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The Medical Practitioner

A Monthly Medical Journal

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Taken on the occasion of the 2nd Anniversary Day Celebrations of the City College, Madras, on the 5th December 1933 under the distinguished presidency of Lt. Col. Q.A.F. Hingston, C.I.E., O.B.E., I.M.S., Ex-Surgeon-General with the Government of Madras. This group includes Medical Licentiates from all parts of India who appeared through this college for the Senior Cambridge Examination December 1933, at the Madras centre.
(An extract from the Press Report regarding this function appears on the reverse.)

Read the following extract from the 'Hindu', Madras—6-12-1933.

THE CITY COLLEGE ANNIVERSARY.

THE PRINCIPAL CONGRATULATED.

Madras, December 6.

The second anniversary of the City College, Madras, was celebrated last evening at the Y. M. C. A., Auditorium with Lt. Col. C. A. F. Hingston, C.I.E., O.B.E., I.M.S., in the chair, when Mr. K. V. Rm. Alagappa Chettiar, Bar-at-Law, delivered the annual address. There was a large gathering present on the occasion.

Mr. K. S. R. Acharya, Principal, presented the second annual report of the working of the College. In the course of the report he stated that the College was not duplicating the work done by the other Colleges in the City and was not coaching candidates for any of the examinations of the Indian Universities. "In this institution," the Principal stated "we have introduced in the place of the existing higher courses of study, the Senior Cambridge Course which, for all practical purposes, gives to the holder of the certificate, the status of a Graduate of a recognised Indian University at minimum cost and minimum time." The principal continuing, said that they had also instituted postal tuition course in several subjects and had successfully trained many candidates. Last month the foundation-stone for the new building was laid and he hoped that with the help of the public, the building would be completed soon.

Mr. Alagappa Chettiar, Bar-at-Law, in the course of his address, congratulated the Principal on the good record he had set up and hoped that the building would soon be completed. The College was supplying a much-felt want and the speaker hoped that the ideals with which the College was started would be realised soon.

Miss Sarla Ben Patel, a postal student from Bombay, in the course of a speech, thanked the Principal for what all he had done to the medical licentiates in the Bombay Presidency by enabling them to appear for higher studies. She appealed to the the authorities of the College to open a branch in the Bombay Presidency. She also thanked the staff of the College for their untiring efforts to coach the students.

The Chairman, also congratulated the Principal on the excellent results of the College. He was especially glad that the College was enabling licentiates in Medicine to pursue higher studies in Medicine. When there was a proposal some years ago to admit Licentiates in the Medical College, the speaker was against the proposal but he was glad that the City College was enabling the Licentiates to proceed to higher studies. The establishment of postal tuition would be taken advantage of by several persons who might find it difficult to attend Colleges. The City College had made a right start and the speaker wished all success to the College in the future.

Mr. K. R. R. Sastri proposed a vote of thanks to the Chairman and the lecturer, after which the meeting terminated.

THE

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ANNUAL REPORT OF THE CIVIL HOSPITALS AND THE DISPENSARIES IN THE MADRAS PRESIDENCY.

Before reviewing the report submitted to the Government by Major General C. A. Sprawson, Surgeon-General with the Government of Madras, we wish to draw the attention of the Government about the discourtesy shown to the existing medical journals in not supplying to them copies of the administration reports of the Medical and Public Health Departments, though such reports are distributed free of charge to the lay press. The section of the public which will be most interested to go through the reports of the medical and public health departments, are the members of the medical profession and it is the legitimate duty of the Government to place such reports on the Editor's table of all the journals, as the criticisms coming from such source will be of immense service to all concerned. Very few members of the lay public take any interest in the reports of the medical and public health departments, they being of a technical nature interesting only those in the medical profession. It may perhaps cost the Government, even at the exhorbitant rates charged for such reports, not more than Rs. 25 a year to supply such reports, to the medical press, an amount which should be considered too trivial taking into consideration the publicity which the journals would give to the work conducted by the heads of medical and public health departments.

As was done by us these few years we shall comment on the report under several heads which are likely to interest the medical profession.

SUBSIDISED DISPENSARIES.

It is most regrettable that the scheme of subsidised dispensaries in rural areas has not attracted the attention of the Government as well as the public to the extent the scheme deserves. The object with which this scheme was first started was mainly to encourage private practitioners to settle in villages, for which purpose they were given a subsidy. It was never the intention of the scheme to convert a dispensary started by a subsidised practitioner into regular dispensary ; yet we find in the report under review that some of the subsidised rural dispensaries were converted into regular ones—a most retrograde step which is suicidal to the subsidised rural medical scheme. The fact that when the subsidised dispensaries are converted into regular ones some other practitioner and not the one already working in the subsidised dispensary is made the medical officer of the newly converted dispensary, is another inexcusable vagary which we notice in the administration of the scheme. It will not be an exaggeration to say that the subsidised rural medical scheme is made use of for exploiting the political ambition of the local leaders. If Government or other public bodies are keen to bring about real village reconstruction in this country they would do well to realise the importance of

medical practitioners in rural areas who should be made one of the main units of such reconstruction work, as there is nothing which a member of the medical profession cannot tackle for the welfare of the village folk.

HONORARY MEDICAL OFFICERS.

Though the number of honorary medical officers working in state hospitals has been materially increasing year after year there does not seem to be any reduction in the number of paid medical officers proportionate to the increase in the number of honoraries. An attempt should be made to cut down the paid staff year after year so that at the end of a specified period there should be only a few paid officers to do administrative duties, the professional work being done by honoraries.

INPATIENTS.

The total number of beds for inpatients available was 9,588. This number is too small for a population of over 47 millions, a large portion of whom are too poor to afford medical treatment, even in the matter of diet and regimen. The inpatient number works out on an average of one bed for 5000 population. In other countries, particularly in America, where the people are certainly more healthy and consequently wealthy, the number of beds available is one for every 270 of the population. A large amount of money now spent for paying highly salaried officers may be saved by replacing the paid staff by the honoraries and such saving utilised for increasing the inpatients.

LABOUR CASES.

The number of labour cases attended by midwives was on the whole 92,340 against 155,405 in the previous year. The decrease of over 63,000 cases is conspicuous and the explanation given in the report that it was due to non-employment of midwives of the sanctioned strength, is not at all satisfactory. The number of births for the whole province may be put down roughly at 164,54,000 at the rate of 35 per millæ and the percentage of them that were attended to by midwives comes to less than 0.6%. Even if all the 1668 midwives on the register attended at the rate of 100 cases per year, still the percentage will come to 1%. So the available statistics collected by the Surgeon-General clearly proves the necessity of training midwives on a larger scale than now.

LEPROSY CAMPAIGN.

It is certainly a blot in the medical administration of this country that the campaign against leprosy should be entrusted to social workers and that medical officers are made to serve under the control and guidance of such workers. Leprosy is as bad a disease as any other and if it has spread in the way it is now doing havoc in this country, it is entirely due to the neglect of the Government and it is the legitimate duty of the Government to lead an intensive campaign against leprosy with the help of social workers and not under them. If venereal clinics could be attached to the state hospitals and patients treated inside them why not patients afflicted with leprosy? In case the Government is in need of finance it will be never wrong on their part to curtail the expenses in the state hospitals for the treatment of other diseases and utilise the amount so saved for the treatment of lepers. After all, leprosy does not seem to be as infectious as the lay people usually take it to be. It is the sight of the disease which has been the cause for the entertaining of false notions of infection of leprosy, as the burnt cases that one sees in the streets though most horrible to look to seem least infectious. The real infective cases are those which are usually not easy of detection.

APPOINTMENTS.

It was certainly a retrograde step on the part of the Government to provincialise Taluk Head Quarters hospitals and such institutions formerly under the control of the local bodies. The Government ought to have guided the local bodies to run these institutions more efficiently and up to the modern standard instead of transferring their management to the Government, as medical relief is one of the most important items which should be legitimately under the direct control of local bodies. The local bodies are as much, if not more, to blame for relinquishing their responsibility to the Government. They have by such an action shown their incapacity to run local institutions. In other words it means that they are unfit for swaraj which seems to be a cry in their lips and not at the bottom of their heart. Consequent on the changed policy of the Government in provincialising only Taluk Head Quarters Hospitals, it has now been found necessary by the Government to stop recruitment of Sub-Assistant Surgeons for employment under the local boards which work seems to have been now entrusted to local boards themselves. Such a step would necessarily create heart-burning in the medical department and the question will be raised by those who were aggrieved as to why the recruitment of the Assistant Surgeons also should not be stopped and both the dispensaries as well as hospitals be run with the help of the members of the independent medical profession with a minimum paid staff for admininistrative purposes.

The appointment of the whole time professor of pathology for which post an officer outside the existing cadre has been appointed, has also created dissatisfaction amongst the members of the provincial service and also in the profession as a whole as the Government by taking such a step did not mind the welfare of the public when they had to post the acting professor of pathology to do the duties of a Surgeon of a district. About another whole time appointment recently sanctioned by Government, that is, the professor of medical jurisprudence, at the Madras Medical College, we have said enough some time ago in these columns criticising the action of the Government in creating two special appointments, one the police surgeon sanctioned some time ago and the other, professor of medical jurisprudence, both appointments, being held by the same officer in other parts of India, such as Bombay and Calcutta, more economically and efficiently too. We have pointed out more than once that the Government seems to be interested in persons and not offices while making appointments in the medical department. It cannot be otherwise when they sanctioned two appointments, the professor of pathology and professor of medical jurisprudence at the Madras Medical College.

MEDICAL EDUCATION.

The most important reform to the credit of Major-General Sprawson is, regarding the training of the medical licentiates in this province, whose period of training was increased from 4 to 5 years. The report says that the syllabus of the new course for the licentiates resembles that of the corresponding examination for the Conjoint Board in England, M. R. C. S., L. R. C. P. Unlike in England where the medical training institutions are run by the profession and not by the State, the institutions for training medical men are mainly run by the Government in this country. We would suggest to the Government whether it will not be economical to give training to all medical students in the same institution leaving it to them to appear either for a diploma or a university degree conducted by two separate bodies. This will help a good way in levelling up the medical profession in the country by removing the inferiority or superiority complex now existing in the profession.

MEDICAL LIBRARIES.

From the report it is seen that books and periodicals are being lent for the members of the independent medical profession at District Head Quarters Hospitals, a fee being charged for such service. It is also said in the report that the total receipt under fees came to Rs. 15,456-6-2 against a total expenditure of Rs. 5,712-8-0. We would suggest to the Government the desirability of introducing the system of lending libraries at the medical school and the college in the city. This will be to the benefit of the members of the independent medical profession, and will be also a source of income to the Government.

ADVISORY COMMITTEES.

The Advisory committees which now exist serve only a spectacular purpose and do not add to the efficiency of administration in state hospitals. The medical institutions under the Government may be made to work more efficiently and under better discipline, if they institute local committees with executive powers instead of advisory committees for the management of the state hospitals. The government are now charging a fee for the treatment of inpatients whose income is more than Rs. 50 and in some institutions in the city there are what are called special wards. If an almoner is appointed for controlling the

There is no point in giving subcutaneous or intramuscular injections of an arsenical compound for syphilis if the compound does not readily form Arsenoxyl.

admissions and charging the people in the hospitals, larger income will be realised by the Government in the treatment of patients in the state hospitals and arrangement could be made for increasing the in-patient strength of almost all the institutions, which reform is more in keeping with the profession than the opening of new out-patients institutions where there is little or no responsibility regarding treatment. The members of the local committee might be nominated by the Government for the the time being to represent variety of interests and not offices, the chairman of the committee should be a lay man of the status of a district collector in the district and of the grade of a deputy collector or at least a tahsildar in localities where deputy collectors are not available, the secretary of the committee being the medical officers in charge of the state hospitals. In addition to the nominated members in these committees all the honoraries attached to the institutions should be ex-officio members of such committees.

Original Articles

ENDOCRINOLOGY

By

Dr. M. S. KRISHNAMURTHI AYYAR,
M.B. & C.M.,

XXVIII

The Effect Upon Human Evolution.

(*Taken from L. Berman's "The Gland Regulating Personality."*)

The all-pervading and deep seated influence of the internal secretions upon life and personality comprises but a fraction of what is known and only a hint of what is to become known. There is an endocrine aspect to every human being and every human activity, normal and abnormal, internal process and its external expression, regulated by laws of which we are beginning to catch a glimpse. Then control promises us now a dominion over the most intimate and inaccessible recesses of our lives in a way comparable only to the control we now exercise over the forces and energies once revered as the instruments of Gods-light, heat, magnetism, electricity, etc. We have learned how to control and change our environment. We are now learning, how to control and change ourselves with the endocrine research which is now progressing.

Since every step of the daily routine or adventure, from waking to sleeping, eating, drinking, marrying and giving in marriage, working, idling, fighting, playing, feeling, enjoying, sorrowing, every shade of emotion and nuance of mood, in short, every phase of happiness and unhappiness, are endocrine episodes in the history of the individual; the sphere of applications is as long, broad and deep as life itself. Not only do the internal secretions open up before us the great hope that life at last will cease to stumble and blunder, manacled by the iron chains of inexorable cause and effect but also provide tools, concrete and measurable, that can be handled and moved, weighed and seen, for the management of problems of human nature and evolution.

Every department of human life, the questions of labour and industry, science and art, education, puericulture, international problems, crime and disease may be eliminated, war and sex, may be understood and handled sympathetically as they have never been before. Customs, morals, codes of procedure and practice, institutions, all these expressions of opinion which may conduct all the currents which contrive the infinite variety of life, will be transmitted to another set of values. A remodelling will take place all along the line. An unstable thymo-centric will not be treated as a criminal but treated in a sanatorium.

THE BASES OF VARIATION.

