of distilled water followed in half to one hour by 2 to 3 ounces sterile Gelatine (Osborne). In case of cirrhosis of the liver, do not give morphine and ice should not be given for sucking. (J. A. M. A.)

Haematuria of Malarial Origin: Sodium Thio-Sulphate 5 to 15 grams every 5 hours. Some give it in larger doses till purging sets in.

Haemoptysis: Nitro Glycerine 1/100 to 1/50 grain hypodermically or Amyl nitras mms. 5 by inhalation or chloroform inhalation, as all these reduce the blood pressure. Ice compress to the scrotum or vulva and Morphia hypodermically to reduce nervousness. Chloral and Bromide either by mouth or rectum dissolved in starch water. Calcium Chloride by intramuscular injection acts like a charm. 1 in 4 solution, 4 mms of this is drawn up into a syringe and then boiling water to be made up to 20 mms. This to be injected deeply into the gluteal region (Rudolf)

In Mitral stenosis, Adrenalin is contraindicated as also in Phthisis. In Pulmonary Tuberculosis, Calcium Chloride grs. 20 cc of 15 per cent solution to be given intravenously. A more simple procedure is to give 5-15 grains of Sodium Chloride by the mouth (M. T. T.)

If due to malaria, Quinine Hydrochloride by injection. Atropine 0·5 to 1 cc of 1 : 1000 (J. A. M. A.). Spt. Turpentine, mms 5 to 10, Mucilage qs, Tinct Camphor Co. Syrup Pruniverg and Syrup Rose each dr. ½, Aqua add ounce 1. This may be given every 4 hours. Emetine gr. 1/3 with Pituitrin 1 cc by injection. Congo red by intravenous injection, 5 to 10 cc of 1 per cent aqueous solution (M. A.)

Notes on Therapeutics, Diagnosis and other Medical Subjects.

TREATMENT OF DIABETIC COMA.

Diabetic acidosis is largely preventable by accurate management, but in spite of the widespread knowledge of the use of insulin, this condition is still one of the most important complications of diabetes mellitus.

The management of diabetic coma requires, first, the certainty that the coma is due to diabetic ketosis. Diabetic individuals are not immune to cerebral vascular accidents, skull injuries, intoxications, epilepsy, etc. They are especially liable to *hypoglycemic* reactions if they use insulin.

Acute diabetic acidosis is a serious emergency and demands immediate treatment. Before giving enemas, applying hot-water bottles, etc., give insulin; then put the patient to bed and apply heat or such other measures as may be indicated. The amount of insulin given depends upon the degree of acidosis. Usually 50 units are given hypodermatically and, in extreme cases, an additional 20 units may be given intravenously. Thereafter, at hourly or two-hourly intervals, 10 to 25 units are given until the hourly urine specimens show no more sugar. Several blood-sugar determinations should be made, in order that hypoglycemia may be prevented.

Fluids in large amounts are to be given, by mouth if possible, or by hypodermoclysis or intravenously. Orange juice by mouth, 200 cc. every two hours; or 500 cc. of ten per cent dextrose solution, intravenously, and 1000 cc. of isotonic salt solution under the skin, twice in twenty-four hours, is about the average requirements.

When the ketosis has been cleared up, sufficient food and insulin must be given to prevent recurrence. The diet prescription and insulin dosage must be made to fit the individual case.

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FINGER NAILS AND TUBERCULOSIS.

Finger nails tell the story of a patient's winning or losing fight against tuberculosis, recent observations by Dr. A. G. Hahn at the Trudeau Sanatorium near Saranac Lake have shown.

Pitted nails were found in every one of fifty cases of active tuberculosis investigated; while 50 ex-patients and normal subjects exhibited smooth nails. A third group, composed of 50 cases of inactive tuberculosis, yielded only three instances of indented nails.

Downward curving of the finger nails is another symptom of lung diseases, though not quite so accurate an index of progress. Seventy-six (76) per cent of the patients with active tuberculosis had down-curving nails, as did half of the inactive cases. Thirty per cent of the ex-patients had retained the incurvature after a cure had been effected, but none of the normal group had the peculiarity.

Extreme blueness of the finger nails is another symptom of the progress of tuberculosis. The bluer the nails, the more advanced the case was usually found to be.

Bloodless Phlebotomist, Vol. VII, No. 6.

PAIN IN THE TESTICLES.

The presence of gas or air in the pelvic tissues that can be palpated by rectum, is indicative of a retroperitoneal tear in an air or gas-containing viscus.

When, upon making an abdominal incision, gas or air is found between the peritoneum and transversalis fascia, in a patient suffering from an injury, a retroperitoneal rupture of a hollow viscus should be suspected.

Early excruciating pain in the testicles, following a severe traumatism to the upper abdomen, indicates retroperitoneal rupture of the duodenum, with a spreading out of bile beneath the peritoneum so as to irritate the testicular nerves, the sympathetic chain accompanying the spermatic artery.—Drs. E. Butler and E. Carlson, of San Francisco, in Am. J. Surg., Jan., 1931.

BLOOD SPITTING.

