

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

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Retired Sanitary Commissioner, Travancore State

AND

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From Dr. Miss G. W. B., M.B.B.S., I/C Women's Hospital,.....The ingredients of the Menestrin Capsules viz., Iron, Quinine, Manganese, Thyroid and Ovary and also the Ayurvedic drug, Ashoka, tempted me to try them on about a dozen cases of women suffering from Amenorrhoea attendant with Anaemia and a tendency of accumulation of fat in the body, especially in the gluteal and lower abdominal region. I am glad to inform you that I had uniform success within a course of one month after treatment. I have reported to you about my experience so that others in the profession might give a trial to this most effective preparation.

From Dr. H. V. G., L.M. & S., Head Quarters Hospital,.....The evil effects on the system of women, due to Amenorrhoea are in many instances worse than those of pregnancy. I had a case of Amenorrhoea in a young unmarried girl aged 19, the condition being six months. The unfortunate fact that the girl was unmarried and appeared more flesh after the cessation of menses—evidently accumulation of fat—made more anxious about their daughter and the matter was made worse when the girl came to my hospital who was consulted by the parents suspected Amenorrhoea to ancy and this nurse advised the parents to use Menestrin Capsules. As one capsule had not the desired effect, the parents consulted me and on examination the girl was not pregnant though physically appeared to be so on account of fat in the lower abdomen, the breasts and also the gluteal region.

The ingredients of Menestrin Capsules have a rational indication for Amenorrhoea due to iron deficiency and Anaemia I advised the parents to continue giving these capsules. After a month's trial the girl had menses; and after a month's trial the parents came to me with good news of the success of the treatment.....I authorise you to publish this letter for the benefit of the public and the profession.

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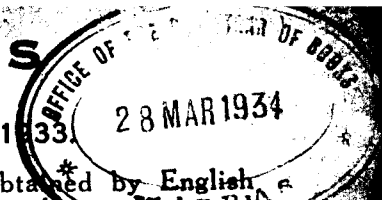
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FEBRUARY, 1934.

[NO. 5

DECISIONS OF THE ALL INDIA CONFERENCES

We published in our last issue the resolutions passed at the two All-India conferences that met in Bombay last December. It was worthy of the Indian Medical Association to have passed a resolution that time had arrived in the interests of the solidarity and the unity of the profession to hold the annual conferences of this association and of the Licentiates in the same place and in the same week as was done last time in Bombay. We went a step further and suggested in these columns last month that it would be most advantageous from all points of view if both the associations met on one platform to discuss not only scientific subjects but subjects affecting the life and prosperity of the medical profession as a whole. We also suggested that till the medical Licentiates are fairly treated, it was not advisable nor expedient for this class of practitioners to discontinue their activities as a separate body. We are glad that the Licentiates' Association decided to refer to the Standing Committee of their association the subject of presenting an united front by identifying themselves with the Indian Medical Association while maintaining the interests of the Licentiates' organisation. So far so good but a later event that the Licentiates had decided to meet at Indore and the Indian Medical Association at Delhi this year, would naturally upset those who had faith in the sincerity of purpose indicated in the resolutions for unity passed by both the

conferences. We trust that the executive of both the Associations will make it possible to meet in a common place convenient for both. The capital city of Delhi will certainly be a better place than Indore. The Medical profession throughout the country will note with great satisfaction that the Central Committee of the Indian Medical Association in collaboration with the Standing Committee of the All India Medical Licentiates Association would investigate the causes of unemployment in the medical profession and draw out a scheme of National Health Insurance. It is a strange irony that though there are not sufficient number of qualified practitioners to serve the needs of medical relief in this country the qualified practitioners suffer intensely for want of employment. We have been repeatedly discussing this vital problem in these columns and pointing out the various causes at work which had brought about this strange irony. The independent medical profession have to compete not only with quacks and charlatans but have to stand the strain of unequal and unwholesome competition with their more fortunate brethren in service. If the elders in the profession sit in conference year after year and solve this great problem of unemployment without doing anything else, the contented and prosperous profession which would evolve as a result of their efforts would be able to tackle all other problems affecting the profession without much difficulty. It would have been more practicable, and hence workable, if this work was entrusted to a smaller committee con-

sisting of representatives of both associations numbering about five or very near this number, each association bearing the travelling and other incidental expenditure in connection with the work of this Committee.

Many other important items have also been referred to the combined deliberations of the Central Committee of the Indian Medical Association and the Standing Committee of the All India Medical Licentiate Association, such as medical relief in rural and urban areas, including the public health and sanitary arrangements for preventing diseases, public health administration with reference to admission of patients, it being the considered opinion of both the conferences that only necessitous poor should get admission in charitable institutions, the rich being charged proportionate to the relief afforded to them. The joint committees have also been entrusted to draw up a scheme of medical education with an uniform standard. All these questions require serious, continued discussions after obtaining the public and professional opinions which can be only done by the joint committee by visiting important cities in all the provinces in India and summoning witnesses who are likely to help the work in hand. The large number of members of the Central Committee of the Indian Medical Association and those of the Standing Committee of the All India Medical Licentiate Association cannot be expected to do this responsible work within one year before these two conferences meet next, as it will not be feasible or practicable for a large number to do the responsible work expected of them on financial and other reasons. So we repeat our suggestion that the Executive Committees of both the Associations choose representatives for a working Committee and entrust them with this work or else from what we could judge from our experiences of the working of these committees in the past, little or nothing would come out of the decisions arrived at the Conferences.

All other resolutions passed at both the conferences such as, protests against the employment of I. M. S. in the civil department and reservation of posts to them, training of midwives and compounders, encouragement of indigenous systems of

medicine and indigenous drugs, would at present serve only a spectacular purpose and nothing more, so long as the profession is not united, and only the unity of the profession would solve these problems with little or no exertion. So it is that the first and most important work before the profession is to bring about unity and contentment and this could be only done if the elders in both the associations sit to work right earnestly in the way suggested by us and carry out the most important work of effecting unity in the profession. It will not be out of place if we repeat what we did last year in these columns while commenting upon the decisions of the All India Conferences in quoting the words of Major-General Sprawson, the then Surgeon-General with the Government of Madras and now Director-General, Indian Medical Service, when he presided over the All India Conference of medical Licentiate in Madras:

"I think the chief drawback from which the Licentiate now suffer is that from which the whole medical profession in India suffers that the profession is not united, but is divided into separate classes, whose interests are not always identical. The medical profession in India therefore cannot always speak with one voice and it loses thereby some of the authority and influence which should belong to it."

This warning coming from an official who is now occupying the most coveted position as the head of the medical administration in this country, would, we suppose not be treated lightly by the profession. So "if once we do away with the compartments in the profession there will be no need for the profession to bend their knees in the way they have been doing." There was a momentous opportunity before the profession to show to the Government their strength and determination, and that was during the period when the Indian Medical Council Bill was on the anvil of the Legislative Assembly. Though it was not possible for the profession to give a form to this bill in the way desired by them on account of the weakness of the people's representatives in the Legislative Assembly, we are bound to say that this contentious measure has drawn the profession much nearer than before and we are not without hopes that in case the Indian members of the Indian Medical Council now to be constituted so desire, they could, with

one stroke, show to the Government their earnestness and zeal to have one united profession, as suggested by Major-General Sprawson who, happily would preside over the new Council, by passing a resolution recommending to the Government of India the urgent necessity in the interest of the profession as well as of the country, of bringing the medical Licentiate within the purview of the Indian Medical Council Act. It is fortunate that persons like Dr. G. V. Deshmukh from Bombay and Dr. T. Krishna Menon from Madras, (we regret we could not mention more names as we are not aware of the results of elections in other provinces), who are against caste distinctions in the profession, have been returned to the Indian Medical Council, amongst the non-officials. Dr. T. S. Tirumurti who has been returned by the Andhra university and who had been a member of the Madras Medical Council, was one of those in that council who voted for the inclusion of the Licentiate within the purview of the Indian Medical Council Bill when that bill came for discussion at the Madras Medical Council a couple of years ago. We hope there will be many more like him who are returned to the Indian Medical Council amongst the Indian officials, and so, our hope, we trust, will not be in vain, and we will have the satisfaction of reporting in these columns next year that Indians, whether they are officials or non-officials, could be trusted for bringing about National Unity in the Medical Profession.

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*Original Articles

INTRA-CRANIAL COMPLICATIONS OF OTITIS MEDIA

By

DR. M. K. SAMBASIVAN, M. B. B. S.

Kumbakonam.

I have ventured to read a paper on this subject for, apart from the very interesting nature of the subject itself, a general practitioner is often called to see cases which happen to come under this category, but owing to the special nature of the case, he is not able to arrive at a perfect diagnosis.

Incidence of Intra-cranial complications due to Otitis media is more common than we expect. But only a few cases come under notice and they do so when they are beyond our control; or very often a chronic Otitis media takes an acute stage during the course of some other disease as enteric fever or pneumonia and soon a meningitis or extra-dural abscess is developed but our attention being switched on to the primary cause, the secondary and the more serious condition is overlooked.

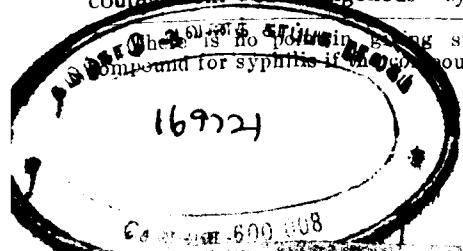
The four most common intra-cranial complications, in the order of incidence are:—

- (1) Extra dural abscess.
- (2) Meningitis.
- (3) Temporal lobe abscess or cerebellar abscess.
- (4) Sinus Thrombosis.

ENTRA-DURAL ABCESS.

This may be open or closed according to whether the abscess cavity is in communication with the pus in the Tympanic cavity or not. When the pus remains there for some time, with suppuration of the outer side of the dura, it is called Pachy Meningitis Externa; if the suppuration goes inside the dura, it is Pach. Interna. When it gets into the Pia and arachnoid it is circumscribed meningitis. Later, this becomes diffuse into brain and C. Sp. canal and produces Encephalitis and still later Brain abscess. Abscess may be in the middle fossa, in posterior fossa; clinically it may be divided into two guised as superficial and deep. All lateral to Eminencia Arquata are sur in other

* Papers read at the Anniversary of the Trichinopoly District Medical Assoc that you the 23rd December 1933, and specially contributed to The Medical Practitioner.



and medial to it-deep. All suppuration in the Trautmans Triangle is superficial and in the region of Labrynth deep in the Post. Fossa.

SYMPTOMS, DIAGNOSIS AND TREATMENT.

Diagnosis of Superficial abscess in the middle fossa is impossible before operation. No special local symptoms can be noticed excepting headache, vomiting, slow pulse and temperature. Deep abscess can be diagnosed before operation. The above symptoms and preorbital pain, neuralgia in the teeth due to irritation of the Gasserian Ganglion. Sometimes there is Gradinigo's Syndrome. This is sometimes present also in acute Otitis due to oedema and serous meningitis near the tip of the petrous bone, but clears up when the symptoms subside, whereas if due to extra-dural abscess it clears up only after operation.

TREATMENT: Do a radical mastoid operation; remove the tegmen tympani; lift the tip of the petrous bone and then the dura. The abscess can be got at. The place between the carotid and the facial nerve must be opened up. But there is no danger to the carotid as it is lying loose in the canal whereas the facial nerve is in constant danger of injury.

MENINGITIS.

SYMPTOMS: Headache on the opposite side. For all intra-cranial complications due to Otitis the headache is on the same side, front or back. Headache due to meningitis is an exception to this rule. Stiff neck or opisthotonus when the disease is well established. In other types of meningitis stiff neck is an early symptom; in otitic type, it is very late. Patient is usually cranky and restless. At times with insane ideas. Temperature may go up suddenly to 102 or 103 and then fall down to rise again after a day or two. During this afebrile period all symptoms may subside. Patient may be apparently all right. In certain cases, after a simple or radical operation, the temperature rises up in which case the possibilities are erysepelas meningitis, sinus thrombosis or brain abscess. Eye symptoms—Abdusson's paresis. If it is on the other side, the prognosis is very grave. Nystagmus is a very important symptom—usually horizontal. A vertical nystagmus does not usually occur in otitic

meningitis but is caused by pus breaking into the ventricles. There is not much change in the eye ground but sometimes there may be an optic neuritis but not a choked disc.

Kernig's sign present and also Bondis symptom. Turn the head to the right when the patient is lying on the back. He lifts his left leg and vice versa.

The lumbar puncture clears diagnosis from the other conditions. All these typical symptoms develop when Otitis is chronic but when it is acute no symptoms may be present, except little fever, headache and vomiting.

TREATMENT: Do a radical mastoid operation and expose the dura both in the middle and posterior fossa. Take off even the edge of the petrous bone and in some cases you have to go even farther; then do a lumbar puncture and remove 20 c. c. C. S. fluid. Prof. Rutin suggests injection of 10 c. c. saline with 0.01 gram of Solgnol into the spinal canal repeated every day and later every alternate day. If necessary, the dosage of Solgnol may be increased to 0.02 or 0.03 gm. After the introduction of this method, which is certainly an improvement on plain lumbar puncture and removal of C.S. fluid Prof. Rutin claims the percentage of cure to be about 50. Solgnol injection can do quite a lot where the infection is not severe, but not if the C. S. fluid is fibrinous. If the meningitis is due to *Streptococcus mucosus* precious little can be done.

TEMPORAL LOBE ABCESS.

PATHOLOGY: may be a complication of sub-acute or chronic otitis. In both the pathogenesis is just the same. Suppuration affects the Tegmen Tympani and produces necrosis. This necrosis produces headache and can stay on for months. Finally, a pachy meningitis externa combined with an extra-dural abscess is produced. The dura gets necrotic in one place, but even long before this, pus breaks through the dura. The infection passes on to lepto meninges and an abscess is produced. Sometimes, the infection passes through the blood vessels piercing the Teg. Tympani producing a microscopic thrombophlebitis. The abscess grows in all directions, but most commonly upwards and medial wards towards the inferior horn of the ventricles.

