

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

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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 duration being six months. The unfortunate fact that the girl was unmarried and appeared to put on more flesh after the cessation of menses—evidently accumulation of fat—made the parents more anxious about their daughter and the matter was made worse when the girl was brought to my hospital who was consulted by the parents suspected Amenorrhoea to be the cause. This nurse advised the parents to use Menestrin Capsules. As one treatment had not the desired effect, the parents consulted me and on examination of the girl, I found her not pregnant though physically appeared to be so on examination of fat in the lower abdomen, the breasts and also the gluteal region.

diagnosis of Menestrin Capsules have a rational indication for Amenorrhoea 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 the success of the treatment. I authorise you to publish this benefit of the public and the profession.

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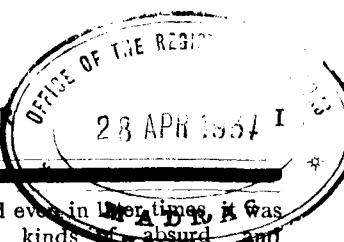
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1934]

THE MEDICAL PRACTITIONER



THE Treatment of Whooping Cough.

By

AN EMINENT PRACTISING PHYSICIAN.

"Whooping Cough is an ancient disease. It may occur at any age, but the greatest susceptibility is during the first half of the first decade of life. There are no definite statistical data on the morbidity of pertussis and the exact number of cases is not known."

The number of deaths directly due to Whooping Cough must be certainly a large one in India though correct statistics is not available or even if available cannot be depended upon as the vital statistics is still in a primitive condition in India.

"The organism causing Whooping Cough is thought to be the Bordet-Gengou bacillus. Other organisms, visible and invisible, are under suspicion as the real cause of the disease. The chief anatomic pathology in pertussis is a catarrhal inflammation of the upper respiratory tract, with a destruction of the ciliated epithelium, in which the pertussis organism is found in large numbers. Complications are not uncommon. Bronchopneumonia, bronchitis, emphysema, atelectasis and tracheobronchial lymphadenitis are frequent complications. Vomiting is quite common, leading to malnutrition. The heart is occasionally enlarged, due to the severe strain of coughing. Injury to the brain by the toxemia of vascular congestion leads to convulsions or other cerebral disorders. Tuberculosis as a sequel to Whooping Cough is not uncommon.

In most cases, the diagnosis is very simple. In mild or atypical cases, the diagnosis is sometimes difficult. A history of exposure to pertussis, a persistent spasmodic cough which is worse at night, in an otherwise healthy child, is diagnostic of Whooping Cough.

TREATMENT.

The treatment of whooping cough has undergone revolutionary changes. In the

Middle Ages, and even in later times, it was treated with all kinds of absurd and irrational folk-remedies. At the present time, a large number of drugs are being used, with little or no benefit. Vaccines, ether and x-ray treatments have also been used, often with discouraging results."

About two years ago I came across the literature of the treatment of whooping cough by KOO-KOOMIN manufactured by the Oriental Research Laboratory, Vepery, Madras. I had at that time a number of whooping cough cases under my care and having not had satisfactory results by all known remedies, pharmacopoeial or patent, I thought of giving a trial to Koo-Koomin. Its ingredients seem to be rationally indicated for the pathological conditions. As referred to above, the catarrhal inflammation of the upper respiratory tract and the destruction of the ciliated epithelium, in which the pertussis organism is found in large numbers, set up spasmodic cough due to tenacious mucus sticking on to the bronchial tubes and which could not be easily expectorated by the child on account of the destruction of the ciliated epithelium. Sodium Benzoate, Ammonium Chloride, Ammonium Carb and the alkaloid of Ashoka and a few Ayurvedic drugs of demulcent properties, which make up the ingredients of Koo-Koomin, liquify the tenacious mucus and facilitate expectoration. Another ingredient Belladonna helps in relieving Bronchial spasm. Hexamine yet another ingredient acts as a germicide in killing the organisms responsible for the disease.

I have used Koo-Koomin in about 50 cases of whooping cough. The results were most encouraging. After two or three days of treatment, the attacks were shorter and milder and the children slept better. In two or three weeks time the cough gradually ceased without serious complications or sequelae. Apart from whooping cough I have since been using Koo-Koomin for all coughs in children especially attendant with spasms and difficult expectoration and invariably I had very good results.

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MARCH, 1934.

[NO. 6

A WARNING TO INSURANCE COMPANIES.

Life Assurance Companies have been rapidly increasing in this country and the public have been evincing keen interest in such companies having realised the necessity of making provision for old age or for dependants after death. The Insurance Companies have been vying with each other in putting before the public varieties of schemes of Life Assurance but a large majority of them have not as yet realised that it would be to the mutual benefit of the public and the companies that the Insurance Companies should secure the co-operation of the medical profession as a whole instead of showing invidious distinctions with regard to the choice of the doctors for examining applicants for insurance. We have discussed in these columns more than once that Insurance Companies should lay down fixed principles in the matter of the choice of the medical examiners depending not only upon the medical qualifications but also merit and experience as the latter count more than mere academic qualifications. Long standing companies have been still following the old groove. They prefer medical men in Government Service to those in private practice even though the latter may possess higher qualifications and may even be senior in service as practitioners. In the choice of the medical examiners from amongst the members of the medical profession, favouritism more than merit and experience, has been counting much so far. Practitioners commanding large practice,

with it public confidence, are less in number in the list of Insurance doctors and there may be found in this list many doctors who depend more on insurance work than professional. Another glaring omission on the part of the long standing companies, is that they have not been entertaining Medical Licentiatees as their medical examiners. The companies which came into existence later have not been so rigid. These recognised qualifications and merit more than the official status of the examiners and allowed Medical Licentiatees to examine applicants insuring for a thousand or a couple of thousand. The medical profession has been feeling that they are not fairly treated by the Insurance Companies and those amongst the profession who have been affected most, are the Medical Licentiatees. The latter discussed about this subject at the last two all India Conferences held under the auspices of the All India Medical Licentiatees' Association that met at Madras in 1932 and at Bombay in 1933. Another all India organisation, the Indian Medical Association which is representing all sections in the medical profession including the Medical Licentiatees, had also their say in the matter and both the Associations which met in Bombay last X-mas passed resolutions unanimously, protesting against the present policy of the Insurance Companies in showing invidious distinctions amongst the members of the medical profession, and urging upon both foreign and Indian companies to put on equal footing all registered practitioners irrespective of their academic qualifications.

We have received a copy of the proceedings of a meeting of the All India Medical Licentiate's Association, Jhansi Branch, and we find in them a resolution warning the Insurance Companies that they should entertain Medical Licentiate as medical examiners. They have also sent a mandate to all the members throughout India that in case the resolution is not heeded to, the members should withdraw their policies and co-operation from such companies who do not treat the Medical Licentiate on equal footing with the other members of the profession. It is a strange yet a very happy coincidence that just at this juncture our remarks on this vexed question (vide Vol. 5 No. 2, November 1933, page 30) did attract the attention of the Chief Medical Referee of one of the Insurance Companies in Madras, The Indian Mutual Life Association Limited. The letter addressed to us by the Medical Referee of this Company has been published in the Correspondence Columns of this issue. We are informed that The Indian Mutual Life Association treats all the members of the profession alike. We wish the noble example of this company is followed by other companies as well; or else the discontent prevailing in the medical profession as a whole and amongst the Licentiate who form the largest number in the medical profession, will likely spread and have an adverse effect on the prosperity of the Insurance Companies, who deny equal rights and privileges to Registered Medical Practitioners.

We do realise that examining persons for insuring their lives devolves a great responsibility on the medical men and this work is by no means always an easy one. We therefore suggested in these columns last November, and once before, that all the Insurance Companies may jointly run a College to impart special training in Insurance work admitting all Registered practitioners to this Institution and that only those who have passed the examination held by a Board of Examiners, preferably chosen from amongst the expert Medical Referees of Insurance Companies, might be considered fit to examine Insurance cases. The interests of the companies and the medical profession can safely be secured by bringing into existence the College

suggested by us. It cannot be said that the prospering Insurance Companies could not afford to run such an institution. Far from being a spending concern this institution would be a source of income to the Companies. The students may be charged a fee for the training given to them. The city of Bombay will be best suited for this purpose.

Original Articles

THE PATHOLOGY OF TUBERCULOSIS—MODERN VIEWS.

By

DR. C. FRIMODT-MOLLER,
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Tuberculosis Sanatorium, Ardyavaram,
near Madanapalle.*

In recent years the study of the pathology of tuberculosis has brought to light many new facts which have modified the whole conception of pulmonary tuberculosis in such a way as to influence both the diagnosis and the treatment of the disease.

It is impossible in a short article to survey in detail the present understanding of the mode of infection in tuberculosis, the importance played by allergy and immunity in formation of the tuberculous lesion in the lungs after infection, its further development or healing, and the different stages of the disease as considered from the point of view of pathological anatomy in relation to the clinical symptoms of the disease. It is only possible to draw attention to a few facts of special importance to the general practitioner.

There is now a common agreement that the infection is chiefly through the lungs; in some countries in the West this is the method of infection in about 80 per cent of all cases of tuberculosis. Recent research has demonstrated beyond doubt that heredity plays no role whatever from a practical point of view, in the development or spread of tuberculosis. There is, to the contrary, good evidence for believing that it is a great protection against the disease to be born of tuberculous parents, provided of course that the child is not infected after birth by its parents.

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

When the tubercle bacilli find their entry into the body the immediate result is a fight between them and the polymorphonuclear leucocytes. These succumb, but when destroyed set free several enzymes which immediately activate the immuno-biological defence mechanism of the body against the infection producing first of all a local inflammatory reaction in the tissue where the bacilli are located thereby fixing them in their place of implantation. Various processes in this inflamed tissue take place, too complicated to describe here, the end-result of which is the formation of the tuberculous lesion which consists of (1) the "tubercle", (2) an exudative inflammation and (3) a granulation tissue rich in connective tissue.

When the lesion is located in the lungs the exudative inflammation is found also as an intra-alveolar exudate consisting of fibrin, leucocytes and degenerated alveolar cells. By this exudate the air is prevented from entering the alveoli, and the area becomes consolidated. This alteration in the lung makes it possible, when the lesion has obtained a certain size to diagnose the disease not only by physical, but also by X-ray examination.

The first lesion is called the primary infection. If located in the lungs it is usually found in the middle of the lung close to the pleura and not in the apex. It is often very small indeed. Usually it heals up leaving a pea-sized scar or a caseous focus walled in by connective tissue. In the middle of it, even many years after, may still be found living tubercle bacilli. This is of the greatest importance, as only as long as there are living bacilli harboured in such a focus is the body in a state of allergy which is the indication of the presence of a relative immunity against further tuberculous infection. A person who is in a state of tuberculous allergy will give a positive reaction with v. Pirquet's skin-test, but only as long as the power of the defensive forces of the body against the disease is not used up. This is the reason why an advanced case of tuberculosis very often gives a negative result of the skin-test, which is therefore in these cases a bad prognostic symptom. It should be mentioned that in some not advanced cases of tuberculosis the skin-test can be negative, although not of bad prognostic significance, as for instance

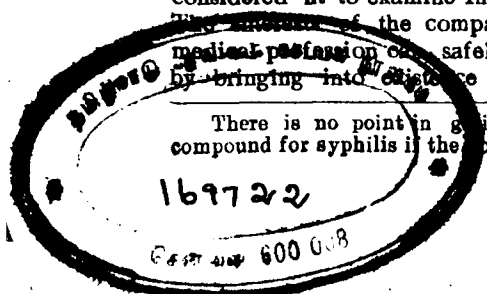
if any other infection is simultaneously present, as measles, or in some cases of pregnancy, or of old age.

Should a body which is still in the state of allergy be reinfected by tubercle bacilli, its defensive forces will immediately react to the infection. This allergic reaction consists of an exudative inflammation at the site of the implantation of the bacilli, which may either have escaped from an old focus or have penetrated into the lungs from outside. The inflammation may be so slight as to be microscopical, or may be so severe that the alveoli and bronchi may be filled with it over an area so large that the exudate is easily seen on the X-ray film and detected by stethoscopical examination.

While the primary infection in far the greatest number of cases heals up without causing any clinical symptoms of the disease it is the later reinfection which gives cause to the severe clinical symptoms. It has now been shown that this reinfection is rarely found in the apices of the lungs but is found below the clavicle. It is the X-ray examinations which have revealed this important fact. Redekar, who examined more than 20,000 persons, was the first to draw attention to this new discovery, since confirmed by other observers all over the world. This lesion is now called the early or the sub-apical infiltration. For all practical purposes this is from the ordinary practitioners point of view the first manifestation of tuberculosis in a patient.

It is true that the clinical symptoms of the sub-apical infiltration are often very vague and may be considered the first stage of a slowly developing chronic disease. Many persons, under these circumstances, have no idea of having any affection of the lungs, but have only felt out of sorts, have lost in weight, and have been subject to "a cold". Nevertheless, when the lungs of such persons are examined by X-ray, an extensive exudative inflammation, even with cavities, may be found.

In the great majority of cases the sub-apical infiltration gives symptoms of a very acute, and very severe disease, beginning with a sudden and violent onset, simulating an influenza, pneumonia, malaria or an attack of enteric. The acute and severe symptoms last for a week or two, after which time they subside, leaving the patients



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in a condition characterized by tiredness and after some time with a little cough and expectoration, considered to be the remnant of the influenza, pneumonia or chronic bronchitis. Such sub-apical cases which are clinically acute cases, although showing within a few weeks extensive lesions with cavities, may when not properly treated develop rapidly to the most severe phthisis ending fatally within a few months. In many cases with an acute onset with high fever an examination of the sputum may, after a week or so, reveal tubercle bacilli to be present, or an X-ray examination will immediately give the diagnosis. These two kinds of examinations are very important, as in not a few cases of sub-apical infiltration, even with extensive lesions with cavities, nothing wrong can be detected in the lungs by the stethoscopical examinations.

The modern view of pulmonary tuberculosis is that the apical type of tuberculosis which has been considered as the early case in the initial stage of the disease is not at all any early manifestation of it, but always the sign of a very chronic and benign form of tuberculosis of the lungs. It has been found by investigation of a great number of such cases that in only seven per cent of them does the patient develop active and progressive tuberculosis or die from the disease. The apical—or the previously so called "early" cases—are those where treatment is least urgent. For years and years these "incipient" cases will continue to be stationary perhaps with small transient acute or subacute episodes which bring them to the doctor to receive a series of injections with different calcium preparations or patent remedies which get the credit for the "cure" when the transient exacerbation of this "early" but really chronic infection naturally ceases.

