

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

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AND

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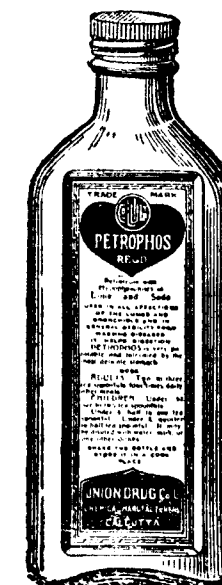
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NOVEMBER, 1933.

[NO. 2

ALL INDIA MEDICAL CONFERENCES.

It is really a happy coincidence that two associations of all-India importance viz, The All-India Medical Licentiates' Association and the Indian Medical Association hold their annual conferences in Bombay this year during the X-mas holidays. It is happier still to know that the reception committees of both the conferences have been co-operating and coordinating with each other and have settled to hold both the conferences in the same pandal to be erected on the open grounds opposite to Goverdandas Sunderdas Medical College, Parel, Bombay. It has been provisionally settled that the conferences of the Licentiates is to be held on 26, 27 and 28th December and the conference of the Indian Medical Association immediately after. The President for the former gathering has not been chosen as yet. The Indian Medical Association had selected Dr. B. C. Roy, M.D., F.R.C.S., of Calcutta, to be the President.

Ever since the Licentiates Association came into existence, it has been uniformly the custom to have the head of the Medical Department of the Province where the conference was held as the President of the conference. After the Montford Reforms the Minister in charge of the Medical Portfolio took the place of the Surgeon-General or the Inspector-General, in presiding over the conference. This custom was as necessary as it was time-honoured.

It could not be otherwise as the Association was started primarily to redress the service grievances of the Licentiates and the conference was the occasion and an opportunity to place before the head of the department directly the grievances of the medical subordinates as the Licentiates are designated in service. These medical subordinates more than any body else should know how far these conferences have been useful to them in this direction. Times have changed and rapidly too and the Medical Licentiates outside service have outnumbered their brethren in service in large proportions and amongst the members of the independent medical profession the Licentiates form the largest section. Consequently larger interests are at stake concerning the Licentiates as a class in their capacity as private practitioners than as medical subordinates. The Heads of the Medical Department have their own limitations. The Ministers in charge of Medical Portfolios though, theoretically independent, are many a time found subordinate to their bureaucratic secretaries. Opinions gathered and arrived at by constitutional and persistent agitation organised by associations of all-India importance may be expected to bear better fruits than humble memorials and pious prayers. It may be even said that it would be unconstitutional for associations of the type of the All-India Medical Licentiates' Association to have one outside association as President for the annual conference. We trust the Reception Committee of the All-India Medical Licentiates'

Conference would choose a President from amongst their fold as the Indian Medical Association have been rightly doing ever since that association became a registered body.

It is said that both the conferences will run a common Medical and Scientific Exhibition. We are glad at the wisdom displayed by the two Reception Committees in running this show conjointly. This arrangement would be an earnest for goodwill and harmony between the Licentiates and other sections of the medical profession constituting the Indian Medical Association. We wish the two Committees arrange for the discussion of medical subjects conjointly too. Such an arrangement would be to the mutual advantage and benefit of both the gatherings. Major Naidu made an indirect suggestion in his presidential address at Lucknow last year for the amalgamation of both the associations. It is certainly a wise step in the right direction but so long as the Licentiates are treated not as equals to the other members of the medical profession it is desirable, nay essential, that they should run an independent association to guard their rights and privileges in the profession. By this we do not claim any superiority to the Licentiates. We wish only to mention actualities. There are a good number of qualifications in the medical profession both Indian and foreign but in the matter of associating with members holding other qualifications the gulf between the Licentiates and others is made to appear bigger than between those holding other qualifications. Time will not be far when the gulf between the Licentiates and other members will get narrower and finally there will be merging. This process of narrowing and merging cannot be effected speedily if the Licentiates do not continue their activities as a separate entity.

Bombay has been maintaining a good name for practical work. We trust it will not be otherwise regarding the activities of two all-India gatherings. Bombay was the place of birth of the All-India Medical Licentiates' Association. It was in 1906 on the 8th of July that the first meeting of this Association was held at the residence of its President, the late Mr. Abdul Razaq, J. P., and for the next few years the annual

conference was held in Bombay itself. Later there was a lull and little or nothing was heard in Bombay about the activities of the Association. The all-India gathering which will meet next Xmas will be the fourth one and the responsibility on the shoulders of the Reception Committee this time are really heavy. From what could be gathered at the last two conferences of this Association the one at Dharbhanga and the other at Madras it could be said that the internal affairs of the Association are far from satisfactory. As was mentioned in these columns last year those that gathered at Madras spent the major portion of their time in office hunting. The destinies of the Association were controlled entirely by the delegates from U. P. and Bengal who hailed in large numbers at both the conferences. We have every reason to believe that there is a probability of the repetition of such activities even in Bombay unless delegates from other parts of India make up their mind to attend the conference in large numbers. We are told authoritatively that three important members of the Association who attended the Madras Conference last year are now occupying important positions in the Reception Committee of the Bombay Conference, one as the Chairman and the other two as Secretaries of two sections and it is also said the Provincial Secretary for the Bombay Province was also present at Madras. We trust these gentlemen will with the help of their colleagues in the Reception Committee be able to guide the destinies of the Association for the good of the class as a whole and not for the individual interests of a few of the office bearers of the past or of the future. All the troubles that were experienced so far, seem to be for want of a sound constitution. The existing rules and regulations are said to be as faulty as they are vague and it is very unfortunate that those who were at the helm of the Association these years would not put the constitution on a sounder basis, nay it looked at times that advantage was taken of the existing faulty constitution to cover the sins of omission and commission by those who were guilty of them. We sincerely hope that Bombay which was the birth place of the All India Medical Licentiates' Association would take the credit of having reformed the constitution and give the Association a new life.

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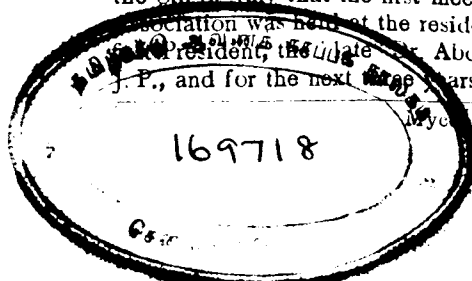
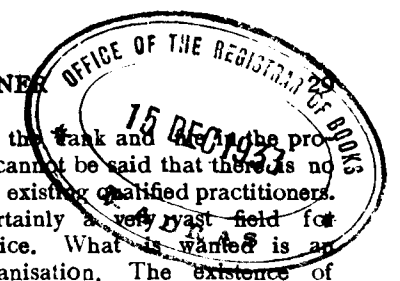
There seems to be little or no trouble at the annual gathering of the Indian Medical Association. This is probably due to its being much younger than the All India Medical Licentiates' Association and those who were responsible to organise this body must have taken advantage of all the existing constitutions and drawn up a workable constitution which gives no room for individuals in the constitution to have their own ways.

We wish the organisers of both these conferences realise that the value and utility of such annual gatherings are to be assessed on the decisions arrived by these gatherings and consequently subjects affecting the life and welfare of the medical profession as a whole, should be the first concern of these conferences. We have been noticing these few years that the conferences organised by the Indian Medical Association concerned themselves chiefly about the transfer of power from the members of the Indian Medical Service to the members of the independent medical profession. This is certainly a legitimate agitation but this would not bring prosperity to the profession as a whole excepting those at the top. The first concern ought to be to bring contentment and prosperity for the members of the profession as a whole. There have been loud complaints both in the press, platform and on the floor of the councils of legislature that in India there was a great dearth of qualified medical practitioners to look after the health of the people, there being not even one doctor for every 10,000 of population. It is a strange irony yet a fact that the rank and file amongst the qualified practitioners are suffering and miserably too, for want of work. We are aware that the Indian Medical Association did feel the need for organising committees in all provinces in India and passed a resolution to this effect at their last conference at Lucknow. The fact that no such committees have come to existence indicates that those who are responsible to run the Association did not take this resolution as a serious business. Even the very resolution regarding this subject was couched in such a language as to reflect no responsibility on any body much less on the Association itself. We trust that the organisers of both the Conferences will take up this matter more seriously and find out ways and means to

find work for the rank and file of the profession. It cannot be said that there is no scope for the existing qualified practitioners. There is certainly a very vast field for medical service. What is wanted is an efficient organisation. The existence of quacks and charlatans and the unhampered privileges allowed to medical men in Government service have been mainly responsible for the unemployment of a large number of qualified practitioners in this country. Both the associations should point out to the Government the necessity of bringing into existence a legislative machinery to put down quackery. All the existing practitioners of all systems should be brought under the control of a licencing body and nobody should be allowed to practice unless he has a licence. Such licencing bodies are in existence in some places such as Goa under Portuguese Government and are working satisfactorily. In Federated Malay States and other native states in Malay under British control the medical officers under Government employ are prohibited in engaging themselves in private practice. Why not introduce such a prohibition in India?

The other important subject that should attract the attention of the two conferences is the need for reform of the existing provincial medical councils so that all those that register themselves in the provincial registers are treated alike in the matter of enjoying the rights and privileges which these practitioners get by virtue of registration. It should be pointed to the Government that when the whole Indian constitution is to change soon with no nominations to democratic institutions, the constitution of the medical councils should also be changed so that the Council has all its members elected and also the President of the Council. Then only one could expect salutary reforms in the working of the medical councils for the good of the profession and the public. Then only the independent medical profession would prosper and thrive. Then only will the existing compartments in the profession disappear and there would be harmony and contentment in the medical profession as a whole.

Rural medical relief is yet another subject which has not been attracting the attention of the all-India Medical Conferences to the extent they should. We have repeatedly



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pointed out that the rural medical practitioner is a most important unit to solve the village reconstruction of which our country is so much in need. We have mentioned in these columns that the scheme dealt elaborately in Major Naidu's presidential address at Lucknow last year is not practical. His suggestion to bring into being a special class of half-trained medical men for rural medical relief is not conducive to the well-being of the villagers. Villagers are certainly in need of fully trained qualified practitioners as these have to work single-handed with little or no facility for consultation and supervision. If the Government should pay medical men for services rendered to the necessitous poor it should be in rural areas and not in urban as in towns and cities a large number of qualified practitioners have settled for practice who may depend upon private practice for their livelihood.

The vagaries of insurance companies especially those existing in India should receive the attention of the medical profession. Invidious distinctions are made between two medical practitioners of equal qualifications, the one in Government service being considered superior to another of the same qualifications in private practice. The Medical Licentiate is not recognised as fit to examine life insurance cases. We do realise that special experience may be necessary for insurance work but it is beyond our comprehension that when the insurance companies trust a raw medical man just passed out, if he is in Government service, more competent than an experienced medical practitioner commanding large private practice. We suggested in these columns last year that insurance companies in India may as well bring into existence a special college to give necessary training to medical men in insurance work and select from amongst those who have passed the necessary test as insurance doctors. Both the conferences did pass resolutions on this subject last year. But mere passing of pious resolutions will have little or no effect unless it is followed by action. So it is desirable that the conferences that meet in Bombay should frame the resolutions in such a way that the insurance companies should be made to feel the effect of such resolutions.

Medical Education of Licentiate is a subject which should be discussed threadbare by both the conferences. The Licentiate have been agitating that the course of training should be raised to the University Degree standard and recently in Madras the course has been increased to 5 years. There is also a feeling that the general qualification for entrance into medical schools should be also raised to the intermediate standard. The medical profession should now seriously consider whether the Licentiate should continue to exist as such when they are made identically equal to graduates. The existing Licentiate especially those of 5 to 10 years standing clamour to be graduates. It is really most unpatriotic that the leaders in the Indian Universities excepting Madras have not considered the desirability of allowing facilities to the Licentiate to qualify themselves for University medical degrees. Their callousness looks more culpable when the Licentiate could get higher qualifications in Great Britain where they are allowed special facilities to qualify themselves for such diplomas within a period ranging from 1½ to 2 years. The admission for a higher entrance qualifications equal to the intermediate or the Senior Cambridge, demanded by the Madras University has not attracted many Licentiate to the Medical College in Madras and the majority of the Licentiate who have been admitted for the M.B.B.S. course belong to provinces outside Madras, and those that do apply for admission for qualifying themselves for the M.B.B.S. degree seem to be doing so not with the intention of gaining more knowledge but only to get promotion in Government service. Whatever be the motive of these licentiate to become graduates of the Indian Universities, it is high time that the other Universities in India should give them facilities to qualify themselves for University degrees. The suggestions of Major Amir Chand, Superintendent, Amritsar Medical School, which were published in our journal last month seems to be not only reasonable but rational. We trust both the conferences would consider this subject and call upon the Indian Universities to allow the Licentiate facilities to qualify themselves for University degrees.

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Honorary Medical Officers will be one of the main items for discussion. It is desirable that both conferences formulate an all-India workable scheme to be given effect to by the Government in all provinces.

Last but not of least importance is the consideration of the Indian Medical Council Bill as it is passed at the Legislative Assembly recently. The agitation conducted in the press has been fruitful to take away the sting of an all-India Medical Register with the exclusion of the licentiate. The conference should consider whether a Medical Council without a medical register will be of any use at all to the country especially to the medical profession and pass suitable resolutions drawing the attention of the Government as well as the public to the uselessness of the bill which will incur a recurring expenditure of nearly a lakh of rupees a year. We might mention that even reciprocity clause will not be workable unless there is a register.

We have dealt with the most important subjects which affect the welfare of the medical profession as a whole. There are many other items of local importance which should engage the attention of both the conferences. There are also other subjects concerning the grievances of those in service all of which should receive the consideration of both the conferences as the decisions arrived at by gatherings of all-India importance will go a good way in drawing the attention of the authorities concerned.

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Original Articles

SOME HINTS TO THE GENERAL PRACTITIONER IN THE MANAGEMENT OF EYE DISEASES.