SYMPTOMS: Patient is crazy and absent minded; sometimes very sleepy. Headache always on the same side, front or back. It is continuous, slow and deep. Rarely, the headache is also associated with typical trigeminal neuralgia, particularly when the abscess grows forwards and presses on the Gasserian Ganglion. There may be little tenderness on percussion over the abscess. Temperature may go up from normal to 102 or 103 and then come down to normal, passing on to a latent stage. In such cases, two stages can be recognised, the latent and the manifest stages. Usually, the patient dies in the first manifest stage or in one of the subsequent manifest stages if he is not operated in the meanwhile. In the latent stage, there may be no symptom at all except little headache and in the manifest stage, one of the characteristic symptoms is the slow pulse, as say, 54 or 64, compared to a temperature of 102 or 103. Sometimes, after a radical or simple operation temperature goes up to 102 or 103 with a pulse rate of 60 or 62 and in all such cases you may be perfectly sure that the patient has developed a temporal lobe abscess. When the abscess is situated on the left side or on the right side in a left-handed patient, he gets aphasia. This otitic aphasia is called amnesic aphasia characterised by the patient's forgetfulness of the names of objects. The patient talks in long sentences. He avoids all nouns, but gives definitions; for example, when a key is shown and asked what it is, he cannot say that it is a key but he will tell you in long sentences that it is an apparatus or instrument used for opening doors etc. These patients seem to have a forgetfulness of the names of all concrete objects. But one word of caution—the presence of amnesic aphasia is not proof positive that the patient has a temporal lobe abscess. If all conditions suggest the suspicion of an abscess, you are justified only in exposing the dura of the middle fossa and proceeding further according to the findings during the operation. Aphasia is also a symptom of tumours in the Temporal Lobe. But it is a complete sensory aphasia. Patient does not talk a word; appears to be completely deaf; but after some time language will be restored but he gets an amnesic aphasia; whereas in abscesses, it starts as an amnesic aphasia which increases and ends in a complete sensory aphasia. This contrary phenomenon is due to the contrary directions of the growths of an abscess and tumour. The other

symptom is Hemianopsia. We know that inside the parietal and temporal lobes we have the Optic Radiations. When there is an affection of the radiation on one side there will be no blindness but only a marred vision. A temporal lobe abscess may destroy the whole radiation and produce Hemianopsia of the other side. But usually only that part of the radiation that lies in the Temporal lobe is destroyed with the effect that patient gets blindness only of the upper quadrant. This partial destruction of vision is a much more common symptom than amnesic aphasia. The finding of a hemianopsia in an ear case may be to a very great extent diagnostic of trouble in the Temporal Lobe—but you must also bear in mind that a cerebellar abscess also may have Hemianopsia.

PRESSURE SYMPTOMS: Jacksonian epilepsy on the healthy and sick sides, facial paresis of the healthy side, paralysis of the expression of the face, a unilateral mydriasis due to the pressure on the Oculomotor nerve—Trigeminal neuralgia and sometimes Abdusson's paresis and contra-lateral Abdusson's paresis, (Syphilis may also produce a unilateral mydriasis. But when an ear patient with peculiar brain symptoms develops unilateral mydriasis you may be sure that he has a brain abscess). Choked disc is least frequent in temporal lobe abscess still less in cerebellar abscess but is most frequent in sinus thrombosis. In brain abscess the eye ground must be controlled both before and after operation. Optic neuritis seen before the operation disappears after this is done; but sometimes it reappears again after two or three days in which case there is retention of pus in the abscess cavity or another abscess or a serious meningitis has developed. Nystagmus is not a special symptom of temporal lobe abscess, but once a while it may be found when the pus goes backwards and presses on the occipital lobe.

C. S. FLUID. More pressure—cloudy sterile fluid—increase of albumen. In Temporal lobe abscess and sub-dural abscess it is not advisable to do frequent Lumbar punctures.

Temporal Lobe abscess is more common in chronic otitis than in acute otitis.

TREATMENT: If the abscess is formed after acute otitis do a simple mastoid operation and expose the dura. If it is the result of a chronic otitis, do a radical operation and expose the dura of the middle fossa. There are two possibilities: (a) Dura-normal—wait.

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

For there is a possibility of your having made a wrong diagnosis. (b) Dura-abnormal, i.e., Dura is thickened and covered with granulations. The normal greyish blue colour of the dura may be changed to greyish red, greenish or yellowish or greyish white. In all such cases an abscess may be strongly suspected. Take a long needle and puncture straight into the exposed dura to one and a half inches. So long as you do not go deeper than that in any direction you are not likely to injure the ventricle. If as a result of this no pus is found, puncture sideways then backwards and then inwards. If still you do not get pus and you have a strong suspicion that there is an abscess, puncture with a knife in the same aforesaid directions. The greatest danger in this method is the terrible bleeding. If pus is found, drain the abscess by means of a rubber tube. But some people still do not puncture the dura, but put in a filiform drain and at every subsequent dressing increase the size of the drain till a large opening is obtained.

POSSIBILITIES: (i) Death, (2) An external meningitis. To prevent this, paint the meninges with Tr. Iodine. (3) Prolapse of the Brain. This is a very disagreeable incident. After incision of the dura put in a lot of iodoform powder and when the prolapse gets necrotic, cut it down. Sometimes even a big prolapse can heal by itself. (4) Pyocephalus, i.e., pus breaking into one of the ventricles. Death is certain. (5) Death due to pressure. (6) Death due to respiratory paralysis more often in cerebral abscess pressing on the medulla.

CEREBELLAR ABSCESS.

Infection of the cerebellum is invariably through the labyrinth. Hence the abscess is always combined with labyrinthitis. The symptoms for both being nearly the same, the diagnosis is a bit difficult. Headache, vomiting, temperature, slow pulse, dizziness and nystagmus; but in labyrinthitis there is nystagmus to the opposite side while in cerebellar abscess the nystagmus is towards the same side.

TREATMENT: Do a labyrinth operation, expose the dura of the posterior fossa, punc-

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

ture the cerebellum and open up the abscess. Death is invariably the result in such cases.

SINUS THROMBOSIS.

The last and the most important complication in otitis media is sinus thrombosis. Next to extra-dural abscess, thrombosis of the sigmoid sinus is the most common occurrence. It is produced in the following three different ways.

1. CONTACT. There is infection of the sinus wall resulting in a periphrinitis. The endo-thelium is destroyed and the formation of the thrombus is aided by the fact that the circulation in the sinus is slow and irregular.

2. METASTASIS. This is a most common method. Clinically this variety is common after acute otitis in young individuals.

3. COMPRESSION THROMBOSIS. An extra-dural abscess compresses the sinus and this compression is enough to produce thrombosis.

There are different possibilities; pus may be between the sinus wall and the bone having no communication with the pus in the mastoid. This is a close perisinus abscess. If the pus is in free communication with that in the mastoid it is an open perisinus abscess. When the abscess itself lasts for a long time it produces chronic inflammation and infiltration of the sinus walls producing sinus phlebitis. When the infiltration reaches the inner wall of the sinus the epithelium is destroyed and a small mural thrombus is formed. Later on, this grows and closes the entire lumen of the sinus producing an obdurate thrombus. In such a thrombus two parts may be easily distinguished, the outer part which is closely attached to the wall of the sinus and limited to the diseased part, and the middle portion which extends both upwards and downwards.

DANGERS OF THROMBOSIS: Metastasis. (i) In the skull: Metastatic meningitis, encephalitis and brain abscess. These metastatic infections inside the brain are practically hopeless except metastatic pachy meningitis in the posterior fossa. (2) In the thorax. Empyema, lung abscess. Prognosis is doubtful but not absolutely dangerous. (3) Abdomen. Abscess in the kidney,

liver and sexual organ. Prognosis bad. (4) Articulations in muscles. Prognosis best as far as life is concerned but bad functionally. In every thrombosis, toxins are produced and these toxins have a deleterious effect on heart muscle, in which a parenchymatous degeneration takes place.

In the beginning, I said that the thrombosis took place most commonly in the sigmoid sinus. After this, the most commonly affected part is the jugular bulb. It is mostly primary after a cholesteatoma. It has a tendency for spontaneous healing. Infection is through the blood vessels that pierce the floor of the middle ear and also from the pneumatic cells around the jugular bulb. The third sinus that gets infected is the cavernous sinus. The infection passes into this through the venous plexes around the carotid. The characteristic symptoms of cavernous sinus thrombosis are exophthalmos, chemosis and ophthalmoplegia but rarely a patient lives to develop these symptoms.

SYMPTOMS: General condition may be fairly good. Rarely a patient may be acutely ill. Fever marked by intermissions ranging from normal to 104°. Chills may be present almost every day. Sometimes there may be no chill at all. In actual practice it is found that chills are more common in thrombosis following a chronic otitis than with acute otitis. Pulse as a rule rises proportionate to temperature. Prognosis is good as long as it is so. As in many other conditions when the rise in the pulse rate is out of proportion to the temperature prognosis is bad. Headache is often slight, localised in occiput and mastoid regions and sometimes also in the forehead. Cerebrospinal fluid: Normal in typical sinus thrombosis but when it is also associated with a pachy meningitis the fluid becomes cloudy but sterile. Other symptoms are petechial haemorrhage, sometimes temporary haemophilia and haemotogenic jaundice. Choked disc may be present but it never produces astrophy of the retina and disturbance of vision.

Ear findings vary according to the otitis being acute or chronic. Acute Sinus thrombosis is produced at the end of the third week at the same time in which otitis produces mastoiditis. There will be abundant secretion, sagging of the posterior and superior walls and mastoidism. In atypical cases

thrombosis may be produced in a week after the onset of acute otitis; the ear picture will be just the same as in acute otitis. There will be no pus in the mastoid and the thrombosis is due to metastatic infection. Plenty of serous exudate, no sagging of the walls and only slight tenderness over the mastoid. Very rarely a sinus thrombosis can also be found behind a closed drum. Chronic otitis is the most common cause of sinus thrombosis, particularly when an acute exacerbation takes place. Leucocytosis is always present. Enlargement of spleen is also a very early sign. A pure tubercular otitis never produces sinus thrombosis but only a pachy meningitis. But when there is a mixed infection thrombosis may also be produced.

DIFFERENTIAL DIAGNOSIS. (1) Atypical otitis i.e., an otitis media in children. Do a paracentesis. If the temperature is due to otitis, it goes down soon afterwards. In thrombosis it persists. (2) Mastoidism. In every case of acute otitis certain amount of mastoid symptom may be present during the first few days. It is a wrong procedure to do an operation in such cases before a perfect diagnosis is arrived at. (3) Incomplete operations. In certain cases of cholesteatoma, if you do a simple operation instead of the radical, there may be some temperature which would never have been the case if the latter operation is done. (4) Wound infection: erysipelas. Diagnosis by the appearance of the wound and the swollen lymphatic glands. (5) Angina: Sometimes produces otitis. Patient may have a temperature and secretion from the ear and tonsils. But secretion is very irregular. (6) Pneumonia: Here also the secretion from the ear will be very irregular. (7) Infectious diseases: Measles and scarlet fever some times produces otitis. If there is secretion and severe ear symptoms after the disappearance of the exanthemata do a radical operation. (8) Malaria and typhoid—Blood examination.

Prognosis is relatively good but depends on many factors, (1) time when you operate, (2) condition of the heart and the blood vessels (3) condition of the meninges in brain. Every complication in these two parts makes the prognosis worse. (4) Findings in the sinus. (5) Metastasis in other organs. (6) The operative technic that you

adopt. It is better to do everything at one sitting.

TREATMENT: In suspicious cases of acute otitis, do a simple mastoid operation and expose the sinus. In chronic otitis do a radical operation and expose the sinus. The possibilities are the sinus wall may be normal or altered. If it is normal and of blue colour you can wait. If alteration has taken place and the sinus wall is covered by granulations, puncture the sinus with a needle. If only the blood is obtained after the puncture you can stop the operation and watch the patient. But if no blood is obtained ligate the jugular vein and open up the sinus. The ligation of the jugular vein is only to prevent metastasis taking place in the organs below. After opening the sinus remove all the clots. If there is no bleeding, the sinus has to be opened and the clots removed till a free bleeding is obtained from the torcula. Finally, when all clots are removed, bleeding is stopped by careful tamponade between the wall of the sinus and the bone or in the sinus itself. The temperature drops down soon after the operation. The upper cut piece of the jugular may be stitched to the skin of the neck and some people do advocate washing out of the lower part of the sinus the irrigating solution passing through the jugular bulb, the upper piece of the jugular vein and out to the skin. This enables all clots to be removed from the jugular bulb. If the whole operation is carefully done, dressings need be changed only the sixth or seventh day, and the patient makes an uneventful recovery.

MODERN SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS

By

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In the short space of about half an hour, I have to speak to you today about the modern surgical methods of dealing with the dreadful scourge of humanity—pulmonary tuberculosis which has a toll of over a million people every year in our country. Of late the lines of treatment and methods

of diagnosis have undergone marvellous changes in many branches of medicine and surgery and one of them is Tuberculosis.

With the aid of x-rays and sedimentation test of blood in addition to the other clinical findings the diagnosis of tuberculosis has become much easier even at the early stages and even regarding methods of treatment the ideas are undergoing changes for the good of humanity. The old methods of sanatorium and climatic cures in conjunction with Cod Liver Oil and Colossal calcium are being replaced with newer ones of pneumothorax, phrenic evulsion and thoracoplasties, thereby not only prolonging the lives of many victims but giving even cures to a number of them. It is not my idea to deprecate in the least the value of sanatorium and climatic cures but considering the enormous expenses involved specially in an economically depressed country like ours and taking into consideration the fact that mostly the lower and middle classes are the victims of this disease are we justified in directing a patient to a sanatorium without giving a trial to the methods, some of which any one could try with a little experience. How many cases we meet with in our daily practice to whom something could be done and how many such cases can be directed to sanatoriums and how many sanatoriums cater to the needs of the poor in our country?

In my lecture I mean dealing with the common methods of surgical procedure as practised in the clinics in the West which I visited, leaving aside all other lines of treatment. 1. Pneumothorax. 2. Phrenic evulsion. 3. Thoracoplasty, partial or complete: the operations differing in different stages of the disease and according to individual needs. As the mass mind is trained in the west and as every lay man knows the disease it is quite possible to get cases at very early stages unlike in our country where the cases that come under our care are usually far advanced. Pneumothorax is the commonest treatment we see for all the early cases in those countries. In Vienna I know very little money is wasted in medicament but one of the three operations is done and if a case is unfit for any one of the three types of treatment it may be then fairly said that no treatment is of any avail for such cases.

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

PNEUMOTHORAX:—Is introduction of air into the pleural cavity thereby forming a pleural pocket which eventually collapses the lung putting it into surgical rest. The diseased portion adheres together, the cavity, if any, slowly becomes smaller and smaller and the activity of the disease is in favourable cases brought under control. We know rest is the most important factor in the art of healing any wound and based on this principle depends the collapse therapy, pneumothorax which gives the required rest to the diseased lung and thus hastens healing.

