

The Medical Practitioner

A Monthly Medical Journal

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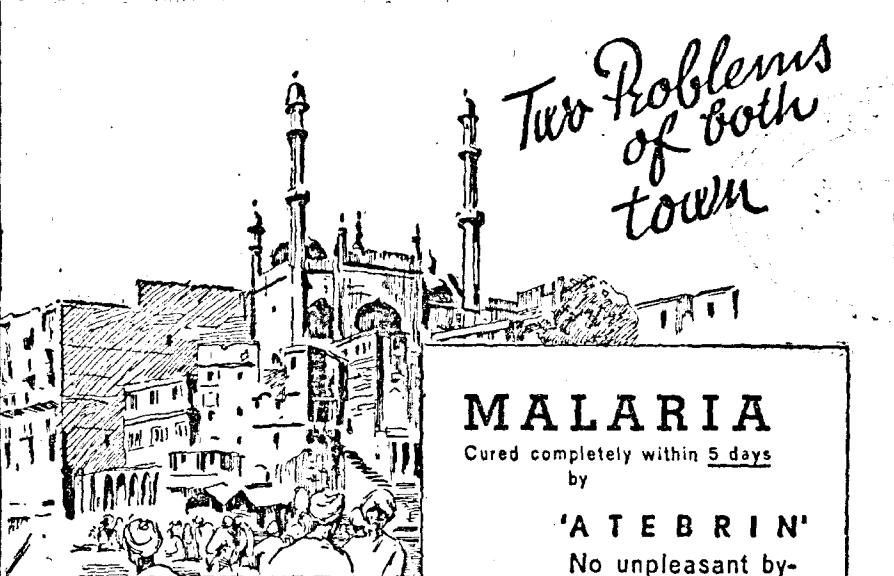
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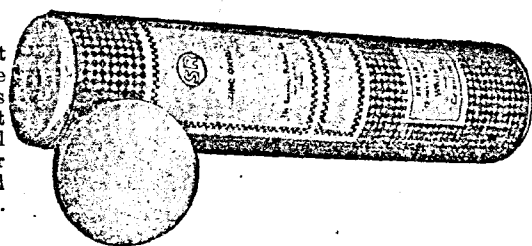
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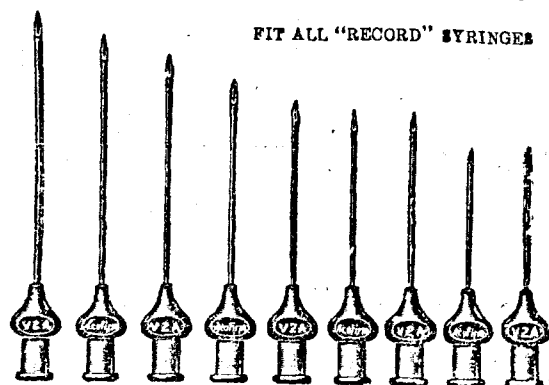
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MAY, 1934.

[NO. 8

MADRAS MEDICAL BUDGET.

The speeches made by the members on the floor of the Madras Legislative Council in criticising the present policy of the Government with regard to Medical Administration and the replies given by the Hon'ble Minister indicate that the department did not receive as much attention as it deserved. Beyond mentioning stray facts coming uppermost to their minds most of the members that took part in the discussion did not come forward with any constructive proposals to bring about economy in the expenditure without effecting the quality and quantity of medical relief given to the people.

About eight members of the Council spoke on the motion for the cut moved by Mr. T. Ramalinga Chetty. It was brought to the notice of the minister by Mr. T. Ramalinga Chetty that large amounts of money were unnecessarily spent on buildings which might be more usefully utilised in giving medical relief. It was also pointed out that there should exist co-ordination between the Allopathic and the indigenous systems of medicine. Mr. V. T. Arasu deprecated the policy of the Government in connection with the rural medical relief scheme which, he said, was most unsatisfactory. He referred to the extension of the honorary medical relief scheme and said that unless the paid medical officers were replaced by the honoraries neither the Government nor the honoraries would be benefitted by such an extension. He

suggested that for the new surgical blocks added to the General Hospital, honoraries should be appointed. He drew the attention of the Government to the necessity of periodical transfers of medical officers in the City and pressed that medical officers in Government service should be debarred from private practice as this privilege, enjoyed by the state paid doctors, had seriously affected the prosperity of the independent medical profession. Mr. Koti Reddi endorsed the views of the previous speaker in the matter of debarring private practice to state paid doctors. Dr. C. Natesa Mudaliar further supported the proposal for the periodical transfers of the medical officers in the city but did not like the idea of transferring those holding high professional appointments. He pressed for the need of the opening of a leper asylum. Mr. A. B. Shetty drew the attention of the Government to the necessity of post-graduate training. The lady member of the Council, Mrs. Alemelumangathayaramma, pleaded for greater facilities for educating lady students and urged the necessity of maintaining separate medical schools and colleges for women. Mr. V. I. Ramaswami Pillai spoke on behalf of the Depressed Classes and said that this class suffered greatly for want of adequate attention especially in mofussil. Mr. Basheer Ahmed pressed the claims of the Muslims in medical service and requested the Minister to appoint women doctors in Taluk Head Quarters Hospitals on a large scale so that the gosha ladies might take advantage of the medical aid available there.

The reply of the Raja Saheb of Bobbili, Minister in charge of Medical Department, was as unsatisfactory as it was faltering. His argument that the increase in the budget of nearly 4½ lakhs of rupees was due to the extra expenditure for paying increments in salaries as a result of the operation of time scale and the expected increase for the treatment of additional patients in the official year, was not satisfactory. It was quite possible for the Government to adjust the increase in the expenditure by taking advantage of the honorary system of medical relief. There were over 20 new appointments sanctioned in the course of two previous years in the grade of Civil Asst. Surgeons in the provincial medical service, for which the honoraries might have been appointed and a large saving effected in the expenditure. It is a pity that the Minister could not conceive of economy by bringing about co-ordination of the indigenous systems of medicine with the Western system. It was quite impossible for any Government to start and maintain separate institutions for all systems of medicine such as Ayurveda, Siddha, Unani, etc., and we pointed out more than once in these columns and elsewhere that the best way of bringing about co-ordination of the systems of medicine in the interest of medical science as well as efficient medical relief, was to create separate chairs for the teaching of the systems in the existing medical schools and colleges and run hospitals to suit the conditions brought about by such co-ordination. The present policy of Government of having separate institutions for each system of medicine is not only uneconomical but will surely retard the scientific growth of the indigenous systems of medicine. Referring to the inadequate medical relief in rural areas the excuse of the Minister was that medical practitioners did not like to settle in villages but preferred the city and towns. The Minister not attempt to find out the various causes at work which did not inspire young practitioners to start practice in rural areas. It was considered at the time of the inauguration of the Rural Medical Relief Scheme that it would serve to encourage junior practitioners to settle in villages. But the scheme is now worked as indentured labour and the spirit of service which might have been at least a few of the medical men, is fast flowing out of them and the scheme

is now worked to serve political ambition of those in charge of local bodies and we are justified in saying from our past experience that the Government is partly, if not wholly, responsible for the existing state of affairs in the subsidised rural medical relief scheme. It is high time for the Government to consider the desirability of shifting paid medical service to rural areas where there is little or no scope for private practice and entrust wholly the medical relief in the urban areas to the members of the independent medical profession. It is a pity that when the Government is increasing the number of honoraries to work in state hospitals it does not conceive of the idea of prohibiting private practice to state paid medical officers with whom the members of the independent medical profession are at present having unhealthy and unequal competition to the entire detriment of the growth of the independent medical profession without whose help it is impossible for any Government to have satisfactory medical relief in the country.

The Minister's general statement that debarring Government medical officers from private practice would be a great hardship was as unsatisfactory as it was unconvincing. There are at present in most of the mofussil towns, members of the independent medical profession holding qualifications equal to, if not superior to those possessed by Government medical officers. Almost all the private practitioners maintain well-equipped dispensaries, and if the rich and the middle class did not take advantage of the members of the independent medical profession on a large scale, it is because they could get medical relief in State hospitals much cheaper than they could get from private doctors as in the latter case they had to pay for medicines, etc., which expenditure was met with by the State in case they availed themselves of the services of the Government medical officers. So the present policy of the Government in allowing private practice to state paid doctors even in mofussil, has been the cause of large expenditure not only towards the pay of the staff in the hospital but also towards medicines and other appliances supplied free to the rich and the middle class patients who could afford to pay for them. The Minister

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Original Articles

PULMONARY TUBERCULOSIS.

Points of Importance in the Diagnosis.

By

C. FRIMODT-MOLLER, M.B., CH.B.,
(COPENHAGEN),

*Medical Superintendent,
The Union Mission Tuberculosis Sanatorium
Arogyavaram, near Madanapalle.*

The diagnosis of a case of pulmonary tuberculosis may be most difficult even with the improved methods of examination now available. Of these methods of examinations there are four which should all be used in every doubtful case, namely, the physical examination, the observation of the clinical symptoms, the laboratory examinations of sputum, stools and blood, and the X-ray examination.

In the West there is now a tendency to rely entirely upon the X-ray examination and almost to dispense with the physical examination. While experience has shown that an X-ray photo is a necessity for the diagnosis of many cases of pulmonary tuberculosis, it has also shown that the diagnosis and prognosis of other cases can only be fully made by the additional information obtained by percussion and auscultation.

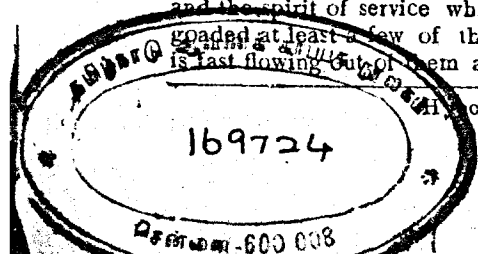
One of the reasons for the discrediting of the physical examination is without doubt a lack of knowledge of how to make it properly. In a country like India this knowledge is all the more important because of so few facilities for X-ray and laboratory examinations, and for this reason I shall confine my remarks in this paper to important points in the physical examination.

THE STRENGTH OF THE PERCUSSION STROKE.

The most common mistake in making percussion is to use a strong stroke. This is very serious, as the finer shades of dulness can only be detected by a very gentle or soft percussion made with a stroke not stronger than just to give a perceptible sound. The reason for this is very easy to understand. When the walls of the air-containing alveoli of normal lung tissue are made to vibrate by the percussion stroke, a certain resonance is produced called the

was not right in adducing the argument that the salaries for the paid medical officers were fixed taking into consideration the income they would derive from private practice. If the Minister takes trouble to go into the history of medical relief in this country after the introduction of the Allopathic system of medicine he would find out that medical officers were allowed private practice to encourage the Allopathic system. Referring to the suggestion of transfer of medical officers from one place to another, the Minister said that the Government had under their consideration a scheme for effecting transfers. But his suggestion that such transfers would be considered especially regarding specialists in diseases such as Tuberculosis and that it could not be possible to effect such transfers regarding officers in the higher rank, looks as if the transfers will have a personal bearing. We learn that quite recently the whole of the subordinate staff in the Government Tuberculosis Hospital, Royapettah, was transferred. Why such a step was not considered necessary or expedient in other hospitals as well, is beyond our comprehension. We have no idea what the Minister means when he referred to "officers in the higher rank." The officers in the Indian Medical Service and Civil Surgeons in the provincial service, are graded officers. The Government have under them more than once teaching institution and if the principle of periodical transfer holds good, it should hold good also in the teaching institutions. The partiality of not effecting transfers in teaching institution, is likely to be misconstrued not only by the public but also by the medical officers in service.

The discussion on the budget estimate for Public Health was as meagre as the grant itself. One or two members who spoke on the subject brought to the notice of the Minister the unsatisfactory condition of Public Health in rural areas and a few spoke in favour and against Birth Control Clinics in State Hospitals.



normal lung-note. In the consolidated area the alveoli are filled with an exudate and the walls of the alveoli are prevented from vibrating with the result that the lung-resonance is modified, or totally disappears, and the note becomes dull or flat. If only a small area is consolidated and a very strong percussion stroke is made, the modification of the normal lung-resonance which the small lesion produced will not be heard, as it will be marked by the normal lung-resonance of the surrounding area brought about at the same time by the too strong stroke. Only when a very gentle or soft percussion does not bring into vibration the surrounding area, can it be possible to detect the dullness due to the small lesion. Therefore the smaller the lesion or the deeper the lesion, the softer must be the percussion stroke to detect it.

Again it is only by soft percussion that the size of the lesion can be determined. If dullness detected by soft percussion disappears on increasing the strength of the stroke, the lesion must either be small or deep in the lung; if the dullness increases with increased strength of the stroke the consolidated area must be of considerable size.

THE DIRECTION OF THE PERCUSSION STROKE.

It is very important to know that the vibration produced by the percussion stroke is conducted in the lung tissue in the direction of the stroke. The lack of knowledge of this fact leads often to mistakes especially at the apices. Here the finger should always be kept in the antero-posterior position and the stroke against it should be perpendicular, at right angles, and not slanting, in order that this vibration produced may reach the upper part of the lung. If the stroke is made slanting, the vibration is conducted to the muscles in the neck or over the shoulder, and a dullness will be heard which is not produced in the lung, and therefore is very misleading.

THE ORDER OF PERCUSSION.

