VOL. IV. No. 12 SEPTEMBER 1933

The Medical Practitioner

A Monthly Medical Journal

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Annual Subscription { Inland Rs. 2. / Foreign Rs. 3. } **Single Copy As. 4.**

VOL. IV.] SEPTEMBER, 1933. [NO. 12

FIVE YEARS' COURSE AND AFTER.

Now that the course of training for the Medical Licentiates has been extended to five years in Madras, we hope that other provinces will follow Madras sooner or later. There will soon crop up important problems as a sequela to the five years' course. These problems will naturally assume two aspects—one concerning the students now undergoing the five years' course and the other the old students who have passed out from the medical schools with four years' course. Human nature being what it is, those who will pass out of medical schools after five years' training will claim superiority over those who had to undergo the four years' course and consequently there will be yet another compartment added on to the compartments already existing in the medical profession. It is therefore essential to foresee this danger and take steps not to disorganise the profession still further.

The history of the existence and growth of the Medical Licentiates has been one of the most vexed and complicated problems and is as old as the advent of the British rule in this country. As was mentioned in these columns very often, this class of medical men were primarily brought into existence by the British Government to assist the army medical officers. So the Government did not concern themselves to impart medical education to them more than what was necessary to perform the duties of dressers later known as hospital-assistants. The evolution of the latter as Licenced Medical Practitioners, was due to mere force of circumstances in spite of the callousness on the part of the Government to supply to the civil population in this country medical practitioners of the necessary qualifications.

So it was that though India is under one Government the dressers and hospital assistants were trained in different ways to suit the then needs of particular provinces. Consequently there could not be any uniformity either in the method or in the manner in which these assistants were trained. This is why education was imparted in Vernacular in some provinces, the course of studies being as varied, lasting from 1½ years to 3 years till about the year 1903 when in some provinces the course was extended to four years and we presume the medium of instruction was changed from Vernacular to English except in Madras where as far as our memory goes, the medium of instruction was in English from the very beginning of the British rule.

Even in 1933 the British Government has not realised their responsibility of bringing about an uniform standard of medical education for the members of this class who form the largest section of qualified medical practitioners in this country. On the other hand the Government moved heaven and earth to bring about a medical council to control the education of the medical graduates which they did—not at all

in the interest of either the public or the medical profession but only to placate the British Medical Council. And for this purpose nearly a lakh of rupees has to be spent year after year, whereas the same Government could not advise the Provincial Governments to spend money to introduce five years' course for medical Licentiates in all the provinces. So the past and the present history indicate the necessity of pointing to the profession especially the licentiates section of it that the five years' course brought about by their agitation would bring more disharmony even amongst the Licentiates unless they solve within a course of 4 years (the period within which the students of the 5 years' course come out from the medical schools) the effects of the sequela of the 5 years' course on the old Licentiates.

There exist at present two class of Licentiates, those who had 3 years' course and the others who had the four years' course. The former will in majority be nearer sixty years of age and almost retired from active practice and the latter range from the age of 25 to 45 and are in the prime of their life. The L.M.Ps of four years' training never grudged nor grumbled in word, thought or deed when the Government conferred the L.M.P. title on the Licentiates with four years' training and permitted those of three years to have the same title. This was really a wise move on the part of the Government. Neither the profession nor the public suffered on account of the Government not making any difference between the 3 years and 4 years L.M.P.s and things will not be otherwise if the Government repeat what they did and recognise the 4 years' L.M.P. as equivalent to those with 5 years' training.

The other question that has to be decided upon, is the necessity or otherwise of the change, in the name of the Diploma to be conferred on those who will pass the 5 years' course. There is a suggestion in some quarters that there should be a change but so far no proper name has been mentioned. The L.M. & S. degree has been abolished by all the Universities in India. Licentiate in Medicine and Surgery will certainly connote what Medical Licentiates really are instead of the term Licensed Medical Practitioner. We commend that the L.M.P. diploma be changed to L.M& S. Such a change should have retrospective effect on all who now possess the L.M.P. diploma. There will be then harmony in the profession especially amongst the new and old Licentiates. There will be little harm or risk if the Government are liberal and the Licentiates, the whole class of them would be grateful to the Government or else the Government would be responsible for creating a feeling amongst the old Licentiates that their agitation to bring about the 5 years' course was after all suicidal.

In this connection it will not be out of place for us to bring to the notice of our readers that the course for the L.M. & S. degree was only for 3 years in some of the Indian Universities, later the course was extended to 4 and lastly to 5 years. Yet there was no grumbling from any quarter, including the Government, to treat 3 years', 4 years' and 5 years' L.M. & Ss. all alike. So the longer period of training cannot stand in the way of the Licentiates for bringing about a necessary reform which would tend to the unification of the medical profession in this country.

There is another talk and that for creating a College of Physicians and Surgeons for the purpose of conferring the Diplomas of License, Membership and Fellowship. Sometime ago we discussed in these columns about Medical Education and said that it was a good ideal to have only one degree as is the case in America and some other countries in the West. But if on account of peculiar and varied conditions existing in India it is considered too risky to grant the sole monopoly of medical education to Indian Universities, a College of Physicians and Surgeons may be brought into existence by non-Government bodies but under a Royal Charter and not otherwise. At present excepting the University of Lucknow all the other medical colleges are run by the Governments of the provinces, the examinations only in such colleges being conducted by the Universities and it will be a stupendous folly on the part of the Provincial Governments to run a rival institution of College of Physicians and Surgeons. So long as the majority of medical schools in India are run by

Governments, this question need not concern the Licentiates and when there is a possibility of the starting of a College of Physicians and Surgeons, we should lose no time to point out to the bodies of such Colleges the place of the Licentiates in these institutions.

It is almost certain that the All-India Medical Licentiates Association which meets in Bombay during X-mas week, will pass resolutions calling upon all the Provincial Governments to follow the lead of Madras in instituting the 5 years' course in the Medical Schools under them. We hope the Conference would also foresee what has been discussed in these columns and see that their past and present agitation to bring about the 5 years' course in Medical Schools does not impair the prestige and status of the existing Licentiates. There are roughly 25,000 Licentiates in India outside the fold of the All-India Medical Licentiates Association, the majority of whom are members of the independent medical profession. We wish one and all of them realise early that in case any change is made in the title of the future Licentiates the changed title should be conferred on all the old Licentiates with retrospective effect or else it will be safer to allow the existing title to continue. To be forewarned being always safe we have done our duty in pointing out what we foresee.

Original Articles

THE PATHOLOGY OF CERTAIN METABOLIC CHANGES IN THE EYE.

BY

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Calcium metabolism, a subject long recognized as of vital interest to the pediatrician, the medical internist, and the orthopedic surgeon, has now become of vital interest to the ophthalmologist. Calcium deposition is one of Nature's honest efforts at repair, whether it takes place in the bones of the rachitic child, around the areas of caseation in a tuberculosis lung or lymph node, or in the injured walls of the cardio-vascular system, or in the coats of the eye ball. But reparative processes when carried to the extreme can become pathological. For example, scar tissue formation, reparative in itself, becomes pathological when it leads to stenosis of the esophagus, intestinal obstruction, etc., So also, calcium metabolism is capable of playing the double role. But before applying its effects to the eye, let us consider briefly, some of the recent observations of factors effecting calcium metabolism.

The external factors effecting calcium metabolism are vitamines, light, and endocrines, besides diet. The similar roles played by vitamine D and sunlight have long been recognized. Some speculations even attribute the richness of vitamine D in cod liver oil to the fact that the cod is a deep-sea fish, and because of its being always out of reach of sunlight, nature has developed this vitamine in the oil of the fish to supply the inevitable lack of sunlight in the abode of the deep-sea fish. In the sunlight, it seems to be principally the ultra-violet and infra-red rays that carry the burden of vitamine D.

Among the endocrines, for a time parathyroid and vitamine D have also been classed together. To be sure there is a high blood calcium in hyperparathyroidism and in hypervitaminosis, but vitamine D increases the blood calcium using the diet as its source which means there is really a raising of the total calcium content of the

body; while excess of the parathormone in hyperparathyroidism, on the other hand, increases the blood calcium at the expense of the *bones* in the body, and also increases the excretion of calcium along with phosphorous through the kidney, thus often producing renal calculi. So in hypervitaminosis we find the calcium in the bones increasing, while in hyperparathyroidism, we find the calcium in the bones disappearing and a generalized osteitis fibrosa taking the place of normal hard bone, so the total calcium content of the body is diminished instead of increased in hyperparathyroidism.

Removal of the parathyroid glands if leading to parathyroid deficiency, produces lesions of ectodermal tissue, such as *cataract*, brittleness and ridging of the nails, loss of hair and dental enamel. Of these, cataract is an especially notable feature among the complications of hypoparathyroidism. Experimentally the injection of parathormone, particularly when the intake of calcium is low, leads to resorption of bone and its replacement by fibrous tissue and cysts in the bone. So keeping up the blood calcium by giving parathormone means we are keeping up the blood calcium at the expense of the bones,—a procedure which must defeat itself in time, especially if the diet is kept poor in calcium. Only in severe hypervitaminosis, when the animal ceases to eat, does the body raise the blood calcium at the expense of the calcium in the bones, but this process goes on much earlier in hyperparathyroidism. It is a mistake then, to prescribe parathormone in place of vitamin D whenever a calcium deficiency is detected in rickets, nutritional tetany, and "disorders of calcium metabolism" generally.

BENEFICIAL EFFECTS OF CALCIUM METABOLISM ON THE EYE: A beneficial role played by the deposition of calcium in the eye is seen in cases of progressive myopia. This near-sighted type of eye is a sick eye with the soft coats of the eye-ball giving way to intraocular pressure. It is a sign of calcium deficiency and calcium therapy has been instituted to harden these tissues and prevent further stretching of the eye-ball. For this reason parathyroid extract has been prescribed with calcium, and probably the "Bemax", recommended to stop progressive myopia, is effective for its high calcium content.

Similarly, recurrent intra-ocular hemorrhages are treated with calcium and parathyroid. Because of the beneficial results from these, one wonders if it indicates a vitamin deficiency in the presence of recurrent intra-ocular hemorrhages. If so, of what sort may this be? A deficiency allied to scurvy has been suggested, but as a matter of experience, it is known that in scurvy the common locations of hemorrhages are in the nose and conjunctiva,—retinal hemorrhages being very unusual in scurvy.

Another type of case benefited by calcium therapy was a child with "the blanched nerves" of optic atrophy. Here, too, gland therapy was combined with calcium administration, thyroid, calcium, pituitary and parathyroid being given.

PATHOLOGICAL EFFECTS OF CALCIUM METABOLISM ON THE EYE CATARACTS: Just as scar tissue, a protective process of repair in nature, can become a menace when it causes stenosis of the oesophagus, intestine, of urethra, or causes occlusion of the pupil or ectropion of the lid, so also calcium deposition may pass from the beneficial effects to the harmful effects of calcium deposition.

Bone formation may occur in remnants of lens left in the eye after cataract extraction. Less advanced stages produce various forms of cataract,—for example, the cataract showing a chalky white lens, is one which contains heavy calcium deposits in the cortex of the lens.

Ordinarily, calcium deposits are due to disintegration of the lens epithelium, and deposition of the lime granules. The deposition of calcium in old age interferes with the nutrition of the senile lens. Also, there is evidence that the body carries a non-diffusible form of calcium; for instance, the serum calcium normally ranges between 9 and 11 mgm. per 100 c. c., whereas the cerebro-spinal fluid calcium ranges between 5 and 6 mgm. per 100 c. c. The inference is that some of the calcium in the blood is in a non-diffusible form. Possibly the piling up of calcium in the process of

cataract formation is due to the fact that it is of the non-diffusible variety.

The foetal lens has a rich capillary network, entirely encircling the lens, but the mature lens has neither blood supply nor nerves. The metabolism of the lens is carried on throughout life by the exchange of fluids seeping through the capsule. Toxins may seep through without there being any perforation of the lens capsule. The method of circulation through the lens is nicely traced in cases of siderosis. When a piece of iron flies into the eye ball and becomes buried in the posterior segment of the eye-ball, the path of iron pigment is formed from behind forwards, as the circulating fluids of the eye carry the particles from behind the lens through the lens and into the anterior chamber. Only a short time after the iron has become buried in the posterior segment of the eye, particles of iron appear deposited in a ring around the surface of the lens at the attachment of the zonular fibers, and there come to rest under the margin of the iris, and beneath the capsule of the lens. Hence are derived the rust cataracts which form on the anterior surface of the lens, under the capsule, after iron has flown into the eye ball. The current of the circulating fluids of the eye is traced entering the lens substance from behind, circling around in it and then emerging on the anterior surface.

When the lens is dislocated, its nutrition is interfered with, but it is interesting to note here that though some lenses become opaque after dislocation, cases are on record of dislocated lenses remaining transparent in the vitreous for as long as twenty or thirty years. The blue tint of the adult lens is due to iron absorption in the normal eye, and the yellowing of the lens in old age may be compared to cornification.

But we all know, it is not only the traumatized lens or the senile lens that is capable of becoming cataractous. The use of the modern slit lamp and corneal microscope has enabled us to discover lenticular opacities early in eyes, not producing any visual disturbances, in a number of cases in which calcium metabolism is disturbed. In an interesting experiment on dogs, the animals were rendered cataractous by thyroid-parathyroidectomy, and it was found that though these animals showed a lowered blood calcium, they had twenty-five times the normal calcium content of the lens.

