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JULY 1934

The Medical Practitioner

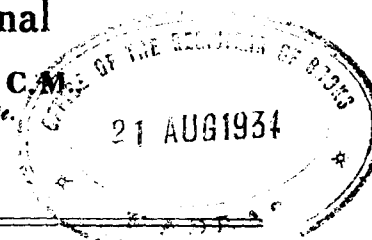
A Monthly Medical Journal

EDITED BY

Dr. M. S. Krishnamurthi Ayyar, M. B. & C. M.
Retired Sanitary Commissioner, Travancore State.

AND

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Members, Madras Medical Council.



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on page XII



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From.....M.D. C.M., (Madras.)

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From.....M. B. Ch. B. (Edin.)

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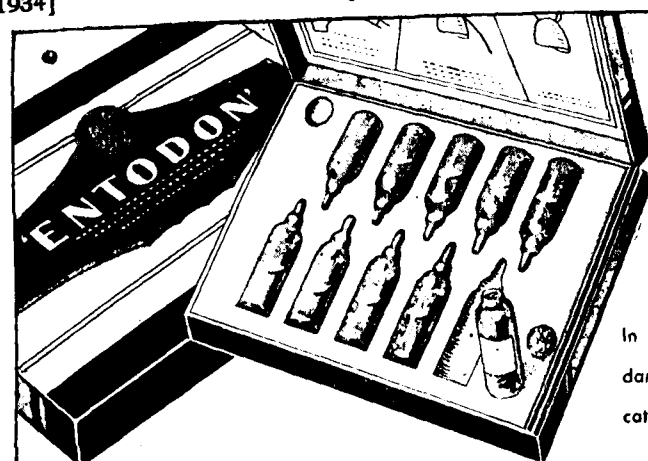
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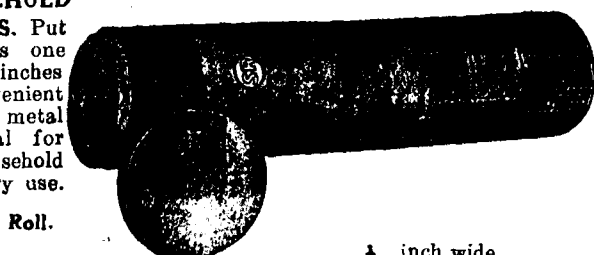
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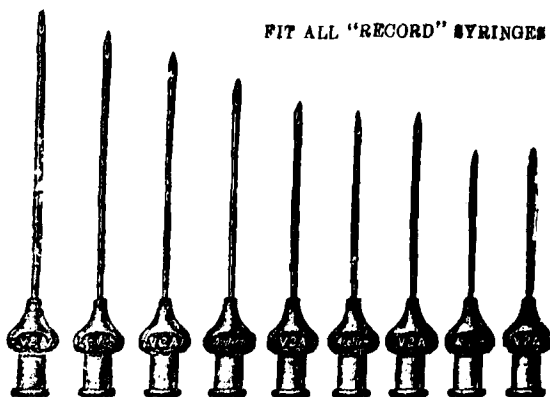
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VOL. V.]

JULY, 1934.

[NO. 10

INDIAN MEDICAL COUNCIL.

A Rare Opportunity.

We cannot congratulate Hon'ble Sir Fazl-i-Hussain who acted on behalf of the Government of India and succeeded in getting the resolution of the Indian Medical Council reversed in favour of the appointment of Dr. Macrae as one of the Inspectors. Nothing of any importance transpired between the date of the first meeting of the Indian Medical Council and its second meeting which took place at Simla on the 12th June excepting an At-Home to the members of the Council by the Hon'ble member in charge of this subject and it is likely that such of the members of the Indian Medical Council both nominated and elected who were against the appointment of the Secretary as one of its Inspectors when the subject was discussed at the first meeting of the Council changed their opinions on account of their being informed about some other points in favour of such a combination. These members would have done justice to themselves, to the public and the medical profession if they published the arguments in favour of the combination for which they were against, before the 12th June. From a letter appearing on the 4th instant in "The Statesman" Calcutta, from one of the members of the Council, it is seen that out of the 25 members that attended the first meeting of the Council, as many as 15 voted against the combination of the posts, and 9 for the combination. So it is evident

that amongst the majority who voted against the combination there must have been nominated members also. It is also said in that letter that two nominated members spoke at length against the Government's proposal, one of whom declaring that "since the Government did not take the Council into their confidence in selecting and appointing the Secretary, the Council could hardly be expected to agree to the same person being appointed as one of the Inspectors". So it is clear that such of the nominated and elected members who were against the combination of the posts of the Secretary and the Inspector at one time, did "swallow their own words." This may be pardonable in the case of nominated members but the elected members owe an explanation to the constituencies who returned them as to the 'metamorphosis' that came over their views. It may be argued that Dr. Macrae once served the General Medical Council as its Inspector in the United Kingdom and hence most fitted for the post of the Inspector of the Indian Medical Council. It is also said that the Council has agreed to select the other two Inspectors out of three, from outside the Council. There was nothing to prevent them to get one from England or even all the three, but it is certainly against all principles and even against the spirit of the decision arrived at by the Council to choose the Secretary of the Council as one of the Inspectors. Secretary of the Council is the sole guiding factor to initiate all the proceedings of the

Council and the strange mentality displayed by a large section of the members of the Council had proved to the world without a shadow of doubt that the Indian Medical Council is another department of the Government of India which has been brought into existence to substitute Colonel Needham. Dr. Macrae with a Council which will sit or stand to the dictates of the Government, will be able to do all that the General Medical Council intended to do through Colonel Needham as the Commissioner. Even granting that the intention of the General Medical Council may be quite good and may perhaps improve the standard of education of the medical graduates in India, the cost involved in the experiment and the humiliation of the prestige of the Indian nation is certainly too heavy a price for the experiment. We have mentioned more than once in these columns that the existing Provincial Medical Councils have powers to appoint Inspectors to supervise medical examinations and force the medical institutions to adapt to the standard of education fixed by the Councils. All the Medical Councils in India are presided over by the Heads of the Medical Department of the Provinces. There was nothing to prevent the General Medical Council to bring about reforms which they have in view, in the medical education, through the existing Councils. This would have been a much easier job and least costly too, as all the Medical Councils in India as they exist today have a rock bottom official majority. We have no accurate account of the affairs of the Medical Councils outside this province; in Madras though the Medical Registration Act was passed as early as 1914, Inspectors to supervise medical examinations were appointed only in 1934 and that, at the instance of an elected member of the Council representing the Medical Licentiates. We stick to our opinion that there is absolutely no need of a Council, of the type of the Indian Medical Council the like of which does not exist in any part of the civilised world. Elections to the Legislative Assembly are fast approaching and the Congress men with Dr. Ansari as their leader and Dr. B. C. Roy as the lieutenant of the leader, have made up their minds to contest the elections. Time is very opportune and should not be lost sight of by the members of the medical

profession, especially the Medical Licentiates who number more than 30,000 all of whom are badly hit by the introduction of the Indian Medical Council Act. This figure added to at least 10,000 graduates is fairly a large number who will be able to influence the result of the elections. We trust the Medical Profession will take advantage of this opportunity and get promises from those who contest the seats in the Assembly that in case they are returned, they would either end or mend the existing Indian Medical Council Act so that it would bring within its purview all the qualified members of the Medical Profession so as to be able to control the destinies of the Medical Profession as a whole.

Original Articles

THE TREATMENT OF PULMONARY TUBERCULOSIS.

I. The Principles of Treatment.

By

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

*Medical Superintendent,
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Arogyavaram, near Madanapalle.*

In order to understand the principles of treatment of tuberculosis it is necessary to call attention to what happens in a person getting an attack of the disease.

If the person has had previously a small infection, perhaps many years ago as is most common, the immediate result of a new implantation is an allergic reaction producing an exudative inflammation. This reinfection may be by bacilli penetrating into the lungs from outside or by bacilli escaping together with tuberculo-proteins from an old focus.

Although this allergic reaction is most severe round the new focus or round the old reactivated one, it influences all the cells in the body and is found to be present in marked degree wherever in the body tubercle bacilli are existing in unhealed or half-healed lesions. The inflammatory exudation created round these lesions not only mechanically closes the lymphatic vessels and thereby prevents further dis-

semination of the bacilli, but stimulates also the production of connective tissue and thereby increases the healing process in the lesions.

The inflammatory exudation, is when mild, a kind of defence against the infection. By it two favourable results are obtained, namely, the fixation of the bacilli in the place of implantation and the diminution of the toxin-producing foci. In other words, the spread of the disease is checked as well as the amount of toxin flowing into the body from the existing foci, with the result that not only do the clinical symptoms due to the toxemia disappear, but also the resisting power of the whole body is supported. This reacts back upon the strongly active lesions where there is consequently now a better possibility of concentrating all the resources of the body in walling-in these very foci and thereby getting the whole infection under control.

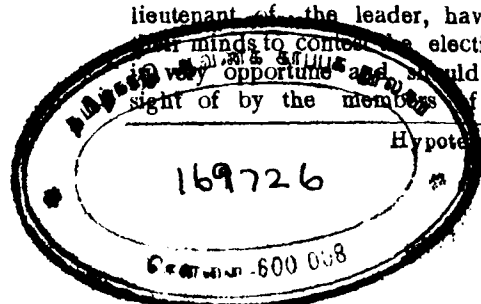
Unfortunately the inflammatory exudation is not always a mild one. If the infection is a massive one consisting of strong, virulent bacilli, or if the immunobiological defence fails on account of being overstrained, the inflammatory exudation will, in spite of its real defensive character, be so severe that it becomes very destructive and very dangerous. In such cases the exudation may be transformed into an ulcer or a small abscess breaking into a bronchus. The spread of the disease may then take place by the ulceration spreading by continuation, melting down the lung tissue, and also by the bacilli-containing pus spreading to new parts of the lung or to the other lung if the pus is not properly coughed up and thereby removed. It is true that on account of the state of allergy in which the body is, the ulcers when evacuating their pus have a tendency to rapid healing and formation of scar-tissue, but the tragedy is that, if the infection is very severe and spreads over a large area of the lung, the patient may destroy himself by the very process of the body's own natural defence-mechanism.

The principles of treatment are therefore on the one hand to reduce and minimise the action of the natural defence-mechanism when it acts too strongly and disastrously, and on the other hand to stimulate and support it whenever it does not act sufficiently to bring about healing. The

whole modern treatment of pulmonary tuberculosis consists of a careful regulation of the defence-mechanism produced by the allergic condition of the body. This must be done in such a way, that the tuberculo-proteins flow from the foci into the organism only to such an extent, but yet to that extent, that they can set up the inflammatory exudation round the foci just sufficiently to stop the spread of the infection and to convert the foci to solid scars, without simultaneously causing new areas of the lung to be infected or the already infected ones to be totally destroyed.

It is, of course, necessary in order to regulate the defence-mechanism in the right way to know exactly when the flow from the foci is too strong to be coped with and when it is too small and should be increased. The indication is whether the flow is too strong or too small or just what is given by the observation of the clinical symptoms by the physical examination, the X-ray examination and the blood examinations. From the point of view of the general practitioner in India it is the observation of the clinical symptoms and the physical examination which constitute the guidance for the regulation of the flow although the X-ray examination and especially the blood examinations give far more exact, and objective information.

The regulation of the flow of toxins and tuberculo-proteins from the lesions is effected by regulating the blood stream through them. The amount of tuberculo-proteins and of toxins flowing out from a focus depends to a great extent upon the blood stream passing through the lesion. All which increases the blood stream causes a washing of these substances into the body in greater amount, and every measure which diminishes the blood stream cuts down the out flow. Any movement or exercise of the body increases the blood circulation, while the only remedy we have to diminish it, is rest of the body. The question is here not only that of physical rest, but that of mental rest as well. Every excitement, and all mental overwork or fatigue gives increased heart function by which more blood is rushed through the lesions with an almost immediate increase of the clinical symptoms, if the patient is much attacked by the disease.



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From what has been said above about the beneficial effect of a mild inflammatory exudation it should not be difficult to understand that the flow from the lesions should be increased just enough to produce such an exudation as soon as the patient shows ability to cope with the flow when the body is at rest. If the body were left at rest longer than the time necessary to cope completely with the flow, there would not then circulate tuberculo-proteins enough to create inflammatory exudation sufficient to build up so strong scar-tissue round the foci that a lasting healing can be obtained. It is therefore imperative at a certain stage of the treatment to open up the flow from the lesions, to just such an extent, that the wanted walling-in of the foci can materialize without any set-back to the patient; this is indicated and can be judged by the four methods of controlling the progress of the treatment. The moment there is an indication of too much flow being allowed, it is necessary to stop it and to prescribe absolute rest until the body has coped with the excess amount of tuberculo-proteins set free. After that it will be found that the exercise which previously proved too much will perhaps now be stood without any set-back, a fact which shows progressive healing of the disease.

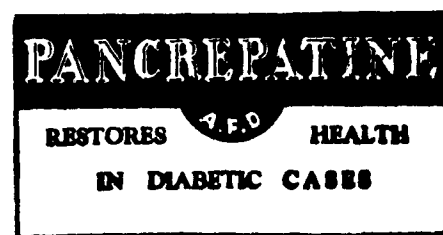
The principles of treatment consist therefore not in rest alone, but in a regulation of rest and graduated exercise in the right proportion in each individual case. It is this regulation which constitutes the special treatment in tuberculosis. All other remedies are only adjuvants helping this special treatment in regulating the natural immuno-biological defence-mechanism, diminishing its action or strengthening it according to the immediate need in the individual case.

It is a very common assumption that the treatment of pulmonary tuberculosis consists simply in the so-called "open-air-treatment". Nothing can be more wrong. If the open air could cure the disease there would be no tuberculosis left in the world after this discovery had been made. Unfortunately this is not so, although there is no doubt that the open air has a great influence in supporting the treatment. It increases the whole metabolism. The patients are not

so restless in the open air, they sleep better, and they very soon get resistant against chills and "colds" which constitutes a great danger to tuberculous patients. While therefore the open air is a great help in the treatment, it cannot be sufficiently emphasized that the principles of treatment are not "open-air-treatment", but consist in a specific treatment which is best carried out under open air conditions for the reasons just given.

At the same time the adjuvants helping the special treatment are very important indeed, as they strongly support the effect of it, and in some cases are the only means of bringing about the rest necessary when complete rest in bed is not by itself sufficient to cope with the flow from the lesions. These adjuvants are the so-called "dietetic-hygienic treatment"; the various drug treatments found to be useful; and in many cases different forms of surgical treatment producing a collapse of the diseased parts of the lungs thereby creating far more rest of the lesions than the mere confinement to bed is able to procure. When a case is complicated by intestinal or laryngeal tuberculosis an adjuvant of great importance is light-treatment, only that great care has to be taken, because this kind of treatment is sometimes detrimental to the healing of the lesions in the lungs.

It is not possible to go into detail regarding the way in which the treatment should be carried out. Yet it may be of help to point out briefly when the clinical symptoms and the physical examination indicate the necessity for absolute rest in bed. It may also be useful to give a short outline of when and how the graduated exercises should be prescribed. This and points regarding the various adjuvants will be dealt with in succeeding articles.



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*DEAFNESS.

