

The Medical Practitioner

A Monthly Medical Journal

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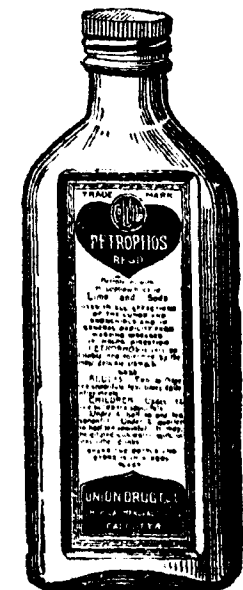


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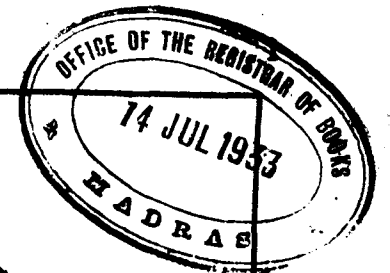
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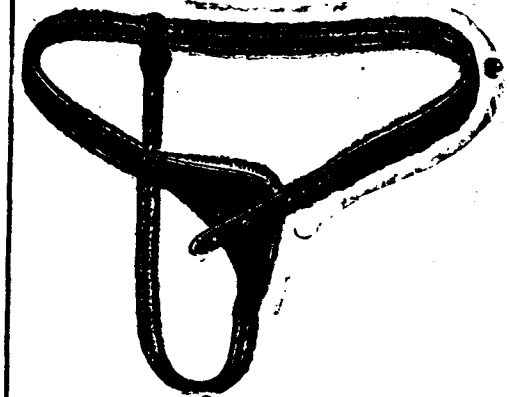
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[NO. 9

RURAL MEDICAL RELIEF.

The most important items which should concern the state and the public with regard to the welfare of the people in India, are education and medical relief, both of which have not been engaging the attention of those concerned to the extent of the importance of these two subjects. Though India is governed by one king, it is very unfortunate that those who are responsible for the government of India have not as yet shown any inclination to bring about uniformity in the methods of education and medical relief and the methods adopted in different provinces are not themselves ideal suiting the needs of the country. As we are concerned only with the medical profession, we would discuss about medical relief only. The subject has been engaging our attention as one of the main themes which concern the aim and policy of our service to the profession. We have been pointing out the defects in the medical administration in this country in general and have been discussing about the urgent need of finding out means and methods of giving medical relief in rural areas as either the Government or the local bodies have not as yet realised their responsibility with regard to this subject, though as much as 90 per cent of the population live in rural areas and are the chief source of revenue to the Government. Of late there have been some signs of awakening regarding medical relief in rural areas, and if our information is correct, Madras was the first province to recognise the necessity of affording rural medical relief and it was the first Chief

Minister with the Government of Madras, the late Rajah of Panagal who conceived this idea and formulated a scheme of subsidising practitioners to settle in villages. Later, a few other provinces, such as the Central Provinces and Burma, felt the need of organizing schemes of affording medical relief in rural areas. But judging from the working of the scheme so far in Madras, it looked as if those that were responsible in inaugurating subsidised rural medical relief scheme, had no clear ideas either of its utility, scope and the method of its working, with the result that this scheme has so far failed to benefit either the rural population or the practitioners employed for the working of the scheme, and therefore, the money spent and now being spent by the Government is to be reckoned as a huge wasteful expenditure.

In Madras, the rural medical practitioner is being paid a monthly subsidy ranging from Rs. 40 to Rs. 50 a month and Rs. 500 worth of drugs per year. He is expected to treat the necessitous poor free, and is supposed to charge for medicines as well as for services rendered to those that are not poor. Though the Government pays the subsidy, the administrative control of the scheme is entrusted to the taluk boards. In theory the subsidised practitioners are independent, but in practice they are at times treated worse than the menial servants of the taluk boards. The idea that this practitioner gets some money from the Government has made the villagefolk misunderstand the scope of the

scheme with the result that the rich amongst them expect not only free medicines but also free service, and in case any practitioner refuses to serve them all sorts of frivolous complaints are made against him. Usually the persons who complain are either the friends or the relatives of the President or any member of the taluk board and there are instances where the rural medical practitioners have been victimised and the fact that the President of the taluk board at times is both the prosecutor as well as the judge has made the position of the practitioner most helpless if not intolerable. It is true Madras stands first with regard to the number of subsidised rural dispensaries, but it can never be said that the scheme as it is worked at present will achieve the purpose for which it was started.

In the Central provinces, it is said that Rs. 50 a month is paid to a practitioner who gives an undertaking to Government that he would settle in a village and in addition he is given a loan of Rs. 300 for purchasing equipments, which amount is to be repaid in monthly instalments of Rs. 10 each in the second year of his service and Rs. 15 a month for the subsequent period. There is no other obligation imposed upon the practitioner. Though the procedure followed in the Central Provinces is good, it is said that the scheme is not developing to the extent of the need of the rural population, and we are not aware whether the blame is on the Government in not encouraging this scheme or whether the Government do not get enough number of practitioners for the subsidy they offer.

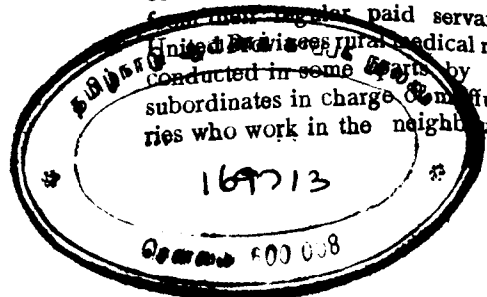
In Burma retired subordinates in the Medical Department are selected to serve as subsidised practitioners in villages on a subsidy ranging from Rs. 75 to Rs. 120. Why a retired official is chosen for a work requiring the zeal and enthusiasm of the youth is beyond our comprehension, but it is to be said to the credit of the Government of the Central Provinces and the Government of Burma that they do not impose on the subsidised practitioners conditions worse than what they demand from their regular paid servants. In the United Provinces rural medical relief is being conducted in some parts by the medical subordinates in charge of municipal dispensaries who work in the neighbouring villages

on some days in the month doing itinerant work. This sort of medical aid serves only as an eyewash and not real relief to the suffering humanity. In Bombay and Bengal, discussions about medical relief schemes in the press, on public platforms and on floors of the Legislative Councils have not so far helped to evolve any tangible results. The idea expressed in some quarters that rural medical relief may be entrusted to village school masters or to such others trained in first aid has been referred to only to be condemned. It is most irrational to consider that for the treatment of patients in villages only half-trained or ill-trained men would do. It should certainly be the contrary. The doctor practising in village parts should be one well equipped not only in professional skill but as a practical man of the world. In urban areas anything could be got for any price; it is not the case in a village where the practitioner has to be very resourceful in rendering relief to his patients depending upon scanty resources. In addition, the village doctor cannot afford to have the facility of consultation. So, on all grounds, it is desirable that the village practitioner should be certainly one possessing more than average intelligence.

Having said so much by way of introduction, we shall next endeavour to put before our readers a workable scheme of rural medical relief. As the scheme is at present worked in Madras, there is not much difference in the principle of working a local fund dispensary maintained at public cost and a subsidised medical practitioner. The rural medical relief scheme is another department under the Government maintained at a cheaper cost than the medical department. In olden days in India when village communities flourished, the village physician of indigenous system existed in each and every village and these were regarded and occupied the position of family physicians. The necessity of having family physicians at present is certainly much more than it was before. In the rural reconstruction scheme, in general, family physicians would occupy an important place. None can diagnose diseases nor cure them as efficiently as the family physician, who, being the permanent resident of the locality, possesses the accurate knowledge of the local conditions and

having varied opportunities of coming in contact with the inhabitants in every day life knows well their constitutions and the diseases to which they are predisposed. This knowledge would greatly facilitate the diagnosis of disease and their treatment. It is therefore essential that the rural medical relief is run in such a way as to encourage the growth of family physicians. This could be only done by making private practice more attractive. As referred to above, the subsidised dispensaries and the regular local fund dispensaries have not much difference in the principle of their working excepting the fact that the medical officer in charge of the former is more poorly paid. The existence of state-paid medical service which has been hampering the growth of independent medical profession in urban areas has similarly handicapped the rural independent practitioners in villages. In urban areas the state-paid practitioner is much better off in the competition, but it is not the case with the rural subsidised practitioner who though in a better position than his unsubsidised brother cannot hope to do much or at least as much as his more fortunate brother in regular Government service. It is the existence of state-paid medical department that is responsible for the non-development of rural medical relief scheme also. The idea of subsidising rural practitioners would not have arisen at all if there did not exist paid service. As things are to-day, it is not possible to get out of the vicious principle of pay or subsidy with regard to medical relief, and we have to make the best of a bad situation. Though the principle of Government paying a subsidy in the way it is being done now is against the growth of family physicians, it will not be possible, so long as state-paid doctors exist, to induce qualified medical men to settle in villages, unless they are shown some encouragement. As mentioned by us a little while ago, the village practitioner should certainly be as well equipped if not better than the one practising in urban areas, and so all possible care should be taken in selecting him. Preference should always be given to the native of the village or at least of the taluk or district. The practitioner should be one who has undergone one year's practical training in Medicine, Surgery and Midwifery after his qualifying examination four months in each

subject. It may also be necessary that he should in addition get extra training in an eye-clinic for at least three months. The Government should chalk out a plan depending upon finances and make it a compulsory obligation on the part of local bodies—if necessary by legislative measures—to maintain institutions for medical relief depending upon the population, distance covered, facilities of traffic and such existing conditions. From information gathered by us so far there should be a health centre for a locality of 8 miles radius in thinly populated villages and of shorter radius in other localities with thicker population. The provincial Government should be the appointing authority of the practitioner to be subsidised by them at least for some time more till our local bodies have improved considerably to manage their own affairs more satisfactorily than they do now. This practitioner may be paid a subsidy of Rs. 50 for the first year, Rs. 75 for the subsequent years, and in case he commands the popularity and respect of the people, he must be given Rs. 100 a month, the period of subsidy in a particular place not exceeding 5 years within which period the subsidised practitioner should manage to maintain himself. It must be the duty of the local board or panchayat concerned to maintain a dispensary and a midwife, and the subsidised practitioner should attend the dispensary for 2 hours in the morning and one hour in the evening at fixed hours. The subsidised practitioner should be independent practitioner, and the taluk board or the panchayat should have no disciplinary control over him. There are many ways for the Government to know about the popularity and efficiency of the practitioner. In case the report about the practitioner is good, his subsidy should be increased to Rs. 75 and eventually to Rs. 100 before the 5 years period. It must be left to the discretion of the practitioner to charge rich people for the supply of medicine at the dispensary and all the money collected at the centre should go to the treasury of the local boards. In addition to the subsidy an amount not exceeding Rs. 500 may be given to the practitioner for capital expenditure towards the purchase of surgical instruments and other appliances required by him. This amount should be recovered



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from the practitioner in small monthly instalments without interest. After the lapse of five years, if the practitioner sticks to the same village, it must be made an obligation on his part to give two to three hours' honorary service every day at the taluk board health centre.

As mentioned above the provincial Government should pay the subsidy to the practitioner in a particular place only for a period of 5 years and shift this contribution to some other locality till all the rural areas in the province get the benefit of medical relief. After 5 years' period health centre whose other expenditure is contributed by local bodies should continue. If after the expiry of the period of five years the once subsidised practitioner does not wish to give 3 hours honorary service in spite of the moral obligation or is found wanting in any particular way or shifts himself for practice elsewhere, the local body should appoint another honorary with or without subsidy depending upon the scope of private practice and the Government will have nothing to do with the future arrangement.

The Public Health Department should utilise the services of the rural practitioner to look after sanitation, conservancy, water-supply, etc. He may also be deputed to prepare vital statistics, and may also be engaged to do child welfare work. School sanitation should also be entrusted to the rural practitioner, and for all this work he should be given an honorarium of at least Rs. 200 per year. In places where there are primary or high schools, he should be employed to teach hygiene, physiology on reasonable remuneration.

The rural practitioner should be under the parental care of elderly practitioners preferably chosen "at least for the present" from amongst efficient retired government medical officers. We have used the word 'parental care' advisedly as we are having too much use of the word discipline in other spheres of life. Service being the only duty and responsibility on the part of the medical men, the word discipline is incorporated with such service. No efficient and sincere service could be rendered by a medical man to his patients unless his life is disciplined. So when a junior medical man is in need of advice and guidance, which is given by a senior to a junior in the right spirit, there will be no need for the use

of the word 'discipline' and with it 'punishment'. A medical man may be a worst offender, and yet go unpunished, for it is difficult at times nay impossible to detect his crime, on the other hand he may be saintly yet not appreciated. So the best control over the subsidised medical profession should be 'parental care and guidance.' There should be at least three elders to guide and control the subsidised practitioners to be in charge of three ranges, North, South and Central. Only persons who love village reconstruction work and not money alone, should be chosen and they may be styled as Inspectors and be paid Rs. 250 a month with travelling allowance. These should be directly under the Government and not under the Surgeon-General or the Director of Public Health.

The salvation of India entirely depends upon village reconstruction, and no work of village reconstruction will be complete unless right sort of earnest medical men take part in it. For there is nothing which a medical man cannot tackle if he is properly trained and put in the way. It may be said that our scheme of rural medical relief is an ambitious one and could not be thought about during these days of financial stringency. If the Government is sincere in the welfare of this country, and if they have belief that the prosperity of India is in her villages, the first charge on public revenues should be village reconstruction work and it is easier for the Government to realise what we have said as they more than anybody can realise that 90 per cent of the revenue comes from the villages. There is no need for the Government to tap fresh resources for the additional expenditure. We have been repeatedly pointing out in these columns that the opening of the dispensaries by the State out of public funds for the treatment of patients is objectionable and prejudicial to the interests of the patients as well as the profession. It is very doubtful if the patients attending the Government out-patient dispensaries in cities and towns are benefited at all, knowing as we do that on an average not even a minute is spent for examining the patients. As serious illness requires constant attention, rest, diet and treatment and as the large majority of the people are too poor to afford these in their own houses, the duty of opening and maintaining hospitals should fall on the

Government until philanthropic gentlemen come forward to assist or relieve the Government of their responsibility. So the unit of State medical relief should be hospitals and not dispensaries, as is the case in Federated Malaya States. The treatment of out-patients should be left solely to private practitioners. In towns and cities where there exist to day large number of private practitioners, the Government should close down the out-patient departments, and money saved utilised for the rural medical relief. The Government are recognising though slowly, the utility of honorary medical officers, but vested interests do not permit them to replace their paid officers by the honoraries who are made to work as supernumeraries. If the Government make up their mind to utilise the services of honoraries, substituting them in the place of the paid staff, there will be certainly a large saving, which could with advantage be utilised for real service of usefulness in villages and by doing so the Government will not be poorer and the people in villages will be healthier and happier.

Original Articles

IN A CARDIAC CLINIC.*

by

DR. T. KRISHNA MENON, M.B.C.M.,

M.R.C.S., L.R.C.P.

PHYSICIAN, GENERAL HOSPITAL AND LECTURER
IN CARDIO-VASCULAR DISEASES, MEDICAL
COLLEGE, MADRAS.

The cases that one sees in a Cardiac Clinic may be broadly divided into 2 classes.