When a patient states that he has coughed up blood, we should exercise considerable care to determine the correct diagnosis. Only about 50 per cent of patients showing this symptom suffer from pulmonary tuberculosis. Hemoptysis is found, not only in pulmonary tuberculosis, but in cardiac disease, in aortic aneurism, in bronchiectasis, in acute and chronic non-tuberculous pulmonary conditions, in lesions of the bronchi, trachea and larynx, in diseases of the blood, in relation to pregnancy and menstruation, in hysteria and due to unknown causes.—Dr. J. Saliba, Albemarle, N.C., in Southern Med. & Surg., Jan., 1931.

News and Comments.

The Indian Medical Council: While 'The Hindu' of Madras regrets at the news communicated to it from Delhi quite recently that the Government of India are delaying the discussion of the Indian Medical Council Bill at the Assembly, we are glad at the decision of the Government and our readers are aware we even made an appeal last month in these columns, to the profession to request the Government through their respective Associations to postpone the discussion of the Bill to next winter, as one of the prominent members of the Assembly, Sir Henry Gidney, who is the only eminent doctor now in the Assembly and who by his public speeches has assured the profession that he would fight tooth and nail to remove all the defects in the Bill, such as, non-inclusion of Licentiates, introduction of a reciprocity clause in the Bill, etc will be absent from India having to attend the Round Table Conference. Sir Henry Gidney is the fittest person to espouse the cause of the independent medical profession, especially of the Licentiate class, for whom he has the largest measure of sympathy. He declared in one of the Calcutta meetings held recently under the auspices of The Indian Medical Association while referring to the recommendation of the Calcutta University about the registration of the Licentiates in a separate appendix in the future Indian Medical Register: "There might be difference according to your degrees, but any attempt to have two categories on the Register of the Council would perpetuate the evil which we desire to stamp out. And I can assure you that when I speak on this Bill in the Assembly, I shall stress this aspect of the question as strongly as I can that we should not perpetuate this compartmentism." As mentioned in our last issue, it is not likely that Sir Henry Gidney can attend the Assembly till the next winter. So, in the interests of all concerned, the postponement of the consideration of the Bill is certainly a blessing.

L. I. Ms. Ahead: It is announced in the press that the Madras Government had recently decided "that certificates granted to Government servants by qualified practitioners of Indian Medicine may be accepted provided that the practitioners are in the employment of the Government and that they are the medical attendants of the Government servants. The question of accepting other certificates has been deferred until the question of registration of practitioners of Indian Medicine is decided." We congratulate the L. I. Ms. and others in the practice of Indian Medicine at the Government Indian Medical School, Madras and specially the Principal of the School that they with Dr. G. Srinivasamurthy as their Head have been able to achieve what the members of Allopathic system of medicine could not do even after the passing of the provincial Medical Act as early as 1914. The old procedure of "counter signature" followed recently by "a second opinion" does not find a place in this G. O. as in old G. Os. concerning registered medical practitioners of the Allopathic school of medicine. While musing over this piece of news so many eventualities come across the mind: (1) Did any important officer of the Government fall ill and was treated at the Indian Medical School Hospital or by a member of the staff of the Indian Medical School, and did such an officer find it rather troublesome or unreasonable to get a medical certificate from a registered Allopathic practitioner and strongly pleaded with the Home Member of the Government of Madras, who is in charge of the portfolio on "regulation of professional qualifications and standard" to confer on practitioners of Indian Medicine the privilege of granting Medical certificates? (2) Did the fact that the Deputy Secretary, Local Self Government Department, who has powers to deal with the medical degrees including the "Indian Medical Degree" is also the Deputy Secretary to the Home Member for the "regulation of professional qualifications and standards" facilitate the passing of the G. O.? (3) Is there a special secret ceremony of initiating the practitioner of Indian Medicine under Government employ to be true disciple of the God or Goddess of Truth and Honesty? (4) Is it after all a national awakening at the Government Secretariat, an Indian member assisted by an Indian Deputy Secretary being in charge of the "regulation of professional qualifications and standards?" The present Chief Minister, and the ex-Chief Minister in charge of the medical department cannot claim much in this direction of nationalism

as they are Indians in charge of transferred subjects and naturally expected to be national in their outlook at least, as nobody could know their 'inner-look.'

It is reported to us that the Madras Medical Council at its last session have passed the following resolution: "The Council recommends to the Government that all registered medical practitioners should be treated alike whether they are in service or in private practice in the matter of issuing certificates for whatever purpose by virtue of their being registered medical practitioners". It remains to be seen if the passing of the above resolution is a lucky or unlucky coincidence just at this juncture. If the Government members who have been so genuinely national in their outlook with regard to the G. O. referred to, mind it, they can surely and magnanimously agree to pass a G. O. putting into effect the principle conveyed in the above resolution. The qualified and registered independent members of the profession should take a lesson from the recent G. O., and instead of entertaining any other feeling regarding this subject, should take advantage of the G. O. as an additional reason for granting them rights and privileges which the statute did confer on them and which the Government have been denying them so far.