We know now that for all practical purposes tuberculosis of the lungs is to be considered as a disease with a sudden and violent onset, most commonly attacking strong, young individuals from 15 to 35 years of age. It is now realized all over the world that such cases have a very serious prognosis and need immediate and prompt treatment as otherwise they may reach within a few weeks the most advanced stage of the disease.

It has also been shown that it is these sub-apical acute cases which constitute the greatest danger for the spread of the disease. While in one investigation the apical, chronic cases were found to have bacilli in their sputum in only 15 per cent, bacilli were present in the sputum of not less than 66 per cent of the sub-apical cases. When such cases are not at all recognized as tuberculosis but treated for malaria or influenza, the danger of the surroundings of the patient being infected is very great indeed.

It is of the greatest importance that the medical profession ceases to hang on to the old, but wrong conception that pulmonary tuberculosis begins as a slow and gradually developing disease with only signs in the apices, and comes to understand that an acute violent onset of a condition with high fever is not against the possibility of the disease being tuberculosis—rather the opposite.

*DEFICIENCY DISEASE AND TRACHOMA.

By

LT. COL. R. E. WRIGHT, C.I.E., I.M.S.,
Superintendent, Govt. Ophthalmic Hospital,
Madras.

Lecture No. 1.

The deficiency disease which is so largely responsible for preventable blindness in children in the Madras Presidency, as also in the greater part of India and other parts of the world, notably China, is the avitaminosis, known as keratomalacia.

Let us briefly consider some of the clinical features of keratomalacia with which most of you, lay and medical, are probably familiar. Its earliest manifestation is a symptom, night blindness, which is therefore not observed in the class of cases we are considering, namely, the young child. It is however the complaint which brings many older children and adolescents to the hospital. The next evidence of this progressive deficiency is the peculiar smokiness of the conjunctiva (illustrated at the lecture by paintings and actual cases). This is the earliest obvious sign just as the night blindness is the earliest symptom. One may meet either or both of these in a youth who is

apparently healthy looking in other respects. They are however danger signals and if it were possible for the baby to complain of the first, or for the mother to detect the second, the advance of the condition to a serious stage might be averted. When the early signs and symptoms appear, if nothing is done to augment the amount of essential food factors in the diet, the case rapidly progresses and wasting sets in; the patient becomes thin, the skin dry and earthy-looking, the hair appears dry and becomes thin, the mucous membranes also show a diminished secretion and the more accessible membranes of the nose and mouth and throat are seen to be abnormally dry. It is generally somewhere about this stage that we have babies brought to the out-patients department. *Pari passu* with the wasting of the mucous membranes, there is an advance in the eye symptoms. As a rule the smoky conjunctiva becomes dry, wrinkled and greasy looking, the cornea becomes dull and lustreless, and eventually opaque. Occasionally the changes in the eye are of a different type and instead of a dry greasiness, we find a wet dull red conjunctiva. In the one case there appears to be a suppression of the lachrymal secretion, in the second it is excessive. But this does not obscure the essential changes. Little patches covered with a sort of white foam appear on the conjunctiva and they are generally situated at either ends of the horizontal diameter of the corneae. The cornea eventually undergoes necrosis and ulceration and if untreated, the ulcer perforates the globe and the eye is immediately lost. Should the condition be improved at the stage when both corneae present large ulcers, the child may be restored to good general health, but remains blind on account of the dense scar tissue opacities (leucomata) of the corneae. Certain of these children who show gross ulceration heal with the formation of thin weak scars of the corneae. Such cases may present themselves some years later with well-marked bulging staphylomata of the corneae. If seen in this state for the first time it would be impossible to tell whether these staphylomata resulted from keratomalacia or other forms of ulceration in early childhood.

It is sometimes quite impossible for the mother to observe the condition of the baby's eyes when she brings the child to the

hospital as by the time she has made up her mind to seek relief it requires an expert to open the lids and examine the state of the cornea, but she has probably previously noted that there was something definitely wrong with the eyes and the progressive wasting of the infant drives her to seek relief. By the time the average mother brings the baby to the hospital, the skin is hanging in baggy wrinkles round the joints, the so-called elephant skin, the mucous membranes of the mouth, nose and throat are wasted, glazed and dry, the thin piping or hoarse croaking voice is hardly recognizable as proceeding from a human being. The alimentary tract is affected just as the mucous membrane of the respiratory tract, and diarrhoea of one type or another is present. When this condition of marasmus is reached, the child is, as a rule, blind, but in spite of the appalling general state, it is a relatively easy matter to restore it to comparative health again with cod liver oil. Even if the child is too ill to take cod liver oil by the mouth or to tolerate it in the intestinal tract, it is often possible to save the life of the child by wrapping it in a flannel binder soaked in cod liver oil. We are not here concerned with the general condition or even the tissue changes in the various mucous membranes. What we are considering is the state of the eyes, and by the time the average baby reaches our out-patient department either one or both the eyes have been so damaged as to result in partial or complete blindness, even though health is restored. This is perhaps all that is necessary to say about the clinical aspect of the condition.

The degenerative condition thus designated is due in the main to a deficiency of vitamin A in the diet; vitamins B, C and D are possibly also concerned so that one may perhaps regard it as a polydeficiency, but we need not now discuss what part these latter food factors play. The signs and symptoms observed in human beings who are suffering from keratomalacia are similar to those artificially produced in animals by withholding vitamin A from the diet referred to by experimentists as xerophthalmia. The clinical evidences of keratomalacia have probably been known for thousands of years although it is only recently that scientific research has enabled us to place the condition amongst the avitaminoses.

* Dr. Elizabeth Mathai University Lectures 1933-34 delivered in the theatre of the Elliot School of Ophthalmology, Government Ophthalmic Hospital, Madras, on 6-3-1934.

The treatment of certain affections of the eye by the same methods as are in due to day for keratomalacia was known to the ancients. The fact that liver was used successfully in treating night blindness in ancient Egypt, Greece, parts of India, Russia, Japan and elsewhere strongly suggests that it was keratomalacia—of which night blindness is such a prominent symptom, which was dealt with. If, for example, the treatment by means of roasted ox liver recorded in the "Book of the eyes" of the Egyptian Papyrus of 1500 B. C. deciphered by Ebers in 1872 was for night blindness,—and this is likely in view of subsequent ophthalmological history,—then it is at least possible that this treatment was for the night blindness of avitaminosis. A reference to the literature bearing on this subject shows that liver administration in various ways was handed down from generation to generation in many countries as a treatment for night blindness. It is unlikely that this would be so if the treatment was not relatively successful. There are records which show that such night blindness sometimes followed fasts and famine, was sometimes associated with xerosis and sometimes went on to complete blindness, which sequence is true of keratomalacia. To those who have lived in keratomalacia-ridden countries, the old records indicate that the night blindness of retinitis pigmentosa and congenital stationary night blindness, which are permanent and not influenced by treatment, cannot have been the sole causes of the night blindness which determined a world wide belief in a treatment which has been handed down to the present day and which we now find in use in remote districts hardly touched by western medicine as a specific for the condition we call keratomalacia. We may therefore argue I think that there is strong probable evidence in favour of the view that successfully treated cases included a high percentage of keratomalacia patients.

Other varieties of temporary night blindness hardly enter into the picture, they are not even now taken seriously by people who live in a primitive way unless some of the other evidences of avitaminosis make their appearance. This degenerative state which we recognise as a deficiency in essential food factors and treat with cod liver oil,

and which the ancients recognised in part and treated with liver in various forms, is a complicated state characterised by a march of symptoms and signs, which in an advanced state includes a partial necrosis of the corneal tissues with softening, sloughing ulceration and resultant blindness;—hence the name keratomalacia.

If untreated death frequently affords a merciful relief and indeed the deaths registered as due to malnutrition, marasmus, and diarrhoea very frequently record the terminations of the lives of infants blind of that eye affection which is such a prominent feature of this deficiency in food factors essential not only to the nutrition of the eye but to the very existence of the organism. When one compares the records of the causes of preventable blindness in children in western countries and in the east, it is noteworthy that keratomalacia plays an insignificant role in the former. Its great importance in India was however pointed out in a paper which I published in the *Lancet* of April, 11, 1931. In that paper it is stated that keratomalacia is almost certainly the chief cause of preventable blindness in children in India. I stressed the words "almost certainly" and am now glad that I did so, as at that time we did not consider that the hereditary blinding diseases should be included in our survey, but as will be pointed out in the third lecture of this series, I am prepared to-day to include this group which is of enormous importance and interest.

Another point may be noted here which goes to show that the responsibility of keratomalacia as a blinding disease may have been under-estimated in so far as that particular publication is concerned. In the year's survey of cases attending this hospital on which the figures quoted were based there were about 30 children totally blinded, and 35 more in which practical blindness resulted. But these figures did not include a number of cases in the same year which are recorded as leucoma or staphyloma or of the cornea and which were partially or totally blind from this cause. It is not possible to estimate with any degree of accuracy the frequency of the various causes of leucoma and staphyloma of the cornea, but we know that the common causes are keratomalacia, small pox, the application of

irritant remedies and the ulcerations associated with acute and chronic diseases of the conjunctiva and cornea other than these. We may therefore include a certain proportion of the cases recorded as blind from leucoma and staphyloma in the keratomalacia group. This would bring the figure for total and practical blindness (and by this one means partial blindness of such a degree as to seriously interfere with earning a livelihood due to keratomalacia for that particular year to between 70 and 75 out of approximately 20,000 out-patients seen in this period. Approximately 3 per thousand of our hospital cases. We shall see later that the collective group of blinding hereditary diseases sometimes equals, but more often exceeds this figure. You must be content with this idea of frequency as I cannot give figures for the general population or what percentage of the total blind of all ages is due to keratomalacia. Figures in this connection want the most careful analysis if they are not to lead us astray. For example one finds in a pamphlet on "Prevention of blindness" by a very eminent official that the census return for blind in India is half a million, but his investigation makes it two millions. A statistician would almost certainly consider the Special Census Officer's figures to be more nearly correct than those of an individual founded at best on a selected and localised survey. We all feel at times that there are more blind in India than the Census return would indicate, but we are not entitled to found a generalised statement on very limited observation which a Special Census Officer could repudiate. As a matter of interest the population of the Madras Presidency is 47,193,602 and the number of blind is 52,279 (1931 Census). The population of England and Wales is 39,290,000 and the number of blind is 46,822 (1927 Census). However in these lectures we are not considering the total blind at all ages but the preventable blindness of children.

With regard to the treatment of the condition by cod liver oil, we have carried out a considerable amount of experimental work in this hospital for the last 12 years and tried numerous substitutes for cod liver oil, some of which were more palatable. We have not however found anything so efficient as crude cod liver oil. It is not necessary to administer it in large quantities. We

have gradually reduced our dosage until now the average daily quantity of cod liver oil administered in the form of emulsion,—for small children is $7\frac{1}{2}$ minims. Of course this does not apply in case the child is unable to take cod liver oil by the mouth. Irradiated ergosterol did not appear to have any better results than cod liver oil, nor did fresh liver, liver powder etc. It would appear from our former work in this connection that vitamin A alone is not so effective in the treatment of the condition as when supplied in conjunction with other vitamins in the form of crude cod liver oil. One hears a great deal about the anti-infective nature of vitamin A, and apparently many experimentists regard the condition they produce by withholding vitamin A from the diet as productive of a condition in which the organism is more liable to invasion with pathogenic bacteriae. As I have explained elsewhere there is no suggestion of this in clinical keratomalacia. I imagine that most of the experimentists have little experience of keratomalacia in bulk as we have. Far from there being any suggestion of an increased liability to organismal invasion the response of a body of an infant almost dead of this deficiency under treatment with cod liver oil contradicts the idea that organismal invasion holds sway. As the alimentary tract may be affected very severely by the bacteria which habitually attack this area, it is sometimes suggested that keratomalacia may follow on dysentery. This seems in our view a mistaken idea and we consider it is the converse which is true, that true bacillary dysentery may attack the individual affected by the tissue damaged by avitaminosis. With this possible exception there is no evidence that the sufferer from avitaminosis is more liable to invasion by pathogens than other delicate children. In fact the pathogens which have already settled in the conjunctiva, cornea, nasal mucosa, throat, lungs, and intestinal tract suffer a rapid defeat very shortly after the patient is put on cod liver oil. These pathogens have for weeks perhaps been leading a saprophytic existence in the very favourite situations where they might have been expected to cause destruction of the individual earlier had they exercised their specific role e. g., pneumococci in the respiratory tract.

PREVENTION:—As suggested in the title of these lectures, this is a preventable disease.

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

ase; it is also an easily treated disease. In spite of this it is probably responsible for more blindness in young children in India than any other single condition. Why then should it not be prevented? Simply because the economic conditions do not permit. The question of prevention of keratomalacia and the blindness due to keratomalacia primarily concerns medical men to the extent of elucidating the nature of the blindness, the cause and treatment of the disease, and the method of its prevention. Having pointed this out to the community at large and the administration responsible for the public health, they cannot do more than relieve the limited number of cases which come their way, instruct others in methods of relief and so try to avoid individual suffering. The disease will gradually become illuminated as better conditions of life become established.

(To be continued).

Abstracts

PROGRESS OF MEDICAL ECONOMICS.

By

EMMET KEATING, M.D., Chicago.

The progress of medical economics has been steadily and increasingly toward the elimination of the family doctor. This progress has been successfully and persistently engineered by several agencies, the medical colleges and health departments heading the list.

It has not been the aim or intention of the medical colleges to eliminate the family doctor. In their efforts to improve the standard of medical education they have, of necessity, emphasized intensive teaching of the specialities. There is nothing about their efforts, in this connection, that merits condemnation, neither is there anything in the possession of extensive knowledge of the various specialities to prevent a physician from being a general practitioner. Such knowledge adds greatly to his ability to serve his community.

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

It is not the fault of the medical colleges that students, receiving a good foundation in each of the specialities, conclude that they should forsake the role of the family doctor to pursue the supposedly easier and more lucrative way of the specialities. The medical colleges may be criticised for permitting the system, in force in some hospitals, of detailing interns to exclusive service in the various specialities. This system has two very grave faults: The intern who gives all his time to the diagnosis and care of patients requiring surgical treatment cannot be expected to fit himself for the role of family doctor; likewise, the intern who confines his attention to the diagnosis and care of patients requiring medical treatment will be very much at sea when confronted with the necessity of determining the presence of conditions that will respond only to surgical measures.