By

BENJAMIN FRANKLIN KILGORE, B.S., M.D.,
Des Moines, Iowa, U.S.A.

The General Practitioner in his great variety of cases is frequently called upon to treat various eye conditions. All too frequently, training in the various specialities is rather sacrificed to the more comprehensive fields of medicine. The large number of patients coming to a clinic after previous unsuccessful treatment elsewhere, often at the hands of the private practitioner, testifies to this end. All too frequently cases of a very serious nature present themselves, with a history and findings clearly indicating that at the onset, the prognosis should have been good. This is particularly serious when the end result means the loss of one or both eyes and its attendant unfortunate economic effects, not only on the patient but upon other members of the family. In general medicine, Nature is often very kind to both the patient and the Doctor; a poorly reduced fracture frequently heals with very little permanent disability, or the patient recovers in spite of the treatment in many medical conditions. But unfortunately, the eye cannot overcome such handicaps so easily, and wrong treatment can be even more injurious than no treatment. With these things in mind, a review of some of the dangers would not be amiss.

Injuries and foreign bodies are probably one of the most common eye complaints that the general practitioner is called upon to treat. And a most innocent appearing injury may be the cause of a lost eye. Foreign bodies very frequently are embedded in the epithelium of the cornea. Removal may be easily effected after the instillation of a few drops of an anesthetic; Cocaine solution, 2 per cent is very often used, and this may in itself lead to complications, which will be discussed in a following paragraph. Pantocaine in 1 to 500 solution is a better anesthetic. The foreign body has already produced a break in the continuity of the epithelial covering and

removal usually enlarges this. When the embedded substance consists of one solid piece, as a small fragment of stone or metal, it is best lifted out by inserting an eye spud beneath it from one side. When however, there is a ring of discoloration surrounding the foreign body, caused either by fine rust particles from a piece of iron, or by burning into the cornea of some hot substance, as sparks from an emery wheel, or hot particles of copper from a trolley wire, seen in street railway workers, this entire area must be curetted out, until only clear transparent corneal substance is seen. Likewise any abrasion of the cornea, where the epithelium is broken, must be carefully treated. The most important phase of the treatment is the bandaging of the eye, after some antiseptic ointment has been applied to the conjunctival sac. Orthoform 4 per cent, Collargol, Boric acid ointment 3 per cent may be used for this purpose. As there is always some photophobia and pain after the effect of the anesthetic subsides, a bandage offers considerable relief to the patient, but more important still it prevents the entrance of infecting organisms into the cornea. Hypopyon ulcers are amongst the most common sources of diminished or lost sight in younger people, and usually originate from such corneal abrasions. Thus it is imperative that extreme care be exercised and the bandage maintained until the epithelium of the cornea has completely covered the denuded area.

It is also not so infrequent, that serious complications may develop as a result of the instilled anesthetic. Many older people have a predisposition to glaucoma and the instillation of cocaine into the conjunctival sac is sufficient to precipitate an attack. The foreign body is painlessly removed after such anesthesia, and the patient sent away much relieved only to return complaining of severe pain. The pupil is still dilated, but this may be attributed to the anesthetic; the ciliary vessels around the limbus show considerable injection and the whole cornea may be a little hazy or cloudy. This may be confused with an infection in the cornea and cocaine again instilled into the conjunctival sac in an effort to relieve the pain. Atropine has also been used to prevent anterior synechia in this supposed keratitis, or hot fomentation applied to combat the

infection. These only aggravate the glaucoma, which may thus continue until all or part of the visual field is destroyed. Thus in all patients of middle life, presenting themselves with a foreign body, the tension should be estimated by finger pressure and compared with the unaffected eye. It is likewise a safe precaution to instill a drop of Eserine, $\frac{1}{2}$ per cent, to contract the pupil after the cornea has been treated. If when the patient returns on the second or third day, the erosion presents a grayish dirty floor and is surrounded by a yellowish-white ring, a serpiginous ulcer has developed from the infection of the erosion, and pain lachrymation, and photophobia are marked and the pupil is narrow. This must be treated vigorously and radically to save as much of the normal cornea as possible. Here atropine is indicated and cauterization of the margins of the ulcer and puncture of the anterior chamber, if tension is high, if the ulcer is deep, and rupture is impending or if pus has accumulated in the anterior chamber.

In all cases where a serpiginous ulcer or hypopyon ulcer develops, the patient should be hospitalized. Ambulatory patients do not as a rule understand the dangers and are apt to be careless in the management of their condition, while if vigorous and radical treatment can be instituted at the onset, much serious impairment can be avoided. If it is not economically feasible, they should be sent immediately to one of the ophthalmic hospitals.

Simple or chronic glaucoma is often unrecognized by the general practitioner. A patient complains of failing vision and a diagnosis of beginning cataract is made. True, it may be complicated by a beginning cataract but the serious disease is the unrecognized glaucoma. The patient still has some vision, so he is told he must wait awhile until the cataract is 'ripe'. But before that time, the vision is completely or mostly destroyed, and operative treatment is of no avail. So such patients should be sent immediately to an Ophthalmic Hospital where the presence of glaucoma can be definitely determined. Likewise, as many immature cataracts are removed by the intracapsule method, without waiting for them to 'ripen', sending them to an Eye Hospital may relieve the patient of that long period

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of waiting in partial blindness, if no glaucoma be present.

The other most frequent disease of the eye encountered by the general practitioner is conjunctivitis. It is very easy to give the patient a collyrium and send him away. But in unilateral cases, a foreign body may be the real cause of the conjunctivitis. Likewise, iritis, and iridocyclitis may be confused for conjunctivitis. So in all cases a thorough inspection of the conjunctival sac, cornea and iris should be carried out. If cornea is not perfectly clear, a drop of Fluorescein solution, (Sodium fluorescein 4 per cent) should be instilled, and the sac washed with saline. In this manner, any rupture in the continuity of the corneal epithelium will appear from this staining. Patients presenting a profuse amount of discharge should have the conjunctival sac thoroughly irrigated with normal saline solution or potassium permanganate 1:5000 or boric acid solution 3 per cent. If the discharge is very profuse, this should be repeated several times a day. Cold applications aid considerably in relieving the congestion. These should be applied for ten or fifteen minutes, and be repeated every two or three hours. Silver preparations, preferably 2 per cent silver nitrate applied to the conjunctiva is most effective in the early stages. Mercury oxycyanate 1:3000, or Argyrol 10-20 per cent may be instilled by the patient several times a day. The discharge should not be allowed to dry on the lashes but be soaked and gently washed away with plain water or boric acid solution. But the most important part in the treatment is to watch the cornea. As long as it is uninvolved, no dire results will follow the infection. Do not bandage any eyes with a profuse discharge. Dark glasses may be worn to relieve the photophobia. If such glasses are not economically possible and the patient complains much of the photophobia, a shield may be devised from a piece of cloth about four by six inches. Two strings are attached, one at each end at the upper corner, so that this shield can be tied around the forehead. The cloth thus hangs in front of the eyes, but not against them.

In conclusion may I caution you to exercise extreme care in treating all abrasions of the cornea, and particularly to bandage all cases. Likewise be prudent in the use

of cocaine in the eye and to watch particularly for early cases of glaucoma. In this manner, many lost or partially lost eyes may be saved.

QUINIDINE IN CARDIAC PRACTICE.

By

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

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To the new world we owe Cinchona. The Spanish explorers introduced it into Europe about the year 1630. The infusion of its bark, used by the Indians for fevers, began to find its place in European Medicine about that period. Since then Cinchona and its active principles have been largely used in European medicine as an antiperiodic, as a vegetable bitter and mainly as a specific for malaria. In 1914, Wenckebach, the eminent Viennese cardiologist, demonstrated the specific effect of Quinine in auricular fibrillation. Frey, in 1918, reported a more effective drug, quinidine sulphate. Since then quinidine sulphate has been in use throughout the medical world for various cardiac conditions. Extrasystoles, paroxysmal tachycardia, auricular fibrillation, auricular flutter and latterly cases of coronary thrombosis with signs of ventricular irritability have all been extensively treated with this drug. The use of quinidine sulphate in auricular fibrillation and flutter with varying results and the apparently similar clinical findings after the use of digitalis has unfortunately left behind an impression that quinidine sulphate and digitalis have similar properties. This is a grave mistake. Quinidine is a powerful cardiac depressant. It has to be used with considerable caution. Cases of sudden death after its use have been reported. It has been suspected to be the cause of production of ventricular tachycardia, ventricular fibrillation, standstill of the heart, a toxic condition of the myocardium and respiratory paralysis. Certain drugs especially those of the quinine group may cause extra-systoles to appear in large numbers together with other

evidences of toxic involvement of the myocardium. It must also be remembered that auricular fibrillation with extra-systoles may appear in the course of quinidine therapy.

Quinine and its isomer quinidine are two of the important alkaloids of cinchona. They resemble each other in their chemical and pharmaceutical properties. What is said of quinine applies equally well to quinidine. Quinine has a deleterious effect on the general nutrition of the protoplasm. It is a general protoplasmic poison. In the heart it shows its effect by a direct action on the heart muscle. The heart is generally slowed and weakened when quinine is given intravenously. Large amounts depress vagus terminations. A drop in the blood pressure is noticed. This is partly due to the weakness of the heart but mainly to the dilatation of the peripheral vessels owing to its toxic effect on the vasomotor nerve endings and directly on the muscle. The cardiac effect is modified and lessened when the alkaloid is administered by the mouth. Quinidine has a similar action but is 5 to 10 times more powerful. A depression of the heart muscle more marked in the auricle than in the ventricle manifests itself in a reduction of conductivity and in a lower excitability in response to natural impulses. Thus the refractory period becomes longer. The strength of the contraction is sometimes increased but this is not constant. The inhibitory ganglia are weakened resulting in an acceleration of the pulse but this may be counterbalanced by the inhibition of the pacemaker. The accelerator nerve remains unaffected. Quinine may be recovered from the urine 15 minutes after administration by mouth. One-third of the total quantity is excreted in the urine, the remaining two-thirds being oxidised in the tissues. The presence of the alkaloid in the urine has been found to bear no relation to its therapeutic effects. The excretion is influenced by a number of factors. Individual variation, diuresis, renal permeability, and muscular effect have all to be considered.

The object with which quinidine is given is based on its preventing or arresting the various forms of arrhythmias or ectopic stimuli. As such, this drug should not be

given in cases with normal rhythm and congestive failure. In fact it will be noticed that the circulation is generally adversely affected during the transition to the normal rhythm. It should not be given indefinitely unless the desired result has been obtained within a short period. Not more than a few days or at the most a week should be the permissible period to decide whether quinidine will restore the normal rhythm or not. The electro-cardiograph has shown evidence of auricular standstill in cases of auricular fibrillation under quinidine treatment. Standstill of the whole heart due to ventricular and pacemaker depression has been suspected in cases of sudden death during quinidine therapy.

Quinidine is used in the treatment of premature contractions, paroxysmal tachycardia, paroxysmal auricular fibrillation, chronic auricular fibrillation and auricular flutter. The method of administration has been fairly regularised. It may be given in powders, capsules or tablets. Where quinidine sulphate was not available I have found Pulvis Cinchona Co. to give satisfactory results, of course comparatively larger doses being given. It is essential before the treatment is instituted to test the patient for any quinine idiosyncrasy. A preliminary dose of 3 grs. of quinidine is administered, quinidine sulphate or hydrobromide being the salts of choice. Palpitation, diarrhoea, headache, nausea, dizziness, buzzing in the ears, urticaria are some of the signs of quinine intolerance. In some cases a heart rate of over 150 p. m. may be found. In non-ambulatory cases and where large doses are given the patient should be kept in bed, the pulse rate should be charted hourly, any sign of distress from tachycardia should be watched for. The ventricular rate may be increased under the drug. It is a wise procedure to maintain the hourly pulse chart during the test period as well as during active treatment. In cases of established auricular fibrillation a careful cardio-vascular examination is necessary. It is dangerous in the presence of heart failure, with venous engorgement and is definitely contra-indicated when there is a history of haemoptysis or recent thrombi or old standing fibrillation. The danger of thrombi, generally from the auricular appendices, being set free on the establish-

ment of normal rhythm in old standing fibrillation and carried into the general circulation should not be overlooked. Quinidine should be avoided in cases of active infection of the heart.

PREMATURE CONTRACTIONS AND PAROXYSMAL TACHYCARDIA.

Wenckebach in 1914, reported the specific action of quinine in premature contractions. Frey in 1918, demonstrated the specific action of quinidine in these cases. In the absence of organic heart disease if these continue after removal of the toxic factors usually suspected of producing the disorder and if the patient is disturbed with the consciousness of these extrasystoles further treatment is warranted. Quinidine sulphate has been successfully used in about 5% of the cases. The same result may be expected in cases of rheumatic or hypertensive arteriosclerotic cardio-vascular diseases complicated by premature contractions. Paroxysmal tachycardia is a continuance of those extrasystoles. As such quinidine may be successfully tried. Lewis suggests intravenous injection of quinine sulphate, 2 grs. well diluted and slowly given, in urgent cases where other remedies have failed. Quinidine sulphate is administered 6 grains daily in divided doses. In severe cases 2-5 grains twice or thrice daily may be given but is not long to be continued.

AURICULAR FLUTTER AND FIBRILLATION.