Another point of importance is that experience has shown that it is easier to hear dullness when passing from a healthy part of the lung to a consolidated one, than *vice versa*. The percussion should therefore begin where it is likely to find healthy lung

tissue, which is over the lower part of the back between angulus scapulae and the border of the lung. From there the percussion is carried downwards to the border the movements of which are ascertained and, then upwards shifting the finger only about an inch at a time. While in persons with a healthy lung there is often found a difference in the percussion note over the base of the lung and over the apex behind the note here being of a higher and shorter quality than at the base, there will never be found over a healthy lung a sudden change in the note when the finger is shifted only its own width from the place where the last stroke was made. If a sudden change in the percussion note is heard, the finger should be shifted its own width below the place and then above it and the difference in the note will now be very marked showing that the intervening space indicates the border of a consolidation in the lungs.

AUSCULTATION-BRONCHIAL RESPIRATION.

In listening for bronchial respiration it is not enough to find a prolonged expiration, as this is found in emphysema of the lung without any consolidation being present. Neither is it enough to find a harsh respiration with even a prolonged expiration as this is not bronchial respiration but is found often in children and in very thin and emaciated persons with no disease in the lungs. Bronchial respiration is characterised by three definite features, namely: (1) the expiration as long or longer than the inspiration, (2) a marked pause in between inspiration and expiration and (3) a changing of the character of the pitch so that it becomes hollow tubular or actually blowing.

Apart from the regio suprascapular on the right side, where physiologically in healthy persons the respiration can be of a slight bronchial character on account of the close vicinity of the bifurcation of the great bronchus, bronchial respiration is never heard without a corresponding dullness being found. On the other hand it is quite possible often to find dullness without at the same time bronchial respiration. This is the case after old pleurisy with a thickened pleura, and where fluid is present in the pleural cavity.

EXAMINATION FOR RALES.

The auscultation must never be finished without asking the patient to give one single small cough and to listen to this and the deep inspiration which should be made immediately after the cough. Over and over again an auscultation without the patient coughing does not reveal any rales or other adventitious sounds, and the result is that the real nature of the disease in the lung may be missed, but if the patient has been asked to cough in the way indicated plenty of rales may be heard, even salvoes of them.

FALSE RALES.

On account of the lack of the knowledge of false or spurious rales, many people have been considered to be seriously ill, although completely healthy, simply because the doctor detected rales in their chests where there were none. It would carry us too far to describe all the different causes for false rales, and it must suffice to mention a few of the most common causes of mistake. When a patient is being examined he is often nervous of the result and therefore liable to swallow his saliva which he also may do after the small cough, and the passing of the saliva down through the oesophagus produces a noise which very easily may be mistaken for rales, if the doctor happens to listen to the back not far from the columna. The way to be sure is to listen again and see that the patient does not swallow.

Another source for spurious rales is hair on the skin, even such small ones that they are practically unnoticeable. If the stethoscope is not kept firm against the skin such hair may produce small, crackling sounds, just like rales heard close to the ear. To eliminate this source of mistake it is enough to moisten the skin with water or vaseline and then listen again, when such sounds will have totally disappeared. Muscle sounds, shoulder noises, border sounds, and friction-sounds, are common causes of mistake, but cannot here be dealt with in detail. In closing, the unpardonable blunder of examining any part of the chest through the clothing must be mentioned because it is frequently seen, and such procedure is very liable to produce false rales, not to speak about causing feeble respiration where none exists.

*OPHTHALMIA NEONATORUM Gonorrhoeal conjunctivitis of the new-born.

VENERAL DISEASES AND THE SEQUELAE OF CORNEAL TRAUMATA AND ACUTE CORNEAL ULCERATIONS NOT INCLUDED UNDER PREVIOUS HEADINGS.

By

Lt. COL. R. E. WRIGHT, I. M. S.

The venereal disease which has the greatest interest in connection with preventable blindness is ophthalmia neonatorum, sometimes referred to as Blenorrhoea or baby's sore eyes. It is an acute conjunctivitis due to infection with the gonococcus which gains access to the child's eyes at the time of delivery. When the maternal passages contain this organism it is always possible for the newly born infant to become infected if precautions are not taken. Should this happen, the newly-born child's eyes soon become red and oedematous and a thin purulent discharge exudes from between the swollen lids. This acute conjunctivitis is liable to be associated with ulceration of the cornea, perforation, and loss of the eye, or as is more frequently the case in this part of India, the ulceration may be milder and eventually heal with more or less opacification of the cornea. The condition is easy to diagnose clinically, but should always be confirmed by detecting the gonococcus in the discharge when examined microscopically. Other forms of blenorrhoea of the new born are met with which are clinically very similar to the gonorrhoeal affection, but in which the Gonococcus is not found. They too are severe and likely to produce great damage if not treated.

This disease has been known and dreaded by accoucheurs for many years and its seriousness as a blinding affection has been fully recognised by both obstetricians and ophthalmic surgeons. In Western countries it is said to be the greatest single cause of preventable blindness. In England and Wales it is held to account for 10% of the total blindness. Now this is a very interesting point because it is certainly not the greatest cause of preventable blindness even in children in India. Why this should be so is not quite clear, but I have elsewhere advanced the suggestion that here in

Madras at any rate we are dealing with a strain of gonococcus which is not so virulent as that which is responsible for the disease in England. At one time we thought that perhaps the rate of occurrence was much less than elsewhere, and we were advised that it was very seldom seen in our sister institution, the Govt. Hospital for Women and Children, Madras. Careful investigation showed that this was not the whole truth. In one year we collected quite a large number of cases amongst babies born in the Hospital for Women and Children. Many of them no doubt did not give the clinical appearances of classical ophthalmia neonatorum, but microscopic examination proved their true nature. Nor was it because these cases had been dealt with at birth in the way which in the West is regarded as the specific prophylactic treatment. Some of them had not been treated prophylactically at all. It was apparently due to the fact that the affection was mild in nature and a possible explanation is as mentioned above, a difference in the strain of the infective organism. It is highly probable that the condition is more prevalent in mofussil villages where skilled medical attention is not available than in cities such as this. Even so the cases which we do see here tend to be mild. Taking figures for our ophthalmic hospital population we find that its incidence for ten years averaged 42 per annum in a hospital average population of 20,000, that is about 2.1 per 1000. This, as you will remember from our first lecture, is a far lower incidence than that of keratomalacia. The relative significance is also affected by the frequency of other conditions such as the effects of smallpox, and irritant remedies which now-a-days are not prominent causes in England and Wales. As time passes and the general social conditions and public health of a country improve the picture of eye disease changes. One has only to look at Dalrymple's atlas of eye diseases published in London in 1852 to realise that the affections depicted as prevalent at that time in London, and now much rarer there, are common in our Madras out-patients department to-day. If we consider the relatively small number of cases which we do see it is also noteworthy that very seldom indeed does the disease produce blindness. This, perhaps, is largely

because of the energetic treatment given, but even cases which come late rarely go on to blindness so that we have come to form the opinion that ophthalmia neonatorum is not nearly such a potent cause of blindness in India as it is in the West. This does not mean that we should relax our efforts to prevent infection. As you may imagine a condition which is the greatest cause of blindness at all ages in England and Wales, and which is definitely preventable, has stimulated a great deal of effort there in connection with its prophylactic treatment. It was found that in spite of a known efficient prophylactic treatment the rate of incidence still remained about where it was some years ago. It is therefore regarded so seriously that exceptional measures have been adopted to stamp it out. The Council of British Ophthalmologists has recommended the Ministry of Health to establish ophthalmia neonatorum centres all over the country. That it be made compulsory for nurses, midwives and medical students to attend at one of these centres for practical instruction.

For many years it has been known that a prophylactic treatment known as Crede's method is a certain way of preventing the disease if properly carried out. This, or some equivalent modification, is adopted in most of the lying-in-hospitals of England and Wales and those elsewhere in Europe. It may be of interest to give the detail of Crede's own directions.—"As soon as the umbilical cord has been cut, the child is to be freed from the vernix caseosa into the adherent blood and mucus in the usual way, and then placed in a bath. The eyes are to be washed with a clean cloth, or better absorbent cotton, not with the water of the bath, but with other clean ordinary water. Then, before the baby is dressed, each eye should be opened a little by means of two fingers and a single drop of 2% solution of silver nitrate brought in contact with the cornea and allowed to drop upon it. No further attention is to be paid to the eye. The instillation must not be repeated if during the next twenty-four or thirty-six hours, there should be a slight redness and swelling of the lids with a mucous secretion."

It would probably be easier and safer to instill the drop of silver nitrate by letting it

fall from a dropper upon the conjunctiva at the inner angle of the eye or in the gap between the lids, without touching the cornea rather than try to follow the detail of the original description. One per cent silver nitrate is more generally recommended now-a-days by British ophthalmologists than 2 per cent. The chief thing is that it should be employed in all cases unless it is absolutely certain that neither the mother of the child nor the father has had gonorrhoea. It would be only reasonable to insist that neither doctors or midwives be qualified to practise in India until the medical authorities are satisfied that they have had a practical experience of the prophylactic treatment of ophthalmia neonatorum as approved by the British Council of Ophthalmologists.

CONGENITAL SYPHILIS

The Syphilitic affection of the eyes which is responsible in some cases for causing blindness in children is known as parenchymatous keratitis, interstitial keratitis, or uveitis anterior. It is one of the most important of the stigmata of congenital syphilis and is included in the triad of symptoms and signs which Jonathan Hutchinson, the great clinical syphilologist described as most characteristic of this condition, the other two being deafness and the peculiar shape, spacing and notching of the teeth since known as Hutchinson's teeth. As a matter of interest I may mention that we seldom observe the deafness of this triad in our out-patients department. Only a few weeks ago I had the opportunity of examining 118 deaf mutes in the School for the Deaf, Mylapore and did not find an instance of congenital syphilis. But this triad alone does not give us the whole picture of congenital syphilis as we meet it. Frequently children coming to the hospital with this chronic inflammatory condition of the cornea are unmistakable as congenital syphilitics the moment they are seen. They always present one or more of the other common stigmata which go to make up the syphilis facies. The skin of the face is inclined to be thick and lined, the face itself is narrow and pinched, the frontal eminences prominent, the bridge of the nose flattened, and tip-tilted by contrast, giving a sunken appearance to the face below the brows. The eyes when affected show a bluish haze, the teeth are irregular, spaced

and notched, the palate highly vaulted. The knee joints may be swollen and contain more or less fluid but are not necessarily painful. The body is undersized and thin, and the child is often precocious. It would be unsafe to diagnose congenital syphilis by the appearance of the teeth and palate alone because we frequently see non-syphilitic children with similar abnormalities of teeth and mouth, but interstitial keratitis itself is characteristic when examined under magnification. It always affects the two eyes, but not necessarily together. A feature of the keratitis is the blue haze which seems to show up more in the Indian eye than the pink crescent or salmon-patch due to deep vascularisation of the upper part of the cornea which is so characteristic in the lighter coloured eyes of Europeans. The affection in the eye however is not confined to the cornea, there is also a deep inflammation due to the infection of the pigmented coats and it is the iritis and choroiditis which frequently do the greatest damage in this affection. Our Indian cases also frequently have massive pale inflammatory deposits on the back of the cornea. We see quite a large number of congenital syphilitics year in year out; for the last ten years the figure averaged 30 cases in approximately 20,000 out-patients per annum, but this is a considerably lower frequency than that given for ophthalmia neonatorum. Relatively few instances are seen in babies and then only when they are in an advanced stage of marasmus and quite likely to die. Those children who survive the general effects of the congenital disease very often find their way to the hospital, if and when eye symptoms appear. Although interstitial keratitis is not common in the first five years, being far more frequent in the next 15, still we may regard it as a disease of childhood inasmuch as the infection required for its production is there at birth. But no matter at what age the eyes show the hereditary taint, the numbers which we see rendered blind by this affection in any one year is relatively small. Many of them now-a-days respond to treatment by organic arsenic intravenously and recover a considerable amount of sight. I did not suppose more than three or four children in any one year would be noted as blind or practically blind of this affection. We see then that congenital syphilis is not so important a cause of preventable blindness in

children as some of the other conditions we have been considering. This does not mean that syphilis, congenital and acquired, is not to be regarded as one of the greatest causes of preventable blindness at all ages; it is, perhaps, the greatest single cause.

The whole clinical picture of syphilis has been modified here in the last thirty years owing to the arsenical method of treatment started by Erlich and the more modern combined methods so that most of our serious eye disease is seen after the fourth than in the earlier decades, but with such considerations however interesting we are not now concerned.