There are many varieties of the apparatus but the principle is the same in all. In the continent they use apparatus with fixed bottles whereas in England the movable bottle types are in use. Personally I prefer a fixed bottle type because it can be managed by one man. The needle is about 2" or a little longer with a pretty blunt point always carrying a stilet.

OPERATIVE TECHNIC.

A thorough physical examination of the patient and radiograph of the chest are essential to successful induction. Some responsible physicians say that a thorough physical examination and clinical finding is more than enough—x-ray being not always needed. I would strongly suggest that it is always safe to have a radiograph in front of you as in this case mishaps can be avoided. In my opinion it is a criminal breach of practice to induce artificial pneumothorax without a radiograph in front of the surgeon.

Having found out the area involved and noting if adhesions are present through the radiograph the site of induction is selected which must be a little away from the site of active process and preferably carried in the mid axillary line with the patient lying on the side with the arm extended over the head so as to keep the intercostal spaces well separated. With the observance of asepsis as for any operation the area is anaesthetised with novocain 2% or percain 1/1000 using two needles one to anaesthetise the skin and subcutaneous tissue, the other to anaesthetise the parietal pleura. Some authorities advise to send the needle straight down to the pleura and after instilling a few drops of the solution slowly draw the needle out gradually depositing some solution as the needle

moves out. But pleura being a very sensitive tissue I should think of first anaesthetising the pleura and then leaving a few drops of the solution on the parietal pleura, give a prick and instil a few more drops. After five minutes the pneumothorax needle which is attached to the cylinder with gas or air with the stop cock turned off is slowly inserted at the intercostal space little by little all the while the surgeon observing the manometric pressure which will indicate a negative pressure of over 4 c. c. or more if the needle is in the pleural cavity; not until then should the stop cock be turned on and air let in. Just above or just below zero manometric pressure reading is always highly suspicious. It indicates that the needle is either in the lung or it may be in the pleural cavity where there are strong adhesions. If there are free regular oscillations of expiration and inspiration indicating a negative pressure of roughly 10 c. c. of water the stop cock may be turned and air let in slowly till about 20 c. c. are injected and again control by closing the tap and advising the patient to take deep breath. If you are sure of the free oscillations and the negative pressure, again let in some more air say up to 50 cc. which may be the least at the first sitting. The quantity of air that is injected at each sitting may be from 50 to 1000 c.c. slowly increasing at each sitting according to individual needs. It is always necessary to ask the patient if he has any respiratory embarrassment which if present, draw out the needle and stop the operation for the day. A slow gradual technic is certainly much more preferable than the old method of injecting large quantities of air which may thus cause not only respiratory embarrassment but also cause undue and sudden strain on the other lung which may not be absolutely healthy as is often the case. Moreover if the lesion is in the left lung too large a quantity of air injected hastily will push the heart to the right and cause cardiac embarrassment.

The second sitting may be the next day and the subsequent one after a week and then once in a fortnight and later on once a month until a good pleural pocket is established. The quantity of air to be injected depends upon individual needs upon the amount the patient can take without any respiratory or cardiac embarrassment—upon the rate of absorption of air between two

sittings—upon the presence or otherwise of adhesions—upon the reaction the other lung shows after the treatment and upon the general constitutional changes. No hard and fast rule can be laid down for any case.

DANGERS DURING INDUCTION. 1. Pleural shock which may be unpleasant—the symptoms are as for any other shock. Treatment: draw out the needle immediately, stop all treatment for the day and give stimulants, hot water bottle and cardiac tonics etc. This complication is unlikely to occur if the parietal pleura is well anaesthetised.

2. **GAS EMBOLISM.** Most distressing and serious complication that may occur during induction is that due to some gas escaping into a blood vessel. An epileptic fit and hemiplegia may carry away the patient immediately or in the course of a day or two. A correct technic, a slow induction and a careful watch on the manometer which without the least doubt should show the presence of the needle in the pleural cavity, will avoid this danger.

IMMEDIATE EFFECTS.

In a properly selected case the effects of a well conducted induction of pneumothorax are marvellous. If a case is having fever there occurs a slow remission of temperature which may touch to normal in from a few days to 3 or 4 weeks when even all other methods would have failed to effect this. The expectoration if plenty becomes less and less changing from purulent to less purulent, thinner and more mucoid in a few weeks time. Cough becomes less troublesome, patients sleep better and look brighter.

If recurrent haemoptisis was troublesome it becomes much less and ultimately may disappear. The patient's general health improves in every way.

But when I am giving these facts it is not my intention to carry you to the domain of a complete cure in cent per cent cases. Many experts who have carried this type of collapse therapy had cures, failures and improvements in the series of their cases depending upon the stage of the disease and the way each individual case reacted to the therapy. For a successful result it is necessary to carry out the treatment at varying intervals for about two years and after that

the case must be closely watched now and again. Considering the remote effects of the treatment I have to tell you that this type of collapse therapy is a life saver for some cases, for some more it prolongs the span of life which would not have been possible in any other form of treatment and yet in some others it is a failure. But on the whole is it not gratifying to know that there is a means available which may cut short the disease, improve the general condition of patients and may even bring about a cure?

INDICATIONS: The best indication is a unilateral affection of the lung at early stages though a perfectly healthy contralateral lung is rare to find. Cases with recurrent and severe or obstinate haemorrhages must immediately be treated with pneumothorax. When the patient is having rapid pulse and high fever and other signs of activity collapse therapy is indicated if it rebels against ordinary lines of treatment. Some physicians are of opinion that it is essential to have one lung absolutely healthy as an indication to do pneumothorax but if that is so the field for pneumothorax will be awfully narrowed. In practice however it is difficult to find an absolutely healthy lung when one lung is pretty advanced. Commencing of the disease in the other lung, is certainly an urgent indication to do pneumothorax in the advanced side as it has been found that the focus in the healthier lung turns quiescent after this. Though I have no records and radiographs of my own cases I have watched the progress of some cases with large cavities whose radiographs were taken at regular intervals after pneumothorax, when I was in Vienna where I did over fifty cases. The cavity is pressed by the pneumothorax and finally it almost disappears.

CONTRA INDICATIONS: Advanced bilateral lesions with active focus in both. Even here it may be possible to prolong the life of the patient by partial pneumothorax on either side or by collapsing each lung alternately. Forlani and Bernard have published records of these types of cases and I have myself the knowledge of some such cases which were treated with certain amount of benefit. Another contra-indication is extensive adhesions of the two layers of the pleura as a result of which it is very difficult or impossible to form a cavity by injecting air

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

But recently the division of the adhesions are done with the help of Thorascopes. Serious involvement of other organs like intestines and larynx with tuberculosis are also contra-indications. There are some cases for whom pneumothorax is either not suitable or has failed to do any good and for such it is necessary to have some other form of collapse therapy. Of these the phrenicotomy or phrenicevulsions and thoracoplasty are the two commonly practised. The idea underlying these is to immobilise the lung and cause collapse of the same.

PHRENIC EVULSION: Though section of the phrenic nerve brings on paralysis of the diaphragm and thus immobilisation of the lung specially the lower lobe it is found insufficient because after sometime the cut ends reunite and therefore a better operation would be to cut the nerve and pull it out from the thorax and excise about 8-10 inches of the same. I have seen a number of operations in Vienna and I have myself two to my credit after I came, one of which I demonstrated to the Chettinad Medical Association some months ago. One of the two showed very good improvement. Regarding the other case I cannot say the operation improved the condition much. The operation is simple and is done under local anesthesia. The patient is placed in a semi-recumbent posture with the head tilted to the opposite side of the field of operation.

Two fingers breadth above the clavicle at the posterior border of the sternocleidomastoid muscle is a depression where the phrenic nerve can be easily reached on the scalnus anticus which is separated from the skin by a small layer of fat only. The incision may be about 1½" long along the posterior border of the sternomastoid. The only structure of importance at this area is the transverse cervical artery which may be tied if need be. When the nerve is bared a few drops of the anesthetic solution may be directly injected on it and then excised. Catching hold the lower end of the nerve it is slowly pulled out almost in the way one deals with the guinea worm. If one is rough in pulling the nerve it breaks off and the results may be not good. About 8-10 inches may be excised. When only one lung is affected this operation may do marvellous good and pneumothorax may not be necessary at all.

The two important indications are:

1. Failure to improve in spite of all efforts to fibrose in cases of unilateral lesion.

2. In cases where pneumothorax is impossible or dangerous owing to extensive adhesions or cortical cavities. In such cases preliminary to thoracoplasty operations this may be tried to test the condition of the supposedly healthy lung. In cases of active basal lesion with softening and expectoration this operation contrary to the common belief is contra-indicated as by this the expulsive power of throwing out the phlegm by cough is stopped and the retained products may cause grave complications. In Vienna they always do a phrenic evulsion as a preliminary to thoracoplasty.

THORACOPLASTY partial or complete is a very serious operation and only an expert in the art of surgery can do the same. This is also done under local anesthesia and I have seen over fifty operations by Prof. Denk, a disciple of the famous Prof. Isels Berg of Vienna. In his hands the number of successful cases are many but I cannot say the same is the case with a slow operator. He is quick and he allows hardly a few drops of blood to be lost in this mutilating operation. In complete thoracoplasty extra-pleural, from the 1st rib to the 11th are excised beginning from as far back as possible on the vertebral side and ending at costal cartilage. The operation is generally done in two sittings; at first the lower five or six ribs are excised and by the second sitting after some weeks the upper ribs are dealt with. The indication is extensive involvement of one lung with perhaps commencing lesions in the other when all other methods have failed to relieve the condition. This should be an absolutely aseptic operation and the wound should heal by first intention.

Considering the contralateral lung to be sufficiently healthy to resume the burden of carrying on the function the indications are:

1. Impracticability of induction of pneumothorax due to extensive adhesions.

2. Poor results of artificial pneumothorax.

3. Economic difficulties of the patient disabling him to carry on the treatment for a long time with induction of pneumothorax.

4. Troublesome recurrent hæmoptysis.
 5. Refusal of the lung to reexpand after pneumothorax.
 6. Chronic tuberculous empyema and pyopneumothorax that are resistant to other lines of treatment.
 7. Acute pyopneumothorax—where patient may recover from the shock and be fit for withstanding the operation.
 8. Embarrassment—kinking or deformity of neighbouring organs like heart, bronchus etc., as a result of fibrous adhesions.
- The contra indications are :
1. Serious disability due to the disease or any other simultaneous cause disabling the patient to withstand the operation.
 2. Serious disease in the contra lateral lung.
 3. Weak heart.
 4. Tubercular lesions in other organs.

Details of the technic of the operation are found in any standard text books on surgery.

I feel I have taken too much of your time. But if I have only made you understand the necessity of switching on to the newer methods of treatment from the old routines I feel I have done my duty towards many patients whom you can almost save from the grasp of death by judiciously collapsing the lung by one of the methods described by me. It has not been my intention to exaggerate the benefits of the methods of collapse therapy but I only attempted to impress upon you the fact that collapse therapy is in properly selected cases the ideal method of treatment and of great economic importance to the patient and the State.

PANCREPATINE
RESTORES **P. P. D.** HEALTH
IN DIABETIC CASES

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

Abstracts

WHAT IS GOOD OBSTETRICS?

By

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Much is being written and said about inferior obstetrics, and it makes one wonder, *just what is good obstetrics?* No doubt too much meddling has been done in obstetric work, and those who know how to apply forceps, or think they do, no doubt have to fight the tendency to "get it over with." Since the use of pituitary extract has become so common, there is, without doubt, too much use of *that*, used to whip up the uterus.

Of course, any injury to the birth canal predisposes to infection, and this manipulation and use of pituitary, certainly make for such injury. Therefore, those who feel that they are qualified may often do more harm than good. I heard one man, who does some surgery, say that his patients all did better than the baby was born before he arrived.

I may be wrong, but I feel that my patients do better when I am present. I see lacerations and puerperal fever, in patients who had been delivered before I arrived, and who had not been examined by me; but, had there been no examinations? I have an idea that there had—by the woman herself. I have some trouble with women of the laboring class, who try to put their hands to the vagina (even while I am there), to see if they can detect any progress. And to my amazement, one woman (not a midwife) informed me that she had examined the patient before I arrived. I think this practice is far more common than physicians realize; in fact, I have never heard a physician refer to it at all, and I wonder if they are ignorant of the practice. It is surprising that there is not more puerperal infection than there is. If the prospective parents only knew a little more, and some of the doctors (figuratively) "knew" a little less, in my opinion we would have better obstetrics.

It takes much patience to practise obstetrics. Every minute of the second stage of labor seems, to the patient, like hours—and

time doesn't fly with the attendant. I continually tell myself: "Time is a great result-getter, and Nature is a wonderful doctor." I also continually impress on the patient that nature *intended* this process to be slow and that every pain helps. If there is any doubt in my mind of the probability of normal delivery, I never impart my doubts to the patient, but try to keep up her courage; and many times, even though I have doubts, a successful delivery takes place normally. If, after five or six hours of good normal labor pains, there is no progress, I use forceps; provided, of course, that the head is engaged and delivery by forceps is possible. Of course, no attempt to apply forceps is made unless the diagnosis of position is certainly made by feeling an ear or some other landmark.

If delivery takes place in the home, it is better if all present give up hope of normal delivery before I do anything radical. Of course, one cannot be governed by what these untrained and sometimes uneducated neighbors think, as *one* will wonder why the Doctor doesn't do something early and *others* believe in letting nature have its course to the end. But if anything happens to the baby soon after it is delivered, I cannot help fearing that the forceps were the cause, and therefore I hesitate to use forceps if I think that the normal forceps can accomplish the result.

TECHNIC IN HOME PRACTICE.

I always use rubber gloves, which are boiled and wrapped in a clean (not sterile) towel, and everything for these cases is carried in a bag used for *this purpose only*. On arrival, I wash well in warm water, using soap freely; dry my hands and clean and dress my nails; again wash well in clean water; then prepare a solution of some antiseptic and soak my hand and also my glove in this and put the glove on wet. Feeling that it is impossible, in some homes, to have asepsis, I stick closely to antisepsis.

All examinations are vaginal; I do no recitals. The finger never enters the vagina without first going through the antiseptic solution. I feel that many times I can aid flexion, and thereby rotation, in this way. As the head comes over the perineum, I take the buttocks in my hands and pull them toward the median raphe, allowing more room and preventing laceration in many cases.