Etiology, Diagnosis and Prophylaxis

By

DR. B. TIRUMAL RAO, L.R.C.P., F.R.C.S.,
D.L.O., F.R.F.P.S.,

Surgeon in charge of Ear, Nose and Throat
Department, King George Hospital,
Vizagapatam.

(Continued from the last issue).

A true classification of deafness could only be made on a pathological basis. But our knowledge of the pathological changes responsible for the production of deafness is so incomplete that a classification based on clinical examination as described in the previous section is accepted as quite a satisfactory basis to start with, viz., A. conductive deafness and B. perceptive deafness.

A. Taking conductive deafness first: It may be divided into 3 categories:—

I. Conductive deafness caused by some obstruction in the external auditory meatus preventing the propagation of sound waves to the tympanic membrane.

II. Conductive deafness caused by changes in the structure or configuration of the tympanic membrane or alterations in air pressure, or the presence of fluid in the tympanum.

III. Otosclerosis.

I. Deafness due to lesions in the external auditory meatus shall first be considered.

The external auditory meatus is lined by skin. It is quite accessible to inspection and palpation by means of a probe. Its lesions are comparatively simple, and as a rule leave no permanent deafness. The most important of them shall now be mentioned.

1. Impaction of Cerumen.

Narrowness of the external ear canal, excessive or abnormally thick secretion, presence of foreign bodies, which act as a nucleus, purulent discharge from the middle ear, exostosis, unskillful attempts at removal, are some of the factors favouring its accumulation. It may escape notice for a long time. The patient may seek relief only when it gives rise to pain, tinnitus, vertigo or cough.

2. Foreign bodies: Every one is familiar with this tendency in children to push in foreign bodies into the mouth, nose and ear. The removal of a foreign body, which has lodged in the meatus for a prolonged period, may lead to a narrowing of the meatus, as a result of perichondritis.

3. In acute inflammatory conditions, such as a furuncle, the ear canal may be occluded partially or entirely. Chronic dermatitis is very often due to a discharge from the middle ear and may produce a narrowing of the meatus.

4. Collapse of the meatus may follow a perichondritis or a mastoid operation.

5. Aural polypi. They are always secondary to suppurative inflammation of the middle ear.

6. Osteomata and malignant disease are rarer causes but the possibility should always be borne in mind.

II. Conductive deafness due to pathological changes in the middle ear has next to be considered.

The middle ear is from the pathological point of view, the most important section of the auditory apparatus as it is the part most frequently diseased. Its pathology can be summed up in the term, "inflammation." It is lined with mucous membrane continuous with that of the naso-pharynx through the Eustachian tube. The naso-pharynx consequently forms the main source of supply of infection for the tympanum.

The inflammations of the middle ear vary from a mild catarrh to an acute suppuration. A catarrh may resolve in its initial stages, or get worse and worse, gradually merging in a suppurative process. On the other hand an initial suppurative process may resolve but leave a catarrhal condition in its wake. While therefore no hard and fast line could be drawn between the various disease processes of the middle ear, it has been customary to adopt the following classification for clinical purposes:—

1. Catarrhal inflammation.
 - (a) Acute and
 - (b) Chronic.
- ii. Suppurative inflammation.
 - (a) Acute and
 - (b) Chronic.

* Paper read at the Fourth Andhra Medical Conference, Bezvada on 30th March, 1934.

By the term catarrh, it is meant that the inflammatory process is confined to the mucous membrane proper. There is little constitutional disturbance. It runs a milder and a more gradual course, but is persistent in its effects. Relapses are frequent and common. It is not dangerous to life.

Suppurative inflammation is an acute process to begin with. The causative micro-organisms are virulent and pus forming. It is accompanied by constitutional symptoms of varying severity. The deeper tissues are frequently involved. It often ends in recovery without a tendency to relapse. It may lead however to grave complications.

The tympanic membrane is the only part of the middle ear, which lends itself to our inspection and palpation by means of a probe. It is by the information furnished by an examination of the tympanic membrane and of the Eustachian tube, that we form a mental picture of the pathological processes in the middle ear.

ACUTE CATARRH OF THE MIDDLE EAR: It is found very often to be due to an extension of catarrh from the naso-pharynx, in an acute coryza. There is some discomfort or a sensation of fullness in the ear. Deafness varies in intensity depending upon the patency or otherwise of the Eustachian tube. There may be a complaint of tinnitus and autophonia or increased resonance of one's own voice. Both ears are usually affected, generally commencing one after the other.

On inspection it is found that the tympanic membrane assumes a pinkish hue and there is some loss of its lustre. A streak of injection along the handle of the malleus, with fine radiating vessels to the periphery may be noticed. The cone of light is broken up. The membrane may be retracted but at a later stage when there is serous effusion, a bulging generally at the postero-superior quadrant is noticed.

A history of recent cold, and evidence of catarrh in the nose and naso-pharynx and the characteristic findings of the acoustic examination confirm the diagnosis.

CHRONIC CATARRH OF THE MIDDLE EAR. It is the result of an acute catarrh which has not completely resolved. Addiction to alcohol and tobacco, gout,

rheumatism, Bright's disease, syphilis and a catarrhal diathesis predispose to it. Adenoids, nasal obstruction, chronic nasal accessory sinusitis, are local predisposing causes. It is insidious in its onset. One ear is generally more affected than the other. It may escape notice until there is an appreciable diminution of hearing in the second ear as well.

It manifests itself in two forms:—

Chronic hypertrophic otitis media and chronic hyperplastic otitis media.

Chronic hypertrophic otitis media is an exudative type of inflammation, with thickening of the mucosa and consequent narrowing of the auditory tube.

Chronic hyperplastic otitis media or dry catarrh of the middle ear is possibly only a later stage of the hypertrophic form. There may be a stenosis of the tube. On the other hand, if the hyperplasia is moderate, it may be unduly wide. The ossicles may be bound by adhesions to the walls of the tympanum and their joints may become ankylosed. This type of deafness is met with in adults. There is a history of frequent colds. The deafness is gradual and progressive in its course, but never becomes absolute, till the internal ear itself is involved. Faracismus Willisii or the ability to hear better in a noise, as for example in a railway carriage or a motor bus, may be present. Tinnitus and occasionally vertigo may be complained of. Fatigue and poor general health aggravate the symptoms.

On examination, the tympanic membrane may be found thickened and retracted, with a fore-shortened handle of the malleus. The short process and the posterior fold are seen to be more prominent. The cone of light is either absent, broken up or abnormally situated. The drum may be found partially or entirely immobile. It may be found atrophied when the long process of the incus and even the tendon of the stapedius may be seen through.

Nose and naso-pharynx nearly always present signs of chronic catarrh.

On functional examination, the results confirm to the characteristic features of conductive deafness, unless the internal ear is involved already, when the bone conduction is diminished and the high tone limit is depressed.

ii. (a) The next subject to be considered is ACUTE SUPPURATIVE OTITIS MEDIA.

It is more frequent in early life.

The streptococcus, the pneumococcus and staphylococcus are the common organisms found on bacteriological examination.

Adenoids, a hereditary proclivity to catarrhal affections and the presence of an old perforation in the drum-head are the common pre-disposing causes.

Of the exciting causes, the place of honour is claimed by acute coryza. The acute infectious fevers, which commence with a catarrh of the upper air tract come next in importance.

Nasal sinus disease, surgical operations in the nose and throat, nasal douching, sea bathing, are rarer causes of infection conveyed through the Eustachian tube.

Infection from the external auditory meatus, after a traumatic rupture of the drum, as after a box on the ear, is not uncommon.

In fracture of the base of skull, involving the petrous bone, the middle ear may be infected through the Eustachian tube or from the external ear canal if the drum head is ruptured.

In cerebro-spinal meningitis, the infection may be passed on to the middle ear through the labyrinth.

The onset is sudden, with acute pain and deafness. Pain is aggravated by such acts as sneezing and coughing. It is worse at night. Tinnitus may be present. There may be a high temperature in children but in adults it is usually slight. There may be a little tenderness over the mastoid region.

Otoscopic examination reveals that the drum is red and congested; the landmarks become less and less distinct and are finally lost. There may soon be a bulging noticeable in the postero superior quadrant, purplish yellow in colour. The ear begins to discharge about the second or third day, through a perforation in the tympanic membrane, with a general relief of symptoms.

It is usual to elicit a history of a preceding severe nasal cold or of an acute infectious fever.

There are signs of conductive deafness on acoustic examination.

ii. (b) CHRONIC SUPPURATION OF THE MIDDLE EAR.

An acute suppuration of the middle ear, instead of ending in complete resolution, may continue to give rise sometimes to an intermittent discharge.

The causes which contribute to this recrudescence are:—unhygienic surroundings, poverty, feeble general health, anaemia, tuberculosis, presence of adenoids, deflected septum, nasal accessory sinus disease, enlarged tonsils and pyrrhoea alveolaris. The inflammatory process gradually spreads deeper and deeper, involving the bone. Granulations or a polypus may be seen on inspection through the meatus.

The patient, as a rule, becomes so used to the deafness and the discharge, that he gradually gives up all treatment. Inadequate drainage may give rise to pain, headache, tinnitus or vertigo. The discharge may be sanious and offensive in odour. Facial paralysis mastoiditis, or an intra-cranial complication may be the first thing that arouses the attention of the medical attendant to the middle ear lesion.

The acoustic examination shows signs of conductive deafness unless the internal ear has been involved.

III. OTOSCLEROSIS is the third subject to be studied under the head of conductive deafness. It is a form of progressive deafness, the result of certain pathological changes in the bony capsule of the labyrinth. There is a bony ankylosis of the foot plate of the stapes in the oval window. Later in the course of the disease, the labyrinth itself is affected.

It is now believed to be non-inflammatory and a primary disease of uncertain etiology. A history of heredity is obtained in about 50% of cases. It is first noticed between 20 and 30 years of age. It is more common in the female sex. Pregnancy and parturition hasten the course. Tinnitus may be the first complaint and may be very distressing.

Deafness is progressive, unaffected by change of weather or place. It is worse after fatigue, bodily or mental. Paracusis Willisii is a prominent phenomenon. Later in the course of the disease, vertigo may be complained of.

There are, as a rule, no changes in the tympanic membrane. The hyperaemic area of the promontary may be seen pinkish through the drum head. There is often a complaint of a feeling of dryness in the external meatus.

The Eustachian tube is patent.

On functional examination, there are the characteristic findings of conductive deafness and this is its only feature in which it resembles a chronic catarrhal condition of the middle ear. The two conditions may coexist.

B. Now, the subject of perceptive deafness, awaits discussion. It is due to some lesion in the labyrinth, the auditory nerve or its nuclei which are all beyond the scope of our physical methods of examination. The diagnosis, therefore, rests upon a careful history, elimination of conductive deafness and functional examination. It is often necessary to call for a thorough examination of general health to arrive at a proper decision. It is curable only in the very early stages. It is more frequent in childhood and old age than in adult life.

Its etiology may be classified as follows:

- (1) Deafness due to toxins circulating in the blood.
 - (2) Deafness due to anaemia, primary and secondary.
 - (3) Deafness secondary to middle ear affections.
 - (4) Deafness due to intra-labyrinthine haemorrhage or suppuration.
 - (5) Deafness due to traumatic lesions of the auditory nerve.
 - (6) Deafness due to tumours of the auditory nerve.
 - (7) Deafmutism, congenital and acquired.
 - (8) Arterio-sclerotic or senile deafness.
- Each class will now be briefly considered.

(1) Now taking up deafness due to toxins circulating in the blood, bacterial toxins claim our first attention. It is only in recent years that focal sepsis has been recognised as a frequent factor in the causation of deafness. Dental sepsis, tonsils and adenoids, nasal accessory sinus disease atrophic rhinitis and intestinal toxæmia require to be carefully investigated into.

Syphilis is a fairly frequent cause of

deafness and a Wassermann reaction should always be done.

Acute infectious fevers in childhood produce a toxic neuritis.

Mumps is a well recognised cause of permanent deafness.

Of the drugs, quinine, salicylates, nicotine, alcohol, mercury, aspirin, oleum chenopodium, carbon tetrachloride have been noticed to affect the auditory nerve. The effects are often temporary but permanent deafness may result.

(2) DEAFNESS DUE TO ANAEMIA, PRIMARY AND SECONDARY.—In anaemia, diminished hearing with symptoms of irritation of vestibular apparatus are occasionally noticed. A sudden depletion of blood may produce a marked degree of deafness.

(3) Deafness secondary to middle ear affections occurs in two ways:

(a) In acute suppuration of the middle ear, it is sometimes noticed that there is a loss of hearing for high tones indicating an involvement of the labyrinth. When this is observed, operative treatment should not be delayed. If the labyrinthitis is suppurative in type, there is a total loss of hearing.

(b) In the later stages of chronic catarrhal otitis media, the labyrinth is involved and a form of mixed deafness is the result.

(4) Deafness due to intra-labyrinthine haemorrhage or suppuration.

A sudden haemorrhage into the labyrinth giving rise to Meniere's syndrome of deafness, tinnitus and vertigo is known to occur in lymphatic leukaemia, Bright's disease and pernicious anaemia. Suppurative labyrinthitis secondary to meningitis results in complete destruction of the labyrinth.

(5) Deafness due to traumatic lesions of the auditory nerve.

In fractures of the base of the skull, the nerve may be severed, or its function abolished by haemorrhage into it or by the pressure of inflammatory products on it.

Deafness sometimes is due to the effects of noise. A sudden explosion may rupture the tympanic membrane. An intra-labyrinthine haemorrhage may take place in addition. People exposed to incessant noise as in factories suffer a loss of the acuity of

their hearing, due probably to degenerative changes in the endings of the auditory nerve.

(6) Auditory nerve tumours are comparatively rare.

(7) Congenital deafmutism, is due to a structural defect in the auditory apparatus of the internal ear. Heredity and consanguinity have been noticed as of etiological importance.

Acquired deafmutism is the result of a lesion of the labyrinth occurring in early life before the individual has acquired the speech habit. Cerebro-spinal meningitis, acute suppuration of the middle ear, congenital syphilis, traumatic destruction of both the labyrinths, in fractures of the base of skull, are the frequent etiological factors.

(8) Arteriosclerotic or senile deafness is due to a degeneration of the organ of Corti.

PROPHYLAXIS.

It is beyond the scope of this paper which has become already too long to enter into a consideration of the therapeutic aspect of deafness and I shall therefore content myself with a brief discussion as to how to prevent it, as it has already been remarked that it is in a large measure preventable.

On a review of the etiology of deafness, it is noticed that, with the exception of congenital deafmutism and otosclerosis, it is an acquired condition. Deafness has also been spoken of before as of two types, conductive and perceptive. Of the two, conductive deafness is much the more frequent. Besides, certain cases of nerve deafness are secondary to middle ear affections. The problem of prevention resolves itself mainly into an early detection and correction of the predisposing factors.

"The seeds of deafness are sown quite early in life when it is easily overlooked." There is a special predisposition to catarrhal affections at this period of life. Improper dieting, malnutrition, exposure to damp and cold tell upon the health of the growing child. The presence of adenoids and the germchoked tonsils subject him to frequent colds and sore throats. The Eustachian tube is shorter, wider more horizontal and therefore easily accessible for infection from the naso-pharynx. Childhood is also the period when the exanth-

mata, whooping cough, influenza, diphtheria and broncho-pneumonia are most frequent. It is during the course of one of these severs, that the trouble generally arises in the middle ear and then one of three things might happen. If the labyrinth is involved the hearing is completely destroyed and the child, if he survives the illness, becomes a deafmute (acquired deafmutism). Secondly, if the inflammation localises itself to the middle ear, there is a discharging ear, which may become chronic.