Prevention:—The prevention of the syphilitic blinding diseases of children resolves itself into prevention of the disease in adult population. This is a most important matter as probably every responsible member of society knows. They also ought to know that syphilis is essentially a disease which is very amenable to treatment and although gonorrhoea is more elusive, it too is amenable to treatment when taken in time. A third thing, which every member of the general public ought to know is that Government has a special or venereal branch of the medical department which practises all the most up-to-date methods of dealing with these two diseases, is in touch with the great modern venereal clinics in Great Britain, is capable of employing the most up-to-date tests, and is ready to do all this free and privately. Unfortunately since this was started as a routine efficient machine it has got a little out of the lime light, it is no longer as fashionable as it was some years ago to attract attention to oneself by rushing round to get a seat in the front row at a venereal or social hygiene meeting. Government too has cooled off a little and the machine which was modelled

on Mr. Lees' organisation in Edinburgh, and was to have been extended to the remotest parts of our Presidency, is in places very hard up for bare necessities and without them in many more. While this "out of sight out of mind" slump has been attacking our anti-venereal campaign, it has become fashionable to publicly boast and collect both money and men (members of the thinned out ranks of sub-assistant surgeons) to tackle social diseases which are not nearly so important and which are in quite a different category such as tubercle and leprosy. These would die a natural death with the betterment of social conditions, and the advance of civilization, whereas the venereal diseases march hand in hand with civilization; at least they have done so up to quite recently and will again do so if the general public allows its perspective to be distorted and its money diverted into less important channels by enthusiastic lay workers, uninformed city fathers, or even a benign Government. I do not mean to infer that the combat of social evils of any sort is not worthy of energetic effort. It is the lack of perspective in social effort and good work which is so defective. Perspective is certainly important in all prevention work if effort is to be properly directed. It is of practical interest to ophthalmologists that the realisation of perspective revolutionised the painting of the Italian Renaissance. It came in a wave of enthusiasm, gradually settled down and has remained ever since as an ordinary feature of that art. If we could only have such a burst of enthusiasm in the realm of local mental perspective it would do much to co-ordinate and enhance the value of the various efforts to correct social evils.

(To be continued.)

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Abstracts

WHAT CAN WE DO TO DIMINISH THE NUMBER OF TONSIL OPERATIONS?

By

T. B. LAYTON, D. S. O., M. S. Lond.,
F. R. C. S. Eng.

*Surgeon to the throat and ear department,
Guy's Hospital and Otologist to the fever
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The discussion held on Dec. 7th last under the auspices of the Fellowship of Medicine, on the subject of excessive operations on the tonsils, shows how strong a feeling there is among an important group of our profession; and the figures brought forward by Dr. J. A. Glover show how grave a situation has arisen by the continued increase at the rate of 2 per cent. per annum of tonsillectomised children, both in our private and in our council schools. But a debate like this does nothing to diminish the incidence of operation unless subsequent action can be taken upon it.

As one who long ago raised his voice against the increase that was occurring even then, I would submit certain principles that I may classify under three groups. The first are clinical, the second administrative, the third group includes some of the influences which seem to me to weigh in favour of these excessive operations.

Clinical.

1. First let us note the Hippocratic maxim that in any course of treatment we must not only consider whether it will do any good but whether it can possibly do any harm. Lord Dawson, at the meeting, accurately described with the eye of an accurate observer changes in the palate that impair its efficiency and that may result from "an operation of perfection." No one can ever guarantee that this will not occur. If this were the only evil result we might discount it against quiet small advantages. But the operation for the removal of tonsils has a greater number of complications to life, as to immediate illnesses, and to post-operative impairment of function, than any other operation of the same magnitude. So long is the list, that if it were read over at the time of consultation any parent would

hesitate to consent to the operation being performed. To say that it is devoid of risk cannot by any reasonable criterion be considered an accurate statement.

2. Next, the operation is never "absolutely necessary." Strictly speaking, this phrase is unsuitable for the type of surgery to which tonsillectomy belongs. It should be limited to the surgery of disorders in which death is reasonably certain if there is not performed an operation that gives a good chance of recovery. Even in a wider sense it is too strong a term to use for this operation. There is no case of rheumatism, nephritis, or other disease in which the tonsillectomy has not been done and in which we can say with confidence that the disease would not have occurred, or would not have progressed, had the operation been performed at some time previously. Further, the operation of tonsillectomy is of such recent origin that those who may still look forward to a quarter of a century of active life are too old to have had it performed in childhood; yet there is no evidence as yet to show that the subsequent generations who have grown up in the age of tonsillectomy are fitter than that which experienced the Great War. The most that we can say is that the operation is advisable, perhaps strongly advisable; but never absolutely necessary.

3. Again, it is but seldom that one can say the tonsils are "obviously diseased." If one does, and if for some reason the operation is deferred, it is likely that it will be found that no harm has come to the patient from their presence. It is probable that there is no operation in surgery upon which a decision is more rapidly made in practice, nor one in which it is more necessary to weigh the pros and cons, not only of the local conditions, but also of the general health, of the habit of mind and of body, and of the hygienic conditions of school, home, and place of occupation.

With these three principles in mind two usual indications should be swept away.

4. The phrase, an "enlarged" tonsil, should be removed from our terminology. The tonsils, for the enlargement of which the operation of tonsillectomy was devised, are not seen to-day, yet succeeding generations of students read and hear about "enlarged" tonsils as an indication for their

removal, without any criterion as to the size which warrants it. We do not to-day remove a tonsil because it is enlarged. We remove it, whatever its size, because we believe that there are residing within it micro-organisms that are harmful to the individual.

5. And so the conception of the "typical adenoid faces" should be dropped.

Clinical observation must always remain our sheet anchor in clinical medicine; and yet it may be wrong. The uncritical acceptance of it by all must always be suspected, and that is what has happened with this. Purely an English conception, it has been accepted neither on the continent nor in America; there has never been any other evidence to support it. Sir Arthur Keith went into it and doubted its association with nasal obstruction; the dental surgeons have for years been studying it and found what they have been taught by the laryngologists is wrong. And finally Mr. Somerville Hastings gave it a death-blow, and yet the idea will not lie down.

If all who decided upon an operation on the grounds of either or both of these two indications were to defer it unless and until they could find other indications without using these two a great improvement would be made.

6. Finally as to function. There are those who say we know not the function of the tonsil, they call it vestigial, and demand of us that we should prove its function. But we know its function from its structure. It is a lymph-gland differing only from the other lymph-glands by its anatomical relationships. If we know not its function we do not know the function of other lymph-glands. The principles which govern the surgery of these apply also to the tonsil.

Administrative.

1. The condition for which we advise operation is not a clinical entity. Therefore decision should not be made at the first examination. The consultant may have to do so when he has the evidence of the practitioner. Even then there may be doubt, and if there is, it is better to defer operation than to decide at once. Delay up to six months or even more is never harmful.

But in the vast majority of cases the evidence of a practitioner is not before one,

or is incomplete and inconclusive. This applies to nearly all out-patient and school clinic work. It is well never to come to a decision at the first attendance and often three or four are advisable.

2. Haste is the enemy of all good work. It is to be feared that the operation of tonsillectomy is often advised in too short a time. It takes longer to decide against an operation than hastily to advise one. In the hurry of a busy out-patient department with rows of patients still to be seen and an appointment to be kept at a stated time it is difficult not to hasten. And yet is it right to ask the parent to confide a child's life into your hands without at least ten minutes' consideration, with another five minutes to explain the matter to the parent? All clinics should be organised so that a minimum of a quarter of an hour is devoted to each individual, though all of this time need not be that of the head of the clinic.

3. Another great cause of ill-considered decisions is the written consent for operation. It can be carried out by a lay clerk and save the time of the doctor; but this should not be. The parents have a right to be given reasons for the advice and to have the opportunity of asking any questions that they may wish. I will not allow these written consents in my department; and demand that each case should be explained, not in such a way that the medical man thinks he has put it clearly, but in such a way that he knows the parent has understood it clearly. One is sometimes told that the intelligence of the parents does not admit this method. Yet I find that is seldom so to-day; and if parents have not had the advantages that we have had they should the more be entitled to our time in explanation. Often, however, this accusation of want of intelligence on the part of parents is the cloak of an inability to explain on the part of the doctor; and the best way to remedy this is by practice.

If these three rules be carried out I believe that a large number of operations would be avoided. It is necessary therefore so to organise our clinics that adequate time can be given to each case. In a paid clinic this is not difficult. The authorities have but to summon cases enough to occupy the average time of the session,

which is usually approximately two and a half hours. It should be easy to deal with the medical man who habitually finishes before time. If he is a quick worker more cases may be summoned, but if he skimps his work it should be insisted that he remains on the premises for the full period.

In voluntary hospitals it is more difficult. Most depend for their financial support upon the number of persons they can attract to their out-patient departments; the number that comes daily is subject to fluctuation; on one day there may be hardly enough to do, on another, if the chief of the clinic were to attend to every case personally, ten hours' work would not be enough to do justice at all. To a great extent this variation must be inevitable, and must be neutralised by a delegation of the chief's duties to assistants who need have had no special experience so long as they are given guidance and the chief retains the final decision as to operation.

But while it may be necessary for an institution to make the total number of attendances a ground for claims upon the charitable public, the number of operations performed should never be so made. They may all have been necessary, but so soon as a competition is introduced the number is certain slowly though steadily to rise.

The other rules of a clinical administrative nature may be enunciated:

4. The first is that operations upon the tonsils should not be performed in the winter months. The best periods of the year for their performance are the spring and autumn, and in a fine year such as the last has been they may be continued nearly up to Christmas time, but once that is passed they are best deferred until the spring, when the milder, finer weather has begun to come again. This is specially advisable in a year of epidemics. I look upon measles as the most serious complication of these tonsillectomies. So highly infectious is it, and so long is the incubation period, that it is impossible to set up any organisation for the continuance of tonsil operations during the prevalence of measles without the risk of a case being operated on during the incubation period so that the disease supervenes upon an unhealed throat. Once one has realised that the operation is not urgent it is easy to shut down all operations during the period; and on no account

to do one in a child that has not had measles. This practice will solve the anxiety of sending the patients home in the winter after operation which, it must be recognised, is not solved by admission to clinic or hospital for three nights unless an ambulance is provided to take them home afterwards.

5. The second is not to operate on the patient living in unhygienic surroundings.

Tonsillectomy is bad for the children of the very poor. There are those who recognise that the squalor in which the child lives and the want of nourishment to which it is subjected are the primary causes of ill-health, but who think that some sepsis in the tonsils is also present; and feel that though they cannot prescribe the proper treatment of a new dwelling and a full stomach they must do a second best by removing the tonsils. The argument is fallacious, for under these circumstances the operation is not a second best. In the vast majority of cases the defective hygiene and not the tonsils is the source of the sepsis; and when there is some sepsis in the tonsils the lymphoid tissue is of greater value in protecting against the hygiene of the home than the organisms within it are harmful.

On the rare occasions where tonsillectomy in such cases must be performed the child should be sent to a convalescent home for a fortnight, transferred direct to hospital, kept there for a week after operation, and then sent back to the convalescent home for another fortnight before being allowed home.

Personal.

The layman often comments upon the disagreements that obtain between the opinions of different doctors, forgetting or perhaps not recognising that these are no greater than in any other sphere of mental activity. We must recognise that such are a part of medicine and must be prepared to withstand those to the face with whom we disagree. It is perhaps a cause of criticism to those who have long looked with disfavour upon the number of tonsillectomies performed that we have not done so more effectually before, and particularly we have not voiced our disapproval of the operation whereby the so called lingual prolongation of the tonsil is removed. In this much of the lymphoid

tissue on the base of the tongue is also taken, and when the adenoids are thoroughly removed the pharynx has practically been flayed of lymphoid tissue. To the best of my knowledge no practising laryngologist approves of this operation. In my opinion it is unnecessarily severe and performed by a method that is unnecessarily dangerous; I further believe that it is fraught with grave consequences to the hearing even when all immediate post-operative complications have been avoided. But it is not with these points that this paper deals. The gravity of the matter lies in the fact that it is those who for years have advocated this operation who have also advised the removal of tonsils in very young children and have performed the operation on numbers of them.

It must be remembered that the great majority of tonsillectomies are not performed by practising laryngologists but by general surgeons or general practitioners many of whom have learnt this operation. It emanates from a single school, and the great influence that it has had on the practice of tonsillectomy may in part be attributed to two things. This school is the Mecca of English medical pædiatrics; and the young men who flock to its wards recognise its eminence in medicine, and tend to accept without criticism the virtue of large numbers of tonsillectomies that they see being performed. Secondly, I know of no other example in the history of surgery where an enthusiasm for an operation is shared by all members of the surgical staff. Surgical schools have become famous for thyroid or gastric work, but the fame has rested upon the efforts of two or three individuals. There have always been others who have not specialised in these operations, and have thereby exerted an influence which has caused the pioneers constantly to think whether they may have done one from time to time that is unnecessary or excessive in extent. At this school alone the whole surgical staff has, I believe, given itself over to this operation to which alone some of its advocates will allow the word tonsillectomy to be applied. Their industry, which is immense may be admired. The leader of the school, fourteen years ago acknowledged to have performed 18,000 such operations in twelve years; and I have reason to believe that some of his successors

have exceeded the annual average of this total. One may wonder, however, whether the constant application of the mind to a dextrous manipulation of surgical instruments has left no time for thought either whether the operation may be wrong in principle or whether the indications for its performance are sufficient in every case.

I propose now to enumerate three groups of persons against whom I have found it hardest to persevere in opposition when I have felt I ought to do so.

(1) The first are medical officers in charge of public and other private schools. I am informed that as a group they disapprove whole-heartedly of the number of tonsillectomies that have been performed on the children by the time they reach their schools. There are, however, some who in my opinion do unduly demand the operation; and they are in a position almost to compel it when they do. Teachers and parents feel that the loss even of a fortnight at a certain age is disastrous to education. If the medical officer fears a further illness next term unless the tonsils are removed, a demand is made for tonsillectomy during the holidays which it is difficult to oppose, even though one knows that the time suggested is dangerously near the last or only infection of the upper respiratory tract to prevent the recurrence of which the operation is advised.

(2) The second are medical officers inspecting school-children in county council schools. So far as London is concerned these as a body probably act as a check upon excessive operation rather than as a spur to it; but when an individual one is an enthusiast for tonsillectomy, he or she may by indirect means exert considerable influence by suggesting that the children should be taken to some certain clinic and by carefully guiding them away from that where it is known that the medical officer advises but a few operations.