The changes occurring in the mineral content of the lens are the same whether the lens becomes cataractous because of senility or because of parathyroidectomy. But the causes back of such changes are very different: in the senile lens, the excess of calcium deposited in the lens is secondary to the condition of the body; whereas in the parathyroid type of cataract, the excess of lens calcium is directly related to the calcium deficiency of the blood due to the parathyroidectomy. How shall we explain this? Is it possible that the lens plays the same game as bone plays with relation to parathormone and that insufficient parathyroid allows calcium to accumulate in the lens as well as the bone? Can we infer on the other hand, that the administration of parathormone will tend to clear up a cataract of parathyroid deficiency just as it leads to the absorption of calcium from out the concellous bone, into the blood stream? This is a field to challenge us to further study. Also, what of vitamines and sunlight in this respect? If vitamine D produces deposits of calcium in the tissues, especially the kidney and the aorta and bone, then can over-abundance of vitamine D or exposure to sunlight produce cataracts?

CATARACTS AND LIGHT: The third factor to which we have referred as affecting calcium metabolism is light. Text books have made speculations on the relation between the glare of the tropics and the great incidence of cataracts in the tropics, but most of the actual scientific research has been done on the ultra-violet and infra-red ray, and on X-ray and radium. Radiational cataract is now a recognized clinical entity. The lens has been found to be more susceptible to infra-red rays, to X-ray and radium than to ultra-violet rays. But lenses which were unaffected by ultra-violet light in their natural state, have been rendered opaque if previously sensitized with calcium chloride in a concentration which in itself is too weak to cause cataract. The combination of the weak calcium chloride with ultra violet rays,—both powerless in themselves,—has produced lenticular opacities.

X-ray has been found to be twice as

injurious to the lens as to the cornea and the conjunctiva, though sometimes the X-ray cataract is quite slow in developing. In cases which have been submitted to X-ray irradiation for vernal catarrh (spring catarrh), the cataracts have been found developing four, five and even eight years after the exposure to the X-ray.

Vogt proved that the "fire-blower's cataract" was not caused by visible rays, or ultra-violet rays, but by the short-waved infra-red rays, from 7500 to 24,000 Angstrom units. As the sclorosing lenses of older people absorb more of the infra-red rays than do the softer lenses of younger people, it is not surprising that older people are more subject to fire-blower's cataract than are younger people.

Cataracts produced by lighting and electric short-circuits are a special form of infra-red cataract. These also develop several months after the injury and may be total, or only confined to the anterior and posterior cortical layers of the lens.

Among the troops in Iraq, observations on the effects of whole sunlight on the eye have been made by P. C. Livingston, who has made a report on the occurrence of such complications as conjunctivitis, lacrymation, contraction of the peripheral visual fields, areas of scotoma, and alterations in the light sense and the light threshold. Perhaps he needs to extend his period of time in observing complications before he can definitely rule out cataract as a possible complication of sun's glare. To prevent these other complications from arising among the troops in Iraq, Livingston recommends tinted glasses of the type to filter out the sun's infra-red rays. He advises the Crookes lenses, B. Plus, No. 240, containing iron oxylate, or No. 217 containing ferric carbonate, or the Vogt lens containing iron oxydal. In addition to the dark glasses he gives atropine drops 25 % b. d. s. or scopolamine hydrobromide 20%.

This is a field to challenge scientific investigation. There is already even in the western countries a great deal of indiscriminate ordering of dark glasses, especially by opticians who are keen on collecting the additional fee for these more expensive lenses. It is a practical question to us out here in the tropics. Are we justified in recommending or prescribing dark glasses to protect people from the risk of Radiational Cataract in the tropics? Has the eye similar powers of adaptation to the sun's rays to those in that the skin shows in its sun-burn? Is it not possible that such individuals as those who rush into a darkened room to work in the tropics and were their dark glasses the minute they emerge into the glare are depriving their uveal tracts of their natural powers of adaptation by which they increase the pigment cells of the retina, choroid and iris?

The pigment of the eye is found principally in the choroidal coat, but there is also pigment attached to the rods and cones of the retina. The pigment epithelium of the retina entirely lines the choroid and obscures its details, except in the albinotic fundus in which such pigment is scanty and the choroidal vessels are then dimly defined as a net-work between the trailing and more distinct vessels of the retina itself. But we must not be surprised to find an albinotic fundus in people who are not albinos. Many times I have seen it in the eye of a person with light hair, or a history of having had light hair in youth before the hair darkened into a darker hue. I have even seen such an "albinotic fundus" in a dark complexioned Indian patient! We need to bear this in mind in our fundus examinations, for, students of ophthalmology often make the mistake of diagnosing a pathological condition with chorio-retinitis, etc., in normal eyes, just because the choroidal pigment is scanty. But as a rule, the dark complexioned races have a very heavy pigment showing on fundus examination,—so heavy that it is usually impossible to get a pink retinal reflex with the ophthalmoscope.

Moreover, the dark-complexioned races normally have brown eyes. So-called brown eyes are merely eyes in which the pigment epithelium lines both the posterior and anterior surfaces of the iris whereas the so-called blue eyes have pigment only on the posterior surface of the iris—that is on the side towards the lens. In these eyes it is just the back layer of pigment showing through the iris stroma which give the blue appearance to the iris.

Pigment epithelial cells are nomadic, and if they can migrate to the skin why not to

the eye? Is the brown eye of the dark-skinned races not just a part of the same evolutionary process of adaptation? If we believe in sun-burning our bodies, should we wed ourselves to dark glasses? Of course, this will not wholly settle the question of cataract because only the outer portion of the lens could be protected by increased iris pigment. But this has some significance because the greater the light that falls on the eye, the smaller the pupil becomes,—simply another evidence of the power of the eye to adapt itself to its environment.

CALCIUM DEPOSITION IN THE CHOROID AND VITREOUS: Not only does bone formation occur in the lens, but it also occurs in the choroid. In this location, it starts as calcific deposits in Drusens, which are little hyalin bodies that form on the glass membrane of the choroid.

The vitreous, also may have opacities due to calcium deposition. Even in slight trauma to the vitreous, calcium may be deposited because the vitreous comes into contact with the aqueous. After lens extraction, when needling is done, the vitreous may slightly herniate into the anterior chamber and then scintillating opacities appear in the vitreous. These are probably not visible to the observer without the aid of the slit lamp and corneal microscope.

OTHER METABOLIC DISTURBANCES: There are many other nutritional and metabolic conditions producing pathology in the eye, such as xerophthalmia, keratomalacia, spring catarrh, etc. But the relation of vitamines to keratomalacia or to night blindness, and the like, seems already fairly well established in clinical experience.

Some recent writers offer suggestions on Spring Catarrh, however. Light is claimed to be the direct local cause of the disease in predisposed subjects who are "vagotoniques", and the following treatment is recommended.

1. Rigourous protection from light for the eyes.
2. Desentization to light by suitable sunbaths.
3. Glandular Therapy.
4. Calcium.

A more recently recognized form of sensitization is sensitization to lens protein. After cataract extraction, sometimes fragments of lens cortex remain in the anterior chamber, especially if it is not an intracapsular operation that is performed. If the patient is sensitive to lens protein, they have a very baneful reaction to it when it is freed in the aqueous. Though no pus forms a regular endophthalmitis develops and the iridocyclitis results in occlusion of the pupil, and finally practically a lost eye. This is a risk to the other eye because of the danger of sympathetic ophthalmia. In the west, some make a point of desensitizing the patient beforehand by injections of lens protein in graded doses. If the first cataract extraction results in lens protein sensitization, it is not safe to operate on the other eye because of the danger of loss of the second eye from the same cause, unless the patient is first desensitized.

KOREMLU DEPILATORY CREAM: Possibly we cannot logically include Koremlu Depilatory Cream in this paper, but whether the effects on the eye are metabolic or toxic, the following information ought to be shared with the profession as well as the laity:

Koremlu depilatory cream contains 7% thallium acetate. Patients who used it for a long time developed polyneuritis, optic neuritis and optic atrophy. Also cataract, keratitis, retrobulbar neuritis and post-neuritic optic atrophy have been known to result from the use of this cream on the skin. The optic condition definitely improved with cessation of the drug and encouraging elimination.

BOILS

By

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GENERAL CONSIDERATIONS: Boil or furuncle results from pyococcic infection of the deeper parts of the pile-sebaceous follicles. Inoculation takes place through scratches, abrasions, friction and rubbing. Certain skin affections, such as scabies, pediculosis, eczema etc. where scratching is a prominent feature, are associated with boils. It is well recognized that boils occur as a complication in diabetes mellitus, Bright's disease, septicaemia and pyaemia. All conditions which tend to lower general

vitality predispose to boils. Anaemia, auto-intoxication, inanition, alcoholism convalescence after an acute illness are potent predisposing causes by lowering a person's resistance.

When an individual's resistance is high, simple traumatism and pyogenic infection give rise to a single Boil which heals up readily in ten days to a fortnight; if the general health is below par, crops of boils keep on appearing at varying intervals over a greater part of the body making the treatment a tedious and prolonged process. This latter state constitutes the condition designated as "furunculosis."

Boils in certain areas call for special notice; on the face and particularly the upper lip, oedema sets in early and there is also a risk of venous thrombosis and eventually cerebral infection, when rigors, persistent and intense headache, high temperature and delirium will indicate a grave prognosis. Blockage by oedema or thrombosis of the cavernous sinus giving rise to exopthalmos has been recorded. When the ceruminous follicles of the external auditory meatus are involved, the patient suffers from intolerable throbbing pain and sleeplessness. The pain may be maddening at times.

Summer season shows a far greater incidence of the disease than at other times of the year—hence the popular appellation "summer boils." Sweating, dust, and want of proper attention to under wear, and neglect of personal hygiene greatly contribute by lowering the resistance of the skin by soddening the protective corneous layer of the epidermis and inducing scratching. Consumption of highly sweetened drinks, and indulgence in pastries and sweets raise the sugar content of the blood and thus favour infection.

TREATMENT may be divided into general, local, vaccine and non-specific therapy, and light exposures.

General Treatment. All departures from general health should be detected and the requisite treatment instituted. Urine should be examined for sugar and albumen; if one or the other or both present, the patient should receive appropriate treatment for the condition. Special attention should be paid to the gastro-intestinal tract. Take measures to combat constipation on general medical principles. In case of furunculosis focal sepsis will have to be attended to.

Four internal remedies have been credited with special action in combating and reducing pustulation. These are sulphur, yeast, stannoxyl, and dilute hydrochloric acid. Each of these have their votaries, and the patients also react to one better than the others.

Sulphur is given in the form of lozenges as sublimed sulphur, (½ to 1 tea-spoonful) mixed with honey or treacle as the first thing early in the morning. It may also be given in the form of Calcium sulphide (1/6 to ½ grain) three times a day. If coated pills are not available, freshly made sulphide pills should be used as it is easily decomposed and oxidised. Sulphur acts as an antiseptic to the skin on being excreted in the sweat and is a mild laxative.

YEAST is prescribed in the form of brewer's yeast (½ to 1 tea-spoonful) thrice a day before meals. Disagreeable symptoms as diarrhoea and colic may set in if ordered in larger doses. Yeast tastes badly and tends to repeat in the breath; smell is also unpleasant. Nuclein a compound of neucleic acid, albuminates, and carbohydrates—and sodium neuclinate (dose 1-2 c. c) as intramuscular injection are better tolerated and possess none of the drawbacks of yeast. All these tend to produce leucocytosis and hence bactericidal inaction. Instead of taking half a glass full of yeast from the top part of the fermenting-tuns, cocoanut or palmyra toddy that has remained overnight in the toddy taverns may be used, dose for adult being one ounce increased to two ounces once a day.

STANNOXYL tablets contain tin (metal) and oxide of tin. Adult dose is 4 to 8 tablets before or after meals. 2 c.c. ampoules for intramuscular injections are also available. Its action rests on the observation that the workers on tin never suffer from boils.

DILUTE HYDROCHLORIC ACID: Caroll Allen had good results with dilute hydrochloric acid, of which 10 to 15 minims were administered in water after each meal thrice a day. Under this treatment, well-developed boils disappeared within a few days and those in the process of development were quickly aborted. Hydrochloric acid acts as a biliary tonic stimulant and corrects dyspepsia. Dilute sulphuric acid is more commonly used than dilute hydrochloric acid; the latter certainly gives better results.

LOCAL TREATMENT. Local treatment is more important than any form of internal or general treatment; in certain cases local treatment is all that is required for the cure of a boil. When the boil is indurated and shows no signs of softening or pointing, it is customary to order hot boric compresses. Care should be exercised in preventing auto-inoculation of the surrounding parts by washing with perchloride of mercury lotion (1 in 5,000) once or twice a day. Abortive treatment should be tried during this indurated stage. It is better to delay opening till the boil definitely points. The boil should not be squeezed to evacuate the pus, which must be allowed to well up and gently cleaned by moist swabs. Squeezing breaks down the leucocytic barrier which limits the spread of the infection. Even after opening, hot boric compresses may be continued with the above indicated precaution.

ABORTIVE TREATMENT is carried out according to one of the following methods.

(1) In the early indurated stage, an intramuscular injection of a polyvalent staphylococcus vaccine (250 millions) is given into the deltoid and twice this quantity repeated after four days. The following local application recommended by Duncan Bulkley may be applied to the boil to relieve pain and hasten resolution. The Formula:—

Acidi carbolici	gr. 10 to 20.
Extracti ergotae liquidi	dr. 1½.
Pulveris Amyli.	
Zinci oxidi	aa dr. 2.
Unguenti aquae rosae	oz. 1.