H. G. Wells emphasised the unique quality of the individual, and how, in spite of the clearest devices of classification, living things ultimately escaped the classifying net by virtue of their tendency for ever to vary. The individual is unique yet when all is said and done that fact remains that between individuals there is a resemblance and among these variation. The conception of a particular chemical make up of the individual, statable and relatively controllable in terms of the internal secretion, supplies a more natural and satisfactory mode of approach to the problem than any

It is not usual for acetylated organic arsenic compounds to readily form Arsenoxyl.

so far suggested. In effect the differences between individuals may fundamentally thus be grouped among the differences which distinguish other chemical substances. The differences between H_2O water, and hydrogen peroxide H_2O_2 lies wholly in the possession by the latter of an extra atom of oxygen in its molecules. All the peculiarities and qualities by which hydrogen peroxide is separated from water are referred to that additional quantity of oxygen. So the diversity of constitution and appearance of two brothers alike in that they have inherited the same internal secretion trends, may be traced to the superiority of the pituitary of the one over the other.

Variation and resemblance are large issues, crucial material of science of biology upon which much has been thought and written. That the proportion of the endocrines determines variation and resemblance, heredity and evolution, is a hypothesis advanced and supported by a large number of facts and capable of the most interesting experimental verification and observation. That a child resembles particularly either of its parents, grandparents or relatives, is good reason for believing that it is because their endocrine formulas are very much alike. When people apparently not blood related at all resemble one another, the same law must hold. Resemblances may be partial or complete, and the degree will depend upon the amount and the ratio of the internal secretion involved. The same endocrine constitutions will produce corresponding physiques, physiognomies, abilities and characteristics. Deviation in endocrine type from that of the original stock more of one endocrine and less of another is at the bottom of the phenomenon of variation, basic for the origin of the new species as well as the extinction of the old. In short, viewing the internal secretions as determinants, by their quantitative variations of a host of biological phenomena furnishes a concrete and detailed foundation for Darwin's theory of pangenesis.

INHERITANCE OF ACQUIRED CHARACTERS.

Darwin's theory of pangenesis was an attempt to harmonise everything known in his time about heredity. It supposed that the various organs of the body gave off into the blood substances, which were taken up by the sex cells and so became responsible of their mother organ in the newly forming individual. Modern knowledge cannot accept all this as a whole. But J. T. Cunningham modified it and according to him the traits and qualities which distinguished the sexes grouped as the secondary sex characters correlated with the special sexual function of the species in which they occur. These traits appear only when the hormones occur which are present in one sex and that only when the gonads of that sex are mature. In some cases they appear only at the period of the year when reproduction takes place disappearing again after the breeding season. Their presence makes certain cells develop in excessive numbers at a particular spot in the organism (as in the growth of breasts from a few sweat glands) or cause them to specialise (to make hair on the face in man or to grow antlers on the head of a stag.) After castration, the hormones being absent, all these points of contrast between the sexes fail to appear. So by analogy we may explain all somatic and psychic differentiation as functions of the glands of internal secretion. It is then probable to outline a mechanism of the inheritance of acquired characters at certain times and consequent adaptation, as follows: (1) a state of lability of cells at a point because of increased or decreased use, (2) an increased or decreased appropriation by them of the hormone controlling their function, (3) a corresponding increase or decrease in function of the gland of internal secretion and so on, (4) an increased or decreased representation of it in the reproductive sex cells in the gonads.

To take a classic illustration, the long neck of the giraffe, the neck of certain animals living in a district populated by trees with high branches, would be in a state of instability. If at the same time, the pituitary for some reasons was unstable and reacted with an extra supply of its secretion, it would stimulate the neck cells to reproduce themselves. In turn the pituitary would become stabilised in the direction of increased secretion and hand on the component of the increased secretion to the sex cells. That component, in conjunction with other factors, would therefore determine the emergence of a definite species character. In other words, the glands of internal secretion, as intermediaries between the environment and body and between the body

and reproductive sex cells or germ plasm, tender the clue to a phase of the puzzle of heredity, adaptation and evolution. It is only a dotted outline of an explanation, to be sure, but are certainly capable of being filled in.

THE BEARING OF BREEDING.

Since the endocrine glands are so subtly sensitive and responsive to environment, and are at the same time so intimately concerned with the process of inheritance, there is no need to stress their importance for practical science and art of good breeding (eugenics). A method of analysis of the factors involved together with rules for the production of the outcome of certain matings, when finally worked out, will elevate its procedure to the level of the more exact sciences.

A man's chief gift to his children is his internal secretion composition. The endocrines are truly the matter of breeding as they are of growth. They are the material carriers of the inherited physical and psychic dispositions, powers, abilities and disabilities from the soma to the germplasm and back from the germplasm to the soma. The term endocrine dominants brings up the enquirers of Mendelism and the relation of Mendelian conceptions of dominant recessive to the internal secretion. The Mendelians have emphasised the role of the unit factor in heredity, and the conservation of the unit factor as an entity through all the adventures of matings. Also, that when unit factors, say of the colour of the eyes, come into conflict, brown and black being mixed with blue and grey, one, the recessive, is submerged but not destroyed by the other, the dominant. So brown or black eyes, dark hair, curly hair, dark skin, and so on, are dominant while blue or grey eyes, light or straight hair, light skin, are recessive. A nervous temperament is dominant to the phlegmatic. A number of psychic qualities have been declared to be Mendelian unit factors: memory, mechanical instinct, mathematical ability, literary ability, musical ability and even handwriting. Most characters, somatic or psychic, are the products not of the action of one internal secretion alone, but of the interlinked activities of all of them. The amount of fat deposited under the skin, for instance, is influenced by the pituitary, the thyroid, the pancreas, the liver, the adrenals, and the sex glands. Other qualities likewise are resultants of a compromise between all the endocrine factors comprising the equation of the individual. If we are to look more deeply into constitution, we must measure the harmone potentials and their mobilisation or suppression.

It will be found that the stability or unstability of an endocrine will have a good deal to do with the part played by it in inheritance as well as in the life of the individual. An unstable pituitocentric marrying another unstable pituitocentric will have children either exceptionally small or tall, or abnormally bright or stupid. It has been noted that the extinction of species has been preceded by a great increase in their size, for example, the case of the great reptiles of prehistoric times. That possibly represented pituitary stabilization in a changing environment. Indeed endocrine instability appears as the fundamental condition of the tendency to vary, endocrine stability the opposite. Certain endocrine facts in relation to heredity should be mentioned. The daughters of mothers who menstruated early themselves menstruate early. Animals fed upon thyroid during pregnancy comparable to the thyrocentric give birth to offsprings with thymus. Women with partial thyroid deficiency or myxedema bear cretins. These are suggestive of what the internal secretions may do to an individual in inheritance and development. Inherited endocrine potential is the maximum reaction of what a gland is capable. A low potential like the instability of an internal secretion gland, may be latent and not made manifest until the proper stimulus, the maximum amount of stress and strain, like accident, disease, shock or war, arrives. We may account for family trends and streaks for varieties and strains among individuals, upon more precise lives based upon endocrine analysis. Finally disturbances of the internal secretions of the extreme sort denominated as disease are well-known. Indeed a number of family diseases or predispositions to diseases have been traced to them. The predisposition in any direction

Some acetylated organic compounds of arsenic are readily eliminated in the urine. Arsenoxyl does not readily pass the renal portal.

will probably be shown to be caused by them within limits.

THE IMPROVEMENT OF RACIAL STOCK.

A vast new territory of enquiry and achievement, as yet totally unexplored, is opened up by the endocrines to the eugenists and those idealists whose most earnest aspiration is the improvement of the racial stock as a necessary preliminary to improvement of racial life. Ability has been shown to run in certain families and degeneracy in others. Yet all of the practical net results have been summed up in the term 'negative eugenics', the eugenics of prohibition and warnings. Now the concept of personality, as woven around a system of chemical reflexes, handed on from generation to generation, is bound to change all that, and to create structure of positive eugenics. It has been said that what radium is to chemistry, the endocrine secretions are to medicine. Just as radium enlightens the chemist about the history of matter and the integrations and disintegrations constituting the life of an element, the internal secretions illuminate the history of the individual, as part of the life of the race, and of its integrations and disintegrations, seeing the individual as a system of chemical substances interacting, will assist enormously to predict the nature, character, and constitution of his descendants, which is essentially what the eugenist is after.

The study of mating will concern itself with the investigation and comparison of the kind of endocrine personality of the offspring. Data bearing upon physique and physiognomy details of anatomy and function, mind and behaviour, will be so co-ordinated, as no eugenist has hitherto succeeded in doing. Laws of endocrine inheritance will emerge, that will bring the control of heredity within measurable distance. Standards and forms of a new kind would be obtained.

A beginning of the study of endocrine inheritance on the pathological side has been made. Some of these have been along Mendelian lines. Following up abnormal growth (making giants and dwarfs) and abnormal metabolism (goitre, diabetes, etc.) it has been stated that it would seem that abnormal growth is dominant in the male, and recessive in the female, while abnormal metabolism is dominant in the female and recessive in the male. If an endocrine abnormality like goitre, cretinism, a dwarf, or a giant, appear in a family, as a sign of endocrine instability, other members of the family will very likely show internal secretion abnormalities. If one gland of internal secretion acts as the centre of the system and the others as satellites, it is possible to trace what would happen to it in the succeeding generations. The time will come when it is possible to advise prospective parents of the consequences of procreation and to forecast the meaning for the race of a particular marriage. Internal glandular analysis may become legally compulsory for those about to mate before the end of the present century. Certain endocrine types appear to be specially attracted to others belonging to the same group. Thus thymus-centred types frequently marry. The pre-pituitary type of male, the strongly masculine, mates often with the post-pituitary type of female, the markedly feminine. The children exhibit the lineaments of the pituitary centred type. The general trend seems to be the establishment of a better balanced equilibriated type. Yet the children often are apt to segregate into pituitary dominants or pituitary deficients. Happiness and unhappiness in marriage should be examined from the standpoint of endocrine compatibility or incompatibility.

The correction of endocrine defects, disturbances, imbalances and instabilities, before mating represents another field. It remains to be seen whether it is possible, in one generation to affect at all the germplasm, hitherto considered by all biologists as environment proof. No one can deny, in the face of multitude of evidence available, that internal secretion disturbances occur in the mother, which when grave, offer in the infant gross proof of their significance, and therefore when slight must more subtly work upon it. Endocrine disturbances in infancy have been traced to endocrine disturbances in the mother during pregnancy. The diet of the mother has been conclusively proved to influence the development and constitution of the child. As the internal secretions influence the history of the food in the body, they affect development in the womb indirectly as well as directly. Certainly, whether or not it is possible to learn how to change the nature of the germplasm within a short time, there are in the endocrines, the

means at hand for affecting the whole individual that is born and sees the light of day.

THE MADRAS MEDICAL COUNCIL.

Review of Work.

(From October 1931 to March 1933.)

By

DR. V. RAMA KAMATH,

Member, Madras Medical Council.

I beg to be excused if I were to reiterate what I said in these columns in December 1931 while reviewing the work of the Medical Council for 2 years from October 1929 to March 1931 that "The Medical Practitioner" came into existence on account of one of the pledges given by me to the electorate when I stood for election to one of the seats in the local medical council early in 1929. It is therefore my duty to keep the readers informed about the proceedings of the meetings of the Council. As the medical council meets only twice in a year in the month of March and October and as the proceedings of meetings are confidential till they are confirmed at the next meeting, it has not been possible for me to make a review of the work earlier than once in two years, as the proceedings of one meeting will be too small a subject for report. In the December issue of 1931 and the January issue of 1932 a review of work of the Madras Medical Council from October 1929 to March 1931 was made and I now attempt to review the work of the council for the 2 years following, i.e., of the 4 meetings held in the months of October 1931, March 1932, October 1932 and March 1933.

Dr. H. Chatterjee, L.M.S., continued to be the Registrar till September 1932 when at the extraordinary meeting of the council held on 20-9-32 Dr. Chatterjee was declared unfit and Major Coshan, who was till then a nominated member of the council, was appointed to act as Registrar in the place of Dr. Chatterjee and at the March meeting of the council in 1933 Major Coshan was confirmed. How this came about will be narrated by me in the course of this article when that item of the proceedings of the medical council will be dealt with. As was done by me on the previous occasion I shall deal with the activities of the medical council for the two years referred to above under five items of duties of the medical council: (1) Medical Registration, (2) upholding the rights and privileges of registered practitioners, (3) exercise disciplinary control over the medical practitioners, (4) control of the medical education both in colleges and schools and (5) conduct elections to the Council.

MEDICAL REGISTRATION.

Section XI of the Medical Registration Act which deals with the subject, making it obligatory on the part of the Registrar to prepare the medical register in the month of January correcting the same up to 31st December preceding, continued to be violated by the Registrar, and the registers for 1931 and 1932 have not been published as yet. The readers might remember my having moved a resolution at the March sessions of the Council in 1930 calling upon the Registrar to explain the delay so far in compiling and publishing the medical registers and that resolution fell through for want of a seconder. It is very unfortunate that the members of the Council including the President did not realise the serious responsibility on their part for such a default nor did the President take the trouble to find out the causes that prevented the Registrar in compiling and publishing the Registers in time every year. I have been receiving complaints from practitioners about the inordinate delay in the matter of their registration. There were instances where practitioners were not registered for two years after their having paid the necessary fees. I did bring to the notice of the President these delays but the Registrar and his clerk managed matters so cleverly and avoided detection. It must be within the experience of all that when sins accumulate and are not atoned for, Providence comes to the rescue. It was so in the case of the sins committed at the office of the Registrar. In 1931 at the October sessions of the Council a complaint from the Chief Medical Officer, the Nizam's State Railway, was the subject of discussion. It was said by the Chief Medical Officer that one of his medi-

It is difficult for a general practitioner to judge an antisyphilitic remedy correctly in an ordinary life time.

cal subordinates had fraudulently got himself registered in the Madras Medical Register. The Council appointed a Committee consisting of Drs. U. Rama Rao, N. Venkataswami Chetty and V. Rama Kamath to investigate the case. At the very first sitting of this Committee it was found out by the Committee that the practitioner alleged to have been fraudulently registered was not in the Medical Register though he possessed a certificate of registration under the signature of the Registrar. In the course of further investigation it was found that the name of the practitioner concerned was not found even in the manuscript register maintained in the office and the manuscript register was found torn and roughly manipulated, many pages being taken out of the book. The Committee brought this matter to the notice of the President who immediately suspended the clerk and later reported the matter to the police. In the meanwhile at the March sessions (1932) of the Council the President brought to the notice of the Council the serious state of affairs at the office of the Registrar and a Committee consisting of Lt. Col. F. J. Anderson and Drs. U. Rama Rao and V. Rama Kamath, was appointed to enquire into the affairs of the Registrar's Office. All the materials so far gathered by me on the reports of the practitioners who wrote to me about the several irregularities at the office of the Registrar were made available to the Commitee and very serious omissions and commissions of criminal nature were detected and it was also thought that the delay in publishing the register was due to the fear of detection of the serious acts committed at the office. During the course of investigation the Government Auditor found that a sum of nearly Rs. 5000 had been defalcated and the clerk of the Registrar's Office who was handed over to the police was charge sheeted for only a small amount of Rs. 45 and odd and was found guilty by the Magistrate who awarded the accused 3 months rigorous imprisonment. He has since been let off on bail and his appeal is pending in the High Court. As the matter being *sub-judice* I refrain from commenting with the purpose of apportioning the blame. The Committee as well as the Government Auditor were of opinion that the Registrar was responsible for the loss of the amount as he delegated his powers to the clerk without the sanction of law. So a side issue in a case which had no bearing for the causes which have been working so as to cause delay in the publication of Registers year after year since 1924, providentially forced the council to investigate the affairs at the office of the Registrar. If the Conncil heeded to consider my resolution in 1930 the Council would not have lost as much as Rs. 5000 or very near the amount and a large section of practitioners would not have suffered on account of the delay in registration.