Thirdly, the initial condition may only be a mild catarrh, and the impairment of hearing quite temporary. But as has already been noticed, there is a tendency for relapses in the catarrhal type of inflammation, which ultimately is responsible for a progressive form of deafness.

It is the duty of the medical attendant therefore, to keep a constant vigil for symptoms and signs of ear trouble during the course of the acute infectious fevers of childhood, not excluding the common cold and institute prompt measures of treatment. La Petra goes so far as to say "It cannot be emphasized too often that to a man who treats children, the otoscope is far more necessary than the stethoscope." In acute otitis media, myringotomy should not be delayed if the pain is very severe, and the usual conservative treatment affords no immediate relief. Persistent discharge from the ear, and deficient hearing are the most common and obvious indications for the removal of adenoids and tonsils, after a fair trial has been accorded, of course, to non-operative measures. Nasal accessory sinus disease is not uncommon in children and should receive attention. Bodily resistance must be built up, dietetic errors must be corrected, and general health improved. Later in life when the patient is met with the signs and symptoms of a chronic otitis media, the naso-pharynx must first be brought into a healthy condition which is the sine-quo-non of success of any therapeutic measures adopted directly for the cure of the rural condition. Dental sepsis, chronic sinus disease, and septic tonsils must receive thorough treatment.

Further prophylactic measures lie in the direction of educating the general public and the educational authorities. A vigorous propaganda must be started to spread far

and wide the gospel of the prevention of deafness. The school medical officer should pay special attention to rural disorders. Stupidity, inattention, and absent-mindedness, defects in voice and speech, and a general backwardness in the class, are very often due to defective hearing. "Preference must be given to hearing tests rather than to disciplinary measures." Indigence, ignorance and indifference are the chief causes of remediable hearing defects. Let us look forward to a time when better economic conditions shall prevail, when children shall have enough of nutritious food to eat, and healthy environment to rest and to play about. Let us look forward to a time when the medical profession as well as the lay public, shall realise in a fuller measure, this serious menace to the happiness and the well being of so large a proportion of the human race.

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Abstracts

An experimental Study of a Rare Case of Hypothyroidism in a Woman.

By

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In September 1930, the following patient came in for consultation. A heavily built woman, with swelling below the lower eyelids and of the dorsum of the hands and feet, not pitting on pressure, aged 28, complained of pain in the long bones and joints and of repeated abortions. On examination, the skin was rough, dry and

scaly, her tongue thick and indented by the teeth, her articulation was slow and difficult, her pulse-rate was 60 per minute. The patient complained of always feeling dull and drowsy, never perspired and was very sensitive to cold; she had also noticed that her hair was falling out.

When she was seven years of age, the patient had, all over her body, multiple boils from which she suffered for nearly a year. The boils took a long time to heal. On account of a few boils she had on her hips, disuse atrophy of the muscles of her lower extremities set in, and it took her nearly three years to regain the use of her legs.

Her blood was examined for the Wassermann and Khan reaction, with negative results. Her urine was normal.

The patient was put on desiccated thyroid extract, $\frac{1}{2}$ grain, three times a day. There was rapid improvement within a week, the symptoms reappearing when the treatment was stopped by the patient. Thyroid therapy was therefore continued permanently. She became pregnant in November 1930, and this time went to term and was delivered of a male child in August 1931. After delivery, the patient discontinued the thyroid therapy, and then noticed that there was a spontaneous and frequent flow of milk in such profuse quantities as to soil her clothes and wet the bed. Occasionally, there was intense nausea, followed immediately after by the squirting of milk from the breasts, with the subsidence of the symptom of nausea. Four months after delivery, the child began to show signs of trouble. There was great difficulty in the passage of urine, attended with considerable pain, and when the agony was at its height, a small quantity of urine would be squirted when the bladder was perceptibly distended. Not finding any relief from the ordinary urinary sedatives, the patient consulted us again, and was put on thyroid therapy. The spontaneous flow of milk ceased and with it the troubles of the child also disappeared.

The milk was yellow in colour and a creamy layer formed at the top on being allowed to stand for a few minutes, leaving a thin fluid below. The percentage of fat in the milk was 4.2, about 0.8 per cent

higher than the normal. Excepting for this single variation, its composition otherwise conformed to the normal, the protein being 1.6 per cent. the sugar 6.1 per cent and the ash 0.2 per cent.

It was argued that something in the system which caused nausea to the mother, was probably also responsible for the violent contractions of the bladder in the baby, and it was likely that this was due to the action of this substance both on the plain muscle fibres of the breast forcing the milk from the glands, and also on the muscle fibres of the bladder, producing a violent contraction, at the height of which a little urine forced itself through the sphincter.

Since the hormone of the posterior lobe of the pituitary gland is known to possess the property of stimulating plain muscles, including those of the gastro-intestinal tract and the breast, thyroid administration was stopped for a few days and the milk examined for the presence of this hormone, with normal human milk as control. This was done by the method described by Burn and Dale, testing its presence on a guinea-pig's uterus. Instead of using guinea-pigs before the occurrence of the first oestrus cycle, the maturer animals were used during the period of oestrus. The animals used weighed on an average 250 grammes. Burn advocates the use of a full horn for a test. Our experience is that if a full horn is used, the height of the rise of contraction is so great that it takes an excessively long time to relax. Segments of horn about 1 cm. long give very satisfactory results. We also found that 15 minutes is too short a time for the uterus to relax when suspended in oxygenated Ringer's solution. The bits of horn have to be well weighed and allowed to remain for more than half an hour to relax fully; and if this precaution is not observed, the results are unreliable. Instead of using the perfusion apparatus described by Burn and Dale we used an apparatus devised jointly by one of us (K. Venkatachalam) and Dr. C. Vareed of the Madras Medical College. Except for these deviations, the method adopted was the same as that described by Burn.

The tone and automatic contractions of the guinea-pig's uterus were increased when 8.5 c.c. of milk from the hypothyroid patient were added to the oxygenated per-

fusing fluid in which the uterus was suspended. This action on the uterus was not marked when even 10 c.c. of milk from a normal lactating woman, five months after parturition, was added to the perfusing fluid though milk from a woman 15 days after delivery stimulates the contractions of the uterus to a slight degree. The guinea-pig's uterus was not stimulated to activity by the addition of 8.5 c.c. of milk from the hypothyroid patient after the patient had been on thyroid treatment for a week.

The contractions of the uterus induced by the milk of the hypothyroid patient resembled those obtained by the addition of pituitrin of the perfusing fluid. If the uterus-contracting factor in the milk is pituitrin, and if the difficulty of micturition in the baby is, as was supposed by us, due to this, injections of pituitrin in an experimental animal must be capable of inducing the vesical conditions, analogous to those from which the baby suffered as a result of imbibing milk from the hypothyroid mother. Experimental confirmation of the supposition was obtained by the following method.

A male cat, 2.3 kilogrammes in weight, was anaesthetized with chloralose and cannulae were introduced into the urinary bladder and the urethra. The bladder was connected to a recording tambour and the urethral one to a drop counter. A carotid cannula was inserted to record the blood-pressure. An injection of 0.25 c.c. of pituitrin into the femoral vein was made. Soon after the injection a volume of the bladder began to increase with the rise of the blood-pressure, the record showing slight stimulation of vesical contractions, and about a minute later the flow of urine was increased. The increased flow of urine lasted for about two minutes, and after this it began to decrease. The bladder-volume came down with the blood-pressure, to rise again gradually until, about six minutes after the injection, it came to the level of the previous rise. From this time onwards, the level of rise was steadily maintained and the vesical contractions began to be more and more active. With the increase in the bladder-volume and the stimulation of its contractions, flow of urine began getting less and less until at last the flow of urine could be noticed only when the vesical contractions reached the maxi-

mum points. Half an hour after the injection of pituitrin, the contractions of the bladder became violent and frequent, while the drops of urine were fewer in number though they came out in quick succession during the height of each vesical contraction.

As a matter of fact, it was only when the results of our experiments made us think that the baby ought to have had an escape of urine in quick succession during the violent contractions of the bladder, we elicited from the parents the fact that the baby used to have squirts of urine when it was having paroxysms of pain.

DISCUSSION.

There is recognition of an inter-relation between the thyroid gland and the functions of reproduction in the female. The gland is relatively larger in women than in men and the conspicuousness and relative size of the feminine thyroid are more marked after puberty than before. In every intermenstrual interval, with the atresia of the follicles after menstruation, theca interna lutein bodies and interstitial tissue appear to be produced and these stimulate the anterior pituitary hormone of the hypophysis to activity which, in its turn, not only encourages further production of theca-lutein bodies but also causes hypertrophy of the thyroid gland. There exists a parallelism between the tendency of certain anterior pituitary preparations to inhibit full growth of the follicles and to intensify follicular atresia, to produce theca-lutein bodies and interstitial tissue on the one hand, and to induce hypertrophy of the thyroid on the other. This suggests that the substance causing thyroid hypertrophy and the luteinization of the ovary are identical. The thyroid that is thus hypertrophied, together with the luteal hormone of the anterior pituitary, causes further atresia of the follicles. This condition is reversed with the onset of menstruation and lasts for a fortnight, during which time there is follicular predominance and decline in the size and activity of the thyroid. Thus during the sexual life of a non-pregnant woman, the thyroid hypertrophies with follicular atresia and regresses when follicular activity again sets in with menstruation. The periodic hypertrophy and regression of the thyroid causes

the rhythmical changes in the sexual physiology of women during their intermenstrual intervals and their menstrual periods and probably accounts for Krishnan's finding that the basal metabolic rate tends to reach a low level during and following menstruation and is high preceding the period.

This process of luteinization of the ovary, anterior pituitary activity and thyroid hypertrophy appear to be intensified in pregnancy, when an increased basal metabolic rate is required to supply the demands of the mother's body as well as that of the growing foetus. Brown has observed that the rate of metabolism is increased in normal pregnant women. Litzenberg and Carey found that lowered metabolism interfered with the continuance of pregnancy. The hypertrophy of the thyroid in pregnant women has been noted even by lay people. The increased girth of the neck due to the enlargement of the gland and the resulting inadequacy of the collars ordinarily worn, used to be considered as a sign of pregnancy. The increase in the size of the thyroid gland observed in pregnant women is an expression of the physiological activity and storage of the iodine-containing secretion. Anselmino and Hoffman have demonstrated the presence of a substance identified as thyroid hormone in the blood of pregnant women from the second month of pregnancy onwards. This substance, when injected into mice, diminishes the glycogen-content of the liver and increases in concentration during the course of pregnancy. Post-partum, it decreases in quantity and on the eighth day after delivery, it completely disappears. According to Bokelmann and Scheringer in pregnancy, the iodine content of the blood is relatively high from the second or third month, increases rapidly till the seventh month, remains at the same level till the ninth month, falls slightly in the last month of pregnancy, and very gradually falls after delivery. From the seventh month onwards, and synchronous with the time when the iodine content of the blood has ceased to increase, there is observed in some women a shedding of superfluous hair—a sign of hypothyroidism—and the appearance of small uterine pains off and on, are observed in certain individuals. The latter symptom is

probably due to the escape into the blood of minute traces of posterior pituitary secretion—also a result of insufficient activity of the thyroid. Whenever there is a lack of thyroid or insufficient thyroid activity, there is always to be found in the blood an excess of posterior pituitary secretion. Herring has noticed that the final product of the posterior pituitary secretion is greatly increased after thyroidectomy and this has been confirmed by later observers. Mott has made a similar observation with regard to a case of myxoedema. Thus the thyroid appears to exercise a controlling influence over the escape of posterior pituitary secretion into the circulation. Thus it appears that as long as the iodine content of the blood of a pregnant woman with a normal thyroid remains high, the posterior pituitary secretion is kept out of the circulation, appears in traces when the thyroid activity is on the wane, bursts out of control when the iodine content of the blood falls below a certain concentration, and enters into circulation in quantities sufficient to cause the labour pains at term. Defibrinated blood from a woman in labour exhibits oxytocic properties not to be found in the blood of men or of women a week after delivery; and transfusion of citrated blood of women in labour to women in the last stage of pregnancy produces symptoms of labour and delivery in 60 per cent of cases. Mayer has found that human cerebrospinal fluid obtained by lumbar puncture during labour, stimulates uterine action when injected intravenously into patients with deficient labour pains and attributes the result to its containing the active principle of posterior pituitary.

Cases are on record in which pregnancy has been found to be maintained in the absence of the ovary, or after thyroidectomy, or without the pituitary gland. The ovary, besides supplying the initial luteal tissue essential for the development of the pregnancy-cells in the anterior lobe of the pituitary, does not seem to perform, during pregnancy, any other function that cannot be taken up by corpus luteum. Allen and Corner castrated female rabbits eighteen hours after mating and were able to maintain the pregnancy till term by injections of corpus luteum. When anterior pituitary has been removed, the thyroid hypertrophies. In cases of partial thyroidectomy, there is hypertrophy of the remnant and

this hypertrophy is not noted when anterior pituitary hormone is administered. An excess of anterior pituitary inhibits posterior pituitary secretion and is also capable of stimulating to activity the corpus luteum which itself had been demonstrated by Knaus to be physiologically antagonistic to posterior pituitary and is, therefore, likely to maintain pregnancy. Thus in cases of thyroidectomy, even though accessory thyroids are not present, or small bits of thyroids capable of meeting the requirements of metabolism are not left behind after the operation, the anterior lobe of the pituitary appears to be capable of compensating for the loss of the thyroid by hypertrophying and sending into the blood-stream the necessary secretion to stimulate the corpus luteum and to keep out the posterior pituitary secretion from the circulation. For the continuance of a normal pregnancy to term, the co-ordinated and the augmented functions of the luteum-stimulating hormone of the anterior pituitary and the thyroid seem to be essential and if one of these is lacking, there appears to come into existence a compensatory mechanism whereby the other hypertrophies and makes good the loss. If this compensation fails, pregnancy is likely to be terminated.

Thus, the thyroid seems to be one of the main factors concerned in the maintenance of pregnancy to term. To augment the metabolic rate in pregnancy, the thyroid begins to hypertrophy from the second month onwards to the seventh month, from which period to the ninth month, it remains stationary and begins to regress at the end of pregnancy. When it is hypertrophying, the posterior pituitary appears to be kept in check; if not, the posterior pituitary, by itself, is capable of decreasing the basal metabolic rate. The lack of hypertrophy of the thyroid from the seventh to the ninth month manifests itself in the shedding of superfluous hair in some women and the escape of traces of posterior pituitary secretion in the blood, causing the small pains felt off and on by certain individuals, during the later months of pregnancy. At the end of pregnancy, regression of the thyroid removes the check so far exercised on the posterior pituitary which, as it were, bursts out of control into the circulation and produces the labour of pains.