If one tries to do *too much*, one is liable to do too little, in some cases to one's regret. I have seen, unwrapped in a bag (apparently a general utility bag) with many other articles, a glove, *taken and placed on an unwashed hand*, applied to the antiseptic solution, and then a version done. Such things are certainly *bad* obstetrics.

THE SUCCESSFUL ACCOUCHEUR

In my opinion, good obstetrics requires an accoucheur with the following qualifications:

Good judgment, which decides, not only *what* to do, but *when* and *how* to do it. A patient may need a premature delivery: the *when*, and the *how*, are important. If there is some permanent reason for it, such as contracted pelvis, and no more pregnancies are desired, *one procedure*, is indicated; if it is some temporary reason and other pregnancies are anticipated, *some other procedure* might be advisable. A high-forceps delivery should never be performed, especially upon a patient without dilatation, who had been delivered successfully at a previous confinement.

Patience to wait for the natural forces of labor to exert their full effect; patience to give a chance for time to work its wonders, rather than hurrying into undue and ill-timed stimulation.

Skill to do the average, and not necessarily the major operations; skill to know what should be done and insistence on its being done by a more skilled colleague, who may be deficient in judgment.

Good judgment is indispensable in the practice of medicine or any of its branches. The experienced eye sees much. The symptoms may seem grave, and yet the appearance of the patient reveals that all is right; or there may be no serious symptoms, and still there is the *something* that says loudly, to the experienced practitioner, "This is a very sick patient"—and time proves that opinion right. It is not following "hunches," but radiating the facial expression, which can be learned only by experience.

Skill is great, but it is not enough. Unnecessary operations and undue haste are not good obstetrics, however skilfully performed.

(*Clinical Medicine & Surgery*, Dec. 1933.)

Notes on Treatment of Diseases.

N. B.—These notes are intended to supplement the treatment given in ordinary text books and are neither expected nor possible to be exhaustive.

Malnutrition of Infants: Insulin 1 to 3 units to be given 10 minutes before meals. As Pancreas contains an enzyme for the promotion and also absorption it is useful. (J. O. T.)

Secretin with Thyroid $\frac{1}{2}$ grain and Parathyroid 1/20 gr. twice a day. As the disease is due to the atrophy of the thymus gland, thyroid gland with anterior pituitary and lymphatic gland are useful. (E. S.)

If the marasmus is due to fat indigestion, albumen water, skimmed milk, Horlick's Malted milk, 1 in 8 are useful, and if due to carbo-hydrate indigestion, Mead's dextro-maltose, protein milk prepared with "casee" of Meads, 20 grs. to an oz. may also be given. If caused by protein indigestion Sodium Citras 1-3 grs. may be given with each oz. of milk.

If due to pyloric spasm Sodium Bicarb $\frac{1}{2}$ gr. to an oz. of milk, Atropine $\frac{1}{2}$ gr. in 2 oz. of distilled water of which 1 mm. to be given every 15 minutes. If due to want of Hydrochloric Acid, Acid milk may be prepared by mixing 2 drms. of deci-normal Hydrochloric Acid with 2 drms. of water and of this mixture 1 mm. has to be added to 1 oz. of milk. The acid is to be added to the milk and not milk to the acid; or $\frac{1}{2}$ gr. of Acetic Acid to 1 oz. of milk. (M. T. T.)

To supplement nutrition Pancreatic Tabloids may be given. For constipation in marasmic children Hyd. Cum Creta gr. $\frac{1}{2}$, Pulv. Rhei Co., grs. 3 may be given three times a day for a long time. (Still.)

Subcutaneous injection of cotton-seed oil commencing with 1 c. c. and increasing to 10 c. c. in the middle line of the back is said to have very good effect, in marasmus in children. (C. M. S.)

Mania: (Acute). Sulphonal acts at times splendidly. Hyoscine Hydrobromide 1/100 gr. hypodermically has a very good effect. If the kidney and heart are healthy Chloral Hydras 10-15 gr. doses may be given. Cannabis Indica 1 gr. of the Extract or $\frac{1}{2}$ to 1 dr. of the Tincture has also very good sedative effect. Cannabis is found more serviceable if 60 gr. of Bromide is combined with it. If the patient is very troublesome and uncontrollable $\frac{1}{12}$ gr. of apomorphine given hypodermically will cause emesis and relaxation of the muscles.

Meningitis: If due to head injuries Urotropine grs. 10 is good. (M. T. T.)

In Meningitis caused by pneumococcus, recovery is rare, but intra-spinal injection of Anti-pneumococcus serum with "Oplochon Hydrochloride" in saline solution is said to be effective. (P. M. S.)

In Cerebro-spinal Meningitis hypodermic injection of Soamin is recommended by eminent physicians as a specific. Anti-Meningitis serum is to be injected into the spinal cord after removing a small quantity of spinal fluid. Chloral Hydras in 10 gr. dose combined with 40 gr. dose of Bromide acts as a good sedative. Blisters to the nape of the neck in patients with comatose condition is also advised. In cases with threatening symptoms of cerebral pressure, perform lumbar puncture and draw off a little spinal fluid proportionate to the pressure symptoms.

Meniere's Disease: Pilocarpine 5 to 8 drops of 2% solution every second day to be given for weeks. (M. M.)

Melancholia: Examine urine for oxalate crystals and if found, give freely Nitro-Hydrochloric acid mms. 5 after each meal in $\frac{1}{2}$ a tumbler of water. Thyroid is useful. To promote sleep Anylene Hydrate in 1-1 $\frac{1}{2}$ drms. doses is said to be very effective. Sulphonal should not be given. Injection of 15 c.c. of blood mixed in 5 c. c. of sterile water into the gluteal muscle repeated every other day is believed to have very good effect.

Menorrhagia: Thymus and Parathyroid are useful, and also Pituitary Gland. Ext. Ergot Liq. 10-60 mms. or Cotarine Hydrochlor 1-4 grs. in pills thrice a day and locally Adrenalin 1 in 5000. But Ergot and Cotarine Hydrochlor should not be given where there is atony of the uterus, due to degeneration of the muscle fibres.

Pot. Bromide 10 grs. several times a day and Extract of Mammary have been tried with success. (Sagous.)

In young girls Post Pituitary given intravenously has been reported to have very good effect. (J. O. T.)

Injection of whole blood subcutaneously in the back has been tried with success. To prevent coagulation the syringe may be coated with sterile petrolax.

Menstruation (during nursing): To prevent this and to increase milk supply Placenta Mammary Co. has been tried with good success.

CLINICAL NOTES

AND

PRACTICAL SUGGESTIONS

Colloidal Therapy

The use of finely divided metals in suspension was a time-honoured practice in medicine and following this line of treatment in more recent years plenty of clinical evidence has been advanced which demonstrates beyond doubt the superiority of therapeutic action of certain metals in colloidal state over the same when administered in the crystalloid one. These colloids are prepared by means of two methods—the electrical and the chemical. Most of the metallic colloids are prepared according to the first one. Roughly speaking the process of manufacture consists in passing electric currents between the two wires of a metal or combination of metals as a result of which we get the finest particles of metals which soon form into a colloidal solution. The metal or the combination exists in a very fine minute division in this solution, uniformly distributed and exposing a wide surface. In Orargol, the preparation which we will discuss in this article there is a combination of colloidal gold and silver electrically prepared from an alloy which contains 10 per cent of gold and 90 per cent of silver.

It is not yet definitely known how these colloidal metals act in the organism, but it is said that after administration they are soon converted into the ionic condition in the system, on which it produces a slow sustained metallic action. Other possible explanations of the action of these colloids are their brownian movements (a characteristic feature of all colloids), surface phenomena, electrical charge and catalytic action like those of the ferments. The pharmacological action is mainly due to the transformation of the amicros, the ultra-microscopic particles which exert some action into the ionic condition. This action exerted by the colloidal metals resembles that of certain therapeutic sera but the former are more potent and reliable. Apart from cases in which specific serum is available the routine and systematic use of Orargol, which is a combination of metals in a colloidal state, is recommended as it is a dependable anti-infectious agent in any

acute infection, whether it is serious, refractory or complicated.

Orargol can be advantageously used in many conditions with high pyrexia due to some septic focus. It is on account of the remarkable success that has attended its use that Orargol has been employed in the treatment of Influenza, Hay-fever, Pneumonia, Broncho-Pneumonia, septic conditions etc.

Ample clinical evidence of the value of Orargol in the treatment of *Influenza* is slowly accumulating. When injected either in the muscles or the veins it possesses the power to shorten considerably the duration of the disease by reducing pyrexia, headache and pains in the joints and muscles. Beneficial effects of this product will be more evident if the injections are commenced as soon as the symptoms definitely point to Influenza. It is therefore a potent remedy for combating this disease and its complications if the treatment is used sufficiently early.

Signal success has attended its use in *Pneumonia* and *Broncho-Pneumonia*. Clinical evidence demonstrates conclusively that it favourably influences the course of the disease by stimulating the development of the immunising processes, which results in the reduction of fever, resolution of the lungs and other attendant symptoms. In *Broncho-pneumonia* of children it acts like charm when given by the mouth. It works more slowly in this way than when injected, but none the less it is very effective. It brings down within a few days temperature as high as 105°F, and allays and cuts short the inflammatory process. Thus many fatal issues are prevented by the timely administration of Orargol.

Another indication in which Orargol can be employed with benefit is *Hay-fever* because of the anti-anaphylactic action it induces. Many persons affected with Hay-fever have been rid of the complaint for several seasons by means of the long-continued use of 'Non-injectable' Orargol.

Orargol if injected sufficiently early will nip in the bud a severe cold in the head and will thus prevent further complications. This it does by reason of its immunising effect on the local tissues.

Because Orargol is a general anti-infectious agent and because it is able to

whip up the defensive processes of the organism it is an excellent remedy in a variety of diseases of infectious and microbic origin. Thus it may be prescribed at the beginning of such diseases as Typhoid fever, Encephalitis Lethargica and other similar infections. It creates a favourable field for the introduction later on, when the diagnosis has been established, of specific sera or vaccines.

The treatment by means of Orargol injections in the early stages of *Septic infections* is of inestimable value. It is at this time that the formation of the protective substances in the organism can be stimulated and hence its use is very valuable. Repeated injections administered for three or four days brings down the temperature and the pulse to normal and the blood-cultures soon become sterile. The local lesions rapidly heal up and the patients feel better within a period ranging from two to four weeks.

In Naso-pharyngitis Orargol acts almost as a specific being an active bactericide without any toxic or irritating effects. In these affections it is best used in the form of a spray or gargle and cotton wool plugs soaked in the solution can also be usefully employed.

In the early stages of acute tonsillitis or Peri-tonsillitis injections of Orargol supplemented by local spray or gargles will frequently help it to disappear soon. In septic tonsillitis it is of great value as it raises the vital forces of the organism to effectively cope with the septic infection.

There is always a good response to Orargol therapy in Vincent's Angina. The thick membranous deposit, the usual accompaniment of this kind of stomatitis, clears off under its regime and the patient is rid of the complaint within a short period.

Many otologists have reported good results following the use of Orargol in acute Otitis Media. Pain is allayed and exudative catarrh or suppuration is benefited. The undiluted solutions, when allowed to remain in situ in these conditions regularly for some days will help to cure them.

Acute mental infections of the furuncular or eczematous type also yield easily to this line of treatment.

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In acute infections of the accessory nasal sinuses Orargol injections have been found valuable adjuncts. In conjunction with other lines of treatment Orargol has been found very useful as it helps the organism to fight with the infections in an effective manner. Along with the local treatment of lavage etc. this treatment aids in clearing the injection within a short period.

In infectious diseases of the urogenital system Orargol can be beneficially indicated. It increases as much as is possible the natural power that the organism possesses of defending itself against infectious attacks. In addition to this it possesses some advantages over inorganic or organic salts of silver which are usually employed in genito-urinary infections. Orargol, when instilled locally either undiluted or diluted, does not damage the epithelium of the urinary passages, acts as an excellent bactericide and does not harden the mucosa even after prolonged use.

The usual effect of the treatment in acute Gonorrhoea or gonorrhoeal arthritis or epididymitis after one or two injections is that the general subjective symptoms tend to diminish in severity and shortly afterwards there is a decided improvement in the local disturbances. Objective pathological signs disappear later on after two or at the most three weeks. The use of Orargol therefore through intramuscular or intravenous injections is recommended in simple as well as complicated Gonorrhoea. When used in the former in the early stage complications can be easily avoided. Refractory or protracted cases may however require a prolonged treatment.

Clinical experience spread over a number of years clearly points out that Orargol possesses some advantages over ordinary colloidal preparations of silver and hence its preference.

(I) It has more activity because of its combination with colloidal gold which is considered to be an effective anti-infectious agent.

(II) When given intravenously it does not cause any reaction, or if it does it is a very mild one because the colloidal gold exists in the preparation in an extremely dispersed state.

(III) Orargol is so prepared that it can be made isotonic in the ampoules, so that no other addition or preparation is needed before injecting it.

(IV) It is miscible in all proportions with all kinds of serums.

The following two cases selected out of the many will convince even a sceptic of the remarkably good results obtained with Orargol:

1. Mr. K. about 35 suffering from typical symptoms of Influenza with bronchitis came to me for treatment. The patient gave history of having suffered several times from the same complaint whenever there was influenza about. On this occasion when he was seen by me he had temperature of 103° with headache, hoarseness, cough and very severe muscular pains. As he had already been dosed for two days with too much Quinine and Salicylates I decided to inject Orargol, 5 c.c. of which were given by the intramuscular route every day together with a little diaphoretic. The next day the temperature as well as the pains and general condition, was almost the same as on the previous day. The injection was repeated and after this improvement seemed to be marked and when one more injection was again given in the morning the temperature came down to normal that very evening, with abatement of all symptoms except cough which continued for some days. Another injection was given the following day just to make sure and he completely recovered on the sixth day and resumed his duty on the seventh. He has since then never suffered from Influenza for a long time. The chief points that interest us are that the recovery was very rapid and the patient who was particularly subject to Influenza never got the infection for a pretty long period.