Medical Ethics: Our readers might remember our having referred to in these columns last month to a laudatory note accompanied by a group photograph in a local daily which we sent to the President, Madras Medical Council, for opinion and comments. We have received a reply from Major General C. A. Sprawson, President, Madras Medical Council, which appears in the "Correspondence columns" of this issue. We thank the Major-General for his prompt reply though we have to say that the reply does not cover all the points raised in our comments last month.

Rural Practitioners to Meet: Dr. S. Ramasubbu, L. M. & S., Secretary, Madras Provincial Rural Medical Practitioners' Association, Viragnur, Salem Dt., wishes us to announce that there is a desire amongst many rural practitioners to hold an annual conference in Madras during the Christmas week and such of those practitioners who agree to this proposal are requested to intimate to the Secretary suggesting also the name of the President for the conference. Majority of the rural practitioners in this Province being Licentiates, it will be quite possible to hold this conference in the same place as the All India Medical Licentiates' Conference and in case the rural practitioners have no objection for this arrangement, they may intimate to Dr. V. Rama Kamath, Publicity and General Secretary, 25th All India Medical Licentiates' Conference, Madras for making suitable accommodation for the delegates along with the delegates of the All India Medical Licentiates' Conference.

All India Conference: May we draw the attention of our readers to a communication appearing in the "Correspondence Columns" elsewhere from Dr. K. S. Ray, Jt. Secretary, Indian Medical Association regarding the All India Medical Conference which will be held this year at Lucknow. The Indian Medical Association is the only representative medical fraternity now existing in this country which admits qualified practitioners of all grades and class both in service and outside and so we need hardly impress on the profession in India that it is their sacred duty to attend this conference in large numbers and make it a success.

Helplessness or Indifference? As referred to in these columns last month, we learn that Dr. V. Rama Kamath brought to the notice of the Government about not summoning of the October session of the Madras Medical Council by the President and that he received a reply that the Government "decline to advise him in the matter". It is an open secret that very often the Secretary of the Department is the Government itself dealing with files on subjects like the affairs of the Madras Medical Council which, as passing events show, is not attracting the attention of the Government, the public and much less the medical profession. Therefore it surprises us the least that Dr. Kamath should receive a reply which connotes that either the Government is helpless to direct the President to do his legitimate duties as required by the Madras Medical Registration Act or indifferent as they are almost sure that neither the profession as a whole nor the public for whom the Medical Act is said to exist are callous regarding the existence of the medical council in this province.

From the replies given by the Home Member on the floor of the local Legislative Council on 1-11-32 it is clear that the Government are aware of grave irregularities such as falsification of accounts, fabrication and destruction of public records and documents and misappropriation of public funds in the working of the office of Registrar, Madras Medical Council. We published in our "Correspondence columns" last month four resolutions of which notice was given by Dr. Kamath to be moved at the October meeting of the Medical Council and which indicate that (1) medical practitioners who paid fees for registration do not find their names in the published registers, (2) that the Council had not taken steps to register the names of such of the practitioners who had in their possession proof of having paid the fees for registration, (3) that the clerk now employed on probation does not possess the required qualification demanded for such a post, and (4) that the financial condition of the Council does not permit the payment of double second class fare to mofussil members, as travelling allowance. There was a meeting on 20th September 1932, specially convened to consider the reports of two Committees appointed by the Medical Council in March last, one to go through the affairs of the office of the Registrar and the other to go through an alleged fraudulent registration. In the published programme of the meeting referred to above there was nothing to indicate that the Government had "communicated to the Council which has been requested to conduct a thorough enquiry into the matter, rectify the irregularities brought to light and submit a report showing the action it has already taken or proposes to take in the matter," as mentioned by the Home Member on the floor of the Legislative Council on 1-11-32. It is reported that Dr. Kamath wrote to Government complaining that the President of the Medical Council did not summon the October meeting on 24-10-32 and the Government passed orders on 26-10-32. We also learn that Dr. Kamath sent his resolutions to the President on 13-10-32. So it may be safely said that the Council had lot of work to do. It was rather not possible for the Government to conduct an enquiry on the complaint made by Dr. Kamath within two days as could be justified from the usual rate of the moving of the wheels of the Secretariat machinery, especially in a matter concerning the Madras Medical Council. If the Government did run the wheels quicker, as they could certainly do if they want, and if the President of the council informed the Government that there was no work to be transacted for the October meeting, the reply of the President cannot be justifiable on the face of the fact that Dr. Kamath did in time give notice of four resolutions, all of which indicated that there was much to be done by the Council. We could only say that the Government could not face a grave responsibility which is certainly not less grave than the replies made by the Home Member on the floor of the Legislative Council on 1-11-32 regarding the affairs of Madras Medical Council.