The second fault is the cultivation of the idea, in the minds of the interns, that general practice is beneath their dignity. The intern who is compelled to follow this procedure is unfortunate, because his lack of general training makes it more difficult for him to become a good doctor. This lack deprives him of the ability to give his patients the best service. That such training adds to his technical ability in a narrow field, is not to be denied, but the gaining of basic general knowledge by the beginner should not be sacrificed to the acquiring of increased technical skill.

FREE CLINICS.

Free clinics, created for the benefit of the student, are necessary adjuncts to the providing of medical education. Were they limited to the worthy poor, who are inmates of the county and state hospitals, they would serve their purpose and private practice would not be injured. There are comparatively few lay people and comparatively few physicians who understand and realize that the encouragement of free medical service to large numbers of poor people is an economic mistake. There are few people who understand or realize that the giving away to poor people of medical service, on a scale greater than that needed to provide actual teaching material, is also an economic mistake. Health is a commo-

dity of the highest value, and the individual who expects to obtain and possess it without paying for it will be disappointed. The clinic patient pays by forfeiting his rights to the service, privacy and attention he would receive if he were in a position to pay even a modest fee.

In the pre-dispensary days, the physicians who treated those unable to pay did so willingly, partly from the eleemosynary standpoint, but more particularly from the selfish standpoint. No one knew better than the physician who treated this class of patients how gratefully they advertised him to their friends. It was well known by his rich clientele that the late Doctor Frank Billings treated his poor patients with scrupulous care. This advertisement was not confined to the class unable to pay, but was communicated all the way up the social scale.

HEALTH DEPARTMENTS AND INDUSTRIAL PHYSICIANS.

What are the aims and intentions of health departments? Health departments were founded primarily to improve sanitation, and, in case of national service, to exclude infected people and infected goods. Health departments were visioned and founded by doctors possessed of the highest ideals. These men had no thought that health departments would, in the course of time, become unfair competitors of those engaged in the private practice of medicine. The discovery of the value of health departments as havens for dishonest payrollers and as a means of providing many jobs unnecessary to the commonwealth, but of great value to political machines, is responsible for the unwarranted existence of present-day types of health departments. The opportunity for buying means of transportation, medical and surgical supplies and enormous quantities of biologicals for free distribution is a luscious political plum.

The third group who have played havoc with both general and special practice is the industrial surgeons. Their existence, in such large numbers, is another example of economic blundering. In every large industrial plant there is and always will be a great and insistent need for industrial surgeons. These men should be few in number and select in quality. They should not practice either medicine or

surgery, but should give their entire time to the improvement of working conditions and to the selection of proper jobs for individual workers. They should encourage employers to pay wages that will make it possible for each employee to choose his own physician.

LAY GROUPS.

The aforementioned groups are, for the most part, medical. We now come to the consideration of lay groups, where the physician is the servant, whose financial or scientific profit is confined to those few doctors who make possible the creation and continuance of schemes of this kind.

Workmen's Compensation Insurance heads this list. Supposedly the friend of labour, it is one of the worst enemies of labour. Supposedly a protector of the employer, it is one of the greatest liabilities of industry.

The last of the groups that threaten the existence of American Medicine has an overwhelming influence that is far reaching and disturbing to the body politic. It is that gesture of good intent, but mountain of economic waste, known as organized charity. Here we have both state and private charity organisations that foster the preservation of the unfit and create a protecting influence, adding to our tax and insurance costs by keeping thieves out of jail and murderers from being promptly executed.

These are the forces that, if not checked, will destroy the private practice of medicine in all its fields, and eventually destroy medicine itself.

THE REMEDY.

The cure is almost entirely in the hands of Organised Medicine, which, if it attempts to remove the profession from lay domination, will assume a responsibility for the execution and completion of a tremendous task. It will have the bitter opposition of the selfish in high places and the mass opposition of an army of doctors who serve in lowly capacities. It cannot be initiated by the men at 535 North Dearborn Street. They are the captains and officers of the ship. Their duties are to carry out the policies initiated by the high command of the American Medical Association, who occupy important positions in the leading medical colleges and large

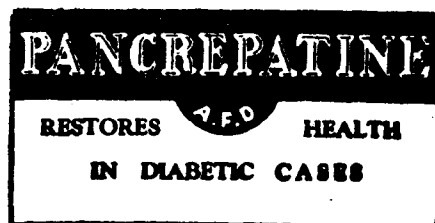
hospitals throughout the United States. They are the ones who have always dictated and will continue to dictate the policies of the organisation. It is right and proper that they should. The duties of the officers at headquarters are to help put these policies in force.

In the past, when invasion of medicine by lay organizations was threatened or occurred, there were a few specialists who quieted objections on the part of doctors by the statement, "The thing is here and it would be better if we went along and guided it, than it would be if we permit it to steer its course without the influence of medical men." This foolish and bad advice was at once championed by those doctors who played the part of political bosses, and objection was immediately silenced. Betrayals of that kind have helped bring us to our present undesirable status.

The remedy is now in the hands of physicians of clear vision, who occupy positions in the high command; men without hope or desire of personal reward, who must take the lead in removing medicine from the domination of lay men and lay organisations. The term "must" does not imply that any one is going to attempt to compel men of clear vision and unselfish spirit to engage in a combat of this kind. It is used in the sense that, if a change is to be made, those are the type of men who will undertake the task. The battle will be on a long front and will include the problem of too many medical schools and the prevention of future graduates from foreign schools, whether American citizens or not, from practicing medicine within the confines of the United States.

2800 Milwaukee Ave.

(C.M.S., Jan., 1934.)



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

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.

Mercury Poisoning: For human beings of average weight 5-15 grains may be considered the lethal dose. Milk and white of egg should be given immediately. Emesis, or gastric lavage, should always be instituted, preferably emesis, as the stomach tube may become clogged. The use of milk should be continued for several days.

The use of specifics such as calcium sulphide and sodium thiosulphate, which aim to precipitate all the mercury in the blood and tissues and allow it to be excreted as nontoxic insoluble sulphides should be had recourse to in every case, as they are harmless and in many cases result favourably. Calcium sulphide is given intravenously as also Sodium thiosulphate both of which should be given by mouth as well. Calcium sulphide 1 gr. in an oz. of water, to be given for every grain of Mercuric Perchloride. The solution must be prepared fresh and filtered through cotton. Specific treatment should be combined with routine method of forcing fluid and the administration of alkaline diuretics and hot packs with colonic irrigation. The following treatment recommended by Weiss is said to result in about 94% of recoveries:

(1) Wash out the stomach with a saturated solution of bicarbonate of soda, continuing until washings are clear. Two litres of the solution should be used. Before withdrawing the stomach tube introduce 6 ounces of a saturated solution of magnesium sulphate into the stomach. (2) Give a soapsuds enema. (3) Give 1000 c. c. of Fischer's Solution in the vein to combat acidosis. (Fischer's Solution: Crystalline sodium carbonate 10 gm., sodium chloride 15 gm., distilled water one litre.) Repeat daily. (4) Give a beverage made by dissolving 4 gm. (1 teaspoon) of potassium bitartrate and 2 gm. (½ teaspoon) of sodium citrate in a glass of water, orangeade or lemonade, six to eight times daily. (5) Colonic irrigation or hot packs may be given.

Carter's antidote, sodium phosphate, will change the bichloride to calomel in vitro,

it is claimed. "Carter recommends 5 to 10 grs. of sodium phosphate per grain of mercury taken plus five grains of sodium acetate in a half glass of water every hour." (Clendening).

Meteorism: Avoid all food for some time, and then give starchy diet in the form of gruel without milk. Apply hot water fomentation preferably Turpentine stupes, to the abdomen. Internally 10-15 mms. dose of Turpentine in capsules or in the form of emulsion every 4 hrs. In obstinate cases Pituitrin 1 c. c. or Eserine 1/50th gr. by injection may be given when there is no obstruction to the intestinal canal.

Mongolian Idiocy: Goat's milk is said to have specific action. Thymus gland either alone or mixed with Thyroid, Adrenalin in combination with Syrup of Hypophosphates of Lime should be administered. (Sagous.)

Migraine: 2 to 4 drms. of 50% solution of Mag. Sulph. is given an hour before rising and the patient should be in a semi-prone position on the right side; at the end of an hour a large tumbler of hot water or hot weak tea is taken.

Pyramidon is useful and also Luminol in small doses combined with 0.3 grm. of valerian root.

Antipyrin grs. 25, Caffein Citras grs. 20, Pot. Bromide grs. 25 to be made into 5 powders one to be taken in water whenever necessary. Phenacitin 20 grs. at the time of the attack and Luminol ½ gr. three times a day during the interval may also be tried. Calcium Lactate taken for a long time seem to prevent attacks of Migraine.

Citrate of Magnesia taken soon after the warning appears, may stop the appearance of Migraine even if there is no constipation.

Before giving any coal tar products the patient should be put to bed and given Tr. Gelsemii 15 to 30 mms. with ½-¾ gr. of Ext. Cannabis Indica every 2 hrs., if the condition of the patient's heart is normal.

As a preventive Soda Sulph. grs. 30, Soda Salicylas grs. 10, Mag Sulph 1 dr., Lithiam Benzoate grs. 5, Tr. Nux Vomica grs. 10, Aqua ad. 4 pints, ½ to 1 glass to be taken every morning half an hr. before breakfast.

Benzoate of Ammonium 10-25 grs. may also be tried.

When the attack is preceded by an Aura, Scintillating Scotoma or Hemianopsia, Adrenalin Chloride (1 in 1000) 10-15 mms. either hypodermically or sublingually will give relief. Ephidrine may be used instead of Adrenalin.

Locally injection of Epinephrine along the course of the parietal or frontal artery preceded by a dose of Caffein, may be tried, or a paste prepared by mixing equal parts of Camphor and Chloral.

In women Migraine is supposed to be the result of disorder of uterine secretion and therefore poly-glandular therapy is advocated, in these cases. Luminol with 0.3 gms. of valerian root is also advised if given twice a day for several days before the expected period. A week before the expected time Ammonium Bromide grs. 30 thrice a day may be also given and immediately before the attack Pheazone grs. 5, Soda Salicylas grs. 5, Syrup Zingiberis 1 dr., Aqua Chloroform 1 oz., may be taken every ½ to ¾ hour until the pain ceases, not more than 4 doses being taken at a time. The disease in women may also be due to Thyroid or Pituitary deficiency. In the former case the pain is dull and occurs on rising, and in the latter case the headache is of a splitting nature. In this case Thyroid, Pituitrin and Adrenalin combined seems to have very good effect. (Sagous). In Migraine coming during the menstrual period either before or after menstruation, injection of Corpus Luteum in the pre-menstrual period every day for 10 days may cause the disappearance of the disease.

TRIED REMEDIES

ZAMA for Eczema, Scabies and allied Skin Diseases.

KOO-KOUMIN for Whooping Cough and other lung affections in children attendant with spasmodic cough.

CAN BE HAD FROM :—

THE ORIENTAL RESEARCH LABORATORY, Vepery, Madras.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

The Treatment of Placenta Praevia.

By

M. PIERCE RUCKER, M. D.

(Abstracted from the *Journal of the American Medical Association*.)

Conclusions.

There are certain fundamental principles in the treatment of placenta praevia that should be observed whether the patient is treated in general practice or in a well-equipped obstetric hospital.

1. The significance of a haemorrhage in the last half of pregnancy should not be minimized. Too often the patient is encouraged with the hope that it will not recur.

2. No pelvic examination should be made until everything is in readiness to manage the patient should it be found that the placenta is presenting.

3. A vaginal pack done as a make-shift, i. e., until help can be secured or the patient can be taken to a hospital, probably does more harm than good. A better plan is to give the patient a dose of morphine and disturb her as little as possible.

4. The importance of blood transfusions is self-evident.

5. One cannot show the cervix too much respect. Dilatation should not be hurried and should be complete before any operative delivery, except a Braxton Hick's version is attempted. If Vorhees' bags are used, a number 5 is preferable. When the bag is about to come through the cervix the patient should be on the delivery table and everything should be in readiness for an immediate delivery should that be necessary.

6. The extra-ovular placement of the bag is preferable.

7. Postpartum haemorrhage had not been a problem in my cases, but its danger should be constantly borne in mind.

8. In the interest of the child, Caesarean section has a place in complete and partial placenta praevia.

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

Acid Urine is Bactericidal.

By

HUGH CABOT, M. D.;

Rochester, Minn.

The old idea that, in inflammatory conditions of the urinary tract, the urine should be made alkaline, is rather thoroughly exploded. In fact, it has been found that a highly acid urine is bactericidal, even without the addition of any of the popular urinary antiseptics, such as methenamin. Urinary acidity produced by a ketogenic diet works more powerfully and quickly than that resulting from the administration of such drugs as ammonium chloride and ammonium nitrate; but the important thing is that the acidity should be of high degree (pH 5.5 or, better, 5) and that it should be produced as rapidly as possible and maintained until the urine is completely sterilized. The organism causing the infection must be known from the start and must be entirely eliminated.

(*Surg. Gyn. & Obst.*, Aug., 1933, p. 265.)

Carbon Tetrachloride as an Anthelmintic.

J. A. CARMAN, (*East African Med. Journ.*, September, 1933, p. 181) discusses the value of carbon tetrachloride in the treatment of hookworm disease and taeniasis. He points out that there is a heavy preponderance of evidence as regards its safety and efficiency in this respect, and, since the drug is now included in the *British Pharmacopoeia*, it can no longer be considered as an experimental remedy. Experience has shown that with careful selection of cases and preliminary dosage with magnesium sulphate symptoms of poisoning do not occur. In the fatal human cases on record the commonest factor present was alcoholism before or after treatment, but in a few cases the patients had been recently anaesthetized with consequent liver impairment. Carman is satisfied that the drug is an effective anthelmintic in uncinariasis and taeniasis. He condemns the exhibition of extract of male fern as being inefficient in dispensaries staffed by native dressers unless the patient has been very carefully prepared. In such circumstances it is likely to give rise to fatal

poisoning occasionally. The author commends a one in four mixture of oil of chenopodium and carbon tetrachloride; with this in several hundred cases he has encountered no untoward symptoms. No food is given to the patients in the evening before treatment. In the morning they take 2 drachms of magnesium sulphate in 2 ounces of water; the anthelmintic mixture is then administered, followed by another dose of the salt. The maximum dose of the vermifuge mixture is 60 minims for a well-developed adult male, and smaller doses for women and children.