Apparently, the thyroid of the patient, referred to at the beginning, had become grossly deficient as a result of the suppurative process the patient was suffering from when she was seven years of age, and the compensatory mechanism failed to respond as a result of continued demands on it over a long period. During the pregnancy this inadequate thyroid, without the compensatory mechanism, was not able to prevent the escape of posterior pituitary secretion into the circulation. Premature escape of this substance probably stimulated the uterus to activity and terminated the previous pregnancies. When thyroid was administered, in addition to relieving the other symptoms of hypothyroidism, pregnancy was maintained to term and a healthy baby was born. When after this, thyroid was withheld, the check necessary to keep the posterior pituitary gland under control was lacking and the secretion was off and on leaking into the circulation, manifesting its presence by the nausea produced in the mother by the pituitrin-stimulation of the smooth muscles of the stomach, and by the squirting of milk by its stimulating action on the smooth muscles of the breasts. The contraction of the muscles of the breasts so induced seems to have been so strong as to have squeezed out all the milk from the breasts, leaving, therefore, none for the baby when applied to the breasts immediately afterwards. Since the nausea disappeared soon after the flow of milk, the milk was searched for the presence of pituitrin and it has been found that this milk, so late as five months after the birth of the baby, is capable of inducing contractions of the guinea-pig's uterus. It has also been found during the investigation that milk of normal women also contains this substance for a few days after delivery. This is probably to help the involution of the uterus, and is under further investigation.

This substance in the milk of our patient disappeared to an appreciable extent after the administration of thyroid, thus showing that thyroid has a controlling influence on the escape of this substance into the circulation. With the disappearance of this substance from the milk of the mother the troubles of the baby also ceased.

Since vesical contractions analogous to

those found in the baby are produced in an experimental animal by the injection of pituitrin, it is clear that the substance in the milk of the mother is identical with pituitrin. On the administration of pituitrin to the animal, the increased flow of urine occurring soon after the injection becomes markedly less in a short time, and with this, the volume of the bladder and the vesical contractions increase gradually without there being any relief in the outflow of urine. The opening of the sphincter, which normally takes place during the contraction of the fundus of the bladder, is prevented in this case to a very great extent by the action of pituitrin on the sphincter. Thus, while the bladder is full and is contracting vigorously, the sphincter is also contracted, affording no relief to the full and contracting bladder, with the result that more and more vigorous contractions are induced in the bladder, only small quantities of urine escaping in quick succession and in squirts during the height of each vesical contraction.

SUMMARY AND CONCLUSIONS.

1. A rare case of thyroid deficiency in a woman, giving rise, in addition to the other symptoms of hypothyroidism, to repeated abortions to spontaneous flow of milk in the mother and to vesical troubles in the baby, has been described.

2. Experimentally it has been shown that the milk of the hypothyroid woman contains a substance capable of inducing contractions of a guinea-pig's uterus at a period of lactation when the milk of normal women does not show evidence of its presence.

3. This substance has been found to be identical with pituitrin.

4. This substance is also found in normal woman till a few days after delivery, probably to help involution of the uterus.

5. The probability of hypothyroidism being one of the causes of frequent abortion, and the effect of pituitrin on the volume of the bladder and its contractions, are discussed.

* * *

(*The Journal of Obstetrics and Gynaecology of the British Empire*—Vol. 41, No. 1 page 35.)

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 INTERESTING CASE NOTES

BY

Eminent Physicians

LIPOCEREBRINE TREATMENT FOR
NEURASTHENIA.

1. Sometime in February last a male patient of middle age suffering from severe attacks of diarrhoea and nervous exhaustion came to seek my advice. The patient was thin and emaciated and his abdomen was tympanitic but not tender. His muscles were thin and flabby. The heart was quite normal in size. He was often seized with attacks of severe diarrhoea accompanied by digestive disturbances such as vomiting and fulness. He had a sort of vague abdominal discomfort and aching pains in the back. At the same time he suffered from severe headaches which kept him in bed and which prevented all concentration of mind and all possibility of mental work. This disturbed him greatly as he was obliged to remain idle which he never liked. I found that he had lost his courage and confidence and was in a bad state of nervous disorder. As the diarrhoea was intractable and refractory I had an X-ray and barium meal done, which showed no signs of malignant or organic disease of the alimentary tract. Urine examination revealed nothing abnormal. Blood when examined showed nearly 40 lacks of Erythrocytes, hæmoglobin 75 per cent colour index and leucocytes being almost normal. I had his stools examined by a pathologist but no organisms either of dysentery or T. B. were detected. I tried Thoroxyl tablets for his diarrhoea, 8 tablets per day. He took these with his diet which was mostly liquid. A couple of days after this his diarrhoea stopped, but still the abdominal discomfort, sense of fulness, vomiting and aching pains in the back continued and he was very uneasy. I stopped Thoroxyl and started giving him Mycol tablets two of which he took four times a day before food, which was more liberal than before. Along with this I injected one ampoule of Lipocerebrine every day subcutaneously. Being in a very low state of health the patient was slow in responding to this line of treatment, but

after twelve injections of Lipocerebrine and Mycol administration for the same period his diarrhoea disappeared, there was no abdominal discomfort and he had gained about four pounds in weight. He is now getting well-formed motions, good appetite and better digestion. The mental condition decidedly improved, he is able to get good sleep and headaches no longer trouble him. He is able now to concentrate well and his face has lost its sallow tinge and worn-out appearance. He is getting up fresh every morning and quite healthy too. I am giving him a further course of 12 injections in order to complete the cure. This was purely a case of Neurasthenia which responded well to Lipocerebrine.

2. This was a typical case of Neurasthenia in a young man, a clerk in a Government Office. I found him a typical neurasthenic lacking decision, courage and confidence and always obsessed with grave doubts about any and everything. He thought that he would not be able to continue his work owing to failing memory and inability to concentrate. In fact the typical symptoms of Neurasthenia were gradually developing. There was mental and physical fatigue, loss of appetite, headache and insomnia. A course of Lipocerebrine injections, twelve in number, was given. He was steadily recovering his mental and physical vigour during the treatment. His appetite had improved, headache had disappeared and he was able to sleep well and get up refreshed. Along with this I had ordered him to take Fer-Ma-Pho, 30 drops of which he took per day half an hour before meals. Another course of twelve injections was given and after this he made a complete recovery and was full of vitality and vigour. His outlook on life steadily improved and he is at present full of enthusiasm and energy. I have advised him to continue Fer-Ma-Pho which he is still doing.

SUCCESSFUL TREATMENT OF RHEUMATISM WITH REIPAR INJECTIONS.

I was called to see a youth of 20 who was suffering for four days from high fever, headache, vomiting and severe pain in the left elbow-joint. There was very little swelling of the joint but it was most tender on pressure or movement. His face, which was flushed, had an anxious expression, and the tongue was heavily coated. The involved joint was very tender on even moderate

palpation. There was history of previous attack of this nature three years back and he had recurring attacks of tonsillitis for the last four years.

The temperature fluctuated between 99° and 102° but it never came down to normal. An irregularly remittent course of fever, pain, swelling, redness and tenderness of the joint, which was very painful on the least movement, history of previous attack and of recurring tonsillitis—all these clearly showed that the trouble cannot be anything but acute articular rheumatism.

Ordinary diaphoretic mixture was prescribed together with Salicylates. For his pains Cryogenine in 7 gr. doses in the form of powders was administered. In addition to this I injected Reipar subcutaneously 6 c.c. i. e. 3 ampoules near the affected elbow-joint. Next day there was not much difference in his condition. The same procedure was continued for three more days. This treatment appeared to have modified the course of the disease as the pain in the affected joint was greatly lessened, his temperature never rose above 99° and there was no headache or vomiting. This state of things continued until next week the right wrist-joint was involved. The pain and tenderness in this joint however was not so severe and the temperature never went above 100°. The same treatment with Reipar injections (4 c. c. only) was continued. In the third week the right elbow-joint was affected but the tenderness and pain on movement of this joint was of a decidedly mild nature. Precordial distress, though present, never became severe. He was perfectly free from temperature, joint-pains etc., by the end of the fourth week with this treatment, but he was enjoined to take complete rest in bed for two more weeks. He was able to leave his bed and move about in six week's time. After this his condition improved rapidly.

ORARGOL INJECTION CURES INFLUENZA.

I was summoned to see a lady aged about 30 who was ill with pain in the head and joints and malaise. Her axillary temperature was 101°. There was running of the eyes and the nose and the throat was congested. In fact she presented to me a typical picture of Influenza. She was having the usual salicylate mixture together with

Cryogenine. This was continued for two days without much relief to the patient except some abatement of the joint-pains and headache. On the third day I thought of injecting Orargol, one ampoule of which I injected intramuscularly. The next day I again injected another ampoule and by evening there was sudden turn for the better, the temperature declining to 99° and the patient feeling better every hour. There was very little pain in the head and the joints. The running of the nose and the eyes had also stopped. The congestion of the pharynx showed signs of improvement. The following day the injection was again repeated and in the evening apyrexia set in and after that there was complete relief from all the symptoms. The whole infection cleared up in four days' time and then convalescence began which was quite uninterrupted. She was recommended Fer-Ma-Pho tonic which she is taking regularly.

BOLDINE RELIEVES CHOLECYSTITIS.

This was a case of a man of 32 who had gastric discomfort with periodical pains in the epigastric region for the last 10 days. He complained of distension of the stomach after meals followed by stomach cramps, sour taste, heartburn and eructations. There had never been vomiting. Bowels were regular but the stools were light-coloured and greyish. Urine was high coloured. Palpation revealed sensitiveness in the region of the gall-bladder and also in the epigastrium. From the patient's history and the importance of the biliary symptoms I was led to diagnose the case as one of dyspepsia due to gall-bladder disturbance. I had therefore to prescribe combined treatment for dyspepsia and Cholecystitis. In the beginning I gave the usual alkaline and alkaline carbonate mixture with a little taka-diastase and pepsin. This had not the desired effect and so I advised Boldine A.F.D. in addition to this, two pills thrice a day. After a week or ten days the patient showed marked signs of improvement. This was continued for three weeks more and the improvement had almost by this time amounted to a cure. The tenderness in the gall-bladder region had disappeared and the patient told me that there was a distinct feeling of lightness in the epigastrium where formerly he had a distressing sensation

of weight and distension. Appetite was completely restored and digestion was satisfactory. Sour taste, heartburn and eructations all had disappeared and the pale and greyish faeces had long since become coloured. The urine was profuse and free. He improved both physically and mentally and he is going on at present splendidly. I advised him to continue taking Boldine A.F.D. pills which act as excellent cholagogues. This state of health is still maintained.

Effective Calcium Therapy.

It was formerly known about Calcium that it only constitutes an important building material to the osseous system but at present it is universally recognised that it possesses characteristic properties which extend on all cells. Now opinion is hardly divided about the fact that Calcium diminishes dispersion of colloids and the permeability of blood vessels. It thus suppresses inflammations and the formation of exudates. It lowers excitability by acting on the motor system as well as on the sympathetic nerve-endings. It checks all kinds of bleedings because coagulability of the blood depends on the calcium present in the organism. It is on account of this knowledge of the relations that exist between calcium on the one hand and cells and tissues on the other that this therapy has gained an increasing importance.

The efficacy of Calcium preparations for oral administration depends upon various conditions of absorption and elimination. A suitable calcium preparation must be rapidly absorbed by the digestive tract. It must have neither a caustic nor an inflammatory action otherwise it may cause diarrhoea. All the properties and conditions are fully met by Pulmo-Calcium which is a white tasteless powder containing all the active principles of tribasic phosphates, carbonates and other salts of lime and magnesia.

Pulmo-Calcium is mostly absorbed by the small intestines. It forms with the fatty acids of the food soluble calcium soaps which are easily dissolved by the bile. The principal functions of Pulmo-Calcium can be grouped as follows:—

1. It regulates the activity of all the cells of the tissues.

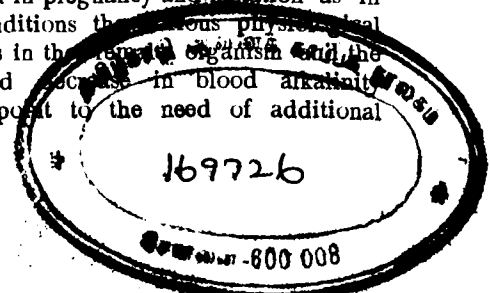
2. It increases phagocytosis.
3. It diminishes the tone of the involuntary muscles of the intestines.
4. It maintains the normal excitability of the nerves and the voluntary muscles.
5. It increases the coagulating power of the blood.
6. It combats and arrests anaphylaxis.
7. It reduces inflammatory processes.

In short the aim of oral calcium therapy by means of Pulmo-Calcium is to remove the balance of electrolytes by a prolonged administration of adequate quantities of calcium in favour of calcium ions. It is therefore very useful and necessary in order to maintain most of the vital functions, whether chemical, dynamical or vegetative.

The indications for the exhibition of Pulmo-Calcium are many and varied and the first that strikes us is Tuberculosis. There is hardly any doubt at present that Pulmo-Calcium exercises a very good influence on some definite symptoms of tubercular infection and the way is thus paved for the cure of the tubercular processes. Although this preparation cannot be considered as a treatment for the primary cause of the tuberculosis of the lungs it greatly helps to bring about rapid cicatrization of the tubercular lesions, brings down the temperature, reduces hyperhidrosis and restores appetite and strength. Progressive exudative processes are as a rule associated with Calcium deficiency and Pulmo-Calcium by supplying the necessary amount of calcium retards these processes. Further, by depositing calcium in the neighbourhood of the affected places it brings about natural isolation of the T. B. Foci. Most of the symptoms in Tubercular infections are due to lack of calcium, intoxication of the visceral nervous system and the resultant disturbance of the equilibrium. By administering Pulmo-Calcium the organism is provided with an adequate supply of Calcium and the disturbed balance of the visceral nervous system is corrected. We have thus been able to improve greatly the symptoms of Tuberculosis by means of Pulmo-Calcium regime.

Pulmo-Calcium can be advantageously indicated in pregnancy and lactation as in these conditions the various physiological processes in the organism and the associated changes in blood alkalinity clearly point to the need of additional

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calcium intake. The growth of the foetus increases the activity of the internal secretory glands and for this more calcium is needed for the female organism. Heart action also which is increased in pregnancy demands more calcium. Besides this the development and the skeletal growth of the foetus demands more calcium. All this extra calcium that is necessary for the gravid organism as well as for the growth of the foetus can be effectively supplied by the daily administration of Pulmo-Calcium during pregnancy.

In addition to this enormous demand of calcium during pregnancy the organism of the mother must also receive its necessary supply of calcium during lactation. Pulmo-Calcium can be given beneficially at this stage also. The infant takes from the female organism about 0.3 grammes of calcium daily. If the mother's organism cannot obtain sufficient calcium from the daily food, the additional quantity required comes from other organs especially bones and teeth. The result is that the mother suffers from caries, osteo-malacia, excitability of the neuro-muscular system and various subtetanic conditions. All these can be easily prevented by the regular intake of Pulmo-Calcium. It is thus evident that a prophylactic and even therapeutic administration of Pulmo-Calcium during pregnancy and lactation is of greatest service.

In nervous debility and neurasthenia improvement in the general condition and at times amelioration and even disappearance of the symptoms have followed the regular use of Pulmo-Calcium for some length of time. These conditions are frequently associated with disturbed metabolism of calcium and phosphorus. Pulmo-Calcium due to its combination determines the adequate functioning of the nerve-cells and reflexes and supplies the proper amount of phosphorus which is an important constituent of the nerve-tissue.

In delayed union of fractures Pulmo-Calcium is of great service as it stimulates osteogenesis and firm union and thus the period of healing is considerably curtailed. In cases of un-united, complicated and compound fractures the conventional adoption of Pulmo-Calcium would undoubtedly hasten healing.