Flutter is difficult to control. Quinidine has been successful in roughly 20% of cases. Digitalis is a better remedy. If after digitalisation chronic auricular flutter reverts to auricular fibrillation quinidine may hasten final reversion to normal sinus rhythm. In some cases where digitalisation has not been successful quinidine may be tried. It has restored normal rhythm in a few cases. But if auricular flutter develops during quinidine therapy of auricular fibrillation it is wise to stop the drug and resort to digitalis. 6 grains of quinidine sulphate every six hours, subject to a maximum of 30 grains in 24 hours, is a safe dosage. If the normal rhythm is not restored in 2-3 days it is wise to stop the drug and administer digitalis instead. Sometimes the withdrawal of the drug restores the sinus rhythm. In recent and paroxysmal fibrillation quinidine has been found a

powerful remedy. Lewis reports 50% as the successful results. It has reduced the attacks in a certain number of cases and eradicated them in some others. But it must be said that full digitalization of the patient with a daily maintenance of digitalis has been more successful than quinidine. In cases of fibrillation treated with quinidine there is still a tendency for recurrence in the majority of cases. During the transition into normal rhythm the electro-cardiograph often reveal impure and sometimes real auricular flutter. Reversal of the T wave and an increase of the P R interval and in some cases signs of intra-auricular block are seen.

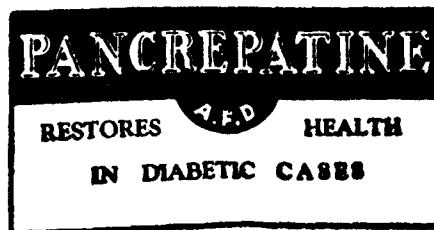
Quinidine sulphate 5 grs. every 4 hours omitting not more than one dose in 24 hours restores the normal rhythm in a few days in favourable cases. The treatment may be continued for a week. The ventricular rate has to be watched and if there are any signs of distress from tachycardia or other complications the drug has to be stopped. It must be remembered that extra systoles may develop in auricular fibrillation under quinidine therapy. In chronic or established auricular fibrillation there are two schools, one which considers quinidine as the best remedy and advise its use in auricular fibrillation even in the presence of organic myocardial or valvular disease. Others consider that full digitalisation with maintenance dose of digitalis for the rest of the patient's life as the best procedure. It is essential to decide whether a normal sinus rhythm is tolerated by the patient. In some cases the patient feels better on the abnormal rhythm. Patients with valvular disease of the heart, massive cardiac enlargement, decompensation are as a rule not benefited by normal rhythm and revert to auricular fibrillation. In each case the decision of giving quinidine must be decided after a careful study of the patient. Dock considers that the restoration to normal rhythm may be effected with quinidine in a majority of cases and be maintained for months if appropriate doses of quinidine be continuously given. It is wise to digitalize most of these patients before starting treatment with quinidine. Stroud reports return to normal sinus rhythm in 60 to 80% of cases and that once the normal rhythm has returned this has been maintained in a few cases with or without

constant administration of quinidine, for five to ten years. In these cases quinidine may be given as follows. After the test dose, quinidine sulphate, 3 grs. is given every 4 hours. If the objective is not obtained within forty-eight hours the dosage may be doubled, six grains every second or fourth hour and continued for seven days. When these high doses are given the patient should be confined to bed and frequent electro-cardiographic examinations be made. If by this period normal rhythm is not restored it is wise to discontinue quinidine and treat the patient with digitalis only or repeat quinidine therapy after digitalization.

With other and safer drugs in hand quinidine has not created a place for itself among the important drugs used in the treatment of cardiovascular diseases. It is of marked benefit only in cases of auricular flutter, which is comparatively rare, and auricular fibrillation associated with hyperthyroidism. In the latter condition quinidine sulphate restores normal rhythm in practically 100% of cases if the thyrotoxicosis has been the sole aetiological factor and the hyperthyroid condition has been cured by operation.

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Quinarsine rapidly controls Malaria.

Abstracts

ON THE TREATMENT OF RHEUMATISM.

By

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Rheumatism is a term often loosely applied alike to real and imaginary affections of the joints, especially in the middle aged. The imaginary rheumatism may be held to cover those cases of very mild fibrositis and muscle trauma which are the frequent accompaniment of unaccustomed exercise, over-indulgence, and exposure to damp and cold. The real affections comprise the principal triad, rheumatoid arthritis, osteoarthritis, and fibrositis and lumbago in severe form, these separately or together forming the picture of arthritis deformans of the continental writers. Subsidiary or concurrent lesions of gout or syphilis must not be ignored.

Common to all these diseases is the complaint of pain, and one ventures to suggest that were the more trivial cases examined more closely, and the advancing cases regarded with less resignation, then perhaps, there would be less need for the elaborate treatments for crippling end-results; the apparently contradictory methods of fixation and absolute rest, the massage and vigorous movements, heat and cold and light of various wave-lengths, to say nothing of the panoply of splints, calipers, chairs, and beds.

If gout and syphilis be kept in mind they can usually be appreciated by their characteristic if sometimes occult manifestations, and the results of Wassermann, Kahn and blood-uric-acid tests. Also if these factors are proved to be present, appropriate lines of treatment, too well known to need description here, are at once available.

The position is not, however, so well defined when we meet with the essentially "rheumatic" case. Through a welter of conflicting facts and theories as to the aetiology of rheumatic diseases two points emerge quite clearly; (a) that arthritis deformans is of an infectious nature at some

portion of its course; and that (b) environmental changes play a large part in determining the course and even the existence of the disease.

Let us consider the latter first. We have to think of (1) trauma and obesity; (2) endocrine disfunction and climacteric; (3) metabolic disorders.

The repeated trauma inflicted especially upon the joints of the lower limbs by a grossly improper posture and gait, is often magnified many times by the co-existing obese state. In women particularly, this vicious circle is frequently to be found. Monstrously incorrect shoes coupled with the corpulence attendant upon carbohydrate overfeeding, throw great strains upon the articular surfaces. Pain soon follows, and with it an encouragement of natural laziness and lack of exercise, followed by a still greater increase in weight. This obesity would appear many times to be part of the general climacteric syndrome and to be related to a disfunction of the endocrine organs rather than to states of over or under-activity of the organs. The thyroid gland is a case in point. Here, for example, the association of arthritis deformans has been noticed not only with hypo but also with hypersecretion of the gland and the elaborate investigations of basal metabolic rate that many observers have carried out have revealed no startling results as regards the predominance of high or low thyroid activity among these patients.

Moreover, it has been shown that endocrine disfunction does not tend to the encouragement of arthritis only at the menopause, both male and female, but that it may well be a significant factor even from childhood. The instability of the vascular reactions in many arthritis has an undoubted basis in their relation to the nervous control of certain aspects of the vasomotor system. Arthritic patients will feel an exacerbation of joint pains with the return of their chilblains; and their medical attendants will observe that vascular stasis, acrocyanoses and the like are usually then more marked, while at the same time the elements of environmental and constitutional disturbance can often be recognised by an adequate examination at the time of the first complaints of pain. If adequate measures be taken to control the obesity, the

thyroid abnormalities and the defects of gait and posture, then the rapid progress of the disease in suitable soil can, in a large percentage of cases, be checked and stamped out completely in many. There would seem to be much evidence that metabolic disorders may be the precursors of focal sepsis rather than one of its after effects.

Whichever is the primary abnormality there is no doubt that a large volume of evidence is being accumulated in favour of the infective origin of arthritis deformans. The origin lies not necessarily in frank sepsis, for in so many cases the areas of chronic infection are so numerous that some small local foci would seem almost inevitable and from these the absorption of organisms and their toxic products proceed according to the reaction of the body as a whole, fulminant in some cases, grumbling on for years in others.

Dental sepsis is a particularly difficult problem and demands particularly careful expert investigation, because being so often of the closed as opposed to open type of pyorrhoea: apparently sound teeth may harbour apical abscesses and granulomata.

Further, inspection by the rhinologist and radiologist, as well as the dental surgeon, is of the utmost importance as a preliminary to the treatment of arthritic lesions, for this often serves to draw attention to other adjacent foci such as the antra and nasal sinuses, which are often as deceptive as the teeth in their absence of objective signs and symptoms of disease.

It would seem to have been the custom until quite recent times to consider all tonsils as infected and requiring tonsillectomy. Lately however, the value of tonsillectomy has been questioned, and statistics have been brought forward to show that except for frankly septic tonsils and recurrent throat infections, much harm may be done by wholesale removal of tonsils. The tonsillar function is mainly defensive, and clear evidence of the hopeless breakdown of this defence must be obtained before removing it.

Intestinal infection has long been the subject of much investigation by bacteriologists and certainly the possibility of large migrations of bacteria (normally resident in the alimentary canal) through the splanchnic lymphatics and vascular bed, gives one

to think furiously. There is little doubt that in cases showing marked lowering of gastric acidity, disturbance of the normal intestinal flora by alterations of pH, by stasis, or fantastic diets, heavy auto-infection can occur, and if the patient is in a lowered state of resistance the bad effect of such bacterial absorption upon "rheumatic" states cannot be denied, although it may not be their essential cause.

Whatever theories be held, the treatment of focal sepsis resolves itself into the treatment of the open and occult types. Attempts can be made at the eradication of the former and if care be taken, the last state is not worse than the first. A complete set of artificial teeth is not the best apparatus with which to tackle a new and unaccustomed diet, while repeated operations may so reduce the general vitality of the patient, that he may fall an easy prey to some secondary infection other than that responsible for his arthritis.

Treatment of the occult cases falls under two headings, cure and relief. For the first the vaccine: protein therapy is paramount with physiotherapy as an important ancillary aid for environmental improvement. For the latter, physiotherapy alone reigns supreme, helped in the more crippled stages by orthopaedic measures and appliances. Logically, the autogenous vaccine should offer a rapid and successful route to cure, as indeed it often does, statistically to the general average of 60 per cent. of cures or marked improvements. The organisms present in the foci of sepsis should be attacked by suitable antibodies put out by the body tissues. The reaction of body having been subnormal to the stimulus of the bacterial antigens in the foci, we must attempt to increase the patient's reaction (i.e., antibody production) by autogenous vaccine.

Much less favourable is the use of vaccine in arthritis in which there is still generalised infection. Little good can be expected from injection of further antigen into a body already blooded with it, and not infrequently severe reactions occur. In cases in which generalised infection is admitted but the pathogenic organism cannot be determined, much use has been made of protein shock therapy. Foreign proteins such as milk, peptone, T. A. B. vaccine and

B. Coli vaccine may be used and possibly much of the good done by stock vaccines arises from shock, although its exact nature is unknown. It seems, however, that the ultimate benefit derived bears a close relationship to the severity of the reaction as judged by malaise and temperature. The claims of the patient to milder treatment often results in the injections being stopped before the best results are obtained. In all cases the greatest immediate relief of actual pain, so characteristic a feature of arthritis deformans, is usually obtainable by means of one of the forms of physiotherapy.

But whatever line of treatment is considered, there is no doubt that a correct choice of methods can be made only after a complete and detailed investigation of the patient, and it is hoped that these short notes will have given at least some indication of the lines along which the research should take place.

(*The Journal of Clinical Research, July 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.

Leprosy: Alipol or Moogrol; and if complicated with syphilis Avenyl injections, Chaulmoogra oil by intradermal route. (I.M.J.)

Pharmasol Chaulmoogra Oil (A.F.D.) is a distinct improvement over the old Chaulmoogra preparations, in the treatment of leprosy. The drug in this colloidal state is completely and readily absorbed and is therapeutically very active. May be given subcutaneously or intravenously.

Oral administration of Copper Sulphate $\frac{1}{2}$ gr. in pills is said to do some good. (I.M.J.)

Parathyroid in the very bad cases (E.S.)

To relieve pain Ephedrine is useful. In cases with thickening in the nerves Sodium Salycillate injections with 2 c. c. of normal saline intramuscularly or intravenously.

Fibrolysin is said to remove Fibrosis and attack the germ. (I.M.J.)

Mycol gives good results in Intestinal Stasis.

Anti-leprol may be taken orally or by injection.

To relieve pain in the nerves intravenous injection of 150-200 c. c. of normal saline.

To prevent thrombosis Sodium Hydro Carpus to be given intramuscularly mixed in the syringe with an equal quantity of blood. (Findlay).

To prevent and cure the effects of Hydro Carpus injections Hexamine by mouth or Sodium Bicarb, Antipyrine, Phenacitin, Fowler's Solution, Quinine, Potass. Iodide. (Findlay).

In ocular manifestations Sanocrysine is said to do good. (Findlay). Chaulmoogra Oil either alone or diluted with 25 to 75% of Olive Oil with the addition of Benzo Cocaine has also been tried in eye complications. (E.S.)

Leucoderma: is caused by the insufficient supply of Amino Acid from the intestines from melaena is evolved. The gut should be cleared of Entamoeba by giving Emetine for 6 days and the stools examined to be sure of the disappearance of the amoeba. Then Bismuth Carb. 1 drm. should be given suspended in water every four hours. After this, Mixt. Hydrargyri Perchloride; locally Oil of Bonelin to be applied several times a day. Too much milk must be avoided in diet, and the protein content in the food should be raised by taking eggs, meat, dholl etc. (I.M.J.)

Yellow Orpiment 1 part, Seed of Psoralea Corylifolia (Bonchiseed, in Sanskrit Kusthughana, in Telugu Bavanchi Ginjulu, in Tamil Karpobhu) 4 parts, should be finely powdered and mixed with fresh cow's urine or in distilled water and the paste applied on the patch twice or thrice a day (I.M.J.).

Leucorrhoea: Arsinae Trioxide grs. 1-4, Ferri Reductum grs. 5, Quinine Sulph. grs. 20, to make 20 pills, one three times a day after food. Hydrargyri Perchloride $\frac{1}{40}$ grain in pill or tablet form thrice a day after food. Sodium Cacodylate injections are also good.

Externally Iodum Resublimatum 1 drm., Phenolin 1 oz., Chloral Hydras 1 oz., to be made into a paste by first rubbing Iodine and Chloral together and adding later Phenolin.

If the discharge is fetid the part should be irrigated with Potass Permanganate lotion $\frac{1}{2}$ drm. to a pint to be used as hot as

the patient can bear. If purulent the following injection is useful. Creoline $\frac{1}{2}$ to 2 drms, Ext. Hydrasis Liquidum $2\frac{1}{2}$ drms, Aqua 8 oz; add 2 teaspoonfuls of this to a pint of hot water. A very useful astringent for irrigation is a saline containing Zinc Sulph 1 drm, Alum 1 drm. Glycerine drms. 6, a teaspoonful of which to be added to a quart of hot water.