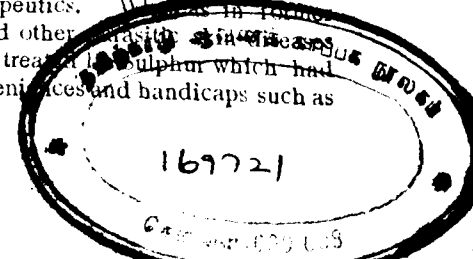
2. I was called to see a young lady of 25 suffering from fever, headache, pains in the limbs etc. The temperature ranged from 101.6° to 99° . The lungs were found quite clear on examination and the liver and the spleen quite normal. The case was diagnosed as Influenza and the routine treatment of Quinine with Salicylates was given. Not even the least sign of improvement was seen after eight days of this treatment. Although the temperature never went above 99° after this, the patient was indifferent, listless, apathetic and answered

questions with great reluctance. On examination once more I found most of the organs normal but there was rigidity of the face with obliteration of the naso-labial folds and stiffness of the extremities. Temperature was at this time 99.2° and the pulse was 62 per minute and there was marked leucopenia. The patellar reflexes were normal but the Babinsky's sign was absent. All these symptoms led me to believe that it may be a case of Encephalitis Lethargica. Having got this diagnosis confirmed by a consultant I gave salines and Hexamine to start with and supplemented this treatment by the intravenous injection of 10 c.c. of Orargol. Although the morning temperature next day was 98.4° it again went up in the evening to 99.4° with however a good pulse-rate i.e. 78 per minute. The same injection, mixture and Hexamine were continued for two or three days with very little improvement. On the fourth day of this treatment both the morning and the evening temperature did not rise above 98.2° . The pulse was good and distinct improvement in the subjective condition was clearly evident. Apathy and indifference gave place to interest and she became more talkative. The stiffness in the limbs disappeared and the expression of the face became animated. This day as well as the next the same treatment was continued. The patient felt much better, the temperature was normal and she was thoroughly satisfied at the rapid change. After this only 5 c.c. of Orargol were given intravenously every other day solely as a precautionary measure while the treatment by mouth was continued. She completely recovered after a week's treatment and began to engage herself in her usual domestic activities.

This case, though comparatively a mild one, was brought under control after four injections of Orargol and the recovery was quite remarkable in view of the fact that the patient was able to leave her bed after ten days of this treatment.

Sarcoptol in Dermatology.

Sarcoptol, the colloidal preparation of Sulphur, has proved its value as an antiparasitic, analgesic and antiseptic in dermatological therapeutics. It has been found to be mainly treated in cases of scabies which had many inconveniences and handicaps such as



objectionable odour, greasy application and irritation, Sarcoptol is entirely free from any of these shortcomings. It does not irritate the skin and it is well tolerated by even the most sensitive skins. When used for long periods it is not toxic or harmful to the kidneys due to absorption. This is so because in Sarcoptol, Sulphur is in fine colloidal suspension. Its action on account of this is more penetrating and more wide. It is therefore a radical and a safe therapeutic measure in many of the skin affections such as scabies, ringworm, seborrhoea, seborrhoeic eczema, dandruff etc. The following excerpts from various cases will be a convincing proof of the value of Sarcoptol in skin diseases.

1. This was a case of Seborrhoeic Eczema in a woman of 35. She had on her face irregular egg-shaped patches covered with brownish-red scales. They varied in size from that of a pea to that of a rupee. These patches at times healed in the centre leaving a circular eruption round about and this always misleads the physician who diagnoses it as ringworm. I presume this mistaken diagnosis had led the previous Doctor who treated this case to employ such remedies as Chrysarobin which had irritated the affection very much. After minute observation of the face and the forehead I examined the scalp where I found similar patches and then I came to the conclusion that this can be none other than Seborrhoeic eczema. Treatment was started in right earnest with Sarcoptol. I advised her, applications of Sarcoptol on the scalp nightly at bed-time, after cleaning the hair with a good soap. She was advised to rub it vigorously so that it should penetrate into the scalp. Diluted applications of Sarcoptol, one part of the remedy to two of water and gradually increasing the concentration, was recommended for application to the face. In three days' time the scales disappeared, the redness of the patches on the face was much less and there was very little itching, hyperaemia or irritation. Four more days of this treatment brought about a complete change in the affection. The patches disappeared both on the face and on the scalp. The treatment was however continued for a week more, at the end of which the face and the scalp were absolutely dry and clear of the disease.

2. Another case was of Dandruff in a lady of 25, who had localised patches all over her scalp. There was in these patches a certain amount of inflammation presumably due to the presence of Staphylococcus Griseous. Nightly at bedtime concentrated Sarcoptol was rubbed into the scalp which was washed next morning with spirit lotion and soft soap. This routine was followed for a week at the end of which the inflammation had lessened and the scales had almost disappeared. When the lady had completed one small-size bottle her complaint had entirely disappeared.

3. Another case effectively treated with Sarcoptol was that of Pityriasis Versicolor in a domestic servant. This affection was of one year's duration. There were irregularly-shaped dry and yellowish-brown patches over the thorax and in both the axilla. After massaging pure Sarcoptol for three days over the affection, irritation and desquamation completely disappeared but the fungi when examined microscopically were still present. The treatment was continued for a week more after which the patient was entirely cured and no fungi were visible under the microscope.

Besides these, Sarcoptol can be used in Scabies for which it is a specific. Correct application of this remedy will free the patient from this ailment in one day. It can also be used with remarkable success in ringworm, seborrhoeic dermatitis and acne. It effectively allays irritation, which property is specially useful in itching and pruritus of whatever origin. This soothing action takes place soon after the application. It is clean and pleasant to use, speedy in action and absolutely non-toxic and non-injurious to the organism.

Treatment of sexual and other allied deficiencies.

From time immemorial the extracts of certain glands were made use of in the treatment of sexual or other disorders akin to them. In India, about 1,000 or 1,400 years back, this treatment was practised, as can be seen from the description we come across in the books of Sushrut and Charak of the use of testes for the cure of impotency. They speak highly of the curative

value of this gland in this and other diseases. As time passed on, this treatment gained a firmer and wider foothold, until a few years back organo-therapy came into the field and became the approved line of scientific treatment of these diseases.

Of late treatment with the combination of the extracts of various organs have come into general use. The effects obtained by the ingestion of these essential principles of the internal secreting glands, although not rapid, is a sure, certain and lasting method of bringing about normal conditions in the deficient organism. Homovir is such a preparation which absolutely conforms to all the demands that are made of an effective and a reliable hormone preparation for defective sexual conditions.

Homovir is a hormone preparation of the male generative gland in combination with extracts of Thyroid, Suprarenal, Pituitary, Prostatic and Yohimbine. The clinical value of Homovir therefore, is due to the fact that this combination of several extracts of glands, together with Yohimbine acts physiologically and therefore definitely and effectively. It is so to say, a kind of tonic which restores the mental, physical and sexual vigour. It supplies the enfeebled male organism with the necessary glandular or endocrine substances which repair and maintain the normal physiological balance. Sexual functional inadequacy and its attendant evils are now considered to be largely the result of endocrine deficiencies, specially—the Thyroid, Suprarenal, Pituitary, Prostatic and Orchitic Glands and the administration of these vital glandular substances in adequate qualitative and quantitative proportion is a highly scientific and rational therapy to restore these deficiencies.

We shall now examine each constituent of this preparation, and we will then be able to realise well the effective synergistic action of Homovir.

THYROID: The dessicated extract of this gland is 0.005 gm. in each tablet. The main function of this extract is that it regulates metabolism and maintains its equilibrium.

SUPRARENAL: This extract is most essential in bringing about body oxidation and detoxication. The tone of the heart as well as the circulatory system depends upon its functional activity. Most of the

physiological processes are stimulated by it, and it is therefore mainly responsible for giving energy and vigour to the organism.

PITUITARY (WHOLE): While the anterior lobe of this gland helps to stimulate the testicular functions and is a good tonic and activator, the posterior one brings about effective contractions of the involuntary muscles, and is an excellent vaso-constrictor.

PROSTATIC: The extract of this gland ensures an intensified specific effect upon the genito spinal centres and brings about effective vascularisation of the genital organs.

ORCHITIC: This extract besides supplying the vital testicular substance to the exhausted genital glands, exerts great influence in maintaining metabolism. It also stimulates the neuro-muscular apparatus and influences osseous metabolism. In addition to the nucleo-proteid material it contains Spermin, an organic base, which assists oxidation of the tissues and acts as a carrier of oxygen. It is thus able to repair and maintain the testicular function and at the same time improve the general condition of the organism.

YOHIMBINE: A small quantity of this alkaloid is added because of its effective stimulation of the internal secretions in general. It has also a positive specific influence on the genital centre of the spinal cord, and on the corpora cavernosa.

Owing to these suitably selected combination of extracts, Homovir exerts an effective excitative action in genital and other deficiencies, and supplies the missing hormones thus re-establishing the normal internal-secretory equilibrium. Homovir is a preparation which does not merely remove the symptoms, but acts upon the cause of the disease by restoring to the body the deficient hormones. The improvement in the sexual functions as well as the general condition makes itself noticeable after a comparatively short time. The biological stimulation which it produces results in the betterment of both the physical and mental condition.

Homovir was primarily employed in the treatment of impaired sexual functions. Its use has now been extended to a very wide variety of conditions, due mainly to the knowledge of the fact that there exists an intimate correlation between the genital

glands and several other internal secretory organs.

IMPOTENCY: It is at present well-known that the testes and other internal secretory glands, besides being responsible for the proper functioning of the sexual system greatly influence the psychological condition. If these glands are either diseased or unable to function properly the result is sexual weakness or impotency, and all other disturbances which follow it, such as, loss of appetite, nervousness, sleeplessness and depression. Homovir, when administered in these conditions brings about a striking reviving and invigorating effect. These patients besides gaining their lost sexual power and vigour, feel better in general health as can be seen from the increase in appetite, disappearance of sleeplessness and improvement in the mental condition. Homovir, by reason of its rational combination is able to overcome this condition remarkably irrespective of its causation.

SEXUAL WEAKNESS. Homovir can be prescribed with success in cases of premature sexual weaknesses, whatever the cause may be. It is able to restore to the body the lost hormones and the whole organism is thereby regenerated. The general physical as well as mental condition is improved, as is evident from the better supply and permeation of the organism with blood. The power of the muscles is increased, energy and vigour is regained and the patient feels quite active and buoyant.

SEXUAL NEURASTHENIA: From the clinical experience of different investigators, Homovir has been found to be quite a suitable remedy for combating sexual neurasthenia. This is due to the fact that in Homovir, in addition to the proper basis of Orchitic Extracts it contains the prostate and the pituitary hormones. From the application of this preparation not only is the patient provided with the hormones that are deficient, but his central as well as the vegetative nervous system is effectively stimulated. The nervous symptoms are thus beneficially influenced and the genital is consequently restored to the normal.

SENILITY: Homovir is of exceptional value in this correlation. By effective stimulation of the various internal-secretory glands,

which have correlation with the testes, the patient is able to get through this period with as little discomfort as possible. The senile trembling and prickling disappear, the skin regains its elasticity and the mental faculties and physical vigour are restored to normal. This preparation will make possible for the patient a normal continuance of sexual competency, and will prevent for a long time the physical manifestations of age. In fact, Homovir regime is a simple and an easy method of rejuvenation and is free from all risks of dangerous and difficult operations.

DISTURBANCES OF GROWTH ETC: Growth depends mostly on the adequate functioning of several glands, such as Pituitary, Thyroid, Suprarenal and Testes. Due to this fact, Homovir because of its composition can be successfully employed in these conditions. The active principles of these glands and the growth promoting hormone of the pituitary contained in Homovir serve effectively to correct these disturbances of growth.

MENTAL PHYSICAL COMPLEXES: Homovir is rightly considered a physiological and rational therapy for mental depression, fear, indecision etc. By reason of its composition, it is a real tonic as it restores mental, physical and sexual vigour. This it does by supplying the enfeebled organism with the necessary endocrine substances, which repair and then maintain for an indefinite period the normal functions.

GENERAL DEBILITY: When this is due to the gonad hypofunction and its attendant evil effects, a course of Homovir injections will usually set the condition right in the majority of cases. It is due to its restorative and tonic efficiency that Homovir is successful in these cases.

Treatment with Homovir can be carried out with extraordinary ease. No special dietary is needed during the course of treatment. Neither the injections nor the tablets have any injurious effects on the heart or kidneys. The injections are painless when given subcutaneously and they never cause any local infiltration. Homovir acts well on a diseased organism, but does not influence so much the healthy one, so that unnecessary fear of increased virility need not be entertained during the course of the treatment.

Homovir is obtainable in specially coated tablets and injections. It is always desirable to resort to the method of injection, because through it we can get more intensive action, and at the same time we can have the patient constantly under control. Moreover, these patients who are very sensitive, neurasthenic and mentally unstable, complain of so many troubles, specially stomach disorders, during the treatment and they attribute it to the preparation when given orally. Tablets should be recommended when there are no such complaints and also to supplement the injection treatment.

Homovir was used successfully by the author in the following case, which will be found very interesting:

R. M. 35 years old came to me for treatment of sexual debility from which he was suffering for the last two years. According to the history that I could elicit from him, it appeared that he suffered from chronic gonorrheal epididymitis about five years back. The patient is strong, well-built and healthy, is married and has two children. The internal organs were found in quite normal condition, but the testes appeared to be somewhat lax. He complained that he was not able to perform the sexual act, that ejaculation was very faulty and took place very quickly. He was mentally much depressed and was not able to do his work to his entire satisfaction. He said that he had undergone all kinds of treatment without much good resulting from them. Homovir treatment was at once instituted, the patient getting the injection every other day. After the course of twelve injections he was given a week's rest, during which time he took the tablets, three daily. Another course of twelve injections were again given after which he took two weeks' rest, tablets being continued during the rest period. A third course of 12 injections completed the full treatment. He continued however taking the tablets. At the end of the first course perceptible signs of improvement began to show themselves. A feeling of the return of virility and sense of comfort and well-being which he never experienced for the last two years appeared, and after another course he began to feel much better in sexual respects. After the full treatment he was quite a different man and his sexual debility, as

also the mental depression, entirely passed away. He was able once more to enjoy life fully which he never did, he said for the last five years.

Some illustrative cases.

A young man, a cook of 35, came to me for treatment of Asthma which he had for the last three years. He was looking very thin and small for his age. The first symptoms appeared three years back when he had a serious attack of coryza and chill. After that he began to get attack of asthma which were extremely frequent. These were usually accompanied by lachrymation, suffocation, oppression and at times tachycardia. As a result of the frequency of these attacks his general health suffered. There was loss of flesh, anorexia and insomnia. On auscultation sibilant and sonorous rhonci and subcrepitant rales were heard all over the chest. These paroxysmal attacks of asthma increased in frequency and severity despite the treatment he had at the hands of several medical men. His general condition had become worse as time passed on. He became much thinner, complained of a constant feeling of weariness. On percussion the resonance was rather exaggerated. Rales and rhonci were heard almost throughout the lungs.