Misce et fiat ungt.

The above is thickly applied, covered with a piece of jackonet or oil-silk and a loose-woven bandage put on to retain the whole in position. Under this regime the pain is greatly lessened in 48 hours and the boils abort in a week or ten days. The stock staphylococcus vaccine may be replaced by Staphar (Bayer) with satisfactory results..

(2) Iodine-acetone. Gallois recommends the following formula:—

Iodi	dr. 1.
Acetone	dr. 2.

The above should be allowed to stand for ten or fifteen hours when it turns black and syrupy. This is painted on with a camel hair brush. This dries readily and the surface appears perfectly black. Over this, a thick coating of glycerinum amyli is applied under a bandage. The process is repeated daily and the boils will be cured in less than a fortnight. Compare these two external applications(Bulkley's and glycerine amyli) with the Indian domestic remedy used for resolving boils. Holy ash mixed with melted butter till it forms a thick cream which is applied to the boil and changed every twelve hours. When pointing is inevitable, tobacco leaf, preferably a piece free from large vein moistened in water is applied to the boil, which opens in forty-eight to seventy two hours.

(3) W. R. Smith uses the following method and thinks it greatly superior to poultices, the majority of local applications, and internal medications. Campbell describes the whole process as:—

He takes a piece of soft linen or borated gauze, rubs some vasline on one side of it, quickly pours on it some chloroform, applies it to the unopened boil or carbuncle and places a bandage over all. It smarts a little at first, but this is soon succeeded by a pleasing, cool sensation. The patient is given a bottle of the remedy, and directed to change the cloth often. In from two hours to one day the boil (no matter how indurated) softens and opens.

(4) If the boil is about to point, collodion may be painted all round leaving a small area free at the summit of the boil. When it dries it exerts a gentle and increasing pressure on the boil which results in its eventually bursting, the core being expressed at the same time.

VACCINE AND OTHER NON-SPECIFIC THERAPY. The object of the vaccine treatment is to mobilize the defensive forces of the body. Staphylococcus vaccine has yielded satisfactory results in the treatment of boils. As mentioned above, in the early indurated stage, vaccine alone is enough to abort the boils. Usually two injections, with an interval of four or five days, will suffice. Stock is as good as autogenous vaccine and there is no delay. Dosage and spacing may be regulated by the local, focal and

general reactions without going through the time-consuming process of estimation of the opsonic index. It is better to begin with a smaller dose, e. g. 100 millions, and four days later to administer another dose of 200 to 250 millions. We obtained uniformly satisfactory results from the use of a proprietary vaccine Staphar (Bayer), one c. c. of which contains one milligram of disintegrated residue of specially fatted polyvalent staphylococci. Advantage is herein obtained by having the entire biochemical constituents of the Staphylococci together with a high lipoid content. Adults may be given an initial dose of 1 c.c. and it is repeated on 3rd or 4th day. Only on very rare occasions a third injection of Staphar will be required. I prefer to make the injection into the subcutaneous tissues over the deltoid, in the flanks, and the supra-scapular fossae on the back, as the cells in the subcutaneous layer are mainly concerned in furnishing the antibodies. In anaemic individuals and children, ½ c.c. may be the starting dose, and spacing may be once a week with advantage. In robust individuals with a number of boils 2 or 3 c. c. may be injected in one dose without any untoward effect.

NON-SPECIFIC THERAPY. Collosal manganese and manganese butyrate have obtained a certain amount of reputation. The latter is to be preferred as it is less painful. Bengal Immunity Company has a colloidal preparation put up in two different ampules to be mixed together at the time of injection. A few cases were tried and the results were good.

X-RAY THERAPY. Use of ultra violet in cases of generalised furunculosis gives striking results. General ultra light baths are useful in securing surface asepsis and tonic effect by an enhanced flow of lymph containing anti-bodies. Large boils can be retrogressed by one or two fractional doses of X-ray.

Space does not permit me to enter into a discussion of the passive hyperaemic treatment of Bier's and the use of Clapp's cups. I have also refrained from entering into a detailed account of the surgical treatment, for the dictum "when there is pus, let it out" is so well-known and always acted on.

Abstracts

MANAGEMENT OF ABORTION*

H. L. WOODWARD, M. D. CINCINNATI, OHIO.

For purposes of management, abortions can best be divided into those occurring in the first three months and after that period. These can again be considered under the heads of spontaneous, criminal and therapeutic abortions.

There is considerable difference in the management in the first three months and in the later period, because, in the first place, during the first period the embryo is of a negligible size and the placenta is not formed, while in the second period the fetus is large enough to require special consideration, and instead of having a diffuse mass of decidual tissue lining the uterus there is a definite placenta and non-vascular membranes.

First Period. In the first three months hemorrhage is the most frequent symptom of abortion and the one most frequently requiring treatment. Dependent upon its severity we can again divide our cases into those which are only threatening to abort and those in which it is inevitable that the uterus must be emptied. Next most frequent as an indication is the cramping pain of uterine contractions. Fever of greater or lesser degree is also found at times and usually indicates the death of the fetus and the invasion of the decidual tissue by various organisms. In spontaneous abortions fever is not so common, but in criminally induced abortion it is a very common feature.

Spontaneous Abortion. In the first three months the earlier symptom of abortion is usually hemorrhage, and at first this is slight and it may or may not be accompanied by cramping pains. This requires immediate treatment to avert the threatened miscarriage, and the most important indications are absolute rest in bed and sedatives to control the contractions. The rest in bed should be complete, the patient not even being allowed toilet privileges. The diet should be light and the bowels kept open only by very mild laxatives, such as magnesia or enema. No drastic cathartics

*Read at a meeting of the Cincinnati Obstetrical Society, January 13, 1933.

should be used. It is best at this time not to make any vaginal examinations, as the manipulation may increase the contractions and bleeding. If the contraction pains are slight, paregoric in one or two-dram doses is good and is usually available in the home; if more severe, codein by mouth or hypodermic, or morphine is necessary. If, in spite of this treatment, the pains continue and the bleeding gets more severe, it becomes necessary to investigate the condition of the cervix, and this can be done by rectal examination, or more satisfactorily by an aseptic vaginal examination. If the cervix remains closed and conical, indicating an unobliterated cervical canal, then further attempts at prevention are justified and may be successful.

Inevitable abortion. If the canal is obliterated by a shortening of the cervix and a bulging of the lower segment of the uterus, the abortion will continue even though at this time the external os may remain closed. With the cervix in this condition further treatment will depend upon the degree of hemorrhage and the presence of fever. If the bleeding is not severe and the patient continues to have contractions, it is well to use morphine in sufficient dosage to make the patient comfortable during the delatation of the cervix and the expulsion of the ovum. The patient must be kept under close observation, preferably in a hospital, because severe bleeding may occur at any time,

Complete Abortion. If the ovum is expelled with an unruptured sac and completely surrounded by decidua, the process of emptying the uterus is complete and only postpartum care is required.

Incomplete abortion. If, however, the sac ruptures and the fetus alone is expelled, or the clear sac of the ovum without the decidua comes away, the abortion is incomplete and further treatment is needed. Usually this consists of the instrumental removal of the retained secundines, as the rupture or expulsion of the sac reduces the size of the uterine content and makes it difficult for the uterus to expel the remaining contents.

Hemorrhage. If the bleeding is severe and the external os is still closed, it is recommended by some to tightly pack the vagina well up into the fornices with gauze, but I much prefer to pack the lower segment of the uterus itself, including the cervix, by means of the tubular packer. This controls the bleeding and at the same time stimulates the uterine contractions and aids in softening and dilating the cervix. If the bleeding is severe and the cervix is open or easily dilatable, it is best to immediately clean out the uterus and thus check the bleeding permanently. For this purpose, in my judgment, a properly designed placental forceps is the best instrument, as one is much surer of getting all the uterine contents and there is less danger of perforation of the uterus. Another advantage is that with the placental forceps it is often not necessary to use an anaesthetic, or at most only a short gas anaesthesia. If the uterus has been packed as a preliminary step to emptying it, the packing is removed after a few hours and the uterus will expell its contents or the cervix will be sufficiently open to allow cleaning out with placental forceps. The above line of treatment is also applicable in afebrile criminal abortions.

Fever. In febrile abortions, whether spontaneous or criminal, my practice is to clean out the uterus at once. The curette, however, is never used, and I think, is a very dangerous instrument in these cases.

First, the curette removes the defense wall, that has been built up against infection, because it removes more of the uterine mucosa than is naturally thrown off with the ovum. In addition, the danger of perforation of the flabby uterine wall of an infected case is much greater than in an uninfected uterus. When the placenta forceps is used gently, as it should be, only the ovum and the true decidua is removed, no few areas are opened up for infection and the danger of perforation is practically nil because the instrument is blunt and the uterine wall is not scrapped. After the careful cleansing of the uterus the temperature usually comes down with remarkable rapidity.

There are two main causes for fever in the criminal abortion, most important of course being the introduction of organisms into the uterus by the dirty instruments used. Secondly, because in most criminal abortions, whether done by the patient herself or by the professional abortionist, the oval sac is ruptured and the size of the

ovum is reduced, causing it to shrink up towards the fundus and making spontaneous dislodgment difficult. This makes excellent material for the rapid growth of organisms and, in my opinion, demands early but gentle removal by the method indicated.

Therapeutic Abortion. Therapeutic abortion is best done in two steps. By this method an anaesthetic is usually not required, or at least only a short gas anaesthetic. This is very important when the abortion is done for severe toxic vomiting, heart lesions, or toxic thyroid. As a preliminary the patient is given a one-fourth grain of morphine one-half hour before being taken to the operating room. The cervix and lower segment of the uterus are then firmly packed with gauze through a tubular packer, usually about a ten-yard strip of packing being inserted, care being taken to pack the cervix especially tight as the packer is forced out. The amount of gauze to be used is, of course, determined by the duration of the pregnancy and the resistance encountered. The gauze causes some uterine cramps, but not severe, and these can be controlled by codeine or morphine as needed. After twenty-four hours the packing is removed. It has served several purposes: first, it has caused softening and some dilatation of the cervix with almost always obliteration of the cervical canal and internal os; second, it has stripped the ovum loose from its attachments in the lower half or more of the uterus, so that it is easily removed later; and it has also produced very complete hemostasis which persists after its removal and during the later removal of the ovum.

When the gauze is removed after twenty-four hours the cervix is found more or less open and softened and the ovum will soon be expelled, or if there is any need for haste it can very readily be removed with the placental forceps previously referred to.

Second-Period Abortions. Abortions occuring from the third month on to the period of viability take on more the characteristics of full-time labor, in that hemorrhage is much less likely to occur and a much greater degree of dilatation of the cervix is required.

If there is much bleeding it is usually due to partial separation of the placenta, either normally situated or in the lower segment, and is best controlled by packing the lower segment and cervix through the tubular packer, or if the cervix is partly open by the use of a small Hegnar or Braun elastic bag in the cervix to complete the dilatation to the extent necessary for the passage of the fetus. At this stage the fetus is often expelled in its membranes with the placenta complete, but if the membranes rupture at times the placenta will be retained and require removal with the placental forceps. The nearer the fetus approaches viability the less likelihood there is of retention of the placenta.

Criminal Abortion. Criminal abortion done in the later period usually takes the form of rupture of the membranes, and after a time the fetus is expelled, followed by the placenta. If dilatation is too slow or fever develops, delivery can be hastened by the use of the bags previously mentioned and the extraction of the fetus and placenta as soon as the cervix is sufficiently open. *Therapeutic abortion.* In this period is best done by packing as before described, but it must be remembered that sufficient dilatation must be obtained before attempting the removal of the fetus.

If, after the removal of the gauze in twenty-four hours, the cervix is not open sufficiently or the patient is not having definite labor pains, a small bag is best used to complete the dilatation. When the pregnancy has developed to five or six months it is often a tedious process to get the long firm cervical canal open, and this must be borne in mind in determining the advisability of induction of abortion at this time.

After Treatment. In all cases after the uterus has been cleaned out it is left empty unless there is a tendency to too much bleeding, when it is packed through the tubular packer. The packing is removed in three or four hours. The patient is kept in bed for about one week.

(*The Journal of Medicine, August 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.**

Kala-Azar: This is sometimes mistaken for Typhoid fever. In Kala-azar the spleen steadily enlarges and the patient is less toxic. The proportion of white cells to red cells falls below 1 in 1000 and there is double rising of temperature in 24 hours.

If Sodium or Potassium Antimony Tartarate fails, intra-venous injection of Urea-Stibamine is very successful. It may also be given intra-muscularly. (I.M.G.)

Amino-Stiburia has also successfully been given intra-venously (I.M.G.)

In children Neo-Stibosan 3 gr. doses may be given intra-muscularly.

Kerosine Oil Poisoning: Empty the stomach and the bowels. Give Hypodermic injection of $7^1/_2$ gr. of Caffeine Sodo-Benzoate. Have recourse to hot water packs.

Keratitis: Holocine 2% solution relieves pain and has a distinct advantage over Cocaine, as the former does not raise the blood pressure.

The treatment consists in finding out the cause of inflammation and removing it. For relieving inflammation unirritating antiseptic lotion should be used such as containing Boric Acid 1 drm. to 10 oz or Perchloride of Mercury 1 in 5000. Eye should not be bandaged if there is much secretion. Bellodona Extract with Glycerine may be smeared over the brow outside the lids.