Leukaemia: Xray and Benzol are recommended. Benzol to be given by mouth in gelatine coated capsules containing 0.5 gm. of Benzol and Olive Oil, the dose being raised gradually to 3.5 gm. daily; or by injection 1.225 grm. on alternate days. If the number of white cells drop to 30,000 the medicine should be stopped (P. M.)

Thyroid Gland 2 grs. thrice a day to be given for one week.

Saline solution intravenously 6 oz. every other day. (Sagous)

In Myelogenic Leukaemia, Fowler's solution in gradually increasing doses is said to diminish the white cells and increase the red cells (J.A.M.A.).

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Tuberculin Treatment of Asthma.

In view of recent interest in new treatments of asthma it may be well to note that Maxwell (*Brit. Med. Journ.*, 2, 1932, page 1182) reported the results of a series of thirty-six cases of asthma that he treated by tuberculin in 1930 and records the state of the patients two years later. The present results are less encouraging than those previously reported, as there has been a tendency to relapse. He includes the cases that he treated subsequently, up to and including 1931, bringing the total to 103. The method yields results which although less promising than they appeared to be at first, are still sufficiently good to warrant a trial of tuberculin in all apparently suitable cases. The material that he used in all cases has been Koch's old tuberculin, which may be conveniently kept in decimal dilutions from 1:1,000 to 1:1,000,000. It is not necessary for the dilutions to be prepared immediately before use, as they keep well under ordinary conditions for at least a month. The initial dose is gauged by

the response of the patient to the Mantoux test. A dose of 0.1 cc. of the 1:1,000 dilution is injected intradermally and the result is read after two or three days, attention being paid only to the area of swelling, for, erythema is apparently of no significance. If there is no swelling, it is safe to begin the treatment with a subcutaneous injection of 0.1 c.c. of the 1:1,000 dilution; if there is an area of swelling less than 1 cm. in its long axis, the initial dose should be 0.1 c.c. of 1:10,000; if the area is between 1 and 2 cm. in its long axis, the initial dose should be 0.1 c.c. of 1:100,000; and in cases in which the area of swelling exceeds 2 cm. in diameter the initial dose should not be greater than 0.1 c. c. of 1:1,000,000 dilution. In the early stages of treatment the interval between the injection should be two or three days. The interval between injections should be gradually increased, but weekly injections should be given for at least six months, after which, in the majority of cases, the treatment may be given fortnightly for a further period of six months. The injections may then be suspended for three months, but a further course of weekly and fortnightly injections should be given to bring the total period of treatment up to a minimum of two years.

(*The Journal of Clinical Research*, July, 1933.)

Infantile Diarrhoeas Treated with Raw Apples.

By

DR. R. MIGNOT.

The treatment of infantile diarrhoeas and other enteritides with raw apples has been found highly successful in Europe.

The apple diet consists of the exclusive feeding of raw apples. The core and pits are removed, the apples are finely grated and a puree thus prepared, which is freely administered raw and without sugar. From 500 to 1500 Gm. are given daily, divided into five feedings, and this is the exclusive diet for two days. The transition diet, commencing the third day, varies according to different reporters, but vegetables are taboo.

Experience shows that one is safe in concluding that the raw apple diet is a simple, unobjectionable procedure whose efficacy

seems incontestable and a method which deserves further use in the treatment of infantile diarrhoea.

(*Clinical Medicine and Surgery*, August, 1933.)

Early Diagnosis of Acute Intestinal Obstruction.

By

DRS. E. I. AND J. M. GREENE, Chicago.

Given a patient, especially one who has previously been subjected to an intra-abdominal operation; who does not look sick; whose temperature is normal; who complains of recurrent paroxysms of colicky abdominal pain; who has or has not passed gas or fecal material either spontaneously or following an enema; who on examination presents little or no local findings of intra abdominal pathosis; who shows increased peristaltic movements, reaching their maximum at the height of the pain, and with the finding of gas and frequently fluid levels in the small bowel on an x-ray plate, the diagnosis of intestinal obstruction is established. With these findings ever present in our minds, hours will be saved, strangulation of the bowel will be minimized, operative procedures will be greatly simplified, and mortality will rapidly fall.

(*Illinois, M.J.*, June, 1932.)

Ovarian Hypofunction.

By

DR. A. A. WERNER.

Ovarian hypofunction may be primary, due to failure of full development of the ovaries, or secondary to pituitary or other glandular deficiencies or to local inflammatory or constitutional disease.

The objective signs are menstrual disorders, with occasional menorrhagia and metrorrhagia if the patient is approaching the menopause; also the appearance of the gonadal type of obesity.

The subjective symptoms are nervous, circulatory and general. The latter include lassitude, easy fatigability, constipation and vague pains throughout the distribution of the sensory nerves.

(*J. Missouri St. M.A.*, Aug., 1931.)

(Continued on page 41.)

Hypotensyl quickly and with certainty reduces blood pressure.

CLINICAL NOTES

AND

PRACTICAL SUGGESTIONS

A new method of treating Amoebic Dysentery.

Emetine Hydrochloride has long been considered to have a specific action upon Amoeba causing Amoebic Dysentery. It has now been discovered by long experience that early application of this remedy showed very little activity specially on the cystic form of Amoebiasis and even some forms of dysenteries have proved absolutely refractory to this line of treatment.

After various experimental and clinical studies Amibiasine has been found out to be an excellent remedy in the treatment of Amoebic Dysentery. It has a much better action than Emetine Hydrochloride in the early stages and its local and general action is more effective and its elimination is more slow and regular. Amibiasine, which is the compound extract of *Garcinia Mangostana*, is soon absorbed by the intestinal mucosa when given internally and is capable of acting directly on the intestinal parasites. Its rapid absorption and deep penetration in the liver are strong reasons for its use not only in Dysentery but hepatic lesions caused by Amoebiasis.

Although Emetine and Ipecacuanha were regarded as specifics for Amoebic Dysentery and its after-effects Amibiasine has proved specially reliable in combating these affections. From the numerous reports of clinicians now available this has become the remedy of choice in Amoebic Dysentery. Excellent results have been obtained with it early in the disease. This does not mean however that old and obstinate cases cannot be effectively treated with it. It has been found that Amibiasine cures Amoebic Dysentery not merely by ameliorating the symptoms but by destructive action on the parasites. Further, it eliminates the intestinal parasites particularly the *Entamoeba Histolytica* and destroys the minute forms and the cysts of the chronic type. Amibiasine is thus efficacious not only against the pathogenic agent of Amoebic Dysentery, but it has been seen that under its regime diarrhoea is controlled, the stools are rendered free from the parasites and their consistence becomes

more and more solid. The pain and tenesmus also pass off and in nearly all cases the patient besides being cured of the condition is generally better.

During the acute stage of Amoebic Dysentery when there is diarrhoea with frequent loose motions containing mucus and blood Amibiasine is of great help. It relieves the symptoms within three or four days but to effect more permanent results and to prevent relapses it is necessary to resort to large doses stretched over long periods of time. It may however be necessary to supplement this treatment by means of Emetine Hydrochloride in severe type of cases. But in milder types Amibiasine clears the intestines of all parasites even if they are in the deeper layers of the intestines. In the majority of cases complete disappearance takes place after three or four days and convalescence then sets in. This however should not prevent the practitioner from carrying on the treatment as there is likelihood of relapses and further inroads of Amoebiasis on the liver and other organs in the body.

There are what are known as the carriers of this disease. Now there is hardly any difference between a carrier and a patient suffering from acute dysentery passing cysts and amoeba. These carriers yield more readily to treatment with Amibiasine. It causes entire disappearance of the cysts from the stools after a few days of this treatment. If this treatment is carried on for two or three weeks relapses are quite unusual.

Hepatitis, which is sometimes met with secondary to active Amoebic Dysentery or latent amoebic ulceration of the colon, subsides rapidly under the influence of Amibiasine. The acute inflammatory condition of the liver soon passes and further complications are avoided. Sometimes the inflammatory process characterised by low fever and leucocytosis requires treatment for prolonged periods but fortunately these cases too yield to this line of treatment.

Despite the efficacy of Amibiasine one cannot deny that there are cases which prove refractory to this remedy. In such cases it is better to combine it with Emetine or other reliable products of Ipecacuanha.

After opening and draining of the liver abscess following Amoebic Dysentery it is a

good practice to keep the patient on Amibiasine as it helps him to get rid of the exciting agents and thus prevent any future troubles.

Another indication in which Amibiasine has been found beneficial is Lambliasis. The enteritis and the consequent diarrhoea caused by this parasite, *Lambli*, is soon brought under control by this remedy. It has been observed that with some patients the parasites are destroyed quickly while others require prolonged treatment. The results in the majority of cases are satisfactory. Under the influence of Amibiasine diarrhoea abates quickly, the cysts in a good number of cases disappear even permanently and the general condition improves rapidly. Continued Amibiasine treatment is in these cases necessary so that the parasites may not reappear.

Various forms of Enteritis yield rapidly to Amibiasine treatment. Diarrhoeas in these conditions are often old, persistent and refractory to treatment. When Amibiasine course is instituted not only does the diarrhoea stop but the chronic inflammatory condition of the intestines is checked and the mucosa are soon restored to the normal condition. Added to this the patient if kept on this treatment for some time puts on weight and there is steady improvement in his general condition which proves that this product possesses an excellent tonic action.

From the remarkable therapeutic results that we are able to obtain with Amibiasine its use as a prophylactic is a natural deduction. It can be strongly recommended to persons exposed to *Entamoeba Histolytica*. It protects healthy persons from this infection. Moreover, as it shows no signs of intolerance even after long use and as it possesses good tonic effects it is eminently suitable for administration to healthy individuals. Another prophylactic use of this product is in cases of carriers of *Amoeba* who are actually not suffering from the disease. In these cases complete disappearance of these amoeba can soon be effected. In the convalescence of Chronic Amoebic Dysentery Amibiasine can be profitably used to prevent the formation of hepatic abscess. It is therefore always advisable to make use of this preparation as early as

possible in persons exposed to this infection.

On account of its perfect tolerability, its rapid healing action of the numerous intestinal ulcerations and its beneficial action on the general condition Amibiasine can be safely employed both as a curative and a tonic in the indications mentioned above. It can be combined with Emetine Hydrochloride without any harm as there is no incompatibility between the two. In fact it supplements very well the action of the latter drug. Amibiasine even if given alone is effective in Amoebic Dysentery. It offers some advantages even over Emetine Hydrochloride which make its use absolutely safe and reliable. The absence of Toxicity even after a prolonged period of treatment can be seen in almost all cases. Another point in its favour is its perfect toleration even by the most delicate stomachs. The results are immediate and complete. With Amibiasine the *Amoeba* are completely destroyed and not merely paralysed as is the case with Emetine treatment. Again, it destroys the cysts which usually resist Emetine Hydrochloride.

Amibiasine is a brownish liquid with bitter taste. It can be kept indefinitely and it is quite free from toxicity. Two to four days treatment in 6 to 12 teaspoonfuls of Amibiasine is all that is necessary in acute cases. In chronic ones 3 to 6 teaspoonfuls of the drug for a week or two is recommended; while the carriers and the patients suffering from the cysts should have four teaspoonfuls on an empty stomach every morning for 10 to 15 days. In severe cases large doses at smaller intervals are necessary. Needless to say that in all these cases diet should receive careful attention.

From the above it is evident that Amibiasine is a great asset in therapeutics for the treatment of Amoebic Dysentery, Lambliasis and diarrhoeas in general are also benefited by its use. Particularly in Amoebic Dysentery it not only helps the destruction of the parasites but the cysts too disappear which is a distinct advantage over the old-fashioned Emetine treatment. The ease of administration and the safety that it ensures in a variety of circumstances

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renders it worthy of attention of all the general practitioners.

Treatment of Hepatic and Biliary Insufficiencies.

Because of the multiplicity of the functions that the liver has to perform it is not surprising to find that its cells, which are considered extremely delicate, get easily out of order. The least attack either of any infection or alimentary intoxication or the slightest digestive disturbances have an immediate effect upon them. If these troubles persist the liver is very much affected. It is owing to this that hepatic insufficiencies are very frequent and the sequelae resulting from them are more numerous. Many of these manifestations are diverse in character such as joint-troubles, skin-diseases, affections of the nerves etc. In such cases instead of treating the various symptoms and the local conditions if the causal factor is effectively tackled, the cure is sure to be certain and rapid. The employment of Boldine is more rational in these cases as it selects in an eminently effective manner those principles which are very serviceable in the regulation of the liver functions.

We have seen that functional insufficiencies of the liver assume various forms. Not only that but they assume various degrees also. These result, as time goes on, in cell degenerations and then may manifest themselves in serious attacks of Hepatitis, Icterus, Hypertrophic Cirrhosis, Digestive troubles, Hepatic Colic and Gallstones. In these cases Boldine maintains the liver function and soon restores the pathological condition to normal. It also prevents further complications. It is therefore always advisable to commence Boldine at the very start. The slightest disturbance in the hepatic function, a little yellowishness in the conjunctivae or urine, the least hepatic colic or some symptoms of biliary lithiasis naturally demand immediate Boldine treatment, particularly if these troubles come in a gouty, diabetic or obese subject. The existence of all these liver troubles necessitates not only suitable dietetic regime but Boldine therapy also.