1. Those which have been diagnosed as Cardiacs.
2. Those which are referred for an opinion as to whether they are really cases of heart disease.

Among the first group come some for directions as to future guidance but very few come for a confirmation of the diagnosis as all these people are firmly convinced that they are cases of heart disease. An esteemed colleague of mine recently expressed that he considered "all patients whose urine reduced copper as diabetics till

proved otherwise." My view is that no person should be considered a cardiac even though symptoms referable to the heart are present till all other possibilities are explored and disposed of. Cabot, the distinguished American cardiologist, summarising his study of over 1,900 cases of 'diagnosed' heart disease in which he correlated the clinical findings and post-mortem findings states that "most heart disease is imaginary". He further asserts that a major portion of a cardiologist's practice consists in *undiagnosing* diagnosed heart disease. The importance of deciding as to whether a patient is a true cardiac or otherwise is obvious. The lay person reads of sudden deaths due to 'heart failure'. To him 'heart disease' becomes synonymous with sudden death; and especially to the nervous or introspective individual it lays the foundation of an anxiety neurosis and chronic invalidism. Once the idea of heart disease is established, every minor manifestation would be attributed to chronic heart disease and no amount of argument or even convincing proof would enable him to disbelieve his cardiac condition and he would be living in perpetual anxiety as to his impending doom.

The basis on which cardiac disease is diagnosed lie on certain objective and subjective symptoms and I shall deal briefly with some of them.

MURMURS. A murmur is taken as a common diagnostic sign of valvular disease. The best heard and the most common ones are those in the apical region or the base of the heart. The apical systolic murmur is the most abused one. One has not to go far to find healthy young men rejected for public service or even studentships solely on an apical systolic murmur. The importance of this murmur as diagnostic of heart disease received its death blow during the last Great War. In many cases with a persistent systolic murmur post mortem findings have shown perfectly healthy valves, whilst in other cases with absence of a murmur gross damage to the valves has been found. Sir Thomas Lewis in his researches on the cardiac condition of many recruits and soldiers says that men with systolic murmurs were in a great majority of cases able to stand the strain of active

* Paper read at the Third Andhra Medical Conference, Guntur and specially contributed to The Medical Practitioner.

service quite as well as those without this sign, subject to their not presenting any other signs of heart disease. In his observations there was very little difference in the after histories of 70 recruits with systolic murmur but showing no other sign of heart disease and 90 controls who had no murmur. I like here to mention the case of a student, aged 18, diagnosed as a case of mitral regurgitation on the basis of an apical systolic murmur in 1926. He was the champion athlete of his school, a keen footballer, played daily 2 to 3 sets of tennis and took part in the rowing contests. He had no subjective sign relating to heart disease—no dyspnoea, no pain, no palpitation and was ignorant of his condition till he was examined for a physical fitness certificate. He was advised to give up his activities, lead a sedentary life and warned of the dire consequences of exertion and exercise. I saw him soon after that. He had no cyanosis, no increased pulse rate, dyspnoea even on exertion and the heart boundaries were normal to a normal athlete. The only sign available was a systolic apical murmur. The first and second sounds were otherwise normal. On the basis of these negative findings I assured him that he was free from heart disease and permitted him to resume his old activities and lead his ordinary life. To-day he is a mechanical Engineer doing hard work and when I saw him again in February 1933 his heart was normal in size and in other findings though the murmur is still present.

Another common type of apical murmur is cardio-respiratory in character. It is systolic in time and varies in intensity with certain phases of respiration. The difficulty arises only when it remains audible even when the patient holds his breath as happens in some cases.

The late Sir James Mackenzie said that the introduction of the Stethoscope has not only hampered the progress of knowledge of heart affections but has done more harm than good. Sainsbury does not even concede that these murmurs have any valvular relation at all and holds that they are not intracardiac in origin. His view is that the murmurs are produced in the pericardial chamber and are due to whorls set up in the pericardial fluid. Murmurs had a greater importance in the old days than now as the methods of examination

available in those days were restricted. With improved facilities that exist now, viz., orthoradiogram, electro cardiograph, improved and easy methods of estimating metabolic rate and other biochemical findings, diagnosis of heart disease solely on a murmur is, to say it mildly, hardly justifiable.

TACHYCARDIA is another symptom to be considered. Is it intrinsic or extrinsic in origin or is it a combination of both? If it is intrinsic definite myocardial disease has to be conceded, but if it is extrinsic the case is not one of heart disease. Many myocardial conditions (inflammatory, toxic, arteriosclerotic) are associated with tachycardia. In these cases definite changes relating to the heart may be observed. The point to be considered is the relation between the force of the beat as compared with the rate. If there is myocardial damage a definite loss in force is found, though if only slight damage is present one has to be satisfied with 'no increase in the force' of the beat. The apex beat is shifted. It may be outwards or downwards depending on whether hypertrophy or dilatation is present. The first sound is relatively weak and sometimes a murmur is present. Lack of force compared to the rate of beat is important. Tachycardia in such cases may be considered as intrinsic. In other cases the physical signs are slight, when a neurosis may be suspected and the tachycardia diagnosed as extrinsic in origin. With a rate of 100-120, regular, and slowing when a deep breath is taken, vagus influence must be thought of. The beat is increased in force, pulse becomes more vigorous and bounding. It is sharp. The blood pressure is slightly raised. With this type the tachycardia is not due to any intrinsic damage in the heart. This phasic variation is present as a result of Sinus arrhythmia and in pronounced cases may give rise to dizziness or fainting and vitiate the perspective. Tachycardia of myocardial origin does not show any reduction with deep respiration.

The patient should be kept at rest and observed. The rate is to be recorded during sleep. Tachycardia of nervous origin shows marked reduction during sleep or when attention is diverted and the patient is at ease. In myocarditis the rate remains up. This test is especially useful in the case of neurotics and children. Tachycardia in

growing young adults does not matter at all. It is part of the growing phase and is found generally in thin lanky flat chested subjects during adolescence. The only abnormality is the increase in rate. The force of the beat is increased and should help in diagnosis. Controlled exercise and adequate nourishment is all that is required. In anxiety neurosis tachycardia is most common. It is also present when there is any toxic factor and a certain amount of difficulty may be experienced in differentiation. This is especially true in the early stages of thyrotoxicosis. The tremor is deceptive; thyroid does not show any enlargement. In anxiety neurosis the sleeping rate is appreciably reduced. In thyrotoxicosis the rate is high even during sleep. Sweating is present, loss of weight and an increased metabolic rate are found. An increased pulse pressure with a definite diastolic drop is of great value in diagnosis of early hyperthyroidism. The thyroid shows a firmness even before any appreciable increase in size can be detected. Focal sepsis *eg.* in the tonsils, sinuses and elsewhere and extraneous toxins like coffee, and tobacco cause tachycardia. In one case under my care the rate returned to normal only on the removal of a septic gall bladder. Early tuberculosis should also be considered. Pallor, lowered blood pressure, rise in temperature especially after exercise are positive signs in tuberculosis. I am only dealing here with tachycardias presenting difficulty in diagnosis and not to obvious conditions like auricular fibrillation or flutter. It may be stated as a general rule that "provided the rhythm is regular and the rate is highly susceptible to changes in posture or emotional disturbances and if there be no other evidence of organic lesion tachycardia by itself should not be made the basis of a diagnosis of heart disease". The significance in the importance of tachycardia may be measured by the exercise response of the patient. Each one has his own pet method of eliciting this. It is better to acquaint oneself with one or two such. Getting up a stool of definite height a fixed number of times, climbing up the stairs, walking, running may all be adapted to ones need. I use rising on the haunches 3-20 times as the test, the number depending on the weight, the condition, and the previous athletic record of the patient. The average adult with a rate of 75 will go up to 100

on 10 such movements and will return to normal or less in $\frac{1}{2}$ — $\frac{3}{4}$ minute on rest. Nervous tachycardia shows a reduction in rate in the first 15 seconds after exercise. No exercise is to be permitted in which the pulse does not come back to the original number in 3 minutes after rest.

DYSPNOEA is not so common in the young as in the older 'bogus' cardiac disease. The weight, physical fitness and previous training have all to be taken into consideration in assessing this symptom. Extraneous conditions like fat and emphysema are factors which produce dyspnoea. In young people it is often associated with effort syndrome. Though the heart is sound there is very little cardiac reserve. It is part of their make up and to use a military expression they possess C class hearts. In older people care should be taken to apportion the relative causation whether to a chronic bronchitis and an emphysema or to myocardial weakness, intrinsic or as a result of fatty infiltration. In some cases of clinically mild influenza dyspnoea out of proportion to the illness have been noticed during the convalescence and later. In these cases the first sound is relatively weaker than normal, exercise response is poor and in electrocardiograms a depression or inversion of the T wave has been found, returning to normal on recuperation of the health. How much of the effect on the T is due to the myocardial lesion and how much it is due to the routine administration of digitalis one sees usually, can only be gauged by the history and other records.

CARDIAC PAIN: Many people complain about cardiac pain and unfortunately we have to assess its value purely on the patients' statement. Exaggerations and distortions are naturally most frequent with regard to this symptom. I have had the best text book descriptions of anginal radiation from non-cardiac cases. The association of cardiac pain with angina and sudden death probably accounts for the interest of the lay man in this subject. True cardiac pain is of important bearing in diagnosis. Circumstances which provoke it, which increase it, the location of origin, extent and direction of radiation have all to be considered and enquired into in detail. In no part of cardiac anamnesis could it be said that too much time has been spent. True cardiac pain comes always

with increased heart load, is aggravated by exertion and is relieved by rest. It is a protective reflex. The amount of exertion necessary to produce the pain depends on various factors like food, wind, cold etc. It is now generally accepted that true cardiac pain is the result of deficient coronary circulation. It is substernal and rarely truly precordial. The impression is that it always radiates to the left. Many cases do not show this radiation. Acute tenderness on pressure over the lower half of the sternum is often the only sign. In the non-cardiac type the pain is invariably submammary, has no relation to exertion, may come on at any time in the day or night and is transient in duration. The sounds are normal and in some cases accentuated. The beat is forceful. It is said that it is found mostly in women but I have seen it with equal frequency in both sexes. Neurotic persons of a high introspective temperament are the victims. Often a sexual underlying factor is present. A feeling of ache over the precordium or better still in the heart itself is complained of by some people when fatigued. It is not associated with exertion. Rheumatic myositis has also to be considered in relation to precordial pain. Acute tenderness on pressure is elicited in such cases.

HEART ATTACKS: A great many things give rise to such. The so called cardiac asthma, coronary thrombosis and angina are the common examples. Dizziness and in some cases faintness suggest heart disease. Excepting in marked aortic regurgitation and stoke-adams syndrome, fainting is hardly caused by heart disease. A vagus predominance is the root cause of such attacks. Well marked sinus arrhythmia may be found in such cases. Sir Thomas Lewis observed fainting on withdrawal of blood in a number of soldiers, the sight of blood rather than the pain of the prick providing the reflex stimulus. Fall in the heart rate with a simultaneous fall in the systolic pressure were noticed in these cases. Bramwell quotes the case of a school girl in whom fainting fits occurred during menstrual periods. The heart and other organs were sound. The syncopal attacks were often preceded by nausea and were evidently due to vagotonia, the heart itself

being sound. An injection of atropin or adrenalin raises the rate and increases the blood pressure with beneficent results in such cases.

CONSCIOUSNESS OF THE HEART BEAT trouble some people and one often sees them in a cardiac clinic—simple palpitation, extra systoles and auricular fibrillation are the common causes. In otherwise healthy individuals extra systoles form the commonest cause. Gastro-intestinal disturbances, extraneous toxins like tobacco or coffee often account for them and with the elimination of these they disappear. In the healthy individuals the extra systoles occur only when the heart beat is slow. It is only when associated with severe myocardial disease or with digitalis poisoning they need be considered as of pathological significance.

I have dealt here only with a few of the problems that confront the cardiologist. I have purposely omitted to deal with obvious cardiac conditions. I wish only to add that the diagnosis of cardiac disease should not be taken lightly and in doubtful cases full use of the ancillary methods of examination, the X-rays preferably by direct screening, the electro cardiograph and the biochemical aids, should be utilised before a final verdict is given; further in the case of sensitive and introspective persons the use of "therapeutic measures which tend to direct the attention of the patient to the heart are definitely harmful and should be studiously avoided."

CATARACT COUCHERS.*

by

DR. C. V. SUBRA RAO, L.M.S. (Hyd.).

I am highly thankful to the president for permitting me to stand before you for a few minutes to express my views, regarding the subject of couching of cataract performed by quacks in villages. You all know that cataract and its treatment forms an important item in the subject of Ophthalmology. I am not standing here to describe to you the various scientific treatments as I am sure that you all are more familiar with them than myself, but interested to express to you something regarding the

country method of cataract treatment, the prevention of which is quite necessary for the development of scientific eye-treatment.

Although there are several varieties of cataracts, the majority are senile cataracts. From my short experience I infer that on an average every village will at least have three or four mature senile cataracts every year, which approximately come to four thousand in a District, all of which, could be successfully treated with suitable scientific operative methods. But I am of view that, not more than 20% of these are undergoing the scientific operation under the hands of the surgeons specialised in that branch. It is our duty to concern ourselves with the fate of the rest of the 80% of the people who do not or perhaps cannot go to qualified surgeons for treatment. There are several reasons why the majority are not coming forward for the proper scientific treatment.

(1) It is evident from the word senile, that it is a condition of old age like grey hair, and the majority are quite unaware of the possibility of regaining their vision by suitable treatment.

(2) Some people are ignorant of the proper place where they can have proper treatment.

(3) The rest though having the knowledge of the possibility of treatment, will hesitate to approach an allopathic surgeon, as they are quite afraid of the methods of surgical interference since their apprehensions are grave suspicions of the safety of their lives. For example I am repeatedly asked by cataract patients in villages in this way "Doctor! We hear that you will remove the whole eye, clean and wash and put it again and that you tie the patient to bed in the flat position for about 12 days without any movement whatsoever." They harbour such views in their minds and are dreadfully afraid to go to a qualified surgeon.

(4) There are instances where the negligence is on the part of the children of the old cataract patients, who ignorantly believe that nothing could be done to the patients as they are told and are on the brink of the grave.

(5) Lastly many have not got the inclination of leaving the village and desire treatment in their houses only.