Where the photophobia is intense a free division of the outer canthus may be made in addition to the usual counter-irritation methods of treatment such as leeches, etc. In addition to the usual antiseptic lotions such as Protargol 10%, Solution Argyrol 25%, Eosine $^1/_2$ to $^1/_4$ gr to an oz. of water is useful.

In the absence of purulent conjunctivitis dry antiseptic dressing is preferable. If the ulcer has a tendency to spread it should be curetted and touched with pure Phenol, or Silver Nitrate solution 10 grs. to an oz., Tinct. Iodine or Acid Acetic Tetrachlor.

If the ulcer still continues to spread actual cautery to be used after making out the area of the ulcer by instilling flourocine after anaesthetizing the ulcer with Holocine solution.

When the acute stage is over, much benefit is obtained by stimulating treatment. The best application is Yellow Oxide of Mercury ointment (4 to 8 grs to an oz. of Vaseline), to which may be added Dionine (4%). Internal treatment for specific causes should not be neglected.

Chronic or Interestitial Keratitis almost always depends upon inherited syphilis, and in addition to the antiseptic treatment, Mercury should be pushed, short of producing salivation, and after the acute symptoms subside Yellow Oxide of Mercury 1 gr. to a drm. should be daily applied. Finely powdered Thymol Iodide is said to be useful in these cases when dusted into the eye every day. Aristol also is good.

In all inflammatory conditions of the eye Turpentine injection subcutaneously or intra-muscularly seems to have very good effect.

In infective corneal ulcers Diphtheria Antitoxin or milk injections are reported to be very useful

It should not be forgotten that many a time the cause of infection of the Cornea may be the disease of the nasal chambers and careful attention should be paid to the thorough cleansing of them if the chambers are infected, Lint soaked in Friar's Balsam is very good in these cases.

Keratolysis Plantare: (thickening of plantar surface of the feet and the hands with pits)—Formalin 5% solution to be painted and the parts to be kept dry.

Keratodermia: (of the palms of hand and toes and sides of feet) is best treated with intravenous injection of 10% solution of Sodium Salicylate.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

ANAESTHESIA IN TROPICAL SURGERY.

BY

C. GRANTHAM-HILL, M.B., (CAMB).

(*Continued from last issue.*)

GENERAL OPERATIONS.

The following notes indicate the general lines of the procedure used.

ABSCESS.—Many of the smaller types of abscess, and particularly cold abscesses, can be opened almost painlessly through an incision previously injected intracutaneously with 1 per cent novocain. Subcutaneous injections should not be used, as the solution will either enter the abscess cavity, where it will be ineffective, or will be forced into the surrounding zone of hyperaemia, where introduction will be painful and possibly dangerous.

AMPUTATIONS.—The fingers and toes are easily removed after encircling them with a band of hypodermic injection, a little novocain being introduced more deeply over the line of the nerves. The same method serves for removing ingrowing toenails and for opening whitlows, but in the latter case, care should be taken not to cause venous congestion by injecting too much of the solution or pain will result.

For amputating limbs, in addition to the encircling subcutaneous injection, the nerves must be blocked by injecting a considerable quantity of novocain into their neighbourhood or, where practicable (as in the upper arm), by exposing them and injecting the trunks under direct vision. This method is extremely valuable in the emergency amputation of crushed limbs.

INGUINAL HERNIA.—Hernia offers one of the easiest and most useful opportunities for local anaesthesia. After subcutaneous or **intracuticular injection of the line of incision, the needle is introduced at a point about 2 cm. internal to the anterior superior spine and is carried deep to the fascia of the external oblique, and the ilio-inguinal and ilio-hypogastric nerves are blocked with 4 or 5 c.cm. of anaesthetic.** Deep injections can then be made round the internal ring, to anaesthetise the peritoneum and cord, or the neck of the sac and genital branch of the genito-crural nerve can be injected after the inguinal canal has been opened.

HYDROCELE AND VARICOCELE.—These are easily dealt with by (1) injecting the line of incision as described and (2) blocking genital branch of the genito-crural and sympathetic nerves by picking up the cord between the fingers and introducing 3 or 4 cm. of solution into it.

TUMOURS OF THE LOWER JAW AND TONGUE.—Local anaesthesia here has the enormous advantage of the collaboration of the patient in spitting up blood which would otherwise find its way into the lungs. A preliminary tracheotomy is unnecessary, and the anaesthetist's intrusions are obviated. For the lower jaw one or both inferior dental nerves are blocked by injection of 3 or 4 cm. of novocain into the neighbourhood of the nerves as they lie near the lingula on the inner surface of the mandible, the needle being introduced in line with the opposite canine and following the plane of the biting surface of the teeth until the lingula is felt. A hypodermic encircling injection is then made into the face, enclosing the area of the operation.

HEMI-SECTION OF THE TONGUE.—This can conveniently be carried out, if the anterior two-thirds only are involved, by blocking both inferior dental nerves as described above, and also the lingual nerves as they lie on the floor of the mouth.

MADURA.—The use of local anaesthesia should be confined to the removal of very small early madura, which can be encircled by a hypodermic injection without risk of penetrating the growth. If the injection penetrates, as it easily may in larger growths, the consequent oedema makes differentiation difficult. The larger growths also need a blood less field only obtainable with a tourniquet for which general or spinal anaesthesia is necessary.

SKIN GRAFTS.—Thiersch grafts are conveniently cut by encircling the area from which the graft is to be taken with a weal of subcuticular injection of 1 per cent novocain.

(Continued on page 319).

illness. It is a general tonic affording an enhanced effect of Iron, Manganese and Phosphorous.

The indications for the administration of this tonic are not narrow. In convalescence and fatigue conditions it has been found that Fer-Ma-Pho has a wonderful recuperative power. The period of convalescence is lessened and all traces of fatigue have vanished after a fortnight's or at the most a month's treatment. General weakness, loss of appetite, sleeplessness and nervousness of these conditions are all rapidly overcome by this tonic due probably to the fact that it acts as a valuable restorative to both the nervous and muscular systems.

Anæmias, run-down conditions, defective digestions etc., are very often so very inter-related that anything which improves one also benefits others and the result thus is a general improvement of the whole organism. In cases of Secondary Anæmias besides the reduction in the number of red-blood cells the patient is listless, has very little appetite, in fact he is quite below par. In all these conditions Fer-Ma-Pho builds up the system by stimulating the appetite, improving digestion and restoring the blood to its normal condition.

In Chlorosis it exercises an animating and stimulating effect upon the physiological activities of all the organs with the result that the original vigour, energy and strength of the organism is restored. The blood-picture is improved and the general well-being is brought about. The patient is thus enabled to resist and overcome further attacks of the disease.

Many vague, ill-defined and obscure conditions characterised by loss of weight, seedy feeling and poor appetite are greatly benefited by the administration of Fer-Ma-Pho. It restores the lost vitality by bringing about regeneration of the blood, improves the appetite and tones the nervous system.

Fer-Ma-Pho is of proved value in the sequelae of many infections such as Influenza, Typhoid or after Surgical Operations or Parturition. Besides exercising invigorating and regenerating effects in these cases it makes up for all the blood deficiencies. It increases the resisting powers and provides the reserves and thus constitutes the best safeguard against future inroads of diseases.

In Neurasthenia and other conditions of nervous exhaustion Fer-Ma-Pho is the most effective tonic as it tones and regenerates both the nervous as well as the sympathetic systems by increasing the phosphorous containing chemicals. Because Fer-Ma-Pho acts on the different systems of the organism the multiplied effect is very great which explains the exceptional efficacy in these conditions.

Fer-Ma-Pho is superior to any other iron preparation specially in children who easily react to iron administration. It does not occasion digestive disturbances nor does it attack the teeth. It is excellently tolerated by the patient and unlike other iron preparations it does not blacken the teeth nor does it give rise to dyspepsia, constipation or meteorism. Its pleasant and agreeable taste enables us to administer it to children who take without much trouble. Its perfect stability prevents it from deterioration. Due to its high concentration small dosages are required.

To sum up Fer-Ma-Pho is an ideal general tonic possessing stimulating and blood regenerating properties. It can be confidently prescribed wherever a tonic or restorative action is needed. It invigorates the system, enriches the blood, strengthens the nervous system and thus removes the majority of the complaints met with in general practice.

Several patients have recouped wonderfully after Fer-Ma-Pho regime. The following two cases taken from many that are treated with this product alone will bear out fully what has been said in the preceding lines.

A lady of about 25 was left very much anaemic after an attack of Influenza. She had lost her appetite, was feeling very weak and was not able to exert herself at all. Her haemoglobin percentage was about 65. She was prescribed Fer-Ma-Pho. She took 10 drops in a little water half an hour before food twice a day. After she had finished two bottles she felt much better, was able to go out for long walks, had good appetite

and her weight had increased by 12 lbs. Her haemoglobin percentage was now 95. She soon regained her normal strength. In fact there was obvious all round improvement. She took one more bottle and felt altogether well on it.

Another case was that of a woman in child-bed. She had delivered about two months back, she was feeling very weak and had very bad digestion. She was not able to feed her child properly due to insufficiency of milk. On examination I found her very anaemic, haemoglobin percentage being 45.6. Fer-Ma-Pho was recommended and she took 10 drops of it in a little water three times a day half an hour before food on an empty stomach. The result was more than I expected. After finishing two bottles pronounced improvement was observed. The general debility, loss of appetite etc. disappeared. Her sallow and pale appearance soon gave place to that of a ruddy one. Haemoglobin was 90% by this time. She was now able to feed her baby well which also began to thrive. Although this lady was taking more than 30 drops per day (the dosage was increased gradually) there was absolutely no constipation or any untoward symptoms either of the teeth or the gastro-intestinal canal. Nor did it induce constipation or other by-effects in the child which she fed regularly. That rapid and unmistakable improvement was effected by Fer-Ma-Pho in this case due to increase in the haemoglobin content of the blood as well as the general stimulation of the system could hardly be doubted.

Neurasthenia and its Treatment.

Neurasthenia is a disease consisting of a combination of nervous and physical symptoms, the general characteristics of which are irritability, abnormal sensitiveness, mental depression and physical weakness. These symptoms develop under the influence of over-excitement of the nervous system due either to somatic or psychic disturbances or specific toxic influences. The important factor in the production of Neurasthenia is the diminished resistance of the nervous system. Sometimes alcohol, sexual excesses, specific diseases leading to Prostatitis or Impotency cause this complex of physical and psychical disturbances which go by the name of Neurasthenia. At times the toxins of Influenza and other infectious diseases reduce the resistance of the nervous system to such an extent that the result is Neurasthenia. Occasionally, Diabetes and other diseases of metabolism cause such mental and physical depression that it often results in Neurasthenia.

Symptoms in this disease are so variable that no one case would resemble another. But in almost all cases a disordered mental state is always accompanied by disturbances of the patient's physical condition. As regards the mental state there is invariably a pessimistic attitude. Irritability and annoyance at the slightest cause, inability to concentrate and dissatisfaction are some of the predominating symptoms. If these latter continue the patient soon develops what is called a self-centred attitude wherein the only thoughts in his head will be about himself to the exclusion of everything else. If the condition remains untreated there is complete development of the Neurasthenic habit which when once established is very difficult to be rooted out.

Besides these, not infrequently, the physical symptoms are also met with. The most important under this heading are :—

1. The patients complain of constipation, loss of appetite and occasionally indigestion.
2. Dyspepsia, headache, palpitation, scanty urine etc. are met with in these patients.
3. Weakness and fatigue.

These patients are usually unable to apply themselves to any sort of work with vigour and energy. In highly educated and intellectual persons the psychical symptoms are generally more marked. Insomnia is usually the rule in these cases.

These patients are sooner or later overcome by extreme mental depression and they consider themselves suffering from a serious malady.

Despite the fact that the symptoms vary from case to case, Neurasthenia is not very difficult to be diagnosed. Lassitude, depression, insomnia, dyspepsia, palpitation and similar other symptoms, which cannot be traced to any gross organic lesion, form at typical picture of Neurasthenia. Some attribute this condition to an infected focus, but its removal has not in any way cured it or even ameliorated any of the

symptoms, while others who consider it to be due to toxic absorption have failed to remedy it by treating this cause.

The therapy of the disease must be directed both to the etiological conditions and to the improvement of physical health. Psychotherapy is the first thing that strikes one in the treatment of this disease; but unfortunately it is a system of treatment which can only be applied by specialists. Sun-light, fresh air, bodily exercises such as walking, sports etc., combined with adequate dieting goes a long way in the cure of the disease. Patients should not be left alone as that results in brooding too much over their condition. They should be kept in healthy and amiable surroundings as much as possible. As regards diet, meat should be deleted from it and carbohydrates, fresh vegetables and hot milk should be recommended.

Although psychotherapy combined with the above regime quickly improves the condition, it is remarkable how under the influence of combined treatment with Lipocerebrine, Fer-Ma-Pho and Hypercytol or Pharmasol Collo-Calcium injections the patients soon lose the feeling that they are ill. Obviously the phosphorised and non-phosphorised lipoids contained in Lipocerebrine are easily absorbed and assimilated and the patients thereby obtain complete benefit of their specific neurotrophic action. This leads rapidly to the disappearance of psychic symptoms. The subjective symptoms soon improve under Fer-Ma-Pho and Hypercytol regime. This is manifested by an increase in the hemoglobin percentage in the blood, rise in body-weight and improvement of dyspepsia and other digestive disorders.