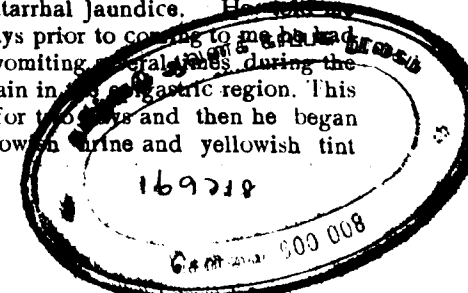
Some inexplicable sense of fatigue, insomnia, habitual constipation, headache, certain skin-affections such as pruritus,

acne, eczemas etc., some digestive troubles such as anorexia, dyspepsia, pronounced loss of appetite—all these symptoms reveal that there is something wrong with the liver. Boldine constitutes the radical treatment of all the pathological processes in these affections. Many types of indigestions and resultant auto-intoxication depend mostly upon insufficient or abnormal excretion of the bile. The exhibition of Boldine in such cases will produce prompt and effective results. Acting as a stimulant to the hepatic cells it causes an immediate increase in the flow of bile. The result is that the putrefaction of the intestines is prevented, their peristalsis accelerated and the absorption facilitated.

By reason of its composition Boldine supplies the necessary ingredients and the various indications thus respond well in a gratifying manner. Each pill contains one milligram of the pure alkaloid Boldoa Fragrans. It stimulates the secretions of the liver and restores in an effective manner the hepato-biliary functions. Without any undue strain it produces a decided drainage of the biliary tract and thus relieves hepatic insufficiency. Boldine may be usefully combined with other cholagogues and hepatic stimulants such as calomel, podophyllin, salines etc. We have seen that most of the liver disorders call for doses in 4 to 6 or even 8 Boldine pills per day to be taken 15 minutes before meals. Relief may be expected promptly and recovery is usually hastened by the restorative effect on the hepatic activity. Boldine in short is an effective and a dependable preparation of *Penmus Boldus* with an elective action on the biliary secretion. Because of this ingredient it combines this property with that of the intestinal regulation, which means that it permits education of the bowels and gives them tone. This effect helps to increase the functional value of the liver.

The two cases under my care fully illustrate the efficacy of Boldine:

1. A young student in the local college aged about 23 came to me for treatment of Catarrhal Jaundice. He stated that two days prior to coming to me he had attacks of vomiting, general pains, during the day with pain in the epigastric region. This continued for two days and then he began to pass yellow urine and yellowish tint



appeared also in his eyes. When I examined him there was epigastric distress and the liver was enlarged one inch below the costal margin. There was present mental dullness, headache and apathy. He tried to attend the college but could not do so. On the fourth day all these symptoms were quite marked. The conjunctivae and the nails showed distinct yellowing so also the urine. The tongue was heavily coated. The sense of oppression over the right hypochondrium was more pronounced. Liver was tender on pressure. Together with the usual hepatic stimulants and salines I prescribed Boldine, 8 pills of which he took every day before meals. After a week of this regime he was completely free from his trouble. The epigastric pain and distress passed off, the tenderness of the liver disappeared, the yellowish tint of the eyes and the nails was almost imperceptible and the urine was quite free from bile. He had a very good appetite and was able to attend college. The mixture was discontinued and he was kept on Boldine alone, 6 pills per day for two weeks. Not only was he free from all the symptoms after this regime, but he felt very active, had very good digestion and was able to put in greater amount of work.

2. Another case was of intermittent attacks of hepatic congestion in a middle-aged person of gouty diathesis. He used to get arthritic attacks now and then due to this congestion. Besides salines I advised him to take Boldine, 6 pills daily. This routine was continued for a month after which the salines were dropped and he was kept only on Boldine. At this time he took only 4 pills every day. This relieved him entirely of the congestion of the liver which was now quite normal. The Arthritic attacks also were few and far between until they disappeared altogether. He is now living quite an active life free from all the former ailments.

Treatment of Chronic Heart-lesions.

Before considering the subject proper let us at the outset deal with the object of the blood-circulation and how it is attained. We know that the cardiac cycle consists of

a systole and a diastole and this only exerts an intermittent pressure on the whole circulatory system but how this intermittent pressure is converted into a constant one in peripheral areas where metabolism and other functions take place we shall consider presently.

It is a well-recognised fact that on the constant pressure that exists between the arterial and the venous system depend the metabolic and other functional processes. Further, it is well-known that the cells of all the tissues of the organism are never in direct contact with the blood. There is a fluid, known as the intercellular fluid, which oozes out and bathes the cells and through this medium the cells of all the structures receive the principles essential for the organism. The normal functioning of this intercellular fluid is dependent on the constant pressure referred to above and osmosis, ionization and other biochemic processes in the body are in turn dependent on the normal condition of this intercellular fluid. This fluid carries with it the products of cell-life and cell-functions for their ultimate distribution and thus the processes of growth and development are maintained in the system.

The intermittancy of the output of the left ventricle of the heart is mostly neutralized by the relationship that exists between the elastic and the muscular coats of the arterial system. Thus a constant pressure is the result. Further, as the blood circulates in the arteries its pulsating character diminishes and there is as a result, in the capillary and intercellular areas a constant pressure which is continued in the venous system.

The object therefore of circulation is to supply the essentials of cell-life as well as necessities for the normal functioning of the cells. When this circulatory equilibrium is disturbed many diverse diseases are the result. Chronic diseases of the Myocardium may be the result of valvular lesions, pathological processes of the entire arterial system, disease of the coronary arteries or the toxic principles acting directly on the myocardium itself.

In order to treat successfully this class of diseases the fundamental principle that one

must bear in mind is that there is an average pressure between the arterial and the venous system which must be kept up i. e. in other words the circulatory equilibrium must be restored and maintained. If one is able to do this one can secure the normality of the intercellular fluid. Experience as well as clinical results have proved that the glucosides contained in Digitalis have the capacity to restore this circulatory equilibrium with a certainty that cannot be doubted. A reliable preparation of these active principles should constitute the remedy par excellence in such diseases and such a one is Digibaine which possesses not only dependable therapeutic properties and activity but has the advantage of being free from provoking any gastric disturbances in large doses or after long-continued administration.

Digibaine is a combination of Digitaline and Ouabaine. It is a reliable standardised product uniform in composition and action and it remains stable indefinitely. It exhibits all the cardiotoxic effects of Digitalis and Strophanthin. It strengthens the contraction of the heart-muscle, improves its elasticity and controls its rhythm. It regulates also the conduction of the stimulus. It has also all the specific actions of Digitalis on the blood-vessels as well as the kidneys. That this product remains active indefinitely has been proved by the fact that even after lapse of a year or even longer its pharmacological efficacy is the same as it was when manufactured.

Digibaine offers real advantages over the pharmacological preparations of Digitalis and Strophanthin because of its potency and unchangeability. It is prompt and reliable in action and is capable of accurate dosage. It is remarkably well tolerated by the gastro-intestinal tract. A rapid therapeutic effect is obtained even by the oral route but in more urgent cases intravenous injections are always advisable. Toxic effects due to cumulative action are not known to occur. A rapid action is ensured because of the effective absorption and excretion and as a consequence there is very little accumulation. Due to its comparative safety and absence of cumulative effects it is eminently suitable for continuous medication in chronic heart troubles.

The continued use of Digibaine has been found of great value in various chronic

diseases of the heart and sometimes practical cures have been effected in several instances and in a number of cases efficient health has been maintained through this medication. Digibaine is indicated therefore in all chronic myocardial affections. It helps to maintain the circulatory equilibrium for a number of years and controls cardiac failure. The patient is thus able to live in comfort for a number of years and lead a useful life.

In chronic valvular heart-disease where there is failing compensation this potent and uniform preparation of Digitalis is an effective therapeutic measure as it prevents reduction of cardiac reserve. The signs of failing compensation in such cases are seen by the shortness of breath, palpitation and abnormal fatigue even on the slightest exertion. All these become much less if the patient is on Digibaine regime. In spite of any other pathological condition it decidedly benefits such cases.

Cases of Auricular Fibrillation are greatly benefitted by the continued use of Digibaine. Similarly cases of Cardiac Arrhythmia are favourably influenced by this product if heroic doses are adhered to. It is better that we have these cases under observation so that we can regulate the dosage according to the effects the drug has produced.

Chronic heart conditions such as Myocardial degeneration and valvular diseases which come more frequently under the care of the general practitioner are best treated by Digibaine as is confirmed by the good results experienced with it by various clinicians. Digibaine has markedly good effects on the heart in these cases. It strengthens the heart-muscle, regulates the pulse-rate and improves the general circulation. This protracted Digitalis medication can be suitably carried out by Digibaine.

Digibaine therefore occupies a distinctive position in Cardiac therapeutics and it can effectively replace either Digitalis or Strophanthin. In the words of an eminent physician, we can say of Digibaine that in chronic conditions of the heart Digibaine "is a persuasive tonic and not a therapeutic lash."

Some of the cases illustrating the efficacy of Digibaine are given:

1. Mr. P. aged 61 consulted me some six months back for rapidity of heart action,

dyspnoea on slight exertion and paroxysmal tachycardia. He was unable to walk any distance without precordial or respiratory distress. He was forced to rest for some time before he was able to continue his walk. On auscultation no murmur was detected but the cardiac sounds were very rapid. The pulse rate was from 95 to 110 per minute. It was impossible to elicit any history to find out any etiological disease for this manifestation of cardiac symptoms. The patient was very much worried as he was not able to leave his house or indulge in other activities. He was prescribed Digibaine, 5 drops of which he took three times a day. He took it in this manner for six months with periods of intermission. At the end of this period the rapidity of the heart action disappeared. There was very little precordial or respiratory distress and he was able to walk a mile or two without much trouble. In fact he was able to resume a moderately active life. He is still continuing the treatment which I advised him to take for at least six months more.

2. This was a case of a middle-aged man who was the victim of Asthmatic attacks from his early twenties. As a result of the frequent attacks of congestion of the lungs for the last so many years his heart was affected. Cardiac hypertrophy was after some time followed by dilation. The heart sounds were very weak, the area of dullness had increased downwards and outwards. He used to get out of breath and even experienced attacks of suffocation when he exerted himself. There was marked oedema of the lower limbs and albumin was present in the urine. Digitalis mixtures and Camphor injections afforded him very little relief. I therefore kept him on Digibaine. He took 20 minims of it per day. This treatment was continued for a month when he felt a little improvement. He was able to move about without getting much out of breath. The treatment was carried on with some breaks off and on for nearly a year. The result was more than surprising. He ceased to have oedema of the legs and he was even able to climb the stairs without breathlessness. At this period he again began to get asthmatic fits. This again told upon his heart. After giving him the necessary treatment for these attacks Digibaine was

continued once more for his heart trouble. After two more months all the symptoms such as dyspnoea, oedema etc., disappeared but there was slight trace of albumin in his urine. He improved remarkably and then he went out for a change. He was taking Digibaine and then he wrote to me from there that he was in a satisfactory state of health and he distinctly felt better. I recommended him to continue Digibaine for some time.

3. A patient aged approximately 58 came under my care some three months back. He gave history of Rheumatic fever when he was young which probably might have affected his heart. This joint-trouble he used to get off and on and as a consequence during the last one year his heart complaint had gone worse. He said that he had greater difficulty in breathing on exertion than formerly. He had palpitation and there was occasional swelling of the legs. On examination I found that there was indication of dyspnoea and cardiac dullness had much extended to the left. Systolic murmur was heard over the apical region. The heart was irregular and the pulse was soft. The liver had enlarged about an inch below the costal margin and albumin was present in the urine. Treatment with Digibaine was commenced. In the beginning an ampoule of 1 c.c., was injected intravenously every day. This was continued for a week when there was satisfactory diuresis, oedema of the legs had disappeared and the general condition was decidedly better. Digibaine was then given orally. He was taking 20 drops per day. After a month the pulse was fuller and more regular about 85 per minute and he was able to sit up in the chair. The liver was still enlarged but albumin was not found in the urine. Digibaine was continued but now only 15 drops were taken. Oedema had absolutely disappeared and the liver was only a finger's breadth below the costal margin. This was after a month more of the treatment. After a fortnight more although he was not quite alright I can say this much that the compensation of the heart was satisfactorily maintained despite the fact that he moves about and even walks for some time out of doors.

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Migraine and its Treatment.

Migraine presents a typical clinical picture which can be easily differentiated from other kinds of headache. The main symptom is paroxysmal headache at times dull and other times piercing. When it is present on one side of the head it is known as Hemisrania. The headache is accompanied by vomiting, cerebral in character and also by a feeling of severe general pressure in the head. Besides headache we come across several eye-symptoms such as scintillating scotoma with narrowing of the field of vision. In some cases even temporary blindness has been developed. Sometimes the ocular symptoms as also the cerebral pressure, become so overwhelming that mental and psychic depression set in and the patient is then unable to do either intellectual or physical work. The attack of Migraine lasts for 10 to 12 hours. Just as the onset of the attack is sudden so also is the recovery. The attack sometimes comes every week with an astonishing regularity or sometimes every month. Frequently a definite cycle has been noticed, the attack coming on at the same hour on the same day with the intervening period of remission.

The etiology of Migraine is very obscure even at the present day. Some consider it to be an angiospasm of sympathetic origin. Occasionally it is an angiospasm of the vascular area of the Trigeminal Nerve. Until recently, Migraine was considered only as a type of neuralgia but at present at least in some cases it is thought to be the result of some Endocrine disturbance reacting on the sympathetic system. There are some who attribute this affection to anaphylactic shock while in some subjects Asthma and urticaria are the causal factors. Another factor in the causation of Migraine is the reflex action of certain digestive disturbances and utero-ovarian affections.

Heredity and neuropathic taints such as Hysteria and Epilepsy were formerly held responsible for this complaint; but now they are considered to be of very little etiological value. Because of psychical disturbances and analogy of symptoms, such as sudden onset, aura etc., migraine was thought to have some relationship with these diseases. The various objections raised against this relationship viz., that Epilepsy brings in its

train some psychic and moral changes which steadily become worse, tending to mental and physical disorganisation which Migraine does not cause, have entirely disproved it. Migraine, on the other hand, does not lead to impairment of mental functions under any circumstances.

The exciting causes of this affection are usually overwork, any severe stimulation, various excesses, emotional disturbances and gastric upsets.