When he came under my care I gave him the following expectorant mixture:

Liq. Arsenicalis	m.ii.
Tr Lobelia	m.v.
Ext. Grindelia	m.xv.
Tr Camphor Co	3js.
Tr Scillae	m.v.
Syr Tolu	3i.
Aq ad	3i.

Send six such doses.

In addition to this I gave him intravenous injections of Iodaseptine every 4th day as he had idiosyncrosy for iodides. I commenced with 2 c.c. until I gradually raised it to 10 c.c. He had about 25 injections like these. At the end of three weeks when six injections had been given there was considerable improvement. As this treatment continued he began to feel better, his breathing became more easy and comfortable. The attacks became less frequent and had lost their severity. There was not much oppression. He began, when he had a month's treatment, to get good sleep, the anorexia had disappeared and he was able

to eat everything with relish. His strength was gradually returning. Examination of the lungs after two months of treatment showed only a few rhonchi here and there. The condition of the heart had also improved. The patient is at present very much better, has recovered his strength and is able to follow his usual occupation. He has not had a single attack of asthma so far i.e. for about seven months. This cure has been obtained by nearly 25 injections and it can be explained by the intensive action of Iodine, without the least signs of iodism.

2. The patient, a young man of 25, had an accidental wound in the great toe of his right foot. Due to neglect, the wound which was between the first and second toe, remained unhealed. Later it started giving him pain for which he had requisition to medical aid. There was painful induration which extended over the dorsum of the foot. Lymphangitis of the foot had also developed and the inguinal glands were tender. This was all due to the wound becoming suppurated. The first day he came to me I advised simple boric fomentations and asked him to keep the foot elevated with some pillows underneath. Next day I opened the wound, evacuated it of all the pus which was smelling badly, and after cleaning it with ordinary tepid water dressed it with wet packs of Bacte-Pyo-Phage. The pain was relieved the next day, and the wound steadily improved until it healed up. The induration and lymphangitis gradually subsided. After the first three dressings he was able to attend to his work, and the wound had to be dressed about eight times before it completely healed up.

3. Another case which responded well to Bacte-Pyo-Phage was that of an abscess of the scrotum. The patient aged about 30 came to me with fever and severe pain in the scrotum. When examined I found it swollen, hard, red and tender. I expected suppuration and advised him to foment it and gave him one ampoule of Bacte-Pyo-Phage in alkaline water in the morning and asked him to repeat the same in the evening. Next day when he came to me he told me that the pain in the affected region was very much less, and on examination I found that the swelling had lost its hardness and had become much reduced in size. The ampoules of the Phage were once more

repeated and the fomentations were continued. The patient had very much improved, fever had gone, pain in the scrotum had almost disappeared and the swelling had become soft and fluctuating. I incised the abscess, took out all the pus and after cleaning it with ordinary tepid water packed the cavity with gauze soaked in an ampoule of Bacte-Pyo-Phage. After this the oral administration of the Phage was stopped, but the dressings were continued. In the course of one week the patient was cured of his wound and he was able to resume his duty. It is to be noted in this case that there was rapid healing of the wound, especially in such a region as the scrotum which usually takes a long time under ordinary antiseptic dressings.

4. I was called to see a patient about 35 suffering from fever. He had pains in the muscles and the joints and slight urticarial signs on the chest and arms. The lymphatic glands in the inguinal region were tender and swollen. I examined him thoroughly but could not arrive at a definite diagnosis until after two days he gave me the history of a rat-bite about a week back. When I came to know this I concluded that it is a case of rat-bite fever and I stopped the Quinine and diaphoretics I was giving, and straightway injected Sulfarsenol (30 cgms.) dissolved in one ampoule of Arseno-Solvent intramuscularly in the buttocks. The same was repeated after a week just to make assurances doubly sure. Not only did the fever come down the day after the first injection with the abatement of all the symptoms, but the relapses, which are frequent in this fever, were prevented. The injections were absolutely painless because of Arseno-Solvent, the medium employed for dissolving Sulfarsenol. Again, tedious and lengthy preliminary procedures were eliminated on account of this medium. There was no swelling nor was there any infiltration at the site of injection. The intramuscular injection was perfectly well tolerated. The effects of Sulfarsenol were not in any way affected by the Arseno Solvent as can be seen from the rapid recovery obtained with the injection. Arseno-Solvent therefore greatly facilitates the administration of Sulfarsenol which otherwise would be a troublesome and time-wasting procedure.

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

Treatment of Glaucoma

By

DR. A. BRAV,
Philadelphia.

Even in cases of glaucoma that require surgical intervention it is best to begin with medical therapy, so as to facilitate surgical intervention.

The following procedure is very efficacious in the first stages of acute glaucoma:

As a non-irritating, alkaline eye wash:

R/Acidi borici	...	gr. xxx (2.0)
Sodii bicarb	...	gr. xv (1.0)
Aqua mentha Pip	...	3 i (1.3)
Aqua distil	...	q.s. 3 iii (90.0)

Sig.: Bathe eye t.i.d.

To contract the pupil use:

R/Eserin salicylat	...	gr. $\frac{1}{4}$ (0.016)
Sodii citratis	...	gr. v (0.325)
Aqua distil	...	3 i (30.000)

Sig: One drop in the affected eye every two hours.

(Am. Med., Dec., 1931.)

Silver Salts in Eye Diseases

By

DR. G. W. VANDERGRIFT,
New York.

Over a period of thirty years' observation and experimentation in eye diseases with innumerable silver salts, the author has found that the most dependable have been, and are, the old 1 and 2-per cent solutions of silver nitrate, and argyrol (mild silver protein) in varying strengths, according to necessity.

(Internal. J. Med. & Surg., Jan., 1932.)

Uterine Inertia

By

M. GARBER, M.D.,
Cleveland, O.

A study of 100 cases of uterine inertia show that its diagnosis presents no difficulties. The increased pulse rate of the mother; her general appearance of being

tired and exhausted; the uterus retracted over the fetus and in a state of increased tone; uterus not relaxing between contractions; fetal parts not easily or not at all discernible; upward retraction of presenting part; rise of lower uterine segment, with increased thickness and tone of the fundus—these signs speak for exhaustion of the uterus as a result of overaction.

The treatment of the first stage of uterine inertia is watchful waiting and the conservation of the physical and mental powers of the patient; forceps or version and extraction during the second stage; prompt and energetic treatment of postpartum hemorrhage in the third stage.

When properly managed, the mortality, and morbidity, both maternal and infantile, in uterine inertia, should not exceed those in normal deliveries.

(Ohio St., M. J. July, 1932.)

Operative Treatment of Corns.

By

W. I. GALLAND, M. D.,
New York City.

Painful corns are pathologically similar to bunions and can be effectively cured by operative means. The operation includes regional anesthesia, administered at the base of the toe; removal of the entire keratinized superficial structure of the corn; and dissection and removal of the bursa and tiny exostosis underlying the site of the corn, which generally overlies the interphalangeal joint above the extensor tendons. The bursa and exostosis are always present and must be removed. In the series of corns on which I have operated, the results have been extremely satisfactory and no recurrences have been noted to date.

(J.A.M.A. March 25, 1933.)

New Therapy for Psoriasis.

By

DRS. H. S. CAMPBELL AND K. FROST.

We have treated 50 patients with psoriasis with intramuscular injections of an alcoholic suspension-solution of autogenous scales. About 0.2 Gm. of scales were obtained ground up, and about 25 c. c. of pure

grain alcohol added. The initial doses injected in the gluteal region were 0.5 c. c. and after three doses increased to 1.5 c. c., which was not exceeded. The injections were given twice weekly. Improvement usually was noticed after 6 injections.

The following results were obtained: In 10 cases the patients did not continue therapy; in 30 cases, with generalized eruptions, cure was obtained in 10, improvement in 19 and aggravation of the condition in 1; in none of 10 cases, in which there were only a few lesions, did healing result, but in 2 improvement was noted.

This treatment is of specific value in generalized eruptions of long standing which have resisted other forms of treatment. The injections may, however, have to be continued for a considerable period.

(*Arch. Dermat. & Syphil., Sept., 1932.*)

Pulse Pressure.

By

Dr. J. S. LANKFORD,
San Antonio.

In the young, the pulse pressure should be about 40 to 50 mm. It can be set down with certainty that, in the young, the diastolic pressure should not exceed 80 and, with increasing years, should not exceed 90 millimeters at any age. Seventy (70) for the one and 80 for the other is safer. Ninety-five (95), at any age, is pathologic, no matter what the condition. As the diastolic rises above the normal, the systolic is likely to fall, in the earlier stages of some depressing forms of disease, thus reducing the pulse pressure. In the earlier stages of arteriosclerosis, a toxic condition and impaired function of the ultimate cells of the body, there will be a gradual rise of all pressures, the diastolic to 100, the systolic 160, the pulse pressure to 60. The pulse pressure gradually rises with increasing cardiovascular disease. A sudden drop in systolic pressure, with stationary diastolic pressure, is a very serious condition.

(*Med. Record & Ann., July, 1932.*)

Temporary effects of arsenic easily counterfeited antisyphilitic effect.

News and Comments.

Earthquake Relief: It is worthy of the noble profession that its members did not lag behind their lay brethren in the field of giving relief to the unfortunate sufferers in Bihar and Orissa on account of the recent earthquake havoc. The Indian Medical Association on their own initiative sent batches of well-equipped medical units to give medical relief to those who were injured and later the General Secretary of the All India Medical Licentiate's Association volunteered help intimating to the Government of Bihar and Orissa that the Association is prepared to supply medical men and women, nurses and compounders and the Government replied thanking the Association and intimating that the services of the Licentiate's Association would be requisitioned when necessary.

The profession has been also rendering relief in the matter of money. The President of the All India Medical Licentiate's Association, U. P. Branch, had sent an appeal to the members in U. P. to lay by one month's salary, or income in the case of private practitioners, as a contribution to the Earthquake Relief Fund and made a fervent appeal to the students of the Agra Medical School not only to go house to house for collecting money but give up all luxuries, such as attending Cinemas, etc., and the money so saved to be contributed to the relief fund. In the city of Madras a subscription list has been going round to collect contributions from the local Licentiate's.

The Indian Medical Council: After the Editorial went to the Press we got the official notification about the constitution of the Medical Council for India which we publish here below for the information of our readers. As expected the majority of the members of the Council are Indians and if these members mind to have a medical profession to serve the interests of this country they have splendid opportunities to agitate constitutionally both in and outside the Council, to bring the whole medical profession under one fold as they exist today without in any way interfering with the aims and objects for which the Council was brought into existence by the Government.

Major-General C. A. Sprawson, Director General I. M. S., President.

Nominated members: Lt.-Col. Clive Newcomb (Madras), Major S. L. Phatia (Bombay), Col. A. H. Proctor, (United Provinces), Col. C. H. Reinhold (Punjab), Lt.-Col. P. S. Mills (Ranchi), Col. K. V. Kukday (Central Provinces), Col. J. P. Cameron (Assam), Dr. Saranjam Khan (N. W. F. P.)

Elected Members: Rao Bahadur Dr. A. Lakshmanaswami Mudaliar (Madras University), Rao Bahadur T. S. Tirumurthi (Andhra University), Dr. A. B. Erulker (Bombay University), Khan Bahadur Dr. K. A. Rahman (Punjab University), Mr. T. M. Bannerji (Patna University), Mr. T. Krishna Menon (Madras Presidency), Dr. G. V. Deshmukh (Bombay Presidency), Rao Bahadur Dr. Debi Dat Pandya (United Provinces), Captain P. B. Mukherji (Bihar and Orissa) and Dr. J. C. Das (Assam).

The above list does not contain the names of elected or nominated members from Bengal. Is this an omission or non-co-operation?

Busy Practitioners no good for Teaching: Amongst the addresses at the Indian Science Congress that met in Bombay last January, "the most interesting and important from the popular point of view and its application to public interests and welfare was the address made by Lt. Col. Sokhey, Director of the Haffkine Institute, Bombay." The subject chosen by Col. Sokhey was "The Relation of Research to Teaching in the Medical Schools of India," and he dealt very skilfully with several problems connected with medical education and medical practice in this country. Though his views about the indigenous systems of medicine will not be accepted by all, he was perfectly right in saying that the term, "western system of medicine" was now loosely applied and that there could be only one system of medicine, that was the 'Scientific System' and that scientific medicine did not debar the use of any agents for therapeutic purposes so long as the worth of such agents were proved by critical experiments. Col. Sokhey concluded his address by saying that "there is little doubt that the teaching of modern medicine cannot adequately be carried out by busy practitioners, no matter how capable. The work requires not only special training and special aptitude but also the whole time of the teachers. They must devote themselves heart and soul to their work."

We hope that the Government in all provinces, who run medical schools and

colleges would have noted the opinion of Col. Sokhey and would consider if their present policy, in allowing not only private practice but also permitting those engaged in teaching to run trade by conducting nursing homes, etc., is conducive to the interests of medical education.

Bombay Corporation: Some of the resolutions and interpellations which were the subject matter of the proceedings of two meetings of the Bombay Corporation held this month were likely to interest the medical profession in other cities as well. Dr. G. V. Deshmukh moved for the abolition of conveyance allowance and honoraria given to the honoraries working at the G. S. Medical College. Dr. Deshmukh's plea was that almost all the honoraries were eminent private practitioners commanding lucrative practice and they could afford to be without such allowances. The interpellation was with regard to the re-entertainment of Dr. Jivaraj Mehta as the Dean of G. S. College, the apparent purpose of the interpellation being an attempt to show that if Dr. Mehta was not re-entertained, the corporation would have saved a pretty large amount.

We cannot deny the good intentions of those who were concerned in the resolution or interpellation referred to above but we are bound to say that the principles involved cannot be sound. It may be a happy coincidence in Bombay that the majority of the honoraries have been commanding large and lucrative practice. The professional worth of an honorary cannot always be judged by the amount of money he makes by private practice. There may be and there are gems, amongst the members of the profession who might not have been noticed, and who in the interests of the profession might be better acquisitions than their more fortunate brethren commanding large practice and if such are denied even the conveyance allowance and honoraria the honorary service will be a monopoly of the rich and not of the deserving. Such of the honoraries who could afford to waive their claim may surely do so and yet continue their honorary work without interfering with the chances of service from their less fortunate brethren who, though not in a position to command wealth, would still serve as honoraries doing justice to the work expected of them.