Recent pathological studies have revealed that in the vast majority of neurasthenic cases the responsible factor is the disturbance of Calcium and Phosphorus metabolism of the organism. Phosphorus as is well-known forms an important constituent of the nervous system and plays an important role in maintaining the proper function of the nerve-cells and the different reflexes. In order to carry out this Phosphorus therapy, Fer Ma-Pho is the drug which affords not only great improvement in physical health but brings about amelioration and at times even disappearance of the nervous symptoms.

Pharmasol Collo Calcium is also invaluable in such cases as it satisfactorily controls Calcium and Phosphorus metabolism which is quite essential for the adequate and proper functioning of the nervous system. The clinical effects of this preparation are unmistakable as no form of colloidal calcium is so readily assimilable as Pharmasol Collo Calcium when given by the parenteral route.

Hypercytol in conjunction with Lipocerebrine can be administered together with specific therapy in Diabetes when they suffer from Neurasthenic complaints. Lipocerebrine because of its lecethin content acts as an excellent physiological alimentary tonic and Hypercytol is beneficial as a stimulant tonic because of its strychnine and arsenic content.

Success is sure to follow if the above-mentioned treatment is carried out in uncomplicated cases of Neurasthenia. If we can free the patient from the etiological influences, the use of Lipocerebrine together with Fer-Ma-Pho and Hypercytol or Pharmasol Collo Calcium for a few months will in most of the cases work out a complete cure.

The following cases illustrate the results that should usually be expected from the above treatment.

1. The patient a male aged about 30 was always in a state of nervous depression and apprehension. Sometimes he had attacks of palpitation and dizziness and he felt extremely weak and exhausted. His appetite was poor, his general health was bad and he was steadily losing weight. It was not possible for him to do steady work. He was always under the apprehension that one of his relations, whom he could not name, had a grudge against him and was trying to wreak vengence on him. Added to this he felt he was becoming impotent. He was losing the grip of affairs and was gradually becoming so to say a victim of what is known as complete nervous breakdown. Considering this to be a case of Neurasthenia, I began with Lipocerebrine and Hypercytol injections which I gave

alternately in the muscles. At the same time he was kept on Fer-Ma-Pho. He took 10 drops of it in a little water half an hour before meals on an empty stomach. He was removed to very congenial surroundings and was asked to indulge in sports and was advised to take good nutritious food. After about a month and a half of this regime there was perceptible improvement in his mental state and he began taking great interest in his work as well as recreations. His nervous apprehensions steadily cleared up, he was able to concentrate and was on the whole looking very much more lively. Physical symptoms also improved. He developed a good appetite and there was steady rise in his weight. The injections as also Fer-Ma-Pho was continued. The improvement thenceforth was progressive. One ampoule of Lipocerebrine alternating with one of Hypercytol was given until he took twelve of each. After an interval of two weeks the same injections were continued. Fer-Ma-Pho was also taken by him. Continuous treatment of this nature together with good nourishing food, healthy and congenial surroundings and plenty of sunlight has restored him to normal health and he was once more his own self. His blood-picture besides the mental symptoms was quite normal and his weight increased at the end of six months by 20 lbs.

2. This was the case of a young woman who had lost her only child about a year back. As a result of this emotional shock she developed such a type of Neurasthenia that it yielded to no treatment as can be gathered from the history her relatives gave. The author was given to understand that she had taken different kinds of medicines from different physicians but no relief had been obtained. There was extreme mental depression and hypersensitiveness to the slightest emotion. She was very much pessimistic, was completely incapable of doing any work and she did not take any interest in music although that was her pet hobby. Sometimes she complained of headache. Loss of memory was rather troublesome and the general weakness was quite evident.

After a course of treatment which consisted of Lipocerebrine and Pharmasol Collo Calcium injections together with Fer-Ma-Pho orally for more than a month, there was great improvement. The injections were given every alternate day intramuscularly and Fer-Ma-Pho daily by mouth. She had twelve injections of each after which she took complete rest for a fortnight. Again the treatment was commenced and this went on for about six months. Her interest in life was quite evident after this as could be seen from the revival of her interest in music. She was able to do her work and was managing the affairs of the house very well. Headache disappeared and the mental depression and hypersensitiveness completely cleared up. She got sound and refreshing sleep and the feeling of exhaustion gave place to energy and vigour. Although the injections have been stopped by now, she is still taking Fer-Ma-Pho.

Some Notes on Felsol—Iodaseptine Therapy.

A study of a number of cases described as Bronchial Asthma, Cardiac Asthma, Nervous Asthma has led us to believe that there are some common factors dominating all these varieties viz. defective working of the sympathetic and the nervous system and inadequate katabolic functions. It is not enough therefore to only inhibit the spasms and give temporary relief but to recommend something which will yield a radical cure. According to pharmacological investigations we have in Felsol a remedy which helps us to achieve these two ends. Felsol is in the form of a powder which gives almost immediate relief of the spasms in every case and at the same time there is a marked tendency to permanence of effect. It lessens the intensity of the attacks, arrests the paroxysms and clears the condition in such a way that there is almost a permanent cure.

This treatment by itself is quite sufficient to abort all attacks of Asthma but sometimes in these cases one will often note that any product might bring relief in acute paroxysms and still such sort of specific treatments cannot be always credited with perfect cure. In order to eliminate this factor the injections of Iodaseptine are advisable and in a number of cases it was discovered that the desired effect was brought about with this treatment combined with Felsol.

Regarding the mode of treatment it should be noted that Iodaseptine should be injected intravenously or intramuscularly in between the asthmatic attacks. Recovery is in average cases complete after 12 injections. At the commencement of the treatment sometimes relapses are observed but that should be in no way be an inducement to discontinue the treatment.Later on, however, they show a favourable course. With Felsol in acute attacks and Iodaseptine in the intervening periods not only are the attacks few and far between but are of less severity. In one case the attack occured five months after terminating the treatment but it never came after that. The age of the patient is no bar to this line of treatment provided dosages according to age are recommended.

With this treatment not only the attacks disappear but the objective signs in the lungs and elsewhere, as evidenced by after-examination, show material changes. The typical rales in practically all the cases disappear or are considerably diminished. We find in the sputum also disappearance of Curchmann's Spirals and Charcot-Leydon Crystals. There is complete absence of Eosinophilia in the sputum after this combined treatment.

A further indication for this line of treatment, besides all varieties of Asthma, is found in Pediatric practice. In cases of Pertussis complete recovery has been brought about by Felsol-Iodaseptine treatment. If dosage of both the products, according to age, are adhered to, the results of the combined treatment are very favourable. Vomiting ceases promptly, the fits of coughing become less and less severe and come at longer intervals until they disappear altogether. Sleep at night becomes regular and the children are able to take proper nourishment. It is thus evident that the antiseptic action contained in Iodaseptine asserts itself in the bronchial tubes so that the specific infection is overcome while Felsol helps to control spasmodic seizures. The illness is thus not merely shortened in duration but is eventually overcome.

Another indication in which the combined treatment can be given with benefit is Chronic Bronchitis. Felsol has been considered a valuable remedy by some in this affection. Its beneficial influence is ascribed to its stimulating effect on the bronchial mucus membrane. This effect is marked specially when there is over secretion. Iodaseptine helps in this affection by its pronounced antiseptic action. By reason of Iodine combined with other antiseptics in it, it is able to destroy the various cocci that are responsible for this affection. Again, this Iodine treatment can be prolonged with impunity as there is hardly any risk of Iodism. The aim of this treatment is, as we have seen, not only to cause disappearance of symptoms temporarily but to eliminate radically the cause of the disease and thus effect a complete cure.

Application of Felsol in Angina Pectoris is at present recognised. Its action is much enhanced by intravenous injections of Iodaseptine. The attacks are relieved by Felsol, the pain is stopped and the patient soon appears in good health without any by-effects resulting. In order to check further recurrence of the attacks injections of Iodaseptine are indicated. Patients unsuccessfully treated with other remedies were rendered free from anginitic attacks by continuous treatment with Felsol accompanied by Iodaseptine therapy. Felsol is more effective in its action if it is given one hour after meals in this affection. Whereas Felsol overcomes the acute attacks, Iodaseptine has a direct influence on the disease itself. It lowers the blood-pressure if it is high, tones the cardiac musculature and improves the well-being of these patients.

The advantages of Felsol over Adrenalin and other allied preparations are numerous. Although less powerful than Adrenalin Felsol has its effects more prolonged. It exerts its action even when administered orally. It scores over Adrenalin in that it does not raise the blood-pressure. Treatment of Asthma with this product is simple and no special diet need be taken by the patient. Judging by the advantages and the efficacy of this method of treatment in the indications mentioned above we see no reason why the profession should not make use of it more widely than it has hitherto done.

Experiences with Pharmasol Trimine.

It is generally agreed that the human organism combats disease by means of the protective substances contained in it. These latter are in the form of colloidal protein particles which circulate in the blood and which are also present in the protoplasm of the lymphocytes and plasma cells. These protective substances begin to act when the organism is attacked by disease. The action is very complicated, and by no means fully understood, but surface oxidation plays some part, as also do electrical charges on colloids, floculation etc. It is thus that an infection is prevented by the effective oxidising action of the protective substances. It is evident therefore that when this action fails or is deficient the organism is attacked by various bacilli and certain infections follow. In order to stimulate and accelerate this oxidising action introduction of certain metals such as Iron and Manganese are the best and when these two are combined with Zinc, the action is more speedy and effective. Such a product wherein these three are found in excellent combination is Pharmosal Trimine.

Pharmasol Trimine is a colloidal combination containing Iron (0.1%), Manganese (0. 1%) and Zinc (0.01%). It is only available in the form of ampoules which can be injected intramuscularly without pain or reaction following it. Pharmasol Trimine holds in suspension the ultra-Microscopic particles of Iron and Manganese in conjunction with Zinc. Its action is due to the power of these particles to act as catalytic agents and play the part of oxidasis or oxidising enzymes. When it is injected intramuscularly it comes in contact with the tissues where its particles are absorbed and circulated in the blood and different ions are set free, which increase and accelerate the protective powers of the serum proteins and the organism is thus enabled to cope more effectively with the invading cocci. Needless to say that on account of the combination of Iron and Manganese these effects are doubled and maximum doses can be injected with impunity.

Pharmasol Trimine has been rightly considered a very remarkable addition to our equipment for dealing with suppurative processes. The injections of this product act in such a way that in many instances they have been found to abort abscesses. If the pus has formed, after evacuating and draining it, Pharmasol Trimine helps to cut short the healing process. It not only cures and heals wounds and ulcers following abscesses etc. but brings about improvement of the patient's general health.

In the treatment of Furunculosis the routine treatment of Pharmasol Trimine injections every third day beginning with ½ c.c. until 6 c.c. have been given produces most favourable results. Not only are the boils aborted and cured but further crops are effectively prevented. Patients suffering from Furunculosis, who are unable for some reason or other to tolerate any other treatment can advantageously be under this Pharmasol regime. Even young children affected with this trouble are benefited by this method of treatment.

In dealing with Carbuncles Pharmasol Trimine administered along the same lines bring about splendid results. Carbuncles heal up, shrivel and scab over in a remarkably short period.

Because of the efficacy of Pharmasol Trimine in coping with microbic invasions of various types its curative value in Erysipelas has been fully demonstrated. The colloidal combination of the three ingredients in this Pharmasol act synergistically in hastening resolution and thus bringing about rapid cure.

In Septicaemias, Puerperal infections Pharmasol Trimine is regarded as a good adjunct to vaccine treatment. In the early stages of these infections it increases the resisting power of the organism and thus helps it to deal with the various cocci in an effective manner.

Pharmasol Trimine can be injected with excellent results in Ulcus Molle and chronic buboes. The latter if treated with this product at the commencement, i.e., before the pus has formed, can be aborted. It helps to heal up Ulcus Molle within the shortest possible period without any local treatment.

In subacute recurrent urethritis due to Gonorrhoea, Pharmasol Trimine should be

injected intramuscularly. It has not only proved of great service in this affection but has been considered by some as a decided advance over former methods of treatment in this disease. It is always advisable to start the treatment early so that best results may be expected. If we begin with 0. 5 c.c. of this Pharmasol together with Blenacrol irrigations twice a day we will find that after fourteen days when 6 c.c. of this preparation have been given that the discharge has stopped and frequency and pain of micturition have disappeared. Examination of the urethra and the prostate will reveal that they have been restored to their normal condition at this period. When the discharge is muco-purulent and small in quantity 7 to 8 c.c. of the Pharmasol in gradually increasing doses are all that is necessary.

In Gonorrhoeal complications by extension this Pharmasol is indicated. In periurethral abscess one injection relieves the pain and if there is not much of suppuration we can even abort it. If there is pus the wound heals rapidly, if the abscess has been opened and cleaned, without leaving any fistula.

It is well-known that periurethral abscess, if untreated, generally terminates in a urinary fistula. This treatment is at times successful in closing a fistula which has remained patent in spite of all treatment.

Sometimes Gonorrhoeal Arthritis yield to this line of Pharmasol Treatment.

In some chronic skin-diseases astonishing results have been obtained if Pharmasol Trimine is injected twice weekly intramuscularly in 0. 5 c.c. to 1 c.c. doses.

In Suppurative Acne this Pharmasol has been found more serviceable than even autogenous vaccines. Improvement manifests itself at the end of a course of six injections. If necessary another course of six injections should be repeated after an interval of about a fortnight.

Intramuscular injections of this Pharmasol preparation have cured Pyodermatitis in a remarkable manner. It clears up this affection after 12 c.c. of the product have been given in proper doses at regular intervals.