In spite of what all had happened, matters do not seem to improve at the Registrar's Office. Anticipating lot of troubles to the practitioners on account of the bad regime of the previous Registrar, when valuable records including the manuscript register were found destroyed, I thought it was desirable to forewarn the present Registrar and moved the following two resolutions this year at the March Sessions of the Madras Medical Council:

(1) " Resolved that such of the medical practitioners, who show *proof of their having paid* the required fees for the registration of their names in the Madras Medical Register and whose names do not appear in the published registers, be registered immediately."

(2) "Resolved that a notification be published three times in two English dailies immediately after the publication of the Register for 1932 to draw the attention of those medical practitioners who might have paid the fees and whose names do not appear in the published register, to show proof of their having paid the money required for their registration and immediately after the production of such proof the names of such practitioners be registered in the Madras Medical Register."

The resolutions had the unanimous approval of the Council. In the meanwhile I have been receiving complaints from practitioners regarding the delay in registration. The Registrar to whom I referred these complaints would not inform me about the cause of delay and as the aggrieved practitioners further complained that even the receipt of their complaints were not acknowledged by the present Registrar I was forced to move the following resolutions at the last October sessions of the Council and I am glad to inform the readers that unlike the fate of such resolutions at the session of the Council in March 1930, the resolutions were unanimously passed.

1. "The Council is of opinion that the Registrar should be able to register a

practitioner in the Medical Register within 8 days after the receipt of his application in case all the necessary conditions for such registration are fulfilled by the practitioner."

2. "The Council directs the Registrar to acknowledge in time receipt of communications received by him."

3. "That a Committee consisting of Drs. U. Rama Rau, S. Rangachariar, M. R. Guruswami Mudaliar and the mover of this resolution be appointed to find out the cause of delay in publishing the Medical Register in time and to report to the Council at its next meeting as to what steps should be taken in future to enable the Council to publish the Register within the time fixed in the Medical Registration Act (IV of 1914)."

Without meaning any disrespect to the office of the President it is my sincere conviction that there should be more supervision over the office of the Registrar by the President. This cannot be done as effectively as the circumstances demand as the President in his other capacity as Surgeon-General with the Government of Madras in the midst of his multifarious duties naturally finds little or no time to discharge satisfactorily his duties as the President of the Medical Council.

RIGHTS AND PRIVILEGES OF REGISTERED PRACTITIONERS.

As mentioned by me in these columns in December 1931, the practice of countersigning the medical certificates issued by private practitioners by state paid practitioners was put an end to in 1930 on account of a resolution moved by me and approved by the Council and at the suggestion of the Government of India this practice was stopped in other provinces as well. The readers might also remember as reported by me in 1931 that when the G. O. on the subject was recorded by the Council, I moved a resolution informing the Government that the procedure of taking second opinion on the certificates issued by private practitioners from state paid doctors was also against medical etiquette. As this resolution was not adopted by the Council I moved the following resolution last year at the September sessions of the Council:—

"Resolved that the Council recommends to the Government that all registered practitioners whether in service or in private practice should be treated alike in the matter of issuing certificates for whatever purpose."

Though there was strong opposition from the official members of the Council including the President, the resolution was eventually passed and the order of the Government on this subject is awaited.

The other items of interest dealt with by the Council for two years under review, will be the subject of another article in the next issue of the journal.

(To be continued).

Abstracts

THE INVESTIGATION OF EARLY TUBERCULOSIS.

By

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It has been my instructive privilege now for several years to see chest cases collected at outpatients, to read what their medical attendants thought of them and had made out of their examination, to arrive at my own findings and opinion, and then to review the whole in the light of sputum tests and X-ray films of the best quality, obtainable without trouble as a matter of routine. The experience has been illuminating but by no means entirely flattering, and I have found my ideas on the subject of pulmonary tuberculosis modified out of all recognition. My reliance upon special investigations has steadily risen, owing very largely to the fear of overlooking early tuberculosis and an increasing realisation of the subtlety of its many disguises. However, I have been comforted by the knowledge that my colleagues are no less lavish than myself in the use of X-rays, and I have yet to meet in the flesh that happy man whose consumption of X-rays is declining because he has learned all there is to learn from them and can rely henceforward increasingly on clinical examination alone. It appears in fact that in chest disease radiological expansion still proceeds apace and has not yet reached its peak even after many years of unremitting growth.

It has been forcibly borne in upon me that this process needs hastening by any and every means if the full benefits of the great modern improvements in methods of treat-

It takes years for a venereal expert to judge an antivenereal remedy with precision.

ment and in diagnosis are to be reaped in our time. What is needed, and needed most urgently now more than ever before, is a drastic reduction in the proportion of cases which still arrive too late for anything curative to be done to help them. Those that do arrive early enough are now much better treated than ever before, with a reasonable prospect of complete recovery which was formerly very remote; but there is still too little evidence of change from the time when it was estimated that fully 90 per cent. of all cases arrived too late for collapse therapy to benefit them, which meant that they had already ceased to be even potentially curable. Why failure on such a scale? What are its causes and remedies?

First, at least in time, amongst the causes come the education of the medical student. We probably all recollect most clearly the first few cases of phthisis we were shown and taught to examine; I picture a man of 40 years of age or older whose symptoms were of the grossest, whose chest seemed to have slipped round to the back and in whom examination with a stethoscope revealed obvious physical signs over every square inch of the surface of his chest except at one base behind. At the right apex we may have heard all the interesting gamut of cavitation signs. It was splendid; particularly when we met his counterpart in the examination hall later. We diagnosed him without difficulty and went our ways feeling that we had gained our licence to practice very much upon our merits as physical diagnosticians. Excellent, but utterly misleading in many ways. Such cases we soon discovered were too advanced for any therapeutics to be of value. As our perspective cleared still further we saw how immeasurably such cases are beyond therapeutic reach, that if we are to think of cure at all they are merely the scum of the off-scourings of all tuberculous material. Conversely those of us blessed with the opportunity of routine investigation of all chest material, both probably and improbably tuberculous, have been forced to realise that to reach the material that lies at the opposite end of the scale, the early curable cases, degree upon degree of refinement of method and standard in physicial diagnosis is needed, until the signs, originally so imposing, are whittled away to a few doubtfully constant clicks in one stethoscopic field or a patch of trivial impairment of the very presence of which we are unsure, of the significance less certain still. Even then many cases escape and physical methods of diagnosis break down altogether. With these cases, the earliest, the best, and the most important, we have been driven to reliance upon special investigations as the principal element in diagnosis.

To certain minds there appears to be something derogatory in being forced to admit dependance on special investigations. Truth is not always flattering. Let it be granted that here we are being drawn away from the great tradition of physical diagnosis on which has been founded all the best clinical work until the last few decades. We may be comforted that phthisis is not alone in this predicament but is merely one of a formidable and increasing group of diseases in which the main role in diagnosis is being played by chemical, bacteriological, and radiological evidence. In phthisis radiology must be accorded pride of place without reserve, and it is not without analogy. In fractures of bones as a profession we have had to be taught by the lay public with pain and degradation that X-rays are essential for the satisfactory diagnosis of all minor and some obscure major fractures, and are also essential for all refinements in treatment. And so it is with pulmonary tuberculosis. Are we going to wait for the same rude mentor to teach us the same rude lesson in another sphere?

Certain of the experts have not hastened the learning of this lesson by their writings, in which the value to them of physical examination has been stressed. How great this value may really be is to the ordinary man wholly unimportant, for they have not failed to confess that it was the outcome of special experience which must be reckoned in decades, and is therefore out of the reach of ordinary mortals. But it has tended to inculcate into the profession at large the belief that it is capable of like feats of prowess—a result these authorities would hardly encourage or countenance.

A further cause of limitation in the adequate training of the student has been the wholesale abstraction of tuberculous chest cases from the medical arts of teaching hospitals by the public tuberculosis service

whose influence in this respect has been entirely bad.

Since the physical examination by the average man is quite inadequate to exclude the disease it follows that, if any success is to attend his diagnostic efforts, he must not only make use of special methods but must know when they are appropriate. He fails at present to have his suspicions aroused in an early enough stage of the trouble to apply the investigations in time. This is probably the most difficult of all the problems to solve, for the symptoms of early phthisis are trivial and obscure in many instances to a degree of which at present there is clearly no conception.

To pass on and consider in brief summary each of the four elements which together form the quadruped of diagnosis in relation to curable tuberculosis:—(1) Physical Signs; (2) History and Symptoms; (3) General Impression; (4) Special Investigations.

1.—PHYSICAL SIGNS.

Negative signs are without significance whether for or against the diagnosis. Trifling positive signs are inconclusive except as an absolute indication for full investigation. Percussion changes are of different value in different hands. I know a competent tuberculosis officer who confesses that he percusses because it is expected of him, not because he hopes to gain any information from it. On the other hand some find it valuable. The fact remains that even in late phthisis the percussion changes are slighter than in a comparable stage of any other gross chest disease, and those who can place reliance on slight percussion changes in any high proportion of early cases are anything but numerous, and such changes are not necessarily indicative of tuberculosis nor of accurate localising value. It is agreed that stethoscopic signs may not appear till very late in the disease and hardly ever occur very early. Patches of fine rales, particularly post-tussive rales, in the upper part of the chest, usually at first in front, are very suggestive but not conclusive. It may be a mere apical catarrh or some other non-tuberculous condition, or it may more often be due to advanced tuberculosis. Occurring at the base such signs are usually, but by no means always, non-tuberculous. Investigation is obviously necessary unless some other obvious cause is found (e.g., circulatory failure.) Gross physical signs do not occur in early tuberculosis except when associated with a pleural effusion, or in the rare instances of fulminant massive disease which are seldom curable even though confined to one side. On the other hand, gross signs are occasionally found on one side only in those fortunate cases which are still unilateral though not early. Sometimes rales are heard about the root of the lung on the side opposite to a frankly diseased lung which are not evidence of bilateral disease. Much more often the other lung shows no signs but is slightly or badly diseased nevertheless. Cavitation signs are never early but cavities are often present early. Moreover, signs really due to displacement of the trachea, though not an early event, may easily be mistaken for cavitation. In general it is true to say that the area over which signs are found falls far short of the real distribution of the disease. Other signs are numerous but of no great value. Obvious changes in contour and movement occur late. In their slighter forms they are neither easy to detect with certainty nor to interpret. Palpation usually reveals nothing that cannot be seen, with the common exception of the apex beat, and that is never shifted in early disease uncomplicated, and quite seldom in disease of curable extent. Gross clubbing of the fingers is practically confined to non-tuberculous disease or occasionally to lesions secondarily infected with tubercle, which are not examples of either early or curable tuberculosis. When the diagnosis is revealed by palpation of the epidymes it is usually too late.

2.—HISTORY AND SYMPTOMS.

Whatever may be the current value of other features nothing can or ever will abate the importance of a full and accurate story, from which arises the suspicion which in turn leads to proper investigation. The difficulty here has been only to a limited extent due to failure to appreciate the significance of the history, but because suspicion has been lulled to sleep by the failure to find confirmatory signs in the chest. Failure to find signs is quite inadequate to allay even the mildest of reasonable suspicions. Any of the following features severally demand full investigation.

(i) A bad family history.

Children of tuberculosis parents, brothers and sisters of the phthisical, and to a rather less extent the parents of tuberculous children should be thoroughly investigated with no respect for signs and little for symptoms. I have seen some startling results follow the application of this principle.

(ii) Frequent colds or attacks of "influenza." Even a single attack of influenza with delayed convalescence in a young person should raise suspicion, and backed by the slightest additional evidence warrants investigation.

(iii) Unexplained loss of weight in youth.

(iv) Productive cough. In those over forty it is seldom necessary to do more than test the sputum, but in the young it is essential to investigate thoroughly every cough of any standing.

(v) Dry cough of several weeks' duration unexplained.

(vi) Unexplained pyrexia of two weeks or more duration.

(vii) Unexplained persistent tachycardia in the young.

(viii) Unexplained hoarseness, night-sweats, dyspepsia or anæmia. None of these are distinctively tuberculous, and the two latter at least would suggest a first search in other directions before carrying out full investigation of the chest, but if nothing can be found the chest must be suspected.

(ix) Hæmoptysis, especially, but not only when profuse, and in the young.

(x) Pleurisy, with or without effusion if it endure more than a few days.