On account of the above difficulties some imaginary, some real, a large number of patients will yield to the persuasive language of the quacks, who have recourse to couching operation. These couchers go from village to village and coax them to undergo the operation for cataract, which they say, they would perform for a couple of rupees or so. It is impossible to dissuade the credulous village folk, from not undergoing the operation. For unfortunately these couchers have created a great impression in the villages in spite of their crude ways. I had an occasion to see a crowd of patients surrounding a coucher in one of the villages, and though I went out of the way and explained to them the real dangers of the operation, they would not listen to me, and faithfully underwent all the ordeal of the coucher. I had taken a photo of couching operation; The patient will be seated down with the head held tight by a person behind and the coucher will stand in front of him. He will ask the patient to look steadily at him, and draw the lower lid with the left thumb and thrust his pointed instrument at the upper part of the limbus with the right hand. The operation is very painful. But it is a surprise that the patient bears it well. At times these couchers do not remove the instrument from the eye till they are promised extra presents, like clothing, rice, shirts or in cash, in addition to the money stipulated for the operation. He will then draw the instrument with the screwing movements and with the instrument there will burst out the vitreous. He will wash the tip of the instrument in any water available and show the people the gummy vitreous sticking to the instrument are floating on the water, as the substance which, he removed from the eye and which he would say, was the cause of blindness. He will then apply a bandage with the country cotton sprinkled with pepper powder and he will leave the patient with the strict instruction that he should not hear any sound whatsoever, in which case, he would say the patient would not get good sight. Usually the coucher sees the patient on the third or the fourth day or at times will bolt away from the village, in case he sees the patient howling with pain, with inflammation in the eye, and loss of vision. If the patient informs the coucher that he sees some light, he will assure that there would be no

* Paper read at the Third Andhra Medical Conference Guntur and specially contributed to The Medical Practitioner.

pain the following day and he repeats his warning that he should not hear any sound. In case the vision is nil, the coucher would say that it was not his fault but it is the ill-luck of the patient, as he must have heard some sound—say barking of the dog, during sleep and this cause he would attribute to the loss of vision.

I need not waste the time of the learned audience by explaining the effect of injuring the eye, with the dirty instrument as one used by the coucher, the result usually following being panophthalmitis and in case inflammation does not take place, by the good luck of patient he is likely to suffer later from secondary glaucoma or detachment of retina and such other complications. It is also to be said that here and there one would see good vision in a patient, who has undergone the couching operation. On the whole it can be said that every coucher in a village might be responsible for making people blind or rather spoiling the chances of cataract patients getting vision at least at the rate of 100—such patients by each coucher for a year.

In conclusion, I want to give a piece of advice to young practitioners like myself, whose lot it is to practise in rural areas that there is a vast field for doing humanitarian work, if instead, of keeping quiet at their residences every village practitioner goes about rural areas and explains to the people the benefits of cataract operation by having recourse to scientific surgical procedure. They should demonstrate to them that the operation is painless and harmless and in case of really poor people do the operation free of all charges so as to encourage scientific treatment amongst the village folk, who if they once turn their minds from the couchers to the qualified practitioner would themselves prevent the cruelty perpetrated by these couchers. Apart from the humanitarian point of view the service rendered to the villagers in good faith will certainly bring the village practitioner commensurate prosperity.

Papaya tablets relieve dyspepsia.

Abstracts

THE DOCTOR AND PLAY

Heart disease has rapidly increased until it leads tuberculosis and cancer. But that is not the worst of it for the doctor, for doctors are leading all others in the death rate. The doctors are dying prematurely. The doctor's life is just too hard. He eats irregularly and imprudently; and sleeps when he can, and the frequently repeated shocks and the burdens that he carries are too great. He is subject to numerous infections and little by little it all affects his heart and that great organ becomes crippled and cannot last a good lifetime. The doctor should play a good part of his time; play joyfully, enthusiastically from young manhood on until he gets old enough to play golf. He should learn to play golf, to master the points to swing the clubs with pleasure and drive the ball with accuracy from constant practice. The hazards, like the obstacles in life surmounted, add strength. He should enjoy the companionship of fine men in the game. What could be more healthful than exercise in the open, breathing the oxygen, enjoying the healing rays of the sun. If you play, play more. Play until you forget everything else. Play tennis. It is interesting, exciting, wholesome exercise. The moving picture in the slow motion reveals the grace and beauty of the game. It is an inspiring and perspiring life in the great outdoors, and fine for pleasure and health. Go to the ball game; become a fan; root with the best of them and learn to love it and cuss the misses; that is the missess in the game, not the girls. Follow football and like it if you can. Perhaps there is no other game where the contest is such good sport, requiring such cool judgment and quick thought, unless it is poker, and that is too confining, among other things. Ride horse back; ride a good horse, a spirited fellow, until you become part of the horse, riding like a Centaur. Ride with the wind; speed with the wind; ride against the wind and feel the boost and thrill of it. Nothing in all exercise so completely brings every muscle of the body into action. That is the life, even if like the Prince of Wales, you tumble to the ground occasionally!

Go to the races and follow the speeding horse. It is splendid and will make any man forget his work and his troubles if he has a speck of sport in him. "The horse, who hath clothed his neck with thunder"! Of all animals, the horse is most interesting, next to man himself. If you haven't a good horse, ride a hobby. Nothing better than the camera. Be a fiend in the field of photography, discovering the beauties of nature and of the animal, and the human creature; putting upon the mat the likeness of everything beautiful. Perhaps your hobby may be collecting—collecting anything from butterflies to rare cacti; or it may be rare old books. Shut yourself in occasionally and read and rest. Go to the humorous movie. In this serious day every man needs a good laugh to expel from his system all the gloom and the toxins and poisons of hardship, physical and mental. Go boating. What is more beautiful or sweeter than a boat on a quiet lake or stream in the moonlight, with a companion, when the mocking birds are singing and all nature is at peace. Take a long voyage on the glorious ocean. Court your wife for a change and watch the results. Whether sweetly emotional, dramatic or tragical, it will be entertaining. Hunt what you like most to hunt, whether it be the bobwhite, which is now calling its mate over the hollow, the squirrel away up in the tree, the fleetfooted deer or the hugging bear. In some ways the hug of a bear is more diverting than to have a man or woman hug you. Not only is the quail calling, but the buck is running, and the turkeys are gobbling at night while the whippoorwill is singing its love song. Love your dog next to your family, but be careful that it is not more than your wife. Spread yourself and spend a nickel for peanut; go to the circus, by heck, and crawl under the tent if you can, like you did when you were a boy. It will be lots of fun. By all means go fishing, the greatest of all sports. The trout is playing in the stream, fighting the falling water with skill and joy and is ready for the hook and the play of the reel. The red bird is singing in the bottom, a gentle breeze is blowing, the lazy clouds are floating here and there. The stream is quiet, peaceful; a turtle sits on a log over there where the moccasin is playing in the water; a "snake-doctor" flits around and darts down to the surface of the water occasionally. Everything portends well. The fish

are going to bite. Shucks, throw the old bag and knives in the corner; shut the door and let's go fishing. Doctors are dying too early.

SAN ANTONIO, TEX. J.S. LANKFORD, M.D.

Doctors and the Soul.

The principal grievance which I have against the doctors is that they neglect the real problem, which is to seize the unity of the individual who claims their care. Their methods of investigation are much too elementary; a doctor who does not read you to the bottom is ignorant of essentials. To me the ideal doctor would be the man endowed with profound knowledge of life and of the soul, intuitively divining any suffering or disorder of whatever kind, and restoring peace by his mere presence. Such a doctor is possible, but the greater number of them lack the higher and inner life, they know nothing of the transcendent laboratories of nature; they seem to be superficial, profane, strangers to divine things, destitute of intuition and sympathy. The model doctor should be at once a genius, a saint, a man of God.—Journal Intime of Henri-Frederic Amiel, Scheveningen, Aug. 22, 1873.

Why Worry.

There are only two reasons for worry; either you are successful or you are not successful. If you are successful there is nothing to worry about. If you are not successful, there are only two things to worry about: your health is either good, or you are sick. If your health is good there is nothing to worry about; you are either going to get well, or you are going to die. If you are going to die there are only two things to worry about: you are going to heaven, or you are not going to heaven. If you are going to heaven there is nothing to worry about. If you are going to the other place, just worrying won't keep you from it. So WHY WORRY?

HOSPITAL HINTS.

(Clinical Medicine and Surgery—April 1933.)

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.

Influenza: Antipyretics are indicated to bring down the temperature as coal tar preparations should not be given. Aspirin grs. 3, Cinchonidin Sulph. grs. 3, may be given every three or four hours to relieve the pain and bring down the temperature. For the depression of the heart Caffein in 3 grs. doses every four hours is better than Digitalis. When collapse threatens, Strychnine with Atropine should be given hypodermically followed by Strychnine by the mouth. For delirium, Veronal or Barbitol Sodium grs. 7 in water to be taken. For bronchitis Ipecac and Pot. Citras in the early stages and Sandalwood Oil or Ammonium Chloride in the latter stages are beneficial. Antimony should not be given. If the cough is troublesome, Cannabis Indica is better than Morphia or Codein. For vertigo and giddiness usually complained of in influenza Sod. Bromide with Ergot and Cannabis Indica are good. The best laxative in the early stages to relieve constipation is Mycol. (A.F.D.) This does not irritate the bowels and bring on intestinal complications as do other drugs. Citrate of Magnesia may also be given. For constipation in the later stages, Ext. Cascara Sagrada Liquidum $\frac{1}{2}$ dr., Tinct. Nux Vomica mms. 5, Tinct. Belladonna mms. 5, Spt. Ment. Pip. mms. 5, Glycerine 1 dr., Aqua ad. one oz. given at 6 P.M. works well. For diarrhoea, Thoroxyl two tablets three or four times a day depending upon the severity of the symptoms acts effectively. For cerebral irritation attendant with insomnia, Brominol 10-15 grs., Chloral Hydras grs. 10-20 Hyoscine gr. 1/100, Aqua ad. one oz. is highly recommended. Ammonium Salicylate grs. 10 followed by intravenous injection of 5 to 10 gr. doses of Soda Salicylas dissolved in 30 cc. of sterile water is said to abort influenza. To promote osmosis, milk one pint saline solution one pint mixed together and given in tumblerful doses three or four times a day is good.

OTHER REMEDIAL MEASURES: Intravenous injection of Iodine-Chaudhuri Solution viz., Iodine 1 dram, Pot. Iodide 1 dram, Aqua distillata 5 ounces and 2 drams,

mms. 20-40 in 10 cc. of saline solution to be repeated after 48 hours. (I.M.G.)

As a preventive, Oleum Cinnamon 2 drms. Liq. Formaldehyd dr. 1, rectified spirit ad one oz. to be sprinkled on a handkerchief and smelt frequently.

The Spanish treatment consists of Phenacetin, Acid Salicylate, Antipyrine, each 0.15 gram, morphia Hydrochlor 0.005 gram thrice a day. 15 doses of this seems to be sufficient to abort an attack. Or Soda Salicylas 6-10 grams, Digitalin, 1-4 gram, Caffein Soda Salicylas 1-2 gram. Dionin 0.02-0.04 grams, Aqua Distillata 200 cc. one tablespoonfull in an infusion of lime flowers half hourly or hourly.

When pneumonia supervenes, injection either intravenously or subcutaneously of Streptococci Serum 20-50 c.c. or a vaccine containing B. Influenza, Pneumococci and Streptococci made from primary culture should be given within 96 hours. For an adult 100 million of each organism, for a child 12 years old 50 millions, of 2 years 10-20 millions.

For post influenzal pyrexia subcutaneous injection of Cresol 1 c.c. of 0.02 gram Cresol. Urotropine in 15 gr. doses dissolved in 4 c.c. of cold sterile distilled water has been used with success. The solution should not be boiled. (I.M.G.)

For children Sod. Salicylate grs. 2, Sod. Citrate grs. 4, Glycerine mms. 10, Aqua Anithi dr. 1, every four hours. If there is cough, Creasote is indicated. (Armytage) At the outset Liq. Opii. Sedatives in 20-30 mms. acts as a specific. (L.W.)

Oil of Ceylon Cinnamon bark 12 mms. in a wine glassful of water at the commencement and repeated in an hour is also recommended. (L.W.)

A mixture of Acetyl Salicylic Acid and Sod. Citras and Caffeine has also been tried to abort the attack. (I.M.J.) and also a powder consisting of Quinine Hydrochloride, Acid Phenitidin and Acetyl Salicylic Acid each grs. 5 for adults and for children $\frac{1}{4}$ to $\frac{1}{3}$ dose to be given immediately after the onset of the disease and repeated depending upon the severity of the case every three hours. Not more than four powders should be given.

Acetyl Salicylic Acid grs. 15, Pulv. Camphor grs. 4, Pul. Ipecac Co. grs. 15, into four powders, one every three hours acts also as an abortive. (Osborne).

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Spinal Anesthesia.

Experimental investigation in the Department of Surgical Research, Temple University, has furnished the following results: 1—The fall in blood pressure following the injection of an anesthetic into the subarachnoid space is not due to a collection of blood in the splanchnic area. 2—When the anesthetic ascends to the fourth thoracic nerve roots or higher, in the dog, there is an associated dilatation of the heart. 3.—The marked fall in blood pressure is mainly cardiac. Paralysis of the intercostal and phrenic nerves interferes with normal chest expansion and diaphragmatic excursion, causing a damming back of venous blood in the right heart and its tributaries. When the ascent of the anesthetic in the spinal canal is gradual, the blood pressure drops gradually and reaches its minimum in from 15 to 20 minutes. When the anesthetic ascends rapidly and sufficiently high to affect, not only the nerve of respiration, but the respiratory and vasomotor centres, and fall in arterial pressure is almost immediate, but may be preceded by an asphyxial rise. Sudden deaths following intraspinal injections may be cardiac, cardiac and respiratory, or respiratory. Adrenalin (epinephrin) and ephedrine have not prevented cardiac dilatation in our experiments. The Drinker respirator alone will resuscitate an animal that has received the full adult dose of a spinal anesthetic into the cisterna. Up to the present time there is no known method of absolutely preventing deaths from spinal anesthesia, but artificial respiration offers the best means for combating respiratory embarrassment and the fall in arterial pressure.

Philadelphia, Pa. Dr. J. O. BOWER AND ASSOCIATES.

Surg., Gynec. & Obstet., June, 1932.

Priapism and its Treatment.

Some of the most common causes of Priapism are: (1) lesions over or near the perineum due to injury or exercise as by weight lifting, cricket ball (2) infections typhoid fever, small-pox, influenza etc., and due to staphylococcal or streptococcal

infections causing meningitis and accompanying myelitis, (3) enlarged prostate and vesical distention often result of indiscrete conduct, (4) constipation, in fact anything that irritates directly or indirectly the genital organ and its appendages. It may not be out of place to mention here about the indiscrete use of drugs such as Yohimbin, Cantharis, Phosphorus 'Kapura' and such like drugs either to cure impotence or for the better enjoyment of sexual passion. These drugs bring about temporary relief or enjoyment and many a time are the causes of Priapism and eventually destroy the functions of the nerves totally and cause the very condition for which the drugs were made use of. Regarding the treatment, all causes that bring about irritation of the genital organs and their appendages should be removed. In my experience Tincture Cannabis Indica mms. 10, thrice a day has proved very useful, with 5 grs. doses of Quinine Hydrochloride in the morning and $\frac{1}{2}$ th gr. Opium suppository at bed time. Light liquid diet, cold compresses to the perineum may be mentioned in connection with diet and regimen. Surgical interference may be required in extreme cases as in Gonorrhoeal Chordee.

Laxmi Dispensary, G. L. DESHMUKH, Girgaum Back Road, L.C.P.S., M.B.B.S., Bombay.

Iodine in Management of Hyperthyroidism.