A Government Committee Again: It looks as if the Government Committees outside the Legislative Council, are constituted by the Government to get artificial approbation to the views of the departmental heads who are usually consulted to recommend to the Government the names of the members to form such committees. It is natural that the departmental heads choose as their collegues such with whom they may have easy sailing. All sorts of devices are in evidence to give such committees a representative character. Such a committee was appointed by the Government to consider the question of revision of rules relating to the appointment of honorary medical officers. This Committee spent only 6 to 8 hours to discuss and come to conclusions about a subject of vital importance to the public as well as to the profession. Later it was found out by the Minister in charge of the Medical portfolio who presided over a meeting held under the auspices of the Madras Branch of the All India Medical Licentiates' Association on 16th July last who mentioned "They had recently a committee to examine the honorary system. He was now told *that their representatives did not do their duty properly*. He would give them another chance. A Committee with two members of the profession in service and two members of the independent profession would be appointed to re-examine the question and he hoped the views of their association would be fully voiced in that Committee." We are authoritatively informed that the Government did not ask the existing medical associations in Madras to choose

their representatives in the committee now appointed to consider how far the honoraries could replace the paid staff in the state hospitals and the Government who through the then Minister in charge of the Medical Department acknowledged that *"their representatives did not do their duty properly"*, have appointed the same member to represent the Licentiates who was one of the two Licentiates in the previous committee referred to by the Minister in his speech. Is it not breach of faith and when the Government commits such a breach who is to give the judgment?

What the Government have failed to do may now be achieved by those who are appointed by the Government from amongst special grade or class of practitioners in service and outside by calling meetings of the medical practitioners from whom they were chosen, to know their views in the matter. We on our part are quite prepared to co-operate with them by sending them series of Editorials we wrote on the subject last year and this year.

Patients to Pay: It looks as if the Government is mainly responsible either here or elsewhere for the state of affairs in the Government hospitals which instead of being resorted to by the necessitous poor, are now freely taken advantage of by the middle class and the rich. It is certainly not a sound policy to entrust medical officers in charge of state hospitals the work of charging well-to-do patients nor is it fair to make invidious distinctions between a well-to-do government servant and a well-to-do private citizen with regard to charging of fees for treatment in the hospitals, such a distinction being not known in any other civilised country. In years gone by, during the regime of the East India Company and even later when the Government became an Empire such a concession was perhaps justifiable to officers recruited from England and Wales just to encourage them to come down to this country. That such concession should continue till this day in case of Government officers even in the position of High Court Judges drawing a salary of Rs. 4000 a month or even more is to say the least most ludicrous.

Quite recently we are told that the Government of Bombay have revised the scale of fees to be paid by in and out patients attending state hospitals as a retrenchment measure and for this purpose defined a "well-to-do person" to be one who is in receipt of an annual income or salary of Rs. 1000 or more or who is a member of a family of such a person. In Madras a "well-to-do person" is defined as one whose salary or income is Rs. 1200 or more. The Bombay Government seems to have passed orders that all out-patients should pay one anna for daily attendance at Government hospitals and annas two in state-aided hospitals. While the fee for in-patient has been fixed at annas eight per each Rs. 100 of income the maximum to be paid not being more than Rs. 10 per day. The Government servants have to be treated free indiscriminately whether they are poor or well-to-do and it is not known if they have to be treated free as in-patients also. In Madras, the existing Government rules (which have not been changed as a retrenchment measure) prohibit advice and treatment for well-to-do patients in out-patients department and the prescribing officers being given the discretion to judge who is poor and who is well-to-do, the rule works very smoothy till the out-patient incurs the displeasure of the officer in charge. Regarding in-patients the rules have been made stiffer i.e more paying, a few years ago, patients being charged according to income from annas eight to Rs. 2/8 for diet, nursing and advice per day in case of persons in the general wards whose salary ranges from Rs. 50 to Rs. 200 or more and in case of patients admitted in special wards the fee ranges from Rs. 5 to Rs. 20 a day for diet and nursing and medical advice, a special additional fee ranging from Rs. 100-50-350 being charged a day for major operations and confinements. There are not many nursing homes in the city of Madras and one or two that have recently come into existence are conducted by members of service at the top. In Bombay affairs regarding in-patient treatment seems to be quite different from Madras; poor patients are seen in larger numbers as in-patients, the rich and middle class usually prefer to be in private hospitals or nursing homes of which there are a good number run by members of the independent medical profession. Out-patients department being always the feeder of the in-patient department, the discretion allowed to the medical officers to certify who is rich and who is poor has made it possible at least in Madras for the rich to attend to out-patient free; and their going into the in-patient department or to the nursing homes depending not so much on the existing rules as the doctors are not expected to know the exact income of the patients. They have to diagnose the income by methods peculiar to each medical officer. It is thus seen that the principle adopted by the Madras and Bombay Governments are the same though in the matter of assessing income and charging of fees they differ and so long the Government do not appoint almoners for the purpose of admitting patients in the hospitals as is the case of charitable institutions in England, the income earned from hospital patients will not be a tangible amount which will relieve the financial burden of the Government usually or even during the days of retrenchment. The rules of admission as well as the methods of assessing fees both in the in and out-patient departments in State hospitals do one thing certain i. e. depleting the income of members of the independent medical profession.

It is highly desirable that the Government bring about an uniform scheme of Hospital Administration so that state hospitals are run only for the necessitous poor with the help of the honorary medical staff; then and then only the Government could expect to be relieved of a big financial responsibility of medical relief and the members of the profession will devote themselves for service and research as is the case in other civilised countries.