Ringworm of the feet and Toes.

I. S. BARKSDALE (*Med. Journ. and Record*, October 18th, 1933, p. 279) discusses the treatment of the so-called ringworm of the feet and toes (athlete's foot). He considers crystal-violet application the method of choice, fuchsin in combination with the heavy metals having proved in his experience a disappointing germicide. Bismuth violet (0.4 per cent in a 10 per cent glycerin solution) gave satisfactory results, but only after repeated application and very diligent and conscientious treatment. It was found necessary to apply the medication every day for a week or ten days. Thymol and salicylic acid, applied on two consecutive nights beforehand, was found to be a useful adjuvant. Finally, what is described as the ideal dehydrating, kerolytic, and germicidal agent, was elaborated: a combination of bismuth violet 1 gram, salicylic acid 2 grams, and ethyl alcohol to 100 c.cm. Two or three daily applications of this mixture arrested the infection, and recurrence was only noticed in cases when all after-care was neglected. The author states that this trichophyton infection is not associated with any impairment of the general health or nutrition, and advises early diagnosis to avoid spread of the disease. He describes the onset as characterized by slightly reddened, moist, and swollen skin between the toes and on the soles and sides of the feet. If treatment is not started, small watery vesicles ensue in twelve to twenty-four hours, with intense itching. Larger lesions follow, with areas of raw discharging subcutaneous tissue usually emitting a foul odour. The clinical diagnosis is confirmed by laboratory detection of the trichophyton.

Thymophysin in Labour.

OTTO WALLIS (*Journ. Obstet. and Gynecol. British Empire*, June, 1933, p. 633) is astonished by the adverse report on the value of thymophysin issued by Roques and MacLeod. He maintains that its applicability is not in straightforward labour, but "in cases of primary and secondary inertia with a not too over-fatigued uterus." He points out that the increase of the performance of the normal strongly working uterus obtained by means of an injection of thymophysin must be considerably less than the increase of the performance of the inert uterus, brought about by equal doses of thymophysin. This use of thymophysin is illustrated by a record of fifty cases in which successive small doses—0.4 c.cm., followed, if necessary, by often no more than 0.02 c.cm., at one-hour intervals—definitely shortened labour. He prefers thymophysin even in the second stage, as less, not more, likely than pituitrin to cause tetanic contractions of the uterus and affect the foetal circulation. He has never met with such adverse effects. The duration of labour is definitely shortened by its use; (1) in conjunction with castor oil for initiation of contractions (it lasted 11 hours 35 minutes and 5 hours 45 minutes in two cases reported), and (2) in a large majority of cases of primary or secondary inertia. He emphasizes the view that the value of such a preparation can only be estimated from its effect in such cases as call for a labour stimulant.

Induction of Labour.

D. G. MORTON (*Amer. Journ. Obstet. and Gynecol.*, September, 1933, p. 323) tried out in 150 cases a method of inducing labour in order to assess its reliability in toxæmic or other urgent indications. The patients included twenty toxæmic cases and 122 normal cases near term. There was one failure in each group. The routine was as follows: at 4 a.m. castor oil 30 c. cm.; at 5, 6, and 7 a. m., quinine 0.3 gram; at 7-30 a. m., a hot enema; at 8-30 a. m., artificial rupture of membranes. This was performed under antiseptic conditions (30 c. cm. of 4 per cent aqueous mercurochrome in vagina) with a fine hook. Pituitrin, 1 c.cm., was then applied intranasally every hour till pains were established. The average number of applications in

multiparae was 2.9, in primiparae 3.2. It was found specially important, in cases where the pains went off, to repeat the pituitrin. Once established, labour was conducted normally, with sedatives, etc., as required. The onset was usually with severe prolonged pains, never tetanic. Foetal heads showed marked moulding, and forceps were required in "a number of cases" owing to secondary uterine atony; but harmful effects on the babies were "notably absent". These induced labours were found to last approximately half as long as spontaneous cases. The main factor in their duration was found to be the degree of obliteration of the cervical canal at the time of artificial rupture of the membranes. There were no maternal deaths and no serious infections. Febrile puerperia appeared in 10.1 per cent of cases—mostly only technical. One baby was still-born; one died on the third day of *B. Coli* infection; one on the forty-second day of prematurity. One foetal complication occurred—a prolapsed cord. This was successfully diagnosed and treated by high forceps extraction, but this method is not recommended in cases where the presenting part is not fixed. The twenty-one cases induced for toxæmia were all markedly successful.

News and Comments.

Yet another Memorandum to Joint Parliamentary Committee: The Hony. Secretary, Bombay Medical Union has sent us a copy of the Memorandum submitted on 26-12-33 by the Union to the Joint Parliamentary Committee on Indian Reforms. Our readers might remember that the Indian Medical Association sent a memorandum to the Indian Members of the Joint Parliamentary Committee sometime ago before the members left for India, and we trust that the representations made by the latter association would impress the members of the Joint Parliamentary Committee the more when yet another prominent association, the Bombay Medical Union, had endorsed almost all the opinions expressed by the Indian Medical Association, pressing the same to the hilt by irrefutable arguments basing on authenticated facts and figures.

At the very outset the Bombay Medical Union gave credit to the Indian Medical

Service as being the "first harbingers of Western Medical Science to India and said that at present this service served only as a millstone round the neck of India checking all advances in the fields of medical relief, medical education and medical research." After discussing briefly the administrative difficulties in working out Provincial Autonomy if the members of the Indian Medical Service are allowed to work under the ministers who have no control over the members of this service, the memorandum deals with the cost of retaining this service which in Bombay Province alone would bring a saving of Rs. 50,000 a year if the I. M. S. are not employed under Government. The memorandum deals with Medical Education, Research, Public Health Departments and Jails, and arrives at the conclusion that both in the interests of economy and health of the country, Indian civilians would do ampler justice to their country, especially in Bombay where there is no dearth of highly qualified medical men, many of whom having higher qualifications than the existing members of Indian Medical Service. Regarding reservation of some of the appointments to European I.M.S., the Union quotes the instance in the city of Bombay where a member of I. M. S. with little or no special training was appointed as a Professor of Midwifery and Gynaecology, when specialists with European qualifications were available amongst the members of the profession in that city. The same arguments have been deduced to replace the I. M. S. by Indian civilians in jail service. The memorandum concluded by expressing emphatically that the civil side of the Indian Medical Service should be scrapped and that the Government of India and the Provincial Governments be given opportunity for recruiting their medical staff, European and Indian, in the open market.

A Federal Health Organisation:

It is a pity that the politicians nor the medical profession in India have as yet realised the necessity of a central body for the administration of Public Health Department in consonance with the Federal system of Government. We are informed that the Public Health Commissioner with the Government of India in his annual report

(See page 146)

Temporary effects of arsenic easily counterfeit antisiphilitic effect.

CLINICAL NOTES

AND

PRACTICAL SUGGESTIONS

An effective treatment of Constipation and Intestinal toxæmia.

Constipation has recently been divided into four varieties.—

1. Atonic Constipation.
2. Spastic Constipation.
3. Obstructive Constipation.
4. Fragmentary Constipation.

Patients who usually live sedentary lives and who do not take sufficient physical exercise suffer from atonic constipation. The bowels in this type are sluggish, have lost their tone and to a great extent their contracting power.

In the spastic type the patients are usually of nervous temperament. As a rule these patients complain of flatulence and griping pains in the lower part of the abdomen. Peristalsis at times is very severe in this variety.

In the third type the mechanical causes such as foreign bodies, adhesions, growths, haemorrhoids, strictures, displaced organs etc. cause obstruction and the result is obstructive constipation.

The last one, the Fragmentary type is characterised by occasional peristaltic movements of the bowels. The patient is inclined to go for stools, but he does not get sufficient or satisfactory evacuation.

All the types except the Obstructive may be seen in a patient at different times, because the colon tries to adjust itself to the different abnormal conditions and may thus manifest these various states such as spasticity, atonicity etc.

We can only achieve success in the treatment of constipation by administering something which will not only bring about proper faecal consistency from the diet, but will educate the bowels to move at a particular time. The medical practitioner, who realises that the cure of constipation lies in the bowels being made to move at a definite time each day, will not employ drastic and irritating purgatives in the treatment of constipation. Education of the bowels therefore is the most important factor and the physician must employ such a remedy which

induces his patients to practise the habit. The fight against constipation must be so directed that the bowels are regulated not only as regards evacuation, but the working of their secretions must be restored to normal. The hardened faecal matter must not be allowed to stagnate and the development of bacterial toxins must be prevented. The physiological treatment of constipation is made possible if the facts given above are borne in mind. This can be done by Mycol in which are combined all the requirements needed to overcome the various pathological facts that go to form constipation.

The *Biliary Extract*, the chief ingredient of Mycol regulates the secretion of bile and prevents coagulation of mucus. It emulsifies and saponifies fats. The gastric juice is alkalised so that hyperacidity is prevented. By acting as an effective disinfectant it prevents fermentation. It stimulates the excito-motor power of the muscular fibres of the intestines and also the secretions of the latter. It is thus of great value in constipation.

It has been demonstrated beyond doubt that *Lactic Ferments* therapy is the most scientific and effective treatment in intestinal putrefaction and the resulting auto-intoxication. This latter sequelae is usual after constipation and hence the inclusion of Lactic Ferments in Mycol. They arrest intestinal fermentation by neutralising harmful bacterial action. They are therefore of great use in all the manifestations resulting from constipation and intestinal fermentation.

Beer Yeast is also included in Mycol to increase leucocytosis in the blood and to thus act as a bactericide. It is also valuable on account of its anti-staphylococcic properties.

There is in Mycol *Agar-Agar* which helps lubrication of the intestines. It is also a great water-absorbent and this property helps to rehydrate the intestinal contents. It softens the hardened matter, corrects the physical condition of the contents of the intestines restoring their normal bulk and softness. The bowels are dilated and stimulated and soon assume their normal functioning.

While cathartics and purgatives cause a harsh chemical action in the bowels and set up violent irritation and inflammation,

Mycol by reason of its ingredients mixes intimately with the intestinal contents and produces a soft, well-formed and easily-moved mass, providing a comfortable bowel action with no irritation, acting at the same time as a good antiseptic. With purgatives the bowels are obliged to move with force and this whips the muscles into violent activity. The adjacent tissues are drained of moisture and the intestinal contents are diluted and liquified. Mycol does none of these things. It brings about the normal faecal consistency, regulates the bowel movements and thus restores the functional activity of the intestines. Purgatives, as has been found out defeat the very object for which they are indicated. They cause the involuntary muscles of the intestines to exert themselves too much, as a result of which they need rest and recuperation. This inactivity naturally lasts for some time and the result is that there is again accumulation of the intestinal contents. Another purgative is then given and the process is repeated times out of number. The delicate and sensitive mechanism, as a consequence, becomes inflamed and later does not act except when severe cathartics are given. Mycol, on the other hand, does not stimulate or force bowel action but effects a gentle, softening and lubrication action and causes natural evacuation without any discomfort or griping. Perseverance with Mycol treatment means excellent education of the bowels.

Besides the administration of Mycol sufficient exercise is the first essential in cases of constipation, because if the muscles in other parts are dull on account of inactivity, the intestinal musculature also fails to act. Exercise therefore will not only benefit the general health of these patients, but will greatly aid constipation. If exercise is not possible massage of the abdomen specially over the colon is beneficial.

It is well-known that constipated people gradually drift towards various conditions such as enteritis, colitis, intestinal toxæmias and auto-intoxication. The intestinal stagnation which results from constipation forms a perfect culture medium for the various pathological bacteria which thrive and produce toxins. The colon therefore becomes a focus for dissemination in the

system of poisons. As a result of chronic constipation the foodstuffs are not properly disintegrated, the hardened faecal matter obstructs the intestines and prevents their adequate movements. The undirected use of purgatives in these cases makes the condition worse, as they send the chyme to hurry through before the digestive process in the small intestines is complete. In such conditions it is highly essential to restore the normal consistency of the bowel contents and adequate bowel peristalsis. In this connection the all important part played by Mycol by reason of its ingredients is really remarkable. The efficient flow of bile in the system, when Mycol is administered, soon overcomes constipation. Its antiseptic and anti-toxic functions as well as its reflex action on the muscular fibres of the intestines make Mycol a powerful remedy to fight against this toxæmia. It deals effectively with all the toxins in the intestines and disinfects the entire digestive tracts.

We have seen therefore how rational and valuable is the use of Mycol in cases of intestinal toxæmia due to constipation. Its use not only brings back formed stools and cessation of foul odour but restores to the organism the most essential material lacking in this complaint, viz. bile. This latter acts as a better antiseptic because while medicinal antiseptics prevent malefic as well as benign fermentation, bile, which is the normal secretion of the intestinal tract is the best for the purpose as it helps digestion, which is essentially a fermentative process. Hence Mycol treatment is the most rational and superior to any other in intestinal toxæmias.

Treatment with Mycol presents absolutely no difficulties. Its pleasant taste and palatability will make even the fastidious take it readily. Its efficacy as regards softening and lubrication of the bowel contents is really an asset. Persons who are habituated to purgatives and cathartics can easily break away from this habit by the regular use of Mycol. Definite dosage is another advantage of Mycol. Because of its composition the results are more prompt and more assured. As is the case with purgatives and other similar preparations there is neither nausea nor retching nor gastric or

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intestinal irritation. Mycol can be taken over long periods of time with no ill-effects whatsoever. Its use for sometime restores normal intestinal function and there is no danger in its employment under any circumstances. Unlike cathartics it may and should be given in such conditions as Haemorrhoids, Cancer, Fissures etc. where its action is beneficial as it helps to soften the hard masses and renders evacuation much easier. Mycol therefore is a valuable therapeutic agent. It is so constituted as to fight effectively both constipation and its sequelae on the etiological and pathological data of the affection. In fact it can be considered as a standard bowel-educator.

Treatment of Staphylococcal infections of the skin.