An interesting note on the role of iodine in this condition is given by Fahrni (*Canadian Med. Assoc. Journal*, July, 1932). The author calls attention to the fact that iodine has been of inestimable value as an aid in preoperative care in hyperthyroidism and has contributed in no small measure to the lowering of the mortality rate in these operations, particularly among those who accept all bad-risk goitres for operation. Nearly two years ago he reported a mortality rate of 0.92 per cent. for the last 844 consecutive thyroidectomies, and since then he has lost only two cases in 530 consecutive thyroidectomies, which makes a mortality rate of 0.377 per cent. There are many factors, such as the period of operation and better surgical technique which are causes contributory to this improvement, but he feels that no such low mortality in this class of patient can be obtained without

the assistance of iodine medication. The postoperative use of iodine is also important. As soon as thyroidectomy has been performed, every effort should be made to keep the patient fairly well saturated with iodine. During the first 24 hours after the operation the patient is often nauseated and may vomit periodically, and the oral route cannot be used for the administration of iodine. The author always gives iodine in isotonic solution of sodium chloride by rectum within an hour after operation, and if the patient is very sick he gives from 1 to 2 gm. of sodium iodide intravenously, once or twice during the first 24 hours. After this, the patient is usually able to take by mouth a sufficient quantity of the drug. If a fairly radical operation has been performed hyperthyroidism will disappear within a week, but iodine should be continued for at least some weeks after operation. The dose should be gradually diminished and as long as the patient remains well no further iodine is necessary.

subject is in a state approximating complete physiological rest. Mental or physical activity causes a rise in the count and there is normally a rise in the late afternoon or early evening. Exercise produces increases varying from 15 per cent. to 48 per cent. of the resting value; an ensuing rest of about 30 minutes results in a fall in the leucocyte count to the resting level. Further exercise produces a rise similar in degree to that first observed. The lymphocytes show the greatest increase. The hypodermic injection of adrenaline is followed by a leucocytosis in which all types of cell show an increase, but the increase in lymphocytes is again most marked. Possibly the leucocytosis following exercise is the result of increased secretion of adrenaline. The lymphocytes are probably derived from lymph glands which contract under the influence of adrenaline, and the glandular cells may be washed out of the bone marrow as a result of an increased blood flow due to the effect of adrenaline on the heart or to the exercise.

—The Journal of Clinical Research,
January 1933

Variations in the Leucocyte Count.

Martin (*Journ. of Physiol.*, June, 1932) has shown that the diurnal variation in the leucocyte count of humans is least when the

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CLINICAL NOTES AND PRACTICAL SUGGESTIONS Simple treatment of Gonorrhoea.

The variety and the multiplicity of products that are recently given out to the profession as remedies for Gonorrhoea baffles the practitioner who finds it very difficult to pick and choose. The different antiseptics that have been tried in former years have not yielded very encouraging results. Then came urethroscopy which opened up new possibilities in the treatment of this disease. There were after this advocates of protein-therapy, acrin-therapy and dye-stuff therapy, but they too soon lost their confidence as the results proved almost disappointing. Vaccino-therapy has however proved its worth and Venereologists are compelled to have recourse to it as it has undoubtedly given the most reliable results. Rheantine, which has been widely recognised and adopted as an anti-gonorrhoeal remedy during recent years, is an entero-coccal vaccine which can be given orally. It is not implied that this is a new method of treatment of Gonorrhoea but the old type of vaccine treatment has been made less harmful and more effective by some scientific processes. There was a long-felt necessity of a simple, convenient and harmless medicament to such patients who are either unable to visit the physicians every day on account of their occupations or who cannot afford the elaborate treatment of specialists. Again there are patients who are averse to any sort of injections. To all such types Rheantine has come as a boon as it is a cheap oral medication with an efficient local effect and a harmless general action.

Rheantine meets the requirements and fulfills the demands required of it as an improved vaccine therapy. It has been demonstrated by experiments as well as clinical evidence that in Rheantine, the antigenic principle i.e., the principle by virtue of which the development of immunity is stimulated in the patient, is very marked. This principle contained in Rheantine is practically free from any toxins which means that it is a comparatively pure product. Fur-

ther unlike other vaccine preparations Rheantine contains very little protein which fact enables us to administer larger and more effective doses. It has been proved that Rheantine is an efficient method of the treatment of Gonorrhoeal discharge. Results of bacteriological investigations have shown that Rheantine is an effective antiseptic and it has a decided anaesthetic action on the urethral mucous membrane. There is a difference of opinion as to the time of administration of Rheantine in Gonorrhoea. Some prescribe it in the sub-acute stage of the disease when the discharge has to a certain extent diminished while there are others who administer it at the beginning of the acute infection. The latter school of thought believes that Rheantine when given at this time is most effective as it diminishes the discharge, soothes the irritation, relieves the congestion of the mucous membrane and thus diminishes the pain. It does not however follow that local treatments at this stage should be neglected, but the use of Rheantine spherules limits the further extension of the infective process and thus renders local treatment more effective. Rheantine by means of its antiseptic and parasitocidal properties destroys not only the gonococci but also the secondary invading organisms. One or two days after administration of this preparation there is soon cessation of the pain of micturation and disappearance of the inflammation of the urethral canal. The patient is, as a consequence, very soon comfortable and is able to micturate easily and without pain. There is no disputing so far of the favourable action of Rheantine as regards its sedative, analgesic action and as regards its cutting short the infection.

A particularly suitable field for the employment of Rheantine is Gonorrhoeal infection either acute or chronic. Rheantine when given early in acute specific urethritis restricts the infection to the anterior urethra and prevents its further spread as well as the complications. The effect of this treatment is shown to advantage in these acute cases by the fact that there is a characteristic change in the clinical symptoms within two or three days. The irritating burning pain of the urethra at the time of micturition usually disappears. The discharge becomes thin consisting mostly of serum mix-

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ed with pus cells. The swelling and the oedema of the infected urethral mucous membrane is lessened to such an extent that the patient passes the urine with very little difficulty and with much less pain. If in conjunction with mild anterior irrigations with a disinfectant, preferably Blenacrol, this treatment is continued for a week or ten days, these favourable symptoms continue until the patient is fully cured.

In chronic Gonorrhoea, Rheantine has proved a valuable routine treatment on account of its bactericidal action on the gonococci as well as the staphylo and streptococci, which are usually found as secondary invaders of the diseased organs. If this treatment is continued for a sufficient length of time further complications can be easily avoided. In addition to this peroral therapy, irrigations of the bladder and the urethra with Blenacrol, prostatic massage and diathermy should also be carried out. The stubborn complications attendant upon this type of Gonorrhoea such as Epididymitis, Vesiculitis and Prostatitis promptly yield to this method of treatment. Rheantine relieves pain in these cases, soothes the mucous membrane and stimulates tissue-repair. Furthermore, it creates such a condition in the region of infection that the pathogenic bacteria are unable to thrive in it.

In Cystitis due to Gonococci, Rheantine has given excellent results either in acute or chronic forms. Together with vesical lavage the spherules of Rheantine can be safely given as it is a combined enterovaccine product. Too large doses at the outset should however be avoided. Not only are the symptoms alleviated, but the duration of the disease is shortened. It diminishes the frequency of micturition and clarifies the urine. It rapidly controls strangury and checks tenesmus and pyrexia. The cases are generally cured within 10 to 30 days and cystoscopic examination has revealed after cure that the vesical mucous membrane has been completely restored to its normal condition.

In chronic Cystitis, however, it is necessary that Rheantine treatment should be continued for some time. It improves chronic vesical catarrh of long-standing without any gastric or other disturbances. Under its influence the symptoms are

rapidly modified dysuria diminishes, the urine becomes more limpid and less purulent and tenesmus disappears.

Systematic administration of Rheantine for some time has been considered a very beneficial treatment in all cases of Gonorrhoeal cystitis whether acute or chronic or whether simple or complicated with prostatitis.

Rheantine has been found of considerable value in Gonorrhoeal arthritis. As this infection is likely to be prolonged and tedious this treatment is particularly indicated as it is devoid of risks and troublesome technique.

Rheantine therefore is a remedy of great therapeutic value in the treatment of Gonorrhoea and its complications. It is well tolerated by the digestive tract no matter in what doses and how long it is administered. It does not cause albuminuria or nausea nor does it have any other by-effects. This product is a vaccine preparation which need not be given by subcutaneous route and which has hardly any reaction. It is therefore preferred in the treatment of patients who do not want the pursuit of their usual occupations interfered with in any way.

The usual dose of Rheantine is two spherules, one hour before meals in the morning and two one hour before night meals. Combined with urethro-vesical irrigations with Blenacrol this dosage is sufficient to cure the patient within 10 days to a month according to the severity of the disease. It generally checks the discharge in a few days, relieves the pain and disinfects the urethral canal. Time is not far distant when Venereologists will prescribe Rheantine in Gonorrhoea extensively and with confidence.

In order to gauge the merits of Rheantine the following case was treated with only that product together with local irrigations of Blenacrol.

S. R. aged about 31 came to me with posterior urethritis and prostatitis. He was ailing for more than one month. Prostate was enlarged and was tender. The second glass showed the urine very cloudy and with filaments. The smear was taken on the slide and stained and when examined under the microscope showed grave

negative intra-cellular diplococci. The patient looked very seedy, worn out and was much emaciated. Irrigations with Blenacrol (4 drachms to a pint of warm water) were given together with prostatic massage. He was prescribed Rheantine, two spherules in the morning and two in the evening one hour before meals. After twelve days the progress in the case began to show itself. The discharge became very limpid and almost serous. The prostate gland decreased in size and was not tender to touch. After two more weeks all the symptoms disappeared and the smear when examined showed almost the absence of Gonococci. The treatment was continued for two more weeks even after the improvement in the clinical condition in order to prevent relapses. The patient has as yet i.e. after four months remained free from all symptoms and complaint of this disease.

Modern Treatment of Syphilis.

If one takes a survey of the modern methods of treatment of Syphilis, one finds that the disciples of the treatment of the disease by means of Bismuth are at present on the increase. The time-honoured view that Salvarsan and its other modified preparations alone are the proper means of treatment of Syphilis needs revision and the modern method is either to supplement the defective action of small doses of arsenic by means of a suitable preparation of Bismuth or to carry on the treatment entirely by it. The combined treatment should not however be carried on indiscriminately because of the particular needs and merits of cases. Bismuth since its introduction as an antisyphilitic remedy was formerly always employed in conjunction with some preparation of arsenic and we were therefore not able to sufficiently gauge its efficacy even after seventeen years of its trial. Benzo-Bismuth, which has been exclusively tried, has proved its value in the majority of cases. From the experiences gathered there is no gainsaying the fact that Benzo-Bismuth has been tried and not found wanting.

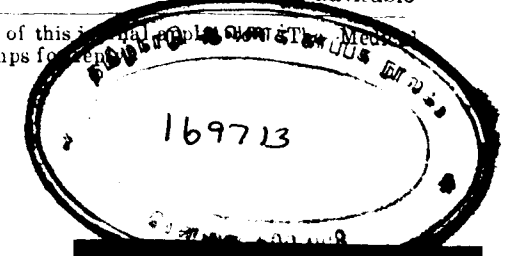
Several physicians have been advocating the use of Benzo-Bismuth from the very

beginning of its introduction. Fresh infections were solely treated with this product in two to three courses of injections. Despite the efficacy of the product and massive doses there will always be a certain proportion of cases which will not respond well to the treatment. We have therefore only to look at the greatest number of cases cured without any ill-effects and without the least signs of intolerance. That should be the criterion from which the product should be judged.

The most important point with regard to Benzo-Bismuth treatment that needs emphasis is the earlier the commencement of the treatment, the better the results. In the primary stage which is most often seronegative it has been observed that nearly 100 per cent of cases are cured by one course of 15 injections of Benzo-Bismuth. In these cases there is absolutely no necessity of combining it with any arsenical preparation such as Neo-Salvarsan or Sulfarsenol. In cases which have a positive Wassermann with either primary affection or secondary symptoms it is possible to effect a negative reaction by administering Benzo-Bismuth in two to three courses of 15 injections. The reaction has changed to negative and has permanently remained so in as many as 73 per cent of cases. It must be admitted however that in certain refractory cases Sulfarsenol was combined with this Bismuth preparation. Most of the cases have been tested clinically and found healthy even after lapse of several years so that we can regard them as definitely cured.

We cannot therefore follow a hard and fast rule with regard to treatment of Syphilis in general. Individual treatment is quite indispensable. The treatment should be in conformity with the stage as well as the nature of the disease the patient is suffering from. The remedy of choice which is least toxic and harmful in the early stage of the disease is Benzo-Bismuth. It should be given intramuscularly twice weekly. The primary healing is attained after three or four injections. The course should be extended to 15 or even 30 injections. If at the commencement of the treatment we find the Wassermann positive it is advisable

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after one course of 15 injections to test the reaction. If the reaction remains positive even after two to three such courses it is better to combine the treatment with injections of Sulfarsenol. These latter should be given alternately with Benzo-Bismuth. This combination treatment is sure to render the reaction negative after four or five Sulfarsenol injections of 42 cgrs.

After finishing both the courses it is always in the interest of the patient to carry on clinical and serological examinations at the interval of two or three months. If we find that the Wassermann reaction is negative every time we may rest assured that no further treatment need be carried on for about two years. If the reaction is negative and the spinal fluid is normal we can declare the case to be definitely cured.

The fears during the past about giving large doses of Benzo-Bismuth at frequent intervals have proved quite unjustified from a number of clinical experiences. It has been shown experimentally as well as clinically that Benzo-Bismuth has an optimum spirillicidal effect. Not only primary affections with negative Wassermann but even with positive one and all cases in the secondary stage can be cured by two to three courses of Benzo-Bismuth. Even one course in some cases has proved efficacious. And in the majority of cases it was hardly necessary to combine the treatment with Sulfarsenol. Nevertheless it must be granted that the combined treatment is the rapid method of rendering the reaction negative; but looking to the easy technique and facility of administration and freedom from by effects and unpleasant reactions Benzo-Bismuth is alone to be preferred. Besides it is a slow but sure method. Moreover, when the Wassermann becomes soon negative it may induce the physicians to break off the treatment prematurely and it is possible that not all the spirochaetes are destroyed at the time. That is a distinct disadvantage with arsenical preparations. Pure Benzo-Bismuth therapy, which must needs be prolonged, makes it possible to find out whether the spirochaetes are absent or not after an appreciable long period and this fact enables us to declare whether the case is really cured or not.

Although Salvarsan and allied preparations of arsenic are considered by far

superior as specifics for this disease nobody denies that they have their drawbacks. A number of cases are met with in which the disagreeable and dangerous by-effects such as nitroid crisis, generalized exfoliative dermatitis and even haemorrhagic encephalitis are observed. These direct toxic influences caused by these specifics have given a good chance to Bismuth preparations. Benzo-Bismuth, a soluble, stable and a non-toxic organic preparation of Bismuth has a definite curing influence on the syphilitic process. Though admitted inferior to arsenical compounds it is decidedly superior to mercurial preparations. Benzo-Bismuth has proved very valuable as a curative agent in the first and second stage of Syphilis and a powerful adjunct in neuro and congenital Syphilis. One finds that curative process unlike Neo-Salvarsan is much slower but one can be certain of the recovery. Benzo-Bismuth as an abortive means is not so good as Sulfarsenol or Neo-Salvarsan, although it is superior to these latter products in making Wassermann reaction negative and keeping it permanently in that state. Another advantage that it possesses is that it acts effectively in these cases in which either Neo-Salvarsan or Mercury fails to act.