Licentiates' Course: Elsewhere in our "correspondence columns" we publish a reply received by us from Major Amir Chand, Superintendent Government Medical School, Amritsar on our comments regarding his views for a four years' course for the Licentiates. While the views expressed by Major Amir Chand are worth the consideration of the profession we still hold that there should be only one standard of medical education. Whether it should be a course for 4 years or 5 years depends upon the quality of the teachers entertained for the purpose. Mere lengthening of the course of medical studies has no meaning if it were to serve the purpose only of aping.

Correspondence, Reports, etc.

Medical Ethics.

From

Major-General, C.A. Sprawson, C.I.E., V.H.S., M.D., F.R.C.P., I.M.S.

President, Madras Medical Council.

I have received your letter of October 29, 1932 concerning a registered practitioner of whom a laudatory notice accompanied by a group photograph has appeared in the lay public press. Such accounts are much to be deprecated and are contrary to the spirit of the Madras Code of Medical Ethics. It should not however be presumed that the practitioner in this instance encouraged or even sanctioned such publication.

Since you ask my opinion on the publication of such matter I reply that when such publication in a lay paper has occurred it is advisable that the practitioner concerned should issue a disclaimer and prevent the publishers from further breaches of medical ethics. I consider also that such breaches of ethics are preferably not dealt with by a Medical Council unless they become repeated and serious; but are best brought before the ethical committees of medical associations where such exist. Experience in other countries has shown that the combined opinion of his fellow-practitioners as shown by discussion at an ethical committee and the feeling expressed and attitude taken by his colleagues in the profession are potent towards exercising a restraining influence on unethical tendencies in a practitioner and that a report to a Medical Council is only necessary in extreme instances.

The Registrar of the Council in such instances as are brought to his cognisance issues in the first instance the official warning notice of the Council to the practitioner concerned.

The cutting sent by you is herewith returned.

Medical Education of the Licentiates

MAJOR AMIR CHAND'S REPLY TO OUR COMMENTS.

I thank you for your comments in your issue of October 1932 on my article "Some Problems of Medical Licentiateship in India" which appeared in the September issue of the Journal of The Indian Medical Association. When I wrote that article I was not ignorant of the Presidential Address delivered by Dr. Jivraj N. Mehta at the Seventh All-India Medical Conference held in Poona in 1931. If, therefore, in spite of that I expressed the opinion that a lower medical qualification than the University degree is a necessity, at least for a long time to come, it only shows that the arguments adduced against it have failed to convert me to his and your views.

Dr. Mehta depended as you say "on an analysis of the Bombay Medical Register," while what has helped me in forming the views I hold on the subject is mainly what I see every day in my Province and not "the speeches on this subject made by the members of the profession who met in conference last summer in Calcutta."

I do not claim to know much about Bombay and Madras and "facts" may be "otherwise" there, but I am not prepared to accept your statement that "it must be so even in the Punjab"—a province about which I claim to know more than you.

Before 1929 almost all the Licentiates qualifying from the Medical School, Amritsar, the only one for male students in the Punjab were employed either by Government or by Local Bodies. Therefore, until then the question whether they would or would not settle in rural areas did not arise. The issue in this Province is hence altogether new and very recent. Doubtless, it is the desire of a majority of them to settle in cities in preference to villages but necessity, if not choice, is diverting them to where they are needed and where they will be able to earn a modest livelihood with comparatively less difficulty. Those who have just qualified from the Amritsar School are coming to me for advice. They seem to have grasped the situation well and although the heart of almost every one of them is pinning for service of some sort, yet they all realise that that being hard, if not altogether impossible, to achieve, the next best course for them would be to settle in rural areas and not in towns where the profession is getting overcrowded and the struggle for existence is becoming keener every day. In fact, new Licentiates have already taken to village practice and I hope I am not unduly optimistic when I say that at least in this Province the Licentiates will eventually and by and by settle in rural practice.

In Bengal too, I believe, it has been found that the Licentiates are better fitted for rural practice than graduates, for the number of medical schools in that Presidency has recently been increased, and I mistake not, there is now a medical school for every division.

Rural Medical Relief Scheme.

MUCH ADO FOR NOTHING.

One of the items for discussion at the Conference of the representatives of the subsidised rural medical practitioners and the Honorable the Chief Minister with the Heads of the Medical and Public Health Departments and the Deputy Secretary, Local Self-Government Department, which met on 4th and 5th April 1932 at Madras, was about the question of disbursing the subsidy through the District Medical Officer, instead of through the President, Taluk Board, concerned. A G.O. has been published regarding this subject on 9-9-1932.

This G. O. No. 1932, dated 9th September 1932, enunciates that on the first day of the month following that to which the claim relates, every rural medical practitioner should prepare in duplicate a bill for the subsidy due to him and the midwife with the necessary certificates (*a*) and (*b*) annexed to the G. O. One copy of the bill should be submitted direct to the District Medical Officer and the other copy through the President of the Taluk Board who should forward it to the District Medical Officer, not later than the 7th of the month with his remarks. The District Medical Officer should peruse the remarks of the President, if any, and then decide either to pass the bill or disallow any portion of the claim. Against every order, disallowing the claim in part or whole, an appeal will lie to the Surgeon-General. If the President of the Taluk Board's remarks are not however received by the District Medical Officer by the 10th, he should proceed to dispose of the bill on the information, if any, available with him. After scrutiny, the District Medical Officer should return the copy of the bill, submitted direct to him to the rural medical practitioner concerned. The latter should cash it at the treasury not later than the 15th. The other copy sent through the President of the Taluk Board should be kept in the District Medical Officer's office as his office copy. After the encashment of the bill, the rural medical practitioner and the midwife should furnish acquittances (stamped wherever necessary) and send them to the District Medical Officer for check with the office copy of the bill and record.