(3) The third, and in my opinion most difficult to oppose, are physicians. Again I do not suggest that all physicians are unduly enthusiastic for tonsillectomies; but some of them are, and others are inclined to demand it when they think it may be needed. The laryngologist's opinion is not always wanted. This is, however, not the whole of the tale. The physician of to-

day does not seem to recognise the Hippocratic maxim with which we began this discussion, nor to realise that in advising an operation he must take some responsibility for any complications that may arise after its performance. The generation that is arising does not seem to appreciate that tonsillectomy in an obese woman of forty-nine may be a very severe operation however skilfully it may be performed.

Further, there does not seem to-day a sufficient appreciation of the relationship of the likelihood of improvement from operation to the stage of the disease under consideration. Thus we may admit that the removal of any focal sepsis is the proper treatment for rheumatoid arthritis; but this does not mean that we should perform a tonsillectomy in an elderly woman who has long shown marked deformities of many joints.

In former days physicians have been the impartial critics who have been the drag upon excessive operations. It will be a bad day for medicine if this healthy influence is removed. The subconscious influences in favour of operation are potent enough without, in addition, the keen young surgeon having to oppose those who should be his best moderating influence.

But when all is said and done we laryngologists have the greatest responsibility. If we think that the number of tonsil operations has increased to an alarming extent we cannot absolve ourselves entirely. It is we that have to teach the subject to the young. It is true that many others do so as well. There is no part of medicine that the tonsil problem does not touch. It is true also that our opportunities for teaching are not great. We have the student but for a few days in all; and with the present crowded state of the curriculum we cannot demand more. During the time he is with us there is hardly time to do more than to teach him to accustom himself to the examination of the upper respiratory tract, and to apply to this area the principles of general medicine and surgery. In learning to make this examination the adults are more suitable than the children. I know that I do not spend enough time in discussion on children with my students. Further, we laryngologists are debarred from exerting the only influence that will

compel all students to attend to a given subject, for we are given no place in the examination system. Yet the subject belongs to our department, and in spite of these disadvantages if we earnestly believe that too many operations are done we must do what we can to prevent them.

(*The Lancet Jan. 20. 1934.*)

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Morphine Intravenously.

By

E. NEWTON SURKUS
Long Beach, Calif.

MANY, if not all practitioners have, at one time or another, stood beside the bed of a restrained, wildly delirious maniac; a profoundly restless pneumonic or cardiac patient; a case of delirium tremens; a victim of ureteral or renal colic; a patient with an acute attack of gall-bladder pain; a screaming, painfully and extensively burned unfortunate; a badly compounded, painful fracture; or one of the many other indications for morphine, wondering why, after the conventional 20 to 30 minutes, the hypodermic injection has not given definite therapeutic evidence of action. In private practice minutes seem hours, in such cases. Very often impatience, on the part of solicitous relatives or friends, may tempt imprudence of therapy on the part of the attending physician, and a sudden accumulative effect of two or three rapidly-given doses of morphine may cause him subsequent concern.

To me, morphine, one of the most commonly used alkaloids, still enjoys the most empiricism, and this fact alone has been the incentive for the observations noted further on, and has prompted the use of the drug intravenously for more definite and prompt action. Nothing need be said, I am sure, of the humane side of the issue when time seems paramount.

The subsequent conclusions are based on 107 administrations of morphine and atropine combined, and on nineteen administrations of Hyoscine, Morphine and Cactoid after formulas No. 1 and No. 2.* The

*Formula No. 1: Hyoscine hydrobromide, gr. 1/100; morphine hydrobromide, gr. 1/4. Cactoid, gr. 1/60. Formula No. 2 is half this strength.

combinations of morphine are made from solutions of the ordinary hypodermic tablets made by any of the reputable houses. One may use distilled water as a solvent, although a pure tap water will suffice.

My appeal is for the more routine intravenous use of the combinations of morphine which I have mentioned, whenever this drug is indicated. The results, in my hands, have been most gratifying, fraught with no untoward sequelae and, if given immediately before an anesthetic is administered, the drug proves more beneficent, particularly if combined with atropine. It is a boon to the surgeon and anesthetist, because of its prompt and certain action, and the fact that it can be given on the operating table offers more than one advantage that needs neither passing mention nor fancy to anticipate. To say the least, one is certain that it has been given and equally certain of its action, when administered in the operating or anteroom preceding the operation. The marked action of atropine, when general narcosis with ether by the open method is invoked, is a very valuable aid in diminishing the accumulation of annoying mucous secretions in the larynx and mouth during anesthesia.

The following conclusions, observations and rules may be accepted as definite:

1.—Action is definite and established in from 35 seconds to 5 minutes after intravenous administration.

2.—The dose administered is the same as for intramuscular or subcutaneous injection. The amount of atropine may be reduced, if desired, by 1/100 grain if no anesthesia is to be employed. A few patients complain of mouth dryness after this method of therapy I, personally, have never reduced the atropine found in the ordinary hypodermic tablet, because such combinations are not manufactured and I have not felt that the amount of action from the atropine was particularly annoying. Obviously, the use of separate tablets of morphine and atropine would regulate the later. The dissolving vehicle is water, and from 15 to 30 minims are employed. The solution is injected slowly in any convenient vein. The usual rule of skin cleansing with alcohol, preceded by painting the area with iodine,

is all that is necessary and is absolutely safe.

3.—Vomiting and nausea are much less common after intravenous administration than after the other methods.

4.—Overaction is neither encountered nor need be feared.

5.—Action lasts from 3 to 12 hours, depending upon the pathosis present, and is definitely smooth, if one may use that word.

6.—Embolization has never been experienced in my series.

7.—Young's rule for children and regulated does for the aged, together with a little personal judgment in other instances, is indicated in this method of therapy.

8.—In conclusion, the value of this method of administration has been so dramatically and satisfactorily demonstrated to me as to leave no doubt of its superior efficacy over the others.

(*Clinical Medicine and Surgery*, Jan. 1934.)

Oxygen Injections for Furuncles.

OXYGEN injections have given very gratifying results in 100 cases of furuncles and paronychia. The oxygen, under high pressure ($\frac{1}{2}$ to 1 atmosphere), is introduced into the centre of the furuncle through a sterile glass cannula or fine injection needle. In the course of a day, 5 to 10 such injections may be given, as needed. The tissue of the furuncle softens with astonishing rapidity, so that the furuncle is emptied spontaneously within 24 to 48 hours. Furuncles of the nose and upper lip especially are cured with speed and leave no disagreeable complications.—DR. C. SALZMANN, in *Schweiz. med. Wchnschr.*, Aug. 27, 1932.

Insulin as an Appetizer.

INSULIN will restore the appetite of the majority of patients suffering from the anorexia of chronic diseases. The average patient requires but one injection a day. The initial dose is 5 units, increased at the rate of 5 units a day, according to the patient's tolerance, up to 20 or 30 units at one subcutaneous injection. The injection is best given before the noonday meal.—DR. O. S. JONES, in *J. Missouri S. M. A.*, Sept., 1932.

A Doctor writes: "I have used Sulfarsenol in ten cases of acute and chronic Gonorrhoea and find it of immense value in curing the same."

CLINICAL NOTES

AND

PRACTICAL SUGGESTIONS.

Treatment of Constipation and Intestinal Bacterial Activity.

Constipation and intestinal stasis are two common and widespread complaints which are frequently neglected or treated without due regard to the cause or correct method of obtaining permanent relief.

The factors inducing constipation are several:—

I. Failure of sufficient food residue to reach the colon.

II. Inactivity of the colon.

III. Spasmodic contraction of the colon.

IV. Failure of the entry of the faeces into the rectum to produce the defaecation reflex.

Constipation may be temporary or chronic, the chronic condition frequently resulting from neglect or incorrect treatment of the temporary variety.

TEMPORARY CONSTIPATION may be induced by several factors such as change of diet, decrease in amount of fluid taken, or a decrease in intestinal secretions as in fever. In people accustomed to regular bowel activity any failure in this movement produces immediate discomfort, which indicates that the headache usually associated with temporary constipation is produced reflexly through the unusual tension existing in the colon or rectum.

CHRONIC CONSTIPATION frequently arises from neglect or incorrect treatment of the temporary form, and is invariably associated with ill-health which is probably caused through the absorption of certain toxic substances from the intestinal tract. Neglect of temporary constipation means that the intestinal muscles are in a state of rest or inertia and prolongation of such a condition will frequently lead to chronic constipation due to degeneration of the muscles concerned. Such a condition is also extremely favourable for the proliferation of bacteria present in the intestinal flora.

ACTION OF BACTERIA IN INTESTINES: In normal health there are numerous bacteria present in the intestines, which are capable

of acting on carbohydrates and protein matter, but these bacterial actions generally take place in different sections of the intestines. Carbohydrate fermentation is usually confined to the small intestines and protein putrefaction to the large intestines. It is important to note that in the region of greatest absorption we find carbohydrate fermentation the end products of which are not toxic, while in the region of lesser absorption we have protein fermentation the end products of which are definitely toxic. This is due to the fact that carbohydrate fermentation yields lactic acid as an end product and the presence of this acid inhibits the activity of the protein putrefying bacteria, consequently protein putrefaction is delayed until the carbohydrate fermentation is completed or the lactic acid is neutralised. In normal health the body protects itself from absorption of the toxic end products of protein fermentation by the rapid passage of the intestinal contents from the small to the large intestines before carbohydrate fermentation is quite complete or at latest before any measurable protein fermentation has occurred. When the intestinal contents pass into the colon, we have a fairly rapid absorption of water but not of other substances. This results in a process of dehydration taking place in the colon which is detrimental to bacterial activity and lessens production of toxic substances. The faecal matter is retained in the colon in a semi solid state, and although it contains an enormous number of bacteria very little absorption of toxic substances occurs. Furthermore certain bacteria present in the intestines may themselves produce toxins which if allowed to develop may produce severe toxic effects. In constipation we have distension of the rectum or colon, which is accompanied by antiperistaltic activity reflexly producing stasis in the small intestines, consequently we have retention of intestinal contents in a liquid state, which condition is extremely favourable to bacterial activity. A consideration of these facts convince one of the importance of maintaining normal bowel activity, in order to avoid absorption of toxic substances or toxins themselves, because even when these toxic elements are not present in quantities sufficient to produce a specific disease, they will nevertheless tend to lower the resistance of the body against other diseases.

The ailments arising through defective bowel activity are numerous, among which we may cite:

FURUNCULOSIS arising from activity of staphylococci in the intestines; stasis of the intestines favouring increased activity of these bacteria.

FLATULENCE—Generally a large amount of gas is formed in the bowels but contraction of the intestines promotes its absorption, hence any relaxation of the contraction, such as we find associated with constipation, favours accumulation of gas leading to a condition of flatulence.

DYSPEPSIA—A certain form of dyspepsia which is of fairly frequent occurrence is associated with excessive carbohydrate fermentation in the colon due generally to an abnormal predominance of bacilli colli in the bacterial flora of the large intestines.

HAEMORRHOIDS—It is generally agreed that both the internal and external variety arise from alterations in the wall of the veins, consequent upon a disturbance of the nutrition or through local infection. Thus it will be realised that constipation must be avoided in order to maintain the intestines in a healthy condition and exclude any possibility of increasing local absorption of toxic substances. Furthermore, constipation produces a local tension which aggravates the distressing pains which accompany haemorrhoids.

LIVER TROUBLE AND HEADACHE—These complaints frequently occur in association with constipation, and arise from the production and absorption of toxic elements in the intestines, which on reaching the liver promote disturbance of normal liver function.

From a consideration of these facts it is evident that normal bowel activity is essential for maintaining the body in a healthy condition and at the same time assisting it to resist any invading pathogenic bacteria. When choosing a remedy for correcting constipation, it is important that the medicament should in no manner aggravate the symptoms, and invariably it will be found that the ideal remedy is one which promotes gentle but permanent activity of the intestines with least derangement of the functions of the alimentary canal. The

administration of drastic purgatives brings the bowels into violent activity with the result, the colon becomes flaccid and does not recover normal activity for several days. Continued use of such purgatives is liable to bring about a condition of tolerance, due to the continued violent actions requiring longer periods for recovery, ultimately resulting in a condition of atonia of bowel muscles. Again, continued use of a drastic purgative may produce chronic inflammation of the gut. Patients requiring a "constipation corrector" will find an ideal remedy in Mycol, the composition of which renders it sure and what is more—perfectly safe, as it in no way complicates any of the secondary symptoms resulting from constipation. Mycol will be found highly effective whether the constipation is temporary or chronic, its administration producing gentle movements with a gradual return to normal activity. The constituents of Mycol are so combined that this preparation invariably overcomes the factors producing constipation. In constipation due to insufficient food residue entering the colon, Mycol rectifies this deficiency by virtue of its Agar-Agar content. Agar-Agar is a non-irritant carbohydrate gelose which is not absorbed in the alimentary canal, but which is itself capable of absorbing and retaining a large volume of water and simultaneously greatly increasing in bulk. In such cases Mycol should be taken with a fair quantity of water, when the Agar-Agar will gradually swell and thus add to the bulk of the intestinal contents passing into the colon and rectum. Here the greater pressure resulting from increased bulk will stimulate to activity the various nerves controlling bowel movements, and thus produce a desire for defaecation.

