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A Monthly Medical Journal

EDITED BY
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Retired Sanitary Commissioner, Travancore State.

AND
Dr. V. Rama Kamath,
Members, Madras Medical Council.

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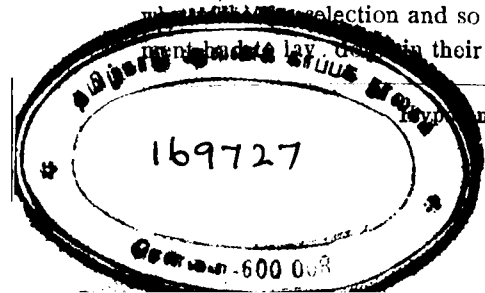
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time and attention to the extent they possibly could, depending upon their other activities as professional men and there were days perhaps months also when a Principal could not find time to step into the college and naturally the head clerk of the college has to act for the Principal and got prominence, with the result that the candidate seeking admission into the college had to depend upon the sweet will and pleasure of the head clerk. Silent agitation conducted by the aggrieved candidates brought into existence a Selection Committee. At this stage the Medical administration was transferred to the control of the Ministers and the Government being run on communal lines, the selection of the candidates depended upon communal formula. Taking the world as what it is, there was no satisfaction in the minds of the public about the admissions made in spite of the Selection Committee. It was said that compromises and conventions interfered seriously in the matter of choice and there came into existence what was called a Reserve List from which the Principal could choose whom so ever he liked and admit him in case any, from the list of selected candidates (by the Committee) did not join the college in time. The Government seems to have been extra vigilant this year and gave definite instructions as to how the selection has to be made. In addition to the observance of the communal formula, the Committee was asked to select candidates on linguistic basis taking due care that proficiency test was not neglected. Candidates who passed the Intermediate examination with Natural Science as their optional had to be given preference to those whose optionals were Physics and Chemistry. Amongst the candidates from both these groups selection ought to depend upon the rank occupied by the candidates in the Intermediate examination. Of course graduates whose optional was either Natural Science and Physics and Chemistry had to be preferred to Intermediates. It is said that when the selections were made from the Reserve List referred to above the Principal, of the Medical College did not observe the rules or the spirit of the rules published by the Government for the guidance of those who had to select and so the Government had to lay down their instructions

this year that the applicant, in the Reserve List should be selected in accordance to the general principles laid down for selection in the Government Order and in case any candidate or candidates who are selected by the committee did not join the Medical College in time the Principal should select from the list candidate or candidates from the group where in such a vacancy has arisen. For example if a selected non-brahmin candidate from Tamil group did not join the college, the Principal should select from the reserve list a non-brahmin Tamilian taking care of the proficiency, preference being given to those belonging to Natural Science group and in case this was a Brahmin vacancy from a particular group the Reserve List selection has to be made from the Brahmin list of course not neglecting the linguistic and proficiency formula. The fact that year after year Government had to give fresh instructions with regard to selection of candidates for admission into the Medical Colleges proves that patronage and favouritism have been vitiating the selection in the past. The Principals of the two medical colleges and members of the Selection Board know best what they did when they all sat together and made the selection this year. It is reported to us that the Principal, Medical College did not observe the principles laid down by the Government with regard to selection of candidates and filled in a vacancy from the Reserve List according to his own discretion. When the Principal of a college who is a servant of the Government does not respect the spirit of the principles laid down by the Government in the selection of candidates, it may be surmised how far favouritism and patronage is likely to vitiate the selections. We take it that the Government appointed the Selection Committee for admitting candidates into the educational institutions as a guarantee that the selections did not vitiate the rules laid down by the Government but unfortunately the experience has been otherwise. The Government can certainly wield disciplinary control over the Principals under their employ and not on the non-officials serving in the Selection Committee. As between the principals and the members of the Selection Committee it may not be possible

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to locate the blame. We therefore suggest to the Government that more fair play and justice could be expected by the candidates seeking admission into educational institutions if the selection is entrusted to the Principals themselves subject to the scrutiny by the Government. Then and then only will it be possible for the Government to find out without any difficulty if what they propose is disposed off by the Principals of the concerning institutions.

Original Articles

THE TREATMENT OF PULMONARY TUBERCULOSIS.

II. The Regulation of Rest and Graduated Exercise.

By

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

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

It was explained in the last article why the special treatment of pulmonary tuberculosis does not consist merely in rest of the body, but in the change of rest and graduated exercise in the right proportion in each individual case. This is the basis for the whole treatment, and in relation to it all other remedies are only adjuvants. The guidance during the treatment with regard to the change of rest and graduated exercise is given by the observation of the clinical symptoms, the physical examination, the X-ray examination and the various blood examinations.

There is no clinical symptom so important to observe and to have as guidance as *the height of the temperature of the body*. Whenever the flow of tuberculo-proteins, toxins, or bacilli from the lesions into the body is more than it can cope with, there is a rise of the temperature above its normal height, and when this is marked or more than transient the rise is called "fever".