In neglected colds, in urticaria there is usually disorder of the capillary vaso-motor system of the skin and the subcutaneous tissues and this is associated with a deficient concentration of calcium in the blood. Pulmo-Calcium treatment frequently sets matters right by restoring the capillary circulation to normal and raising the calcium level in the blood.

In enteritis and persistent diarrhoea, Pulmo-Calcium has a calming and astringent action on the intestinal tract. Its spasmolytic action is very useful in painful spasms and peristalsis of the intestines due to irritation.

Pulmo-Calcium acts specifically in Bronchitis specially of the chronic type. It helps to arrest inflammations and prevent or absorb exudations and thus bring about a cure.

Another new field opened for Pulmo-Calcium therapy is diseases of the heart. Where formerly digitalis was used alone, Pulmo-Calcium together with digitalis increases the tone of the heart-muscles, reduces pulse rate and lowers blood-pressure. Again Pulmo-Calcium so prepares the nerve-endings of the heart that the action of digitalis is complete and effective.

From what has been said above it is quite evident how useful and serviceable Pulmo-Calcium is therapeutically. This preparation is perfectly tolerated and it does not cause any gastro-enteric disturbances such as nausea, vomiting, anorexia or vaso-motor phenomena. Complete faith and security placed in this product is therefore not undeserved.

Treatment of Sexual Disabilities in Men.

That a great amount of research and investigation of the hormones carried on recently has proved of special importance in the study and treatment of sexual disorders is well-known to every medical man. It is from these investigations that we have learnt that there exists the closest possible connection in the human body between the hormones of the generative glands and those of others in the organism. It is only necessary to mention here the decisive importance of the hormones of the Pituitary in

connection with the sexual function because of the close relation between the hormones of the two glands concerned. It is because of this inter-connection that the therapy with the combination of the various extracts of the endocrine glands is gaining a firmer hold day by day. Medication with the combination of these extracts has therefore come into general use and has also assumed great importance. It has become the most rapid means of effecting reinvigoration and the results obtained by the ingestion of these various essential principles of the different internal secreting glands are more certain, durable and permanent than those obtained by direct grafting in vivo. It is due to their inter-relationship that the combination is the most rational means of increasing the activity of the organism and the sexual functioning dependent thereon. Such a product which combines in it the extracts of the different glands required to bring about normal functioning of the sexual apparatus is Homovir. Its efficacy lies in the fact that it is not only a combination and potentiation of the therapeutic action of the hormones, but of the medical components also.

Homovir contains besides the desiccated extracts of various glands Yohimbine which acts as a stimulant of the internal secretions and exerts a tonic action on the nervous system. As a result of this combination Homovir provides a preparation which makes it possible to treat the cause of various sexual disorders by means of hormone therapy and at the same time to effect rapid tonic action on the nervous system. Homovir does more than merely stimulate the internal secretions. It ensures a full supply in proper proportions of the hormones necessary for adequate functioning of the sexual apparatus. Homovir contains Orchitic extract combined with Thyroid, Suprarenal; Pituitary (whole), prostate and the alkaloid Yohimbine. These desiccated extracts contained in Homovir are not of the ordinary variety, but are properly tested and are absolutely of uniform strength of action. It therefore guarantees an adequate and constant proportion of specific hormones. The Orchitic Extract in it helps to perform the normal genital action while the other extracts influence it well directly or indirectly. Due to this reciprocal action of the endocrine glands the normal function of the

genital organs is brought about, the general state of health is regulated and the normal activity of the nervous system is regained. Thus under the influence of Homovir the genital functions become normal, the heart, the circulatory system and the muscles are strengthened, the general condition is improved, the exhaustion and somnolence etc., disappear, the appetite, digestion and metabolism are also restored to normal.

The chief indications in which Homovir can be successfully used are functional weakness of the male genital organs, sexual neurasthenia and impotence. In these cases besides the psychological causes the endocrine functions are disturbed or disordered. Homovir is the best remedy available for these cases, as by promoting a better supply of internal secretions connected with the sexual functions it exerts local influence on the genital organs. By reason of its being a general tonic Homovir raises the resistance of the nervous system, heightens the reflex excitability and stimulates the spinal centres of the genital organs. It is thus that the functional weakness is overcome. Clinical results have borne out that sexual neurasthenia and impotence due to any cause can be well influenced by Homovir tablets in combination with the ampoules. In addition to the improvement of the sexual function a favourable influence is noticeable in the general condition as well as the patients outlook and disposition.

Homovir has been found of excellent service in the various forms of impotence. By stimulating the internal secretions as well as making good the deficient supply it acts on the spinal centres of the genital organs and also upon the blood-vessels. It is thus a sexual stimulant which acts by correcting and providing the defective endocrine functions and the internal secretions. The nutritional and functional condition is improved by means of hyperaemia brought about. Homovir is a real and rational tonic which restores the enfeebled function and promotes vigour, energy and sense of well-being.

Homovir is an ideal remedy for sexual neurasthenia. This latter is usually the result of sexual abuses and irregularities. By supplying the enfeebled organism with endocrine substances essential for the repair and maintenance of normal functions and by acting as a physiological tonic to the

nervous system it restores sexual, physical and mental vigour. It acts almost specifically in this disease.

In Sterility (Male) it is well-known that the whole defect lies with the endocrine glands specially the testes. If this gland is either diseased or defective the whole normal balance is upset. In order to restore the balance and to correct the abnormality, Homovir in the form of ampoules supplemented by tablets is very beneficial. It corrects the insufficiency of the glands and because of the combination of the various gland extracts it brings about the usual reciprocal action of the internal secretions. As a result the testes with other endocrine glands gradually begin to function normally and sterility is thus corrected.

Homovir can be employed with success in cases of mental depression or exhaustion due to sexual disorders. In these conditions there is always endocrine functional disorder of the genital organs and cessation of the normal nervous stimuli. Under the influence of Homovir the genital functions speedily become normal and due to improvement in the general condition and stimulation of the nervous system the depression and exhaustion disappears. Due to the inclusion of the thyroid and the pituitary the appetite digestion, in fact the general metabolism resumes its normal course.

In the treatment of so-called organic neurosis associated with the disturbances of the sexual function Homovir is found to be very beneficial. Although the psychic factor is of very great importance in these cases, still, medicinal treatment cannot be altogether ignored. Homovir corrects the sexual disturbances and tones up the nervous system. By the presence of Yohimbine in it Homovir brings about dilatation of the blood vessels of the genital organs and when the sexual disorders are thus corrected by this as well as the internal secretions, the nervous system is also strengthened. Homovir is very useful in such neurosis and various forms of psychic disturbances.

In all conditions of weakness produced by bodily and mental exertion as well as psychic depression accompanied by loss of appetite and sleeplessness Homovir renders signal service. It effects local and consti-

tutional improvement. Hypogenitalism, the usual accompaniment of these conditions, is overcome, the nervous system is strengthened and stimulated and improvement is soon evident.

In cases of Eunuchoidism, Homovir increases the general functional capacity, reduces the weight and ameliorates to a great extent this awful condition.

Homovir exercises a favourable influence in all psychic and physical conditions of weakness and exhaustion particularly in the sexual sphere. This it does by restoring the endocrine functions of the entire group of glands required to bring about normal sex functions. With the rapid improvement in the glandular system and the restoration of nerve substances the organism regains all the elements required for tissue-building as energy. There is under the influence of Homovir a return of healthy sexual characteristics as also physical and mental vigour and a well-balanced state of health. As a result of all this, there is so to say, rejuvenation of the whole organism. Patients under the regime of Homovir not only show a reviving and reinvigorating effect of the sexual function, but also regain their lost weight, strength and vigour. Homovir is therefore clinically the most effective and rational therapy that a general practitioner has at his disposal.

The following case of a sexual neurasthenia fully demonstrates the efficacy of Homovir.

A young man of 30 sought my advice sometime in January last for sexual incompetence. He gave history of sexual abuses during his early twenties as well as Gonorrhoea three years back. When he came to me I could not find any trace of the latter disease. He told me he was getting worse day by day. I found that there was profound depression. He was very apathetic and was not able to do steady work. There was insomnia of a neurasthenic type which did not yield to any medication. Depressed outlook, incapacity for work and a feeling of general fatigue were the symptoms that worried him too much. I started him on Homovir combined with Hypercytol injections. These were given alternately. This treatment was supplemented by the tablets, six of which were taken by him per day. After

twelve injections of each, complete rest of one week was given. Another interval of one week's rest was advised before further treatment was commenced. After this he was kept only on Homovir tablets. The result of this prolonged treatment not only restored his sexual function to the normal state, but cured him of all his psychoneurotic troubles. He gets very good sleep and has a good appetite. He is better also from the nervous point of view, and does not feel any fatigue. The general condition has improved remarkably and the mental depression and the physical fatigue have entirely disappeared. In fact he is keeping admirably well at present.

Relapsing fever and its treatment.

Relapsing fever is an acute infectious disease due to *Spirochaeta Recurrentis* or Duttoni characterised by hyperpyrexia cloudy swelling of the heart, liver or kidneys or haemorrhagic infarction in the viscera and enlargement of the spleen. The attacks have a tendency to recur, two to three or as many as eleven relapses being recorded.

The disease is due to infection with either the *Spirochaeta Recurrentis* or Duttoni. Mostly young males between 12 and 25 are likely to be attacked. Faulty hygienic surroundings is a great causative factor specially when an epidemic is prevailing. The exact mode of infection is not known although it is said that it takes place through the bites of bed-bugs or lice.

After the period of incubation which extends from four to ten days there is a sudden rise of temperature with a distinct rigor. Severe headache is complained of and there are also pains in the back and limbs with extreme prostration and giddiness. Anorexia, nausea, vomiting and inordinate thirst—all these are very common. Blood may be present in the vomit and diarrhoea is usually the rule. The temperature rises somewhat rapidly reaching from 102° to even 106°. It is of the continued type lasting for six to seven days and ends in crisis. The attack is succeeded by another, which may be of shorter duration or milder in character. As many as four or five exacerbations may occur.

As regards the physical signs some peculiar cutaneous eruptions are occasionally seen but they are by no means characteristic of the disease. The tongue is at first moist and coated with yellowish fur but later becomes dry, brown and fissured. Sordes collect on the teeth and the gums or the tongue is sometimes found covered with numerous ulcers. The pharynx as well as the tonsils or in the majority of cases congested. The liver and the spleen are moderately enlarged and there is often abdominal pain and tenderness. The heart is full and strong and the pulse may vary from 120 to 140. It is not in exact proportion to the rise of temperature. Lungs usually remain clear, but bronchitis, lobar pneumonia or hypostatic congestion may be occasional complications. Jaundice is very common and epistaxis and vomiting of blood may at times be present. Delirium is very rare and if at all present is of the noisy kind. The urine is high coloured. Its specific gravity is also high and it may show a trace of albumin. When jaundice is present bile is present in the urine.

Spirochaeta will be found in the blood during the febrile period.

Diagnosis is comparatively easy. There is either the history of the epidemic or of the patient having resided in the tropics. The sudden rise of temperature, its continuation for a week and its abrupt termination on the seventh day are also characteristic of the disease. Again the typical intervals which separate the febrile periods are present only in Relapsing Fever. Examination of the blood taken during fever and detection of the *Spirillum* in it confirms the diagnosis.

The prognosis is very good. In dissipated and debilitated subjects it may be unfavourable. A fatal termination is seldom seen unless complicated by pneumonia or hypostatic congestion of the lungs.

As regards prophylactic measures they should be aimed at the destruction of bed-bugs and body-lice and their eggs. Avoidance of insanitary dwellings is also necessary.

The first essential in the treatment is complete rest with careful nursing and dieting specially after the crisis when the

patient has a ravenous appetite. Medicinal line of treatment consists in administering some form of arsenicals as Relapsing Fever is a Spirochaetal disease. The best form of arsenical that is available is Sulfarsenol by means of which the treatment can be carried out with ease and efficacy. One dose of 36 cgms or 42 cgms in an adult according to the needs of the case is usually sufficient to bring down the temperature and to cause destruction of the Spirochaetes in the blood and to prevent relapses. Sulfarsenol can be administered safely in the subcutaneous region with the help of Arseno-Solvent, thus avoiding the trouble and risks of intravenous injections. Some of the cases resistant to other arsenicals have been found to yield very well to Sulfarsenol. The best time to inject this is when the temperature is on the rise directly the diagnosis is made. One injection is usually enough to bring down the temperature. It should by no means be given during the apyretic period as it would not prevent recurrences then. If for some reason or other Sulfarsenol is not administered when the first attack is on, one should wait till the first relapse and then it should be injected only when there is a rise in temperature. It should also not be given when the crisis is imminent as there is a grave risk of setting up a reaction resulting from the intense destruction of the Spirochaetes and the liberation of the toxins with the resultant aggravation of symptoms. A fatal collapse may even ensue due to all this. Sulfarsenol should best be injected during the pyrexial period as soon as the diagnosis of Relapsing Fever is made.

Albuminuria is no bar to the treatment in this disease.

The efficacy of Sulfarsenol in this disease is equal if not superior to that of the arsenobenzenes. Further it offers certain remarkable advantages which facilitate the work of the physician in this affection. With the help of the Arseno-Solvent it can be injected beneath the skin and without it into the muscles. This is a unique advantage as the difficulties technical or otherwise, of the intravenous injections are real, especially in a patient who is either restless or delirious. In all cases the injection is completely and absolutely painless. Another advantage that it possesses over other arsenicals is its local as well as general tolerance which is absolutely perfect. Unlike other arseno-benzenes it does not render blood incoagulable nor does it coagulate the albuminoid bodies in the cells. Sulfarsenol being a product of a clear and definite composition offers even with Arseno-Solvent a solution constant in composition it has guaranteed effects and it is of regular tolerance. Further, the arsenic in Sulfarsenol is of that quantity, which despite its rapid elimination, is capable of bringing about phenomena of arsenical saturation. Albuminuria is no contra-indication to its use in this disease. Since it is the arsenical best tolerated, its use in Relapsing Fever is very beneficial. In brief as Sulfarsenol is characterised by remarkable efficacy, high degree of tolerance, rapidity of action and above all easy administration it is the best arsenical that can be employed in this disease.

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Notes on Treatment of Diseases.

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

Obesity: Non Specific Protein injection as "Well's Peptone" and Thyroid feeding are found effective while other treatment failed.

Rest in bed is essential; exercise is not only bad but makes the condition worse. The temperature of the body is to be raised by means of hot pack. Thyroid Gland is better with Pituitrin and Iodine, in the form such as—Elixir Thyroid mms. 10 (gr. 1), Elixir Hypophysin dr. 1 (gr. 1½), Colloidal Iodine dr. 1 in Chloroform water. Pituitrin to be effective should be given as whole gland.

Iodobesin is a rational combination of endocrine substances specially indicated for the treatment of obesity. It contains Hepatic, Pituitary, Orchitic, Ovarian, Thyroid and suprarenal Extracts suitably combined with Iodalbumen.

Serum of horse immunised against diptheria is good as it acts by causing fever and raising temperature.

If there is kidney disease, salt free diet and Novasural every fourth day and afterwards Salyrgan should be given. The good results may be continued by the administration of Lipolysin and then Thyroid and Pituitary.