It has been found from extensive clinical experience that the application of Stannoxyl has cleared up many of the skin lesions due to staphylococcal infections which had proved obstinate and refractory to vaccine treatment. The action of Stannoxyl does not depend so much on its power to destroy the micro-organisms but on its ability to increase the resisting power of the patient and on the immunisation it produces in the affected regions. Stannoxyl tablets supplemented by injections of the same has proved very successful in suppurative conditions of the skin, where other treatments have failed. The chief value of Stannoxyl seems to lie in its power to fortify the host against Staphylococcal infections and this is the explanation of its remarkable success in Furunculosis, Carbuncle, Sycosis, Styes and other pyogenic infections of the skin. The main feature of this treatment is relief from pain that it brings about, and if the treatment is used sufficiently early, boils, carbuncles and such other septic processes may even be aborted. Stannoxyl therefore should be given a chance in all these conditions before incisions are made. If the injections or even the tablets are taken in time, the lesions will most probably abort but in case the suppuration has already taken place a single injection of Stannoxyl or tablets taken for two or three days will soon bring it to a head. After incision dry dressings with liquid Stannoxyl will soon heal up the wounds.

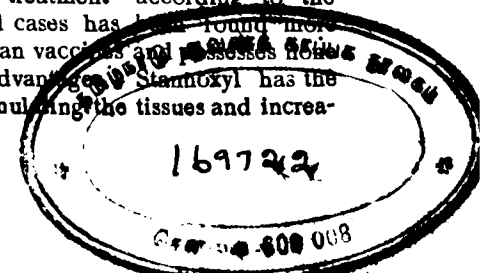
The following few cases fully illustrate the efficacy of Stannoxyl:

1. A young adult of about 25 suffered from Furunculosis of the face and the head for a long time, specially in hot months. He had used vaccines with no result at all. The multiple boils all over the face troubled him a lot and opening and dressing them every time caused him not only a good deal of trouble but also worry and expense. Treatment was started with Stannoxyl injections when he came under the author's care. One ampoule was injected every day and this was supplemented by tablets, six of which he took every day. Eight days of this treatment cleared up the Staphylococcal infection completely. He continued taking the tablets even after the cure. He finished three bottles of the tablets and the trouble has not recurred so far i.e. for more than a year now.

2. Another male adult suffering from suppurative acne, which was very refractory to other kinds of treatment, was treated by Stannoxyl injections and tablets. Twelve injections were given, each on alternate days. He was advised to take tablets also, six per day. This routine he continued for one month. He was much better after this and the acne cleared up to a great extent. After another month's treatment with tablets alone, he completely recovered leaving no trace of the disease, not even black-heads.

3. This was a case of a sty in the eye. Examination showed that it would run a very bad course. The same treatment viz. Stannoxyl injections and tablets were continued. Six injections were given but the tablets were continued for nearly a month. After three injections there was marked improvement in the condition and after three weeks of this treatment no trace of the trouble could be observed in the eyes. He was kept on the tablets for some time as he complained of recurrence of this trouble. It is needless to add that he was advised to take Cod-liver Oil along with this treatment.

Stannoxyl treatment according to the above typical cases has been found more successful than vaccines and possesses none of their disadvantages. Stannoxyl has the power of stimulating the tissues and increa-



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sing their resistance to fight with the micro-organisms. In Stannoxyl we have therefore the means of enhancing the local tissue protective power. It does away with surgical interference to a great extent and also troublesome fomentations and baths which are really unnecessary and at times dangerous. Simple ingestion of these tablets and if necessary injections are in the majority of cases all that is needed to bring about a cure. In case boils have burst or carbuncles opened, they should be dressed after evacuation of pus with compresses soaked in a lotion of Stannoxyl liquid in which form it is also available. The strength of the lotion should be from 2% to 4%. It ensures easy separation of the sloughs and rapid healing of the wounds.

A Brief Review of Present Ideas on Diabetes.

A review of diabetic treatment necessitates a consideration of all factors associated with this disease. Naturally the process of carbohydrate metabolism and abnormalities connected with such metabolism constitute the chief points for discussion when considering Diabetes Mellitus, a thorough investigation of this process being essential for the formulation of a rational method of treatment.

The carbohydrates ingested are acted upon by various enzymes and ferments and converted into simple sugars, chiefly glucose. This passes into the capillaries of the small intestines which pour their contents into the portal vein, rendering the blood in this tube extremely rich in glucose. However in normal metabolism the percentage of glucose found elsewhere in the blood is very small, any rise above a certain concentration leading to its excretion in the urine.

The glucose present in the blood affords the chief source of energy for all muscular work and carbohydrate nutritive processes in the body; the greater the amount of energy expended the greater the oxidation of glucose. A consideration of these facts reveals a constant need of glucose, the amount varying with the energy expended, thus it

will be realised that in order to meet this constant but varying demand, it is essential the body should have a reserve supply of glucose in some form or other.

The question now arises—How is this glucose stored in the body? The kidneys play very minor part by inhibiting the excretion of glucose from the blood until the concentration exceeds .18 per cent, when this is exceeded it is excreted in the urine.

The main store of glucose is to be found in the liver, this organ performing the important function of storing glucose in the form of glycogen and releasing it in accordance with body requirements. The glucose present in the portal vein while passing through the liver is converted into glycogen and deposited in the hepatic tissue. When the demand arises this glycogen is discharged into the blood stream which conveys it to the body tissues. Here the glucose is again converted into glycogen and temporarily stored, this action taking place particularly so in the muscles. When the muscles or other tissues assume an active role this glycogen is again reconverted to glucose and oxidized, and it is this oxidation which provides the energy for muscular activity and helps in maintenance of body temperature. This oxidation which accompanies any activity on the part of the body means an unceasing consumption of glucose, replacement of which is essential for maintaining normal body activity. The storage of this glucose reserve in the form of glycogen, with its discharge into the blood stream when the demand arises, constitutes one of the important functions of the liver.

Thus we have several processes concerned in normal carbohydrate metabolism. These are:—

The conversion of glucose into glycogen in the liver.

The reconversion of glycogen into glucose in the liver and its discharge from this body in order to maintain the sugar concentration in the blood.

The formation of glycogen from glucose which takes place in the muscle tissues, its storage and release in the form of glucose when required for oxidation.

The oxidation of sugar in the tissues.

Consideration of these facts makes it quite obvious that these processes must be regulated and adapted one to the other in order to ensure normal carbohydrate metabolism which is essential for the healthy body. How and by what this regulating mechanism or carbohydrate metabolism is controlled has always been a perplexing problem, but during the last few years much light has been thrown on this subject.

That the Islets of Langerhans in the pancreas secrete a hormone called insulin which has a prominent part in carbohydrate metabolism is a well known fact. Its importance has frequently been demonstrated by removing the pancreas of animals which results in the onset of diabetes mellitus.

Clinical research has revealed that this pancreatic hormone, insulin, is concerned in regulating the storage of glycogen in the liver, and controlling its discharge in the form of glucose to meet the requirements of body tissues—where oxidation of glucose takes place—insulin also being one of the factors influencing this oxidation. Any reduction in this regulating action of insulin is accompanied by excessive concentration of blood sugar—due to inability of the liver to store glycogen in the normal manner, while the tissues cannot utilise the sugar in the blood, thus producing toxic effects whereby the tissues are unable to meet their energy requirements—resulting in general muscular weakness etc. Again, when the body is unable to oxidise its carbohydrates we frequently find this is accompanied by incomplete oxidation of fats, with a resulting liberation of acetone bodies. The presence of these bodies may lead to acidosis which often results in severe symptoms such as coma.

Thus we find the regulating function of insulin must vary if normal carbohydrate metabolism is to proceed, but how the optimum regulating function of insulin is ensured has entailed much investigation.

A brief review of the therapeutic action of insulin will now be helpful.

Insulin when administered orally has proved quite inactive, but when injected it rapidly produces a reduction in the concentration of blood sugar by enabling the tissues to take up this sugar which is conver-

ted into a reactive form through the intervention of some activating agents apart from insulin, thus permitting the tissues to metabolise the sugar, in addition it promotes storage of glycogen in the liver, and restricts the production of sugar in the liver from proteins and fat, a process which is greatly increased in diabetes mellitus. Clinical observation has shown that the proportion of insulin required to carbohydrate intake is not a constant factor but varies appreciably from time to time; also, provided the caloric value of the diabetics-balanced diet is kept constant, the carbohydrate intake can frequently be increased without a corresponding increase of insulin being required. A rarer example of decreased insulin efficiency is found in those diabetics who become resistant to insulin injections. In such cases usually there is either some disturbance of the hepatic functions or a definite hepatic lesion. Further it has been shown that the severity of Diabetes is not proportional to the lesion in the islets of Langerhans, sometimes the diabetes being quite severe while the lesions are not so or are absent.

This apparent variability in insulin activity led to investigation of whether diabetes is essentially due to deficiency of insulin or to some unknown factors which control insulin action.

Work connected with this has lately shown that insulin as found in the pancreas is inactive, its activity being regulated by several factors. Among these are the humoral and neurogenic stimuli which come into prominence after the intake of food, and function by their action on the Pancreatic tissue stimulating the discharge of the inactive insulin or insulinogen. This insulinogen which is now present in the blood stream passes to the tissues where it assumes its activity through the intervention of certain activating agents present in the tissues. The presence of these agents has been established by various experiments foremost among which is one entailing perfusion of the pancreas and heart with Lock's solution containing glucose. It has also been revealed that the pancreas itself secretes hormones which on entering the blood stream influence the activity of insulin in oxidising the sugar present in tissues.

These discoveries add support to the clinical observation that insulin injections are

followed by a latent period prior to insulin activity, and on considering data obtained during research this period is probably necessary for these activating principles to convert the insulin into an active form. Numerous experiments have been performed with the object of substantiating these facts and each provides further evidence of the importance of these stimulating and activating agents in connection with insulin function.

Recent work in connection with Diabetes Mellitus indicates the presence of another insulin body existing in the tissues and which has been called tissue or cellular insulin. This is supported by experiments carried out with depancreatized dogs, which have been fed with glucose. During their existence which varied up to 18 days or so, only a portion of the glucose taken has been excreted, as much as 50% being utilised, which reveals the presence of some body capable of assisting the tissues to oxidise glucose, without the addition of insulin to the diet.

Again plants are capable of metabolising glucose, and since insulin cannot be isolated from their cells, they must contain some principle enabling them to oxidise their sugar, and which possesses properties similar to insulin.

Another feature of great importance when considering the cause of Diabetes is the function of the liver. An autopsy performed on a diabetic person invariably reveals lesions in the liver. Markowitz, Mann and Bollman have shown that immediately after removing the liver from a dog, insulin exerts its usual activity, but that several hours or more later large doses of insulin may exert no action on the blood sugar. Again results have been obtained which show that during the stage of liver necrosis and fatty degeneration which follows poisoning with chloroform there is a subnormal tolerance to a combined test of insulin and oral glucose, but that during that stage of liver regeneration when the organ is full of young cells there is a supernormal tolerance to the test. Further, reported cases of insulin resistant diabetics are now numerous and in practically every one an abnormal condition of the liver has been found.

From consideration of these facts it appears that the liver not only functions by storing glucose in the form of Glycogen, but also plays an important part in providing certain principles which influence insulin activity.

It must also be recognised that in cases where diabetes is not primarily caused by lesions in the liver, any derangement of carbohydrate metabolism external of the liver will impose an extra strain on liver tissue, and if it is unable to cope with this extra work the result will be—breakdown of normal liver function, possibly with lesions in the tissues, accompanied by precipitation or increase of diabetic symptoms.

Considering these facts it is now evident the rational treatment of diabetes should consist of rectifying the basic cause of this disease and not rely solely on the temporary replacement of insulin—which is represented by the continuous insulin injections identified with diabetic treatment in the past. Treatment on these lines means the introduction into the system of the various hormones and principles which beneficially influence the discharge and activity of insulin. Thus a preparation suitable for oral administration should not only contain the correct extracts from the liver and whole pancreas but should also have these so prepared that they are not rendered inactive by gastric secretions.

We now have a preparation which meets all these requirements in Pancrepatine, making a distinct advance in diabetic treatment. The extracts in Pancrepatine are representative of the whole pancreas and liver, thus this preparation contains not only those hormones which influence insulin activity but also a certain amount of insulinogen; treatment with Pancrepatine providing many improvements when compared with that of insulin.

A comparison of the relative values of insulin treatment and Pancrepatine treatment is now opportune.

In insulin treatment administration has to be by injection, oral administration not being possible on account of insulin being inactivated while passing through the alimentary canal.

The dose of insulin has to be regulated according to the concentration of blood sugar, because an overdose may produce marked toxic effects, due to excessive reduction of blood sugar concentration producing symptoms of hypoglycaemia, such as faintness, sweating and sometimes the patient even becomes delirious. Thus insulin injections generally demand constant medical supervision. Again, insulin only provides a substitute for the Pancreatic insulinogen producing temporary improvement of symptom only which generally means continuous treatment accompanied with permanent restriction of diet.

Pancrepatine on the other hand certainly provides a more rational method of treatment. It is now realised that its hepatic extract is a valuable factor in treating Diabetes, whether the disease is primarily caused by some derangement of function in liver tissue or otherwise; since this hepatic extract will assist the faulty liver to perform its carbohydrate regulating function and stimulate regeneration of hepatic tissue; also, this extract will function as a safeguard of the normal liver by aiding it to cope with any extra burden imposed on it through derangement of carbohydrate metabolism outside the liver. Another important feature is the pancreatic extract which is representative of the whole pancreas, and consists of the secretions which have been shown to influence insulin activity, along with a certain amount of pancreatic insulinogen. Pancrepatine possesses one more factor enhancing its value, this is its facility or oral administration, rendered possible by the special gluten coating of the tablets protecting it from the inactivating action of the gastric secretion.

Compared with insulin the action of Pancrepatine is slow, but nevertheless more permanent, with the result its administration is perfectly safe and the patient requires no constant supervision in order to avoid an overdose which in the case of insulin frequently produces marked toxic symptoms.

Where a rapid reduction of blood sugar is required insulin injections are necessary, but where this is not so it will be found that most diabetic patients respond extremely well to Pancrepatine alone. Pancrepatine is also a valuable adjuvant to insulin, in cases where the injection treatment is necessary;

its incorporation in this regime producing a gradual decrease in quantity and frequency of insulin injections required, this being brought about through the introduction into the system of the various hepatic and pancreatic secretions contained in the extracts composing Pancrepatine, and which are absent from insulin injections.