It is necessary, in order to diagnose the presence of fever, to know what is to be considered the normal temperature of the body. No single figure can indicate the

normal temperature as in healthy people the temperature varies normally within certain limits and has a rhythmical change which occurs daily. The marking of most thermometers with an arrow at 98°4 as indicating "the normal temperature" of the body is absolutely misleading and has done and is doing much harm. This marking was made because it was believed that 98°4 was the average temperature within the twenty-four hours. It serves absolutely no purpose to consider the daily average to be the normal temperature, when a healthy person has less than 98°4 in the morning and considerably more in the afternoon and evening. I have met many people who thought that they were ill and perhaps suffering from tuberculosis, because their temperature in the afternoon was constantly above 98°4. If it had not been for that unfortunate arrow on the thermometer these people would not have suffered from the fear of having fever.

Before describing the daily rhythmical change of the temperature in a healthy person, it must be pointed out that all the figures given in this paper are rectal temperatures. This way of measuring is by far the most reliable, and I have reason to believe it is especially true in India, and should be used in a disease like tuberculosis, where a rise or decrease of a few points should often result in a change in the prescribing. When the necessity for measuring the temperature per rectum is properly explained, the patient will have no objection; at least among more than 5000 patients we have not had a single one refusing to take the rectal temperature.

Under ordinary circumstances the normal temperature is in the morning, just after waking, from 97°3 to 98°0. Thereafter a slow rise takes place until about 2 p. m. when it is from 98°6 to 99°1. Between 2 p. m. and 6 p. m. the normal temperature reaches its daily maximum of from 99°1 to 99°5. After 6 p. m. the temperature begins to fall and reaches its daily minimum about midnight. From this it may be understood that any temperature from 97°3 to 99°5 may be considered as normal, but only if it corresponds to the temperature which is to be expected at that hour of the day. A temperature of 99°1 which is normal about 2 p. m. should be considered

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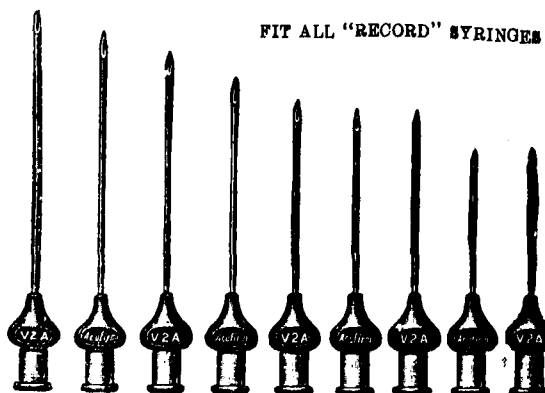
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GOVERNMENT PROPOSES PRINCIPAL DISPOSES.

Selections of candidates for admission into the Madras Medical College has a history of its own and the process adopted at the Madras Medical College has been followed in the other teaching institutions in the presidency as a matter of course. In the early years of the existence of the college very few private students applied for admission and of those that were trained at the college, the majority consisted of stipendiary students belonging to the civil or military apothecary grade and the hospital-assistant grade. As time went on more and more admissions were sought for the University courses, the L.M. & S., and the M.B., C.M., (later converted into M.B., B.S.). As the college got fuller with the university students the government abolished the grade of the male civil apothecary class and the civil and military hospital assistants pupils were given a separate school at Royapuram. During those days there was no rush for admission; later when the pay and prospects of assistant-surgeons were raised, applications for admission into the college naturally increased. In the early days the Principals of the college had not much difficulty in choosing the candidates for admission as then the applicants did not outnumber the strength which the college could accommodate. As referred to above when the university medical education became popular on account of the Government

increasing the cadre and prospects of the assistant-surgeons, the rush for admission proportionately became greater and greater. With the popularity of university medical education coincided the changes in the office of the Principal Medical College. Till about 1910, the Principal of the Medical College was also the Senior Medical Officer of the Government General Hospital. He was debarred from private practice and devoted all his time and attention as an administrator looking after the medical education both in the college and the hospital. He could therefore afford to be above favouritism and patronage having little or nothing to do with the outside world. Later it was not possible for the Government to find one amongst the senior members of the I.M.S., for the combined post of Senior Medical Officer, Government General Hospital and Principal, Medical College as the senior members did not wish to give up the lucrative private practice. Consequently the post was split into two, both the officers being allowed private practice. Ever since this splitting took place, the Principal Medical College and the Superintendent, Government General Hospital could not naturally devote as much attention about the administration under their control for obvious reasons. As the subject of our comments is the selection of candidates for admission into the Medical College, we restrict our comments with regard to this topic itself. Under the changed conditions, the Principals of the Madras College devoted their

fever if found in the morning just after awakening.