Those who took part in the interpellation regarding the re-entertainment of Dr. Mehta would have done better justice to themselves and also to the profession if they applied to the Commissioner Bombay Corporation for the information they were anxious to know rather than interpellate in the way they have done, unless the Commissioner denied them even the non-confidential information asked of him. Parties and factions do exist in all public institutions, but the members of a profession which has the credit to be known as the 'noblest' would do well to be more delicate in their investigations which quality should be one of the most salient features of the members trained in medical science, especially when persons concerned in such investigations hold the very responsible position of training young men for the "noblest profession."

A Golden Jubilee: The Bombay Medical Union celebrated its Golden Jubilee on the 21st last month and at a dinner given by the Union which was attended by persons in high position such as, High Court, Judges, Members of the Legislative Assembly and local Legislative Council, Dr. Jehangir J. Cursetji, the oldest surviving member of the union presided. Dr. Jehangir began his address by referring to the aims and objects of the union about which he said, he "had the good fortune to lay the first foundation stone of the gradual but steady rise and progress of the Independent Medical Profession in India, by bringing together its somewhat conflicting interests and aspirations into a common fold. It has in fact drawn these units loosely scattered in the different provinces of the Empire of India, into a homogeneous whole, and firmly cemented the bonds of good fellowship and mutual professional interests within the circle of an united medical fraternity. It has also broadened our limited outlook and vivified our dormant activities for the advancement of our legitimate aspirations in the field of practical medical politics with the gratifying result if I may venture to say so without meaning any invidious distinction or unfriendly reflection that the Bombay Medical Union has come to be recognised, both by the Government and the general public, as the accredited

mouthpiece of the medical profession in India."

He then narrated how in 1883 during the course of an ordinary conversation one evening between the late Drs. B. S. Shroff, D. B. Master and himself, these trio first conceived the idea of the necessity of a social club "to establish and promote friendly intercourse amongst medical men, both young and old, which might in time attain, if properly supported and judiciously managed, a certain *locus standi*, from which it would have an authoritative voice, both with the general public and the Government, on matters medical and related directly or indirectly to our professional interests." An important feature of this movement said Dr. Jehangir "was the holding of regular monthly dinner at the rooms of the Union, in which *all members had to join*. It will be readily admitted that we cannot afford to dispense with it entirely, because it is the one feature that has largely contributed to the continuance of the spirit of *bon-homie* and professional *comaraderie* that has been kept up in our midst, notwithstanding the petty differences of opinion that will at times arise in this as in all other well-conducted bodies. And it is for that very reason that I here beg to make an earnest appeal to all our members, that this very essential feature should *not* be neglected but compulsorily revived, if not every month, at least once a year, at our annual dinner, where we could have an opportunity to invite also the newly qualified young graduates of that year as our guests, and introduce them to the cordial welcome of our members, as in the days of old."

The Union began with 12 members, the only surviving two amongst the twelve being himself and Dr. Sir Temulji B. Nariman who resigned the membership of the Union some years ago. The first meeting of the Union was held at the Great Western Hotel on 22-12-1883 when a sumptuous dinner was given to the members of the profession. The Union went on smoothly between the years 1897 and 1907 when the members of the Union fell down to an insignificant number of only twenty. Fortunately the Union did not lose courage and twelve of its members undertook to run it at their expense and there was steady success. Later the first Baronet of Bombay, the late

Sir Dinshaw M. Petit made a handsome donation of Rs. 10,000 for the foundation of a library for the use of the Union which was called the Hon'ble Sir D. M. Petit Medical Union Library. Since then, Dr. Jehangir said, the Union steadily progressed and is now a most influential and useful body. He referred to the services rendered by the Union and its individual members to the medical profession and mentioned the names of the late Dr. K. P. Bahadurji, Sir Bhalchandra Krishna and Drs M. D. D. Gilder and Sir N. Choksy. He said the Union had to fight great odds against the vested interests of the Indian Medical Service whose members had been trying to retard the growth of the independent medical profession. He mentioned an instance in 1887 when the members of the Indian Medical Service stoutly stood against the proposal to change the name of the degree from L. M. & S. to M. B. B. S. In spite of such opposition Dr. Jehangir narrated that the Union had done splendid work in the matter of guarding the rights and privileges of the independent medical profession and he pointed out that at present a large number of practitioners who are members of the Union have not only proved their competency but superiority over the members of the Indian Medical Service.

Dr. Jehangir mentioned the part played by the Union in agitating against the passing of the Bombay Medical Registration Act in 1912 as they did not like the idea of "inserting the names of both qualified and unqualified practitioners on one common roll." (The unqualified practitioners here referred to are evidently the Medical Licentiates Ed.) He then referred to the part played by the Union with regard to Indian Medical Council Bill and expressed his gratitude to Sir Fazl-i-Husain for the 'happy result' in the passing of this Bill and also mentioned the name of Sir N. Choksy for 'his very able and single-handed fight for our profession within and outside the Council of State.'

Before closing he appealed to the members to be united and continue the work as members of a noble fraternity and announced that a friend of the late Dr. B. S. Shroff had sent him Rs. 2,300 to be credited to the funds of the Union as a separate account for the purpose of awarding a gold medal

of the value of Rs. 100 to a member of the Union for a thesis on any scientific subject. Dr. Jehangir gave the Union Rs. 700 for two oil paintings, one of Dr. B. S. Shroff and another of Dr. Dinshaw Bamanji Master to be hung in the Union premises.

The achievements of the Bombay Medical Union for a period of half a century of its existence will be certainly appreciated by all concerned but the members of the Union should note that the non-recognition of the Licentiates by them as qualified practitioners is certainly a serious *blot*. No other medical Union, Association or Medical Society, in this country had done this injustice to this class of practitioners who not only form the largest bulk but the real backbone of the whole profession. This omission is all the more unjustifiable and glaring when the Union counts amongst its achievements the starting of the College of Physicians and Surgeons under which auspices the medical Licentiates in Bombay Presidency are being trained, and many of the Union members have been decorated with the title of F. C. P. S. without undergoing the necessary ordeal demanded of Licentiates for getting such decoration. Eminent and influential members of this Association who were also its Presidents, such as Drs. G. V. Deshmukh and K. K. Dadachanji have openly declared that the Medical Licentiates are not only qualified practitioners but have good record of medical and surgical work to their credit. We trust that there will be many more in the Bombay Medical Union who recognise the medical Licentiates as their brethren in the profession, and hope that time will not be long when Drs. Deshmukh, Dadachanji and others in the Bombay Medical Union agitate and remove this *blot* of non-recognition of medical Licentiates as qualified practitioners. Or else the Bombay Medical Union will find a place in the list of reactionaries who are against progress and peace in the nation building work which should be the chief concern of all true patriots in this country.

Doctor and Patient: A successful medical practitioner should not only be proficient in his knowledge of professional subjects but should have other qualifications to infuse faith in those whom he treats, was the subject-matter of the advice given by H. E. Sir Malcolm Hailey, the Governor of United Provinces to the medical students

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

when His Excellency presided over the Foundation Day celebrations of King George Medical College, Lucknow, on 16-1-34. We could do no better than quoting the very words of the Governor:

"Year by year Medical Science becomes more specialised in every one of its branches. But, however advanced be the study of the technique, yet here as in every art which proceeds from theory to practice, the human factor still remains supreme. You may be weighing the symptoms of the patient and diagnosing his ailment, but, believe me, he is scanning with more anxious eye than yours the nature of the man to whom he looks for help. In a moment which is often one of physical distress and bodily fear, he is thinking not merely of your degrees, but of your capacity and character, nay, the conscience of the man in whose hands he has placed his life. It is for this reason we want to attach so much weight to wider educational influences. I can ask for the King George's men nothing better than that its students shall read no trace of fear or doubt, but satisfaction in the eyes of the patients."

Bogus Degrees : It is common knowledge in this country that bogus institutions award qualifications similar to those granted by recognised schools and colleges. At times a letter or two are added, such as the letter H after M. B. or M. D., to denote another system of medicine which is not Allopathic. There are also some who do not add or subtract any letters and yet go undetected though there exists an All India Act called the 'Indian Medical Degrees Act of 1916.' In this Act, "Western Medical Science" is defined as the Western methods of Allopathic medicine, obstetrics and surgery and does not include Homeopathy or Indigenous systems of medicine. Section 6 of the Act runs thus :

"Whoever voluntarily and falsely assumes, or uses any title or description or any addition to his name implying that he holds a Degree, Diploma, Licence or Certificate conferred, granted or issued by any authority referred to in Section 3, or recognised by the General Council of Medical Education of the United Kingdom, or that he is qualified to practice Western Medical Science, shall be punishable with fine which may extend to two hundred and fifty rupees, or if he subsequently commits, and is convicted of, an offence punishable under this Section, with fine which may extend to five hundred rupees."

So it is clear from the sections in the Act that the degrees and diplomas granted by recognised Allopathic institutions should not be conferred by institutions of any

other system or no person who is not qualified to practise Western Medical Science, could practise the Allopathic system of medicine. In spite of the existence of this legislative measure neither the Governments nor the existing Medical Councils who only could take action for the violation of the sections in the Act, have been so far taking any serious steps to stop bogus practice in this country.

We are glad to hear that the Punjab Medical Council is at present taking action and have launched many prosecutions against bogus degree holders. It is learnt that the Madras Government are taking a very lenient view in this matter and have been shirking their responsibility in spite of the requests from the Madras Medical Council requesting them to help the Council in getting rid of the bogus degree holders. Though the existing Councils are very defective they have representatives of the different sections of the medical profession and it is open to the representatives of the medical profession to move the Councils to take action and if all the Councils join together and begin prosecuting the bogus degree holders, it is very likely that their number will decrease very soon and the Councils will be doing the legitimate work expected of them in protecting the interests, the rights and privileges of the qualified medical profession.

Ophthalmological Conference: Our readers might remember that an esteemed correspondent complained in our columns about the inactivity of the all-India Ophthalmological Society in not holding the annual conference and later when it was announced that the conference would be held last year at Calcutta, brought to our notice that ophthalmologists in Government employ did not evince as much interest as they should in the activities of the all India Ophthalmological Society though they took part in ophthalmological conferences held outside India, which these officers did at Government cost. We made suitable comments in these columns suggesting the desirability of ophthalmologists in Government employ in taking keen interest in conferences of all India nature giving the benefit of their vast experience to the profession as well as the public. As was reported in the columns of this journal last month, the all-India Ophthalmological conference was

held last Xmas in Calcutta under the presidentship of Lt. Col. Duggan from Bombay and the eye specialists both from the Government Medical College Eye Infirmary and from the Carmichael Medical College, co-operated most heartily in making the Calcutta session of the Conference a success. Though Lt. Col. R.E. Wright, I.M.S., could not attend the conference, he contributed a valuable paper and Madras should be proud that in spite of the absence of Col. Wright at the conference, he has been unanimously elected President for the next year's conference to be held in Madras, and in case Madras does not invite the conference, to be the President of the Conference to be held in Lucknow.

Subsidised Practitioners : The grievances of subsidised practitioners in the rural areas of Madras Province were being discussed at a conference which met in Madras last Xmas and from the resolutions passed at the conference it could be seen that the subsidised rural medical relief requires a thorough overhauling. The arrangement by which the subsidised practitioners are kept under the control of Taluk Board Presidents has been the main cause for the scheme not working satisfactorily. It was too much for the Government to expect in an average Taluk Board President, administrative capacity to control medical institutions and medical men. Now that the Government itself has found the uselessness of Taluk Boards, time seems to be very propitious to press on the Government the standing request of these practitioners to appoint a committee for organising the rural medical relief scheme and consider the desirability of handing over the management of the scheme to a representative District Committee.

Policy Versus Person : It is most regrettable that Lt. Col. Webb, the Director of Public Health, Madras, had made up his mind to retire from service and the coincidental news that a woman Assistant Director of Public Health, Miss Veerasing Chinnappa has been re-appointed on probation for one more year immediately after the termination of her service as a probationer has naturally set people musing on so many possibilities and probabilities which might have worked for the sudden determination of Col. Webb for retiring from service. It will be too

much to attempt commenting on gossips though many a time gossips turn out to be true. The Public Health Department and the public are really sad that Col. Webb should leave Madras, nay India, for good. Village reconstruction with a view to find out a remedy for the depressed economic condition of the people, has been practically demonstrated by Col. Webb, by launching a scheme in a rural area nearby the city in the District of Chingleput, when the Public Health Commissioner for India and the Director General, Indian Medical Service, have been writing volumes of reports about the necessity of such a scheme at the imperial capital Delhi. This one activity of Col. Webb if not anything else, ought to have weighed with those who have been responsible in forcing Col. Webb to seek retirement from his versatile activities as a Director of Public Health. The prospect of a person's certainly too small and insignificant a price against the value of lives of teeming millions who fall a prey to preventable diseases on account of poverty and ignorance.

Graduates to be without a Representative : Old order of things continue at the office of the Registrar in spite of the action taken by the Madras Medical Council in replacing an old Registrar by a new one. A vacancy occurred in the Madras Medical Council due to efflux of time and Dr. T. S. Tirumurti vacated his seat last October. There is a provision in the Madras Medical Registration Act to hold election for a future vacant seat two months prior to the seat falling actually vacant, and it has not been possible for the Registrar, Medical Council, to hold election for one of the two seats to represent the graduates of the Madras and Andhra Universities and for one year till next October the graduates will be not fully represented in the Council.

Do Resolutions Mend Matters? We learn that Dr. V. Ramakamath has given notice of two resolutions which he intends moving at the next March session of the Madras Medical Council. They are :

(1) That a Committee consisting of three members be appointed to help the President in his executive duties in connection with the working of the Madras Medical Registration Act on the model of the statutory committees for the same purpose existing in other provinces;

(2) The Council respectfully suggests to the Government the necessity of adding a section

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

to the Madras Medical Registration Act (IV of 1914) for the purpose of preventing quacks from practising the Allopathic system of Medicine and Surgery.

It is evident from the first resolution that as matters stand now with the Head of the Medical Department as the President of the Medical Councils, the framers of the Act in almost all the provinces thought it was desirable to have a Standing Committee to do the executive duties. The Head of the Medical Department has too much to do regarding his routine work and it is natural that he cannot give as much attention as he ought to for the executive supervision over the office of the Registrar. It has to be said that Dr. V. Ramakamath has been attempting to bring about reform at the Madras Medical Council and has also achieved something but the repetition of omissions and commissions at the office of the Registrar has perhaps suggested this member to go to the root of the disease. We wish Dr. Kamath good luck and trust after the passing of this resolution there will be less room for complaints against the Registrar's Office.