In Eczemas, Seborrhoic and otherwise, this Pharmasol has given good results. The use of this remedy in conjunction with local soothing applications, goes a long way in not only ameliorating itching etc. but even in curing the condition.

Pharmasol Trimine is one of the products largely employed in acute cases of coccogenic Sycosis. The injections besides exerting a sedative action destroy the cocci by increasing the resisting power of the blood and bring about improvement in a gratifying manner.

From the above it can be seen that this harmless simple treatment can be employed in a variety of indications with splendid results.

The description of the following case will convince the practitioners of the efficacy of this treatment and they will realise that it warrants at least a trial in similar affections.

Sometime last month a patient, a boy of 17, came to me with a wound on his left palm. The wound was gaping with unhealthy margins. There was very little discharge. The wound was showing the least signs of healing. The patient was running temperature. The diagnosis obviously was that there was some coccogenic infection of the wound. The patient looked very ill and moribund. I injected 0. 5 c.c. of Pharmasol Trimine in the deltoid muscle. The area round about the wound showed signs of inflammation the following day. After three days I repeated the injection 1 c.c. of the drug being used. The next day there was striking and immediate improvement. The inflammation had subsided to a great extent and the fever had gone down. After one more injection the granulation tissue was distinctly visible. In all 6 c.c. of the product had been given at the end of which the wound looked quite healthy and the edges has almost approximated. Two days later the wound had completely healed. The patient thus made an uneventful recovery under this treatment.

(*Continued from page 318*)

A native man, 50 years of age, entered hospital with a tumour of three months' duration projecting from the external surface of the left mandible. There was an indurated ulcer on the external alveolus opposite the premolars, and the submaxillary lymphatic glands were enlarged but soft. After removal of the teeth, morphia and hyoscine were injected and the left inferior dental nerve blocked inside the mouth with 5 c. cm of 1 per cent novocain. A line of subcuticular injection of the same solution was next described round the tumour, and carried forward to the symphysis mentis. Through an incision carried back from the angle of the mouth, and dividing to include the skin adherent to the tumour, the whole mass, together with the body of the mandible from the symphysis to the angle, was removed in one piece. The divided skin and mucosa were sutured. Healing occured by first intention, and the glands gradually subsided. The growth proved to be an epithelioma invading the bone.

SPINAL ANAESTHESIA IN GENITO-URINARY OPERATIONS.

Spinal Anaesthesia is of inestimable value in supra-pubic prostatectomy on account of (a) the excellent relaxation, (b) the absence of shock and toxic action on the kidneys, and (c) the almost total absence of haemorrhage due to the fall in blood pressure. If the removal is not done under direct vision and the prostate bed sutured, care must be taken that reactionary haemorrhage does not follow the rise in blood pressure some hours after operation. In many cases it is advisable to anticipate this by exerting pressure on the prostate bed by means of a haemostatic bag or gauze plug attached to a catheter in the urethra to which a weight can be suspended.

LOCAL ANAESTHESIA IN GENITO-URINARY OPERATIONS.

LIGATURE OF HAEMORRHOIDS.—Piles can be satisfactorily ligated under local anaesthesia, which gives better relaxation of the sphincter than even deep general anaesthesia. The relaxation appears to last longer with the former method, thus giving freedom from pain after operation. The anus is first encircled by a weal of subcutaneous 1 per cent novocain. One finger is then placed in the anal canal, and under its direction a needle is passed, at intervals of about 2 cm. deeply into the sphincters and under the anal mucosa, 2 c.cm. being injected at each spot. The needle point should be kept moving so as to avoid injecting into the veins. After a few minutes the sphincter will be found relaxed, and the operation can proceed.

SUPRAPUBIC CYSTOTOMY.—Either for the removal of calculi, or as a preliminary to prostatectomy, suprapubic cystotomy is easily performed under local anaesthesia provided that novocain can be injected via the urethra. It is particularly useful in the case so often already on the edge of uraemia, in which there has been long-standing prostatic obstruction. Ten to twenty cubic centimetres of 5 per cent novocain with two drops of adrenalin are first injected into the bladder with an ordinary urethral syringe, the bulbal urethra being massaged to pass the solution upwards. A hypodermic weal is next formed along the line of the supra-pubic incision with 1 per cent novocain, a little being also introduced beneath the rectus sheath. The bladder is then exposed in the usual way, a further injection being made into the thickness of its wall before it is opened. If the peritoneum has to be stripped up as is sometimes the case in contracted bladders, it should first be infiltrated with novocain.

FISTULA IN ANO.—This is treated as for hæmorrhoids.

LOCAL ANAESTHESIA IN EYE, NOSE, AND THROAT OPERATIONS.

Many operations on eye, nose, and throat are so commonly performed under a local anæsthetic that no comments are needed. The following, however, may be less familiar.

TRICHIASIS.—The operation of splitting the inverted lid margin and tarsal plate and inserting into the cleft an epithelial graft from the lip can be done under local anaesthesia as follows. The conjunctival sac is anaesthetized by instillation of cocaine drops at half-hourly intervals thrice in the ward, morphia being given with the third. On the table, the lid affected is injected with 2-3 c. cm., of 1 per cent novocain, a little being also introduced with a fine needle into the conjunctiva of the under

side of the lid. The lip which is to provide the graft will also need an injection of 2 or 3 c.cm.

ENUCLEATION OF THE EYE.—This can be done painlessly by injecting 1 or 2 c.cm. of 1 per cent novocain to the neighbourhood of the otic ganglion, the needle being passed inwards along the outer wall of the orbit for a distance of 2 cm. and then a little towards the nasal side. A little solid cocaine may also be placed in the conjunctival sac and, if there is blepharospasm, the lids should be injected with novocain.

CONCLUSIONS.

It is emphasized that no originality is claimed for any of the procedures or technique described, all of which are fully described in textbooks of local anæsthesia. Of these, the writer has found Farr's to be the most useful. The intention has been to give a brief account of the type of case found most suitable for spinal and local anaesthesia in a general surgical practice in the tropics.

(*THE LANCET*, 11th February, 1933, p. 295).

News and Comments.

Indian Medical Council Bill Passed: Neither the Government nor the members of the Legislative Assembly can be congratulated for the passing of the Indian Medical Council Bill in the way it was done. Nothing better was expected from the Legislative Assembly as it is constituted at present. The members, at least the non-official section of it, have either betrayed their ignorance as to the need of a measure of the nature of the Indian Medical Council Bill in the form it was passed or they were too weak to stand the official tactics displayed in a variety of ways by Sir Fazl-i-Hussain as a faithful servant of the Government, with whom the interests of his official position weighed more than those of the country and those of the medical profession. After all, the members of the Assembly virtually did what they condemned when the Government of India brought a proposition for the appointment of a Commissioner to do the self-same work which this measure contemplates to do and that, at a cost of a recurring expenditure of nearly a lac of rupees which work the Commissioner would have done for a couple of thousands or perhaps a little more. It may be argued that the question of reciprocity would not have been solved by a Commissioner appointed by the Government. The provincial Medical Registration Acts provide a separate section for this purpose and the Provincial Acts might have been easily amended to bring the British qualifications also under the reciprocity section of the existing Acts. So, to those who are ignorant of the scope of the existing provincial Medical Acts it may look as if many changes have been made in the Bill in order to meet the criticisms of the public. We repeat what we said before that the members of the Assembly are not only guilty for having betrayed their ignorance as to the necessity of the passing of a Bill in the form it is now done but also guilty of culpable neglect of their responsibility as people's representatives in incurring a heavy expenditure required for the running of the Indian Medical Council Bill.

Panel System for Doctors: The members of the independent medical profession in Karachi should be congratulated on their having conceived the idea of the necessity of launching a scheme which while providing for free medical aid to the necessitous poor will solve the economic question of unemployment in the medical profession.

The medical practitioners of Karachi mustered strong under the auspices of the Sindh Medical Association at the instance of Dr. T. K. Uttam Singh and after discussion came to the conclusion "to do away with the present system of public dispensaries wherein a single doctor attends on a number of patients within a few hours giving them only hurried attention. According to the proposed panel system people would be asked to contribute one (?) per head to the Municipality and select their own doctors from among the doctors appointed by the Municipality as the panel of doctors. According to the number of patients on the list of each such doctor he will be paid twelve annas per head per year and he will attend to patients. Medicines will be dispensed at the Muncipal dispensing stations established in various localities. Visiting charges will be concessional as fixed by the Municipality. The doctors under the panel system will however, be permitted to treat non-panel patients as private patients. People whose income, after deducting Rs. 25 for each member of the family, exceeds seventy-five rupees will not be permitted to join the panel system".

It is reported that the Karachi Municipality will shortly consider the suggestion conveyed to them by the members of the independent medical profession. We wish the members of the profession in other cities and towns in India follow their brethren in Karachi. We also hope that the Indian Medical Association and the Medical Licentiates' Association which meet in conference during Xmas at Bombay would include such and similar topics in the agenda for the consideration of the conferences and bring about a solution for relieving the present economical strain from which the independent medical profession suffers seriously.

Retrenchment in Bengal: It must be within the knowledge of our readers that some of the Provincial Governments and also the Central Government appointed Committees to effect retrenchment in all the departments of Government administration including the medical. Out of these the two committees that seem to have grasped clearly the items of unnecessary expenditure are the one appointed by the Government of India and the other appointed by the Government of Bengal. Their decisions were as bold as the occasions that demanded such conclusions. We referred in these columns some time ago that the Retrenchment Committee of the Central Government suggested the necessity of abolishing the post of the Director-General of Indian Medical Service. We learn that the Bengal Retrenchment Committees recommend the abolition of the post of Surgeon-General. Of course such and similar recommendations which could effectively relieve the Government of their financial strain without affecting the efficiency of administration will never be considered by the Governments as now constituted and naturally will be thrown out by the Governments concerned. We mention these two incidents just to keep our readers informed that the day will not be far when such posts as referred to above would assume quite different names with functions suiting the needs of the country.

Dean for the G. S. Medical College, Bombay: All the hopes of Dr. Jeevraj M. Mehta returning as the Dean of the G. S. Medical College, Bombay, are frustrated and the Bombay Corporation will soon have to select another Dean in his place. Apart from the responsibility of the office, the post carries a salary very near that of the Head of the Government Medical Department. So necessarily there is likely to be not only keen competition but controversies resulting perhaps in unseeming scenes on the floor of the Bombay Corporation; and, if our information is correct, statements are being made both in the Press and in Club Talks which may at any time be questioned in the Civil and Criminal Courts.

The spirit of democracy and self-determination has a tendency to dominate in youths and elders alike with the inevitable result that parents are not in a position to guide their children, much less the teachers in schools and colleges. The words, *duty* and *obedience*, do not convey to, at least a few misguided elements their real meaning. We wish all concerned in the choice of a Dean to a medical college, realise that the institutions which are concerned in the healing art are to be treated as sacred places. The words *duty* and *service* should be borne in mind both by the teachers and the taught in these institutions. These are not places for rank *gallantry* or *chivalry* of the type one is disgusted to see at times in these institutions. The medical profession is the noblest and yet has opportunities to lead one out of the moral track wittingly or unwittingly. It is therefore most essential that the person in charge of the administration of medical institutions should be a stern disciplinarian. We trust that those concerned in the selection of the Dean for the G. S. Medical College, would do their duty for a cause and not for individuals.

Adopt a Scientific Outlook: Was the gist of advice given by Dr. C.V. Raman when addressing the students of the Bangalore Medical School on 28-8-33. Dr. Raman pointed out that medicine was the synthesis of all sciences and medical men had been amongst those responsible for the foundation of many of the great Academies. He quoted the example of two great men,

one Dr. Thomas Young and the other Herman Von Holmes, both of whom gave up the medical profession and contributed to scientific pursuits. The former was first a professor of Natural Philosophy. He then took to Medicine and drifted back to Physics and in the 19th Century he was the most prominent physicists. Herman Von Holmes having first taken to medicine experienced that medical men in general were ignorant of Physiology and he became a professor of Physiology. Later he found that Physiologists were woefully ignorant of Physics and therefore took to Physics and became a Professor of Physics and made a great name in the world of Physics. Still later he found that Physicists were ignorant of Mathematics and took to Mathematics, in which field he made a mark. Finally he took to Philosophy and became a profound philosopher. Dr. Raman emphasised the need for advancement of scientific knowledge and rightly said that in all practical sciences like Medicine, there was a tendency to look for immediate results and it was therefore natural that medical men were usually impatient to diagnose particular diseases. He said the ways of science are mysterious, the result often came from unexpected quarters. Nature was like women and would not yield unless sought for, for her own sake. There was a time when Dr. Raman said that Science was pursued for its own sake but at the present day the tide was reversed. He advised the students that if they studied medicine for mere professional interests he was sure they would be left behind. Medicines of the future he remarked lay in the hands of science. All the same Medicine could not ignore the past. In conclusion Dr. Raman observed, "Do not think that you are only a medical man. The moment a medical man forgets that he is not only a medical man but also a man of science, then he could be written off as one who would have no lot or part in the future of the profession. The medical man should have a readiness to recognise truth. The young students who had taken to medicine had an honourable profession in front of them." Dr. Raman hoped that they would all be inspired by the same fire, by the same devotion that leads a man of science to seek for the truth, ever and ever.