It would carry us all too far to mention in detail all the fallacies in judging whether fever is present or not. It must suffice to mention just a few. The most common is the lack of knowledge about the physiological rise of temperature in many women a week or more, or shortly before the menstruation, when the temperature in the evening can rise to 100°0 without this being abnormal or an indication of fever. Another fallacy is not to take into consideration "the exercise temperature", as many healthy people register 100°0 or even up to 101°5, after brisk exercise of the body. When there is doubt about whether a person suffers from low fever or not, the temperature should only be taken after 20 minutes complete rest of the body, as all exercise temperature will have disappeared within that time. A serious source of fallacy is to use a wrong thermometer. As every thermometer, even the best one, is liable to become inaccurate, it should be tested a few times a year. It is also necessary to point out that the thermometer should be kept in the rectum for at least five minutes and in the mouth seven, in order to register correctly the temperature of the body, and this applies even to the so called "half-a-minute" thermometers.

It is a serious mistake in the treatment of a consumptive to take the temperature only in the morning and evening. At least in the beginning of the treatment it is very necessary to have the temperature taken four times a day, in order to be sure whether fever is present or not. In many cases a rise of temperature occurs only late in the morning or in the middle of the day, while the temperature early in the morning and in the evening show normal height. If the temperature were taken only in the morning and evening, many cases of slight fever would not be recognised at all.

Rest in bed should be prescribed whenever fever is present, as this symptom indicates a too strong flow of tuberculo-proteins and toxins from the lesions, and in the beginning of the treatment the patient should be kept in bed until two weeks after the fever has disappeared without any medicine being given for the

fever. In some text-books it is mentioned that if the fever does not disappear after one or two months rest in bed, it is of no use to continue to keep the patient confined to bed. This is absolutely wrong. We have seen many patients, who have been kept in bed continuously on account of fever, losing it only after six to nine months, but then becoming completely well and keeping so after discharge. If, however, the fever does not disappear after a few weeks, it is imperative to consider whether any adjuvants not definitely indicated immediately in the beginning of the treatment, such as collapse therapy or sanocrysin or other remedies should be prescribed in order to support the natural defence-mechanism in minimising the flow from the lesions or their effect in the body.

When the patient has become free from fever without any drug treatment a *short walk* of a few hundred feet should be prescribed morning and evening. If this small exercise produces a rise of temperature, the patient must again be confined to bed at least for a few days before another attempt of exercise is tried. If this short walk has been well stood, after two weeks the exercise should be increased up to two furlongs, morning and evening, for a further period of two weeks. *The next grades*, if the previous ones have not caused the slightest fever, are walks up to four furlongs for a fortnight and then up to a mile morning and evening. Experience has shown that in India, it is best not to increase the exercise above two miles a day, for a very long time.

Tuberculous patients have been found to be especially liable to have a higher exercise-temperature than healthy persons. An exercise-temperature in a consumptive of 100°4 is not always a symptom of fever, but, on the other hand, such a rise of temperature due to exercise should not be allowed to occur, as a patient cannot without harm expose himself to the same amount of fatigue and exhaustion as a healthy person. If the exercise-temperature rises too high, above 100°0 or 100°2, the patient must again be confined to bed for a short while or the exercise must be reduced, because a too high exercise-

temperature occurring for some days may not disappear again even if the exercise is stopped, but may run into real fever. The temperature of the patient should therefore be taken immediately after the walking-time is over in order to see whether the exercise-temperature is too high. When graduated exercise has been prescribed and is continued daily without too high an exercise-temperature, it is nevertheless best to control a few times a week whether the exercise-temperature disappears within 20 minutes. If it does not disappear within 20 minutes the patient has after all been prescribed too much walk and must again go to bed for a few days, or the exercise must be reduced.

It is not always possible outside a sanatorium to prescribe the graduated exercises in terms of furlongs, as the patient may not have any opportunity of walking in big gardens or on beautiful roads. When such an opportunity is not present and the walks have to be limited to a small compound or a few paths or small roads, it is much more practical to prescribe the graduated exercise in terms of time. As a patient should always walk very slowly, a walk for five minutes corresponds to a walk of one furlong, that is to say that twenty minutes walking about is equal to a walk of four furlongs.

When a patient has reached the stage of two furlongs walk, morning and evening, without any undue rise of temperature, it is not necessary that he should be confined to bed the whole day in between the times for the graduated exercise. He can be allowed out of bed and be permitted to move in his room or in his house, but it is absolutely essential that he takes complete rest on bed three times during the day. The best time for these periods of complete rest is from 9 to 10 a. m. just after the morning walk, from 1 to 3 in the middle of the day, and from 6 to 7 p. m. after the evening exercise. The patients should always go early to bed, not later than 9 p. m. These hours of rest should be strictly adhered to even after the patient can walk two miles daily, and if possible for some months after his discharge; but if not possible then he should at least try to secure a two hours rest at some time of the day, for a year or more.