Turning to details we can mention several Syphilitic abnormalities on which Benzo-Bismuth has a highly favourable influence. Aortic insufficiencies, aortic aneurysm or hepatic cirrhosis respond well to this treatment. Numerous venereologists have experienced favourable results with Benzo-Bismuth in syphilitic affections of the nervous system. This is because Benzo-Bismuth can easily reach the nervous system, as is evident from its presence in the cerebro-spinal fluid soon after the injections. It is also valuable in congenital Syphilis.

Taking into consideration the dangers, if there are any, that Benzo-Bismuth therapy entails we find that it is much to be preferred to either mercury or arsenical preparation in this respect. Benzo-Bismuth when injected hardly causes any pain and there is absolute absence of any infiltration at the site of injection. The worst that may happen is that it may cause a brownish or black ring along the gums. This soon passes off and should in no way prevent one from continuing the treatment. No stomatitis

occurs even after prolonged treatment of Benzo-Bismuth. Provided stipulated doses are administered the kidneys are not affected at all. Moreover, the preparation remains quite stable in tropical climates. Judging from these advantages that Benzo-Bismuth offers over Mercury or arsenical compounds we can say that its application in Syphilis is fully justified.

Epilepsy

Epilepsy is a chronic progressive disease characterised by periodic loss or impairment of consciousness with or without convulsions. It is more frequently met with in males. Race has no influence either on the frequency or causation of the disease.

The chief predisposing factors that are responsible for the disease are heredity, Syphilis or alcoholism in the parents. Those children who are likely to get the disease have certain stigmata from the very beginning as evidence of their inheritance. They have either microcephalic or macrocephalic heads. Some of them have a symmetry of face or the head or ears, while others have certain deformities of the limbs or have irregular or poorly shaped teeth.

As regards the pathology of the disease not much is known. Some say that it is a functional affection while others believe that there is some mal-development of the motor portion of the brain. There has been however microscopic evidence to show that the motor cortical cells are either under-developed or not developed at all. The disease appears in infancy but never starts after the age of twenty. The exciting factors are either toxemic or gastric disturbances.

There are three chief varieties of the disease viz. Major Epilepsy or Grand Mal, Minor Epilepsy or Petit Mal and Psychic Epilepsy.

Major Epilepsy or Grand Mal may or may not be preceded by an aura. This latter may consist of a feeling of dizziness or temporary blurring of vision or noises in the ears or sensations of numbness either in the extremities or in any of the viscera.

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This aura lasts from a few seconds to a minute or two and is usually followed by an attack. The patient becomes unconscious, falls to the ground and may hurt himself. There is rigidity of the whole body due to tonic contracture, the head bending forward, the fingers and the teeth clenched, the face blue and the eyes rolling in any direction. The patient bites his tongue and froths at the mouth. After some minutes this stage is followed by relaxation, the patient recovers soon or after some hours but feels very weak and exhausted.

In Minor Epilepsy or Petit Mal there is partial or slight loss of consciousness. This variety consists only of an aura followed by a dazed feeling which lasts hardly more than a few seconds.

In the variety known as Psychic Epilepsy the patient loses consciousness for a second or so and performs certain mild and automatic movements and then resumes his occupation in which he was previously engaged. The patient has absolutely no idea of the occurrence. Psychic Epilepsy is generally followed first by Petit Mal and later by Grand Mal. Sometimes all these types are found in one person.

If the disease is not properly treated the prognosis is poor. The attacks become more frequent, more severe and last longer. If the treatment has been instituted early and with vigour cure can be expected especially in mild and recent cases. The earlier the onset and the greater the frequency of the attacks the worse the prognosis. If a person gets the disease after the 20th year the attacks are rather few and far between and are of a milder nature. In the majority of cases the mental functions are impaired to a certain extent. This may result at times in total loss of intelligence and the patient may suffer from what is known as Epileptic insanity or Dementia. The patient rarely dies in a fit but frequency of fits tends to shorten life as is seen from experience that an epileptic rarely reaches old age. The patient usually dies of some intercurrent disease.

Turning to the treatment of the disease, which is regarded as progressive dependent on a special nerve-constitution, we have



to take into consideration prophylaxis, etiology, pathology and also the symptoms.

As regards prophylaxis of the disease certain social measures should be adopted and dietetic restrictions enforced.

Indulgence in any sort of alcoholic drinks should be prohibited. Certain excesses should also be forbidden such as mental or bodily exertions, indigestible food-stuffs and excessive consumption of meat. Again, epileptics should choose only such occupations where a sudden fall into a state of unconsciousness would not involve them in any danger. Masturbation which is responsible for many cases of epilepsy should be fought by means of social and medicinal measures. The treatment of causal indications is also a necessity. The cure of Syphilis or Tuberculosis, if Epilepsy is the result of these, by means of appropriate medicines such as Sulfarsenol or Benzo-Bismuth and Aurothysin or Aminobiase respectively is very important. If Epilepsy is in part due to Malaria, Gout or any disease of the metabolic disorders or toxic conditions treatment suited to these should be carried out. Thus in Malaria Quinarsine is the best remedy, in Gout Urogenine should be tried and in toxic conditions Mycol with suitable diet should be prescribed. The improvement of the general condition by means of a carefully planned regimen of suitable nourishment goes a long way in the cure of the disease.

Coming to the treatment proper in order to annul the increased excitability of the cerebral cortex present in this disease it should resolve itself into three heads:

1. Hygienic
2. Dietetic and Psychic
3. Drugs.

As stated before we have to restrict excessive activities of any sort in the case of epileptics. We have to keep them from such abnoxious influences such as stimulating drinks, excitement of any kind and mental and physical over exertion. They should be made to live in a strict and regular way. Concerning the dietetic measures salt-free diet with plenty of milk and vegetables should be recommended. Psychic treatment is also important in the management of this disease. It consists in improving the frame of the mind of the patient by

means of healthy surroundings and favourable environment.

Among drugs several preparations of Bromides have been recommended but a very useful and effective one that has stood the test of time is Elixir-Bromo-Valerianate. Inas-much as the disease is chronic it needs treatment for long periods. We have therefore only to prescribe such a preparation that is free from any by-effects or impurities, that has a synergistic action and that will not upset the stomach or intestines. Elixir-Bromo-Valerianate complies with all these essential requirements and hence its use in the treatment of Epilepsy is most advisable. Its long-continued use, if the diet is kept relatively salt-free, will bring about a distinct clinical improvement without any cumulative action or toxic symptoms. It appears that no harmful effects on the mucus membrane of the stomach have been experienced with this remedy. As regards dosage the practitioner should ascertain the minimum doses necessary to keep the patient free from attacks. One tablespoonful in water thrice daily after food is quite sufficient in any case. Dosage for children should be smaller according to their age. To ensure permanent results this Elixir should be taken for at least a year.

The employment of Elixir-Bromo-Valerianate together with dietetic and general measures is all that is needed in most cases for the cure of the disease. But in a great number of epileptic cases this exclusive treatment is of no avail. The use of this Elixir is meant for the control of the seizures through the affected centres but this sedative action in certain cases will not suffice. That means the disease is not attacked at its source. In such cases it has been pointed out that Pharmasol Collo-Calcium acts well by augmenting the effects of Elixir-Bromo-Valerianate because Calcium is an effective physiological sedative. It paralyzes the epileptic stimuli through desensitization of the ganglia and the nerve-endings but does not inhibit the functions of the cortical centres. By the use of a carefully planned therapy of Pharmasol Collo-Calcium in conjunction with Elixir-Bromo-Valerianate very satisfactory therapeutic results can be obtained. This Calcium Pharmasol has become a necessity for the adequate treatment of Epilepsy. It secures adequate retention of Calcium in the body

and therefore utmost utilization of it by the organism. It checks the somatic effects of Bromides. The daily doses of the Bromide preparation, which cause depression or lax feeling, can be much reduced under its influence. The most remarkable effect that this Pharmasol achieves is that it not merely secures adequate sedation and control of the seizures but prevents inhibition of the intellectual centres. It has been demonstrated frequently from a large amount of clinical experience how ideal this combination treatment became in the cure of Epilepsy.

Disturbances of the Menopause.

Despite the fact that the climacteric period, known by various names such as 'Change of life' or 'Critical age', is a physiological process it is marked not precisely by menstrual process but is also accompanied by many other disturbances of a circulatory or nervous nature. At this period the whole organism is subject to disturbed function. The general metabolism is lowered and it is not rare to come across digestive or circulatory disorders or even psychic symptoms.

This period, which generally comes between the age of 40 and 50 or sometimes as late as 60, is a period of great stress and strain in the majority of women. The suppression of menstrual function does not come to an end suddenly but is at first irregular and sometimes excessive. It may not come for months together but may appear after three or four months in the form of profuse haemorrhages. The general system does not remain unaffected by these irregularities. There is malaise, abdominal pain, cramps in the lower extremities heaviness in the pelvic region etc. Occasionally the chief complaints may be insomnia, extreme irritability or more or less marked conditions of excitement at times maniacal and at times of a depressive nature. The insomnia increases sometimes to such an extent that it becomes very serious. Another symptom and a most constant one is that subjective phenomena known as 'Hot flushes.' These are very distressing sometimes rising to the face

giving it a rosy tint. These sensations of heat extend to all regions of the body ending mostly in profuse sweating. The character even in certain cases changes and melancholia may set in. There is loss of memory and a state of neurasthenia may occasionally establish itself.

These distressing symptoms are fundamentally the result of the disturbed balance of internal secretory glands. Menopause may be considered to be a period of transition from active sexual life to passive period of rest. This phenomena is regarded by several pathologists to be a vascular change which follows the loss of internal secretion of the ovary. At this period atrophic and retrograde changes begin in the ovaries until they cease to function. The result is that there are rapid changes from high to low blood-pressure and the disturbance of certain physiological activities. These latter are maintained by the interaction of several endocrine glands during the sexual period of a woman's life. At menopause this physiological equilibrium is disturbed because of the progressive diminution of the ovarian secretion. The many symptoms that are met with are manifest during this period of readjustment and last until the whole physiological balance is set right on a basis which has to do without any ovarian influence.

This latter theory should not, however, prevent us from arresting the symptoms because if these symptoms remain untreated they may tend to congestive disturbances which may result in haemorrhage in any organ or part of the body. Thus several cases of apoplexy, pulmonary haemorrhage or rupture of an aneurysm are on record due to neglect of these symptoms. It is therefore incumbent on the profession not to delay in combating these symptoms and for this purpose a remedy is needed which not only makes up for the deficiencies of the internal secretions but regulates also the circulatory activity. It is with this dual purpose in view that Gynocalcion M is presented to the profession as both opotherapeutic and medicinal principles are embodied in it.

In Gynocalcion M the ovarian extract is combined with the orchitic and also with

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Calcium and Manganese lactate and Calcium Lactophosph. The entire extracts of the glands are utilised in the product and they are kept in such a state that they are not subject to any alteration. This is a preparation which puts the nervous system at rest and at the same time acts as a good sedative to the uterus. This conduces to regain the mental balance which is lost during this period. While Valerian preparations and Bromides increase the vascular congestion of the pelvic viscera and cause depression and more sleepiness respectively Gynocalcion M proves very useful and valuable eschewing all the disadvantages. By reason of its combination of ovarian and orchitic extracts of whole glands together with calcium and manganese salts it effectively and with ease exerts a rapid and definite modifying and sedative action. It compensates for the internal secretory deficiencies in an adequate manner and also tones up the blood-vessels and co-ordinates the effects of the disturbed nervous system. Thus the period of readjustment soon sets in and the patient within a short time is relieved of her symptoms. To be really of help to the patient Gynocalcion M must be administered at least 10 days every month in a dose of 12 dragees per day.

Experiences with Orargol.

Orargol is indicated in all acute infections especially Influenza because the non-specific immunity which it produces plays a very important part in diseases of this nature. The early use of Orargol is advisable as it protects the organism against pathogenic agents at a time when the specific antibodies have not developed. The preparation helps to cut short the disease, prevents complications and hastens convalescence.

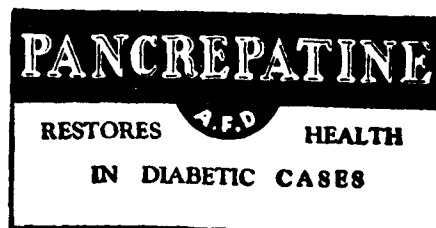
Details of a few particularly noteworthy cases under my care are given below :

1. Mr. S. B. aged 35 came to me complaining of pain in the head and limbs, running of the nose and malaise. His temperature was 100°6'. I thought it to be a case of Influenza and prescribed the usual Salicylate mixture. The next evening when I saw him I found him worse with a temperature of 103°4'. Although no physical signs could be made out in the lungs still he was looking a picture of anxiety with

dyspnoea and quick pulse. He had violent headache and great depression. I gave one injection of Orargol 5 c.c. intravenously. Next day there was sudden turn for the better, the temperature declining to a little over 100° and the patient felt distinctly better. I gave another injection by the same route as before the following day. Fever came down to normal after this and the patient was entirely free from any symptoms two days later. Convalescence set in after this.

2. A school-boy 15 years old came to me for fever, headache, cough, cold in the head and severe pains in the limbs. The case being diagnosed as Influenza I injected intramuscularly Orargol 5 c.c. at once. To my great surprise he came to me next day quite free from fever. The temperature which was 102°8' the day before came down to 97°. There were no symptoms except slight coughing which was probably due to the bad kind of pharyngitis that he had. Just to make assurances doubly sure I gave a second injection. No more treatment was necessary from the next day as he was completely cured. This case illustrates the efficacy of Orargol, the timely injection of which prevented complications and ensured rapid recovery.

These are some of the cases which I had occasion to treat. Although we cannot ascribe all the good results to Orargol entirely it cannot be doubted that it helped a good deal and even cut short the disease. Again it cannot be gainsaid that it is so harmless that it can be given even to children under one year. The absence of any undesirable reaction is a great point in its favour especially in acute cases where the patients are rather bad. The injection can be given intramuscularly or intravenously and even by the oral route. Many clinicians have confirmed, after their own experience with this product, that it entitles to distinct preference.



News and Comments.

Rotarians to the Rescue: The Indian Public and the medical profession would with gratitude welcome the idea that the Calcutta Rotary Club have included in the list of their activities the reform of the Hospital Administration in Calcutta. Quite recently they held a meeting well attended by the members of the medical profession including those who were in charge of hospital management. The whole question of hospital administration and organisation was discussed threadbare and the condition now obtaining at Government Hospitals in Calcutta were the items of discussion and member after member not only criticised but strongly censured the policy of the Government in not taking advantage of the honorary system of medical relief which would curtail the expenditure on salaries and would bring a surplus that could be utilised for not only increasing the in-patient accommodation but also in giving better comforts to the patients with regard to nursing and other details. It was noteworthy that the discussion was started by the chairman of the Public Affairs Committee of the Rotary Club, Mr. W. J. Herridge and continued by Mr. M. S. Davidson, the prominent European members of the club and will be appreciated as they are better judges not likely to be biased by racial or service prejudices. Their intimate knowledge about hospital administration in the West especially in Great Britain would certainly add to the weight of the arguments put forth by them particularly in connection with the knotty question of replacing the paid medical officers by honoraries. The following words that came out of the lips of Mr. Davidson would convince our readers of the depth of feelings even amongst the Europeans with regard to the wasteful expenditure incurred by Government on salaries of medical officers :

"The system now in force in the principal hospitals in this town is not economical, and in these hard times anything that is not justified by the results must be cut out. There are 35 I.M.S. officers employed in the various hospitals and their pay and allowance absorb annually just over Rs. 8½ lakhs. The present system of staffing the principal hospitals with I. M. S. men cannot possibly be economical, since their pay is not based on actual services rendered but on rank. To quote the case of one hospital only where nine I.M.S. officers are on the

visiting staff, their pay absorbs Rs. 1,32,400. Now if we refer to the hospitals in England, we will find that no such expenditure is incurred since beyond a couple of resident medical officers the whole of the medical staff is on a purely voluntary basis."