Bile extract may be regarded as the most important ingredient of Mycol, since bile functions in the digestive tract by inducing peristaltic activity, and stimulating intestinal secretion. In addition bile extract has a mild disinfectant action, reducing the pathogenic organisms present in the bacterial flora of the intestines. Beer yeast and lactic ferments, two other components of Mycol both produce a disinfectant action in the intestines. Beer yeast is valuable in the treatment of furunculosis of intestinal

origin, since it appears to raise the opsonic index for strepto and staphylococci. Yeast inhibits the development of certain putrefactive bacteria in the intestines and also possesses a mild laxative action. The value of lactic ferments in producing a healthy condition of the intestines is a well known fact. It exhibits a powerful inhibitory action on the other bacteria associated with excessive carbohydrate fermentation in the colon, and which is frequently responsible for a common form of dyspepsia. In treating cases of intestinal fermentation Mycol treatment should be continued for some time in order to allow ample time for the proliferation of the lactic acid bacilli present in the lactic ferment. During proliferation in the intestines lactic acid is liberated and it is the production of this acid which is responsible for the inhibitory action on the bacteria responsible for abnormal carbohydrate fermentation. The combination of the ingredients of Mycol is such that we have a preparation which is not only highly rational but is also quite inoffensive and perfectly safe. Mycol contains no oily substance which might coat the intestines and hinder absorption of food material. The laxative action of Mycol is such that the stools are invariably soft and thus produce no irritant action on the intestinal walls. Furthermore its action is gentle, which means that the intestinal muscles are not thrown into violent activity, which, if of frequent occurrence is liable to result in chronic constipation or even chronic inflammation of the gut, such as occasionally results from frequent administration of drastic purgatives. This action of Mycol in producing soft stools with a gentle motion renders it valuable in treating the constipation associated with piles. Constipation creates a local tension which increases the distressing pains which accompany haemorrhoids and treatment with a powerful purgative will also considerably aggravate this pain due to its bringing all the surrounding muscles into violent activity, whereas Mycol action being gentle, will be found to relieve this local tension, which is soon followed by reduction of the haemorrhoidal pains. Again in chronic constipation it will be found that continued treatment with Mycol produces a regular gentle activity of the bowel muscles, which results in the ultimate restoration of the tone of these muscles, evidence of which

will be found in the decreased dosage of Mycol required as the treatment continues.

Not of least importance is the fact that Mycol treatment may be continued with perfect safety. It contains no toxic substance and produces no detrimental secondary effects.

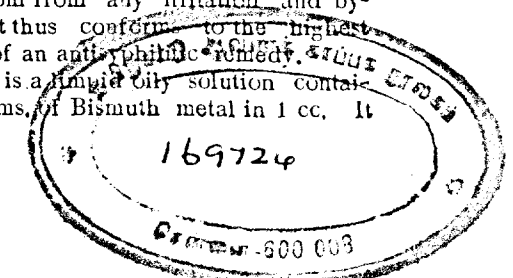
Therapy of Syphilis with a Bismuth preparation

If one takes a survey of the methods of treatment of Syphilis during recent years one finds that the disciples of the energetic treatment of the disease by means of a Bismuth preparation are on the increase. Due to this there are a number of Bismuth preparations coming up and the clinician therefore is confronted with the problem of selecting the right one. Before making his choice he must see that the preparation has not only been experimentally tested but has been found clinically effective. The practitioner must demand from a well-standardised antisyphilitic preparation various requisites before he decides to use it. The first one is that it must contain an adequate amount of Bismuth. The injections must be painless and the deposits of the salts must not remain for a long time at the site of the injection. The preparation must have a marked spirochoeticidal activity and non-toxicity. If it is not an effective spirochoeticide, it means a prolonged and ineffective treatment. Besides the toxicity and undesirable by-effects cause serious damage to patients and need proper limitation of dosages. Again it must not cause irritation and tissue damage at the site of injection, because in addition to causing pain to the patient it deters him from taking any further treatment. It must quickly heal the external manifestations of the disease and it should have marked action on the Wassermann reaction. Further it must favourably influence the general condition of the patient. The clinician will therefore do well to place his complete reliance on Bivatol, which effectively fulfills all the above demands made of a Bismuth preparation. This is evident by its high Spirochoeticidal potency, low toxicity and freedom from any irritation and by-effects. It thus conforms to the highest standard of an antisyphilitic remedy.

Bivatol is a simple oily solution containing 4 cgrms. of Bismuth metal in 1 cc. It

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is basic Bismuth-a-carboxethyl-b-Methylnonoate and is a perfectly neutral body. Hence it does not give rise to pain on injection. When BivatoI is injected into the muscles it soon enters the circulation in its natural state on account of the favourable influence on it of body lipoids. Later on it soon breaks up in a state, which easily becomes soluble in the alkaline fluids of the organism. It owes its rapid action and progressive assimilation to its entry into the circulation soon after injection into the muscles and its easy solubility in the body fluids. It appears from clinical evidence that BivatoI acts at first provocatively and as the treatment proceeds, its action becomes more certain. This is what is known as progressive assimilation and this slowly developing action is continuous. The continuity of therapeutic effects is always advisable in a disease of the nature of Syphilis.

The use of BivatoI is recommended in all stages of Syphilis. Considering its therapeutic action upon the clinical symptoms in different stages it is in no way inferior to Salvarsan and other allied preparations. In the primary stage with a negative Wassermann the chancre and the shotty inguinal glands soon disappear after two or three injections. Even with a positive Wassermann in this stage Spirochaetes could not be traced after 3 to 4 injections. Sometimes the manifestations of the primary stage have been found to clear up and disappear even after the first or second injection of BivatoI.

In the secondary stage the action of this Bismuth preparation is surprisingly rapid and excellent, at any rate far more powerful and energetic than that of Mercury. Hypertrophic papules and mucus patches answer promptly to this line of treatment. The papules are soon reduced in size and mostly disappear after four or five injections, while the mucus patches require at the most two or three injections before they yield. Skin lesions also are favourably influenced. Large pustules and ulcerations heal up quickly under BivatoI regime. Syphilitic alopecia, condylomata, headaches and joint-pains are soon brought under control by means of this remedy. Regarding its effect on the serum reaction, it has been noticed that the positive Wassermann

changes towards the termination of the treatment into the negative and is inclined there. This result has been marked in nearly 80% of cases treated with BivatoI in all stages of the disease. The quantitative turning occurs quite steadily and without much oscillations as the treatment proceeds. This steadiness in the serum reaction resembles that of Neo-Salvarsan and other arsenicals which proves that BivatoI is chemically as active as these latter preparations.

It seems beyond doubt that the tertiary stage of Syphilis has a good tendency of getting cured under BivatoI. The symptoms of this stage improve strikingly and heal up well under the influence of this preparation. The serum reaction is more easily influenced in this stage than in the secondary one. BivatoI really ensures maximum curative effects in this stage due to the molecular position Bismuth occupies in this preparation. Unlike other Bismuth products, which are soon hydrolysed in the system, BivatoI ionises in such a way that the Bismuth in it remains in the electro-negative position. This fact explains its remarkable efficacy in penetration in brain and nervous tissues and hence its therapeutic potency in neurosyphilis. Whether it is gummatous ulcer or lancing pains of Locomotor Ataxy improvement usually sets in after 8 or 10 injections of BivatoI. Gummata are either absorbed or rapid formation over it of epithelial covering is formed if the BivatoI treatment is persisted in. Skinning over and healing of tuberculous and serpiginous ulcers also take place. In the treatment of the tertiary stage BivatoI is therefore quite dependable.

From the experience of several clinicians it has been discovered that there is no reason to discard BivatoI as an abortive remedy in the therapy of Syphilis. On account of the intense serological action that it brings about it can be said without fear of being contradicted that a very early start of BivatoI therapy will effect an abortive cure of the disease. Negative Wassermann reaction is obtained so rapidly and the destruction of the Spirochaetes takes place so very quickly with this lipo-soluble Bismuth product that it can be considered in no way inferior to arsenicals and arsenobenzenes as an abortive remedy for Syphilis.

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Treatment of Congenital Syphilis can be better carried out with BivatoI on account of the inherent difficulties of intravenous injections in infants. Subsidence and healing of the various efflorescences with the disappearance of Spirochaetes from the lesions occur after 6 to 8 intramuscular injections. BivatoI can be considered as a strengthening remedy as is seen by the rapid increase in the haemoglobin content of severely anaemic syphilitic infants. It is always better to begin with small doses and if these are well tolerated, they should be gradually increased. Uninterrupted treatment with BivatoI usually brings about rapid and permanent cure of Congenital Syphilis. It is therefore a suitable remedy if used properly and with care in the syphilis of the new-born and infants.

The advantages of a product like BivatoI, which can be injected intramuscularly, over the customary Salvarsan and allied preparations cannot be overemphasised. Besides the various technical difficulties that it overcomes, BivatoI can be injected easily, painlessly and without irritation into the muscles. With it there can be no troublesome accidents as is often the case with intravenous injections of certain arsenical preparations. BivatoI is a good effective, reliable and non-toxic preparation of lipo-soluble Bismuth. Furthermore, considering its therapeutic power BivatoI is superior to Mercury and has far less by-effects. The Spirochaetes disappear quickly, so also the clinical manifestations and all these results are brought about without the least degree of toxicity to the organism. It is well tolerated in almost all cases and does very little harm to the gums, liver or the kidneys. Its prompt absorption ensures its rapid action. The retention of the Bismuth atom in BivatoI in the electro-negative position makes it markedly effective in the syphilis of the nervous system. Another potent fact about BivatoI is its effect on Wassermann test. Considering its advantages and therapeutic action BivatoI is not inferior to Salvarsan and is therefore strongly recommended in general practice. This is specially useful in those cases where there exists an idiosyncrasy against arsenic or mercury or where the disease is refractory to either Salvarsan or any mercurial preparation or where there exist some technical difficulties as regards intravenous injections.

The following case under the control of the author was treated with BivatoI only and the results fully justify its further employment in similar complaints:

A patient suffering from manifestations of secondary syphilis came to me for treatment. Presumably he was not treated till he came to me. He had a multiform rash on the trunk and forearms. He had deep rhagades on the tongue, papules on the lips and ulcers at the angles of the mouth. He complained of severe pains in the joints especially at night. Lymphatic glands were felt at the inguinal regions. BivatoI injections were at once started. The first two were given at the interval of 48 hours and the next six were given twice weekly. The last four were administered every fortnight. After about four injections the morbilliform rash had completely faded and four more resulted in the total disappearance of rhagades and healing of ulcers in the corners of the mouth. The joint-pains also disappeared but the Wassermann test was slightly positive after about a month of this treatment. He was advised to continue the treatment but unfortunately the author has lost sight of him.

Some interesting clinical results.

1. A patient of about 40 came to me complaining of stubborn constipation, which he himself told me, had resisted all diets and treatments advised by several Doctors. According to the history elicited, it appeared that he had suffered from various functional troubles of the intestines for the last two or three years. He said that he did not pass motions sometimes for four days and at times even for a week. Occasionally he did pass two or three stools, but they were quite insufficient and were passed after a good deal of straining and physical exertion. The motions were hard and oval, a sort of scybalous mass, covered over by mucus and at times stained with blood. Besides this severe constipation the patient complained of breathlessness on the slightest exertion, felt fatigued and was not inclined to work. He suffered off and on from headaches, insomnia and there was itching practically of the whole body. The patient did not however show any signs of emaciation.

Examination of the patient revealed nothing abnormal in the heart. The sounds

were regular and the beats strong. Beyond slight enlargement of the liver there was nothing worthy of note in it. The colon, however, specially the descending one was distended in its entire length. It was tender on pressure, from the splenic flexure down to the sigmoid portion.

The patient was immediately put on Mycol treatment. As many as two tablets three times a day were prescribed. He took these before food which consisted chiefly of fruits, vegetables and liquids. No other medication was given. The good results were clearly perceptible after a week's treatment. Slowly the stools were regulated and he used to pass clear motions at least twice a day. After three weeks of this regime the liver was not felt below the ribs and the tenderness over the region of the descending colon could not be elicited. At this time he was also advised light massage over the whole length of the colon. The result was beyond expectation. He passed two or three well-formed motions daily without any trace of mucus or blood and he was also getting very good appetite. The dose was reduced after three weeks and he was thenceforth taking only three tablets per day. This result was perfectly maintained later on. The general condition improved, the breathlessness and fatigue no longer troubled him and itching completely disappeared. His condition at present is excellent from every point of view. He is still taking two tablets per day, one before each meal.

2. I was called one night to see a lady aged about 42 suffering from severe lumbar pain. The patient was apparently in much distress as the pain was very violent causing her to cry in agony. The paroxysms of pain used to come on the slightest movements of the body. The skin was warm and the temperature was 100 and pulse 96. The tongue was furred. On auscultation of the heart and the lungs nothing noteworthy was found. Palpation and pressure on the abdomen evoked no pain. Even in the lumbar region there was no pain on palpation or deep pressure. The urine was scanty and dark coloured, otherwise the examination revealed nothing abnormal in it. All this indicated that the pain was due to the lumbar muscles being affected by Rheumatism.

The pain was provoked by active movements. She had anorexia, headache and nausea.