As previously pointed out any kind of physical exercise, or any mental excitement, increases the heart function and the blood circulation through the lesions with increased flow of toxins into the body. From this point of view it is very important that the patient should not cough too much, as a strong attack of cough is a very severe physical exercise. *The cough* has therefore to be properly dealt with, especially the dry, hacking cough without any expectoration. On the other hand the cough must not be interfered with in such a way that the sputum is not brought out from the lungs, as the retention of the bacilli-containing expectoration in the lungs is harmful and dangerous as a cause for the spread of the disease. It is, however, not difficult to train a patient not to cough but to bring up his sputum without any real cough or strain. A real decrease of the cough and the sputum is a good sign that the patient is progressing well and that the treatment is effective, although some patients can for a very long time, under certain circumstances, continue to have a little cough and sputum in spite of the disease having become inactive.

It is true that *gain in weight* is a favourable symptom, but as a guidance for the treatment it is often an unreliable sign. In quite a number of cases an increase in weight can be observed for some time, while nevertheless the patient is losing ground which is indicated by the other clinical symptoms and especially by the blood examinations, and ultimately also by loss of the temporary gain.

As a guidance for the proper change of rest and graduated exercise in the individual case it is a great help to observe also the *general condition* of the patient, because less restlessness, better sleep, increased appetite, feeling of less fatigue, and a cheerful and brighter state of mind are all signs of a decreased toxæmia and of a progressing healing of the lesions.

The general practitioner in India will have to rely upon the *physical examination*, besides the observation of the clinical symptoms, as guidance during the treatment.

It may not be out of place to warn against too frequent examinations of the chest. Every examination is not only a strain on the patient on account of the natural excitement as to its result, but it is often a real physical exercise making the patient tired because of his having to cough considerably during the auscultation. In quite a few cases there has been observed a rise of temperature, even up to 101°0, and in more rare cases an haemoptysis shortly after the examination. Moreover, frequent examinations of the chest are not necessary, since changes in the physical signs require some time to materialize. It is best not to make a thorough physical examination more than once a month.

That which is most important to ascertain by the examination is disappearance or not of previously present rales, or perhaps appearance of new ones. Decrease of increase of the number of rales is of equal importance, as well as any change in their character. If rales are increasing or becoming more moist, or even resonant, it is a bad sign. When rales become resonant it indicates a softening of the lesions, a melting down with possible cavity formation. The more the rales become dry and crepitant, the better the progress.

Should the examination reveal dullness and bronchial respiration over an increased area, it is of course an indication of the spread of the disease. In such a case the patient should immediately be confined to bed, if he has been allowed any graduated exercises. Such a spread can be so slow and insidious that it can take place for some time without producing fever or without any other clinical symptoms indicating it. Here again the blood examinations and the X-ray examination are of immense help, as in many instances they indicate the spread of the disease, or a worsening of the condition of the patient, long before even the rise of temperature does so, or before it is possible to find this out by the physical examination.

Although the regulation of rest graduated exercise constitutes the specific treatment of pulmonary tuberculosis, various adjuvants are of very great importance in support of the whole treatment. The next article will

deal with some points with regard to these adjuvants.

HEREDITARY DISEASES.*

BY

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

Superintendent Government Ophthalmic Hospital, Madras.

In opening this last lecture of the series, I wish to thank the members of the staff of this hospital, medical and non-medical, to whom I am indebted for help in connection with references to cases, literature, hospital records and other matters.

It might seem at first sight that hereditary blinding diseases hardly come under the category of "preventible," but I hope to show later that they do. Some ten years ago I would not have included them amongst the chief preventible causes of blindness in children, but I am prepared to do so to-day. When for certain reasons it occurred to me last year that the hereditary blinding diseases might be so classified I began to collect a few facts in this connection. A survey of our hospital records and a consideration of our experience with such diseases convinced me that if we treat this group as a whole, we have a cause of blindness which is probably more important than any other single cause. In the first lecture of this series, I referred to my publication in the "Lancet" of April 1931 in which a case was made out for keratomalacia as the greatest cause of preventible blindness in children in India. I now propose to suggest that the hereditary diseases taken as a collective group may be considered as filling this role, at all events, in South India. Let us first look at a list of hereditary diseases which are apt to cause blindness or practical blindness, not necessarily a complete list, and see which of them we observe in our hospital population and with what frequency. As a matter of interest I shall include in this list some conditions which do not necessarily cause blindness, only defective vision, but these will be noted.

* Dr. Elizabeth Matthai Lecture 1933-34. Third Lecture.