The rural medical practitioner, prior to the passing of this G. O. was receiving his subsidy by not later than the 8th of every month in the shape of a cheque, on submitting a bill with the necessary enclosures direct to the President, Taluk Board, on the 1st of every month. The additional subsidy given to the rural medical practitioner by some Taluk Board Presidents from the Local Funds, in addition to the Govt. subsidy also drawn on, the same bill without any complicated procedure or additional trouble, as the Taluk Boards were adjusting the accounts quite easily. But unfortunately, the present G. O. No. 1932 dated 9th September 1932, with all its paraphernalia, is an encumbrance rather than an unavoidable inconvenience to the rural medical practitioner, as he will not receive even his inadequate subsidy before the 15th of every month. In addition to this he has to submit another separate supplemental bill direct to the President, Taluk Board, every month, if he were to receive any additional subsidy from the Local Funds, according to the conditions laid down in the bond, executed by him.

The cogency of the argument that the rural medical practitioners are a sort of independent medical practitioners who render prompt and necessary medical aid in all times of need to the necessitous poor and suffering humanity of the rural areas is also much perturbed by this G. O., as it added an enhanced subordination to the Presidents of the Taluk Boards concerned, restraining the little freedom enjoyed by this class of workers previously.

The G. O. states that the rural medical practitioner should encash the bill by the 15th of every month soon after he receives it from the District Medical Officer who passes and returns it to him by the 12th of every month. It makes no alternate provision for the bill to be encashed after the 15 of the month, if the medical practitioner is unable to encash it by that date either due to his absence from the village, when he takes casual leave in the interval between the 12th and 15th of any month at times or due to any other unavoidable circumstances. The absence of this provision in the G. O. is a great handicap to the medical practitioner concerned.

It is a great pity and strange irony to hear that the inventors of this complicated G. O. drawing fatty salaries and allowances every month were not magnanimous enough to realise and ventilate the undiscovered troubles of the rural medical practitioners by redressing their grievances promptly and by raising their annual subsidy and status considerably. As long as a subject demands no financial strain, it is absolutely easy to pass any rule with innumerable clauses.

The remedy of reform suggested by them is worse than the disease itself. It looks as if the Government have not realised the spirit and purpose of the scheme. Though in theory the subsidised rural medical practitioners are independent, they are practically treated like those employed under an indentured system of labour.

If the scheme of rural medical relief is not worked in the proper spirit with which it was inaugurated it will be a wasteful item of expenditure, benefiting neither the rural population nor the members of the noble profession.

The paragraph No. 6 of the G. O. regarding the monthly payment states that the amount due for a month works out to Rs. 41-10-8 in the case of a rural medical practitioner with L. M. P. or L. I. M. qualification. The rural medical practitioner is in a very disadvantageous position, as he is handicapped by the authorities that open the rural dispensaries and by the

lay public among whom he works, as the former think that the patients pay him adequate remuneration for his services and pay an annual subsidy which is not enough even to attend to the bare necessities of his life and the latter pay nothing to him with the erroneous impression that he is highly paid by the administrators and that he is provided with an adequate supply of drugs and necessary equipment.

Hence the subsidy for a rural medical practitioner with L.M.P. qualification should be raised to at least Rs. 75 per mensem, i.e., the starting minimum salary of a fortunate sub-assistant surgeon in Government service to maintain his dignity and status in the society, attending to the bare necessities of his life. He gets no contingency allowance and no annual increment during his service and no pension during his old age. The rural medical practitioner (in charge of many rural dispensaries) has to perform the multifarious duties of a doctor, compounder, midwife and the menial staff under most humiliating circumstances in remote villages, as he is not provided with any sort of subordinate staff. If the Government are unable to raise the subsidy immediately due to the financial crisis, they should at least strongly advise the Local Boards concerned to pay the raised amount from the local funds, as the rural medical practitioner serves both under the local board and the Government.

I hope that the Secretary to the Rural Medical Practitioners' Association, Madras, will endeavour for getting the subsidies disbursed through the District Medical Officer earlier than the 15th of every month without any interference by the President, Taluk Board, on submitting a bill with the necessary enclosures to the District Medical Officer alone, on the 1st of every month for the subsidy of the previous month and prevent much inconvenience, by addressing the authorities concerned on the subject.

M. SATYANARAYANAMURTHY, L. M. P.,
L. F. Rural Dispensary,
Thagarampudy, Vizag. Dt.

Rural Medical Practitioners' Association.

(NUZVID TALUK BOARD)

The first anniversary of the Nuzvid Taluk Board Rural Medical Practitioners' Association was celebrated on Sunday the 30th October 1932 at Nuzvid in the Government Hospital premises under the presidentship of Dr. P. R. Venkatrama Iyer M.B.C.M. District Medical Officer, Kistna.