The other resolution needs no comment. As it is, the Medical Registration Act does not prevent the quacks from practising and it may be perhaps not quite practicable to prevent quacks from practising. This has not been possible in other civilised countries but it is quite possible to prevent unqualified people to practise Allopathic system of medicine about which they know nothing especially when Government have provided ample facilities for the training of practitioners of Allopathic system of medicine. We trust the Madras Medical Council will pass this resolution unanimously and show an example to the other Provincial Councils to do likewise.

District Medical Associations: It is a happy sign of the times that during recent years medical associations have been started in almost all District Headquarters. Two such Associations, one of Trichinopoly and the other of the East Godavary, recently celebrated their anniversaries and from a perusal of the annual reports it is found that both these associations have been doing splendid work.

The annual gathering of the Trichinopoly Association was held in Trichinopoly on 23rd December 1933 under the president-

ship of Rao Bahadur Dr. M. Kesava Pai. A report of this gathering was published in the December issue of the journal. There were 74 members on the role of this Association in the year 1933 and at the time of the report there were 99 members and the increase is attributed to Dr. C. E. R. Norman, Chief Medical Officer, S. I. Ry. who in addition to having enrolled himself induced his staff to do likewise. The average attendance at meeting is said to be 50. Another feature worth noting is that a few practitioners from the adjoining Districts of Tanjore and Pudukottah are members of this Association. There have been co-ordinating activities between this and the Medical Association of Chettinad. The Association has been registered and the Government have been requested through the Surgeon General to grant not only leave but travelling allowance to the members in service to give them facilities to attend the meetings. The monthly meetings have been made attractive by a member or a group of members giving an at home. Lt. Col. Mehta, District Medical Officer, vacated his seat as the President making room to Dr. C. E. R. Norman who will be President of the Association for the current year. The success of all associations depend upon the Secretary and we congratulate Dr. P. A. S. Raghavan for piloting the affairs of the Association very efficiently, from its very inception and on his having been re-elected as Secretary for the current year. Amongst the members Dr. T. S. S. Rajan has been a tower of strength to the Association.

The East Godavary District Medical Association conducted the 2nd anniversary at Cocanada on 20-1-34 under the presidency of Col. K. V. Ramana Rao, District Medical Officer, Guntur. At the outset there was a business meeting at 3 p.m. for the election of the office bearers for the current year. Major T. S. Shastri was elected as President and Drs. V. C. Kamaraju and P. Audinarayanaswamy were elected as Secretaries and Drs. S. Swamy Naidu, B. S. S. Prasada Row and Miss T. E. Stephens as members of the Managing Committee. There was a tea party at 4-30 p.m. The meeting was largely attended and Dr. P. Kutumbiah, Physician, King George Hospital, Vizagapatam, and Dr. M. G. Kini, Surgeon,

K. G. Hospital, Vizagapatam, were specially invited to address the gathering on professional subjects. The former spoke about Rheumatism and its treatment and the latter about the treatment of compound fractures. The lectures were highly appreciated by the gathering. Major T. S. Shastri, the President of the Association, demonstrated some interesting cases. Lt. Col. Ramana Rao enlightened the audience with a humorous speech. The report submitted by the Secretaries gives a very good record of the activities of the Association which seems to have been rejuvenated during the tenure of office of Major Shastri during which period the membership steadily rose and was 157 at the end of the year, perhaps the largest number when compared with the strength of the other District Medical Associations. Major Shastri has been also mainly responsible for the increased activities of the Association. A special feature of this Association has been to hold the monthly meetings at different centres in the District and at every gathering there were other social activities such as tea parties, dinners, dramatic performances, etc., all these activities serving as a healthy relaxation once a month to the members of the Association. For the purpose of smooth and harmonious working, the rules of the Association did not permit its members to discuss subjects of a controversial nature outside those relating purely to the profession. The subject on Medical Ethics was once keenly discussed and the Association came to an understanding that the activities of the Association would in themselves help in creating good relationship between individual members of the profession and that there was no necessity for framing any hard and fast rules concerning this subject. It was also found necessary to have a rule that the District Medical Officer of East Godavary should always be the President of the Association.

We appreciate the laudable selfless work of Major T. S. Shastri who though the President of the Association did not grudge to co-ordinate actively with the other office bearers, so much so as mentioned in the report itself Major Shastri was "President, Secretary, Managing Committee, all combined in one, but for whose driving force and enthusiasm, the Association would not have been what it is to-day, a strong har-

monious and successful organisation." We congratulate the energetic Secretaries Drs. V. C. Kamaraju and P. Audinarayanaswamy for conducting the affairs of the Association very efficiently.

Congratulation: We learn that Rao Bahadur Dr. T. S. Tirumurthi who is one of the three University representatives in the Governing Body of the Indian Research Fund Association has been elected by the latter body to represent them in the Special Committee for Scientific control of the All-India Institute of Hygiene and Public Health, Calcutta. The special committee referred to has among its functions the appointments for the Institute to its Medical Research Department. We congratulate Rao Bahadur Dr. Tirumurthi and trust he will play his part to the satisfaction of the profession as a whole.

Erratum: On page 81 of the January issue in line 34 Second column, read "abrogation" as "abnegation."

Correspondence, Reports, Etc. The Fourth Andhra Medical Conference, Bezwada.

INVITATION.

Dear Doctor,

The Fourth Andhra Medical Conference is to be held this year at Bezwada in Easter on the 30th and 31st March 1934 and we cordially invite you to participate actively in its deliberations.

Arrangements are being made for an Exhibition of Medical and Surgical Appliances and Drugs.

Members of the profession are earnestly requested to contribute to the success of the conference by attending as delegates and by sending papers containing original ideas bearing on Modern Medicine and Surgery and on new methods of treatment. Clinical demonstrations are also solicited.

Papers should reach the secretaries before the 10th March 1934. The delegate fee is Rs. 2 which may be sent in advance to the Treasurer, Dr. J. Dakshinamoorthy, Bezwada, or paid at the conference.

We specially request all the Doctors in the Kistna District to enroll themselves as members of the Reception Committee and help to make the conference a success.

We hope that, through your co-operation, we may be able to advance the cause of Medicine and promote the interests of the profession, by decisions arrived at the conference.

Yours sincerely,
G. M. SIVASUBRAMANYAM,
D. KAMESWARA RAO,
A. UMAPATHI MUDALIAR,
Secretaries.

Reviews.

ADMINISTRATION REPORT OF THE KING EDWARD VII MEMORIAL HOSPITAL AND THE SETH GORDHANDAS SUNDERDAS MEDICAL COLLEGE, BOMBAY, FOR 1932-33.

The report is as usual very interesting and instructive and we congratulate the Dean and the staff both paid and honorary on the excellent work turned out by them year after year. The number of beds available in the city of Bombay in the state, municipal, and private institutions comes to 4166 and on population basis Madras has only half that number, the actual number of beds available in Madras being 1694. The Dean rightly laments the inadequacy of the number of beds. In the United States of America, Germany and England and Wales there are 39, 56.9 and 53.4 beds respectively for every 10,000 population while in Bombay it comes to 20.9 and Madras 2 per 10,000. Considering that India is a poor country where the large majority of people cannot afford scientific treatment much less the diet and regimen necessary during the treatment of diseases, it is essential that the number of beds in charitable institutions, made available to the people, should be proportionately higher than those in European countries. Large amounts of money are being spent now on costly buildings and salaries. This expenditure should be cut down by not spending money on unnecessary costly buildings and by employing honorary staff in the State Hospitals. A former Governor of Madras while opening a hospital at Nandyal some years ago observed that instead of wasting money on expensive buildings it must be spent in affording medical relief, and yet the policy in this province has been otherwise.

In the Seth Gordhandas Sunderdas Medical College the number of students undergoing training is more than that in the Vizagapatam

Medical College and the cost per head per student per year comes to Rs. 414 while in Vizagapatam it is nearly treble and in the Medical College, Madras, double. The cause for this high expenditure in Vizagapatam and Madras is due to the non-employment of honoraries for teaching work as is done on a large scale at the Seth Gordhandas Sunderdas Medical College. It is noteworthy that the honorary staff in this college in addition to spending time in teaching, are engaging themselves in research work while in the two colleges in Madras Province, little or nothing is being done in this direction, and the professors teaching important subjects seem to be spending more of their time in private practice and other work of remunerative nature. The several items of research conducted at the Gordhandas Medical college are not only useful to the Science of Medicine but to the economic condition of the people of this country. We would certainly like that the report of this college catches the eyes of the Government of Madras.

MEDICAL DIGEST. THE SPECIAL CONFERENCE NUMBER, DECEMBER, 1933. PRICE AS. 8.

The publishers of The Medical Digest have issued a special publication last December embodying in it abstracts of the proceedings of the two All-India Medical Conferences which met in Bombay in the last xmas week. The readers of The Medical Digest would have appreciated the services of its publishers in case the proceedings of the conferences appeared in full and in case the organisers of both the conferences withheld the publication of the proceedings of these conferences in the lay press.

THE BOMBAY MEDICAL JOURNAL. Special Jubilee Number in commemoration of The Golden Jubilee of The Bombay Medical Union, 23rd Dec. 1883-1933.

The November and December issues for 1933 of the Bombay Medical Journal have been abridged and made into a special jubilee number. Excepting an Editorial concerning the Golden Jubilee the rest of the proceedings of the jubilee do not find a place in the journal. Perhaps the next issue of the journal will make up for this deficiency. As the report of the proceedings of the Golden Jubilee appears in the News and Comments Columns we could not repeat what we have said there. We wish the Bombay Medical Union a long life of usefulness.

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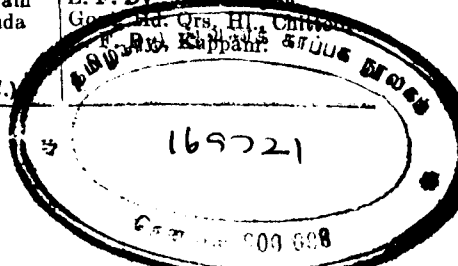
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2	" T. Perrazu	Govt. Hd. Qrs. Hl., Vellore	Itinrtg. Dy., Maharattipalayam.
3	" Abdul Aziz Tuni Sahib	Leave	Govt. Gen. Hl., Madras.
4	" K. Jagga Rao	L. F. Dy., Rampachodavaram	L. F. Dy., Gajapatinagaram.
5	" Y. Suryanarayanamurthy	L. F. Dy., Gajapatinagaram	" Kurupam.
6	" V. Kameswara Rao	" Pattikonda	" Cumbum.
7	" A. Venkataramana	Cumbum	" Yerragondapalem.
8	" K. P. Chidambaram	Govt. Hd. Qrs. Hl., Trichy	" Marungapur.
9	" P. Palaniyandi	Hd. Qrs. Hl., Tanjore	Govt. Dy., Devakottai.
10	" A. R. Shunmuganathan	L. F. Dy., Aruppukota	c/o D. M. O., Ganjam.
11	" S. Vaidyanathan	Agency Duty, Ganjam	Govt. Hd. Qrs. Hl., Cuddalore.
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13	" Miss G. Guruswami	Govt. Hd. Qrs. Hl., Vellore	Govt. Hl., Tiruvannamalai.
14	" G. V. Raghava Rao	Govt. Hd. Qrs. Hl., Guntur	L. F. Dy., Achampeta.
15	" K. P. Kunhiraman Nayar	L. F. Dy., Karkal	" Mannarghat.
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17	" M. A. Subramaniam Pillai	Govt. Dy., Devakottai	L. F. Dy., Aruppukottai.
18	" A. P. Joseph	Leave	c/o Vizag Agency Surgn., Koraput.
19	" D. Raja	Agency Duty, Vizag	Govt. Ophth. Hl., Madras.
20	" K. N. Kesava Pillai	Govt., Hl., Tellicherry	L. F. Dy., Kollengode.
21	" N. P. Subramaniam	L. F. Dy., Kollengode	Govt. Hl., Tellicherry.
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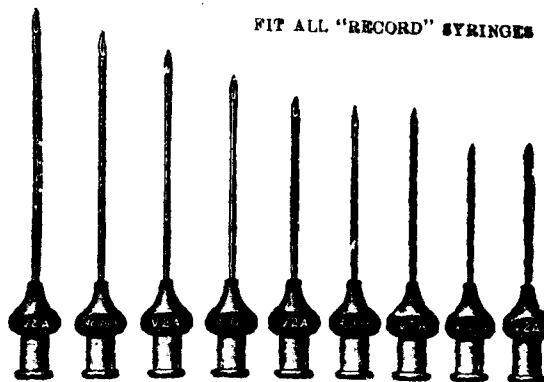
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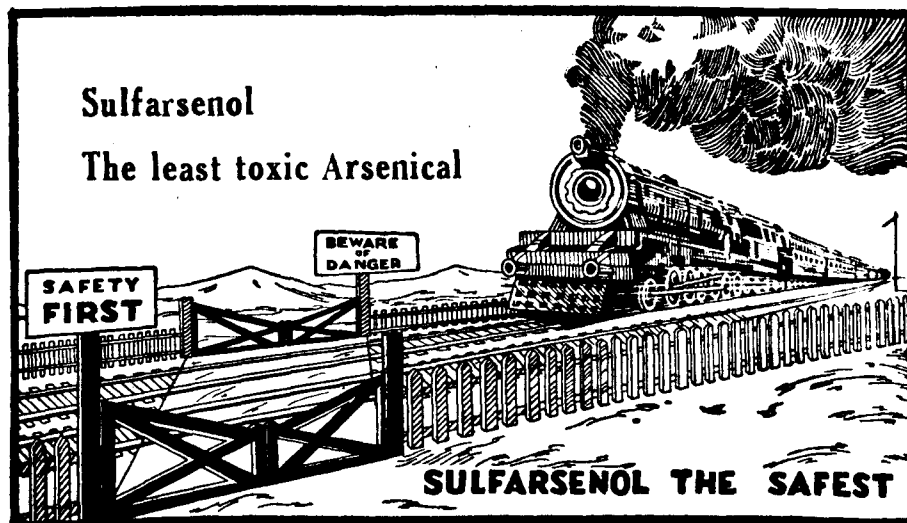
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