Hitherto the treatment of Migraine has been far from satisfactory. Now that the various etiological theories have been brought forward they should be taken into consideration when the treatment is decided upon. It should be undertaken only after a thorough and methodical examination of the patient. The treatment should be confined chiefly to influencing the exciting diseased conditions, in such a manner that the stimuli reaching the cerebral centres are rendered inert. Thus digestive disorders, constipation, anaphylaxis, asthma and other etiological factors should receive our attention.

As regards drugs Cryogenine stands supreme while in some cases treatment by bromides introduced by Charcot is also useful. This latter treatment can be satisfactorily carried out by Elixir-Bromo-Valerianate as it does not necessitate any change in the diet nor does it cause any secondary effects. Latterly this combined treatment—Cryogenine for the attacks and Elixir-Bromo-Valerianate during the intervals—has enjoyed a very good reputation. The Elixir lessens the irritability of the cerebral cortex and effects vaso-dilator action in the cerebrum to such an extent, that the attacks after some lapse of time become few and far between, while Cryogenine brings about the cessation of the attacks by acting as an effective analgesic. After continuing this combined treatment for some time even in severe cases Migraine disappears entirely or even if the attacks recur, the symptoms are very mild and trivial. The scheme of treatment consists in long-continued daily administration of the Bromo-Valerianate in tablespoonful doses twice or thrice daily after food. These doses are sufficient to keep the brain mildly depressed and thus the excitability or the irritability is prevented.

Lasting and beneficial results only follow after an uninterrupted course of treatment. The doses should however be decreased in course of time as the liability to the attacks diminishes.

To give relief during the attacks Cryogenine should be administered as it has superseded all other similar products due to its superiority in action. It is rapidly absorbed and becomes effective half an hour after administration. Its action as an analgesic lasts for several hours. Large dosages however must be resorted to, to get complete relief. Usually there are no after-effects as the product is soon decomposed and rapidly eliminated. There are no effects on or interference with digestion, respiration or circulation. Cryogenine has invariably proved to be an excellent sedative in Migraine, even when accompanied by vertigo and vomiting and even when general health has been impaired.

Although this combined treatment brings about noticeable diminution in the duration, severity and frequency of the attacks and in many cases the patients have become completely free from the trouble, even after the treatment has been discontinued still

the rational treatment in some cases demands that the causal factor should be diagnosed and tackled. In cases where Endocrine disturbances are suspected, one should always look out for symptoms of hypothyroidism, which is invariably present in this complaint. In such cases administration of Opocrin Thyroid will always produce beneficial results. When anaphylaxis is the cause it is better to notice which type of diet induces the attack. Vegetarian diet is always beneficial when this is the causative factor. When constipation or hepatic insufficiency is traced as the etiological factor Mycol should be prescribed as very satisfactory results are obtained with it.

Generally milk, carbohydrates, meat and other fermentable foodstuffs should be deleted from the diet. The amount of nitrogenous foods should be reduced. In some cases even fish must be omitted from the diet. In conjunction with this dietary the administration of the various lines of treatment according to etiology and symptoms outlined above can easily bring under control any refractory case of Migraine.

CALCIUM THAT IS ABSORBED

THE daily adult requirement of calcium amounts, according to highest authority, to 0.45 gram (7 grains) per day. It can be predicted that the intake of a very large proportion of patients is far below this requirement. Our great interest in Cod-Liver oil, violet rays, vegetable diets, etc., should not blind us to the fact that after all they contain little or no calcium. The satisfactory use of lime requires a number of considerations, such as (1) acidity of the upper bowel (2) alkaline metabolic end products, (3) a balanced administration of phosphorus, magnesium and the alkaline bases. These considerations are fully met in

CALCIONATES

Three teaspoonfuls = the lime of 1 pint of milk
Calcionates is supplied in 4 ounce bottles.

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(Continued from page 40).

Insulin and Cellular Insulin.

When we speak of insulin to-day, we usually mean the pancreatic insulin only. But is that the only insulin? Or is pancreatic insulin necessary to the organism? From the millions of clinical experiments which have been performed with insulin in Diabetes it appears that something having the action of insulin is necessary for healthy metabolism. Yet in some diabetic cases insulin fails to act.

In animals of the invertebrate class there is no pancreas and even plants can oxidise glucose though no insulin has ever been extracted from them. J. J. R. Macleod says that every living animal cell can oxidise glucose and form glycogen, whether the animal has a pancreas or not. Every living animal cell therefore has an insulin action. This insulin action has led to the belief that most cells of the body contain insulin, but chemical analysis has failed so far to disclose it. Only the insulin action can be proved, not the presence of insulin.

TUTTLE'S THEOREM.

Dr. G. H. Tuttle introduced the idea of cellular insulin in his "Theorem of Insulin" (Lancet, Sept. 23, 1933).

"Diabetes represents a diminished state of carbohydrate metabolism which is due to a deficiency of insulin action. By introducing insulin subcutaneously this deficiency is completely overcome and the metabolism returns to normal. Therefore, the action of insulin is necessary for normal carbohydrate metabolism. Conversely, whenever carbohydrate metabolism takes place as shown by the respiratory quotient, insulin must be present; and finally, as a corollary, no carbohydrate metabolism can take place unless some kind of insulin is present. Conclusion: wherever carbohydrate metabolism occurs some kind of insulin, either pancreatic or cellular, or both, must be present."

In S. Soskin's experiment on depancreatized dogs, after the entire removal of the pancreas, the animals showed during the first five days that some insulin action still went on (respiratory quotient 0.7). One animal tested gave an average oxidation of glucose 54 grammes per day over 17 days. There was usually an increase in the meta-

bolic rate for glucose about the tenth day after the operation sometimes reaching 0.9 after 14 days or more. But so far no success has followed the attempts made to isolate insulin from the tissue of depancreatized dogs. Cellular insulin must have a different chemical composition from pancreatic insulin.

Pancreatic insulin cannot by itself cause the oxidation of glucose. Some activator or activators are required. In the case of cellular insulin, either it can act by itself, or else the necessary activators are present in the cell along with it.

Pancreatic insulin is discharged into the circulating blood by two kinds of impulse (1) Hormone action, which is the generally more active method and (2) nerve impulse, which comes into play for minor adjustments only.

In the majority of cases of Diabetes the islands of Langerhans are not degenerate. As a rule only after the disease has progressed for a long time is such degeneration discoverable. Such disease of the pancreas as is found in advanced diabetics is probably the result of inaction or inertia, in the same way as a muscle becomes degenerate if not used. The whole story of diabetics so far as we know it, points to one conclusion.

Diabetic symptoms are not usually due to the failure to form insulin (or insulinogen) but to a failure to discharge the insulin into the circulation.

Although insulin itself is not active when given by mouth, the hormones which provide the impulse to send the insulin into the circulation are active when given orally, and that is the secret of the success of Pancreatine. Pancreatine contains the "Insulinogen", the "cellular insulin" and the hormones which stimulate the sending of the pancreatic insulin into the circulation by the islands of Langerhans.

If Diabetes is caused by the absence of the impulse to secrete insulin from the islands of Langerhans (which contain the insulin) into the circulating blood, surely there is at least the hope of a cure by restoring this impulse.

News and Comments.

A Paradox: "Efficiency at home and Honour abroad," was the object of the Bill. So said, Sir Fazl-i-Hussain while concluding his speech on the Indian Medical Council Bill before it was passed. It is absurd to say that the Bill which now concerns only the medical graduates who are perhaps a fourth of the strength of the number in the medical profession, would bring about efficiency in the medical profession. Equally absurd it is to say that the new measure would bring "honour abroad." Far from bringing honour either to the country or even to those who espoused the Bill it has brought discredit. The passing of the bill has displayed the nervousness of the India Government and weakness of the members of the Assembly. The former could not but placate the General Medical Council, Great Britain; the latter fell an easy prey to the manouevring of the Government members. The Reciprocity Clause with a four years period within which the General Medical Council was asked to recognise the medical colleges of the Indian university served only as a ruse. Even after four years period, if the General Medical Council refuses to recognise the Indian Medical degrees, the Indian Medical Council is practically powerless to give effect to Reciprocity Clause refusing recognition of the British Medical qualifications. The Medical Register is the only legal evidence of recognition of medical qualifications and as the publishing of all-India Medical Register was given up in the Bill as recently passed, in what way would the Indian Medical Council demonstrate the non-recognition of the British qualifications by them? The existing Provincial Medical Acts have made the position of those with British qualifications quite secure as there is a section in all the Acts that those registered in the British Register should automatically be registered in the provincial registers. So, till the Provincial Medical Acts are amended immediately by introducing Reciprocity Clause or till the Government of India pass an order that, if within 4 years of the passing of the Indian Medical Council Bill, the General Medical Council does not recognise the Indian Medical Degrees, the Government of India would

not appoint anybody with British qualifications as Government Medical Officers in India, 'honour abroad' cannot be claimed by Indian Medical Council Bill.

A Useful Suggestion: Dr. Robert Cochrane, the Medical Secretary of the British Empire Leprosy Relief Association (London) had been to India and Ceylon recently for conducting investigations regarding leprosy. It is said that he had submitted a report to the Executive Committee of the British Empire Leprosy Relief Association and amongst other things, had suggested the supreme importance of training medical men in the diagnosis, treatment and prevention of Leprosy and urged that Leprosy should be a subject for final examination in medical institutions in India and Ceylon. Certainly a useful suggestion which will go a good way in the campaign against Leprosy. It is usual with some examiners to ask the candidates questions regarding diseases which are not commonly met with. Medical Students should have a good grinding in the principles of theory and practice of medicine in general and should have a very intimate knowledge of all the common diseases prevailing in this country. It should be compulsory on examiners to ask questions either in theory paper or practical on social diseases such as Leprosy, Tuberculosis and Venereal diseases. If this is done a good portion of the campaign against these diseases would be solved very easily. Lay men have at present usurped the place of the medical profession in combating social diseases though they cannot get along without the help of medical men. If practitioners who are well trained in the diagnosis, treatment and prevention of diseases take up the campaign soon after they leave the medical schools and colleges they will not only be able to control the diseases efficiently but will grow as useful and popular medical men who will have little or no difficulty in introducing themselves to the public for medical service.

Government Quinine Policy: The policy of the Government in the distribution of Quinine in combating Malaria was the subject of a resolution by Hon'ble Sir Nasarwanji Choksy, a specially nominated non-official member of the Council of State,

Sir Choksy quoted statistics and adduced that 1 out of every 3.5 deaths in India are due to Malaria and according to figures arrived at by Col. Chopra there was roughly an economic loss of 33 crores of rupees due to deaths by Malaria. Sir Choksy compared the concern of the Italian Government towards the Malarian stricken, who distributed 20 tons of quinine free to a population of 20,000 infected with Malaria, to that of the Government of India who distributed only 16 tons free to a population of 50,000,000.

Sir Choksy suggested that quinine should be distributed at 12 rupees per pound through village headmen and that the Government should set apart 10 to 20 lakhs of rupees towards the supply of quinine to Malarian stricken population. Sir Choksy's imagination did not go far enough in making his recommendations to the Government. Malaria is a disease prevalent in India not only in rural areas but in almost all the big cities, like Bombay, Madras, Calcutta and even Delhi, the seat of the Government of India and one hears that recently the Health Officer of Delhi was down with it. In addition to causing death directly Malaria has been the indirect cause for the spread of Tuberculosis not to mention other ailments. In spite of such danger from Malarial infection those in charge of the health of the public in this country should feel humiliated that they have not been able to check this infection even in cities which are the seats of the Government. Members of the profession whether in service or outside, some at least, cannot absolve themselves from their responsibility. There are instances in some cities of a few medical men having been able to amass wealth by treating cases of Malaria or perhaps by half treating them. Malaria is one of the few complaints where a medical man can be sure of the success of his treatment and create an impression on his patient by forecasting that his patient would not have an attack the day after successful treatment. The doctor who minds popularity and with it money would not prescribe quinine at all. After a good dose of an antipyretic such as Aspirin, Equinine and Syrup would be usually prescribed by him and many a time when Equinine is not successful quinine injection would be had recourse to. As soon as fever stops the

patient gives up treatment. The practitioner is busy with his practice and does not and cannot find time to tell the patient that once a man is infected with Malaria he should take quinine at least for a couple of months and if he is in an infected area take quinine as a preventive regularly twice a week. Such an advice is not appreciated by the patient. Consequently every month the same patient comes and attends for 3 or 4 days, till he is free from fever. He will get gradually into cachectic condition without manifestation of high fever and insidiously suffer from tubercular infection or some other incurable disease.

The only sure method of combating Malaria both in urban and rural areas is by the conjoint activities of Public Health Officers with members of independent medical profession, both of whom should do team work with the spirit of co-operation and co-ordination and not with a spirit of rivalry. The Government should supply quinine to medical men at cost price and quinine should not be distributed by lay men such as village postmaster or headman. Mere drugging with quinine at times does not cure Malaria. On the other hand there are instances where administration of quinine by lay people has brought evil reputation to quinine. We are familiar with the tales of ignorant people in villages who complain that quinine brings an enlargement of spleen, the fact being otherwise. Many a time the villager takes little or insufficient dose of quinine or does not get proper treatment for the effective action of quinine on the system (an alkaline fever mixture or brisk purge not being prescribed) and finds a hard swelling in his abdomen which he ignorantly attributes to his having taken quinine. The distribution of quinine should be entrusted to subsidised rural medical practitioners who should not only be given attractive subsidies to go and settle in malarial tracts but encouraged and appreciated for the good work turned out by them.

Malaria is a disease which is not only not incurable but efficiently preventible also and the money spent by the Government would give tangible results and make the Government popular and also prosperous. When the economic loss is 33 crores the Government should set apart not a meagre sum of 10 or 20 lacs but a larger sum proportionate

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

to the loss of 33 crores, the economic loss referred to above. Nearly three fourth of the amount budgetted for the Medical Department is spent on salaries. Sir Choksy would have done better justice to the subject and as a nominated member of the Council would have impressed on the Government the necessity of entrusting medical relief in urban areas to the members of the independent medical profession on voluntary basis and of utilising the money so saved for anti-malarial and other useful purposes of relieving human sufferings in rural areas where scientific medicine not being so popular there will be better justification for employing medical men for curative work. Then only this country can expect to be rid of preventive diseases such as Malaria and many more.