After a group photo and light refreshment the meeting was commenced at 5 p. m. Thirteen rural medical practitioners were present.

After the prayer, Dr. N. Rama Rao Secretary of the association proposed the District Medical Officer to the chair and the same was seconded by Dr. S. Sree Rama Rao. The annual report of the association was read by the secretary and it was unanimously passed by the meeting. Then a number of papers were read on professional subjects. The first was a paper on a case of metrorrhagia which was later on complicated by hemiplegia by Dr. P. Anjayya. The next was on the subject of Asthma by Dr. N. Rama Rao. The third was an interesting humorous paper read by Dr. Suryanarayana Rao of Tanuku upon the precepts for a medical practitioner. Then S. Sree Rama Rao read a paper on hysteria and lastly Dr. S. Hanumantharao read about therapeutics of Gold. After each paper the President enlightened the audience by giving out his experiences in those diseases dealt with giving room to the members for discussion over the various subjects.

Verses composed in Telugu language by Dr. V. Sitharamayya and Mr. A. Venkataramayya were recited wishing the Acting Surgeon and District Medical Officer a long life and prosperity.

The President in his concluding remarks thanked the society and the members for having invited him to preside over the occasion and wished the association a bright future.

Trichy District Medical Association.

A monthly meeting of the Trichinopoly District Medical Association was held at 5 P. M. on Saturday the 15th. instant in the residence of Dr. K. V. Gopala Krishna Ayyar, the Assistant District Medical Officer who was "At Home" to the members. There was a fairly large gathering

including Mr. S. Ranganathan, O.B.E., I.C.S, the collector, and his wife.

Dr. T. V. S. Sastry moved a resolution that members of the profession pay visits to cherries and slums and render assistance to depressed classes by removing bad cases to hospitals or prescribing to ordinary cases. He also requested the District Medical Officer and the Chairman of the Municipal Council to permit them of such prescriptions being dispensed free in hospitals and dispensaries. After being seconded by Dr. Ragavan, there was a lively discussion in which Dr. Rajan and Dr. Sarma took part and explained how best the scheme could be worked out. The resolution was carried unanimously.

Dr. T. S. S. Rajan introduced to the audience Sjt. Bisweshwara Nath Baigal of Agra, the reputed opticisn who by his own industry and perseverence built up his pebble industry at great personal sacrifice, and called upon him to speak a few words. Mr. Baigal gave a short history of how he started his industry at Agra, the difficulties and troubles he underwent and the scant help he received from the public and the cold reception by the Government for his schemes. He was however persevering through the help of patriotic and rich countrymen.

In bringing the meeting to a close, the Secretary thanked the hosts for the sumptuous tea, and the guests for responding to the invitation of their Association in spite of the inclement weather. He also thanked Mr. Baigal the lecturer of the evening for his instructive lecture.

All India Medical Conference Lucknow.

Dr. K. S. Ray, Jt. Secretary The Indian Medical Association writes:—

I have pleasure in informing you that the invitation of the Lucknow Medical Association to hold the next IX All-India Medical Conference has been accepted and the Conference will be held at Lucknow during the Christmas week, the exact dates of the Conference will be aunounced later on. I have been authorised to extend the invitation on behalf of the Reception Committee formed at Lucknow to all the members of your Association and also through you to all medical practitioners in your parts. Rai Bahadur Dr. B. N. Vyas of Lucknow has been elected Chairman of the Reception Committee. Major M. G. Naidu has been nominated President of the Association for the ensuing year.

In order to make the Conference at Lucknow thoroughly representative of the medical profession of India, as in the case of the previous conferences, it is necessary that the co-operation of the members of the various associations should be freely given to our Lucknow colleagues in the successful organisation of the Conference. As on previous occasions this Conference will consider many important problems affecting the vital interests of the medical profession of India and notably the Indian Medical Council Bill.

There will also be a Scientific Section where scientific papers and discussion on interesting case notes will take place. Our Lucknow friends count on the help received from the members of the different associations in this matter.

Owing to shortness of time it has not been possible to extend the invitation individually to members of the profession all over India. I am, therefore, approaching you for help in this connection and shall be obliged if you could give as much publicity regarding this Conference as possible through your local papers or otherwise so that a large number of delegates may attend the Conference to guide its deliberations and take part in the Scientific Section. The Delegation Fee has been fixed at Rs. 5.

The Reception Committee are making every effort to provide accommodation for the intending delegates in a suitable Bungalow at Lucknow and only the actual boarding expenses will be charged. Delegates who intend to attend the Conference are requested to communicate with Dr, T. R. Swarup, Secretary, Lucknow Medical Association, Lall Bagh Circus, Lucknow, for accommodation etc. Further particulars will be supplied on request by the Reception Committee.