Briefly, Pancrepatine may be defined as a rational method of treatment, its objective being the restoration and maintenance of the hormone equilibrium influencing insulin activity, correcting derangements which appear to be the primary cause of Diabetes Mellitus.

Some interesting Case-notes.

BY A PRACTITIONER.

1. Sometime in the middle of November last, a male patient of about 28 came to me with a diffuse swelling of the right axilla. I was told that about a month back he had injured his right wrist as a result of a fall on a sharp instrument. The wound was sutured and dressed but after three days an apparent diffuse lymphangitis of the forearm set up which disappeared after five or six days of treatment. Approximately a fortnight later there developed a diffuse swelling in the right axilla which gave him great pain. The general symptoms were very severe. Temperature ranged between 101° and 103° and the movements of the affected shoulder were restricted and very painful. Hot fomentations were advised and an ordinary diaphoretic with bromides was prescribed. The next day the symptoms were just the same. He passed a sleepless night and looked very much worried. Examination of the local swelling showed signs of decided fluctuation. I therefore took a crucial incision on it after sterilisation and anaesthetisation, and drained a lot of pus. After cleaning the wound with hot water I dressed it with wet packs of Bacte-Pyo-Phage. Next day although the temperature was 99° still the area round about the wound was diffusely swollen. This was nothing but lymphangitis started after the incision. This swelling, which was not clearly defined extended from the scapula to the sternum. The wound also discharged a certain amount of pus. I gave him orally one ampoule of Bacte Pyo-Phage in a glass of water mixed with a drachm of

Soda Bi-Carb. morning and evening besides the usual compress dressings of the same Phage. The third day the patient was free from fever, he had slept well and the general condition had improved. The same routine of Bacte-Pyo Phage orally as well as locally was continued. Two more days of this treatment brought about a great change in the patient's condition. The lymphangitis had almost disappeared and there was no pain or pressure. Movements of the shoulder were more free and also painless, suppuration had ceased and the wound was granulating. The same treatment was continued for three more days. The wound healed, the inflammation had entirely disappeared and the patient was absolutely all right. The oral treatment of Bacte Pyo Phage, however, was continued as a precautionary measure for two more days.

This case is really remarkable in that such a severe and intense infection yielded to the application of dressings soaked in Bacte Pyo Phage together with the internal administration of the same, in a rapid manner and without much trouble.

2. A middle-aged man of about 50 after returning home from hospital came to me for some tonic. He had suffered from severe constipation alternating with pain and diarrhoea of about a year's duration. As it yielded to no drugs he was operated upon and a mass of hard faeces was removed under an anaesthetic. After the wound had healed he developed an ischio-rectal abscess, which was also operated upon. It took a long time to heal. At this period he suffered from diarrhoea and was becoming more and more emaciated. He was also very worried and his mental condition began to deteriorate. The patient, when he came to me for a tonic, was in a very bad mental and physical condition. Emaciation was extreme. I advised Fer-Ma-Pho, 10 drops of which he took three times a day half an hour before food. After finishing one bottle there was a marked improvement in the patient's condition. The mental condition was getting almost normal. He regained an excellent appetite, taking his food with much relish and began to put on weight. Within a few days after commencing the second bottle he had gained over

a stone in weight. The physical and the mental condition changed for the better and emaciation gave place to normal weight. He was quite fit in every respect after about two and a half months by which time he had finished three bottles of Fer-Ma-Pho. This is then one of the best tonics for post-operative recuperation.

3. A young boy of 20 was given to the pernicious habit of masturbation. No amount of medicines would wean him from it. In the beginning I prescribed a bromide mixture with Tr. Valerian Ammoniatum and Tr. Belladonna. He was not at all amenable to this line of treatment though it was continued for a long period. I then prescribed Elixir-Bromo Valerianate together with Fer-Ma-Pho. The effect of this combination was more than I expected. It not only acted as an anaphrodisiac and a sedative but as a tonic to the nervous system which in this case was much shattered as was evidenced by over-irritation and hypersensitiveness. Later on I kept him on Fer-Ma-Pho alone, which helped him to build up his nervous system and also to get rid of his evil habit. Fer-Ma-Pho can therefore be used with good results in most of the cases of increased libido and acts both as an effective anaphrodisiac and an excellent tonic to the nervous system.

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(Continued from page 144)

has strongly advocated the necessity of such a central body and also suggested the appointment of a Commission representing all allied interests to consider all the factors relating to health, especially population, finance, wages diet, etc. for paving the way of the economic uplift. It is also said that in 1932 Major-General J. W. D. Megaw, the then Director-General of Indian Medical Service, did point out to the Government of India that responsibilities of the Federal Government for the health of the people should be clearly defined and that in any country which had a federal form of Government it was found essential to arrange for a central machinery to secure co-ordination in health problems and to provide for a control over the Provincial Governments by Federal Government. The idea suggested by the Public Health Commissioner for the appointment of a commission does not seem to be a new one as it is said that nearly ten years ago, a resolution was passed at the instance of (the then) Lt. Col. Megaw, suggesting to the Government the desirability of appointing a commission to make a thorough enquiry into the wastage of life and economic depression in India.

We welcome the idea of having a federal health organisation for India. The functions and responsibilities of this central health organisation can be worked satisfactorily if, as suggested by the Public Health Commissioner a Commission is appointed soon on the lines suggested by him. This subject being of great importance to the welfare of this country we shall revert to it once again elsewhere in the near future.

The Indian Medical Council: Our doubt about the omission of the names of the nominated and elected members from Bengal to the Indian Medical Council has been cleared. The names from Bengal with a few additional names from other provinces have since been published as under:

NOMINATED MEMBERS: Sir Hassan Suhrawardy, Dr. J. N. Duggan, Dr. C. L. Houston, and Col. D. P. Gail.

ELECTED MEMBERS: Dr. B. C. Ray (Calcutta University), Dr. K. S. Ray, (Bengal Presidency) and Dr. M. K. Kapur (Punjab).

The Council met at Delhi on 9-3-34 for the first time. Sir Fazl-i-Hussain addressed

the meeting before the regular business commenced. He appealed to the members to work in perfect harmony with the University authorities and establish a standard of University medical education with a view to secure "efficiency at home and honour abroad."

The Council then proceeded with the election of Vice-President; Colonel Sir Hassan Suhrawardy and Dr. Deshmukh were nominated and the former was elected as the Vice-President.

With regard to the election of members to the Executive Committee the Council came to an agreement that the Committee should consist of three representatives of the Universities, one representative of the elected group and another from the nominated element and the following members were duly elected:—Major Bhatia, Dean of the Grant Medical College, Bombay, Dr. Vyas, Dr. Erulkar, Dr. B. C. Roy, and Dr. T. Krishna Menon. The Council seems to have requested the Government of India that the members should be given the same scale of daily and travelling allowances as those of the members of the Legislative Assembly. Dr. F. Macrae has been appointed as the Secretary of the Council on a salary of Rs. 2250 per mensem. He has been brought down from England on account of his special qualification, having served as an Inspector for the General Medical Council, Great Britain. Evidently he must have been recommended by that body to the India Government. It was expected that he would serve the Indian Medical Council in the same capacity. But the Council has passed a resolution to the effect that there should be three inspectors, one for Medicine, the other for Surgery, and the third for Midwifery and these need not necessarily be members of the Council and Dr. Macrae has been assigned the place of the Secretary to this group of inspectors. Sir Fazl-i-Hussain seems to be perturbed and it is very likely that the Government of India would not give its assent to this resolution and refer this subject to the Council.

As has been expressed by us repeatedly there was no need for the inauguration of a costly Council and have as costly a Secretary for standardising the Indian Medical University Education. It was very unfortunate as could be judged by subsequent events that the

Legislative Assembly threw out the proposal of the appointment of a Commissioner suggested by the G. M. C. at the very outset. In the place of one Commissioner we have now a Council with a Secretary who for all practical purposes would take the place of the Commissioner.

The elected members must have known what they were at when they competed for the seats. The nominated members must be loyal to those who sent them to the Council. So no good purpose will be served in trying to go against the current. Any reference by the Government to the Council has to be decided by a meeting of the Council which would mean waste of time and money. The whole bargain is a costly one and no use in making the bargain more costly by obstructing the programme of the General Medical Council.

Indianisation of I. M. S.: Hon'ble Mr. Jagadish Prasad moved a resolution in the Council of State on 7-3-34 urging that there should be 50 per cent of Indians in the Indian Medical Service and that competitive examinations should be held in England and India simultaneously for recruitment. Mr. Syed Raza Ali who was formerly a member of the Public Service Commission opined that it was not possible to have a competitive examination simultaneously in both countries in such a manner as to introduce uniformity of standard. He preferred the present method of recruitment by selection. Major General Sprawson said that though the present ratio was 2 British to 1 Indian it actually worked at present 1.7 British to 1 Indian. He said that the ratio should increase proportionately to the increase of Indianisation of the Army and the present ratio should be retained in the interest of British families in India.

Competitive examination is certainly better test than selection and if selection could be done in India for this service why not hold competitive examination for the same purpose? The argument of Major-General Sprawson that European doctors are needed for treating British families cannot be relished these days as it savours of racial bias which cannot be encouraged in the interest of good Government. The

employment of Military medical officers on the civil side should on no account be encouraged though there can be no objection of British medical men settling in India as private practitioners who should take their chances in life as do their Indian brethren. The fusing of practitioners of both nationalities on equal terms will, in certain respects, be conducive for the advancement of medical profession in this country.

A Combined Function: On 26-3-34 His Excellency Sir George Frederick Stanley, Governor of Madras, declared open three sets of buildings (1) the new Surgical Block of the General Hospital, (2) the Radiological Institute and (3) the Pathological Institute of the Medical College.

Major-General Sprawson, till recently the Surgeon-General with the Government of Madras, and now the Director-General, Indian Medical Service, came all the way from Delhi to attend this function, and while thanking His Excellency and Lady Beatrix Stanley for their kind participation in the function, said that it gave him great pleasure to see the practical completion of the fine buildings. He said that the financial and other difficulties for the adjustment of the space of land available for the building, were overcome with the help of the Government and other authorities concerned and the buildings were completed so that His Excellency could open them while he was still in Madras.

It is said that these palatial buildings have cost the Government over twenty lakhs. The purpose of medical education at the Madras Medical College might have been better served these days of financial stringency if less money was spent on spectacular buildings and more for actual treatment of the suffering humanity. These three blocks of buildings have served another purpose; they give publicity to the existence of three autonomous subdivisions in one educational institution in the city of Madras. Elsewhere in this country and in other civilised countries the responsibilities of the institution for giving medical education are under the control and guidance of one individual. This is as it should be in the interest of medical education or else there

cannot be proper co-ordination of work and many a time there will be clashing of interests which is detrimental for the training of medical students. All the various subjects in Medical Science are taught to the students with one common ideal of making a student an efficient medical man. It is therefore desirable that those who teach all the correlating subjects to the students should be under the disciplinary control of one individual who should have no other work, public or private, except the control over the institution of which he is the head. It was so in Madras some twenty years ago and the person who was in charge of the Government General Hospital including the radiological section of it was the principal also of the Medical College. The present arrangement of the creation of three autonomous institutions, however convenient it may be to the officers in charge of them, has affected the discipline and efficient control over the medical education of the students trained in these institutions. Major-General Sir Frank Connor, the new Surgeon-General with the Government of Madras, was once in the teaching staff of the Calcutta Medical College and the Medical College Hospital, both the institutions being under the control of a Dean, and it is expected that he will be in a position to compare and contrast the relative advantages and disadvantages of having an institution for the training of medical students under three autonomous departments and bring about healthy reforms, minding the medical education and not the interest of the individuals who serve under them.

Stanley Medical School: 27-3-34 was a gala day at the Royapuram Medical School, Madras, when His Excellency Sir George Frederick Stanley, Governor of Madras, inaugurated the five years' course and gave his kind consent to call the school after his name. Those who attended public functions in this school in the past, would certainly be filled with joy that a once neglected institution situated in a corner of the city of Madras, was lucky that day in attracting a gathering consisting of high and influential officials in Government service and also a large number of doctors connected with the medical education in the Medical College, Madras, who have been conspicuously absent at the School at various gatherings in the past. We will not be far wrong

when we say that the presence of the head of the Government of this Province in the school premises that day must have contributed a good deal in bringing about such a happy change and trust that those present on that day will continue to evince the same concern in the institution in future. We congratulate Lt. Col. V. Mahadevan, I.M.S., most heartily on his sagacity in having the inauguration ceremony of the five years' course performed by His Excellency the Governor of Madras, before His Excellency laid down the reins of his office in this Province, and more than that, on his success in gaining the sympathy of the public as well as the Government by calling the Royapuram Medical School after the name of His Excellency Sir George Frederick Stanley. The future progress of medical education in this school is now well secured and as was well said by Major-General Sprawson who was one of the principal speakers that day, the students of the Stanley Medical School should conduct themselves worthy of the encouragement given to them by His Excellency Sir George Frederick Stanley.

The speeches delivered on the occasion would appear in the newspapers but we wish to point out to our readers one or two significant items in the speech made by Major-General Sprawson who in addition to his being the Chief Medical Adviser to the Government of India, now occupies the unique position as the President of the newly-constituted Indian Medical Council. Major-General Sprawson amongst other things said that prior to his being a medical student, the course of medical studies in England was only for four years and still earlier it was even three years. In spite of the difference in the course of studies, the General Medical Council which came into existence on account of the passing of the Medical Registration Act in Great Britain brought within the purview of that Act all medical men then existing whether they be of three years course or four years and even those without any training in any recognised school and yet it has not been possible in this country to do likewise when the All-India Medical Council is brought into existence. The Major-General was of opinion that the existing title of L.M.P. ought to continue and that in his own country when the courses of studies in the

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

medical institutions were increased the names of the then existing diplomas were not changed. In Great Britain and other civilised countries the history of medical education in medical institutions have been quite different from that in India on account of various reasons and circumstances. The name of the degree, M.B. & C.M., was changed to M.B. B.S., in Madras to denote the actual training received by the University students. The title L.M.P. indicates that one possessing it, is only licensed to practise Medicine and Surgery and is certainly not as dignified as it ought to be and we consider it may be desirable to initiate a new title for all the diploma holders past and future, and the title of L.M. & S. in our opinion will be more suitable than the title L.M.P., especially so as this title has ceased to exist as an University degree. We also feel it desirable to point out that if there is to be any change in the title of the medical licentiates that pass out from the School after the five years' course, all the other existing medical licentiates should be permitted to use the changed title as was done when the title of L.M.P. was conferred upon them some years ago; or else there will be one more subdivision in the castes now existing in the medical profession.