No Married Woman Doctor Wanted: is the opinion expressed by the Commissioner, Corporation of Bombay Municipality, while he recommended the termination of the services of a lady doctor, in charge of one of the maternity homes, who at the time of her appointment was given preference being unmarried, none of the married doctors being selected for similar posts. The Lady Doctor recently took leave for two months in connection with her marriage. The termination of her services has been ordered after she enjoys the leave for two months. We have no idea if there exists any women association in Bombay, and if it does, what their view is. In Travancore State which is considered a free country for women, the women have revolted against the recommendation of the special officer appointed for reforming Educational Department, that married women teachers should not be employed under the Government. The attitude of the Travancore Government is keenly watched. We learn that Major General Sprawson who till recently was the Surgeon-General with the Government of Madras, now Director-General, Indian Medical Service, is also of opinion that married life in women is incompatible for exigencies of Government service. Evidently Major Sprawson might have been troubled a lot by the lady doctors under him, for leave in connection with marriage or confinement. From the financial point of view of the employer and the

health and happiness point of view of the lady doctors, the latter should serve their husbands and children and not anybody else after marriage, especially so if the husbands are earning members.

Indian Institute of Preventive Medicine: We congratulate the organisers who are the authors of the scheme to bring into existence a Research Institute to be called "The Indian Institute of Preventive Medicine." We will not be able to do better justice to convince our readers about the need and usefulness of the scheme better than by quoting the portions of the appeal published by the authors in the lay press:—

"A truly Indian Institute of Medical Research with the object of tackling the vital health problems of the nation has now become imperative. During the last few years assurances have been received from a number of keen and able workers who are prepared to devote their lives to make this scheme a success. The objects of this Institute will be to carry on research in the medical sciences, to train a band of research workers, to apply the knowledge obtained to clinical practice and to preventive medicine, and to disseminate the knowledge of hygiene among the masses, making its service available to them either free or at a low cost.

"The Institute will be called the Indian Institute for Medical Research with six departments to start with—bacteriology and pathology; tuberculosis bio-chemistry and nutrition; protozoology; experimental pharmacology and indigenous drugs inquiry; diagnostic laboratory and clinical work, with which the propaganda and preventive service will be incorporated. More sections will be added as soon as sufficient funds are available.

"Each department will be under a Director, assisted by a suitable staff. Adequate arrangements will be made to stimulate research by taking in a sufficient number of stipendary and voluntary workers. The entire organisation will be governed by a Governing Body, composed of eminent scientists, representatives of various bodies mentioned in the memorandum and a few departmental directors. The Governing Body will carry on the administration and will present their report at the annual meeting of Fellows and Members of the Institute.

"The first Governing Body will consist of the following:—

Sir Nilratan Sircar; Mr. A. R. Dalal, I.C.S., (Retd.), Director, Tata Sons; Dr. T.S. Tirumurthi, Professor of Pathology, Vizagapatam Medical College; Dr. V. D. Khanolkar, Offg. Dean, Seth Gordhandas Medical College, Bombay; Dr. S. Subba Rao, Senior Surgeon, Mysore State; Rao Bahadur Dr. B. N. Vyas, formerly Professor of Pharmacology, Lucknow Medical College; Dr. K. S. Ray, Professor

of Surgery, National Medical Institute, and Chairman, Public Health Committee, Calcutta Corporation; Dr. A.C. Ukil, Prof. of Bacteriology, National Medical Institute and Visiting Physician, Chest Dept., Medical College Hospital, Calcutta; Dr. H. Ghosh, formerly Director of Biological Laboratories, Bengal Chemical and Pharmaceutical Works Ltd., Calcutta; Dr. N. Banerjee, Visiting Physician, Howrah General Hospital; and Dr. B. C. Guha."

It is not mentioned where the Institute would be located. From the bulk of the members coming from the city of Calcutta, it may be surmised that Calcutta may perhaps be chosen. There are very few members on the governing body to represent Madras and Bombay and fewer still to represent other provinces. There are in Madras, Bombay and also other cities eminent members of the medical profession who in addition to being useful contributors of knowledge to the Institute would be in a position to supply the sinews which in our opinion count more than knowledge especially to begin with. We hope the governing body as now formed is only provisional and that they have power to co-opt. Medical Research institutions are to be the primary concerns of the medical profession as a whole and we suggest to the organisers to make it possible for every humble medical practitioner of whatever system to take part in the activities of the Institute. As there are Government Medical Research Institutions in Calcutta it may be advisable to locate the proposed Institute either in Bombay or Madras depending upon the support the scheme would get from the public as well as from the members of the medical profession. Later as funds permit branches may have to be started in other parts of India. Then only the scheme will have a national outlook.

In the meanwhile may we suggest to the authors of the scheme to place the same before the All-India Conferences that meet in Bombay during next Xmas, it being a legitimate subject for the serious consideration of the members of the medical profession.

I. M. S. Before Select Committee: We learn from Reuters' Agency that three I.M.S. Officers, Col. R.F. Baird, Lt. Col. C. J. Dunn and Lt. Col. H. H. Broome were the last witnesses before the Select Committee on Indian Reforms. Col. Baird expressed his opinion that medical adminis-

tration was undergoing deterioration due to too much interference of Ministers; he talked about mal-administration of local bodies and waste of public money on indigenous systems of medicine. Lt. Col. Dunn suggested an all-India Public Health Act and the last one opined that medical education has deteriorated on account of too rapid Indianization and urged that so long as western system of medicine was taught in medical institutions professional appointments should be filled in by Europeans. It is also telegraphed by Reuter that there was lively discussion about the cause of unpopularity of the I. M. S. and that Col. Baird expressed that it was owing to the belief that the I.M.S. enjoyed excessive pay and emoluments from private practice and declared that the I.M.S. was prepared to abandon private practice if it resulted in the better understanding of the independent private practitioners. He said the real attraction of the I.M.S. was not the pay but the professional opportunity it afforded.

What is reported by these witnesses might not be far from truth, but we must view these opinions from the Indian point of view. Democracy in India is in its infant stage and party considerations more than efficiency has been so far weighing very much with the policies of the ministers. Morale of the local bodies in general has not been what one would expect. The fact that the officers in local bodies prefer to be under Government rather than under the control of the local bodies and that the Government has been forced to provincialise superior appointments in local bodies is enough evidence if any evidence is required at all, to prove that local bodies do not command the confidence of its employees. There is no doubt that some money is wasted on indigenous systems of medicine. We do not for a moment say that indigenous systems of medicine should not be encouraged. But the money spent should be in the right way. For example the way in which the Government school of Indian medicine, is run in Madras has been questioned by many practitioners of indigenous system itself. That institution is now supplying to the public medical practitioners who are neither allopathic nor indigenous and practically many of the practitioners who passed from that institution have been prac-

tising more of allopathy than the indigenous system. We have said more than once in these columns how the indigenous system could be encouraged to the mutual good of both the systems. We agree that medical education has suffered a good deal these few years though the curricula of studies are materially on the increase. The type of European I. M. S. officers 20 years ago are quite different from those we are having now. There was military discipline in every hospital and the officers loved their position more than money. When the love of money came, discipline naturally suffered. During the period of transition when medical department portfolio was slowly going down from European Executive Councillors to the Indian and later to Indian Ministers, the quality of I.M.S. element also materially suffered and no wonder when Indianization of offices took place the heritage just then prevailing in the medical institutions naturally followed. This is why the medical education has suffered. But with all the troubles which are bound to be there for some time during the days of change of power from a white bureaucracy to a brown democracy, the country should suffer and by such sufferings only she and her people will grow wise.

Before closing we wish those in service, whether the I. M. S. or the provincial officers, would specially note what Col. Baird expressed about the cause of unpopularity of the I. M. S. He was perfectly right in mentioning that the unpopularity was not due to the service but to the excessive privileges and emoluments from private practice. We do not think that during the days of Col. Baird, running of nursing homes, chemists shops and such trades were allowed and when these trades are now included in the privileges enjoyed by service men, the measure of unpopularity against service will be manifold greater. Will our popular Ministers note what Col. Baird says, especially the last portion of his evidence, that the professional opportunity more than money would still attract best of men from England for service in India even at the loss of the privileges of private practice?

A. F. R. C. S. Congratulated: Under the above caption in the Correspondence

Pancrepatine is preferred for oral treatment of diabetes.

Columns appears a brief summary of an at Home given in honour of one Dr. A. V. Baliga, L. C. P. S. (Bom) F. R. C. S. (Eng). who recently returned from England after a successful career, as a Fellow of the Royal College of Surgeons. We admire the ability and courage of this young Licentiate, who immediately after he qualified himself as a Licentiate at the national Medical College, Bombay, went to England and got one of the highest qualifications which a doctor could get in England. We are told Dr. G. V. Deshmukh was mainly responsible for encouraging this young medico to sail for England to follow Dr. Deshmukh's footsteps, who years ago after qualifying himself as a Licentiate at the Grant Medical College, Bombay, went to England and obtained the highest double qualifications, M. D. (Lond) and F. R. C. S. (Eng). We congratulate Dr. Baliga most heartily and hope he will have a bright, successful and prosperous career in Bombay under the guidance of Dr. G. V. Deshmukh, whom Dr. Baliga rightly calls as his "revered chief."

Correspondence, Reports, Etc

The All-India Medical Licentiates Association.

The 26th Conference of the All-India Medical Licentiates Association is to take place in Bombay during Xmas holidays and I wish to give a brief account of the activities of the Association in the past making an appeal to the old veteran leaders to transfer the responsibility of running the Association to the young members of the Association who in their turn should take advice from the retired leaders and continue the good work the Association has been able to achieve so far.

Bombay is the birthplace of the Association in 1906, the first meeting being held at the quarters of the late Dr. P. S. Ramachandrier in the premises of the Parel Laboratory, the late Dr. Abdul Razack, J. P., as its first President. The idea of starting the Association was first conceived by the late Dr. P. S. Ramachandra Iyer in collaboration with Dr. Jamitram, B. Desai and the late Dr. J. M. Pandya. The latter

was at the time in charge of the Byculla Police Hospitals and the former was working along with the late Dr. P. S. Ramachandrier in the Parel Laboratory in connection with the Plague Commission. It was most opportune that the Association was lucky to have as its first President the late Dr. Abdul Razack, who had just retired from service and was one of the most popular and leading practitioners in the city of Bombay. I have also to mention the selfless services rendered by Dr. R. H. Golwarkar who was then working in the Bombay Trust. The Association got the hearty support of the leaders in other provinces of India and Burma excepting U. P. and Bengal. The worthy trio, the late Dr. P. S. Ramachandrier, Dr. Jamitram B. Desai and the late Dr. J. M. Pandya, felt it necessary to have an organ of its own for the Association, and with that idea they requested me to hand over the journal, the "Hospital Assistant" which I was editing at the time. Rightly or wrongly I did not take in this suggestion and thought it will be to the interest of the class if two journals were run for the same purpose. So I continued editing "The Hospital Assistant" for 12 years till the year 1918 when I had to stop it due to unforeseen financial difficulties and my private domestic circumstances. As referred to above a separate journal for the Association was started in 1907 to which was incorporated the Agra Medical Club journal.

Your readers, especially the Licentiates section of it, must be familiar with the activities of the Association from its birth till this day. The members of the provinces of U. P. and Bengal stood aloof for some time, and later joined the Association in large numbers and it is no exaggeration if I were to say that the destinies of the Association at present are completely in the hands of our brethren in those two provinces. In the intervening period the members in Gujerat, Madras and Central India and Punjab, were guiding the activities of the Association and it will not be out of place for me here to mention the names of Drs. Joseph Benjamin of Ahmedabad, Venkappa of Madras, Rai Bahadur Sarju Prasad of Indore, Murray of Burma and Kazan Chand of Punjab, who did all that was possible for them to popularise the Association in their respec-

tive provinces and it was a very unfortunate circumstance that the activities of the Association in Bombay dwindled gradually, so much so that little or nothing was heard about the Association till quite recently. It is really the signs of times that the young Licentiates in Bombay should have conceived the idea of reviving the activities and give a new life to the Association in the very place where it was born. I should congratulate most heartily the young licentiates in Bombay who have invited the Conference to that city and I am sure with the zeal and enthusiasm of the youth, the Bombay Conference will be a great success and I appeal to my brethren both in the province of Bombay and outside to muster strong to the city of Bombay during the coming Xmas week and by their united action show to the world that the medical licentiates are second to none in their capacity for organisation and service.

Before closing, it will not be out of place for me to make a special appeal to the present worthy General Secretary and my friend, Dr. Rai Sahab Ram Narain Lall, who is at the helm of the Association, to guide the activities of the Conference in such a way that the old leaders retire giving place to the young ones.

KOLHAPUR CITY } R. V. BAPAT.
12-11-33. }

The Trichinopoly District Medical Association.

A monthly meeting of the above Association was held at 4 P.M., on Saturday the 14th, October 1933, in the premises of the Trichy Medical Union Ltd., China Bazaar, Trichinopoly, when about 40 doctors were present.

The Directors of the above Union were "At Home" to the members.

Dr. P. A. S. Raghavan, the Secretary of the Association proposed Dr. T. V. S. Sashty to the chair.

Dr. T. S. S. Rajan welcomed the members to the Union and solicited their co-operation in furthering the Union which had in view the opening of an ante-natal Clinic, a Circulating Library and a Research Laboratory.

After reading the minutes of the last monthly meeting by the Secretary, Dr. R. Kalamegam, B.A., M.B.B.S., read an interesting paper on "Rhinitis" which was followed by a discussion.