Dr. Raman's advice to medical students was more an example than a precept worthy to be followed by not only medical students but by those who teach the students. Dr. Raman wished the students to study medicine not only in professional interest but with a view to advance science. The present tendency is to learn medicine in personal interest and not even in professional interest. How far the medical profession in general is far behind the ideal inculcated by Dr. Raman could very well be imagined than discussed by us. We wish we had a few Ramans in the medical profession also.

Hidden Cases of Leprosy: "Leprosy problem" is viewed in variety of ways by the rich and the society people. Though many pity leprosy for their misery, there is a section who can't stand the sight of lepers with their dislocated faces or limbs. The laity are generally not aware that most of the cases they see in streets going about begging, though hideous to look at, are really not dangerous with regard to the spread of infection. These are 'burnt out cases' who are not infectious at all, the infection having been burnt away in those parts of the body which latter give them a very bad appearance.

In the city of Bombay as in other big cities there is always an influx of beggars who migrate from one place to another for begging. They naturally go to places where they will be likely taken care of. In Bombay due to special legislative measures vagrant lepers are arrested and put into the Asylum. The lepers who are devoid of means of livelihood court such arrests. This is why leper beggars from other provinces migrate to Bombay and it is said that the largest number of such imported beggars are from Madras. There was a large Government Leper Asylum in Madras which was abolished, the Government preferring to subsidise a leper settlement in Chingleput far away from Madras City. This settlement is run by Christian Missionaries and the administration is conducted in quite a novel way, the lepers having to cook their food themselves. Consequently such of the beggars who came to know that they would be taken care of in an asylum, find their way to Bombay and even to Karachi and court arrest. Want of special legislation in other provinces preventing lepers to expose themselves in public streets, has necessarily added to the number of lepers in the existing leper asylums which are found not sufficient. The authorities in charge of these asylums are therefore forced to send away imported lepers to their respective provinces with no security of their not returning back to Bombay.

Such of the provincial Governments who had not special legislation for preventing lepers appearing in public streets, perhaps justify their action on account of the fact that the majority of cases seen in the streets are not really infectious being 'burnt up cases' and some of them have recourse to special measures in combating leprosy, such as the Leprosy Clinics, etc. The real danger of the spread of leprosy arises from hidden cases of which there would be a very large number and no comprehensive scheme has so far been devised to prevent infection from such cases. We learn that the Commissioner to the Corporation of Bombay will soon put before the Bombay Municipal Corporation proposals of a comprehensive scheme to prevent danger from hidden cases of leprosy. The profession will watch with interest this new scheme.

A Farewell Dinner: In connection with the departure of Surgeon-General C. A. Sprawson as Director General of Indian Medical Service a farewell dinner, we understand, is being arranged at the instance of Lt. Col. Newcomb and Rao Bahadur Dr. P. K. Warrier. It is noteworthy that members of the independent medical profession will be the hosts along with their brethren in service. This is the second such dinner we are having in Madras to bid farewell to the departing Surgeon-General, the first one was given to Major-General (now) Sir John Megaw, the then Surgeon-General, on the eve of his departure to Delhi, as the Director-General, Indian Medical Service. We are glad, nay most happy, that there will be an unique occasion for the members of the profession in service and outside to meet in most cordial feelings to bid good-bye to one who was their head both officially and non-officially the Surgeon-General occupying the most coveted position as the head of the medical department and as the President of the Madras Medical Council.

It is usual at such functions to eulogise the services of the guest who in return gives a general idea of the programme of work he expects to do in the bigger sphere to which he is elevated. We trust the hosts as well as the guest will give the public and the profession an opportunity to know what they are at.

Two Doctors of Philosophy: If study leave is a justifiable charge on public revenue at all, it is so in the case of those who are given such leave for advanced study of Anatomy, Physiology, Biology and such subjects the proficiency gained in which does not bring material gain to those to whom such leave is granted. We admire the zeal and devotion of Dr. U. Venkataraya Nayak and Dr. P. Ramachandra Rao for the advancement of scientific knowledge, who in spite of their not being sanguine of brighter prospects in service after their return proceeded to London and became Doctors of Philosophy, the former in Anatomy and the latter in Pathology.

Dr. Nayak was a bright student of the Madras Medical College; so also Dr. Rau. Dr. Nayak was the recipient of the Johnstone Gold Medal for general proficiency, as a student throughout the five years' course. He showed a special aptitude both for Medicine and Surgery and won prizes and medals in these subjects. He joined service in 1921 and his career throughout his service was in the teaching line, the subject he taught being Anatomy as a demonstrator in the Madras Medical College and lecturer in two medical schools, Vizagapatam and Royapuram, excepting a brief period when he taught Pathology to the students of the then existing Medical School at Madura.

Dr. Ramachandra Rao passed out of the Madras Medical College in 1919 and was for a time House Surgeon in the Government Hospital for Women and Children from where he was recruited in the Indian Medical Service during the last Great War. After nearly four years' service in the Indian Army, the major portion of which he spent in the North Western Frontier, he resigned his temporary commission in 1923 and was appointed as Assistant District Medical Officer, Vellore, soon after. Later he was appointed as Assistant to the Professor of Physiology in Vizagapatam Medical College in which capacity he served till 1925, when he became the

Assistant Professor of Pathology in the same Medical College till he left for England in 1931 for higher studies.

Independence of outlook should be one of the chief traits in those who have shown special aptitude for research. We trust the subordinate position these two Ph.Ds. have to occupy in service will not hamper their thirst for further advance of their scientific knowledge which in their case may serve like fountains in the two teaching institutions, Medical College, Madras and Medical College, Vizagapatam from where medical graduates are supplied to the profession and the public. We congratulate both most heartily and wish them a long life of usefulness.

An Invention: We congratulate Dr. F. R. Parakh, M.D., M.R.C.S., one of the eminent obstetrician and gynæcologist of Bombay for having contrived a special cannula for injecting medicated solutions into the uterus and quote below the description of the Cannula in the words of the author:—

Anyone who has been injecting Mercurochrome-Glycerine in the Uterus for Septic conditions, must have experienced certain difficulties in keeping the medication in the cavity for any length of time. The usual method of injecting the solution with a long metal pipe or a catheter and removing the same immediately afterwards, allows the solution to drain away especially when the cervix is not closed. This new Cannula (as illustrated) which is made in three different sizes to suit individual cases, has a small self-closing Trap-door which opens one way only. A long intra-uterine metal pipe fixed to an ordinary 20 c.c. record syringe is passed through the cannula into the uterine cavity, the solution injected and the pipe removed. As the pipe is being removed, the self-closing trap-door closes. As the cannula is fairly tightly fitting the cervix, no fluid can escape, and the cannula with the solution in the uterine cavity can be allowed to remain as long as it may be necessary.

I have to thank Messrs. N. Powell & Co., of Bombay for making this instrument for me.

Correspondence, Reports, Etc

X All India Medical Conference.

TO BE HELD AT BOMBAY.

At a meeting of the medical profession of Bombay held under the auspices of the Indian Medical Association (Bombay Branch) at Blavatsky Lodge, it was decided to hold the X All India Medical Conference in Bombay on the 27th, 29th and 30th December next.

Dr. G. V. Deshmukh, who presided, explained the object of the Indian Medical Association and also the necessity of making the Conference a success. He said Bombay had no occasion for the last 24 years to hold an All India Medical Conference and an Exhibition along with it and hoped this Conference of the Medical Profession and the Scientific and Medical Exhibitions held along with it will be a great success.

The following five sub-committees were appointed:

(1) Executive Committee—Chairman—Dr. G. V. Deshmukh.
(2) Finance Sub-Comittee—Chairman—Dr. G. V. Deshmukh.
(3) Exhibition Sub-Committee—Chairman—Dr. K. K. Dadachanji.
(4) Scientific Sub-Committee—Chairman—Dr. V. N. Khanolkar.
(5) Reception Committee.

It was resolved that every member of the medical profession is eligible on payment of a fee of Rs. 10 to become a member of the Reception Committee.

The offices of the Reception Committee are at 127 Girgaum Road, Bombay, in the rooms of Dr. D. D. Sathaye, the Joint Secretary, Indian Medical Association. Members can send in their form and fees to the above address. Cheques may be drawn in the name of Dr. G. V. Deshmukh.

Members of the Medical Profession are invited to attend the Conference and make it a success by personal attendance and reading Papers of Medical Interest. As it is not possible to send invitation to individuals, this general invitation through public papers should be taken as personal invitation.

Further information can be obtained from Dr. D. D. Sathaye, General Secretary, 127, Girgaum Road, Bombay, 4.

An appeal to the Bombay Medical Licentiates.

You are perhaps aware that the next session of the All India Medical Licentiates Conference is to be held in Bombay during Xmas 1933. The Medical Licentiates all over India are now faced with a most critical situation and unless they are organised to present a solid front, they will be brushed aside in these days of competition and vested interests.

The chief problems before our class today are:—

(1) Indian Medical Council Bill, where we demand an equal status with other registered medical practitioners in the country, both regarding inclusion in the register and due representation on the Council.

(2) Raising up the present standard of education to 5 years so that the approved minimum will be reached through-out India.

The problems which are before us in the Bombay Presidency are:

(i) Reconstruction of the Bombay Medical Council so that the present class distinctions in that body should go and a uniform register of medical practitioners be maintained and it should be thoroughly democratised.

(ii) A thorough over-hauling of the constitution of the College of Physicians and Surgeons of Bombay, which is at present a preserve of only a particular section of medical practitioners in Bombay, so that the licentiates who are the real constituents of that body, should get a due place in the affairs of that body.

(iii) Question of honorary appointments at the different civil hospitals where licentiates of approved merit and experience should be eligible for appointment to these posts— their experience and skill in individual cases should out-weigh mere degrees and diplomas.

(iv) Teaching appointments at the various medical schools:—Some teaching appointments should be reserved for the licentiates, so that they can get opportunities to gain experience and hold senior posts wherever possible.

(v) The present designation of Sub-Assistant-Surgeon should be stopped and for the present a requisite number of

Assistant Surgeon's posts should be reserved for licentiates.

(vi) As soon as the minimum standard of education is established, recruitment to the Bombay Medical Service should be made from the Licentiates and Graduates on a uniform basis preferably with a competitive examination.

There are also other problems like medical certificates, Insurance examinations etc. which must be solved by united action.

For this purpose the medical licentiates in the Bombay Presidency should be organised under the auspices of the All India Medical Licentiates Association. This body has been working for the interests of our class for the last 27 years and its branches are well organised in U. P., the Punjab, Bengal and Madras. This has enabled the licentiates in those provinces to secure various privileges in their provinces.

In Bombay Deccan there are more than five hundred licentiates but there are only 2 or 3 district branches of the Association. It should be our aim to organise one branch at every district place so that at the ensuing conference, Bombay will be properly represented.

I have therefore to appeal to you to convene a meeting of all licentiates at your place, if their number is at least five, so that a branch of the Association can be started there. The following information will be useful to you for starting a branch.

1. A branch can be started, at a place if there are *five* members.

2. Where no branch can be started, members can join the Association in their individual capacity.

3. The annual subscription is Rs. 4, and admission fee Rs. 2. This entitles the member to a free copy of the monthly Journal of the Association.

As soon as a branch is started or individually, Rs. 6 should be collected per member and the amount should be sent to the treasurer of the Association on the following address:—Dr. A. N. Khosla, Tanda, District Hoshiarpur. The information of having started the branch should be sent to me as well as to the General Secretary, Rai Saheb Dr. Ram Narain Lal, Ram Nivas, Mussorie.

I will gladly send you any other information required on the subject.

I have in the end to appeal to you to give your full co-operation in the uplift of our class and to help in the organization of the same.

With best wishes,

502, Narayan Peth, Poona City, 3-9-33. } V. D. SATHAYE, *Provincial Secretary.*

The Chettinad Medical Association.

"Under the presidency of Dr. N. C. Appaya L.R.C.P. M.R.C.S. D.G.O., the above association held its usual monthly meeting on Saturday the 19th August, at the S. M. S. High School, Karaikudy when Dr. S. T. Achar, M.D. first physician, Tanjore Government Hospital, delivered an interesting and very instructive lecture on "Some recent advances in Medicine." A lively discussion followed in the modern treatments of diseases like Diabetes, Tuberculosis and Gastric ulcers in which the members took part. After a vote of thanks from Dr. T. S. Shetty, the Secretary, to the learned lecturer and the guests the meeting came to a close at 8 P.M.

The Trichinopoly District Medical Association.

A monthly meeting of the above Association was held on 26-8-33, at 5 P.M., in the Government Head Quarters Hospital, Trichinopoly, when about 35 members were present. Dr. R. Kalamegham, B.A.M.B.B.S., was "At Home".

Dr. T. K. Ranganathan, B. A. L. M. S., demonstrated three clinical cases of Syphillis.

Dr. Rajan introduced Dr. T. S. Shetty of the S. A. Hospital Kanadukatthan, Chettinad, as an energetic young man who had enriched his knowledge by a recent visit to the West and called upon him to deliver his lecture.

Dr. Shetty delivered an interesting lecture on Gonorrhœa and its treatment, at the end of which there was an interesting discussion in which about half a dozen doctors took part.

With the concluding remarks of the Chairman and with a vote of thanks proposed by the Secretary, Dr. P.A.S. Raghavan, to the Chairman, Lecturer and the Host, the meeting terminated.

Kistna District Rural Medical Practitioners' Association.

The following resolutions were passed at a meeting held at Masulipatam on 26-8-1933 under the Presidentship of the District Medical Officer.