Influx of German Doctors: The influx of German and Jewish Doctors in Bombay has become the subject of keen discussion amongst the members of the medical profession who are openly divided into two groups, one strongly protesting against their entry, the other strongly sympathising with those who are exiles from Germany due to political persecution. Consequently interrupting scenes marked the proceedings of a meeting of medical men held at Blavatsky Lodge, Bombay on 11-3-34. Two resolutions were finally passed; one recorded indignation at the unrestricted admission of non-Indian doctors and dentists in Bombay and other parts of India from foreign countries which debarred Indian nationals from practising in those countries. The second resolution while sympathising with the Jewish and German doctors demanded legislation laying down restrictions on non-

Indian doctors as regards immigration, naturalisation, registration, etc.

The members of the medical profession did a right thing in discussing about a subject which was likely to affect the growth and prosperity of the medical profession in this country. The section of the profession who opposed the above resolutions ought to have considered about the consequences in allowing foreign doctors to settle in this country when Indians could not do the same in foreign countries. They were no doubt charitable, but "charity should always begin at home." The rank and file in the medical profession find it very hard to maintain themselves on account of unhealthy and unequal competition with their Indian brethren in Government service and also with practitioners of indigenous systems of medicine. How could they suffer more having to compete with another section of foreign doctors when they have to deal with highly credulous masses in this country?

Medical Economics: Under the caption "Progress of Medical Economics" we have published an article from an American doctor in the "Abstracts" columns of the current issue and we wish our readers to go through this article. Free Clinics, Health Departments, etc., seem to threaten the growth and prosperity of the medical profession in America in spite of the fact that the medical officers in charge of such charitable institutions are whole-timed and not allowed private practice. The state of affairs in India are much worse. Here the medical officers are not only paid fat salaries but allowed to enjoy the privileges of private practice without any restriction whatsoever. There exist in America well-organised medical associations to protect the rights and privileges of the medical profession. We have none of the type that exist in other civilised countries. Almost all the medical societies in India are run on sectarian lines and even the only existing non-sectarian society, the Indian Medical Association, has not been able to do much to the profession on account of the existence of different grades in the profession. The author of the article under reference complains that even an association of a national type, the

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

American Medical Association, has not been able to achieve anything to solve the problem 'medical economics' in that country. There are certainly many more forces at work in India hampering the growth and prosperity of the Independent Medical Profession which, if not checked, will destroy "the private practice of medicine in all its fields and eventually destroy medicine itself."

Madras Medical Budget: The discussion on the Medical Budget during the last session of the Madras Legislative Council was not so illuminating as it used to be in the past. It looks as if the people's representatives now find that little or nothing comes out of their criticisms or perhaps they were not posted with necessary information for the purpose. Instead of a persistent and constructive policy, drifting and adjustment to the policy of drifting has been the main feature of the medical administration in this province. Heavy expenditure was incurred in the past on account of multiplying of posts and transforming of juniors in the lower grade of service to the higher grade. We have been discussing in these columns such a wasteful policy and though new appointments and transformations are now on the decrease, there are tendencies for recrudescence of the old policy, as is evidenced from the figures in the Medical Budget for the current year. Our readers might remember that we brought to the notice of the authorities in these columns that there was no need for a full-time Professor of Medical Jurisprudence in the Madras Medical College and that the Police Surgeon could be entrusted with the work of teaching of medical jurisprudence as is the case in other presidency towns, like Bombay and Calcutta. If we remember right, this post was the subject of discussion on the floor of the Legislative Council and the Government reply was that the professor would be in charge of teaching both in Schools and College in the City and that the new appointment was more economic financially. The Budget Estimate for the current year has provision for additional staff to serve under the new Professor. There is yet another provision for the staff in the new Surgical Block in Government General Hospital. Whatever might be the justification in giving additional staff to the Professors of Medical

Jurisprudence there cannot be any justification in creating new appointments specially in the subordinate grade when efficiently trained medical men are available to serve as honoraries. It is most unfortunate that the Government do not realise that the best service they can give to the public and to themselves is to turn out good general practitioners, as three quarters of students passing out of medical colleges and schools will pass into general practice. This ideal service could be realised if and when Government employs honoraries to almost all subordinate posts in State Institutions.

On the whole an increase of 4½ lakhs over the last year's figures is found in the budget. There is always a loud talk about village reconstruction and it is a pity that neither the Government nor the public have so far realised that medical relief is one of the most important items in village reform. If paid medical service is justifiable at all it should be in rural areas. But we find the reverse in the policy of the Government of Madras. Some years ago they inaugurated a scheme of Subsidised Rural Medical Relief. Year after year its growth is dwindling and the Government while spending lakhs for Medical Relief in urban areas, not as many thousands are spent for Subsidised Rural Medical Relief. The discussion on the motion for a cut for the purpose of criticising the policy of the Government regarding Medical Relief will be commented upon either here or else in the next issue.

A Startling G. O. with no Effect: Recently an Order was passed by the Government giving notice for termination of services of as many as 23 Assistant Surgeons. The order on the face of it seems to be drastic but some of those who received, these notices say that it is a "paper G. O." meaning thereby that it will not affect them. The term 'paper appointments' is familiar; 'paper G. O.' is a new development. About two years ago when some appointments were abolished in the Medical Department on account of retrenchment and simultaneously a fresh batch of Assistant Surgeons were recruited in the department, we did question then the wisdom of the Government. The result of this policy has been that a large number of medical officers, have been these two years put on reserve duty in many hospitals both in the city and the mofussil, doing little or nothing at all except drawing their salaries

at the end of every month. It now transpires that the vacancies expected two years ago are to be filled in now by about 20 newly recruited Assistant Surgeons and so the notice for the termination of services regarding at least these 20 seems to serve the very opposite purpose for which they are made to appear. It is also said that the remaining three will also be provided for before the notice of termination of service is given effect to. Why waste ink and paper on such G.O.s and with it lot of money too?

Dangerous Advertisement: Our readers might remember that early this year there were two or three reports in the columns of The Hindu that one Dr. P. S. N. Moorthi Naidu had obtained permission from the authorities to conduct experiments on lepers at the Manamadura Leper Asylum with a specific invented by him. Later one European lady by the name, Sister Trafford, wrote in the columns of The Hindu that she was an eye witness of the wonderful cures effected by this specific. After a few days it was reported that Dr. Naidu was refused facilities for his experiments and that he would conduct these experiments elsewhere. It now transpires as could be seen from the report in the Hindu dated 15-3-34 "that the allegations made by Dr. Naidu that proper facilities had not been provided for his demonstration are quite unfounded. The District Medical Officer (Ramnad) has further reported, that he saw the leper patients who told him that they have had no improvement and therefore they preferred the treatment they were given before. On the 30th January, about a week after Dr. Naidu undertook the demonstration of his treatment, the office of the Surgeon-General desired to have information as to the composition of the drugs which Dr. Naidu used in his treatment and the District Medical Officer accordingly desired Dr. Naidu to furnish the information. The request was not complied with." On further enquiries we learn that Dr. Naidu is not a qualified practitioner and that the European lady Trafford was formerly employed at the Manamadura Leper Asylum and her services were dispensed with sometime ago and that Dr. Naidu did not only not supply information

regarding the composition of his specific but left Manamadura immediately after the query. Sensational news naturally feed newspapers and journals, and gives wild publicity to what is stated. Therefore all possible care and caution should be taken by all concerned in giving publicity to news of the nature under reference or else such sensational news is sure to cause immeasurable harm to the lives of the people who are likely to put faith in such news though it might advertise a person or a commodity without incurring any expenditure.

Medical Council Elections: As reported in these columns last month an election ought to have been held last August for filling up the vacancy caused by the expiry of the term of office of Dr. T. S. Tirumurti, the member representing one of the two seats for the graduates in this province. The lapsed election will be held early and precepts intimating to the electors about the vacancy will be issued by the President of the Medical Council early next month. There will be another vacancy next September on account of the expiry of the term of office of Dr. V. Rama Kamath who is representing the Registered Medical Practitioners in the 3rd group. The precept for this election will be issued early in July. We are informed that both Drs. Tirumurti and Rama Kamath are seeking re-election.

The latest published medical register is very defective. The addresses of a large number of practitioners are not correct. The electorate will be deprived of their franchise if voting papers are posted to wrong addresses and the money spent for sending the voting papers to these wrong addresses will be a waste. May we therefore suggest to the electors to write to the Registrar, Madras Medical Council, 81, Mount Road, Teynampet, P.O., Madras, intimating to him the change in their addresses as early as possible?

A Request: We have commenced to send complimentary copies of the journal to the medical practitioners in Madras Province whose names appear in the newly published medical Register, some of whom must be subscribers of the journal already.

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

As the initials in the name appearing in the newly published medical Register are misleading, it has not been possible for us to avoid the mistake of sending the complimentary copy to one already in the subscribers' list. We have therefore to request such of those who have been receiving more than one copy of the journal to be good enough to return the journal to us pointing out the mistake committed in our office.

Correspondence, Reports, Etc.,

A Healthy Reform.

In your issue volume 5 No. 2, Nov. 1933, page 30 you have mentioned "The Medical licentiates are not recognised as fit to examine life Insurance cases."

In the Indian Mutual Life Association Ltd. of which I am the Chief Medical Referee no such invidious distinction as mentioned in your esteemed paper is in force. Medical licentiates and Graduates, both in and out of Government Service are given equal rights and we have on our role such Medical Examiners.

I trust that in justice to us, you will correct the impression that is conveyed to the public by your above statement and give this letter a place in your journal.

T. KRISHNA MENON
Chief Medical Referee.

Plea for a National Medical Association.

Communalism and sectarianism are no where more idealised than in the Medical profession of India. There is the independent section, service section, again the graduates, the licentiates, the I. M. S., the England-returned and so on, all in such water-tight compartments that even by a mischance there is no possibility of one passing on or diffusing into another. This state of things has been first brought about in service for its own purposes. The distinctions are perpetuated by special legislative measures such as the Medical Council acts. Consequently sectarian associations have sprung up all over the country. Thus we have the licentiates' association, the service men's association, association of I. M. S., of the rural

medical practitioners, women doctors and what not. No doubt these associations have played their part nobly. They seem to have out-lived the purpose. For want of a proper coordinating factor all these could not think and act in the terms of the nation and the profession as a whole. Consequently, in no way are these assets for the nation.

In other civilised countries we hear of only one medical association for each nation with a national and nation-wide programme to which all members of the profession high or low, rich or poor, in service or in private practice, owe allegiance. Local associations are only branches of the parent association. Thus you hear of the British Medical Association for the whole of Great Britain and every member of the profession where-ever he be in the whole world prides in calling himself a member of that association, and he is generally benefited by it. Similarly in America there is only one association the American Medical Association. At the present day we in India have no such union. Our helplessness was betrayed fully in our fight against the unwanted All India Medical Council Bill. Besides, while all civilised countries have been trying to have uniformly high standard of Medical Education, in this country there are people who believe that different grades of knowledge are required in the medical profession basing on the absurd principle that the life of a rural man is cheaper than that of his urban brother.

It is therefore essential that there should be one association for the whole of India with provincial branches. May I therefore appeal to all sectarian associations now existing in this country to find their way to affiliate themselves to the Indian Medical Association which is run on the same principles as those of the British and the American Medical Associations?

Tanuku. S. SATYANARAYANA, L.M.P.

The Nellore District Medical Association.

Report for the year ending 3rd March 1934.

I have very great pleasure in submitting the following first annual report of the Nellore District Medical Association.

The thought of organising a district medical association for Nellore was first suggested by Dr. Venkappa of Madras and initiated by Dr. Krishna Rao, District Medical Officer, Nellore. An appeal was issued to all medical men in the district by me, and the response was so ready that the first inaugural meeting was held on the 4th December 1932, with 29 members on its rolls.

Membership: The year opened with 28 members, of which 18 were resident and 10 non-resident. There are 52 medical men in Nellore District both in service and in private practice. It is hoped that all of them will enlist themselves as members of the Association.

Subscription: The membership fee is Re. 1 per month, or Rs. 10 annually for resident members and Rs. 5 annually for non-resident members.

Meetings: Ten meetings were held during the year under report, one business meeting, the rest being for the discussion of medical subjects.

Members' Activities: Dr. M. A. Salam was elected to the Nellore District Board and Dr. B. Janardana Naidu to the Nellore Municipal Council. The Association takes this opportunity of congratulating them.

Habitation: The Association feels grateful to the District Medical Officer and the President, District Board, Nellore, for allowing the use of the District Medical Office rooms and the meeting hall of the District Board for holding the meetings.

Conclusion: The work turned out during the year has been on the whole, satisfactory. There is yet scope for the development of this Association and the future will greatly depend on the co-operation and enthusiasm of the medical men of the district. I place on record the services rendered by Dr. K. Krishna Rao, District Medical Officer and Dr. S. Raghunatha Singh, Joint Secretary, but for whose help and co-operation, the Association would not have been able to achieve much. I thank one and all of the office-bearers and members for the help rendered by them.

NELLORE, } M. K. Rajagopala Chari
3rd March 1934. } Secretary.

Nandyal Registered Medical Practitioners' Association.

The second annual meeting of the Association was held on 20-1-34 in the Municipal Council Hall when Dr. P. Venkat-narayana, L. M. S., presided. Dr. Varadier, D. M. O., and Dr. Subrahmanyam, D. H. O., were also present. Dr. Subrahmanyam gave an account of the working of the medical associations in the west and after tea, Dr. Hymans-De-Tiel delivered an interesting lecture on "Pain in Gynaecology" and Dr. S. Ramadas, L. R. C. P., M. R. C. S., on Gonorrhoea and its treatment as done in the Madras General Hospital.

Dr. Ramadas in charge of the Taluk Head Quarters Hospital, was elected President, and Dr. B. Sukhavanam as the Secretary for the year 1934.

Subsidised Rural Medical Relief.

Dr. S. Sreerama Rao, L. M. P., Kanu-mole, Krishna Dt., makes the following suggestions regarding Rural Medical Relief Scheme.