The treatment was started with Salicylates, diuretics and Salines. Even after three or four days of this treatment no amelioration in the symptoms was noted although the pain was less acute but more diffuse. Later on Cryogenine in the form of powder was administered. She took about 30 grs. of this every day in addition to the Salicylate mixture. This had the desired effect in bringing down the temperature and relieving the headache. The pain in the lumbar region had become dull. After this the temperature remained normal, the pulse was about 73 and the anorexia gave place to good appetite. The patient was able to leave her bed and resume her usual duties although she was troubled by the dull aching pain in the back. At this time I thought of injecting Iodaseptine in the muscles which I did after one or two days. I injected 5 c. c. of the preparation in the gluteal muscles every other day. After six injections the dull aching pain slowly began to fade away and she began to feel a sense of relief. Six more injections were given after which definite progress for the better ensued. She was completely relieved of the discomfort and she was able to move and walk without any difficulty. She was given one more set of six injections in order to prevent recurrences of the complaint. The good results of this treatment have persisted so far i. e. even after the lapse of six months.

3. A lady of about 30 was getting asthmatic attacks off and on for the last two years. Family history showed that her father and mother were asthmatics. The asthmatic paroxysms used to start after some indiscretions in her food. Before the setting in of these paroxysms she always had a feeling of discomfort and tightness over the chest for one or two days. At the time of the attacks she felt that it was impossible for her to breathe, had to sit up in bed and she was compelled to rush to the window for some free air. The attacks used to last for three or four days and their course was almost the same despite all kinds of treatment. She was troubled very much during the attacks by cough, expectoration and

dyspnoea and when the attack subsided the expectoration became copious. There was no rise in temperature at all.

Examination during the attacks showed that there was hyper-resonance spread over the surface of both the lungs. The cardiac dullness was much diminished. Auscultation revealed harsh breathing which could be heard even at a distance. The breath-sounds in both the lungs were accompanied by fine, squeaking rales. Her expression was anxious and she was sitting with her whole body inclined forward grasping her knees.

In the intervals between the attacks the expiratory murmur was prolonged and low in pitch with rales scattered here and over both the lungs.

These periodic attacks of spasmodic dyspnoea together with the characteristic signs of the disease showed that it was asthma.

Treatment was started with Felsol for asthma, and in the intervals Iodaseptine injections were given intravenously. She took one powder three times daily during the attacks, which helped her to get rid of these attacks. The intravenous injections were given twice a week. In all she had twelve of these.

The favourable effects of this combined treatment were discernible after a month. The attacks became few and far between and each subsequent attack was very much lessened in severity. The lungs were completely clear some days after the twelfth injection. A subjective feeling of well-being started after this, her cough stopped and her appetite as also her weight increased. She is at present very much better and is not troubled any more by the paroxysms.

Some illustrative cases.

1. A lady aged 28 came for advice regarding her Dysmenorrhoea and extreme nervousness. Menstruation ever since her puberty was very painful and irregular. The flow appeared after every two or even at times three months. The pain was very acute and lasted longer than three days and was not relieved by aspirin or other palliatives. What troubled her more was the state of nervousness which disquieted her very much. She felt much irritated and there was general lassitude and fatigue on the least exertion. She experienced during the periods heat flushes, nausea and at times vomiting. Ovaro Thyroid Opocrins were

prescribed and 8 of these were taken by her daily. One month after this treatment the lady was much better so far as the nervousness and fatigue were concerned, but the pain during the periods persisted although it was not of the same intensity. The flushes and the nausea were almost the same. She was asked to continue the Opocrins, which are now supplemented by the injections of the same preparation. These were given every other day. When seven of these were finished it was noticed that at the next menstrual period she complained only of vague pains in the hypogastrium, but there was complete absence of the heat flushes and not the slightest sign of nausea. There was above all complete disappearance of the state of nervousness. The injections were continued, so also the Opocrins. She received in all 12 injections. The flow at the next menstrual period was normal and absolutely painless. The fatigue as well as the lassitude has entirely vanished and the periods are now regular and free from any troubles. She was asked to continue the Opocrins for some time with an interval of rest for one week after every 15 days of the treatment.

2. A patient about 45 years old had a characteristic gummatous ulcer on the lateral aspect of the left leg. It was of the size of a hen's egg sharply circumscribed, gray in colour and showing a caseous centre with a fibrous translucent periphery. W. R. was strongly positive. Besides Bivitol injections the patient was given Pot. Iodide internally, but as he developed severe headache, coryza and gastric disturbances this was stopped and he was given only Bivitol. After five to six injections the central caseous mass of the ulcer began to cicatrise. The peripheral zone after a few more injections was slowly being converted into fibrous tissue. The blood was examined for the Wassermann Reaction which was found slightly positive after a course of 12 injections. A further course of treatment, which consisted of 12 injections, was given and his symptoms have entirely disappeared and the reaction now is absolutely negative.

Some interesting cases.

1. A young man of 28 came to me complaining of headache, sore throat, general malaise and fever. On examination I found that his throat was badly inflamed and the

temperature was 102°. He complained of pain in the throat. He was treated with the usual paints such as Mandles, Protargol etc., but unfortunately the local condition remained unaffected. In fact it grew worse. The inflammation assumed a severe form a few days later and the patient had rigors, rise in temperature and more pain in the throat. I prescribed the following mixture:

Pot. Chloras	grs. 4.
Tr. Aconite	mms. 2.
Tr. Ferri Per.	mms. 10.
Mag. Sulph	dram. 1.
Liq. Strychine Hyd	mms. 2.
Liq. Hydrarg Per dr.	$\frac{1}{2}$.
Aq. Chloroform	ad one ounce.

for each dose.

In addition to this I painted to the throat with Orargol and asked him to gargle it with the solution of the same preparation. Temperature dropped down to normal two days after this and the congestion of the throat was much reduced. Two more days of the same treatment made the patient completely free from his ailment. The inflammation of the throat had totally disappeared and he was able to attend to his duty after six days of this treatment. This result, I should think, was mainly due to Orargol, which is an active bactericide, absolutely non-toxic and non-irritating even to the mucous membrane. This fact enabled me to apply it to the throat, the inflammation of which yielded to it rapidly, when other applications had failed.

2. This case is of a middle-aged lady of 55 who suffered excessively at the climacteric. After the cessation of menstruation she had severe "Hot Flushings" followed by profuse sweating. Several times in the day she had these attacks, a hot stage, a cold stage with rigors and lastly a stage of perspiration. The perspiration was at times so abundant that she had to change her linen. These frequent attacks of sweatings coupled with her low vitality led to bronchitis which used to trouble her very often. As a result of the frequency of these flushings and sweatings she developed a pronounced state of neurosis. She was irritable and restless and would burst into tears at the slightest provocation. She frequently displayed a marked tendency towards depression. Fortunately all these symptoms were not accompanied by menorrhagia. She suffered like this for four

months before she came under my notice. I started the treatment by injecting into the muscles Ovaro-Pituitary ampoules A.F.D. every other day supplemented by the Opocrins of the same preparation. She took six opocrins per day. After a course of six injections together with the Opocrins for that period the flushings as well as sweatings became far less frequent. The lungs which formerly were full of sibilant and sub-crepitant rales were now quite clear. A notable improvement in the condition was established after the full course of twelve ampoules. She however continued taking the Opocrins, three bottles of which she finished. After the completion of this treatment there was complete disappearance of all the symptoms. All the nervous manifestations in addition to the hot flushes and sweats no longer troubled her. Her lungs were clear and her general condition was definitely better.

3. A young man came to consult me for suppurating adenitis in the right axilla. The duration was of three months. He was tired of dressings and was very uncomfortable on account of the bandages round about the chest. History as well as microscopic examination eliminated tubercular origin of these glands. He was otherwise quite healthy, his weight was constant, his appetite good and there was no temperature. I made a crucial incision on the crude suppurating wound and after cleaning it with warm water put on wet packs of Bacte Pyo Phage and dressed it in the ordinary way. He was given injections of Hemo-Cyto-Serum, one ampoule of 5 cc every other day. There was no change for the first few days but after ten days the wound began to show signs of healing. The mass in the axilla began to diminish in size and became mobile. Many of the glands began to separate. After 20 days the wound began to show clear granulations and the suppuration had completely stopped. After five weeks the cicatrization was complete and other glands had become much diminished in size. The injections were continued until he had in all twelve. After two months the glands were found much diminished in size, his weight increased by 8 lbs and he was feeling very lively and active.

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News and Comments.

Aswini Clinic: We draw the attention of our readers to a prospectus received by us and published in the Correspondence columns about a medical institution recently started at Calicut called The Aswini Clinic. The home is to be managed by "a governing body who have no pecuniary interest in its success but whose sole object is to place all the advantages of modern medical science within the easy reach of even the poor."

The aims and objects of the Clinic are laudable. It is to serve the members of the public in providing facilities of medical relief on up-to-date scientific lines. The members of the independent medical profession at Calicut and its suburbs should be thankful to the organisers for giving them exceptional opportunities for service. The huge problem of satisfactory medical relief to the public cannot be solved by the Government. The independent medical profession alone has to be depended upon for this purpose. State medical service has been a barrier to the healthy growth of the independent medical profession in this country and the existence of Government Medical Institutions under the charge of paid officers with no such institutions under the control of the members of the independent medical profession, has been so far the sole cause for the latter not being recognised by the public as capable as their brethren in Government service. It was not possible for individual members of the independent medical profession to start institutions of the scale and style run by the Government. Unfortunately the public have not so far realised that the fabulous amount spent by the Government for medical relief, is the hard-earned money paid by them to the Government as taxes and that they did not get commensurate return for the money so spent. A very small percentage of the members of the public are served by the Government institutions and the amount actually spent for relief is much smaller than that spent for the salaries of medical officers. It is really a very happy irony that a retired Government medical officer and one appreciated both by the Government as well as by the public during his official life happens to be the chief guiding spirit of this new venture. We trust under the

guidance of Rao Bahadur Dr. T. M. K. Nedungadi The Aswini Clinic will have a bright future. The ideal put forth by the governing body of the clinic is a splendid one. It is idle to depend upon the Government for medical relief. As has been referred to by us here and very often pointed out in these columns the medical relief could only be solved by the united action of the members of the medical profession with the help of the public. We trust the public of Calicut will not lag behind in encouraging this pioneer institution whose progress will be keenly watched not only in this province but throughout India and we trust that the citizens of Calicut rich and poor would realise their responsibilities to make this praiseworthy scheme a success. Their noble example will be followed in other parts of this country and Calicut will get all the credit for solving the question of medical relief in this country.

Menace of Foreign Doctors: The tolerant and non-intervention policy displayed by the Government of India with regard to the dumping of foreign doctors in India is neither justifiable nor prudent. May we refer the Government of India to the reply of the Minister of State, Home office to a communication from the Executive of Glasgow and West of Scotland Branch of the Medical Practitioners' Union, who drew the attention of the Home Government to "the unfairness and absurdity" of foreign refugees being allowed to obtain British qualifications with a view to starting practice in Great Britain. The official reply was that every foreigner admitted to medical studies in Great Britain would be warned that his admission would afford no guarantee that he could be allowed to settle to practise in Great Britain when qualified. The position in Germany and Austria seems to be that those who practise in those countries should not only possess medical qualifications granted there but should be the Nationals also. On the face of these solid facts it is unconceivable why the Government of India refused to protect the interests of the Indian practitioners in India. Is the callousness on the part of India Government due to the fact that the country is not having a National Government as in Great Britain, Germany and other foreign countries?

The German doctors have now settled in Bombay and the medical profession in that

city is very much agitated and at a meeting of the medical and dental profession in Bombay held on 18-3-34 a strong committee had been appointed to guard the profession against this menace of unrestricted dumping of foreign doctors. It is possible, nay, probable that the infection of the menace will spread to other cities as well. And now that the Government has refused to protect the interests of the medical profession, they should depend upon self help and start an intensive campaign before the vested interests take a deep root. We trust that influential associations of all India importance such as the All India Medical Licentiate's Association and the Indian Medical Association would take up the matter in right earnest before it is too late to mend matters. We are glad to note that a resolution was passed at the last meeting of the Bombay Medical Council making it penal for the registered practitioners to associate themselves with foreign medical practitioners who do not possess qualifications registrable in Great Britain. Such a resolution passed by the Bombay Medical Council might not materially help the situation effectively as unregistered practitioners are not prohibited in this country from practising medicine and surgery. Yet this is a move in the right direction and serves the purpose of making the Government of the land feel their callousness in this affair which is of vital importance not only to the profession, but to the country as a whole. We trust that the medical councils in other parts of the country would follow the good example of Bombay.

Amalgamation or Effacement? We are informed that there is a suggestion in certain quarters that the All India Medical Licentiate's Association should be amalgamated with the Indian Medical Association. The idea first cropped up last December when both the Associations held their annual conferences in a common place at Bombay. Anticipating the turn of events we had our say in the matter in our Editorial columns last November on the eve of the meeting of these two all-India organisations. We suggested and welcomed the idea that it would be to the mutual advantage of both the associations if the reading and discussion of the scientific subjects was conducted on a common platform and said

that it might be also advantageous in certain respects to hold the open session of both the conferences under the guidance of a common President. But we did warn the licentiates that time was not ripe to effect the fusion of both the associations. In all civilized countries excepting India a minimum standard of medical education is recognised and with it there is equality of status. Though there exist in those countries higher medical qualifications there does not exist the inferiority or superiority complex. Neither the majority of members of the medical profession nor belonging to the licentiates class nor the Government have yielded to the agitation conducted by the licentiates for the recognition of their legitimate aspirations. Agitation against Indian Medical Council Bill was an occasion when leaders in almost all the provinces in India spoke and wrote vehemently for the inclusion of the licentiates within the purview of the Indian Medical Council Bill and a member of the Indian Medical Association suggested at the Subject Committee meeting of the conference held under the auspices of this body at Bombay last December that in case medical licentiates were not brought within the purview of the bill, the medical council should be boy-cotted. The fact that this suggestion was not brought forward as a resolution at the open session indicates the nervousness of our leaders to sympathise with the licentiates to the extent they appear to feel for them. There exist even this day medical associations in India such as the Bombay Medical Union, who do not even recognise licentiates as the members of the medical profession. We would suggest to such of the patriotic licentiates who are keen for the amalgamation, not to misdirect their zeal, but concentrate their activities in setting the house of their Association in order and allow the Association to continue to exist as a separate entity till the caste system in the profession is abolished totally. Any attempt at fusion at this stage is likely to bring about disruption in the Licentiate's Association which might eventually lead to the effacement of the Association itself.