It is anticipated that the consideration of the Indian Medical Council Bill, which has been introduced at the Legislative Assembly and referred to a Select Committee, will not be taken up at the special session at Delhi in November. It would therefore be all

the more essential that the Lucknow Conference should pass resolutions regarding this Bill supporting the demands of the Indian Medical Association on the different clauses of the Bill and it would therefore be desirable that the Lucknow Conference should be attended by as many delegates as possible from the different provinces of India. It is hardly necessary for me to dilate on the importance of the Conference which besides focussing the attention on all the important problems concerning the welfare of the medical profession, affords an excellent opportunity of social intercourse between the different members of the medical profession in India.

List of Postings of Sub-Assistant Surgeons and Second Class Health Officers for the month of October 1932.

No.	Name of Sub-Asst. Surgeons.	From	To
1	V. Krishnamurthy	Leave	Police Training School, Hl, Vellore.
2	A. Tyagarayan	L. F. Dy. Gingee	c/o P. D. B., Chingleput.
3	M. V. Subba Rao	Govt. Hd. Qrs. Hl, Guntur	Govt. Hl, Ongole.
4	P. K. Gopala Panikkar	Govt. Hd. Qrs. Hl. Cuddalore	L. F. Dy, Gingee.
5	M. V. Rajasekhara Rao	King George Hl, Vizagapatam	c/o P. D. B., Anantapur.
6	V. Kameswara Rao	Leave	L. F. Dy, Pattikonda.
7	K. Srinivasa Rao	L. F. Dy, Pattikonda	c/o Civil Surgeon, Vizag. Agency.
8	K. Thiagarajan	Govt. Hl, Koraput	Govt. Hd, Qrs. Hl, Tanjore.
9	M. Pichumani Ayyar	Govt. Hd. Qrs. Hl, Ramnad	c/o Principal, Madras Forest College, Coimbatore.
10	C. Suryanarayana	Leave	c/o P. D. B., Ganjam.
11	B. B. Behari Mithra	Leave	Govt. Dy, Sompeta.
12	T. R. Subrahmaniam	Govt. Hd. Qrs. Hl, Ooty	Canal Dy, Vettikadu.
13	M. Venkobachar	Canal Dy, Vettikada	c/o P. D. B., Bellary.
14	V. G. Parthasarathy Naidu	Leave	c/o P. D. B., Trichinopoly.
15	P. Palaniyandi	L. F. Dy, Manappari	Govt. Hd. Qrs. Hl, Trichinopoly
16	P. J. Asirvatham Pillai	Leave	Govt. Dy, Devakkottai.
17	B. Subba Rao	Govt. Hd. Qrs. Hl, Cuddapah	c/o P. D. B., Cuddapah.
18	V. Ramakrishnan	L. F. Dy, Vonipenta	Govt. Hd. Qrs. Hl, Cuddapah.
19	H. Ghulam Mohammad Saheb	Leave	Govt. Hl, Ariyalur.
20	P. S. Kalyanasundaram	Govt. Hl, Ariyalur	c/o P. D. B., Trichinopoly.
21	N. Gopalan	L. F. Dy, Thathiengarpettai	c/o P. D. B., Trichinopoly.
22	V. Viswanathan	Leave	L. F. Dy, Sriperumbudur.
23	H. M. Hande	L. F. Dy, Sriperumbudur	Govt. Hd. Qrs. Hl, Nellore.
24	B. V. Suryanarayana	Govt. Hd. Qrs. Hl, Nellore	Govt. Hl. Kanigiri.
25	P. S. Ramaswamy Ayyar	L. F. Dy, Ayyampet	L. F. Dy, Aranthangi.
26	R. Krishnamurthy	L. F. Dy, Aranthangi	c/o P. D. B., Tanjore.
27	P. Satyanarayana Rao	Special Asst. Agent, Balliguda	Govt. Hd. Qrs. Hl, Cocanada.
28	V. Krishna Rao	Leave	c/o D. M. O., Ganjam.
29	K. Satyanarayana Raju	L. F. Dy, Ganjam	Govt. Hd. Qrs. Hl, Kurnool.
30	K. S. Rangaswamy	L. F. Dy, Yerakondapalam	c/o D. M. O., Ganjam.
31	P. Sitaramayya	Leave	L. F. Dy, Kaikalur.
32	K. V. Subba Rao	L. F. Dy, Kaikalur	c/o P. D. B., Kistna.
33	M. Kuqjunny Menon	Govt. Hl, Tellicherry	c/o Civil Surgeon, Vizag. Agency.
34	K. R. Ganesa Mudaliar	Leave	X-Ray Institute, Govt. General Hl, Madras.
35	M. Lakshmanan	X-Ray Institute, Govt. Genl. Hl, Madras,	Govt. Hd. Qrs. Hl, Berhampur.
36	M. Venkatasubba Rao	Govt. Hl, Ongole	c/o P. D. B., Guntur.

List of Postings of Second Class Health Officers for the month of October 1932.

No.	Names of Second Class Health Officers.	From	To.
1	M. S. Govindarajulu	Atmakur, Nellore	Hin[illegible]
2	K. M. Thomas	Trichinopoly	D[illegible]
3	A. Pattabhiraman	Dindigul	[illegible]velly
4	K. Srinivasa Sastri	Salem	Trichinopoly.
5	C. Ramachandra Rao	East Godavari	Vizagapatam.

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