Hereditary diseases and Average rate of incidence per annum in our hospital population of approximately 20,000

Tapeto-retinal degenerations.	Retinitis pigmentosa (usual classical form)	35	} 40
	" pigmentosa sine pigmento	3	
	" punctata albenscens	2	
	" pigmentosa centralis		
	Fundus albenscens with hemeralopia congenita (Oguchi's disease)		
Symmetric familial degeneration of the macular region or periphery other than Tapeto-retinal, with or without other degenerative features.	Progressive heredo-degeneration of the macula, with or without	From 0-8 to 4	The only cases observed which we can fit in to this group are those of progressive heredo-degenerations of the macula with or without pigmentation.
	demenetia, with or without pigmentation.	(This figure will be explained below)	
	Familial chorioiditis (Doyle)		
	Tay-Sachs amaurotic family idiocy		
	Atrophia gyrata chorioidæ et retinae		
	Atrophia chorioidæ et retinae totalis or chorioideremia		
	Nystagmus (other than those associated with recognizable lesions of media or fundus)	12	
	Buphthalmus (infantile glaucoma)	7	
	Gloma	5	
	Ectopia lentis (congenital dislocation of the lenses)	6	
	Coloboma of the iris and choroid	5	
	Microphthalmus	3	
	Anophthalmus	0.6	
	Albinism	1	
	Hereditary optic atrophy (Leber's disease and varieties not recognisable as such)		
	Aniridia		
	Congenital cataract	9	
	Oxycephaly (Tower skull, Turmschadél)	0.2	
	Familial corneal degenerations (symmetric, lattice-like or nodular) Gruenow's disease)	1.4 Nil	
	Congenital colour blindness night "		
	Hereditary high myopia		
	Blue sclerotics		

The total hereditary diseases recorded as such taking the lowest or known figure in the second member of the series averages 91 for five years. This may be expressed as approximately 4.55 per 1000 in our hospital population, whereas the figure for keratomalacia (total and practical blindness) was 3 per 1000.

It might be argued that it is doubtful if some of these are definitely hereditary, but on the other hand there are certain conditions which might perhaps have been included e.g., the "phakomatoses" of Van der Hoeve embracing the three affections coupled to the names of Bournville, Recklinghausen, and von Hippel-Lindau.

This list will, however, serve our immediate purpose the lecture does not purport to be an exhaustive study of the hereditary blinding diseases. We may conveniently consider them in two groups as suggested by Treacher Collins, in his address at the International Congress, Washington 1922; (a) those in which the tissue involved has from the first been imperfectly developed, and (b) those in which after full development degeneration sets in. As examples of the first, the hereditary errors of development resulting in anatomical defects and deformities, we have such conditions as:

- Buphthalmus
- Ectopia lentis
- Coloboma of the iris and choroid
- Microphthalmus
- Anophthalmus
- Congenital cataract
- Tower skull.

They are comparable with hereditary defects with which the ordinary lay person here is probably more familiar such as extra fingers.

Treacher Collins also includes hereditary functional disturbances under this head such as nystagmus, congenital colour blindness and congenital night blindness as having some anatomic basis.

As examples of (b) we might include the first two series of grouped conditions on our list and others such as hereditary optic atrophy, familial corneal degenerations etc.

With reference to the second group he says, "widely as these affections may at first appear to differ they will be found to present similar characteristics which allow

them of being grouped together in a classification of eye diseases founded on a pathologic basis."

All these diseases are hereditary in the sense that they may be met within several siblings of the same generation and all (with two exceptions) "in several different generations." The exceptions are amaurotic family idiocy and some types of symmetric macular pigmentary degeneration in which the individuals die before child bearing age. The former hardly concerns us as it is said to be confined to Jewish strains and we have never seen an instance of it here. They are all bilateral, non-inflammatory and indicate degeneration in certain definite groups of cells, "which having reached a full degree of development and functional efficiency have then undergone degeneration." The time of onset of degeneration varies. They fail not because of any toxicity or avitaminosis or lack of endogenous secretions, but from imperfect cell vitality so that they are unable to maintain their nutrition in full development. As Sir William Gowers, quoted by Collins, says they fail "from imperfect life, from abiosis, in what may be designated abiotic atrophy or abiotrophy." The cells degenerate earlier than usual due to some inherent cause. He pointed out that all cells tend to decay and die eventually, but some decay abnormally early. We do not necessarily apply the word death to this inherent failure of vitality, we speak of it as degeneration. We do not know what the force is which keeps tissues from a failure in vitality, but it is convenient to refer to this unknown quantity as vital force and to assume that lack of it means degenerations. The cells of the body are either in a state of evolution to maturity or involution to decay. Collins quotes Paget to the effect that "premature degenerations are to be considered therefore methods of atrophy—as defects rather than perversions of the nutritive process—or as diseases only in consideration of the time of their occurrence." Collins following Paget and Gowers regards all such hereditary conditions as abiotrophies.