In spite of the emphatic statements of all writers it seems still to be necessary to utter special warnings on the subject of the significance of cough, pleurisy, and hæmoptysis in relation to pulmonary tuberculosis. Cough with sputum is, when tuberculous, essentially a feature of comparatively advanced disease whether curable or not. Cough without sputum may occur very early, but it is often slight, it may be ignored by the patient, or fear may induce him to deny it. A history of cough must thus never be relied upon as a necessary accompaniment of early disease. Protracted pleurisy and gross haemoptysis, unless they can be shown to be due to other types of gross disease (aneurysm, mitral stenosis, neoplasm, bronchiectasis, &c.) are tuberculous, and to be dealt with as such. Haemoptysis is seldom ignored by either doctor or patient, but prolonged pleurisy does not receive the equally profound respect that it deserves. I see so many cases in which months or years previously a "diagnosis" of "pleurisy and pneumonia" has been made, followed by no attempt to discover its cause by appropriate investigation of the chest, a high proportion of them advanced consumptives, that I can with difficulty refrain from blasphemy at the mention of it. Circumstances that call for the utterance of this piece of nonsensical jargon should shriek tuberculosis at the least meticulous medical man, and demand the fullest investigation of the chest the moment the illness called by such a name abates.

The list of indications for investigation is formidable, but may be considerably shortened by certain contra-indications. The first is age. In patients over 35 to 40 years of age it is permissible to be less searching, because there is as a rule neither the same urgency for treatment of rapidly advancing disease, nor the same hopeful prospect from the use of collapse therapy. Moreover, sputum tests become more dependable with the passage of years in those cases, a much reduced proportion, in which radical treatment may be of benefit. Apart from those cases in which a satisfactory alternative diagnosis is forthcoming two classes of case offer little prospect in the search for tubercle—those with large hearts from whatever cause or with a distinctly raised blood-pressure or with mitral stenosis, and those with a frank history of winter cough extending over many years. In them it is advisable to test the sputum whenever present, but to go no further unless it proves positive.

(To be continued.)

No new remedy for syphilis should be used till well known experts have pronounced it to be active.

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.

Madura Foot: Intravenous injection of Neo-Arsiphenamine and Mercurochrome (220) weekly and on alternate weeks respectively has cured the disease without any need for amputation (I. M. G.)

Malarial Fever: (Major Gilchrist method) Quinine by mouth should be the routine method for treating Malaria. Concentrated solution of Quinine or tabloids of Bi-hydrochlor of Quinine or any other soluble preparation should not be given on empty stomach. As the absorption of Quinine is slow in intestines no purgative should be given along with Quinine but a preparatory purgative-Calomel followed by a saline purge-should always be given. As a prophylactic Quinine should be given after evening meal. In cerebral and comatose cases Quinine should be given intravenously. the ordinary dose being 7½ grs. of Bi-chloride of Quinine.

In abdominal type of Malaria attended with much vomiting, intramuscular method is preferable. Concentrated solution should not be used as it is likely to cause induration or even abscess. The Quinine should always be dissolved in normal saline and the solution should be warm while injecting.

Paroxysm in Malaria is considered to be an anaphylactoid symptom usually known as 'protein shock,' provoked by the injection of foreign protein and it is due entirely to the acidity of blood. Therefore alkalanising of the blood should be had recourse to. For this purpose Quinine should not be dissolved in mineral acid (Citric acid being used instead) and a preliminary alkaline mixture containing Sodium Bicarb grs. 60, Sodium Citrate grs. 40, dissolved in an ounce of water should be given followed by Quinine Sulph. grs. 10, Acid Citric grs. 10. and water 1 ounce. (I.M.G.)

Of all the alkaloids of Cinchona quinidine is most effective. But Pulv. Cinchona fabrifuge (Indian) is useful for prolonged use. The treatment to be effective, should be continued for at least 31 days. The fabrifuge of Cinchona may be given thus:—

Pulv. Cinchona Fabrifuge, grs. 10; Acid Citric, grs. 20; Mag Sulph. grs. 30; Ext. Glycyrrhizae Liq. 1 dram; Spirit Chloroform mms. 10; Aqua add 1 oz. The mixture to be given during the alkaline stage of digestion after meals. For the first week three times a day and later twice daily.

For algid, cerebral and comatose cases or where on account of vomiting it is not possible to have oral medication, Quinine Hydrobromide 2½ to 7½ grs. may be given intravenously twice in 24 hours. As the injection causes a fall in blood pressure it is always advisable not to give injection when the blood pressure is below 100. In cases having low blood pressure injection of Adrenalin 0. 3 c. c. may be had recourse to. A slight dizziness is experienced at times by the patient but it usually disappears after a few minutes. It is desirable that the patient should be on the recumbent posture soon after injection is given for at least 20 minutes and the solution for intravenous use should be prepared afresh. (I.M.G.)

In children with comatose condition a lime juice bath has beneficial effect. For this purpose hot water should be saturated with lime juice until the water tastes somewhat sour. The child should be immersed in such water for thirty minutes.

Malaria (Intermittant); Methylene Blue 1 to 2 grs. in capsules may be given 7 to 10 hours before the expected paroxysm, in cases where Quinine fails. Nutmeg (a small dose) may be given simultaneously with Methylene Blue to prevent stranguary.

If the chill is severe as to endanger life, Chloroform may be inhaled preceded by Tr. Opii by mouth or bowel or Morphia 1/6th gr. with Atropin 1/60th gr. hypodermically; quinine to be given 2 or 3 times before the expected attack or at the sweating stage. (Hare)

Pernicious Malaria: Quinine should be given intravenously or intramuscularly as there is no use of giving the same orally. 10 to 15 grs. of a suitable salt of Quinine may be used. In the haemeturic type Quinine should not be given and instead

(*Continued on page 67.*)

Temporary effects of arsenic easily counterfeit antisyphilitic effect.

CLINICAL NOTES AND PRACTICAL SUGGESTIONS

On Combining Pancrepatine Treatment with Insulin Injections.

While the majority of ordinary "diabetic" patients are easily treated by efficient doses of Pancrepatine, alone, there are cases which urgently require insulin as well as cases which unexpectedly refuse to respond at first to the oral remedy. In all such cases Insulin is the only other resort at least for the first period of treatment.

It does not follow however that such individuals are condemned to injection treatment for the remainder of their lives.

In nearly all such cases a gradual transition from Insulin to Pancrepatine can be successfully achieved.

Where the blood sugar tests can be carried out the change is perfectly safe and perfectly controllable. All that is necessary where blood tests are being done, is to commence Pancrepatine treatment side by side with the Insulin injections.

As the Pancrepatine begins to take gradual effect the lessened requirements of Insulin will be evident from the blood tests.

In rural practice, and where the patient cannot afford to have blood tests done, the transition from Insulin to Insulin cum Pancrepatine and from this to Pancrepatine alone can be carried out with exactly the same safety as the continuance of Insulin alone.

Where the dosage of Insulin is controlled by urine tests, the control of Insulin cum Pancrepatine can with equal safety be controlled in the same manner.

If daily quantitative tests of glucose can be made, give besides the Insulin say six Pancrepatine pills per day, and after two days reduce the Insulin dosage by about twenty to fifty per cent, and watch the effect for a few days.

If the treatment during the transition stage is so arranged that a small percentage of glucose is detectable in the urine, there can be little danger of over dose of Insulin.

If circumstances are such that reliance must be placed on specific gravity tests for the control of a case then whether the treatment be by Insulin alone or Insulin with Pancrepatine, it is advisable that the sp. gr. should be kept always a little above normal, to reduce the possibility of Insulin over-dose.

Only after the Insulin is entirely displaced by Pancrepatine or under blood test control, can the sp. gr. of the urine be safely allowed to come down to normal.

The rule is to give less Insulin than the amount necessary to keep the urine normal and let Pancrepatine be taken till the sugar begins to disappear when the Insulin dose is at once reduced till a slight reappearance of sugar occurs.

If the disappearance of sugar continues to progress, again reduce the dose of Insulin. If there is no further improvement increase the amount of Pancrepatine up to 12 pills per day if necessary, gradually reducing the Insulin till it is no longer required.

Application of Endocrine substances in Obstetric practice.

Surgical measures have occupied so predominant a place in Obstetric practice that medicinal treatment has received scant attention in it. Modern research in Endocrine therapy has, however, turned the tables and where formerly only the post-pituitary extract was given a place, a host of Endocrine substances have been employed because of their unusual practical value in some of the toxaemias of pregnancy and complications and sequelae of child-birth. Here we will deal with the Pituitary and the Ovary only.

Considering first the Endocrine substance which is pre-eminently used, the Pituitary, we find that it has a wide field of application in Obstetric practice. It is a well-known fact that it cannot be used to induce labour. Provided the os is dilated and there is no disproportion between the pelvis and the foetal head it can be indicated in

1. Insufficiency of labour pains in Primary and Secondary stage of labour.
2. In all cases where formerly forceps was used.
3. Post-partum haemorrhage.
4. Atonic condition of the bladder in pregnancy.

5. Post-Partum atony of the intestines.
6. Asphyxia of the new-born.
7. Osteo-malacia.

Now the pituitary preparation that can be used with confidence in all these indications is Opocrin Pituitary. The use of this Opocrin has been tried with success by various obstetric physicians. One ampoule of this preparation has been injected during the second stage of labour. The contractions are accelerated and delivery is readily effected. This is due to the fact that Opocrin Pituitary, after injection, circulates in the blood and sufficiently and effectively tonicizes the uterine muscles and brings about normal uterine contractions in this manner.

Although the controversy about the advisability of Opocrin Pituitary injection in the third stage of labour is raging, still the prophylactic doses of this preparation have given good results. Opocrin Pituitary injection is justified as a prophylactic as it is possible to avoid atony by it. Intravenous injection of this preparation in this stage of labour is always effective in producing contractions of the uterus. The third stage of labour is greatly shortened. The expulsion of the placenta takes place immediately and the loss of blood is significantly reduced.

The application of Opocrin Pituitary has almost done away with the necessity of the employment of forceps at least in 50% of cases. It should be regarded now as a general rule that as soon as one finds that a forcep is necessary, one should inject at once an ampoule of Opocrin Pituitary, if the os uteri is dilated, if the head of the foetus rests on the pelvic floor, if there is no marked contra-indication present in the general condition of the mother and if the delivery is to be hastened because of some imminent danger either to mother or child. The use of the forceps is thus reduced in more than half the cases and even in those cases where forceps must needs be applied Opocrin Pituitary has to a certain extent helped the birth. The main advantage offered by this therapy is that it absolutely excludes injuries both to mother and child if proper indications and adequate dosages are followed.

Insufficiency of labour pains, either primary or secondary which are usually met with after the reposition of the prolapsed umbilical cord or which follow artificial rupture of the membranes in Placenta Praevia or which are seen when the head is large and pelvis contracted is another province in which the application of Opocrin Pituitary helps a great deal. In such cases if os uteri is dilated and the head is on the Pelvic floor, intramuscular injection of Opocrin Pituitary is advisable as it produces proper contractions and brings about an easy delivery. In these conditions intravenous injections of this product are not recommended as it has rather a too rapid action on the uterus which is not at all advisable. It has been observed that in 80% of cases complete success has been attained. If the effect of one injection ceases, say, generally after approximately an hour, another injection should be repeated. There are only a few contra-indications to the exhibition of this treatment viz., high blood-pressure, rigidity of the cervix and threatened uterine rupture.

The use of Opocrin Pituitary in cases of post-partum haemorrhages is of great advantage particularly if no Pituitary product has been given during parturition. It has a salutary effect in checking haemorrhage because of the contracting effect of this preparation on blood-vessels.

The atonic condition of the bladder either in pregnancy or after delivery can be easily removed by one or two injections of Opocrin Pituitary. The tone of the organ is soon restored and thus the urine passes freely. We meet with various atonic bladder disturbances during pregnancy and at times it becomes overstretched due to the retroflexion of the uterus. Considerable success can be obtained in restoring these conditions to normal by means of Opocrin Pituitary injections.

The usefulness of this Opocrin in post-partum paralysis of the intestine has been experienced in the majority of cases. The bowel tone is once more brought to normal and their peristaltic movements are soon effected. These effects are accomplished even in some cases with peritonitis.

* For any information adverted to in the columns of this journal apply to : The Medical Practitioners' Service Bureau, Vepery, Madras, with stamps for reply.

Another indication in which the application of Opocrin Pituitary has been found useful is the asphyxia of the new-born. If the lungs and the bronchi are not filled with mucus this asphyxia can be controlled by one or at the most two injections of this product.

Another severe complication of pregnancy in which this antagonistic action of the ovary and the pituitary is clearly manifested is Osteomalacia. In this disease the activity of the ovary is greatly increased. This is accompanied by dilatation of the vessels of the bone-marrow. This vaso-dilatation results in a passive hyperaemia which leads to resorption of the bones. This is in brief the pathology of the disease. Taking the basis of this theory we can at once say that castration is the best method of treatment, but this is rather too radical a method to be tried in each and every case as it means complete abolition of the ovarian function, which is an irreparable action. This treatment, therefore, can be reserved only for the most severe cases and for women who have already borne many children. Opocorin Suprarenal injections have given good results in such cases. However Opocrin Pituitary therapy has proved much more beneficial than any of the treatment hitherto applied. It is truly a specific and useful means of treatment.

It has become clearly evident that the risks and disadvantages of the surgical treatment have been done away with by this Opocrin Pituitary. There are very few still-births and vaginal or perineal tears influenced by the use of this Opocrin. There are again no intracranial haemorrhages due to this method of treatment. Unless wrongly indicated there are no tetanic contractions due to these injections.

Turning to the other Opocrin, Opocrin Ovary, let us examine its value in this practice. Every practitioner is aware of the great assistance that the ovarian substance offers in the complaints of pregnancy. Its beneficial use has been particularly stressed in the dangers of Eclampsia as well as Hyperemesis Gravidarum. It has been demonstrated that these two latter complaints are the result of the overactivity of the adrenal-pituitary system in this condition. This increased activity stimulates the sympathetic system. The action of the Ovary, on the other hand, inhibits the activity of the sympathetic system. So we see that the ovarian substance compensates for the hyperfunction of the Pituitary and the Suprarenal. A suitable product for effecting this result is Opocrin Ovary.

In Eclampsia the Opocrin Ovary acts as a good sedative to the fits. It suppresses the vascular spasms and lowers the blood-pressure. All these increased activities are due to excessive function of the Pituitary and Suprarenal to which the ovarian substance acts as an antagonist.