Onychia: For the removal of nail, apply Fehling's solution on the nail, protecting the surrounding tissue with vaseline and apply a rubber finger sheath for twelve to twenty-four hours and then the nail can be shaped. Afterwards apply White Field's ointment to the matrix. (5% Benzoated laid added on to 3% Salicylic acid), Apply 6% of Potassium Iodide with equal parts of liq. Potas and alcohol, or 50% Pyrogallol acid in Olive Oil. Then wash with 0.2 to 1% solution of Bichloride of Mercury, and afterwards apply Ammoniated Mercury ointment.

Orchitis: Guaiacol mms. 15, Glycerine mms. 45 or Guaiacol dr. 1, Lanoline drs. 4, to be painted everyday. Compresses of saturated solution of Magnesium Sulphate are beneficial. A strong solution of Silver

Nitrate (grs. 60 to one ounce) may also be painted to the scrotum.

Osteomalacia: Codliver Oil or Sodium Morrhuate by injection and Collosol Calcium by injection are said to have very good effect in the treatment. Hypodermic injection of Adrenalin one 1 c.c. of 1 in 1000 solution and also Infundibulin have been tried with success. Calcium Phosphate in 15 to 30 grs. doses has also been tried.

Otitis Media: In purulent cases Subgalate of Bismuth is good. Syringing, if done at all should be gentle. The ear should be cleaned with cotton swabs soaked in alcohol.

In the early stage instillation of a few drops of Adrenalin solution 1 in 1000 or packing cotton soaked in it prevents the formation of pus.

Hydrogen Peroxide should not be used in cases of inflammation of the external ear. After gently syringing the ear, B.I.P.P. Ointment consisting of Bismuth 1 part, Iodoform 2 parts, Petrolatum 1 part should be used.

for Otagia instill 10 drops of a solution made up of Choloral Hydras, Phenol, Camphor each grs. 20, Liquid Iodex 1 Oz., Anaesthesin 1.5 parts, Olive oil 50 parts or Anaesthesin 4 parts, Alcohol 25 parts, Glycerine 25 parts, may also be used for the same purpose.

Otorrhoea: Syringe ear gently with warm boric lotion; then drop in Hydrogen Peroxide. Later, instill into the ear ½% aqueous solution of Acroflavine and plug the ear. The meatus may be syringed with ½% aqueous solution of Acroflavine, then cleaned with Hydrogen Peroxide and afterwards pure Acroflavine dropped into the ear. Instillation of Ether after cleaning and drying the ear is also recommended. 2% solution of Mercurochrome after syringing the ear is also advised. Calot's solution is good in cases where Mastoid involvement is ruled out. The solution consists of Guaiacol gram 1, Creasote grams 5, Iodoform grams 10, Sulphuric Ether Grams 30, Olive Oil add grams 20. The Meatus is thoroughly cleaned, granulations removed after application of Cocaine and Adrenalin. The meatus is filled with absolute alcohol for 10 minutes and then dried. Later, a powder containing gr. 1 of Iodine and 100 grains of Boric Acid is insufflated into the

meatus as to fill the cavity fully. The patient is advised not to touch the ear except to mop out any discharge which should be done with cottonwool. This process is to be repeated at intervals of 4 days, then once a week; later the treatment is repeated without cleaning with alcohol. Complete cure can be expected with this treatment in a few weeks.

Oxaluria: Potas Citras and Lemon Juice are said to dissolve the oxylates. Acid Sodium Phosphate in doses up to 1 ounce diluted in 100 ounces of distilled water is very effective in reducing the size of Oxalate Calculus.

Ozena: There is no better remedy than Ichthyol. After washing the nasal cavities with 5% solution of Ichthyol, they may be painted with pure Ichthyol or plugged with cottonwool saturated with 20 to 30 per cent solution of Ichthyol.

Oriental Sore: Berberine Sulphate 1 to 2 per cent solution of the acid salt should be injected in and round the sore and Antimony Tartrate or Emetine Hydrochloric injections given intravenously.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Abdominal Pain in Children.

This symptom is very common in pediatric practice. On analysing these cases one can divide them into two groups; those in which the disease is evident and pain is one of the many symptoms and those in which no disease is evident. Diseases that might cause this are those of the intestines, the stomach, the lung, the pleura, the liver, kidney and the bladder. Infectious diseases like measles, scarlatina, influenza, and typhoid may cause abdominal pain. To the other group belong cases in which it is not possible to find definite evidence of any disease. These children are not in bed; they have no fever and if they have it is only a low grade one; but this is very rare. The pain comes on at intervals which may be of varying durations and sometimes it may come a number of times during the day. The duration of the pain is short, either a few seconds or minutes, barely longer. Some children have very severe pain. They suffer violently, become pale and cry. They

locate their pain either in the region of the umbilicus, or above the umbilicus and occasionally below the umbilicus. The moment the pain passes away they carry on with their usual games. This pain has no connection whatever with the food. Children who suffer from anaemia or from constipation suffer though this symptom may be found in children who are healthy and good-looking. Amongst some of these one is able to find after careful prolonged search certain anatomical conditions removal of which causes the disappearance of the pain. Sometimes one cannot find any cause for the pains. They come and go without one knowing why, even after they have persisted for some months or years. Considering the former group, chronic appendicitis is one of the common causes insisted on by the surgeon. These cases are described as cases of appendicular colic where a foreign body either in the form of a seed or a worm having entered the appendix, is not expelled in spite of the peristalsis and these attempts at expulsion give rise to the pain which is repeated. Some cases of pain appear when there is an adherent appendix or when the appendix is displaced. Some surgeons ascribed this to a mobile caecum to diverticulum of Meckel and different pathological conditions. Drachter reports a number of cases of epigastric and supraumbilical hernias which have been the cause of this pain. Others consider that the early stages of the formation of ventral hernia may give rise to similar pain. In young infants one meets with intersusception. This starts with severe pains and other symptoms. Some authors consider that these repeated pains in infants are due to temporary invaginations which resolve by themselves. Next to appendicitis the cause of such pains is tuberculous mesenteric glands. This condition occurs gradually and at the beginning there may be no other symptoms except dull pains in the abdomen round about the umbilicus. Worms is another cause of abdominal pain. Many parents bring their children who have passed worms for pain in the abdomen. After giving a vermifuge the patient may get better, some don't. It has been found by the author that in the majority of cases where he has found worms there have been abdominal pains as well. Professor Ylppo has found that in children that suffer from these vague pains there are anomalies of the

stomach and its functions as demonstrated by the radiograph. In others there is gastrotosis, and he also found hypo-acidity. Another cause of pain in the abdomen may be a mobile kidney or renal colic. A mobile kidney is rare in children. One sometimes meets it in children between the ages of 6 and 14 years and more particularly among the girls. Biliary colic may also be the cause of severe pain; on the whole it is fortunately very rare. Then there is another where after careful examination no cause can be found but a number of children get well after treatment in the hospital, where an examination and perhaps a little local application has a psychological effect on the patient and they leave the hospital quite well. This last group is probably a group of neuropaths in whom the abdominal pain is brought about by intestinal spasms and of very short duration which are generally passed unnoticed by healthy children.

[A. Lnus, *Archives de Medicine des Enfants*,
Page 345 January, 1834.]

Syphilis in Pregnancy

The monthly bulletin issued by the U.S. Public Health Service for March contains an exhaustive article on "Syphilis in Pregnancy." Five clinics contributed material for this painstaking research work. The total number of patients studied was 3,817. The results of these investigations are given in considerable detail. We can only find room for a few excerpts:

Seventy-eight per cent. of pregnant syphilitic mothers in whom treatment was instituted before the fifth month bore living, apparently non-syphilitic children as contrasted with only 61 per cent when treatment was started later. Moreover, there were more than three times as many syphilitic children in the latter group as in the former.

Adequate treatment in the form of 10 injections of an arsenical and 10 injections of a heavy metal during the pregnancy period insured living, apparently non-syphilitic children in 91 per cent of the cases when the treatment was begun before the fifth month. When much of the arsphenamine and little of the heavy metal was used 85 per cent. of the mothers bore living, apparently non-syphilitic children as did 75 per

cent. to whom little of the arsphenamine and much of the heavy metal was administered. Even with inadequate treatment (little of both arsphenamine and heavy metal) 67 per cent. more living, apparently non-syphilitic children if treatment was begun before the fifth month of pregnancy.

When treatment was started after the fifth month of pregnancy, with little of both preparations, only 62 per cent. of the mothers bore living, apparently non-syphilitic children. Only 5 per cent. bore syphilitic children after the institution of even little arsenical, little heavy metal when treatment was begun early, as against four times as many when treatment was begun after the fifth month of pregnancy. Much arsenical and little heavy metal treatment instituted early insured the children being born alive and apparently non-syphilitic in 85 per cent. of the cases, while with the treatment begun after the fifth month this percentage dropped to 55. Moreover, with this type of early treatment only 5 per cent. bore living, syphilitic children and eight times as many when treatment was begun after the fifth month.

(*The Medical Times London*, June, '34.)

News and Comments.

Medical Council affairs: We draw the attention of our readers to the statement made by Dr. B. C. Roy, Member of the Council and the Executive Committee of the Indian Medical Council published in the Correspondence columns. Dr. Roy states, that the Government managed "to induce the recalcitrant members.....to swallow their previous decision," in connection with the appointment of Dr. MacRae as one of the Inspectors. The more we think of these affairs the more are we convinced that the Indian Medical Council has served no other purpose than that of an apple of discord. We reiterate what we have said in our Editorial this month and many times before, that the Indian Medical Council serves no good purpose and the only object as proclaimed by the Government of India which this council is supposed to serve is the improvement of the standard of education of the graduates, which could be most satisfactorily and with no additional expenditure to the State, can be accomplished through the existing Provincial Medical

Councils. We trust the profession will strengthen the hands of Dr. B. C. Roy in the struggle which he has undertaken with Dr. Ansari as his Captain to rid the country of many ills of which the Indian Medical Act is one.

Poisons' Act in U. P.: The Government of United Provinces have recently added some amendments to the rules framed under Poisons' Act XII of 1919. The poisons named in the schedule are Aconite, Atropine, Carbolic Acid, Chloral Hydras, Digitalis, Strophanthus, Sulphanol etc., Though the Registered Practitioners have been exempted from taking a licence for stocking and sale of the poisons mentioned in the amendments, they are required to keep a daily account of the stock and sale of as many as 250 preparations. The hardship and the attendant worry to which the practitioners are subject to may be easily imagined. On account of the amendments, the Medical Profession in U. P. has been forced to agitate in all possible ways. Almost all the Medical Associations in U. P. have made representations to the Government and we are glad to learn that the U. P. Medical Council did take up the cause of the aggrieved Medical Profession and informed the Government that the Registered Medical Practitioners should not be required to keep an account of the stock and sale of scheduled poisons. At the March session of the U. P. Legislative Council this subject was one of the items of interpellations and the Government stated that the amendments were necessary, "to prevent unqualified practitioners from using poisonous drugs the therapeutic action, doses and uses of which are not known to them, to minimize the risk of poisons and narcotics getting into the hands of criminals and drug addicts, and to standardise the varying practice in regard to poisons' licenses in the case of medical practitioners now in vogue in districts.....". But the actual wording and working of the amendments have gone far beyond the object and purpose for which the amendments were passed by the Government. It is too much for the Government to expect a qualified and registered practitioner to maintain a register to note down the quantity of each of the poisonous drugs with their preparations which as stated above roughly come to about 250. The practitioner is required in addition to

note down his signature in full and also the addresses of the patients to whom the prescription containing poison is prescribed. The labour and time involved in this desk work would necessarily interfere with the legitimate work expected of the practitioner in curing and relieving human ills. It is very unfortunate that the Inspector-General of Civil Hospitals of the United Provinces who is the chief adviser to the Government in all matters concerning the profession and who is also the nominated President of the U. P. Medical Council, was ignorant of the fact, that soon after the Medical Councils came into existence, the Provincial Medical Councils in India have by a resolution approved the Code of Medical Ethics published by the General Medical Council Great Britain and that there is a clause in this Code about the sale of poisonous drugs and any registered practitioner found abusing his rights in the sale of poisons, is liable to have his name erased from the Register. The Inspector-General of Civil Hospitals instead of sympathising with his brethren in the profession seemed to have said on the floor of the U. P. Legislative Council that in England, the rules regarding the sale of poisons by medical men were more drastic and mentioned about the clause referred to by us in the Code of Medical Ethics as if such a clause did not appear in the Code of Medical Ethics published by the Medical Council of the United Provinces. We wish the Meerut Medical Association which has rightly taken a lead in this matter affecting the honour and prestige of the medical profession, would point out to the Inspector-General, the existence in the Code of Medical Ethics published by the U. P. Medical Council, of the drastic measure referred to by him in his speech on the floor of the Legislative Council and request him to point out to the Government that there is no necessity to hand over the members of the profession to the Excise Department when he himself with the help of the Medical Council, can deal with any registered practitioner in case the practitioner abuses his rights and privileges as a registered practitioner with regard to the sale of poisonous drugs. We trust that the other local Governments would not copy the example of the U. P. Government in unnecessarily humiliating the Medical Profession on imaginary grounds.

Primary F. R. C. S. Examination in India: It is said that about two years ago when Major-General Sprawson was the Surgeon-General with the Government of Madras, he and Col. Anderson, the then Principal of the Vizagapatam Medical College made representations to the authorities of the Royal College of Surgeons of England with a view to have the Primary Examination for F. R. C. S. in India. In response to this representation the Secretary of the Royal College of Surgeons recently sent a cable to Dr. MacRae, Secretary, the Indian Medical Council that the authorities were willing to hold the primary examination in India in the 3rd week of December this year, in case there were 30 candidates who should each pay Rs. 360 as the examination fee. We learn that it is settled to hold the examination in Madras and that the examination commences on 27th December. Students and graduates who wish to appear for this examination have been asked to apply to Dr. F. MacRae c/o The Director-General, Indian Medical Service, Gorton Castle, Simla. The members of the medical profession and medical students who are eligible to enjoy the facility afforded to them, should be thankful to the authorities of the Royal College of Surgeons of England, and specially to Major-General Sprawson and Col. Anderson who have been mainly responsible to persuade the authorities of the Royal College of Surgeons to show India the same concession regarding the Primary F. R. C. S. Examination as they have been allowing the Dominions of Australia and Canada. From time immemorial, the authorities in charge of Medical Education in Great Britain have always been sympathetic to the aspirations of the Indians. The Medical Licentiates were allowed from the very beginning of their existence, to qualify themselves for any registerable diploma in Great Britain within a period of 2 years extra studies, whereas, they were refused the same concession in the country of their birth. The Madras University which has been allowing the Medical Licentiates to qualify for the M. B. B. S., degree, did so with the spirit of a stepmother and even this step-motherly affection is wanting in other Universities so far, in spite of agitation. We agree with one of our local contemporaries that the concessions allowed to Indians in holding the Primary

F. R. C. S. Examination is "a landmark in the history of medical education" in this country but we fail to understand how the Indian Medical Council could take credit for this achievement. On the other hand the accidental coincidence of the granting of this concession by the Royal College of Surgeons and the deputation of Dr. MacRae to act for this body is viewed by the profession with mixed feelings.