We may find it difficult to fit in certain of the hereditary affections under such a grouping, but this does not alter the fact

Hypotensyl tablets contain a special hypoplastic principle of the spleen.

that it helps us to link up a number of diverse conditions to a common base. As an isolated example which does not appear to fit in with either group we might instance glioma, that new growth of childhood which only shows its degeneration after a period of excessive proliferation of cell elements. It occurs no doubt after the retina has attained maturity, but is hardly to be designated a degeneration or abiotrophy in its proliferating stages. The layman would in fact label it a malignant disease or cancer.

We will now turn to a consideration of our hospital records and see which of these hereditary diseases, degenerations or defects of development we meet with in South India and with what approximate frequency in our hospital population. This is shown in parallel column with the preceding list. Our approximate annual outpatients attendance is 20,000, and we have taken an average of the number of cases of hereditary diseases occurring over a period of five consecutive years where this has been possible.

Our considered opinion is that this figure must be enhanced. For example with reference to symmetrical familial macular degenerations, we have for a long time observed curious macular degenerations which we feel ought to be placed in this group because of their ophthalmoscopic similarity to known cases in the group, but which we are unable to prove as familial because of the difficulty in obtaining an accurate history or an examination of other members of the family. Many such cases show a central degeneration without pigmentation and without mental defect which we are wont to describe ophthalmoscopically as having a resemblance to "beaten brass", "beaten cooper," or "beaten silver." The disc may show more or less atrophic changes and of course the vision is poor. We feel that such cases ought to be included in the group, but they are classified under ordinary fundus diseases, not hereditary, for want of evidence.

It may be noted also that congenital high myopia has been omitted from the list of figures, as, when seen in young children, it is difficult to be sure if we are dealing with a single condition which may be so named, but a certain number of our cases would be included in this category by

many. Aniridia has not been mentioned as we do not remember to have seen more than two cases in the last 14 years.

Glioma, ectopia lentis and buphthalmus are probably more frequent than the figures indicate.

Hereditary optic atrophy has not been recorded. We do not remember having seen more than two such in the last 14 years, which were diagnosed as of the Leber type but a considerable amount of optic atrophy is seen in young children and classified under fundus diseases (optic atrophy), which we feel ought to be included under the title hereditary optic atrophy.

Congenital colour blindness and congenital night blindness are not included as they are not productive of a sufficient degree of damage to vision.

On the other hand in exycephaly blindness does not occur in all cases, and congenital cataract may be treated with great improvement to vision; albinism and retinitis pigmentosa may be associated with sufficient vision to enable the individual to earn a livelihood, as also mystagmus and coloboma of the iris and choroid, but a reduction on account of these would hardly counterbalance an enhancement. I think we might assume a practical blindness rate of 4.55 per 1000.

Retinitis pigmentosa, the commonest member of the Tapetoretinal degenerations, heads our list. It is a progressive disease and whereas it sometimes does not go on to complete blindness till late in life, the majority of our cases show very defective vision comparatively early.

It is said that 33% may be deaf and 4% deaf mutes. We have not noted this frequency of association and although we may have missed making observations in many cases it is most unlikely that we would fail to observe such a marked association as 33%. I have recently had the opportunity of examining 100 deaf mutes from the School for the Deaf, Myslapore, and in this series of children, there were three with retinitis pigmentosa, two Hindus brothers, and a Scotch girl, one of the very few Europeans in the Institution. We see extraordinary diverse forms of Tapetoretinal degenerations, but our criterion in diagnosis is the peculiar quality of the atrophy of the optic disc and the characteristic changes in the vessels of the retina

rather than any particular form of pigmentation or the lack of it. The commonest form is retinitis pigmentosa with obvious migration of pigment, more towards the periphery of the retina, but the pigment is not distributed in the bonecorpuscle pattern so frequently seen in European countries. It is more irregular and patchy. As has been pointed out by Kirkpatrick it is frequently associated with consanguineous marriages in South India.

Some of these diseases show peculiarly interesting features. Glioma, for example, the curious malignant growth of the retina occurs more frequently in young children and kills early except in the rare cases (with us) in which one or both eyes are removed and the individual lives to child-bearing age and possibly transmits the condition to future generations. I agree with Bickerton (British Medical Journal, January 1934) when he says "the death of a child with glioma of the retina is an appalling experience for parents and child, and may take as long as two years. The law which forces us to withhold euthanasia in these cases at the same time forces us to act in a barbarous and monstrously inhuman fashion, and is, in my opinion, indefensible."

(to be continued).

Abstracts

THE EARLY DIAGNOSIS OF CANCER OF THE FEMALE GENITALIA.

By

LEON J. TIBER, M.D., Ph.D., Los Angeles, Calif.

Cancer of the female genitalia presents an important problem to the medical profession. There seems to be an attitude of indifference to this serious affliction. This indifference is due to various misconceptions: First, that cancer of the female genitalia is rare, or that, when present, it is hard to diagnose in its early stages; and second, that, when diagnosed, the prognosis is almost hopeless. If we realize that these premises are grossly incorrect, much unnecessary suffering and death can be prevented.