It is the sympathetic system on which the closure of the pylorus depends. In Hyperemesis because of the stimulation of this system the pylorus remains closed and hence the troublesome vomiting. The Opocrin Ovary compensates for the over-activity of the pituitary and the suprarenal and makes the closure of the pylorus impossible and thus the normal evacuation of the stomach into the intestine is easily effected.

This Opocrin Ovary is the most certain and dependable product in the above indications. It does not lose its specifically active substance during the manufacturing process and hence its action is more exact and its effects more specific.

Effective treatment of Diabetes with an oral product..

Despite modern advances in the pathology of Diabetes Mellitus we have not been able so far to discover the ultimate cause or causes of the condition. That in this disease there exists pancreatitis with fibrous tissue spread everywhere in the organ, specially in the Islets of Langerhans is true; but how these changes are brought about is a great perplexing problem of Diabetes. Many pathologists put forward heredity, obesity, overfeeding, infection, some nervous conditions as causes but these can only be suitable soil in which the seeds of Diabetes can grow abundantly. Again the various degenerative changes seen in the pancreas are only the result and not the cause of the disease. Some pathologi[illegible] the retention of the pancreatic secretion may be responsible for the inflammation, which in turn may cause the diabetic condition, while

there are others who observe that there is disturbance of the digestive enzymes as well as the internal secretions. Again there are several who argue that the whole pancreas is defective, and therefore any factor which injures it or puts it out of order may cause the disease.

Whatever may be the cause and the pathology of the disease it is true that there is a certain amount of alimentary toxaemia and consequent functional disturbance on account of which the organism is incapable of oxidising glucose which accumulates in the blood and passes into the urine. There is simultaneously a gradual decrease in the amount of Glycogen usually found in the liver.

It is therefore essential in treating diabetic cases to bring about and control the oxidation of sugar and the storage of Glycogen in the liver. The treatment should be so adjusted that in oxidising sugar and in reducing the amount of carbohydrates the normal metabolism of fats should not be upset, and at the same time the carbohydrates that are taken in should be properly utilised. Most diabetics have a pancreas which is not wholly damaged and there is at least a small amount of internal secretion of the organ which is just sufficient to utilise the carbohydrates. This is what saves the patients from acidosis. From this we can see that the internal secretion of the pancreas, however small in quantity, enables the diabetic to metabolise the carbohydrates and this is quite essential to bring about oxidation of fats. Diabetes Mellitus is not only a simple defect of sugar oxidation due to insufficiency of the internal secretion of the pancreas but a disease of metabolism in which there is not only defective utilization of Carbohydrates but also of fats and proteins. Our object in treating the condition should therefore be, to reduce the blood-sugar, and promote regeneration of the pancreatic tissues. To meet all these requirements of therapy we must have a preparation in which are embodied all the active principles of the pancreas which influence the various stages of carbohydrate metabolism, and which influence the various deficient digestive enzymes. But this also is not enough. Another gland of great importance viz. the liver is necessary because in Diabetes there is always some structural disturbance of this organ which converts glycogen into blood-sugar. In order to overcome this hepatic incompetency and to prevent rapid conversion it is essential to add hepatic extracts to such a preparation. To carry out such an adequate treatment of Diabetes we must have in addition to the entire pancreatic hormone, complex hepatic extracts. This beautiful combination can be found in Pancrepatine.

Pancrepatine contains all the active principles of the pancreas, as the extract of the whole gland is incorporated in it, as also the hepatic extracts. The preparation is in opocrin form with a special coating of vegetable gluten which prevents any action of the digestive processes in the stomach, but when it enters the intestines it is immediately split up and absorbed. The composition of this preparation is based on the recent researches in the pathology of this disease, and the reliable and powerful extracts of fresh glands contained in it help to rapidly correct the various organic defects that contribute to the causation of the disease.

The extract of the whole of the fresh gland, pancreas, is included in Pancrepatine because it has now been found out that in Diabetes Mellitus it is not only the insulin activity of the gland that is deficient but there are other functional defects of the organ which need correction. The several active principles involved in this gland remedy the functional disorders and restore the normal secretions of the pancreas and thus establish normal metabolism concerned with the gland usually found in health. With the restoration of the internal as well as the external secretory activity of the pancreas, there is an adequate supply of certain enzymes which in turn bring about normal digestion and absorption.

Another gland whose secretions are found equally essential for controlling the oxidation of sugar and proper storage of glycogen in the liver, is the liver itself, whose extracts are found in Pancrepatine. These extracts provide the anti-glycogenolytic principle which successfully overcomes the transformation of Glycogen into blood-sugar and maintains the adequate quantity of Glycogen

in the liver. In Diabetes there is always a certain amount of alimentary toxaemia accompanied by other functional disturbances of the digestive system, which results in improper oxidation of sugar and this accumulates in the blood and passes into the urine. The liver extracts in this preparation act as excellent antiseptics and by supplying bile and other internal secretions correct all the functional disorders connected with the alimentary system. Oxidation of Glucose, formation and storage of Glycogen, digestion and absorption of food and utilization of carbohydrates, fats and proteins—all these are made to function normally by means of these extracts.

Pancrepatine, as we have seen from the foregoing remarks, contains all the substances which directly influence all the affected processes of metabolism met with in Diabetes Mellitus. It does not merely reduce the blood-sugar but it helps to correct all the defective phases of metabolism, digestion and absorption, and also exerts a regenerating effect on the injured pancreas.

It is because Pancrepatine represents the whole pancreas that it is effective in this disease. Insulin, the usual specific remedy, does not represent the entire pancreas and it is therefore unable to control polyuria and other diabetic symptoms, although it may help the sugar to disappear from the urine. It is also not possible to maintain normal nutrition with it. Something more from the pancreas besides Insulin is essential for keeping up the normal metabolism. This may be either some digestive ferment or some other internal secretion. There may be also some other substances in the Pancreas in addition to Insulin which influence carbohydrate metabolism. It has been shown experimentally as well as clinically that oral administration of a carefully prepared pancreatic product is more valuable than Insulin injections, and the addition of liver extract probably secures for it other elements for the maintenance of normal metabolism. We know that there is a marked alteration in the external secretory activity of the pancreas and the liver in Diabetes Mellitus. These facts must be taken into account during treatment. Hence the application of Pancrepatine, in which are incorporated the active principles of both the glands, is quite obvious. It is easily absorbed when given orally, it effectively lowers blood-sugar, increases glycogen storage and combustion of sugar. It offers therefore the most in the therapy of this disease.

Insulin is considered to be at the present moment the specific remedy for this disease, but as it shows some imperfections and as this treatment alone is not enough the profession has naturally taken to Pancrepatine which is safer and absolutely non-toxic. While Insulin has a transient action and requires to be administered under the skin or into the vein, Pancrepatine is permanent in its effects and can be given orally. It does not treat the symptoms but attacks the disease at its very roots and consequently the results are lasting. Its administration is easy and free of all dangers. Again, Pancrepatine represents a well-balanced and a fixed quantity of the extracts of Pancreas and Liver which are capable of prolonged biological influence. It effectively replaces disagreeable injections. Constant medical attendance is unnecessary in Pancrepatine regime as it need not be dosed individually as the reduction of sugar is fairly regular. It is perfectly harmless and can be taken continually without running any risks of harmful complications. The functions of the stomach are not affected by it.

In brief, Pancrepatine has become at present the treatment of choice for Diabetes. It aids the process of regeneration of the diseased pancreas. It is harmless, non-toxic and free from dangers. It rapidly causes the disappearance of sugar from the urine, abolishes glycosuria without causing hypoglycemia. With the regeneration of the pancreas and the restoration of the hepatic competency, normal digestion and absorption is established, the defective metabolism is brought to normal, the disease is rooted out and the general health and the mental activity is improved beyond expectations.

Some interesting case reports.

1. P. S. a young clerk came to me for treatment complaining of easy fatigue and exhaustion and also impotence. On examination I found that there was nothing irregular so far as his constitution was concerned, and there was absolutely no history of any specific disease. I could however

elicit from him that he had suffered from chronic colitis two years back and since then he had not felt quite fit. After complete examination I could come to the conclusion that it was a case of Neurasthenia and the impotence that he complained of was only psychical, as his sexual organs were quite normal anatomically and physiologically. The irritable weakness of the nervous system coupled with the inability to perform the sexual act contributed to demoralise him to a great extent. He felt very much downcast and depressed and his general condition became gradually and continually worse. He had taken all sorts of patent medicines for impotency as advertised in the lay papers, but so far no tangible results were obtained from them. I kept him on Hypercytol-Homovir treatment, the injections of which were given in the muscles and the skin respectively on alternate days. After 12 injections of each some positive results in his condition were clearly visible. He began to get regular sleep, he was able to do his daily work to his entire satisfaction, his appetite improved and his general condition was much better. After a week's interval of complete rest in which no treatment was given, the same injections were repeated, Hypercytol and Homovir alternately. After a series of another 12 injections of each the feeling of nervous debility and depression was overcome and he was capable of having sexual intercourse. Another week's rest followed by a course of 12 injections of each made him absolutely all right. All the nervous manifestations such as irritability, insomnia and lack of concentration all disappeared and he was once more his normal self. Homovir tablets were however continued for about two months as a precautionary measure.

2. The patient was a young man of thirty who was off and on troubled by severe headache and profuse nasal discharge for the last two years. He said that he got these attacks particularly when he was exhausted and tired. Headache was specially felt more above the eye-brows and this area would soon begin to be swollen and to throb violently. The headache lasted sometimes for the whole night and sometimes continued in the morning also, or at times it would last from 10 to 12 hours. Simultaneously there would be profuse mucopurulent discharge from the nose which would trouble him for two to three days. This complaint was so very troublesome that he was absolutely tired of life. These attacks had recently become so very frequent that he was very much disgusted. Examination of the eyes and the ears showed that the vision and hearing were quite normal. Suspecting Sinusitis transillumination was done by a specialist who declared that all the accessary sinuses were not in any way diseased. Another specialist considered it to be Hypertrophic Rhinitis and the whole affected portion was accordingly cauterised. No improvement followed this procedure. Later on the inferior turbinate bone which was supposed to cause the trouble was scraped several times. No good resulted from this also. When I began my treatment I did not give him, being myself sceptic, much hope of a cure but I told him that I would try certain injections if he agreed to take them. Examination of the nostrils revealed congestion of the mucous membrane in both, but no ulceration or any other abnormality. I thought of having recourse to Pharmasol Collo Calcium injections from which I thought he would derive some benefit. Accordingly I gave him 1 c. c. of the Pharmasol twice weekly in the veins. Besides this I prescribed the oral preparation, two teaspoonfuls of which he was taking twice daily. He was given Cryogenine tablets two of which he was advised to take with hot water whenever the headaches became troublesome. After nearly three months of this treatment with occasional intervals of rest the attacks of Rhinitis as well as of headache became gradually less frequent until they were absolutely rare. The intravenous injections were given after this only once a week (2 c.c.). This treatment was continued for three months more. During the first month he had occasional attacks both of Rhinitis and headache though in a mild form, but the latter two months were quite free from the attacks. Later on the injections were stopped and he was taking only the oral preparation. At present, that is, after nearly six months there is no trace either of Rhinitis or headache and he is thoroughly enjoying his life and attending

to his work regularly. The results obtained with Pharmasol Collo Calcium were really unique but it must however be noted that unless the treatment is steadily pursued and persisted in, one should not expect much good out of it. If a suitable patient of the type that I had is available, it is worth while trying this treatment which I am sure will yield splendid results.

3. A young married lady came to consult me for vomiting, which, she said, would not yield to any medicines. On examination and enquiry I found out that it was a case of Hyperemesis Gravidarum. The lady informed me that she was unable to retain anything not even water for the last eight days. The smell of certain kinds of foodstuffs caused so much nausea, retching and vomitting that it was really beyond endurance. Soda-Bi-Carb, cerium oxalate and other alkaline treatments were given in vain. Even Bromides with Cocaine-Hydrochloride (1/8 gr. doses) had no effect. Luminal was tried with no good results. After this Sodium Bromide with Chloral Hydras in milk and water was administered in the form of an enema but that too proved unavailing. At last it occurred to me that I should try some ovarian product and Ovaro-Pituitary Opocrins were then administered. She took eight of these daily and the result surpassed all my expectations. The next day she told me she was infinitely better and there was only occasional vomitting. She was able to take some liquid nourishment which she could not retain for the last eight days. The same Opocrins in the same dosages were continued for two more days at the end of which she was quite all right. There was not even a trace of the slightest nausea. She was able to retain and digest everything that she took and she felt absolutely all right. After this I advised her to take Pulmo Calcium which she is taking regularly. This was done because of the usual shortage of Calcium during pregnancy, the reason being that the foetus has to be supplied with a large quantity of Calcium by the maternal organism.

Resistant Cases.

Ehrlich's Warning.

Over twenty years ago Professor Ehrlich, the inventor of 606 even while he still hoped for "The Great Sterilisation" warned us of the fact that the Treponema Pallida and other parasites of that tribe could become immune to arsenical compounds.

In spite of this warning, repeated and confirmed many times since, it has been the rule rather than the exception to leave incompletely cured such cases of Syphilis as come up for treatment.

When a patient wants an injection of 606, he gets it, and goes his way. Innumerable strains of more or less arsenic-resistant treponema must have been produced and so we get cases of Syphilis more or less resistant to arsenical treatment.

There are no cases of active Syphilis resistant to Benzo Bismuth.

There are up to now no signs of any bismuth-resistant strains of Treponema Pallida capable of surviving an attack by means of Benzo Bismuth.

The only difficulties in treating by bismuth are those of distribution and of toxic symptoms.

The distribution obtained with Benzo Bismuth is the best for all Bismuths because it is soluble, and the toxic symptoms are found to be negligible by all who are experienced in this form of Bismuth Medication.

Unique Experiences with Septicemine.

The main postulates for an ideal internal antiseptic are that it must be sufficiently powerful in the presence of serum, it must not be too irritating to the tissues and it must stimulate the granulating process. Judging from this standard, Septicemine, an ideal combination of Iodine and Formaldehyde, can be considered the best as it complies with these essentials remarkably well. It is very active in the presence of a serum. It does not inhibit phagocytosis and its intravenous administration is well tolerated. It is therefore a unique remedy for combating all septic conditions.