Bombay Medical Council: From the extracts of the proceedings of the Bombay Medical Council dated 5-2-34 we find the council had adopted a resolution moved by a member, to the following effect:—

Resolved that the Code should be amended so as to require the avoidance by registered medical practitioners: (1) Associating with foreign medical men who do not possess a medical qualification recognised for registration by the General Medical Council as an additional qualification. (2) Associating with medical agents of manufacturers whose sole object is to advertise products of particular manufacturers. (3) Publishing, or sanctioning the publication of, in lay papers, the subject or substance of lectures in the diagnosis or treatment of diseases to be delivered by them.

The first part of the resolution has been referred to by us a little while ago. The second clause is not of much importance, but the third one requires the consideration of the profession as a whole. Of late we have been noticing the publication of the proceedings of the meetings of several medical associations in the columns of the lay papers, and are of opinion that such publication might not serve any good purpose except of publicity and thus indirectly serve as an advertisement. There are a pretty good number of medical journals in this province and also in other provinces as well and the medical associations would serve their individual interests as well as the interests of the profession in case they publish the proceedings of the meetings of the associations in the medical journals only.

Tonsil Operations: In the "Abstracts" columns of the current issue of the journal we have published an article under the caption "What can we do to diminish the number of Tonsil Operations" by Dr. T. B. Layton, D. S. O., M. S., Lond., F. R. C. S., Eng., Surgeon to the Throat and Ear Department, Guy's Hospital, and Otologist to the Fever Hospitals of the London County Council. This thought provoking article by one of the most eminent specialists in London deserves careful reading. To quote the author's words, "It is probable that there is no operation in surgery upon which a decision is more rapidly made in practice, nor one in which it is more necessary to weigh the pros and cons, not only of the local conditions, but also of the general health, of the habit of mind and of the body, and of the hygienic conditions of school, home, and place of occupation." It is therefore wise to follow "the Hippoc-

ratic maxim that in any course of treatment we must not only consider whether it will do any good but whether it can possibly do any harm." A plea for fewer operations for Tonsils and Adenoids in children is being pressed by eminent elderly specialists in Europe and America and we wish the young enthusiastic specialists in India will do well to follow their example.

Improved Snake-bite Serum: The Snake-bite serum prepared at the Central Research Institute, Kasauli has been still improved. The serum now issued by the Institute is concentrated four times the original strength so that, a dose of the serum is made four times as effective as that previously in use. A further advantage of the concentrated serum lies in the fact that in the process of concentration, most of the foreign animal matter present in serum, and sometimes responsible for disagreeable reactions, is removed and the product is as purified as it is concentrated.

Surgical Treatment for Facial Paralysis: Two famous surgeons and 26 baboons have given the world a cure for facial paralysis. The surgeons, Sir Charles Balance, Vice-President, of the Royal College of Surgeons, and Dr. A.B. Duel, of Manhattan Ear Hospital, have been collaborating for eight years. By experiments with baboons in Dr. Duels's research laboratory, eight miles from New York, they found it possible to repair the facial nerve by grafting it together with a piece of nerve from another part of the body. Then they tried an operation on a baby five months old, whose facial nerve had been severed. Dr. Duel grafted the broken nerve together with 27 millimetres of another nerve taken from the baby's thigh, and within three months the child's face became completely normal. Since then the remarkable discovery has been made that if a piece of nerve used for grafting is removed from the patient about ten days before the operation, the time for complete recovery is halved. Dr. Duel successfully carried out this operation on between sixty and seventy patients in America.

(The Times of India.)

A Soviet Discovery: From time immemorial in Tibet and China people have been using for medicinal purposes horns of spotted Siberian reindeer. When cut in

the Spring the horns are covered with "velvet" and are charged with a maximum quantity of blood. Two years ago the Soviet Institute of Science asked Professor Pavlenko to investigate the curative properties of antlers and if possible, to isolate the active principle. The Professor named the isolated substance pantocrine, as the word "pantei" meant antlers in Russian language. For the last six months a group of Moscow doctors have been experimenting with pantocrine which they find a valuable tonic especially for fatigue or muscular weakness, including heart ailments.

It must be within the knowledge of our readers that the antlers find a place as a therapeutic agent in the indigenous systems of medicine in this country. It will be worth while for those in the profession interested in pharmacology to investigate the curative properties of antlers as their brethren have done in Moscow.

Serum Treatment for Cataract: It is now believed that cataract may be cured by inoculation without the need for any surgical operation. This statement is based on a discovery by Dr. Felix Lavagna, chief surgeon of the Monaco Hospital (France). He states that cataract is a microbial disease and as such can be treated by a serum. It has for a long time been thought that the retina of the eye was clouded by formations of crystals which had a purely chemical action. Dr. Lavagna claims to have proved that the microbes are the source of the trouble. Through experiments with guinea pigs he has shown, he says, that he can produce cataract by injections of virus, and that by subsequent injections of serum obtained from the same virus, can cure it. One very interesting discovery, he mentions, is that the bacillus which is responsible for the disease finds a specially favourable field for its mischievous activities in those who are subject to rheumatism and are suffering from arteriosclerosis. Another point the doctor claims to have established is that cataract develops much more rapidly in subjects already suffering from a bacterial disease than in others. He holds that the efficiency of the serum has been shown by the fact that 80 per cent. of the guinea pigs inoculated with the virus alone contracted the disease, whereas of those which had been

given the antitoxin, 65 per cent. showed complete immunity. (Times of India).

A Queer G. O.: The Madras Government have recently passed an order prohibiting its medical officers from making use of the private laboratories for Government work. The wording of the order looks very queer indeed. The probabilities are otherwise. And a G. O. prohibiting Government medical officers making use of Government laboratories for their private patients would have been more justifiable as the Government is likely to lose in this case, but in the other case the Government have nothing to lose. The G. O. looks as mysterious as it is queer. Yet it must have a history of its own at the Secretariat. Whatever be the history we cannot congratulate the author of such petty histories.

Culpable Neglect: X-ray examination for the diagnosis of Tuberculosis of lungs and later for knowing the condition of the lungs to adopt suitable treatment is a necessity and it is a sorrow, nay cruel sight to see a large number of patients being sent every day from the Government Tuberculosis Hospital, Royapettah, to the Government X-ray institute at the Government General Hospital. This procedure is highly objectionable for the patients suffering from a grave disease for which rest forms one of the most if not the most important part of the treatment. The patients sent for X-ray examination to the X-ray Institute are also deprived of their timely diet and those interested in the treatment of Tuberculosis could conceive what a grave risk it is to deprive the patients suffering from Tuberculosis of timely diet and rest. It is true that the patients are sent to the X-ray Institute on a motor ambulance car. But it is a cruel sight to see them patiently suffering on the verandah of the X-ray Institute from 8 A.M. to 2 P.M. awaiting their turn without food and rest.

Can it be said that the Madras Government cannot afford to spend three or four thousand rupees which may be required to fix up an X-ray plant in the premises of the Tuberculosis Hospital itself?

A Suggestion: We are informed that quite recently the Assistant-Surgeon in charge of the Local Fund Hospital, Ramachandrapuram

took leave and in his place the Sub-Assistant-Surgeon working at Biccavol Local Fund Dispensary has been temporarily appointed; consequently Biccavol Dispensary has been temporarily closed. From the civil medical list we find that a private practitioner is working as an honorary at the Ramachandrapuram hospital. It would have been a wiser step and in keeping with the principle of encouraging the system of honorary medical relief scheme, if the existing honorary was made to act for the Assistant-Surgeon at Ramachandrapuram. By the latter arrangement the public of Biccavol would not have been deprived of medical relief even temporarily, and the Government would have saved also some money to be paid towards the travelling allowances of the medical officer that is temporarily posted to Ramachandrapuram.

We would suggest that there would not be better opportunities to put the honorary system under trial than the appointment of the honoraries temporarily to act for the paid medical officers especially in the mofussil towns.

Madras Medical Council: Rao Bahadur Dr. T. S. Tirumurti has been returned unopposed for the seat vacated by him in the Council to represent registered practitioners in the second group of the Madras Medical Register. Two more vacancies have accrued in the council, one on account of the resignation of the membership by Dr. R. J. Dyson, who resigned his seat on account of his absence in India. The other vacancy is on account of the death of Dr. S. Rangachari. The former represented registered practitioners in the first group of the Madras Medical Register and the second, the second group. The precepts announcing these vacancies will soon be issued to the electorate.

The Council terminated the services of Major F. W. A. Coshan, after one year of his service as the Registrar of the Medical Council; and in his place Mr. J. P. Pinto, B.A., the senior superintendent of the office of the Surgeon-General has been appointed as part-time Registrar. Mr. Pinto possesses the qualifications necessary for the post of a deputy collector and it is expected that during his term of office as the Registrar, the affairs of the Madras Medi-

cal Council will take a better turn to the satisfaction of all concerned.

First L. M. P. to be M. B. B. S.: Dr. M. D. Barve B.Sc. (Nagpur) is the very first medical licentiate who underwent the M.B.B.S. course as per new regulations of the Madras University and completed the same last April. He seems to be the best amongst the licentiates who joined the Madras Medical College in 1932. He passed the first M. B. Examination in December 1932 and the second M. B. in April, 1933 topping the list of successful candidates, obtaining distinction in Pathology and highest marks in Hygiene and Ophthalmology. He is expected to take a high rank amongst the candidates who passed the final M. B. B. S. at the Madras Medical College last April.

Correspondence, Reports, Etc.

The Aswini Clinic, Calicut.

Srimathi V. K. Janaki Amma, Hon. Secretary of the above clinic writes:—

A medical institution called "The Aswini Clinic" has been started at Calicut and registered under the Societies Act XXI of 1860. The objects of the clinic are:—

1. to provide good and proper medical aid to the public.
2. to provide the facilities of a well-equipped hospital to the members of the medical profession.
3. to investigate problems relating to health.
4. to elaborate methods for the improvement of health and sanitation.
5. to do such other things as will promote the above objects.

And these objects are to be achieved by

(a) bringing the clinic to the level of a first rate hospital equipped on modern lines and staffed with specialists.

(b) allowing the members of the medical profession to treat their cases at the clinic.

(c) conducting health propaganda either independently or in conjunction with other organisations.

(d) bringing into existence a library and a museum.

All individuals or bodies who make

financial contributions to the clinic are members of the clinic and they are:

1. Patrons—those paying a sum of Rs. 1000 and above in one or more instalments within a year.

2. Benefactors—those paying a sum of Rs. 500 and above in one or more instalments within a year.

3. Life Members—those paying a sum of Rs. 250 and above in one or more instalments within a year.

4. Ordinary Members—those paying an annual subscription of Rs. 25 or more.

5. Sympathisers—those paying any amount less than Rs. 25 a year.

The members are entitled for free treatment depending on the amount they contribute. In addition to that, they have the privilege of having treatment at a concession rate. The clinic is managed by a governing body who have no pecuniary interest in its success but whose sole object is to make it available for the public—rich, middle and poor classes alike—all the facilities of modern medical science with home comfort. And to the extent funds permitting, free treatment will be given to the necessitous poor.

Following are the members of the governing body:—

1, Rao Bahadur Dr. T.M.K. Nedungadi, L.M.S., President, 2. P. S. Mamoo Koya Haji Sahib Bahadur, Vice-President, 3. Srimathi E. Narayanikutty Amma, B. A., Hon. Treasurer, 4. Srimathi V. K. Janaki Amma, Hon. Secretary, 5. Dr. V. K. Vaidyer, L. M. & S., Medical Director, 6. Sgt. R. N. Bijur, B. A. and 7. Sgt. V. Sankaran Nair, B.A.L.T.,

The Members of the Medical Staff are:—

(1) Dr. B. Gopala Menon, M.B.B.S., (2) Dr. K. T. P. Nambiar, L. M. & S. D. G. O. (3) Dr. N. Achuthan, M. B. B. S., (4) Dr. (Miss) M. P. Radha, L. M. P. and (5) Dr. (Mrs) S. Simon, L.M.P.

S. Paramasiva, B.A., G. D. A., R. A., has been appointed as Hon. Auditor and the Malabar District Co-operative Bank Ltd., are the Bankers for the Clinic.

Treatment of Hydrophobia.

The annual report of the Pasteur Institute of India, Kasauli, just received, says: The

year under review is an important one inasmuch as it is the first year during which the results obtained in researches covering a period of some years were given a practical application in the method of treatment employed.

It had been shown by these researches that large doses of vaccine were superior to small doses in preventing rabies and that the Paris strain of virus was superior to the Indian strain in antigenic value. To give practical application to these results during 1932, the Paris virus alone was used in manufacturing vaccine and a scale of dosage was devised which ensured a much higher average dose of vaccine per patient than had previously been in use.