One of the reasons for the existing pessimism regarding cancer of the female genitalia is the reluctance on the part of the

patient to seek advice for supposedly unimportant symptoms. Thus it has been reported that, in a large series of cases of carcinoma of the cervix, at the time the patients presented themselves for examination, 71 per cent were far advanced and 28 per cent showed limitations to the cervix, leaving a small margin of from 1 to 2 per cent in whom early cancer of the cervix was found curable. Other reports show that 95 per cent of all patients presenting themselves with cancer of the cervix are beyond the stage of early diagnosis and offer a very poor prognosis, even for a three to five-year cure.

Clark and Ferguson report that, in patients who came under observation six months after the first symptom manifested itself, the prognosis varied thus: 60 per cent were inoperable; 1 in 7 had a chance for a five-year cure. After six months, only 1 in 26 had a chance for a five-year cure. While in cancer of the body the chances for cure are greatly improved, in cancer of the external female genitalia the prognosis is even worse. With such appalling facts it is apparent that we must seek some way of combating this dreadful malady.

Carcinoma of the female genitalia causes more than one-fourth of all the deaths from cancer. Carcinoma of the cervix exacts a toll of 10,000 deaths every year. It is the most common form of cancer in the female, except carcinoma of the stomach. Next in frequency is carcinoma of the body of the uterus. Out of 31,000 cases of carcinoma, the uterus was affected primarily in more than one-third of the cases. Of 12,000 patients admitted to a European gynecologic clinic, 4 per cent had cancer of the uterine cervix, and 3 per cent of those with cervical cancers had never been pregnant.

Carcinoma of the body of the uterus is much rarer than carcinoma of the cervix, and more insidious, for 42 per cent of body cancers are in multiparas. Carcinoma of the ovaries is not very rare. It occurs as a secondary manifestation of otherwise non-malignant cysts and cystadenomas, of ovarian and parovarian origin, and as a remote metastatic implantation from carcinoma of other organs. Carcinoma of the vulva is rare and almost entirely limited to women beyond the menopause. It is usually grafted on some chronic inflammatory

lesion, especially leukoplakia or the dermal changes of an old pruritis, as well as in kraurosis. It occurs in virgins, nulliparas, and multiparas. It may be primary on any part of the vulva and is most common on labia majora, the clitoris coming next.

Primary vaginal cancer is rather rare and usually starts on the posterior wall. The initial stage may be single or multiple warts, an elastic nodule or a flat infiltration. A fungating mass, readily breaking down and bleeding, is characteristic. Another form is a granular, ulcerated area, with infiltrated margins. Still rarer is a carcinomatous infiltration, rigid and contracted.

There are numerous difficulties which prevent the early diagnosis of cancer of the female genitalia. The first is the insidious character of the disease. The patient may have quite an extensive lesion without much warning. She usually has symptoms, but they are similar to changes occurring every month of her menstrual life-cycle. After the menopause most women, because of the absence of manifested activity of their sexual organs, think that those organs are protected from diseases. Again, leucorrhoea which is very common among women, is considered a natural thing, provided it does not reach a stage of extreme annoyance.

Other reasons for not seeing a doctor are: ignorance, prejudice and poverty or fear. Many times the cancer patient has been treated by quacks or others, who know of someone who was cured by some well advertised nostrum. Again, some people fear to know the truth and evade seeing the physician.

On the other hand, physicians have not taken the symptoms of carcinoma of the female genitalia seriously enough. The general practitioner has not the time to inquire thoroughly into the history of the patient's complaint. Some have a timidity or lack of inclination to do a detailed bimanual examination, especially in regard to a speculum examination or other special tests. Many are still in the habit of prescribing douches for all abnormal conditions of the female genitalia. When the patient comes to a regular practitioner while her lesion is in an early stage, the chances are that it will not be easily recognized, and dangerously dilatory treatment will be instituted until it is too late for cure. There really is not much use in urging the laity to

consult its physicians periodically, unless physicians pay closer attention to the symptoms and learn to diagnose cancer in its incipency.

Etiology.

There are many theories as to the cause of cancer. Of all claimed causes, one seems to have the best claim to supremacy. Clinical experience has shown that, regardless of the underlying cause, certain factors, namely irritation and infection, have an etiologic bearing. In speaking of the etiology of cervical carcinoma, Howard A. Kelly, states, "From over forty years of clinical observation, I am convinced that the trauma of pregnancy, followed by an infection of the cervix, with thickened lips, eversion of the mucosa and a constant mucoid or mucopurulent discharge, will account for a large number of these cases. For this reason I make a point, in every instance, either of wiping out the diseased mucosa thoroughly with the actual cautery, or, if any radical operation is indicated, as in fibroid tumors or pelvic infections, of removing the entire cervix with the uterus, where the cervix appears unhealthy."