The following two typical cases are good evidences of the efficacy of Septicemine :

A lady, approximately 30, came to me complaining of fever with rigors, headache, vomiting and diarrhoea. The fever was 103.4°. Diagnosing it as Malaria I gave her a diaphoretic and Quiniue mixture. Next morning there was no fever and the lady was quite free from pains etc. but in the evening the temperature again rose to 103.7° with rigors, and she had terrible pains in the joints, specially the knee. Having thought this to be nothing but Malarial infection I went on pushing Quinine in larger doses, but the fever did not respond to this therapy at all. Later when the temperature became constantly high I had to send the blood for examination, which showed a little leukopenia, about 8000 leukocytes. There was at this time intense pain in the head and in the muscles of the neck, back and limbs. Rigidity of the muscles of the neck, and intense pain on slight movement of the head aroused my suspicions about Meningitis and a pathologist was consulted. He made cultural studies of the miningeal fluid, which revealed the presence of intracellular diplococci. The anxious expression, dulled mental condition, spastic muscles of the nape of the neck, petechial eruption on the extremities, thorax and abdomen—all these together with the laboratory findings confirmed my suspicions. The heart on auscultation was found to be rapid, the pulse being 130 per minute. The urine was scanty and contained a trace of albumin. Besides anti-meningococcal serum and the usual diaphoretics with Bromides and Salines, ice to the head, mouth washes, oral hygiene and wet cupping etc. Septicemine was given intravenously twice daily. Three days of this treatment was sufficient to bring down the temperature. The patient remained afebrile after that, and passed into the convalescent stage which proved of short duration.

2. Another case successfully treated with Septicemine was that of a boy 16 years old. He used to have fever every evening with rigors. I thought it to be a case of Malaria and gave him the usual Quinine mixture. This continued for fourteen days, but the fever would not come down despite large doses of Quinine. After this red spots on his forearms and the trunk were noticed. I suspected Enteric fever, but the pulse was very rapid and the Widal was also negative. I gave him a diaphoretic mixture and Urotropine powders. Two days of this treatment produced no signs of improvement but in addition to all the other symptoms he developed stiffness of the neck and on examination I found Kernig's sign quite positive. The red spots became a little bigger. The blood-picture according to the pathologist who was consulted, was leukocytes 14760, immature forms 1 per cent, lymphocytes 10 per cent, non-segmented nuclei 30 per cent, segmented 45 per cent and monocytes 3 per cent. Meningococci were found in blood culture. In spite of the usual mixtures and anti-meningococcal serum the fever continued with increase of rash, more stiffness of the neck and all other symptoms more or less exaggerated. After this Septicemine was added to the regime and was given twice a day intravenously. Two days later the fever came down to 100.6° with distinct amelioration of symptoms. A day later the temperature was 99.2° and the disappearance of the stiffness of the neck was quite marked. The Kernig's sign could no longer be demonstrated. The next day the temperature came down to 97.4°. The patient now entered the convalescent stage, which was speedy and uneventful.

The clinical symptoms of both these cases agree with those of Meningitis. It is well-known that prognosis in attacks of Meningitis is usually unfavourable. Autogenous vaccines have been tried with doubtful results. Anti-meningococcal serums have been given occasionally with success, but in many cases they have failed ; but distinct success has been attained when together with the serum, Septicemine has been given intravenously. The more severe the case the more the number of injections that are necessary every day, no matter how high the pyrexia may be. The majority of cases have been successfully treated when this addition is made to the customary treatment.

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(Continued from page 66.)

Sodium Thiosulphate in 60 gr. doses may be given 3 or 4 times a day until the bowels move freely. To control vomiting and retching Morphia with Atropin is good.

Malaria (Remittent): Quinine to be given in 5 gr. doses every four hours preceded by a purgative of Calomel (Calomel and saline purge) and in case the vomiting is severe Quinine should be given intravenously. In this type, urticarial rash usually appear all over the body. Adrenalin and Spleen Extract is highly spoken of in these cases and so also Stibenyl.

Malaria with Enlarged Spleen: Injection of Adrenalin reduces the size of spleen within 5 to 10 minutes and drives the malarial parasites to the peripheral circulation. It is better to give Adrenalin only after a few days of the administration of Quinine and then stop, not using it more than 4 or 5 times.

Berberin and its salts are said to be good in cases of malaria with enlargement of spleen. It is to be given in wafers or in water with Quinine and Iron. (J.A.M.A.)

Plasmochin may be given when Quinine fails, either alone or with Quinine. This preparation may be given intramuscularly also. It is good also for reducing the size of the spleen and it is the only remedy to kill gametocytes, and thus prevent mosquito infection.

Quinarsine (A.F.D.) is another valuable preparation for the treatment of Malaria. It causes rapid disappearance of gametocytes from the blood. It can be had also in the form of pills for oral use.

Atebrin controls fever, brings about the disappearance of the asexual form of the parasite but has no action on P. Falciparum. (I.M.G.)

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

Sodium Nitrite in High Blood Pressure.

(From THE LANCET, London: September 16, 1933).

Inasmuch as the kidney function is impaired in some patients with raised blood pressure, either as a primary or secondary event, it is important to know what effect, if any, drugs used with the object of reducing pressure will have on this function. S. Weiss and L. B. Ellis have noted the effect of sodium nitrite on cardiovascular and renal function in normal people, in essential hypertension with and without renal involvement, in glomerulonephritis, and in patients from whom one kidney had been removed. They first studied the symptoms produced by large doses (3 to 5 grains), and found the commonest to be headache, weakness, giddiness, and faintness, the latter verging on unconsciousness in extreme cases. However, severe symptoms were seen in only about one-sixth of the patients. The heart-rate was usually increased by a few beats per minute, but the minute volume output of blood remained practically unaffected. The reduction of blood pressure with sodium nitrite was found to be greater in the hypertensive than in the normal individuals, although when expressed as a percentage of the initial pressure the drop was about the same in both. The reduced pressure was maintained rather longer in the hypertensive patients, though even in them it did not exceed two hours. The fall involved the systolic to a much greater degree than the diastolic pressure ; it averaged 35 mm. Hg. in the hypertensive cases, but occasionally the reduction was very great, for example, from 240 to 80 mm., such a fall being usually though not invariably associated with pronounced symptoms. The effects of the nitrite on renal function were the same in all groups of patients. Studied with the urea-clearance test—i. e., output of urine per minute multiplied by the ratio urine-urea concentration/blood-urea concentration—this function was never found to be improved after exhibition of the drug ; it was either decreased or more commonly unaffected.

The conclusion reached from the investigations that sodium nitrite lowers blood pressure by a direct action on the smooth muscle of the larger arteries was based on the unchanged cardiac output, the relative stability of the diastolic pressure, and the absence of flushing of the skin; the last two observations are arguments against a dilatation of the smaller arteries, arterioles, and capillaries. Severe symptoms are explained by supposed selective action of the drug on different vascular areas, e. g., fainting in a patient in whom splanchnic arteriolar dilatation is relatively pronounced, while the cerebral blood flow is impaired from a lack of corresponding arteriolar relaxation. This selective action is attributed to physiological differences in the tissues concerned, but in diseased conditions another factor may operate to cause variable responses—namely, local vascular degeneration. In view of the inconsistancy and short duration of its action, its failure to dilate arterioles, and a tendency to produce unpleasant symptoms, the authors consider sodium nitrite to be unsuitable for the treatment of high pressure cases. Moreover, since it may diminish renal function, its use in any case with damaged kidneys is held to be irrational.

Raw Apple Diet in the Treatment of Diarrhea.

BY

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A number of German physicians have published papers on the raw apple diet in the treatment of diarrheal conditions in children during the past three years, and all have reported favorable results.

The treatment consists of a diet solely of scraped or grated raw apple. Fully ripe and mellow fruit should be used. It is peeled and cored, then scraped or grated to a pulp. The child is given from one to four tablespoonfuls or more of this pulp every two hours, depending upon the age.

In 70 patients, ranging in age from nine months to eleven and one-half years, an average of thirty tablespoonfuls were administered daily for two days. Sometimes sugar was added because the child objected to the sour taste. Nothing should be given besides the apple unless the patient craves liquids or is toxemic. In those conditions, weak black tea is allowed in small amounts. If the apple alone is refused, it is possible to mix it with banana pulp (which makes it more palatable) and obtain favorable results. Treatment should be instituted as soon as possible after the onset of symptoms.

After forty-eight hours of apple therapy, the patient is given a transitional diet as follows: 7:30 a.m., cooked cereal (without milk), toast, cocoa, 1 cupful (made of water); 12:00 noon, soup with rice, potato gruel, scraped beef, toast; 3:00 p.m., toast and tea; 6:00 p.m., cereal (without milk) or cottage cheese, toast, banana, cocoa (made of water).

The child is kept on this diet for forty-eight hours, and then gradually returned to his normal diet. Milk is the next item added, then vegetables, and the fruits last.

The types of diarrhea observed were as follows: Thirty-eight (38) patients had enteritis; 20 had parenteral dyspepsia; 7 had dyspepsia of dietetic origin; and 5 had sub-acute colitis. The predominating symptoms were fever, frequent loose stools, abdominal pain, toxicosis and convulsions. The highest temperature in any one case was 106 °F; the greatest number of stools in any case was 32 in twenty-four hours. The average temperature was 102 °F. (rectal) or less. The average number of stools was from 7 to 12.

The results of treatment were; The temperature was reduced to normal, on the average, in from thirty-six to seventy-two hours; formed stools appeared in twenty-four hours or less, on the average, in all cases; the number of stools per twenty-four hours decreased rapidly; in the older children, on whose statements one could rely, abdominal pain was not increased by the diet and usually disappeared rapidly; relapses rarely occurred.

The action of the apple pulp involves a number of mechanical, physiologic and chemical principles. The inhibition of intestinal peristalsis acts in part for its prompt effect. Of marked importance are its maintenance of nutritional requirements and its power of preventing serious loss of water.

(*Am. J. Dis. Child., Jan., 1933.*)

Even some experts have fancied (for a year) that Cacodylate of soda was effective against syphilis.

News and Comments.

New Year Greetings:—When we sent our Greetings last year to our readers, the important topic that concerned the medical profession as a whole in India was the Indian Medical Council Bill. We appealed to the profession to put forth an united front and convince the leaders in the Legislative Assembly that the Bill should either be voted down or should be amended to suit the Indian conditions. The medical profession did its part of the duty most honourably but the majority of the people's representatives in the Legislative Assembly betrayed their weaknesses in being a party for the passing of the Bill which with certain modifications has since been entered in the Statute Book. The formation of the All India Medical Council will be the subject of importance to the profession early this year. Though the medical profession did meet with great disappointment with regard to the passing of the Bill there are still opportunities open in variety of ways during the formation and working of the Indian Medical Council which should be taken advantage of and a measure which the Government got passed, should be made use of for bringing about necessary reforms in the medical education in this country with the purpose of not only bringing into existence up-to-date scientific practitioners to look after the welfare of the people but also for putting an end to the caste system now prevailing in the profession, and which has been hampering the growth of the independent medical profession. We trust that though due to inherent defect in the medical administration in this country, the majority of members constituting the Indian Medical Council will be Government officials, they will be Indians. In addition to three members to be nominated by the central Government each provincial Government has to nominate one from their respective provinces. All the Indian Universities have to elect one from amongst the members of the medical Faculty and the registered practitioners holding Indian University qualifications and other qualifications recognised by the Act are to elect one from each province. The total number of members constituting the Council is not mentioned in the Act and will perhaps be known after the actual constitution of the Council. One of the chief objections to the Bill was that the Council would not be a democratic body but would consist of a large majority of Government servants and hence will be virtually an official body. We wish the Indian official members of the profession realise that amongst the many other compartments, two compartments—official and non-official—now existing in the profession are as artificial as they are temporary. The moment the official doctor retires from service he automatically enters the non-official compartment and so their interests as professional men are identical with those in private practice. In addition to the Government nominated members almost all the members that will be returned by the Indian Universities will be Government officials. It has been so in Madras Province where the Madras and Andhra Universities have returned two Government medical officers. It cannot be otherwise in other Universities. There is only one seat in each province which could be contested by a non-official member of the profession. The official section in the medical profession have now a splendid opportunity to show a gesture to their non-official brethren in the profession and bring about better feelings and with it harmony in the medical profession by not contesting this seat. It is painful that a few prominent members of the provincial medical service in Madras did try to set up a rival but were frustrated in their attempt—we should say providentially—on account of the nomination paper of the candidate not reaching the office of the returning officer in time. We earnestly hope that the Government officials in other provinces will not put one amongst them as a candidate for election for this seat. The section of the medical profession which has been grievously hit on account of Indian Medical Council Act are the medical licentiates and we appeal to all the voters both in Madras province and other provinces to choose one from amongst the non-officials, who sympathises with the legitimate aspirations of this class of medical practitioners and get their gratitude. There should be at least a few in the newly constituted council to uphold the cause of the licentiates when matters concerning them are likely to be the subject for discussion in the Council. The medical licentiates though themselves are not voters can surely work out the way for their sympathisers to the seat referred to above, by canvassing votes for such candidates.

We hope and trust that the election will be fought on principles and not on personal grounds. This is a momentous occasion for the members of the profession to express their fellowship and bring into existence a medical council which will function for the common interest of the medical fraternity as a whole and not any special section of it. Though the Government of the land did not mind the interests of a section of the members of the medical profession who have been rendering them ideal service in war and peace, we trust the Indian medical profession which will be represented in the Indian Medical Council would by the end of one year of its existence show inclinations to bring about necessary reforms in the constitution of the Council to make it useful to the medical profession as a whole.

While wishing our readers a happy New Year, we pray Almighty to guide the members of the newly constituted Medical Council to bring about peace and harmony in the medical profession in this country though the Indian Medical Council Act was passed for quite a different purpose.