Honorary Medical Officers: In response to a circular from the Office of the Surgeon-General with the Government of Madras, the Superintendents and Civil Surgeons in charge of hospitals in the city and mufussal have submitted a list of the medical institutions where there is scope for honorary medical service. This list has been published in our Correspondence Columns for the information of our readers. The list comprises of almost all medical institutions in the city of Madras and the Head Quarters Hospitals of seventeen important districts including King George Hospital Vizagapatam. It is noteworthy that the Vizagapatam Medical College could accommodate one junior demonstrator in Bacteriology. It is also a piece of good news that the Government intend appointing a honorary surgeon for the new Surgical Block recently opened in that institution. There is also a vacancy for the post of a honorary ophthalmic surgeon at the Madura Head Quarters Hospital, the honorary ophthalmic surgeon working in that institution having resigned his appointment. We have been repeatedly mentioning in these columns and elsewhere that though the Madras Government has materially increased the number of honorary appointments they have not consistently changed their policy with regard to the medical administration, and brought into existence another department of honoraries under the control of the Surgeon-General. So long as the honorary medical officers are kept under the control of the paid medical officers there will come into play the superiority and inferiority complex a very grave disease which if not eradicated early is likely to hamper the healthy growth of honorary system of medical relief. The recent history at the Madura Head Quarters Hospital where the honorary ophthalmic surgeon had to resign his appointment should convince the Government of the desirability of changing their medical

administration policy if they are really anxious to work out the Honorary Medical Scheme for the benefit of the public and of the medical profession. It is said that a patient attending the Eye Clinic at the Madura Government Hospital complained to the Superintendent making some serious allegations against the honorary surgeon. The Superintendent of the hospital had to conduct an enquiry which was naturally resented by the honorary and even before the enquiry reached the final stage of a report to the Surgeon-General, the honorary resigned. The perusal of the rules published by the Government regarding the appointment of honorary medical officers in Government hospitals and the service conditions laid down in that order (Vide G. O. No. 1610 P. H. 29th July '32) would convince all right thinking people that neither the patient who made the complaint against the honorary ophthalmic surgeon nor the Superintendent of the Madura Hospital is to blame. The honorary did a right thing in valuing his prestige and status more than his position as a honorary. We referred in these columns some time ago about a report made by the Superintendent General Hospital to the Surgeon-General about a honorary medical officer working in the General Hospital regarding the opinion of the condition of a patient under the direct charge of the honorary. The rules lay down that honoraries should not interfere with other patients in a hospital excepting those under their charge. But nothing is mentioned in the rules preventing the Superintendent of a hospital interfering with a patient under the charge of an honorary. The Office of the Surgeon-General may have in the files many such reports from the General Hospital and perhaps from other hospitals as well. It is high time for the Government to make necessary changes regarding hospital administration consistent with the honorary system of medical relief. We did suggest the changes and shall revert to the subject again in the near future and remind the Government w at they are.

Justice at Last: Our readers might remember that in these columns under the caption "Is it exploitations" we commented on the action of the Kistna District Board in having closed the subsidised dispensary at Gollapalli and opened

a regular dispensary at the instance of the then existing Nuzvid Taluk Board. We are glad to learn that the subsidised practitioner at Gollapalli put in a straight fight and appealed to the Government and the order of the Government disapproving the action of the Kistna District Board has been published in the Correspondence Columns. It is reported that the existing subsidised practitioner was threatened by the interested party with violence and the local police had to interfere. Such and similar devices to frighten and send away the existing practitioner being of no avail, the Vice-President of the Kistna District Board who seems to be very keen in sending the subsidised practitioner out of Gollapalli, seemed to have sent for this practitioner after the receipt of the G.O., and suggested a compromise referred to in the G.O., i.e., in case the District Board agrees to appoint the subsidised practitioner as the medical officer of the regular dispensary, and the latter consents to this proposal, the District Board may convert the subsidised dispensary as a regular one. This compromise appears to us like a trap to capture the subsidised practitioner. The moment this practitioner gets into District Board service, he cannot but obey the orders of the President or Vice-President and it is very likely that he will be transferred from Gollapalli, and later perhaps sent out of service on some plea or other which is all that is required by those who are interested in opening a regular dispensary at Gollapalli and the person whom the interested party wished to have at Gollapalli will be put in charge of the regular dispensary. It costs a local body all told only a thousand rupees or very near this amount for one year to run a subsidised dispensary whereas, a regular dispensary will cost on an average Rs. 4,000. To this has to be added the contribution towards pension or provident fund. So a local body if it be prudent and minds the welfare of those entrusted to their care, should prefer to run subsidised dispensaries instead of regular ones, as with the cost required for a regular dispensary the local body can run four subsidised dispensaries. A District Board, is a more advanced democratic institution than a Taluk Board, we trust the enlightened members of the District Board, Kistna will give their serious consideration to this matter and counteract the

evil influence of interested members amongst them and run the Gollapalli dispensary as a subsidised one under the charge of the existing subsidised practitioner who, we are told is very popular amongst the village folk. In that case the extra amount set apart to convert the subsidised dispensary at Gollapalli into a regular one, may be spent most advantageously in starting three or four more subsidised dispensaries in Kistna District.

Aswini Clinic: We learn that The Aswini Clinic Calicut whose prospectus we published in the Correspondence Columns last May, and about which we commented in these columns is to be formally opened by Mr. G. K. Devadhar M.A., C.I.E., President, Servants of India Society, in the third week of August. We are glad to learn that the organizers have been able to secure the services of Rao Bahadur Dr. P. K. Warriar retired civil surgeon and till recently personal assistant to the Surgeon-General with the Government of Madras as the consulting medical officer to the clinic. We trust that under the guidance of two eminent retired civil surgeons, Rao Bahadur Dr. T.M.K. Nedungadi, the President of the clinic and Rao Bahadur Dr. P. K. Warriar, the consulting medical officer, the clinic will visualise the hopes expressed by us in these columns a couple of months ago.

Eye Hospital: Hospitalisation and not Shop-keeping should be the ideal of the members of the medical profession and it is really a very good sign of the times that young enthusiastic private practitioners in this province have been realising such an ideal. We learn that a private Eye Hospital will be opened on the 2nd August at Trichinopoly under the joint partnership of Drs. G. Joseph Gnanadickam and O. V. Muthukrishnan. Rao Bahadur Mr. C. J. Paul B.A. the Collector of Trichinopoly would conduct the opening ceremony of the new institution. Dr. Gnanadickam, soon after he qualified himself as a doctor has been working at the Sweedish Mission Eye Hospital, Tirupattur, first as an assistant and later as the Chief Medical Officer of that institution. He has had exceptional opportunities to gain experience and knowledge and has made a mark as an Ophthalmic Surgeon. We are sure that under his management the private eye hospital to be newly started by him and his partner Dr. O. V. Muthukrishnan will grow a very

popular home of service for the treatment of the eyes. We wish both the doctors good luck and a long life of usefulness.

Obituary: We are extremely sorry to announce the sad news of the sudden passing away of Lt. Col. N. M. Mehta, I. M. S., District Medical Officer Trichinopoly on 19-7-34 at 11 P. M. Lt. Col. Mehta was recruited in the Indian Medical Service in 1914 and was placed permanently under the Government of Madras in 1924, his first appointment being in the General Hospital as the Resident Medical Officer. After a few months he was posted as the District Medical Officer, Guntur and then for a short time as the Civil Surgeon at Cochin and later at Coonoor where he served till 1927. Afterwards he was transferred as the District Medical Officer Cuddalore for a short time. In 1928, he was posted to Trichinopoly as the District Medical Officer, where he served till 1930, when he was transferred to S. Kanara as the District Medical Officer. In 1932, he was transferred to Coonoor as Civil Surgeon and from that station he came back to Trichinopoly as the District Medical Officer which position he occupied till his sad end. Col. Mehta being of a very amiable disposition was very popular wherever he went. He had very high ideals and was appreciated and respected by those who knew him. He was a well wisher of the Medical Practitioner from its very inception, and was very particular to send us his good wishes every year which served to encourage us a good deal. He was a very loyal servant of the Government and as good a nationalist. We offer our heartfelt condolence and sympathies to his only son Master Mehta now at Lahore.

Madras Medical Council Election: Election proceedings are now in full swing. I had to contest against five rivals in 1929 and the electorate returned me with an overwhelming majority. It is probable that I have to contend against as many or perhaps more and it is equally probable that a few disappointed old rivals of mine may appear in the field or set up others to do so. The duty of the electorate towards me as a tried friend is clear. I appeal to them to be vigilant and return me to the council to continue my humble disinterested work for them and to the medical profession as a whole.

V. RAMA KAMATH,

Correspondence Reports, Etc.,

A Letter Addressed to "The Statesman" Calcutta

BY

Dr. K. S. Ray,

MEMBER INDIAN MEDICAL COUNCIL.

Sir,

With reference to your editorial of July 4th, (Dak Edition) dwelling on the works of the Indian Medical Council at their last two meetings, your readers would undoubtedly be interested to learn something of the reverse side of the medal.

In the first place, I will like to make it clear that in the controversy as to the three Inspectors no attack was made by any member on Dr. F. Macrae personally. He was an absolutely unknown figure to India as late as four months ago. The objection centred on the appointment of the Secretary of the Council, whoever he may be, as one of the three Inspectors. Such a dual appointment is not countenanced by the General Medical Council or any other medical body and it has serious objections which are not overcome by the plea of financial expediency. It will be recalled how a few years back the Legislative Assembly indignantly rejected the demand for the salary of Col. Needham who, it was proposed, should act in India as a Commissioner for the G. M. C. to inspect the standards of medical education in this country and nothing will convince us that the G. M. C.'s withdrawal of recognition of Indian medical degrees was not reprisal for the action of the Legislative Assembly. It would now seem that Government has circumvented the Legislative Assembly by a subterfuge and given us a Macrae for Needham. It is the manner in which this has been accomplished that so reprehensible. If the framers of the Indian Medical Council Bill had so much as suggested that the offices of the Secretary and Inspector could have been combined, I doubt if the Bill would have had any chance of passing through the Assembly. Suspicion of the Government's real intention would immediately have been aroused. As it is we feel that a nominee of the G. M. C. has been forced upon us and the facts in regard to Dr. Macrae's appointment

been thus out. No applications were called for, he was accepted by Government at the recommendation of the President of the G. M. C.

In regard to the resolution passed at the first meeting of the Council, to the effect that the Secretary should not be entitled to an Inspectorship, this was certainly not carried out by a small majority, the actual figures are fifteen for and nine against. Of the twentyfive members who attended the meeting 12 were nominated and 13 elected. So that the majority included some nominated members. I may mention that two of the nominated members spoke at length against the Government's proposal, one of whom declaring that since the Government did not take the Council into their confidence in selecting and appointing the Secretary the Council could hardly be expected to agree to the same person being appointed one of the Inspectors.

The fact is that the reversal motion was brought forward in spite of a regulation to the effect that similar motion could not be brought before the Council within a period of one year and the other most extraordinary fact is the metamorphosis that came over the views of certain nominated (and even elected) members. The question being asked in Medical circles is "What influence was brought to bear on these members to cause them to swallow their own words?" If regard is had to the composition of the Council, it will be seen that the elected bloc is always at a disadvantage and Government can always depend on the nominated bloc and a few stray elected members to pull them through. I will not touch on the propriety of the President of the Council taking part in the voting and also in his interpretation of the rules.

The composition of the Indian Medical Council reveals it as a mere subordinate department of the Government. We did not think its real character would be so quickly and strikingly revealed. The "objectors" may be a minority, but they have the satisfaction of knowing that they have the entire confidence of the thousands of the Indian medical profession.

Medical Council Affairs.

DR. B. C. ROY'S STATEMENT.

Dr. B. C. Roy, member of the Council and the Executive Committee, Indian Medical Council, in the course of a statement says:—

The Indian Medical Council Bill was passed by the Assembly after they rejected the proposal of appointing Col. Needham, the nominee of the General Medical Council as an Inspector. What led the Assembly to take this step is well-known and does not require recapitulation.

In the Bill before the Assembly or at the Select Committee no proposition was included or suggested that the Secretary should also be an inspector. A provision was made in the Bill, however, that for the first four years the Governor-General will appoint the Secretary. Why did not the Government place before the Select Committee or the Assembly their proposals that the appointed officer should combine the duties of an Inspector and a Secretary?

The Government asked the President of the British General Medical Council to nominate a person who would combine the duties of an Inspector and a Secretary and get a salary of Rs. 2,500. Why did the Government take this unusual step?

Having made this appointment, a proposition was put before the Indian Medical Council on the 9th of March that this Secretary should be appointed an Inspector. By 15 votes against 9 the proposal was rejected. It cannot be suggested that these 15 members were not the "rational and responsible elements in the Council." In their "unfettered" judgment they passed a resolution denying the privileges of inspection to the Secretary appointed by the Governor-General-in-Council. Why did they do so?

In January last, the Governor-General-in-Council, under powers given to them by the Act, promulgated certain regulations. Section 4 of this regulation lays down that no "motion" can be taken up by the Council which substantially raises the same question which had already been discussed in the Council within a year previously. This regulation—a wholesome regulation—was not promulgated by "politically-minded" notorious people, but by the Governor-

General-in-Council. Why was this regulation broken and who did it?

"POLITICAL MANOEUVRE"

Government received a shock to find that 15 respectable members of the Council refused to fall in with the views of the Governor-General-in-Council who arranged that the Secretary should not act as an Inspector. Messages were sent to all Provincial Governments by the authorities of the Indian Medical Council to induce the recalcitrant members, some of whom were nominated by Government, and others though not elected were yet amenable to Government pressure to swallow their previous decision and meet again in June within "three months" to rescind their former resolution. Why were the Government so anxious to break their own regulations? Would it have made the "heavens" fall if the decision of the Indian Medical Council arrived at in March, had been followed to prevail a little while longer? But the Government, for reasons best known to themselves thought otherwise and asked the nominated President to call a meeting of the Council in June in Simla. Why?

After a prolonged discussion, as Dr. Deshmukh mentioned in his statement, Sir Fazl-i-Hussain at an informal meeting held on the 11th June agreed to a compromise. Unfortunately his experts conscious of the strength of their position, refused to agree to the compromise. Why?

Just before the meeting of the Council, on the 12th of June, we were told that the proposal for a compromise made by me at the meeting of the Council to adjourn the meeting for half an hour to find out if there was any way out of the impasse was turned down by the President and one of the members went to the length of stating that even "if the regulations had been technically violated, since the Government wanted the decision to be changed, they had no business to question such an order from the Government." I do not say that the Government is responsible for such effusions on the part of members, but I do assert that before this meeting of the 12th June, the Government brought to bear sufficient pressure on some of the members, forcing them to recant their previous decision. No new facts were placed before the meeting which would explain such volte

face. If this is not a political manoeuvre, I do not know what it is. Those of us who objected to the procedure adopted, had nothing to say for or against on the ground that it was done at the back of the Assembly, that it had no precedent and because in order to achieve their objective the Government adopted methods open to objection. It was a clear case of interference on the part of the Government with the working of the All-India Council. We are not prepared to tolerate such action.

List of Hospitals in Madras Presidency at which there is scope for appointment of Honorary Medical Officers.

MADRAS CITY :

GOVERNMENT GENERAL HOSPITAL, MADRAS. (Honorary Woman Medical Officer is also required). GOVERNMENT RAYAPURAM HOSPITAL, GOVERNMENT HOSPITAL FOR WOMAN & CHILDREN, GOVERNMENT OPHTHALMIC HOSPITAL, GOVERNMENT ROYAPETTAH HOSPITAL, GOVERNMENT VICTORIA CASTE & GOSHA HOSPITAL, (Honorary Woman Medical Officers required). GOVERNMENT TUBERCULOSIS INSTITUTE.