The same Rotarian Mr. Davidson referred later about the unjustification of allowing private practice to state-paid doctors: he said :

"I would draw attention to the fact that most of the medical officers now holding well-paid positions in the hospitals are also private practitioners and their income from private practice is probably three to four times as much if not more than the pay they actually receive for their hospital services. Yet most of them attend hospital for a about three hours a day on the average only, probably excepting Sundays. It might be mentioned here that any surgeon or physician in any hospital at Home receiving pay for his services is not allowed to have private practice. There may have been reasons years ago why the voluntary system was impossible, but conditions have radically changed since then and there are plenty of expert and experienced medical men in Calcutta, Indian and European, who would be ready and willing to render voluntary services if called upon."

The other important item of of discussion was regarding the Nursing Staff and Mr. Davidson deplored the meagre and inadequate nursing arrangements now obtaining at Calcutta Hospitals. He suggested that the Indian Nurses should be largely employed not reserving the posts to Anglo-Indians only who are paid more liberally than their Indian sisters for the same work done. He suggested :

"Most of the nurses are Anglo-Indians who receive a certain fixed salary. There are plenty of Indian nurses to be had if only some better balance was possible in the pay of Indian nurses. The main reason why Indian nurses are at present largely unobtainable is due to the great difference in pay offered to them in comparison with the Anglo-Indian nurses. I am reliably informed that the pay offered to Indian nurses is only about a third of what is paid to Anglo-Indian nurses. The information our Committee was able to obtain leads us to the conclusion that if the pay was more or less equalised even on a reduced scale, plenty of Indian nurses would be obtainable to look after Indian patients and the new scales in themselves properly adjusted would allow of a large number of nurses to be employed for the same capital outlay."

Other details such as delay in the treatment of out-patients due to lack of efficient management, paucity of medical staff, dressing orderlies, delay in the admission

of in-patients, payment of illegal gratuities to menial staff, callous and unsympathetic behaviour of hospital staff towards the patients, did not escape the attention of those who took part in the discussion.

Hospital administration and management is quite the same in all provinces in India as what is complained of in Calcutta but the provincial Governments have not or would not mind taking note of the gravity of the situation. It is really the signs of the times that European residents in Calcutta have taken up this work in right earnest. We trust the discussions at Rotary Club will be followed up till results are achieved. The Calcutta Rotarians would be doing best service to India if they send a report of proceedings of their meeting in Calcutta to all the provincial Governors and the Ministers in charge of medical department. It is certainly a reliable and faithful record of the state of affairs in state hospitals in India. We hope the Rotary Clubs in other cities like Madras and Bombay will follow the noble example of their brethren in Calcutta. Before closing, we would like to bring to the notice of Mr. Davidson that his information about honorary system in Madras is not quite correct. There is no doubt a larger number of honoraries employed in State Hospitals in Madras but the fact that those honoraries are supernumeraries has made hospital administration worse than before. The paid staff have now less work in the hospital and more leisure to engage themselves in private practice with the result that some of the officers of Government at the top could spend their time more profitably to themselves in the management of nursing homes, chemist-shops, and other such trades. Regarding the employment of Indian nurses it has to be said to the credit of the Madras Government that no invidious distinction is made between Indian and Anglo-Indian Nurses in the province though it is complained by nurses of both these nationalities that their European sisters are given preference. Bombay Government seems to be worse sinners as the Bengal in this respect.

Revision of salaries: The Government of Madras have recently published a G. O. (No. 311 - Public Services). The portion dealing with the medical services does not convey a clear idea of the Govern-

ment with regard to new appointments such as full time professors of medicine, mid-wifery, ophthalmology in Vizag. Medical College, of medicine and surgery in Royapuram Medical School and of mental diseases and tuberculosis in the Madras Medical College. At the Vizag. Medical College and Royapuram Medical School there had been professors for the subjects mentioned in the G. O. and the Superintendent Mental Hospital, Madras, was so far teaching mental diseases for the College students but Tuberculosis was not taught, till now as a special subject. The G. O. is likely to be interpreted that other new professors are to be recruited apart from those now existing and who have been doing hospital work in addition to the teaching of the students in colleges and schools. The appointments in the Provincial cadre are divided into (a) general branch (b) teaching appointments (clinical and non-clinical), (c) miscellaneous. The pay of the Civil Assistant Surgeon has been reduced from Rs. 200 to Rs. 175 and the maximum Rs. 450 to 400. The Civil Surgeon starts with Rs. 450 instead of Rs. 500 and gets the maximum Rs. 750 instead of Rs. 900. An unjustifiable distinction has been made with regard to Assistant Surgeons in King Institute by fixing their salary from Rs. 200 to Rs. 480, the maximum being more than what the maximum salary was for an Assistant Surgeon before the date of the G. O. under reference. The fact that the medical officers at the King Institute are allowed private practice and in addition earn a fair proportion of the fees charged for private patients at the Institute, makes this distinction most invidious.

The number of teaching appointments remain the same. There was much room to effect economy regarding these appointments. It may be said that the professorial appointments could not either be lessened or substituted by honoraries just at present but with regard to clinical and non-clinical tutors and assistants, assistant lecturers and assistant professors it could have been a financially economic measure if some of these posts were offered to honoraries with a short time allowance. Many of these assistants have only 3 or 4 hours work at the most and decent graduates would have filled these posts for a part time allowance of Rs. 100 a month whereas the Government

have to pay the grade salary of the Assistant Surgeon and meet in addition the expenditure towards pension.

The number of appointments in each cadre is not given and it is stated that the Government could fix it as necessity arises. It is a pity that in spite of past experience in this department where appointments were made and new posts created indiscriminately causing later heavy financial responsibility, the Government did not fix even temporarily, the appointments for each cadre. It is doubtful if all the clinical and non-clinical tutors and assistants mentioned in G. O. are necessary especially those set apart for the Madras Medical College, who seem to be beyond all proportions taking into consideration the strength of students in other teaching institutions such as the Vizag. Medical College and Royapuram Medical School. The course of studies at the Royapuram School has now been increased to 5 years and it is desirable that this school should have proportionate increase in the staff. The abolition of Tanjore School would necessarily force the Government to revert lecturers of Physiology and Anatomy who belong to a special teaching cadre with much higher pay, to the General Branch but the Government will be morally and legally bound to pay them the salary they are entitled to draw in the special cadre. This is an instance of a glaring indiscretion in making special cadres in the teaching institutions instead of putting the whole teaching staff in one cadre and the Government would have been well advised if they divided at once the medical staff into such cadres which denote the nature of work done and not depending upon the convenience and liking of the officers serving under them, and at present 3 such cadres would have covered the whole field (1) Administrative (2) Teaching and (3) Miscellaneous.

It is said that a special officer has been deputed to frame rules and regulations and conditions of service basing on the new salaries. The work of this special officer seems to have been very much simplified at least with regard to medical department. In no other department of Government, whole time officers are allowed private practice as in medical department which might have been justifi-

able in the interest of the public so long as there were not enough number of qualified practitioners to cater to their needs. Times have changed and callousness on the part of the Government in not having considered the desirability of prohibiting private practice to their officers is most deplorable and may even amount to breach of faith when it could be remembered that more than one Honourable Minister promised on the floor of the Local Legislative Council that the Government would consider the desirability of prohibiting private practice to State paid doctors when the opportunity of revision of salaries occurs. It is not likely that another more opportune occasion would arise than the one now under the consideration of the Government especially at a time when the Government have approved the system of honorary medical relief.

We trust the Special Officer will not fail to consider this question dispassionately and recommend to the Government the necessity of prohibiting private practice to full time Government Officers who are paid as liberally in this department as in others.

Five years course for Licentiates: We congratulate the boys and girls who will be lucky in getting admission into the Medical schools in Madras and Vellore that they will be the first batch to get the benefit of five years training which was so far the monopoly of the students in colleges though the students both of the colleges and schools were finally meant to practise the art of Medicine and Surgery. We cannot attribute this event entirely to the agitation of the Licentiates nor to the zeal on the part of the Government in bringing out this belated reform in the education of the Licentiates though it has to be said that without agitation nobody much less the Government would have felt the necessity of bringing about the much desired change in the curriculum of studies of the Licentiates. But we will be failing in our duty if we do not express the feelings of gratitude on behalf of the profession and specially the licentiate section of it to Surgeon-General Sprawson and Major Mahadevan the Superintendent of Royapuram Medical School who did all that was possible for them in persuading the Madras Government to sanction the 5 years' course and that at a time of financial stringency. They

had the grit to convince the Government that financial responsibility to effect this reform was trivial and could not be an excuse. The fact that the Government yielded and started the reform in spite of the policy of retrenchment they had to adopt in all departments would prove that the excuse of other provincial Governments in not starting this reform on the ground of want of finance is imaginary. If our estimate is correct, it will not cost the Government of Madras more than a couple of thousands more to run the first year's course. The extra subjects to be taught in the first year, are Biology and Physics and in the second year Organic Chemistry and Bio-Chemistry. So the 2nd year may also cost another couple of thousands and for three years following there cannot be extra-expenditure worth mentioning as the subjects taught during the later period are the same as before the reform. The extra expenditure will be partly met with by the enhanced school fees. So practically the financial commitment on the part of the Government will be little or nothing. Now that benighted Madras has shown the lead we trust that the other Provincial Governments will follow suit. If they don't they will be answerable to the charge of culpable neglect of responsibility.

We learn with great satisfaction that the course of studies will be identical to that of the membership of the Royal College of Physicians and Surgeons of Great Britain, which again is much the same followed at the Glasgow University.

The most important event in levelling up the medical profession has taken place in Madras and we feel most happy that the policy adopted by The Medical Practitioner towards this goal has not been in vain.

Licentiate students pull well : There was real anxiety both amongst the students as well as the lecturers in the Madras medical Schools about the results of examination held last April as the percentage of marks for passing had been raised by the Government to 40 for the first three years course and 50 for the final year. We were naturally inquisitive to know the results and are glad that both the boy and girl students in all the schools have fared remarkably well, the percentage of passes being more this year all through,

the percentage of passes in the final year at the Lady Willingdon Medical School being 58.82, Royapuram Medical School 57.14, Tanjore Medical School 47.72 and Vellore Medical School for women 45.

We congratulate the staff as well as the students of all the schools on their successful efforts in scoring a very satisfactory percentage of passes. The students did pull well in reaching the goal of 50 percentage of marks in the final year and thus raising their prestige and status. All credit to the Royapuram boys who initiated and invited on their own accord the harder ordeal of securing 50 percent for the pass and bore it well in spite of an unequal competition between them and their sisters who have been enjoying the privilege of not being required to study the diseases of the male urinary and genital organs as the examiners scrupulously avoided asking them questions on those diseases especially in the practical examination while the male students had to stand the test of questions on diseases of both the sexes.

This state of affairs make us ask a pertinent question; is it a right course to exempt lady students from studying the diseases of the male organs. We can say with authority that such an exemption was unknown in old days at Royapuram when it was a mixed school nor, we presume, such a privilege is claimed by the lady students in the other institutions here and elsewhere.

L. M. Ps at the Medical College : Out of 5 licentiates that appeared for the 2nd years M. B. B. S. examination only two passed. Ten licentiates will be admitted this year to make up 15 for the whole course, this being the number permitted by the college authorities. Out of the ten that are admitted this year, eight are from the Madras Province including native states and the other two are from Bengal. Preference is given to Madrassese and in all cases the qualification of the applicants weighed more in the matter of choice, those employed in teaching institutions seem to have been preferred. Naturally applicants from outside the Madras Province are disappointed with regard to selection. It is reasonable that preference should be given to Madras candidates. We sympathise with the disappointed candidates from outside Madras. It is certainly pitiable that the

Universities in other provinces have not followed the example of Madras in opening the Medical College doors to the licentiates. In case any University makes up its mind to permit the licentiate for the degree course we would request them not to follow Madras blindly. The condition that the licentiates should pass the Intermediate Examination or the Senior Cambridge Examination with 3 distinctions has taken away all the grace in the concession allowed to the licentiates for the M. B. B. S. course of the Madras University.

More speculation: Newspaper reporters keep people amused or make them muse. They are also capable of doing and undoing things and an atmosphere of speculation is always being maintained. Regarding the post of the Surgeon-General with the Government of Madras it was first reported as a lively contest between three Colonels familiar to Madras. The latest report had excluded two of them keeping in the field only one of the three, the ex-Inspector-General of Prisons of Madras doing at present double duties in Assam, we mean Colonel J. P. Cameron. With him are panelled a Knight now doing military duty and till lately the Surgeon of the Calcutta Medical College Hospital, Col. Sir., F. P. Connor and an Indian Colonel the Inspector General of Civil Hospitals in the Punjab. It is now surmised that in all probability Col. Cameron would be appointed to the post as he is expected to have better knowledge of Madras conditions without prejudices as he was not in touch with the Medical Department.

Unnecessary Disturbance : In this country offices seem to exist for persons and not persons for offices. Major-General Sprawson should be Director-General of Indian Medical Service. He should relieve Major-General Megaw. What is to become of the office of Surgeon-General with the Government of Madras and the schemes and programmes pending disposal by the Government? This matters the least perhaps so long the ladder of the Surgeon-General can take him to the top story occupied by Director-general. Nobody would grudge the use of the ladder but the sudden kicking of the ladder is likely to create unnecessary disturbance till the vacant chair is filled in. It is said that the final choice of the

Surgeon-General for Madras is likely to take some time especially when the competition concerns three different provinces. Why not leave the chair vacant till such time? Does not the Surgeon-General while in office leave his chair and be at the Hills or on long tours and the office work managed without a hitch by his personal assistant? No doubt there was a time when it was considered a sacrilege if an Indian acted for an European. It is not so now. Most technical and scientific work in medicine and surgery is now being done by Indian Officers, creditably and efficiently too. Even the unbreakable existing rule which called upon the Government to reserve some posts only for the European members of I.M.S. such as the posts of 1st Surgeon, 1st Physician Government General Hospital and the Superintendent Government Maternity Hospital, have been recently made more pliable. Fortunately there is no restriction anywhere laid down so far that the Surgeon-General should be a member of I.M.S. and that an European. And when there is nothing to prevent the local Government to make the personal assistant officiate for Surgeon-General and that too for a very short period, why should the Government of Madras keep things disturbed in teaching institutions, the Government General Hospital and the Medical College, by temporarily removing the Superintendent of the General Hospital who is also the 1st Surgeon and the Professor of Surgery Medical College. Such an arrangement will unnecessarily cost more money also. It is not fair nor even right to ask Lt. Col. Croly to officiate as Surgeon-General doing duty at the General Hospital and the Medical College.