Future of the I. M. S.—Elsewhere in our Correspondence columns is published an abstract from the memorandum presented to the sub-committee of the Round Table Conference by the Council of the British Medical Association, indicating the apprehensions of the Association regarding the future of the Indian Medical Service in case the proposal of the sub-committee that the Civil branch of Indian Medical Service should cease, is to be given effect to. On the cessation of the civil branch, the sub-committee had suggested a new method of recruitment by the Provincial Governments to provide for a war reserve and for attendance on British officials and their families. The method suggested is to recruit British practitioners on contract basis as members of the respective Provincial Medical Services.

The conclusions reached by the Council of British Medical Association are as imaginary as they are unfounded. The argument put forth by the council that a military reserve of British Medical Practitioners would not be available is absurd. Mention has been made in the sub-committee's report that the new method of recruitment contemplates a war reserve also and the Council of British Medical Association did refer to this war reserve in the body of the memorandum submitted by them to the sub-committee. The fact that there would not be adequate medical attendance on British Officers and their families savours of selfishness which is against high and noble ideals, of the medical profession. The medical profession is considered to be the most noblest—if we could use a double superlative degree—and the council of the British Medical Association are likely to be looked down upon by the whole medical fraternity for their having given expression to a sentiment which should not be countenanced at all. There should not be feelings on commercial basis in the medical profession and if they do exist amongst the patients it is the duty of the profession to treat such sentiments as a disease and prevent this disease instead of trying to spread it especially at a time when all possible efforts should be made by all good thinking people to bring about good relationship and harmony between England and India. The plea that there should be a due proportion of British personnel in medical administration, research, public health and teaching, does not speak well of an Association which has a good record for the scientific advancement of medicine. Whatever might be the arguments adduced for communal representation in other departments of public service, it is preposterous to conceive of such representation in medical services where the aim should be to have the best man, as this department is concerned only with human lives. This very argument may be used against importing outsiders in India as the Indian nation does not get the benefit of the experience gained by the outsiders in medical service which they did at the cost of India, after these officers retire and settle outside India. British women representation in Medical Services in India stands on the same footing as that of British men and need not be discussed separately. If there is any department of Government where political considerations should not weigh in connection with reforms it is the Medical. If Government did not recruit European Medical officers in England for the Indian Medical Service giving them special privileges in service in addition to high salaries, a large section of British medical practitioners would have settled here for private practice and the independent medical profession would have been richer for it. There exists in India at present a large number of Indian medical practitioners possessing much higher qualifications than those possessed by majority of British medical men in service and if they have not made a mark, it is due to want of opportunities. There is no need for any special reserved appointments for British medical practitioners. At the same time there should not be any bar for recruiting them for whatever purpose with equal opportunities with the Indian medical practitioners. Merit, experience and ability should count in the choice of medical men in Government service and not any other consideration.

Sir N. Walker's Evidence: During a period of over 2 years from 1931to1933 when there was prolonged and ardent discussion about the Indian Medical Council Bill the Government of India through its officials had been repeatedly assuring that the Biil was drafted with the only purpose of having statutory control over medical qualifications and standards. But nobody was satisfied with the statements made on behalf of the Government as the Medical Licentiates who formed the largest bulk of qualified practitioners in this country were left out of the purview of the Bill. The Bill has now become an Act and evidence is forthcoming from the President of the General Medical Council, Great Britain, that this Act is serving only the G. M. C., and not the medical profession in India. In proof of our statement we have quoted herebelow a portion of the address by Sir. N. Walker made to the General Medical Council at its winter session :—

".....Much of the discussion centred round the claim for admission to the Indian register of licentiates educated in Indian medical schools, with which the council was not concerned. The difficulty had been solved by dropping the proposed Indian register, and the Act established a council for medical education and standards only. The General Medical Council would welcome the establishment of an All-India Medical Council....."

Glad News At Last: The medical profession in India would be very glad to learn that Dr. Jivaraja N. Mehta who has been recently released from jail has been reinstated by the Bombay Municipal Standing Committee as the Dean of the King Edward Memorial Hospital and Seth Gordhandas Sunderdas Medical College. It may be remembered that Dr. Mehta while in jail applied for additional leave which was refused on account of a Government order. As Dr. Mehta could not claim reinstatement legally, he gave an assurance that he would not in future engage himself in any outside activities which might interfere or lead to the interruption of his duties as the Dean. Dr. Mehta is an ardent Swarajist and his soul went out of his body and courted jail happiness for some time. Dr. Mehta must have realised that an ardent Swarajist could render excellent service to his country without courting jail. He has splendid opportunities of training young men for service and the institution of which he was the head and is once again the head, owes its present popularity to the selfless work turned out by Dr. Mehta in his capacity as a Swarajist. Swarajism has to be worked out in different directions. Medical relief is one of the most important items for the welfare of the people and if Dr. Mehta does not bother himself with anything else excepting the institution under his charge and inculcates the spirit of service in the boys trained in these institutions he would be serving Mother India right royally.

Indian Medical Council Elections: It looks as if the India Government has received a mandate from some unknown quarters that the Council must be brought into existence within a fixed time in the near future, or else one could not understand the hasty and unsatisfactory manner the elections are conducted in connection with the return of a combined representative for the graduates of medicine of Indian University and for others in the provincial register whose qualifications are recognised by the Indian Medical Council Act. We have little or no time to know how the other provincial governments who are authorised to conduct the election for this seat conduct these elections; but from what we see at Madras we could say that those who are responsible to conduct the election in this province do this work with little or no seriousness of purpose. First and foremost the voters' list contain series of mistakes both of omission and commission. The addresses of a large number of voters are not correct and no sufficient opportunity was given either to the voters or candidates to get the voters list corrected. Hardly within two weeks of the publication of the

There is no point in giving subcutaneous or intramuscular injections of an arsenical compound for syphilis if the compound does not readily form Arsenoxyl.

final voters' list the nominations are called for and the election is to take place within 3 weeks after the date of nomination. The returning officer is the Surgeon-General with the Government of Madras who is also the President of the Madras Medical Council and it is inexcusable that the addresses of many of the medical officers under him are not correctly entered in the voters' list. Evidently the Surgeon General depended upon the Registrar, Medical Council, for the preparation of the electoral roll and when the Registers for 1931 and 1932 were not published by the Registrar, how could he supply the returning officer an up-to-date corrected list of those that were registered till the date of the preparation of the electoral roll. We wish good luck to all the candidates and sympathise with them for their uphill work.

Medical Act Violated ?: It is certainly unbelievable yet true that there are medical officers under the Madras Government who are not registered in the Madras Register, though Sec. 4 (2) of the Madras Medical Registration Act of 1914 prohibits medical men to hold Medical or Public Health appointments under the Government. It is reported to us that Lt. Col. Webb, Director of Public Health, is not in the Madras Medical Register. So also Sir Frank Connor, the Surgeon General with the Government of Madras. We got this information for the first time from a candidate for election for the Indian Medical Council. The Registrar, Medical Council, to whom we referred this news had to acknowledge that he had no evidence of the Registration of both of these officers. This is not the first time when important officers of the Government failed to get themselves registered in the local Medical Register before they took charge of office. About 5 years ago the then Surgeon-General held office for sometime without being registered till this fact was brought to the notice of the Government in connection with a controversy about an impending election to the medical council at the time. May we suggest to the Government the desirability of passing a G. O. authorising the Personal Assistant to the Surgeon-General to see that medical officers coming to this province from outside are registered before they assume charge of their office. We make this suggestion as the Personal Assistant has been a local officer so far.

A Good Move: We congratulate the Andhra University in their successful attempt to be autonomous. The Senate recently decided to conduct the medical examinations by themselves. It is also noteworthy that one of the members of the Senate proposed a resolution at the last meeting of the Senate that the Vizagapatam Medical College and King George Hospital, should be also brought under the control of the Andhra University as is the case with such institutions at the Lucknow University. The resolution was not passed as the Vice-Chancellor gave an assurance that he would move in the matter himself and get all the necessary information regarding the feasibility of the Andhra University taking such a step. We did propose this reform long ago in these columns with regard to Madras University. We trust time will not be long when all Universities will have the direct control over the institutions where education is imparted under their control.

Transfers: We have said in these columns more than once that the Government do not seem to have any fixed principles with regard to transfer of important medical officers under them and seem to be more interested in the persons holding appointments than in the institutions themselves. Or else the transfer of Lt. Col. Anderson from Vizagapatam to Madras could not be explained. Lt. Col. Anderson had been the Principal of Vizagapatam Medical College perhaps from its very inception and had been responsible to bring the medical college, Vizagapatam, to a high standard of efficiency. Yet the Indian Medical Act, on the report perhaps of G. M. C., did not recognise the medical degrees granted by this University though the examinations were conducted so far by the Madras University whose medical degrees are recognised. Soon after the new Indian Medical Council comes into existence arrangements will be made by the Council to inspect the Vizagapatam Medical College. Just at this juncture the permanent Principal of that College, Lt. Col. Anderson is transferred from that institution. If the Government thinks it is desirable that there should be tranfers from

It is not usual for acetylated organic arsenic compounds to readily form Arsenoxyl.

one teaching institution to the other why should not they do so with regard to other offices also? There will be better discipline and less heart-burning in the department if the Government works on principles and not conveniences. It will not be out of place to mention here that even in case Lt. Col. Anderson had to go over to Madras for purposes known to the Government itself, the Vizagapatam Medical College, ought to have had the services of a person who was connected with that institution having not only teaching experience but also the working knowledge of the Medical College at Vizagapatam. On a previous occasion when Lt. Col. Anderson had to go on long leave, a senior professor of the college, who had also acted as the Vice-Chancellor of the Andhra University, was rightly and justly appointed to act as the principal. It would have been in the interests of the institution if the same person or one like him who was in no way disqualified to serve as a principal of the Medical College had been appointed to that place and Capt. Ebden who was recently recruited in the civil branch of the Indian Medical Service and who was not, till then, in charge of any teaching institution, might have been made the Surgeon of the K. G. hospital and also its Superintendent. We mean no disrespect to anybody concerned nor hold plea for particular persons. We trust our criticisms will be appreciated in the spirit they are offered.

Fruitful Agitation: Under the caption 'A Neglected Institution' we wrote an Editorial in February 1932 and gave details of necessary improvements to the Government Victoria Caste and Gosha Hospital, Madras. Copies of that issue of the journal were sent to the members of the local Legislative Council in addition to the concerned members of the Government. We are glad to note that our criticisms were not in vain. At the last meeting of the Madras Legislative Council more than one member interpellated the Hon'ble Minister in charge of Medical Portfolio about this hospital and the Hon'ble Minister gave sympathetic replies and informed the house that urgent improvements to this institution were being made and other improvements involving large expenditure will be taken up as early as possible. It is a happy coincidance that the Raja Saheb of Bobbili whose ancestors had been evincing keen interest towards the welfare of the patients of this hospital is now the Minister in charge of Medical Department and we trust his sympathies will go a good way in effecting necessary improvements for this institution.

A Good Example: Dr. R. J. Dyson, M.B.CH.B., D.P.H., Chief Medical Officer, M. S. M. Ry., did set a very good example with regard to selection of candidates for service as subordinate medical officers in his department. It is said that there were over 300 applications for four vacancies in the cadre of Sub-Assistant Surgeons, from candidates possessing local registerable qualifications, including many graduates. Out of such applicants about 36 were sent for interview and Dr. Dyson surprised them by asking whether they would sit for an oral examination in medical subjects. Some quietly went away and the rest submitted themselves for the competitive test. Out of these 2 graduates and 2 licentiates have been selected.

Dr. Dyson is a member of the Madras Medical Council and must have realised the necessity of treating all the registered practitioners alike when they applied for the post of Sub Assistant Surgeons in railway service. The test he applied is worthy to be followed by others in authority including the Government. What is required in the medical profession is practical knowledge and skill and the best test for the purpose is the one used by Dr. Dyson of having a practical examination without previous intimation. This test has also proved that for all practical purposes there is not much difference between the college and the school medical education. We wish that Dr. Dyson will carry this test further and remove the bar that now exists before the licentiates in railway service for promotion as Assistant Surgeons.

A Correction: We very much regret that due to an error committed by the clerk in charge of taking precis of news from different parts of India, we made a mistake in our Editorial columns last month while commenting upon the medical conferences, in mentioning Dr. B. C. Roy as the President of the All-India Medical Conference instead of the All India Medical Licentiates' conference. This mistake might have to a certain extent affected our

criticisms as, for the first time the licentiates preferred to have a non-official to preside over their annual gathering, instead of the head of the Government medical department, which had been a convention with them heretofore. All the same, the principle advocated by us that the President for the annual conference of the licentiates should be one amongst them, and not an outsider, holds good.

Correspondence, Reports, Etc.

Future of the I. M. S.

Abstract of the Memorandum submitted by the Council of the British Medical Association to the Sub-Committee of the Joint Parliamentary Committee.

The Indian Medical Service is acknowledged to be one of the finest medical services in the world. In the past it has attracted to it medical men of the highest professional attainments, whose work in India and elsewhere has been of outstanding importance in the fields of medicine, surgery, public health, education, and research. There is every justification for asserting that the work of members of the Service has been, and still is, of incalculable value to the welfare of the peoples of India.

It is a military service composed of British and Indian commissioned officers recruited in London by the Secretary of State for India. Its members serve in military employ with the Indian Army for a period of years, after which a proportion is deputed for rival employment either under the Government of India or the Provincial Governments.

In Civil Employment.

While in civil employment the officers are utilised in various forms of medical work, including administration, education, research, public health, and prison service or as civil surgeons; or as district medical and sanitary officers, where they are in charge of local hospitals and serve the civil population, including British officials and their families. They constitute the pool from which a war reserve is available on mobilization or emergency. However employed they form, as a whole, the civil branch of the Indian Medical Service.

Should this branch cease to exist as proposed, the strength of the Indian Medical Service in its new form would be approximately 350 officers, British and Indian. The present strength of the civil branch is 300, giving a total strength, military and civil, of 650. What appeal would the new Service make to young British medical graduates contemplating a career in one of the military medical services of the Crown? Prior to the war there was a great competition for entry to the Indian Medical Service, the total strength of which was then about 750. The prospects and varied opportunities of professional employment in the civil branch (the strength of which was then about 500) was at that time and has always remained, unquestionably the main inducement to most candidates.