With the concluding remarks from the Chair and a vote of thanks to the hosts, the Lecturer and the Chairman, the meeting terminated.

A monthly meeting of the Trichinopoly District Medical Association, was held in the Government Hospital, Srirangam, on 12-11-33 when about 40 doctors were present. In the unavoidable absence of, Lt. Col. N. M. Mehta, I.M.S., Dr. T. V. Swaminatha Sashtry, presided.

Drs. S. Janaky, M. S. Kuppuswami Iyer, and K. A. Chidambara Iyer were "At Home".

Dr. K. A. Chidambara Iyer demonstrated from the Hospital a case of infective granuloma of the pudenda which was resistant to treatment, and Dr. Kuppuswami Iyer, a case of diabetic-cellulitis of the leg cured without amputation.

Dr. T. S. S. Rajan, showed a specimen of an excised uterus with a tumour which he had removed a few days back and gave case notes on the same.

Dr. R. Sambhasivan, read an interesting paper on "Nutrition", aided with charts and statistics.

Dr. P. A. S. Raghavan, the Secretary, then brought forward a resolution that the annual-gathering which comes off in December be made into a medical conference of the Southern Districts and that a number of doctors be invited to deliver lectures, read papers and have discussions. This was unanimously carried.

With a vote of thanks to the Chair and the Hosts and Hostess the meeting terminated.

P. A. S. Raghavan,
Secretary.

The Kristna District Rural Medical Practitioners' Association.

An ordinary meeting of the above association was held in the District Head Quarters Hospital, Masulipatam on 21-10-1933 at 4 p.m. with M.R.Ry. Dr. P. R. Venkatarama

Boldine A. F. D. helps in Jaundice and dissolves Gallstones.

Iyer, Avl., M.B.C.M., the District Medical Officer and the President of the Association, in the chair. After reading of the minutes of the previous meeting by the secretary it was unanimously resolved to hold the meetings hereafter once in two months instead of three months in conjunction with those of the District Medical Association. It was then put for discussion the contemplation of inviting the provincial R.M.P. conference to Masulipatam as suggested by the secretary and the majority decided to postpone it to next year since the association was only recently organised.

A paper on the Liver Enlargement of infants was read by Dr. N. Rama Rao L.M.P. of Gollapalli dealing with its probable causes, signs and symptoms and the efficacy of the Homeopathic medicines in that disease which he has been trying.

The President enlightened the audience upon that subject and in his closing remarks impressed upon the audience the importance of their getting popular in their villages by which only the grievances in general of any R. M. P. would be prevented with regard to their managing authorities.

N. Rama Rao L. M. P.
Secretary.

Tanuku Medical Association.

The 3rd anniversary of the Tanuku Medical Association and the 3rd Bi-monthly meeting of the West Godavary District Medical Association was held on Saturday the 11th November, 1933 at Tanuku at Dr. Ch. Sathiraju's upstairs. Nearly 80 Medical Practitioners from all over the District attended the function. Dr. V. Sreenivasa Rao, M.B. & C.M., District Medical Officer, West Godavary was voted to the chair. The Secretary of the Tanuku Medical Association read an interesting report on the activities of the Association during the year 1932. The nature of the constitution for the District Medical Association was then discussed at length and a federal type of constitution was voted for by a majority of 25 against 16. Refreshments were served on a grand scale after which interesting papers were read on "The use of Mercurochrome in Medicine and Surgery" by Dr. V. Purnarao, "The Senile cataract" by

Dr. E. Dikshitlu, "Optimism in medicine" by Dr. Ch. S. John which were supplemented by valuable discussions by some of the members present. The function came to a successful termination with a vote of thanks to the President and the host. All the members present were entertained at a dinner that night by Dr. Ch. Sathiraju.

Subsidised Practitioner.

Though the Government has said that the Rural Medical Practitioners are not regular subordinates, and they are independent medical practitioners, entitled to practise for their own benefit, many of the Taluk Boards and District Medical Officers, treat the Rural Medical Practitioners worse than full timed paid subordinates. It is a well known fact, that the Rural Medical Practitioners, are not provided with pucca buildings, paid compounders, privilege leave, provident fund or pension, periodical increments, future prospects, etc., and they are asked to work both morning and evening just like a pucca dispensary of a big town. In the rural dispensaries, generally poor village folk who had to earn their bread by manual labour resort for treatment. They come in the morning hours. In the evening hours, though the dispensary is kept open, no body comes. More over, if the rural dispensaries are asked to be kept open both morning and evening, where is the time for the subsidised practitioners to practise for his own benefit? One does not understand wherein lies the independence, for the Subsidised Medical Practitioner.

Again, at present the subsidies are being drawn from the Treasury. The Rural Medical Practitioners prepare their bills and send a copy to the District Medical Officer, and one to the President Taluk Board. The District Medical Officer after scrutiny and counter signature, forwards the bills to the practitioners. These bills will have to be again transmitted to the District Treasury Officer for pre audit. This sort of circuitous procedure involves delay, unnecessary and avoidable expenditure, both to the Government and to the practitioners. The District Medical Officer can easily and locally deliver all the bills to the Treasury Officer for pre audit, who is also in the same station just like himself (District Medical Officer). The Government saves a lot in postage. Similarly, the Rural Medical Prac-

itioner saves the postage he spends for sending the bills for the Treasury Officer for pre audit. So I request that the Government will see its way to remedy the defects and do the needful in the matter.

Pudupalayam. A. SUBRAMANIAM, L.I.M.

A. F. R. C. S. Congratulated.

Under the auspices of the Reception Committee Executive of the All-India Medical Licentiate Conference in Bombay, an at Home was given to Dr. A.V. Baliga, L.C.P.S. (Bom) F.R.C.S. (Eng.) on Sunday, the 22nd October 1933 at the residence of Dr. U.B. Narayanrao. Dr. G.V. Deshmukh M.D., (Lond.) F.R.C.S. (Eng.) presided. There was a large audience and amongst the guests were Drs. D. D. Sathaye, V. M. Kaikini and J. D. Dhruv. Dr. Narayanrao congratulated the guest of the evening, Dr. Baliga, who, Dr. Rao said, was perhaps the first medical licentiate in India, who by dint of his perseverance and ability obtained this unique success as a Fellow of the Royal College of Surgeons in England. He was also the first licentiate who was appointed as House Surgeon in the King Edward Memorial Hospital, Parel, immediately after he qualified himself as a licentiate. Dr. Rao said that that was only possible due to the strenuous fight put up by Dr. Deshmukh before the authorities of the K.E.M. Hospital, who till then would not appoint licentiate as House Surgeons to that Hospital; and it was worthy of Dr. Baliga that he visualised the expectations of Dr. Deshmukh.

Dr. Baliga expressed his heartfelt gratitude for the honour shown to him by his brethren. He explained in detail about his studies in England and emphasised that his success was entirely due to the strong and timely support of Dr. Deshmukh, whom he called as his "revered chief." He also expressed his gratefulness to the two successive principals of the Bombay National College, where, he was the student, Drs. Sathaye and Kaikini, who, he said, were a source of inspiration to him.

The guest was also congratulated by Drs. Kaikini and Sathaye. Dr. Deshmukh made a speech at the end expressing his delight for being present at the gathering that day. He advised the licentiates present that they should not harbour any inferiority complex

and get along serving the public as per-severingly and intelligently as they have been doing heretofore. He deprecated the caste distinction now prevailing in the profession and said that while he was young he was always treated by a licentiate and quite successfully too. He said that the majority of the people in this country are under the treatment of licentiates, and they were none the worse for it. He eulogised the hard fight put in by the licentiates in connection with the Indian Medical Council

Bill and said that if there were any changes brought about in the bill, as recently passed at the Assembly, it is due to the efforts and influence of the licentiates over the members of the Assembly. He said he was of opinion that merit and ability more than qualification that counted much in the profession and advised the audience to follow the example of the licentiates like a Mogha in the Punjab and a Ramarao in Madras.

Circulars.

We have been requested by MESSRS HAVERO TRADING Co., Ltd., to inform our readers that their Head Office running by the name: BAYER-MEISTER LUCIUS, HAVERO TRADING Co. Ltd., PHARMACEUTICAL DEPARTMENT, will be removed from Calcutta to Bombay on or before the 15th December, 1933. The new address of the Head Office will be:—

P. O. BOX 642, COMMERCE HOUSE, BALLARD ESTATE, FORT, BOMBAY.

ORIENTAL RESEARCH LABORATORY, VEPERY, MADRAS.

We have been receiving requisitions from practitioners for the supply of Kookoomin, Zama and Menestrin Capsules at special discount to the profession. It is not possible for us to allow concession for the supply of these specialities unless three bottles of each are ordered at a time in which case we shall allow 10% discount over the cost and in case Rs. 25 worth of these specialities are ordered at a time, we shall allow a special discount of 25%.

The specialities so far put in the market by us, have been tried and found effective by eminent physicians and all the specialities are useful for the practitioners for prescribing the same in their daily routine.

THE TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION.

It is proposed to hold an Academic Conference in connection with the annual gathering of the above Association at Trichinopoly on the 23rd December, 1933. Members of the profession are cordially invited to be present and such of those who wish to attend and deliver lectures are requested to intimate to the undersigned on or before the 10th of December, '33. Boarding and lodging will be free.

P. A. S. RAGHAVAN,
Secretary.

The Handbook of Indian Medicine or The Gems of the Siddha system.

BY
T. G. RAMAMURTHI IYER.

The author begs to announce that the pages of the book, have been increased to double the contemplated number, and numerous illustrations are being added to make the book more useful to the readers. Pains have not been spared to present a book of more practical value. The artists require time to finish the blocks, from my own drawings, hence the delay for publishing.

Arrangements have been made to publish the book by the first week of January 1934 and I trust there will not be any further delay.

The concession of publication price will cease from the 25th November '33.

List of Postings of Sub Asst. Surgeons for the month of October, 1933.

No.	Names of Sub-Asst. Surgeons.	From	To
1	Dr. M. Varantharumperumal	Festival Duty	L. F. Dy., Orattanadu.
2	" K. Vanamaraju	Leave	" Sriharikota.
3	" C. Chintan Nair	L. F. Dy., Sriharikota	c/o Vizag Agency Surgeon, Koraput.
4	" P. Kunhambu	Agency Duty, Koraput	Govt. Hd. Qrs. Hl., Salem.
5	" M. A. Seshan	Leave	L. F. Hl., Sankaranayinarkoil.
6	" P. J. Asirvadam Pillai	L. F. Hl., Sankaranayinarkoil	Agency Duty, Koraput.
7	" T. R. Ramachandran	Leave	L. F. Dy., Ottapidaram.
8	" N. Padmanabha Rao Naidu	"	Forest College, Coimbatore.
9	" A. R. Shunmuganathan	L. F. Dy., Aruppukottai	c/o D. M. O., Ganjam.
10	" S. Krishnaswamy Iyengar	Training, Govt. Gen. Hl., Madras,	Dt. Hd. Qrs. Hl., Tanjore.
11	" T. Gnanaya	Dt. Hd. Qrs. Hl., Tanjore	L. F. Dy., Papanasam.
12	" T. K. Gopala Rao	Leave	L. F. Dy., Aruppukottai.
13	" M. Lakshmanamurthi	L. F. Hl., Venkatagiri	" Guntakal.
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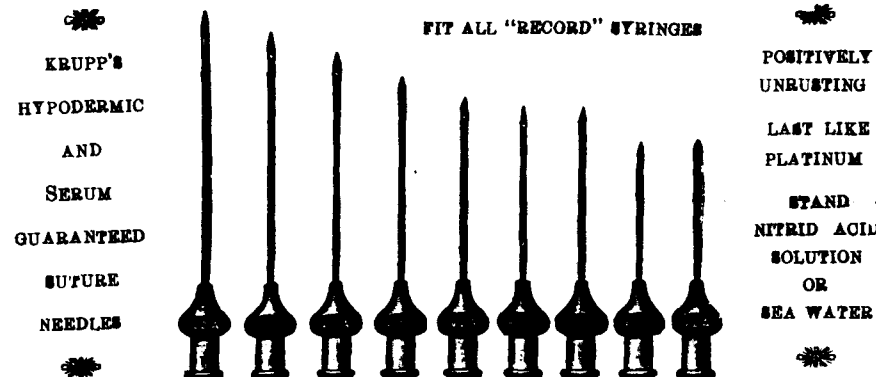
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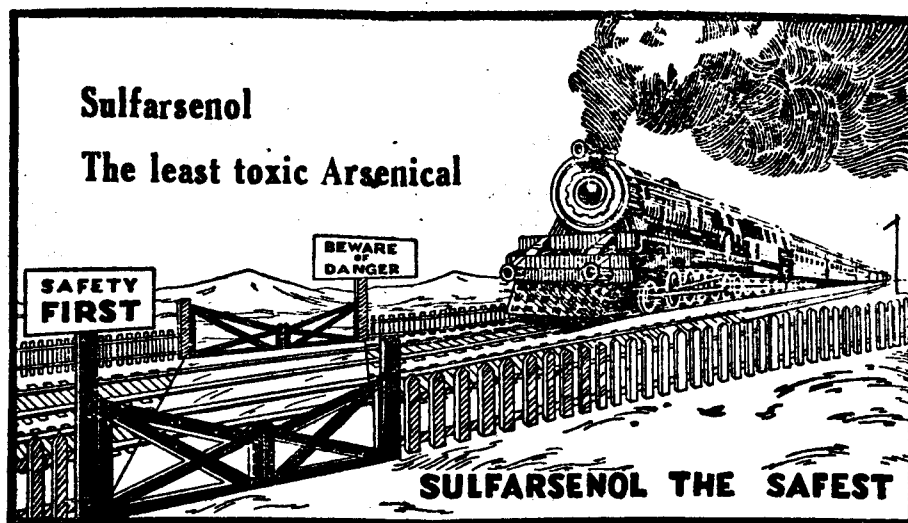
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