Double Mystery : Double murder is the phraseology used in Criminal Courts when two murders are involved in one event. The phrase double mystery does now find a place in the events happening at the Madras Government Secretariat as is evidenced in the following episode.

Quite recently the Surgeon-General with the Government of Madras brought to the notice of the Government that it was not a sound policy to maintain subsidised dispensaries in places where the daily attendance was below 12. Accordingly the Government ordered seven months notice to subsidised practitioners in 19 places of

which two were in the district of South Kanara, Kaup and Perdur. The former is on the sea-coast, a healthy locality within 8 miles from the Headquarters, Udipi where there is not only a pucca Government Hospital but also a well-equipped mission hospital. There is also a qualified independent private practitioner at Kaup who had settled there years before the Udipi Taluk Board first contemplated to locate a rural dispensary in this village. A few months before this rural dispensary was started, the Government passed a G.O. on the recommendation of the Surgeon-General that a subsidised dispensary should not be located in a place where there was a qualified medical practitioner and though it was most degrading and humiliating for the Government to swallow their own order, the then Chief Minister allowed the running of a subsidised dispensary at Kaup in spite of protests from the existing private practitioner which matter was commented in these columns. It was also pointed out that the practitioner who was subsidised at Kaup was a relative of the President, Taluk Board, Udipi. History has been repeated at the Secretariat with regard to the closing of the dispensary at Kaup though it is a mystery to right-thinking people how the Chief Minister could permit again the running of a rural dispensary at Kaup which he once ordered to be closed along with 18 dispensaries in other districts on the report of the Surgeon-General. Of the two dispensaries that were ordered to be closed, the other is the one at Perdur, a malarial ridden area which is far away from Government medical institutions and where there is no other available qualified medical practitioner. This is a double mystery experienced at the Secretariat during the regime of two successive Ministers and these mysteries cannot be explained unless an unknown person plays witch-craft at the Secretariat. Is it possible many will ask?

No End of Troubles: There can never be an end either to the troubles of the subsidised rural medical practitioners or to the G. Os or their periodical interpretations so long the rural medical relief scheme is run in the way it is being done now. The subsidised practitioners are independent in theory but their lot is certainly worse than paid servants. They cannot enjoy leave, the maximum number of days permitted in

the year being only 15 days and even to avail themselves of this leave there are at times insurmountable obstacles in the way. Elsewhere in the "Correspondence Columns" appears a recent G. O. on the subject.

We learn that the Bhimavaram Taluk Board intends to shift a subsidised dispensary at Yendagandi to another village, Viravasaram where two qualified practitioners have long settled as private practitioners. If this were true it would be against G.O. No. 2923 P. H. dated 21-11-30 where it was laid down that subsidised dispensaries should not be started in localities where qualified practitioners had settled to practise. The Government have flouted this G.O. in Kaup, South Kanara District. Nobody can be sure what would happen in West Godavari. Our advice to the practitioners is that they should keep the Government informed about what was likely to happen before it is too late to mend matters. These are days when the Government depend on votes and there is a prevailing idea that patronage brings votes. So better to be forearmed and to forewarn. We have faith in persistent agitation for any good cause. Back-door methods are against public interest and sure to bring those who utilize them to grief, whatever position they may occupy. We trust the would-be aggrieved practitioners of Viravasaram keep the Government informed what is happening at Bhimavaram Taluk Board.

The Madras Taluk Board Act of 1920 as amended requires the panchayat in the taluk boards to maintain or provide funds for rural dispensaries. Accordingly the Government seem to have called upon some taluk boards to find out how many rural dispensaries under them can be transferred to panchayats. It is a very strange coincidence yet true, that one of the members of a panchayat who is seeking election to be President of the panchayat sought the help of a subsidised rural practitioner, to canvass votes for him which the young doctor declined. Later it so happened that this member of the panchayat, got elected as the President of the panchayat. The young practitioner's heart is now throbbing with all sorts of fears. Is the Practitioner to look after patients or himself at least for some time is a pertinent question on the lips of villagers?

The only cure for all these ills is to make the position of the subsidised practitioner so safe and secure that he could get along with his work of village reconstruction and not village politics and this is not possible under the present scheme.

Rural Sanitation: It is reported that the Director of Public Health has drawn up a scheme to get the help and co-operation of subsidised practitioners to look after rural sanitation. The working of the Rural Medical Relief Scheme is very faulty and unless and until the scheme is completely overhauled it is too much to expect from the subsidised practitioners any help in this direction when the life of majority of them is far from pleasant. The fat salaried officers of Government do not usually realise how hard it is for a private practitioner to keep the hungry wolf off his door and expect all sorts of honorary work for the mere patting on the back. We wish the Director of Public Health and other officials who are keen on village reconstruction, go through the Editorial in the current issue and find out for themselves the desirability of launching an ideal Rural Medical Relief Scheme both for curing and preventing diseases.

Taluk Board Medical Service: Though devolution of power is the ideal that is to be aimed at, practically this is fraught with evil with regard to administration of local bodies where corruption, undue influence and all that is undesirable seem to be the rule. Here and there in some districts there are medical institutions solely under the control of taluk boards and we have in our possession a document which gives a detailed history of the vagaries of a taluk board president. A clerk employed in a taluk board office was lucky enough to become the president of the very taluk board and the moment he got the reins of office, this old clerk got dizzy and could not perhaps tolerate that a L. F. Sub-Assis-

tant Surgeon was getting a fatter pay than he used to get in the position of the clerk and reduced the grade of pay of this medical officer from Rs. 105-5-125 to 60-4-80 without assigning any reasons. Fortunately the good services rendered by this aggrieved medical officer to the public stood in good stead and the board unanimously declined to give effect to the reduced grade and fixed it at 75-5-100 permitting the medical officer to draw the maximum. Eventually it was possible for this medical officer to persuade the taluk board to restore the old grade of Rs. 100-5-125 though for a short period when suddenly the board, brought the pay down to Rs. 60 as a measure of retrenchment. Thereupon on appeal a grade of Rs. 75-5-100 was fixed and finally approved by the Government which they did passing strong strictures against the board for having been the cause for demoralising the status of this medical officer.

It is certainly a matter of great disappointment that the Select Committee of the Madras Legislative Council who recently suggested the provincialisation of assistant health officers and assistant surgeons failed to suggest to include in the list the L. F. sub-assistant surgeons. Apart from the grievances of these medical officers under taluk board service of the nature referred to by us above, these officers are in sole charge of medico-legal work to execute which impartially they should be under nobody's obligation and be even independent of those who pay them. Taluk boards are governed by party politics and it is in public interest to see that professional opinion is not influenced on consideration of the parties. May we appeal to the Government as well as members of the Legislature to provincialise the Local Fund Medical Service and keep the Local Fund dispensaries under the administrative control of the District Boards?

PHONE No: 3034.

Dr. S. R. BHAT

M. B. B. S., L. D. Sc. (Calcutta)
DENTAL SURGEON

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Correspondence, Reports, Etc.

Late Dr. A. M. Vaiyapuri Mudaliar.

We regret to record the death at the age of 60 at his residence in Royapettah of Dr. A. M. Vaiyapuri Mudaliar, Retired Medical Officer, Krishnampet Infectious Diseases Hospital, Madras on 25th May. He was ailing for about a week of Pneumonia. He left behind him, his wife, three sons and a daughter and a large circle of relations and friends to bemoan his loss.

He is one of the sons of the late Mr. A. M. Mariappa Mudaliar, Engineer whose name is well-known in Madras in connection with the restoration of the Red Hills Tank, which is the chief source of water supply to the city. Dr. Vaiyapuri Mudaliar received his education in the Madras Christian College. He then joined the Madras Medical College and after qualifying for the Diploma of Licensed Medical Practitioner entered the Health Department of the Corporation of Madras, as a Sanitary Inspector and served creditably in the various branches of the Health Department. He rose to the position of a Medical Officer and was placed in charge of the Krishnampet Infectious Diseases Hospital. He successfully tackled several epidemics of Small-pox, Cholera and also Plague. He was held in high esteem by his superior officers and the public. He was a Member of the Health Propaganda Board and being keenly interested in Health Propaganda work, successfully carried on Health activities for nearly two decades. He was the author of "Cholera, its Prevention and Treatment" which was highly commended by Col. Russell, Col. Bradfield and others. He was also joint author of another book "Mosquitos and Malaria". After his retirement he was appointed as an Honorary Presidency Magistrate, Madras.

An Ingenious yet Faulty G.O.

I read with interest your comment under the caption "An ingenious yet faulty G.O." The G.O. may be faulty, but cannot be ingenious. The authors of the G.O., and others know full well, that the Medical Registration is a reserved subject and is in the hands of an Indian Member. But one must not feel shy to admit that it is an anachronism in diarchy, that the Medical Educa-

tion is a transferred subject and the Medical Registration is a reserved subject. The sooner, both Medical Education and Medical Registration are brought under the control of one member, the better.

Therefore the present arrangement of opening a separate register by means of an executive order is only, I think, a temporary stop gap arrangement intended to level up the existing practitioners of Indian system of medicine.

According to this G.O. there will be two classes of practitioners A and B. In the A class, practitioners trained in a recognised institution alone, will be admitted. In B class, practitioners of experience and merit alone will be admitted. But as years roll on, A class will naturally increase and B class decrease proportionally. Because, after a period of 5 years from the date of the G.O. there will not be any recruitment for B class. Casualties will be decreasing the numbers in B class. Ultimately there will be only one class, viz. A consisting only of practitioners trained in a recognised institution like the Government School of Indian Medicine. Then and then only, it will be possible and feasible for bringing out a legislation to register the indigenous practitioners by means of an open legislation, instead of an indirect executive order. I am sure we will get medical Swaraj, earlier than political Swaraj, and then the Act of 1914, will easily accommodate the practitioners of Indian Medicine. Till such time, the G.O. No. 231 of 1st February 1933, is absolutely necessary and quite essential, in the interest of both the public and the profession.

Pudupalayam. A. SUBRAMANIAM, L.I.M.
Member Central Board of Indian Medicine.

[We fail to see why the correspondent is not generous and objects the use of the word "Ingenious" which only means 'well contrived', though he himself explains the necessity on the part of the framers of the G.O. for wisely contriving and bringing about the Registration of the practitioners of the Indian system of Medicine. We only questioned about the legality and the unworkable nature of the G.O. with regard to the function of the Central Board of Indian Medicine to try practitioners in disciplinary cases. We wish either this correspondent or anybody else clears a reasonable doubt raised us by our comments on this subject.—Ed.]

Leave to Subsidised Rural Practitioners.

G. O. NO. 545 P.H. DATED 8TH MARCH 1933.

In G. O. No. 1701, P. H. dated 17th August 1925, the government stated that rural medical practitioners might, for sufficient reasons, avail themselves of casual leave for 15 days in the year subject to a maximum of ten days at a time inclusive of recognized holidays. In paragraph 2 of G. O. No. 1388, P. H. dated 28th June 1932, the government stated that the period of casual leave which was limited to fifteen days should be converted into leave of absence from duty for the same period without any limit as to the number of days for which a subsidised rural medical practitioner could be absent at a time.

The Surgeon-General enquires whether rural medical practitioners can avail themselves of recognized public holidays in addition to the period of fifteen days specified in G. O. No. 1388, P. H. dated 28th June 1932, or prefix or affix the holidays to the leave of absence with the approval of the presidents of taluk boards concerned. The Government consider that as rural medical practitioners are private practitioners, they can, with the permission of the president, taluk board, on each occasion, avail themselves of public holidays except sundays and also prefix or affix such holidays to their leave of absence provided that they do not remain in their own stations during the holidays and are not conducting private practice elsewhere and that their period of absence from duty does not exceed fifteen days at a time.

(By order the Government, Ministry of local self-Government.)

S. G. SENGODAIYAN,
Deputy Secretary to Government.

Reviews.

FORTY YEARS OF PSYCHIATRY
WILLIAM A. WHITE, A.M., M.D., SC. D.,
Nervous and Mental Disease Publishing
Company, New York and Washington.

Psychiatry has only been recently developed as a branch of Medicine and Dr. William A. White, is connected with it from its origin and the book reveals clearly and unmistakably his intimate knowledge of the subject. Hitherto mental diseases were considered to be incurable

and the treatment consisted only in physical restraint and hypnotics in an asylum. It was only after psychology was removed from academic philosophy and developed into a biological science the treatment of mental diseases was made possible and the institution in which these diseases are treated are named hospitals instead of asylums. Psychology has not only to deal with the treatment of mental diseases but has been brought into requisition in criminal courts, in industries, social and school work. Indeed civilization itself is a matter of the psychology of the peoples functioning at a social level of integration. Till now man has devoted all his energy, skill and knowledge in controlling his environment and has enormously complicated this and has not paid adequate attention to himself and finally he discovers himself among all these enormous powers which he has at his disposal and which science has made possible and is very properly alarmed at the possibilities to which his newly formed powers may be turned for like everybody else, they are ambivalent and as powerful for evil as they are good. The utterings of mad men are not without meaning. They are the language of the disease. If any doctor like Dr. White would take the trouble of noting down patiently everything the mad man may say and consider them in the light of the state or regression and their environment they will be clear and full of meaning, better than what sane men say and do, as it is said that language was given to man to conceal his thoughts and reason for the purpose of enabling to find a good and logical excuse for the things he had done. The advancement of Psychology has not kept pace with the times because the officers appointed for mental hospitals are said to be not properly selected and the number also is very few. Dr. White says that there should be one medical officer besides the superintendent for every 150 patients. In India the condition is much worse. The officers selected are chiefly on communal basis and the number hopelessly inadequate. While there are several private nursing homes for the treatment and care of insanies in other countries, in India particularly in Madras there are no private nursing homes for insanies. The book is an admirable one and requires to be studied not only by medical men but others in charge of criminal justice and those engaged on social and school work.

A Materia Medica of Pharmaceutical Combinations and Specialities

By Dr. U. B. Narayana Rao, with an Introduction by Dr. G. V. Deshmukh, M.D. (Lond.),
F. R. C. S. (Eng.), Crown Octavo, 375 pp. (50 blank interleaved pp.)

Price Rs. 2-8-0.

This useful book was reviewed in the columns of The Medical Practitioner last August and ever since, the undersigned have been receiving lot of enquiries from the members of the profession. Over 2200 preparations of various manufacturers both in India and outside have been dealt with in this book in a way most useful to the practitioners. The book is available for sale at the office of:

THE MEDICAL PRACTITIONERS' SERVICE BUREAU,
VEPERY, MADRAS.

List of Postings of Sub-Assistant Surgeons and Second Class Health Officers for the month of March 1933.