Candidates of Right Type.

Since the war, difficulty has been experienced in maintaining an adequate supply of candidates of the right type. The reasons are probably twofold. In the first place there has been a general disinclination on the part of young graduates to enter a military medical service of any kind, a situation which has led to diminished recruitment for all the medical branches of the Defence Forces of the Crown. In the second place there has been, so far as the Indian Medical Service is concerned, a progressive reduction of professional opportunities in civil employment, as the civil strength fell from 500 to 300. The reduction has undoubtedly directly and adversely affected, recruitment and has created a feeling of uncertainty as to the future. There has been also the uncertainty arising from the changing political conditions. Many men consequently who might otherwise have joined the Indian Medical Service for a lifelong career in India have turned in other directions for professional employment.

Diminished Prestige.

The proposal of the Services Sub-committee that the civil branch of the Indian

Some acetylated organic compounds of arsenic are readily eliminated in the urine. Arsenoxyl does not readily pass the renal portal.

Medical Service should cease withdraws them opportunities which, as already stated, have been, and still are, the main inducement to intending candidates. The proposal, if adopted, apart from other considerations associated with consequent diminished prestige, or with political developments, will prove disastrous to the prospects of the future maintenance of successful recruitment for the Indian Medical Service in its new form.

On the cessation of the civil branch the Services Sub-committee contemplates a new method of recruitment to provide for a war reserve and for attendance on British officials and their families. The method suggested is to recruit British practitioners on a contract system through the Provincial Governments for service as members of the respective Provincial Medical Services.

Status Enjoyed.

What appeal would service under such conditions make to British practitioners? Much would depend on the type of contract, which would no doubt be of a high order. There are, however, other considerations. At present the Indian Medical Service officers in the civil branch belong to an all-India service, hold commissioned rank, and enjoy a status similar to that held by members of other all-India Services such as the I. C. S. or Indian Police. It is not stated what, if any, opportunities are to be provided for administrative and professional advancement of British Practitioners who join the Provincial Medical Services, or what if any, opportunities are to be provided in the research, public health, prison, or other fields, or what the status of the doctors would be as compared with officers of the All-India Services. The system of "listed" appointments for British officers is to be abolished.

These are questions of supreme importance in considering the prospects of obtaining medical practitioners in adequate numbers or of suitable qualifications, not only for the provision of a war reserve and European medical attendance, but also for the maintenance of a due proportion of British personnel in the medical fields above enumerated. The British practitioners are to be obligated in their contracts to undergo military training and render military service. Military training is to be provided after instead of before, employment in the civil departments, and whatever duties are allotted would be undertaken without a knowledge of the language or customs of the people, and without that experience of the diseases of the country now acquired by junior officers under the supervision of their seniors while serving in the military branch.

Recruitment Difficult.

The maintenance of successful recruitment under existing conditions is difficult. The changes which the new proposals foreshadow must necessarily increase the difficulties of recruitment in the future. The provision of a high-class type of European practitioner is of the first importance to European candidates who contemplate joining the I. C. S., the Indian Police, or other Services, who desire a choice of European practitioner for themselves and their families. It has been well said that the "European element in other Services is dependent upon the Government's ability to provide qualified European doctors." Failure of recruitment, therefore cannot be contemplated.

Conclusions Reached.

The Association is forced to the following conclusions—namely:

1. That the successful recruitment of the Indian Medical Service would not be maintained if the civil branch of the Service were discontinued, as proposed by the Services Sub-Committee of the Round Table Conference.
2. That successful recruitment would not be maintained under the scheme proposed by that Sub-committee for employing British medical practitioners for contract service in the respective Provincial Medical Services. From this point would follow (a) that a military reserve of British medical practitioners would not be available in time of war or emergency; (b) that adequate medical attendance on British Officers and their families by British medical practitioners would not be made.
3. That medical provision in India, including administration, research, public health, and teaching, should include a due proportion of British personnel.
4. That the Women's Medical Service for India should be expanded, and include a due proportion of British medical women for administration, research, and teaching.

(The Times of India)

Trichinopoly District Medical Association.

FOURTH ANNIVERSARY.

Under the auspices of the Trichinopoly District Medical Association a Clinical Conference of the medical men in the Southern Districts of the Presidency was held at Trichinopoly in the National College when practitioners from almost all the districts in the South were present. The proceeding commenced with the reading of the welcome address by Dr. T. S. S. Rajan. Dr. P. A. S. Raghavan, Secretary, presented the annual report. The election of office bearers for the next year took place and Dr. C. E. Norman, Chief Medical Officer, S. I. Ry., was elected President and Dr. Raghavan re-elected Secretary, and Dr. R. Sambasivan as Treasurer. Rao Bahadur Dr. M. Kesava Pai, M. D., O. B. E., Director, Government Tuberculosis Hospital, Madras, presided over the Conference.

Dr. Rajan, while welcoming the guests, referred to the past history of the Association, which he said, did useful work for the past three years in spite of number of vicissitudes which at a time frightened its existence. It was a welcome relief to him that trained medical men of the allopathic and indigenous systems of medicine were increasing in numbers and the consequent competition had brought about the existence of specialists in the field. Dr. Rajan was of opinion that the profession was not overcrowded just at present. He said that there might not be more room for practitioners in urban areas and therefore the practitioners should make up their mind to settle in rural areas in larger numbers so that there may be one medical practitioner for every 1000 population in rural areas. He advocated the ideal of the vidyans of the good old days who rendered unconditional service to those in need and allowed the relief afforded to speak for itself. He was for compulsory universal state relief and the multiplication of free hospitals all over the land and for this purpose suggested the reduction of expenditure in the present state hospitals by replacing paid staff by the honoraries. He appealed to the rich philanthropists to endow hospitals and sanatoria which should have free services from practitioners. Dr. Rajan said that in addition to national state medical relief and the multiplication of hospitals which would go a good way in preventing over-crowding in the medical profession, another good and useful channel for diverting the activities of the profession was research. He also added, new discoveries prolonged human life and had a great economic value to the state. He deplored that research work in India is yet in its infancy and bitterly complained that the Government was not spending enough in this direction. He appealed to the profession to create enthusiasm in the minds of the public for the cause of research, themselves making a practical application of their knowledge in understanding and relieving human suffering. Increased efficiency and skill, said Dr. Rajan, was bound to come as the result of competition and the public will have the benefit of having medical service at competetive rate without deterioration in quality, enabling the poor to summon the services of the doctor to his door with due regard to his sense of self-respect, without waiting at the crowded gates of a charity hospital. Dr. Rajan closed his address by eulogising the services of Rao Bahadur Dr. M. Kesava Pai, the President of the Conference as an outstanding physician and a specialist in Tuberculosis, whom he wished a long life of usefulness even after his retirement from service.

Dr. Kesava Pai, the President of the Conference, laid special stress on the resposibilities of the medical profession in developing the sanitary conscience amongst the masses which he said would go a good way in the prevention of diseases and the development of national health and physique, as the epidemics of infectious diseases were levying a heavy toll of mortality in India, not to mention of the infantile mortality and the high death rate from diseases like Malaria and Tuberculosis. He wished the family doctors to be real propagandists and as such their services ought to be honorary. With the same purpose to serve humanity at large, he suggested the need of having a large number of medical men in the health propaganda associations in every district. It is unfortunate, he said, that the health conscience, was not as much awakened in medical men as it ought to be. Dr. Kesava Pai said: "The physician or surgeon, whether in public service or otherwise, very rarely goes beyond his daily routine of clinical examination and treatment. No attempt is made to analyse the work done, investigate disease from the scientific standpoint, or even to keep oneself posted with the most recent developments in the treatment of disease. We have a fair number of good physicians and surgeons amongst us, men of intelligence and capacity, but very few that try to add their quota to the scientific aspect of medicine by research work or scientific investigation of disease. There is a large number of tropical diseases and conditions that are awaiting investigation but though in the years gone by, we had to depend on research workers from foreign countries to investigate them from the etiological, pathological and therapeutic standpoint, it is high time that we ourselves try and shoulder further responsibility." The President then spoke about Tuberculosis with reference to its early diagnosis, treatment and prevention and appealed to the medical men to take keen interest in the campaign against Tuberculosis. He laid special stress on Birth Control which in addition to preventing miseries in large families would play a good part in the prevention of Tuberculosis by conserving the energies of the mother and enabling the parents to devote more time and resources to the growing children in their charge.

There was then a demonstration of clinical cases to the gathering and later scientific papers were read by Dr. C. E. Norman on "Colour Vision"; Dr. R. A. Johnson on "Medical Experiences in Europe and America"; Dr. T. S. Shetty on "Modern Surgical Treatment of Pulmonary Tuberculosis"; Dr. L. S. Narayanaswamy on "Vernal Catarrh"; Dr. R. Subbiah on "Failed Forceps"; Dr. B. S. Viswanathan on "Modern Conception of Pulmonary Tuberculosis"; and Dr. M. K. Sambasivan on "Intra-cranial complications of Otitis Media".

With a few closing remarks from the President the Conference came to a close.

Lt. Col. N. M. Mehta, I.M.S., and Dr. T. S. S. Rajan, were "At Home" to the guests.

Medical Conferences.

BOMBAY SESSION.

The 26th conference of the All-India Medical Licentiates Association opened its session on the 24th instant at Parel, Bombay, under the Presidentship of Dr. B. C. Roy. The session lasted till the 26th afternoon when in the same *shamiana* the All-India Medical Conference met under the Presidentship of Dr. Ansari.

(The Proceedings of both the conferences will be published in the next issue of the journal.—Ed.)

The Nellore District Medical Association.

A meeting of the above Association was held at the Head Quarters Hospital on 29—11—33. The Vice-President, Dr. K. Annappa Naik, presided. Dr. M. Sreenivasa Rao, Medical Practitioner, Nellore, read a paper on "The ravaging effects of venereal diseases." There was a lively and interesting discussion on the subject. Dr. A. Ananthanarayana, M.B.B.S., Hon. Venereologist of the Hospital explained in full the diagnosis and treatment of syphilis.

M. K. RAJAGOPALACHARI,
Hon. Secretary.

The Fellowship of U. P. State Medical Faculty.

The U. P. Government on the recommendation of the U. P. State Medical Faculty has been pleased to confer the degree of F.S.M.F. (Hon) on Dr. S. L. Sharma, Member of the Governing body of the U. P. State Medical Faculty, Member of the U. P. Medical Council and President of All-India Medical Licentiates' Association, U. P. Branch, for his meritorious services to the Medical Profession.

(We congratulate Dr. Sharma most heartily—*Ed.*)

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

No.	Names of Sub-Asst. Surgeons.	From	To
1	Dr. S. Ramanathan	Leave	Dt. Hd. Qrs. Hl., Tanjore.
2	„ P. Kunhambu	Govt. Hd. Qrs. Hl., Salem	Forest College, Coimbatore.
3	„ T. Joga Rao	Govt. Hl., Russelkonda	L. F. Dy., Purushottapur.
4	„ Vasa Narasimham	Govt. Hd. Qrs. Hl., Berhampur	L. F. Dy., Purushottapur.
5	„ K. N. Kesava Pillai	Leave	Govt. Hd. Qrs. Hl., Calicut.
6	„ K. P. Kunhiraman Nair	Govt. Hl., Kasargod	„ „ „ Mangalore.
7	„ G. Suryanarayana	L. F. Dy., Kurupam	c/o D. M. O., E. Godavari.
8	„ K. Jagga Rao	„ Rampachodavaram	L. F. Dy., Kurupam.
9	„ K. Chinnappa Reddi	Leave	Govt. Hd. Qrs. Hl., Chittoor.
10	„ Mrs. S. J. Gnanadurai	„	Govt. Hl., Russelkonda.
11	„ K. Krishnamurthi	Agency Duty, Vizag	Govt. Hd. Qrs. Hl., Kurnool.
12	„ T. R. Subramania Iyer	Canal Dispry., Vettikadu	L. F. Dy., Vidayapuram.
13	„ Miss K. Annapuranam	Govt. Hd. Qrs. Hl., Ramnad	Govt. Hl., Sivagunga.
14	„ T. A. Akbar Shah Sahib	Govt. X-Ray Inst. Madras	Hd. Qrs. Hl., Tanjore.
15	„ N. Sakharam Rao	Govt. Ophth. Hl., Madras	„ „
16	„ J. Suryaprakasa Rao	Leave	Gen. Hl., Madras.
17	„ S. Ramanathan	Hd, Qrs. Hl., Tanjore.	L. F. Dy., Vaithiswarankoil.
18	„ E. Vijiam Naidu	Leave	Festival Duty Tiruvannamalai.
19	„ S. V. Ramanayya	L. F. Dy., Chetput	„ „
20	„ S. T. Thiagaraja Pillai	„ Perumpanayur	L. F. Dy., Orattanadu.
21	„ J. Papayya Raju	Leave	Govt. Hl., Bhimavaram.
22	„ D. Narasimha Raju	Govt. Hl., Bhimavaram	Hd. Qrs. Hl., Bellary.
23	„ P. Sanyasi Rao	Hd. Qrs. Hl., Bellary	c/o I. G. of Prisons, Ooty.
24	„ N. Padmanabha Rao	Leave	Govt. Hd., Qrs. Hl., Guntur.
25	„ B. Subba Rao	Govt. Hd. Qrs. Hl., Guntur	Agency Duty, E. Godavari.
26	„ T. S. Ramachandran	„ „ „ „ Madura	L. F. Dy., Sholavandan.
27	„ M. Raman Nambiar	Leave	Agency Duty, Koraput.
28	„ S. Narasimhan	Itinerating Dy. Mahratipalayam	„ „ „
29	„ K. V. Krishnan Nair	L. F. Dispry., Walavanur	„ „ „
30	„ M. Satyanarayana	Vizag. Agency	Intertg. Dy., Mahratipalayam.
31	„ E. Vijiam Naidu	Festival Duty, Tiruvannamalai	L. F. Dy., Valavanur
32	„ G. V. Raghava Rao	Vizag Agency	Govt. Hd. Qrs. Hl., Guntur.
33	„ M. Kunjunni Menon	„ „	„ „ Madura.
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