1. Subsidy must be Rs. 800/-. 2. The restriction that the Rural Medical Practitioner should get his medicines from the Government Medical Stores only, should be removed, and he should be permitted to purchase medicines at the nearest and cheapest medical stores. 3. Arrangements should be made to keep the R. M. P. in touch with all modern scientific developments by granting him study leave for a period not exceeding one year once in every five years on full subsidy. 4. Every dispensary should have a midwife and a ward-boy and the necessary surgical instruments including a midwifery and tooth set. In the absence of a pucca building for the dispensary a reasonable amount may be set apart from the Taluk Board funds as house rent. 5. The R. M. P. may be allowed 40 days casual leave in the year to a maximum of 15 days at a time while permitting him to attend meetings of the medical associations of which he is a member without counting such days as casual leave. 6. The present system of disbursing subsidies should be simplified in such a way as to be speedy and regular.

Dr. A. Subramaniam, L. I. M. Subsidised Medical Practitioner, Pudupalayam, and Member, Central Board of Indian Medicine, writes:

Though Rural Medical Relief is working for nearly a decade it has not improved. Many instances of victimisation by the Presidents, Taluk Board, have been brought to the notice of the Government and the public. As the scheme works at present, the rural medical practitioners are neither the servants of the Government nor of the Local Boards, yet they are treated worse than full-timed servants. The rural medical practitioners are made to work both morning and evening like full-timed medical officers in charge of pucca Taluk Board dispensaries. They are expected to do this work without the help of a compounder or a midwife. In view of the difficulties experienced by the subsidised practitioners, the Government would do well to convert these subsidised dispensaries into pucca dispensaries under the management of the District Boards. This could be very well done without much extra expenditure, by the Government paying the District Board at the rate of Rs. 800 a year for each dispensary, the amount now given by them for each subsidised dispensary towards the subsidy of a practitioner and a midwife, and the additional expenditure being met by the District Board out of the income they are likely to derive by the abolition of the Taluk Boards.

Reviews.

THE HANDBOOK OF INDIAN MEDICINE

OR

THE GEMS OF SIDDHA SYSTEM

By

DR. T. G. RAMAMURTHI AYYAR.

Sri Vani Vilas Press, Erode. Price Rs. 5.

The book evidently shows the labour and time taken by the author in its compilation. The author rightly says that the book is chiefly intended to provoke thought and stimulate further study and research. That the Siddha System is an ancient one and has much advanced in the long past, and that even now it is found efficient in the treatment of some diseases, there can be no denying. But any science, if it is to progress, should advance with the times along with other sciences. The Western Allopathic system has advanced very much since the time of Hippocrates and Galen, but similar advancement is

not observed in the case of Siddha system. There are several reasons for this state of affairs, the important one being want of funds. Even as it is, instances are not wanting, where medical cases, after having undergone treatment under the Western system without any effect, have been successfully treated under the Siddha system. It is not merely imagination, nor mere philosophising to say that for diseases pertaining to a country, the remedy is found in the same country. For the proper treatment of diseases, (1) the diagnosis must be arrived at correctly with the aid of the latest and up-to-date appliances; (2) only such medicines which have been scientifically analysed, standardised, should be taken by the quickest path, oral or parenteral, as may be required; (3) diets must be prescribed after ascertaining their constituent parts and nutritive value suited to the disease and the habits of the patient. To achieve this chemical, physical and physiological and bacteriological, research laboratories are required. In the absence of philanthropic persons as a Rockefeller in India, the Government alone must find funds for such institutions. It is not possible for any Government to start and maintain such institutions for each System of Medicine, Western, Ayurveda, Unani, etc. The only possible way to advance is to amalgamate the Indian system with the Western system and to provide separate chairs for the learning of indigenous system of Medicine and Pharmacology in the existing schools and colleges. The Indian Schools of Medicine now established in Madras and elsewhere, are after all hybrid institutions. How far these are going to be fertile is not known, but it is said that all hybrids are infertile.

We congratulate the author for the way in which he has brought out the book and we hope that it will stimulate Indian doctors, whether following the Western or indigenous system, to research work. The advancement of medical science in India, suited to the Indians, must be made in India and by Indians.

M. S. K.

ARSENO-SOLVENT.
A Painter's Solvent for Sulfarsend

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

(Continued from February issue).

List of Postings of Sub Asst. Surgeons for the month of January, 1934.

No.	Names of Sub-Asst. Surgeons.	From.	To
49	Dr. S. Jagadisan	Leave	L. F. Dy., Sholavandan.
50	" K. Varadarajan	Govt. Hd. Qrs. Hl., Chingleput	Pasteur Inst. Coonoor.
51	" T. R. Manickam Pillai	L. F. Dy., Nilakkottai	Central Jail, Cannanore..
52	" B. Jagannatham	Munpl. Dy., Kurnool	C/o D. M. O. Visagapatam.
53	" K. R. Parthasarathy	Agency Duty, Vizagapatam	Govt. Hd. Qrs. Hl., Chingleput.
54	" T. S. Ramachandran	L. F. Dy., Sholavandan	Agency Duty, Visagapatam.

List of Postings of Second Class Health Officers for the month of January, 1934.

No.	Names of Second Class Health Officers.	From	To.
1	Dr. V. S. Natarajan	Rameswaram	Mettur.
2	" A. Gopalan	Saidapet	Rameswaram.

List of Postings of Sub Asst. Surgeons for the month of February, 1934.

No.	Names of Sub-Asst. Surgeons.	From	To
1	Dr. N. Saktharam Rao	Hd. Qrs. Hl., Tanjore	L. F. Dy., Orattanadu.
2	" J. Ponnuswamy Pillai	Govt. Hl., Attur	Govt. Hd. Qrs. Hl., Coimbatore.
3	" Miss I. S. Swamidoss	Leave	Govt. Hl., Prodattur.
4	" Mrs. Grace Doss	Govt. Hl., Prodattur	" Russelkonda.
5	" S. Sessa Reddi	Leave	L. F. Dy., Rapur.
6	" B. Yerram Raju	Plague Duty, Anantapur Dt.	" Duggarajapatam.
7	" M. Gopala Acharya	L. F. Dy., Duggarajapatam	Govt. Hl., Kanigiri.
8	" K. Krishnamurthy	Govt., Hl., Kanigiri	L. F. Dy., Podili.
9	" Mrs. F. Mathuranayagam	Govt. Gen. Hl., Madras	Govt. Hl., Tiruvannamalai.
10	" K. Sankaranarayana Unni	Agency Duty, Vizagapatam	L. F. Dy., Yercaud.
11	" C. R. Narayana Iyer	Police Hl., Malappuram	Govt. Hl., Dindigul.
12	" Abdul Jabbar Sahib	Govt. Hl., Dindigul	Govt. Hd. Qrs. Hl., Berhampore.
13	" K. Jagga Rao	Leave	L. F. Hl., Gajapatinagaram.
14	" Y. Suryanarayanamurthy	L. F. Hl., Gajapatinagaram	" Kurupam.
15	" R. V. Narasimham	Leave	Govt. Hd. Qrs. Hl., Guntur.
16	" P. V. Krishna Iyer	"	C/o D. M. O., Ganjam.
17	" K. Vallabha Rao	Govt. Hd. Qrs. Hl., Berhampur	Govt. Hd. Qrs. Hl., Cocanada.
18	" Miss M. Chacko	Lady Goschen Hl., Mangalore	" " " " Anantapur.
19	" Varadarajulu Naidu	Leave	Munro's Hl., Gooty.
20	" D. Maduranayagam	Govt. Hd. Qrs. Hl., Ramnad	Govt. Hd. Qrs. Hl., Palamcottah.
21	" K. V. Narasimha Rao	Medl. School, Rayapuram	Govt. Hd. Qrs. Hl., Chingleput.
22	" L. Veeraswamy	Govt. Hd. Qrs. Hl., Kurnool	Munpl. Dy., Kurnool.
	" Md. Ali Sahib	Leave	Govt. Hd. Qrs. Hl., Nellore.
	" N. Narasimha Rao	Plague Duty, Dharmavaram	Govt. Hd. Qrs. Hl., Salem.

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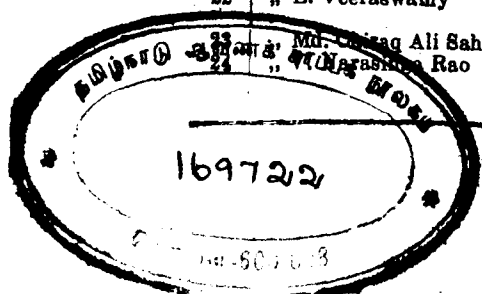
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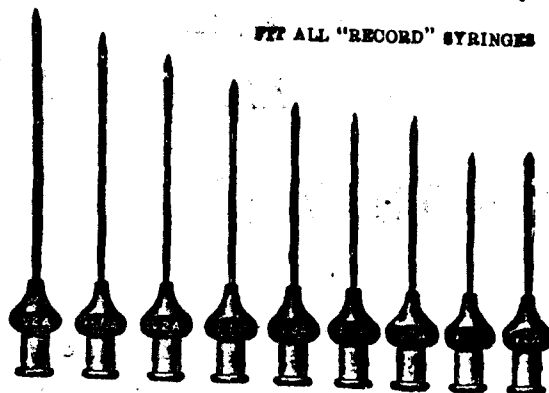
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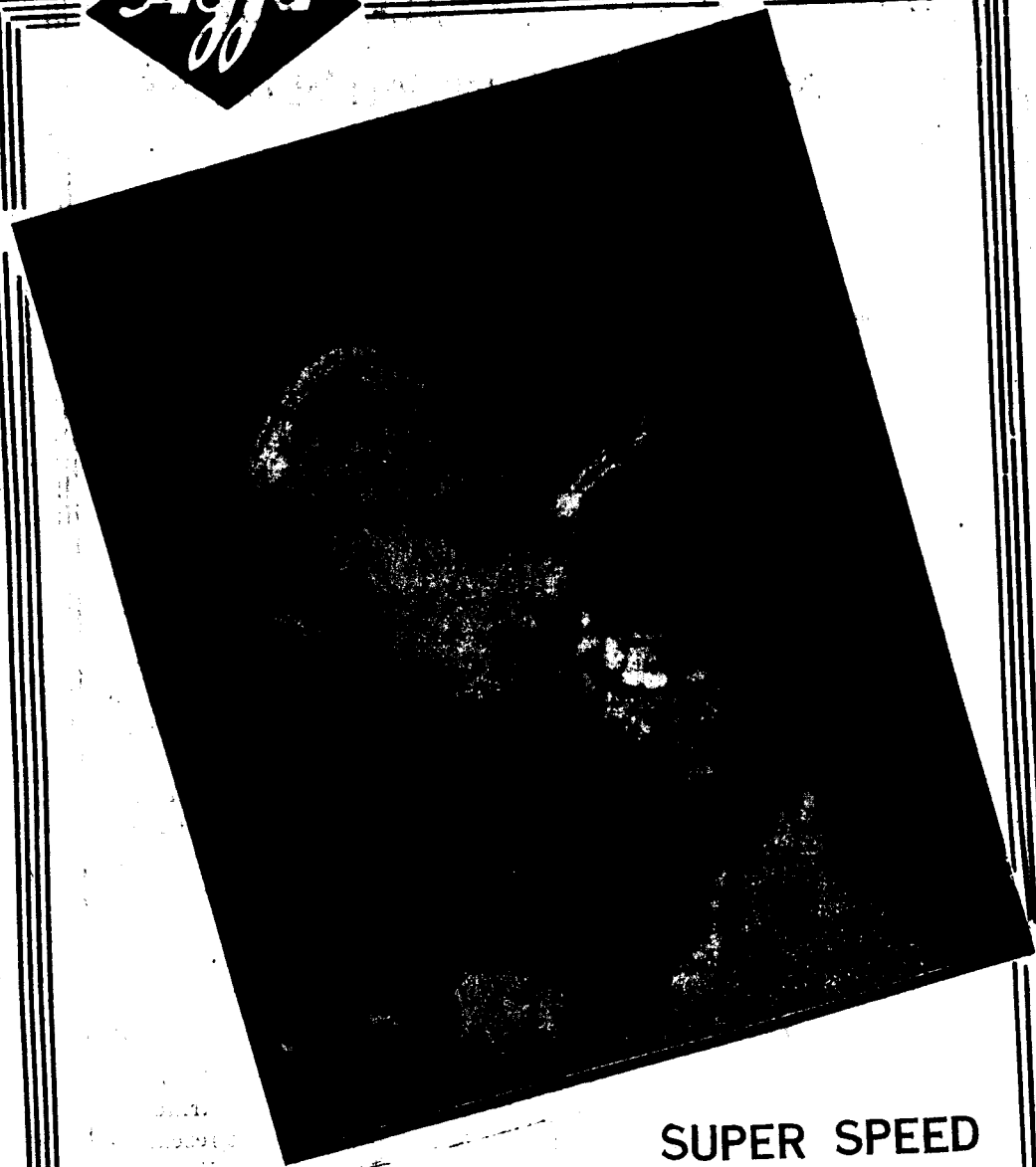
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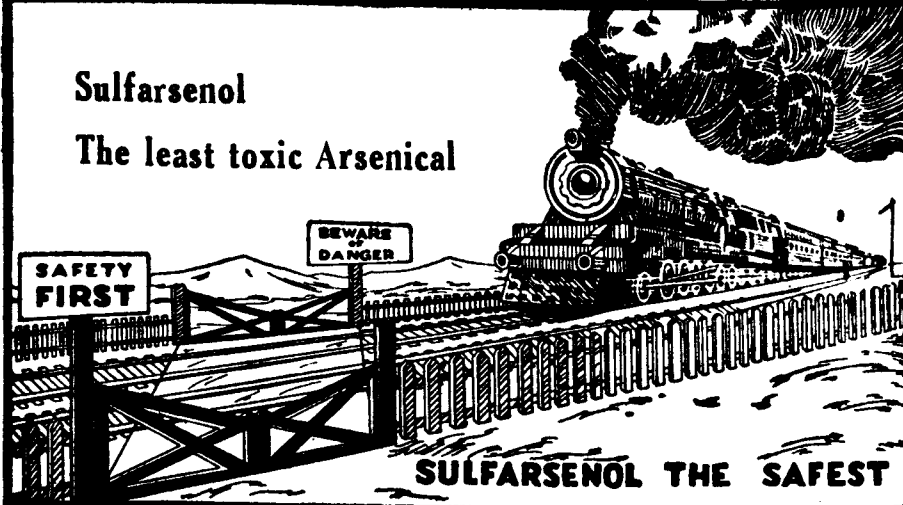
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