No.	Names of Sub-Asst. Surgeons.	From	To
1	Dr. M. V. Ganesan	Leave	Govt. Hd. Qrs. Hl., Masulipatam.
2	" C. Narayana Menon	Govt. Hl., Cochin	Govt. Hd. Qrs. Hl., Mangalore.
3	" M. Kelu	Govt. Hd. Qrs. Hl., Mangalore	Govt. Hl., Cannanore.
4	" J. Suryaprakasa Rao	Govt. Hd. Qrs. Hl., Bellary	c/o P., D.B., Bellary.
5	" M. Subba Rao	L. F. Dy., Kanekal	L. F. Hl., Alur.
6	" Md. Ayooob Khan Sahib	Festival Duty, Narsapur	L. F. Dy., Chintalapudi
7	" T. K. Nagarajan	Mahamagam Festival Duty	L. F. Dy., Sendurai.
8	" M. H. Dorairaj	L. F. Dy., Sendurai	L. F. Dy., Aravakurichi.
9	" N. A. Abraham	L. F. Dy., Mimisal	c/o Civil Surgeon, Vizag. Agency.
10	" J. R. Moses.	L. F. Dy., Enangudi	c/o Civil Surgeon, Vizag. Agency.
11	" K. Ramaswami	Leave	Govt. Hd. Qrs. Hl., Madura.
12	" M. Pichumani Ayyar	Mahamagam Festival Duty	Asst. Port Health Officer, Tuticorin.
13	" A. M. Arulanandam Pillai	Tuticorin	Govt. Hd. Qrs. Hl., Madura.
14	" T. Gnaniah	Govt. Hl., Srirangam	Govt. Hd. Qrs. Hl., Trichy.
15	" K. Natesan	Govt. Hd. Qrs. Hl., Trichy	L. F. Hl., Lalgudi.
16	" M. S. Kuppuswami Ayyar	L. F. Hl., Lalgudi	Govt. Hl., Srirangam.
17	" K. Appu Kurup.	Pykara Construction Works	Govt. Hd. Qrs. Hl., Salem.
18	" P. Padamadan	Leave.	L. F. Dy., Bangalowpudur.
19	" P. A. Narayana Iyer	Govt. Hl., Chidambaram	} Agency Duty, c/o Civil Surgeon, Vizag Agency.
20	" V. Sivasambu	Govt. Hd. Qrs. Hl., Tinnevely	
21	" P. Sanyasi Rao	Govt. Hd. Qrs. Hl., Bellary	c/o D. M. O., Ganjam.
22	" K. Kamaraju	Leave	c/o D. M. O., Ganjam.
23	" A. N. Subbayya	L. F. Dy., Melattur	c/o D. M. O., Ganjam.
24	" L. A. Subramania Iyer	L. F. Hl., Srivaikuntam	Govt. Hd. Qrs. Hl., Chittoor.
25	" N. S. Parameswaran	Govt. Hd. Qrs. Hl., Chingleput	
26	" P. Muthukrishnan	Govt. Hd. Qrs. Hl., Chittoor	Govt. Dy., Saidapet.
27	" V. Ramakrishnan	Govt. Hd. Qrs. Hl., Cuddapah	L. F. Dy., Porumamilla.
28	" S. Venkataswamy	L. F. Dy., Porumamilla	Govt. Hd. Qrs. Hl., Cuddapah.
29	" K. N. Subramania Iyer	Mahamagam Festival Duty	L. F. Dy., Sultan's Battery.
30	" K. Natarajan	L. F. Dy., Nattam	c/o Civil Surgeon, Vizag Agency.
31	" T. R. Manickam Pillai	L. F. Dy., Gudari	L. F. Dy., Melattur.
32	" R. Varadarajulu Nayudu	L. F. Dy., Melattur	L. F. Dy., Enangudi.
33	" R. Someswara Rao	Govt. Dy., Venkatapalam	Govt. Hd. Qrs. Hl., Bellary.
34	" G. Raghavayya	Govt. Dy., Dabugam	Govt. Hd. Qrs. Hl., Nellore.
35	" T. V. Ramanathan	Govt. Dy., Dharingbadi	L. F. Dy., Kayattur.
36	" M. Govinda Menon	L. F. Dy., Kayattur	Govt. Hl., Srivaikuntam.
37	" M. Venkataramanjulu Naidu	Govt. Dy., Minicoy Island	Govt. Hl., Chidambaram.
38	" P. Ramalingam Nainar	L. F. Dy., Mantapam	L. F. Dy., Tiruppattur.
39	" M. Vaidyanatha Iyer	L. F. Dy., Tiruppattur	c/o Insp. Genl. of Prisons, Ooty.
40	" V. N. Narayana Iyer	Mahamagam Festival Duty	Govt. Hl., Kumbakonam.
41	" A. Govindakutty Nair	Govt. Hl., Kumbakonam	L. F. Dy., Ayyampet.
42	" R. V. Narasimham	Mahamagam Festival Duty	Govt. Hd. Qrs. Hl., Guntur.
43	" K. R. Ganesa Mudaliar	Govt. X-ray Institute Madras	Govt. Hd. Qrs. Hl., Cocanada.
44	" Abdul Razak Sahib	Govt. Dy., Saidapet	L. F. Hl., Mettupalayam.

List of postings of Sub-Asst. Surgeons for the month of March, 1933. (Contd.)

No.	Names of Sub-Asst. Surgeons.	From	To
45	Dr. S. Jagadeesan	L. F. Hl., Mettupalam	Govt. Hd. Qrs. Hl., Ooty.
46	" K. Govindan	Govt. Hd. Qrs. Hl., Coimbatore	L. F. Dy., Palladam.
47	" C. Chintan Nair	L. F. Dy., Palladam	c/o Principal, Madras Forest College, Coimbatore.
48	" N. P. Ramanuja Charyulu	Govt. Hd. Qrs. Hl., Cocanada	L. F. Dy., Varanashi.
49	" T. Joga Rao	Leave	Govt. Hl., Russelkonda.

List of postings of Second Class Health Officers for the month of March, 1933.

No.	Names of Sub-Asst. Surgeons.	From	To
1	Dr. T. Velumayil Pillai	Health Inspector, Usilampatti Range	Asst. Dt. Health Officer, Salem Dt.
2	" S. Ramier	Health Inspector, Omalur Range	Rural Sanitation Health Officer South Arcot.

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Read the following quotation from the 'Hyderabad Bulletin,' Hyderabad, dated 8-6-33, under the head, 'THE CITY COLLEGE, MADRAS.'

"The attention of those who are anxious for bright careers may be drawn to the splendid opportunities provided by the City College, Madras, under the able guidance of its Principal, Mr. K. S. R. Acharya, B.A., L.T., F.R.E.S. (Lond.). The College has set out to meet the need for Cambridge courses in the preliminary, Junior, Senior and Higher examinations. ... The College provides excellent postal tuition course and the fact that during the last few years, its results have been very satisfactory, ought to attract students. Further particulars about the courses, fees, etc., may be ascertained on application to the Principal."

"THE UNEMPLOYED YOUNG MEN WHO BECOME UNEMPLOYABLE."

Nor is this all. It has also opened a special department for providing the educated young men and women with suitable posts both in the Imperial and Provincial Government and Railways. It is known to all that many in spite of their high qualifications fail to get suitable employment for the simple reason that they do not know when to apply, how to apply and to whom to apply.

We inform the candidates the dates when the Railway Board, the Imperial Government and the Provincial Government hold examinations periodically for the recruitment of hands to serve in their various departments; and also coach them up for these examinations by post. The result is that many who are at distant places even beyond 2000 miles from Madras, are able to take advantage of it and solve their unemployment problem for good.

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To meet the requirements of other candidates who were unable owing to poverty in early boyhood, and similar causes to reach the minimum qualification necessary for the Senior Cambridge, a new department has been started to coach up candidates by post.

for the Madras Matriculate Examination. It is also intended to meet the needs of the Elementary School Teachers who wish to improve their prospects in their line by means of a Matriculation certificate. Others also are admitted to the course. This department commences work on 1-7-1933.

"THE EDUCATION OF YOUR CHILDREN, THE FUTURE CITIZENS OF THE MORROW."

WORK FOR THE MOTHER LAND.

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Read what the great Seer Ruskin says on this:

"He only is advancing in life, whose heart is getting softer whose blood warmer, whose brain quicker, whose spirit is entering into living peace. And the men who have this life in them are the true lords or kings of the earth—they, and they only."

The word 'educate' in the latest Oxford Dictionary is defined as "give intellectual and moral training too." Most of the tragedies in the education of young men whom we meet to-day lies in the fact that education was not given to them according to this but some stuffs were crammed into them which they were made to repeat in the examination hall which secured them degrees. No wonder they are failures in life.

To avoid such tragedies and to give them opportunities for the harmonious development of their physical, intellectual and moral faculties, this college has started a Residential School where individual attention is paid to each pupil by experts in the line. Only pupils of 13 and above are admitted and coached up for this Senior Cambridge Examination in the course of two years.

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Principal.

A NOTE FOR YOUR KIND ATTENTION.

The City College, Madras, has so perfected its postal Tuition course for the Senior Cambridge Exam., of December 1933, that it caters admirably to the needs of all candidates who are scattered throughout the length and breadth of India and Burma from Sharigh in Baluchistan in the N. W. to Fort Morton near the Chinese Frontier in the N. E. Every mail brings in appreciations from them. The following is a true extract from one such letter received this morning from Burma:—

".....I am now paying more attention and time to the studies. So far the lectures have been very easy and easily learnt. It is a great credit to the College that taking into consideration the fact that the Medical Licentiates who have since long many years left their schools or colleges are taught the subjects each of them almost from the Alpha in such a manner that they can be easily learnt in a short time without the other helps or references being necessary. So complete are they and so easy to learn. It is a pleasure to study them. Very seldom such chances as these occur. This is a golden opportunity."

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The original formulae and composition is found in the MATERIA MEDICA by Dr. U. B. Narayanrao.

Santuben cures all cases of T.B. including complaints of catarrhal nature. By its use the grave symptoms of T.B. disappear rapidly. Coughing stops, bodily weight and appetite increase, temperature falls, night sweats are reduced and finally Tubercle Bacilli in sputum and blood disappear.

Lt. Col., F. E. Gunth, Physician to Margret Hospital for Consumptives writes that he always switches on Santuben with the happiest results.

Many Doctors in Bombay and up-country have sent their appreciations.

My general representatives for India, MADAN TRADING Co., 185, Princess Street, Bombay 2, will be pleased to forward to any Doctor, interested in the treatment of such cases, complete literature and samples for trial for convincing themselves as to the treatment of Tuberculosis with Santuben.

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PH. D., M.A., F.C.S., BERLIN, GERMANY.

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THIS IS ANOTHER PHARMACEUTICAL PREPARATION OF DR. RICHARD WEISS
FOR THE PROPHYLAXIS AND TREATMENT OF ELEPHANTIASIS.

Elephantiasis (Filaria Bancrofti) belongs to the most terrible of diseases to be found in tropical and subtropical countries. We are now acquainted with the fact that the filamentous worms, called Filariae, come in question as excitors of this disease. They quarter themselves in the lymphatic glands, and rob the glands of their normal activity.

This circumstance has led to the recognition of the fact that, as a prophylaxis as well as for the effectual treatment of Elephantiasis, a healthy organism capable of resistance, is an important proviso. It is for this reason that the modern hormone-therapy plays an important part in grappling with Elephantiasis.

The new hormone preparation *Lymphothormon*, conveys to the body in the form of an effective combination, all those hormones which the lymphatic glands need in order to function properly, and thus to stimulate the glands once more to perform their normal functions. The new preparation contains the most important hormones for nourishing the human body. In addition to the hormone of the thyroid gland, the male sexual hormone, and in addition to the hormone of the hypophysis (pituitary gland)—to the importance of which Professors Aschheim and Zondek have specially called attention within the last few months, — the hormone of the suprarenal capsule. By the administration of these hormones, the capability of the lymphatic gland in resisting the Filariae, is considerably heightened.

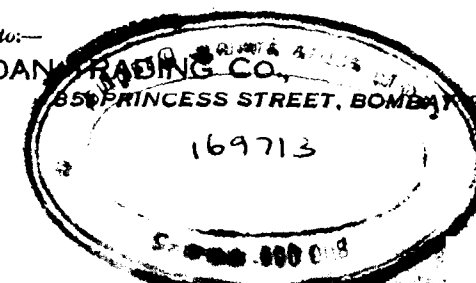
However, as one is compelled to employ all possible means at one's disposal in the fight against this contagious malady, the disinfecting medicaments are also added to the hormones, and bring about the destruction of the group of Filarian excitants. Of these medicaments, Trypoflavine must be mentioned in the first place.

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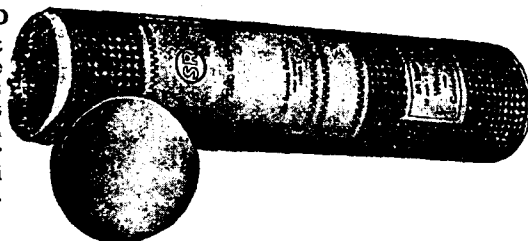


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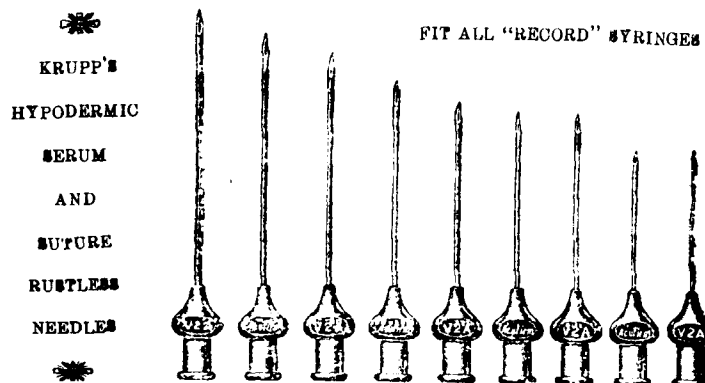
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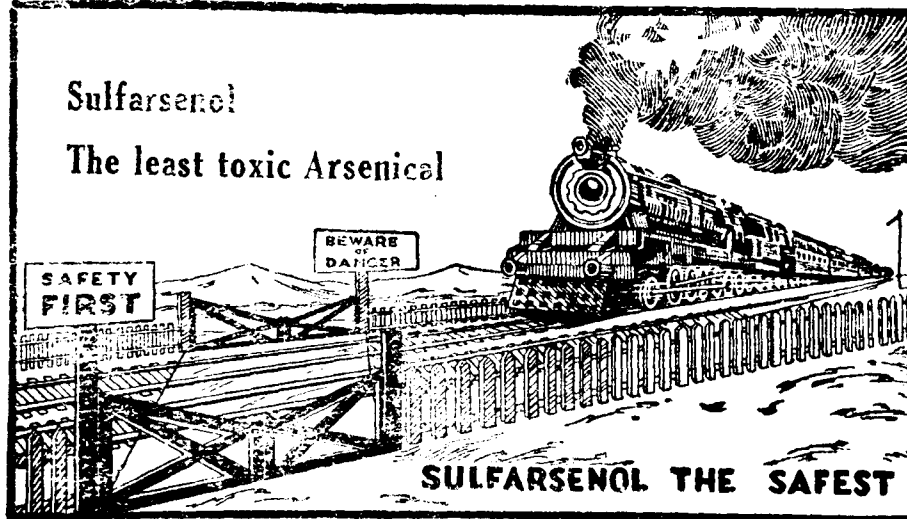
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