This Association places on record its deep sense of grief at the sudden and untimely death of Dr. K. Venkataratnam, L. M. P., Rural Medical Practitioner at Chennur and resolves to convey its condolence to his bereaved family and members.

2. This association requests the Taluk Boards in the District to contribute liberally towards the needs of the Rural Dispensaries in the shape of extra subsidies, midwives, compounders and ward boys.

3. This association is shocked at the injustice done to the licentiates by excluding them from the All India Medical Register and requests the Government to do them proper justice, in view of the record of their service to the country.

4. It has been brought to the notice of this association that some Taluk Boards intend to replace the present Rural Medical Practitioners by new incumbants stipended by the Boards. This Association therefore protests against such action on the part of the Taluk Boards which is contrarary to the letter and spirit of the Rural Medical Relief scheme.

Puri District Board Medical Association.

SECOND ANNUAL CONFERENCE.

(Extract of Resolutions passed).

I. This Conference requests the Chairman, District Board, Puri to recognise this association as a permanent body at the next meeting of the District Board.

II. This conference authorises the Secretary of the Association to collect from all the Medical Officers under the Board their legitimate grievances, if any, and try to put them before the Chairman, District Board, Puri, and the Civil Surgeon, Puri, in consultation with the President of this conference for early redress.

III. This conference authorises the Secretary of the Association to arrange to register the association as early as possible.

IV. This conference requests the Chairman, District Board, Puri that in the interest of the Medical profession no dispensary doctor should be transferred to the public Health Department.

V. This conference requests the Chairman District Board, Puri to move the authorities concerned through proper channel, to raise the course of studies of the L.M.Ps to 5 years providing a uniform standard of education and also to include the L. M. Ps in the All-India Medical Register.

VI. This conference requests the Chairman, District Board, Puri, to sanction a sum of Rs. 30 every year for subscribing the following medical journals and distribute them through the Secretary of the Association to keep every member up to date.

LIST OF JOURNALS:

(1) Indian Medical Gazette.
(2) Indian Medical Record.
(3) The Medical Practitioner.
(4) The Antiseptic.
(5) All India Medical Journal.

VII. This conference requests the Chairman, District Board, Puri to approach the authorities concerned to extend the privilege of doing Post mortem examinations and also to grant certificates for Police cases and to have no barrier for any of the doctors serving under the District Board, Puri to hold charge of the Bhuvaneswara Dispensary which is maintained by the District Board.

Reviews.

ADMINISTRATION REPORT OF THE SANITARY DEPARTMENT OF TRAVANCORE, FOR 1107, M. E.

This is evidently the last report of the Sanitary Commissioner. The Sanitary Department was organised as an independent department under a Sanitary Commissioner in 1895. Now it is proposed to amalgamate it with the Public Health Department, a new department started about 4 years ago. The Bacteriological Laboratory and Chemical Examiners Department, are to be merged into this department. Of course there is some meaning in the inclusion

of the Bacteriological Department, but as the Chemical Examiner's Department deals merely with medico-legal cases, the wisdom of its inclusion is doubtful. No paid officer seems to have been appointed in charge of Public Health Department but an honorary Deputy Director is appointed on an honorarium of Rs. 250 a month. It is usual practice obtaining in other countries, also, to appoint honorary officers in the Medical Department. Such appointments are not only economical but helpful to the doctors so appointed. The appointment of honorary officers, in the Public Health Department is unknown anywhere. It is rather undesirable to give honorarium which means practically pay, for honorary officers; nor is it wise to appoint officers as honoraries, who have retired with super-annuated pension. Medical Relief is purely a private affair with which the State should have very little to do. On the other hand Public Health Department is a public one and must be maintained by the State. For a small state like Travancore the existence of two independent departments, Medical and Public Health, the duties of which overlap very often, is unnecessary. The two departments may be combined and placed under an officer designated, Director of Public Health and Hospitals,

The Report under Review shows valuable work done during the year. The Commissioner says that the birth rate of vital statistics during the last 10 years may be put between 30 to 40 per milli. However the Commissioner of the last census estimates it at 46 per milli, a rate which exceeds the maximum limits of reproductivity among human beings. We congratulate Dr. Chandy for the efficient administration of the department and wish him peace and happiness in his retirement.

ANNUAL REPORT OF THE CALCUTTA SCHOOL OF TROPICAL MEDICINE AND THE CARMICHAEL HOSPITAL FOR TROPICAL DISEASES, 1932.

This comprises within it the reports of the Director of the School of Tropical Medicine, the Director of the Carmichael Hospital for Tropical Diseases, the Professor of Tropical Medicine, the Professor of Bacteriology, Pathology, and Helminthology, the Professor of Protozoology, the Professors of Serology and Immunology, the Professor of Pharmacology, the Professor of Entomology, the Professor of Hygiene, the Professor of Public Health Laboratory Practice, the Kala-azar Research Department, the Professor of Chemistry, the Hookworm Research Department, Bowel diseases Research, the Leprosy Research Department, the Diabetes Research Department, the Filariasis Research Department, the Respiratory Diseases Inquiry, the work of the Radiological and Electro-therapeutic Department, the Superintendent, Pasteur Institute, the Endowment Fund of the Calcutta School of Tropical Medicine.

The mere contents indicate the all-embracing nature of work done and the intimate connection which each has with the health problems of the tropics. The reports are well written and show the volume of work done at the institutions. Lt. Col. Acton rightly says: "The more one works in a large institution the more one is convinced that the proper place to do research work is in such institutions, because one can obtain help on every aspect of a problem. A research may lead into the domains of mathematics, pharmacology, chemistry and other sciences, Special knowledge on these subjects can be obtained only with great difficulty by small isolated units working in remote parts of India."

At one time when the All-India Institute of Hygiene and Public Health was under construction, it was talked about that the B. Sc. course in the Madras Medical College should be abolished and the students of Public Health course should undergo the course of study in the All India Institute in Calcutta. But we fear that false prestige stood in the way of the abolition of the B. Sc, course in Madras. Only one or two students form the class now, and the money spent for training a couple of students cannot but be a waste. Further, for the prosecution of special studies, a place where facilities for such studies are largely available should be selected and Calcutta is now the only place where such facilities exist. It is desirable that not only in Madras but in other provinces, institutions where training is given in public health course by the Government should be abolished and all the students sent to Calcutta for such training. We congratulate Col. Acton and the other staff of the Calcutta School of Tropical Medicine for the good and valuable work turned out by them.

MEDICAL DIGEST.

(A MONTHLY MEDICAL JOURNAL, BOMBAY.)

We welcome most heartily our contemporary THE MEDICAL DIGEST which came into existence in April last in Bombay. It is usual with the journals, including the medical, that the name of the Editor or Editors is published on the title page, and as we do not find such a procedure being followed by the Medical Digest, we trust we won't be held responsible for such an omission.

The friends and the well wishers of the Medical Digest may know who edits the journal and though we may put ourselves in that category, we do not wish to risk any statement except what is published, and that is, that the Medical Digest is under the management of Dr. M. N. Talati.

The policy and aim of the journal may be grasped from what appears in the Editorial on "Ourselves" in Vol. I No. I of the journal and we do not wish to add anything more except faithfully quoting what is mentioned therein :

"Firstly supplying to medicos particularly to the class of practitioners, a mass of matter authoritative in respect of quality and upto date as to a piece of information, secondly a steady and persistance maintenance of this effort without allowing or causing it to suffer for any reason whatever. Thirdly the continued enlightened cooperation, consequent upon the unimpared appearance of the two above discussed features by the medicos both moral as well as material in the matter of this journal. Fourthly and lastly a persistant winning thought on our part to mould the difficulties across our path so as not to obstruct us as potential thorns in our journey but to serve in our present venture as instruments of health and success to the end."

Regarding the business side of the activities of the journal the Editorial statement to the following effect is worth noting :

"It has been the universal experience that competition feeds and nurses the strong and weeds out the weak and the in-efficient."

We feel that the aims and objects of the journal, including the business principles adopted by it, do not require any more elucidation from us.

We congratulate the Managing Editor, Dr. M. N. Talati, for his enterprise and wish him good luck.

THE ANTISEPTIC.

SPECIAL NUMBER ON VENEREAL DISEASES.
JULY 1933.

Editing of Special Numbers on important diseases is one of the main features of the journals of the type of the Antiseptic. Venereal Diseases have been eating the vitals of all nations both in the West and in the East.

Very effective measures are being adopted in the West in leading a campaign against venereal diseases both by the medical profession as well as the laity, with the result that venereal infection is efficiently controlled and the victims are made to live healthier and less miserable lives. But in India though there are some signs of aping the methods employed in the West for combating venereal diseases much has still to be done. The Editors of the Antiseptic should be congratulated for having conceived the idea and brought into existence a special number on venereal diseases. As many as 190 pages have been utilised for the contributions from specialists in veneral diseases. As much justice as was possible has been done to this subject in the treatment of the varieties of manifestations of these diseases. The Special Number will be a valuable addition to the library of the general medical practitioner who can't afford time to read larger volumes on the subject.

List of Postings of Sub Asst. Surgeons for the month of August 1933.

No.	Names of Sub-Asst. Surgeons.	From	To
1	Dr. Miss A. Janaki Ammal	Leave	Govt. Hl., Palghat.
2	„ K. Narasimham	L. F. Dy., Addatigala	c/o I. G. of Prisons, Ooty.
3	„ T. Achutha Rao	Central Jail, Rajahmundry	Govt. Hd. Qrs. Hl., Cocanada.
4	„ R. Venkataraman	Leave	L. F. Dy., Kulitalai.
5	„ P. S. Kalyanasundaram	L. F. Dy., Kulitalai	c/o D. M. O„ Ganjam.
6	„ E. I. Devapriyam	Govt. Hl , Kadiri	Govt. Hd. Qrs. Hl., Chingleput.
7	„ M. Lakshmanamurthi	Festival Duty	L. F. Dy., Venkatagiri.
8	„ V. Narasinga Rao	„	L. F. Dy., Melattur.
9	„ S. Krishnaswamy Iyengar	L. F. Dy., Melattur	Govt Gen. Hl., Madras.
10	„ K. Gopalan	Leave	Agency Duty.
11	„ G. Raghavayya	„	Govt. Hd. Qrs. Hl., Anantapur.
12	„ P. Ananda Rao	Govt. Hd. Qrs. Hl., Masulipatam	L. F. Dy., Kudligi.
13	„ M. Venkatachari	Festival Duty	Govt. Hd. Qrs. Hl., Cuddappah.
14	„ A. Krishna Rao	„	„ Cocanada.
15	„ H. Manjunath	„	„ Berhampore.
16	„ A. Rajagopala Rao	„	L. F. Dy., Macherla.
17	„ Vasa Narasimham	„	c/o Principal, Madras Forest Collage, Coimbatore.
18	„ D. Satyanarayana	„	Govt. Hd. Qrs.Hl., Masulipatam
19	„ K. Kamaraju	„	L. F. Dy., Hadagalli.
20	„ R. Sivaramamurthi	„	L. F. Dy., Porumamilla.
21	„ S. Ramachandra Rao	„	Govt. Dy., Palacole.
22	„ C. Doraiswami Mudaliar	„	Govt. Hd., Qrs. Hl., Chittoor.
23	„ C. Ramamurthi	„	L. F. Dy., Indukurpet.
24	„ P. S. Srinivasan	„	Govt. Hd.Qrs. Hl., North Arcot.
25	„ C. Manicka Mudaliar	„	Govt. Hl., Conjeevaram.
26	„ G. Venkataramayya	„	L. F. Dy., Chaglamari,
27	„ M. Venkobachari	„	„ Korugodu.
28	„ M. V. Rajasekara Rao	„	L. F. Dy. Thanakal.
29	„ A. Satyanarayana	„	Govt Hd. Qrs. Hl., Kistna.
30	„ J. Suryaprakasa Rao	„	„ Berhampur.
31	„ R. V. Narasimham	„	Govt. Hl., Tenali.
32	„ M. Goparaju	„	„ Rajahmundry.
33	„ T. Jaga Rao	„	„ Russelkonda.
34	„ Y. Suryanarayanamurthy	„	„ Gajapathinagaram.
35	„ Khan Sahib Mohammad Ali Sahib	Leave	Govt. Hd. Qrs. Hl., Coimbatore
36	„ T. Maduramuthu Pillai	„	„ Ramnad.
37	„ G. Ramanujaswami	L. F. Dy., Macherla	c/o I. G. of Prisons, Ooty.
38	„ D. Madhavan	Leave	Govt. Hd. Qrs. Hl., Chittoor.
39	„ S. V. Raghavalu Naidu	L. F. Dy„ Shermadevi	„ „ Trichinopoly.
40	„ B. Subba Rao	Leave	„ „ Guntur.
41	„ S. V. Ramanayya	Govt. Hd, Qrs. Hl., North Arcot	L. F. Dy., Chetpat.
42	„ C. Seshagiri Rao	L. F. Dy , Chetpat	„ Merkanam.
43	„ S. Thiagaraja Chetty	Dt. Jail, Madura	Govt. Hd. Qrs. Hl., Salem.
44	„ R. Narasimham	Govt. Hd. Qrs. Hl., Salem	Leprosy Duty, Chingleput.
45	„ M. Veerabhadra Rao	L. F. Dy., Porumamilla	Govt. Dy., Badvel.

Reg. No. M. 2528.

Printed at THE INDIA PRINTING WORKS, "Sri Nivasam" Mylapore and Published by the Managing Editor, DR. V. RAMA KAMATH, 147, Purasawalkam High Road, Vepery, Madras.