MUFASSAL HOSPITALS.

NORTH ARCOT DISTRICT :—Head Quarters Hospital, Vellore, Government Hospital, Gudiyattam.

SOUTH ARCOT DISTRICT :—Head Quarters Hospital Cuddalore.

BELLARY DISTRICT :—Head Quarters Hospital, Bellary. Government Woman & Children Hospital, Bellary. (Honorary Woman Medical Officer required). Government Hospital, Kayadrag, Government Woman & Children Hospital, Adoni. (Honorary Woman Medical Officer required).

CHINGLEPUT DISTRICT :—Head Quarters Hospital Chingleput, Government Hospital, Conjeevaram.

CUDDAPAH DISTRICT :—Government Hospital, Proddatur.

CHITTOOR DISTRICT :—Government Head Quarters Hospital.

COIMBATORE DISTRICT :—Head Quarters, Hospital Coimbatore, Government Hospital,

Tirupur, (Honorary Woman Medical Officer required). Government Hospital, Erode. Government Hospital, Kollegal.

GANJAM DISTRICT :—Government Hospital, Chatrapur, Government Hospital Russelkonda.

GUNTUR DISTRICT :—Government Hospital, Tenali.

KISTNA DISTRICT : Government Hospital Gudivada.

SOUTH CANARA DISTRICT :—Government Head Quarters Hospital, Mangalore.

MADURA DISTRICT :—Government Head Quarters Hospital.

MALABAR DISTRICT :—Government Woman & Children Hospital, Calicut. (Honorary Woman Medical Officer required). Government Hospital, Ponnani. Government Hospital, Cochin.

NELLORE DISTRICT :—Government Headquarters Hospital.

THE NILGIRIS DISTRICT :—Government Headquarters Hospital, Ootacamund.

SALEM DISTRICT :—Headquarters Hospital, Salem, Government Hospital, Namakkal.

TINNEVELLY DISTRICT :—Government Hospital, Tuticorin.

TANJORE DISTRICT :—Government Hospital, Negapatam.

VIZAGAPATAM DISTRICT :—King George Hospital, Medical College, Vizagapatam.

Local Self-Government Department.

G. O. Ms. No. 1673 P.H., dated the 9th July 1934.

READ THE FOLLOWING.

From M.R.Ry. N. Rama Rao, No. Nil, dated the 8th April 1934, 28th April 1934 and 19th and 24th May 1934.

From the President, District Board, Kistna, Rc. No. 3589 of 1934, dated the 17th May 1934.

Endorsement of the Surgeon-General, R. No. 1209-Est., dated the 18th June 1934.

ORDER.

The President, District Board, Kistna is informed that the rural dispensary at Gollapalli can be converted into a regular dispensary only on the expiry of the agree-

ment between Mr. N. Rama Rao and the Nuzvid Taluk Board or if the agreement is terminated with the consent of Mr. Rama Rao and the District Board. As neither of these conditions has been satisfied the proposal for conversion already approved by the District Board cannot be given effect to. The dispensary should therefore be continued only as a rural one. If however the President, District Board is prepared to appoint Mr. Rama Rao as the officer in charge of the proposed regular dispensary the latter may consent to the immediate termination of the agreement in which case only the proposal for conversion can be given effect to now.

(By Order of the Government, Ministry of Local Self-Government).

S. G. Sengodiayan,
Deputy Secretary.

Meeting of Jhansi Medical Practitioners.

A meeting of Medical practitioners of Jhansi was organised by Dr. I. N. Saxena under the auspices of the local Medical Licentiate's Association on July 17, 1934. Dr. A. Viswanathan of Madras, who is touring Northern India with the purpose of organising Medical Associations in these parts of our country, addressed the members of the Medical profession who gathered in strong numbers under the presidency of Dr. M. L. Atri L. M. S., a leading medical practitioner of the place. The lecturer stressed the necessity of forming District Medical Associations, of the desirability of concerted action, and of the perils of class divisions and disputes within the profession. He pointed out, that as a result of appalling lethargy and disunity in the ranks of the profession, Indian Medical Council with a preponderating official majority and with no high purpose, has been foisted on the profession ostensibly with the purpose of setting right the "Higher medical education" in this country, but really to make it an instrument through which the British Medical Council may perpetuate its authority over Medical Services and education in this country. The creating of the Indian Medical Council, and the recent appointment of Dr. MacRae as one of the Inspectors on a high salary which once the Legislative Assembly voted down when the British

Medical Council proposed Col. Needham as Medical Inspector of Indian University Standard, the lecturer said is the triumph of the diplomacy of the British Medical Council and that the time has come when our profession should so organise itself as to make such things impossible in the future. He exhorted in conclusion, that no difference should be made between the licentiates and graduates, that they should sail together for ever, that they should start their own research institutions and that they should set up such a high standard of professional efficiency, dignity and ethics as would be a model for the West to follow.

His appeal went home to the hearts of those present and an Association under the name of "Jhansi Medical Practitioners Association", was formed with Dr. M. L. Atri L.M.S., as the president, and Dr. I. N. Saxena, Member of U. P. Medical Council, was requested to help in the organisation of the Association. Dr. Mohan Lal Mahera M.B.B.S., was proposed to act as Secretary.

The visitor spoke also on the "Recent advances in Malaria" which was well appreciated by the profession.

The Jhansi Branch of Medical Licentiates' Association was 'At Home' to the members present.

The Trichinopoly District Medical Association, (Registered.)

A monthly meeting of the above Association was held on Saturday the 30th June, 1934, at 5 p.m., at the Coronation garden, Trichinopoly, when about 40 members were present. Lt.-Col. N. M. Mehta, I.M.S., District Medical Officer, Trichinopoly, presided. Dr. N. Safulla, L. M. & S., was "At Home".

After reading the minutes of the last meeting by the Secretary Dr. P. A. S. Raghavan, Dr. T. S. S. Rajan, read an interesting paper on "Evipon sodium Anaesthesia" and explained the advantages and the precautions to be taken in administering the same. Dr. R. Kalamegham, B. A. M. B. S., made a few remarks on the experiences at the Government's Head Quarters Hospital, Trichinopoly. Lt. Col., N. M. Mehta, I.M.S., made a few remarks on its limitations and concluded by saying that it had its own limited usefulness.

He then called upon Dr. S. Ramasubbu of Viraganur, to say a few words about Subsidized Medical Practitioners. Dr. Ramasubbu explained the need for forming a District Association of the Subsidized Medical Practitioners and that it might work as an annexe of the Trichy District Medical Association. Dr. M. R. Subramanyam of Gujiliyamparai, moved a resolution to that effect. Lt.-Col. N. M. Mehta, opined that the matter may be considered by the Executive Committee of the Trichy District Medical Association and decided latter.

P. A. S. RAGAVAN,
Secretary.

Subsidized Medical Practitioners Meeting, Trichinopoly.

A meeting of the Subsidized Medical Practitioners of the District was held in the coronation gardens Trichy, at 7 p.m., on 30-6-34 under the presidency of Dr. S. Ramasubbu of Viraganur and it was resolved that an Association of the subsidized Medical Practitioners of the District may be formed, with Dr. S. Sethurama Rao of Uppiliyapuram, Trichy District, as President, Dr. M. R. Subramanyam of Gujiliamparai as Secretary, and Dr. M. R. Bhat of Pulivalam, as Treasurer. It was resolved that this Association be affiliated to the Madras Provincial Subsidized Association. It was also resolved that this Association be linked to the Trichy District Medical Association.

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

No.	Names of Sub-Asst. Surgeons	From.	To
1	Dr. P. C. Ramachandra Raju	Leave	Govt. Royapuram Hl., Madras.
2	„ Y. Suryanarayana Rao	Govt. Royapuram Hl.	Stanley Medl. School, Madras.
3	„ C. Ramachandra Ayyangar	Stanley Medl. School	Agency Duty, Vizag.
4	„ C. Padmanabha Menon	Mentai Hl., Calicut	L. F. Dy., Omalur.
5	„ S. Kanthimathinathan	L. F. Dy., Omalur	Govt. Hl., Chidambaram.
6	„ I. A. Samuel	L. F. Dy., Porto Novo	do. do.
7	„ I. P. Sankara Menon	Vizag Agency	Govt. Hl., Tellicherry.
8	„ Mrs. C. M. Alexander	Leave	do. do.
9	„ Mr. E. M. Kuruvilla	Govt. Hl., Tellicherry	Govt. Hl., Ponnani.
10	„ M. Jagga Rao	Govt. Hd. Qrs. Hl., Guntur	Govt. Hl., Tenali.
11	„ A. Satyanarayana	Govt. Hl., Tenali	L. F. Dy., Chilakalurpet.
12	„ C. Appalachary	L. F. Dy., Chilakalurpet	L. F. Dy., Kovvur.
13	„ S. Vaithianathan	Govt. Hl., Kodaikanal	L. F. Dy., Andipatti.
14	„ J. Suryaprakasa Rao	Govt. Institute of Radiology, Madras	Stanley Medl. School, Madras.
15	„ P. K. Narayana Nambiar	Govt. Hl., Coimbatore	L. F. Dy., Kangayam.
16	„ U. N. Shama Rao	L. F. Dy., Kangayam	Govt. Hl., Tuticorin.
17	„ A. V. Suryanarayana	Govt. Hl., Chicacole	Govt. Dy., Sompeta.
18	„ B. Ramanatha Mitra	Govt. Dy., Sompeta	Govt. Hl., Chicacole.
19	„ V. Ramakrishnan	Govt. Hd. Qrs. Hl., Cuddalore	Agency Duty.
20	„ P. Siviah	Leave	L. F. Dy., Tiruvotthiyur.
21	„ M. Audinarayanaswami Naidu	L. F. Dy., Tiruvotthiyur	L. F. Dy., Sathiavedu.
22	„ M. Gopalan Menon	L. F. Dy., Sathiavedu	L. F. Dy., Pulicat.
23	„ A. Thyagarajan	L. F. Dy., Pulicat	L. F. Dy., Uttiramerur.
24	„ C. Manicka Mudaliar	L. F. Dy., Uttiramerur	Govt. Hl., Conjeevaram.
25	„ B. V. Suryanarayana	Govt. Hl., Kandukur	Agency Duty, E. Godavari.
26	„ A. Krishnappa	L. F. Dy., Nachiyar Kovil	Agency Duty.
27	„ Mrs. N. Chamu Nayar	Leave	Govt. Hd. Qrs. Hl., Chingleput.
28	„ Mrs. J. V. Lingam	Govt. Hd. Qrs. Hl., Chingleput	Govt. Mental Hl., Madras.
29	„ Miss. R. Gnanadikam	R. M. Dr. Hd. Qrs. Hl., Tanjore	Govt. Hl., Kadiri.
30	„ C. R. Narayana Iyer	Govt. Hl., Dindigul	L. F. Dy., Melur.
31	„ L. Jagannatha Rao	L. F. Dy., Kovur	Govt. Hl., Bhimavaram.
32	„ V. Ramanujachari	Leave	L. F. Dy., Chintalapudi
33	„ M. S. Narayanaswamy Iyer	Surgn Genl's Office Madras	Engineering College. Dy., Guindy.
34	„ K. Ramasami	L. F. Hl., Vriddhachalam	Agency Duty.
35	„ V. Krishnamurthy	Season Duty, Ootacamund	I. D. Hl., Ootacamund.
36	„ K. Rajamannar Naidu	Govt. Hd. Qrs. Hl., Cocanada	Agency Tour Duty.
37	„ V. Jagannadha Rao	L. F. Hl., Bobbili	L. F. Dy., Chetpet.
38	„ N. Krishnaswamy Iyer	Agency Duty E. Godavari	Govt. Hd. Qrs. Hl., Chingleput.
39	„ T. Ramadoss	L. F. Dy., Porumamilla	Govt. Hd. Qrs. Hl., Chittoor.
40	„ K. S. Ranganathan L.R.C.P. (Lond) M. R. C. S. (Eng.)	King Institute, Guindy	L. F. Hl., Vriddhachalam.
41	„ P. K. Gunasagaram	Leave	Police Hl., St. Thomas Mt.
42	„ C. Venkatanarasimham	Police Hl., St. Thomas Mt.	Govt. Dy., Ponneri
43	„ K. R. Parthasarathy	Govt. Dy., Ponneri	L. F. Dy., Sriperumbudur.
44	„ P. Balasundaram	L. F. Dy., Sriperumbudur	Govt. Hd. Qrs. Hl., Chingleput.
45	„ Miss. G. Guruswami	Leave	L. F. Dy., Ambasamudram.
46	„ Miss. K. Parvathi Devi	Municipal Dy., Nagore	Presidency Jail for women Vellore.
47	„ S. N. Jagadisa Iyer	Leave	c/o I.G. of prisons, Ootacamund.
48	„ M. A. Seshan	Leave	Govt. Hd. Qrs. Hl., Coimbatore.
49	„ T. Subramania Iyer	Leave	L. F. Dy., Tiruvadanai.

WHOOPIING COUGH

Whooping cough in an epidemic form is now prevailing in some parts of India. Herebelow we quote again the opinion of an eminent practising physician regarding the treatment of whooping cough with Koo-Koomin. Members of the medical profession will be well advised to keep a stock of Koo-Koomin a tried and safe remedy.

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

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

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

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

TREATMENT.

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

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

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

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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 are so combined that if taken in doses indicated for the purpose and within a week of the cessation of the normal menstruation, they help in bringing about healthy menstrual flow and thus prevent pregnancy. So it is the safest **Contraceptive** that could be taken by mouth and is not harmful to the system.

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

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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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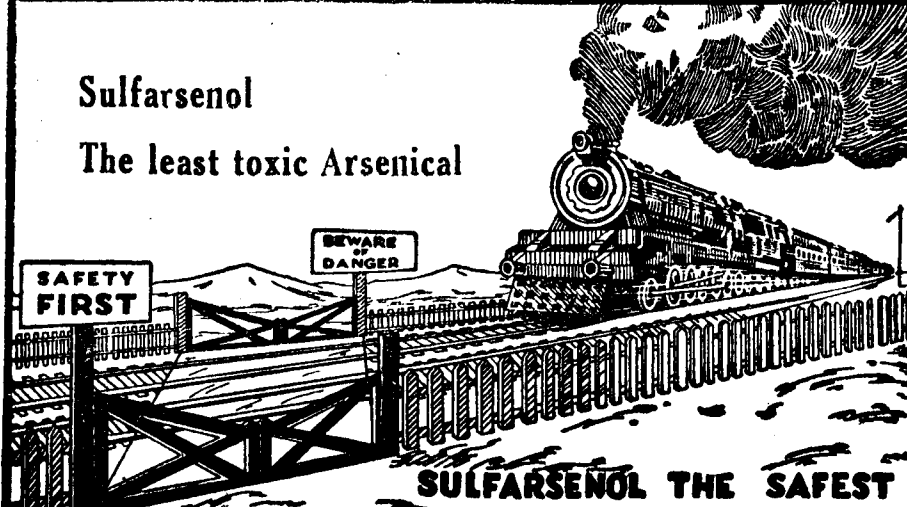
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