The result of these measures was that the total number of deaths from hydrophobia was over 27 per cent. less than in any previous year since comparable statistics were available, in spite of the fact that the number of persons coming for treatment was much greater. This appears to be a notable achievement and indicates a distinct advance in methods of treatment.

It should be stated that in estimating the relative efficiency of different methods of treatment, the total number of deaths from hydrophobia considered in conjunction with the numbers treated is a much better criterion of the efficiency of the treatment than the actual death rate per cent. because the latter can be artificially lowered by the inclusion in statistics of large numbers of persons not actually at risk, while a large drop in actual deaths denotes more accurately a real saving of lives.

Following is the table showing numbers treated and total deaths for the years 1925 to 1932. (European and Asiatics).

year	total treated.	total deaths.	percentage death rate.
1925	8,623	138	1'60
1926	8,372	149	1'78
1927	8,437	126	1'49
1928	8,574	103	1'20
1929	8,365	135	1'61
1930	9,653	118	1'22
1931	11,147	107	0'96
1932	12,801	73	0'57

Complaints attributed to antirabic treatment have been received from 89 patients. As is usually the case most of these complaints bear no casual relationship to the

treatment and need not be further detailed. No cases of post-treatment paralysis occurred.

Italian Scholarships for Research Workers.

The following press communique has been issued by the King George Thanksgiving (Anti-Tuberculosis) Fund of the Indian Red Cross Society, Simla:—

The Italian Fascist National Federation against Tuberculosis places at the disposal of the International Union against Tuberculosis six scholarships at the "Benito Mussolini" Institute in Rome.

The conditions submitted are as follows:

These competitive scholarships, of a value of 6,000 liras respectively, plus board and lodging, are intended to enable foreign medical practitioners to stay at the "Benito Mussolini" Institute in Rome for the purpose of following a course of studies. This stage of eight months will correspond with the academic year (from November 15th to July 15th) including the usual holiday periods.

The scholars shall reside at the institute.

The scholarships shall preferably be awarded to young physicians who are already familiar with tuberculosis problems and who wish to improve their knowledge of this branch of medicine.

The kind of work undertaken at the Institute will be subject to an agreement between the Director of the Institute and the candidate.

The publication expenses resulting from this work may be defrayed partly or entirely by the institute.

The scholarship shall be awarded at the summer session of the executive committee, which will meet this year in connection with the Conference of Warsaw, on Monday, September, 3, 1934. The names of candidates, accompanied by particulars as to their age, qualifications and professional experience, must be forwarded to the Organising Secretary, King George Thanksgiving (Anti-Tuberculosis) Fund, Indian Red Cross Society, "Sherwood" Simla, W. C., so as to reach him not later than 1st July, 1934.

Royal College of Surgeons.

INDIAN CANDIDATES' SUCCESS.

A meeting of the Council of the Royal College of Surgeons of England was held yesterday, with Sir Holburt Waring, the president, in the chair. The granting of diplomas to a large number of members and students was announced. A diploma in gynaecology and obstetrics was granted jointly with the Royal College of Physicians, to K. S. Jayakar, of Bombay.

Diplomas of membership were granted to the following Indian candidates who have passed the final examination in pathology, medicine, surgery and midwifery, of the Examining Board of England:—

A. K. Acharya, Calcutta and West London; A. H. Bartley, Bombay and West London; Ruth M. Campbell, Bengal and Royal Free; A. E. De Sa, Bombay and Middlesex; J. A. Dhacka, Bombay and University College; V. Prasad Gupta, Lucknow and West London Hospital; N. H. Merchant, Bombay and University College; G. P. Neogy, Bengal and London; S. Rameshwer, Lucknow and Middlesex; G. L. R. Tapsell, Madras and St. Mary's.

Trichinopoly Medical Association.

Dr. V. Iravatham invited the Association to Thirukkattupally, Tanjore District, where a meeting was held on 28-4-34 at 5 P.M. at the local High School.

Dr. R. Sambasivan presided.

After passing a condolence resolution on the death of Dr. S. Rangachari, a clinical meeting was held. Dr. Iravatham demonstrated a number of important cases and showed to the audience many X-ray pictures. Dr. T. S. Rajan spoke about an operation performed by him for the excision of the uterus. Dr. C. Fernandez read an interesting paper about "The Eye complications in Syphilis". Later in the night there was a sumptuous dinner at the Grand Anicut. Dr. Iravatham was thanked by the Secretary for his invitation and the function came to a close late at night.

An ordinary meeting of the Trichy District Medical Association, was held on 19-4-34 at the bungalow of Dr. T.S. Rajan who was "At Home" to the members of the Association about 75 of whom attended, the occasion coinciding with the marriage of his grand daughter. The bridegroom

Dr. R. Srinivasan, M.B.B.S. was also present at the meeting. Lt. Col. N. M. Metha, I.M.S. District Medical officer presided. Dr. C. E. R. Norman, Chief Medical Officer, South Indian Railway, read a paper on "Dysentery" and a discussion followed in which many of the members took part. There was also a dinner the same night at which most of the members were present.

P. A. S. RAGHAVAN,
Secretary.

Masulipatam Medical Association.

A meeting of the above association was held on 6-5-34 in the Town Hall Masulipatam with Dr. Y. Sivaramayya, M.B.B.S., in the chair. A condolence resolution on the death of Dr. S. Rangachari was passed and the Secretary Dr. A. Seshagiri Rao was authorised to collect donations for Dr. S. Rangachari Memorial Fund.

The Secretary made a few suggestions for the future working of the association and a resolution was also passed whereby practitioners of other systems of medicine

in and around the town of Masulipatam could be enrolled as associate members with all the privileges of the association, but with no power to vote, or stand for any seat in the executive.

A. SESHAGIRI RAO,
Secretary.

All India Medical Licentiate's Association, Lahore Branch.

The Lahore Branch held three meetings in March on the 5th, 23rd and 29th and three meetings in the month of April on the 11th, 12th and 24th respectively.

In addition to the discussion on various topics of local importance two resolutions were passed to persuade all the life insurance companies existing in the city of Lahore to appoint licentiate as their medical examiners and another important resolution was passed requesting the authorities concerned to provide facilities for the medical licentiate to appear for the M.B.B.S. degree of the Punjab University.

MENESTRIN CAPSULES

A Sure Remedy for Amenorrhoea
and

A Harmless Contraceptive by Mouth.

In consultation and in collaboration with eminent gynaecologists and reputed physicians we have been able to put into the market a safe and sound medicine—**Menestrin**—which cures **Amenorrhoea** and works as a **Contraceptive** if taken within a week of the cessation of the expected menstruation.

The chief and important ingredients of Menestrin are Quinine, Iron, Manganese, Ovary and Thyroid substances combined with a suitable vehicle to present it in the form of capsules.

The main causes of Amenorrhoea are Anaemia or other constitutional diseases causing Anaemia and defective development of the Uterus, Ovaries or their appendages. If Amenorrhoea continues for a long time the patient suffers from all sorts of vague nervous symptoms attendant with Obesity.

The ingredients of Menestrin capsules are valuable tonics and restoratives. They improve the condition of the blood and the two endocrine substances Ovary and Thyroid make up for any deficiency in internal secretion of these glands in the human system, restore the normal function of the Ovaries and reduces the accumulation of fat if any.

Iron and Quinine in suitable doses have been found to bring about tonic contraction of the muscular fibres of the uterus and the ingredients of Menestrin is so combined that if taken in doses indicated for the purpose and within a week of the cessation of the normal menstruation, it helps in bringing about healthy menstrual flow and thus prevents pregnancy. So it is the safest **Contraceptive** that could be taken by mouth and is not harmful to the system.

Over 5,000 doctors have tried Menestrin capsules for the treatment of **Amenorrhoea** and as a **Contraceptive** and found them successful.

DOSES: For the treatment of **Amenorrhoea**: One for a dose to be taken twice a day immediately before food.

As a Contraceptive: One for a dose to be taken thrice a day just before food.

The capsules are made of gelatine and should be swallowed with hot water when they are easily dissolved in the stomach. Under no condition the capsule should be opened.

N. B.—Hot hip-bath will aid the action of the capsules; the patient should not expose herself at least for half an hour after the bath. In case the patient cannot afford to have hip-bath she should dash over the lower abdomen hot water at the time she takes her daily bath. There is no restriction about diet.



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AND DRESSING FOR
INFLAMMATION
AND

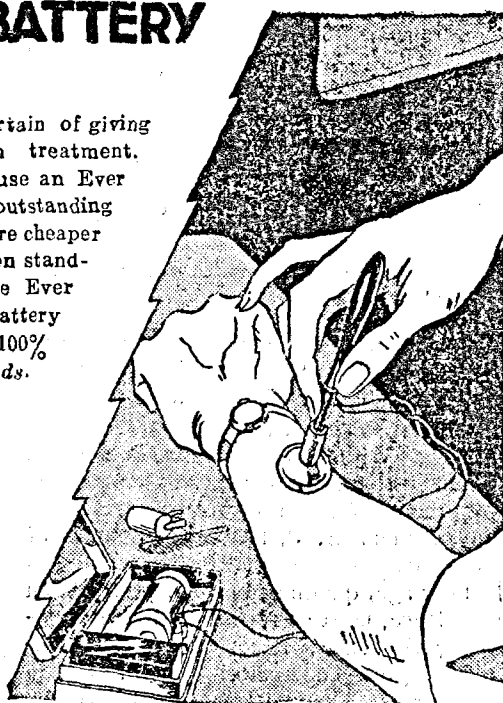
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List of Postings of Sub Asst. Surgeons for the month of April, 1934.

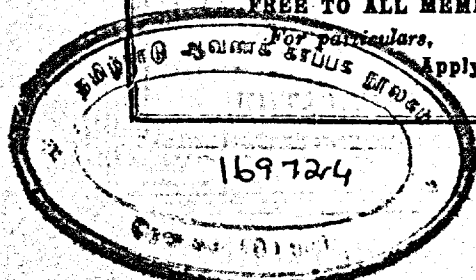
No.	Names of Sub-Asst. Surgeons.	From.	To
1	Dr. V. Narasinga Rao	Plague duty, Guntakal	R. D. Govt. Hd. Qrs. Hl. Anantapur.
2	" P. Rama Rao	Govt. Hl., Chatrapur	Govt. Hl., Russelkonda.
3	" B. Joga Rao	Dist. Jail, Berhampur	Govt. Hd. Qrs. Hl., Berhampur.
4	" Mrs. F. Mathuranayagam	Govt. General Hl., Madras	Govt. Hl., Puttur, S. K.
5	" M. H. Dorairaj	Govt. Hd., Qrs. Hl., Madura	L. F. Dy., Nilacottai, Madura Dt.
6	" S. Vaithianathan	L. F. Dy., Nilacottai	R. D. Govt. Hl., Kodaikanal.
7	" K. N. Chamukutti	" Tirthala	" L. F. Dy. Nilakottai.
8	" P. Lakshminarayanamurthi	R. D. King George Hl., Vizagapatam	Govt. Hd. Qrs. Hl., Vellore.
9	" V. Narasinga Rao	R. D. Govt. Hd. Qrs. Hl., Anantapur	C/o D. M. O., E. Godavari.
10	" A. Parasayya Naidu	L. F. Dy., Kupam	Govt. Hl., Udayagiri.
11	" Muhamad Ali Sahib	Govt. Hl., Udayagiri	C/o D. M. O., Ganjam.
12	" B. K. Tatachari	L. F. Dy., Additigala	c/o R. D. O., Peddapuram.
13	" A. N. Subbiah	Ganjam Agency	Govt. Hd. Qrs. Hl., Trichy.
14	" E. Avudainayagam Pillai	Govt. Hd. Qrs. Hl., Vellore	Police Hl., Vellore.
15	" V. Krishnamurthi	Police Hl., Vellore	R. D. Govt. Hd. Qrs. Hl., Ooty.
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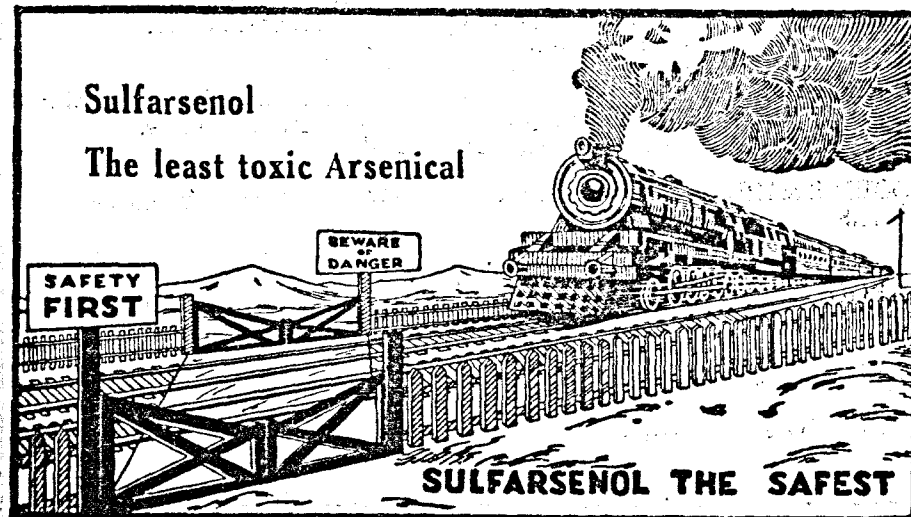
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