Cancer of the cervix is preceded by pregnancy in 97 per cent of the cases; especially when the cervix has been lacerated and the lacerations have been neglected, or have become eroded or subject to constant irritation. The ages of these cases range from twenty years up to senility. It is as frequent in whites as in negroes. It is not more prevalent among the poor than the well-to-do. However, the highest percentage of operable cases occur among the better class of patients.

Symptoms and Signs.

In carcinoma of the uterus, the first symptoms to attract the attention of the patient or the physician may be a discharge of blood from an internal ulcerated surface. But conditions other than cancer may give rise to similar symptoms. So the symptoms of early cancer are not distinctive and should only serve to arouse suspicion of the presence of that disease. In this situation, the more certain the diagnosis, the less the probability of cure.

If cancer of the female genitalia is to be detected in its early stages, a thorough knowledge of pre-cancerous lesions, as well as its earliest symptoms, must be possessed

by the physician. One must learn to look with suspicion on such lesion as keratosses, fissures, moles, chronic ulcerations and indurations, and the benign tumors which so often precede the development of cancer itself. Erosions and lacerations of the cervix of the uterus are the most common factors which predispose to cancer of the cervix. Kraurosis and leukoplakia of the vulva are forms of superficial lesions, benign in origin, which exhibit a definite tendency to malignant change. Cystic tumors of the ovaries, and polyps of the uterus which are benign in character, are capable of malignant transformation.

The early diagnosis of cancer of the uterus demands a prompt digital and visual examination. The appearance of a discharge should be regarded as a suspicious sign especially if the discharge is bloody and not related to catamenia, or appears after the menopause. If the discharge appears irregularly, after exertion, straining at stool, the use of a douche or after intercourse, it is suspicious of carcinoma of the cervix. Any change in the character of the discharge, even though not bloody, especially if it becomes more profuse, more foul, more watery or more irritating, should arouse a suspicion of malignant disease of the uterus.

On examination one may find an indurated excoriation or ulceration of the cervix, which may be within the os. Later there may be deep infiltration or a productive cauliflower growth, with ulceration, bleeding and offensive discharge. In carcinoma within the cervical canal, a uterine sound or a cotton-wound applicator should be introduced within the cervical canal, up to the margin of the internal os, and if one feels a roughened, perhaps a slightly depressed surface, which bleeds easily, it is very good evidence of carcinoma. In these cases we must rely on microscopic examination of tissue removed with a small curet.

In cancer of the body of the uterus one usually finds an enlargement of the uterus, with a history of a watery discharge and hemorrhage. Diagnosis in body carcinoma is ordinarily determined by curettage and examination of tissue.

In carcinoma of the tube or ovary there usually is abdominal swelling and a feeling of weight or pressure. On examination one

finds nodular masses bilaterally, especially when a Krukenberg tumor is present. The Krukenberg tumor is metastatic in origin, from a breast or an abdominal viscus. Carcinoma of the ovary is present in the comparatively young and after the climacteric and may vary in size from small growths to a mass as big as a man's head. Carcinoma of the tubes is present after the climacteric only, and is usually small in size. The development is very rapid and metastases are numerous. In a woman past the menopause, a free, watery discharge from the vagina, not due to infection or irritation, with a tumor-mass lateral to the uterus, should give rise to the suspicion of a papilloma or papillary carcinoma of ovaries or fallopian tubes.

Primary vaginal cancer is rather rare and it usually starts on the posterior wall. The initial stage may be single or multiple warts, an elastic nodule, a flat infiltration or a fungating mass, readily breaking down and bleeding. Another form may be a granular ulcerated area with infiltrated margins. Still rarer is a carcinomatous infiltration, rigid and contracted. The symptoms usually found are a foul discharge, hemorrhages, dull, aching pain and difficulty in defecation and micturition.

Carcinoma of the vulvo-vaginal gland is rare. It occurs usually in women past the menopause. It may appear in the form of a swelling, often painless; or it may be firm, show a tendency to fixation and break down early. Primary carcinoma of the labia minora is very rare. It may appear as a nodule or hard and painful induration, with early breaking down. Primary carcinoma of the clitoris and hymen is very rare, but when present it offers little difficulty in diagnosis. When in doubt, do a biopsy.

Summary.

In conclusion, to make an early diagnosis of carcinoma, we must emphasize certain things in our daily work:

- 1.—A complete history, especially in regard to an irregular vaginal discharge which is watery, spotting or bleeding, regardless of the age of the patient.
- 2.—A bimanual examination in all female patients except virgins, as well as a speculum examination. In doubtful cases, make a combined recto-vaginal examination—it may reveal surprising things.

Hypotensyl tablets reduce Diastolic Hypertension.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Eosinophilia

By H. G. LAMBERTY, L.R.C.P. and S.,
Edin.

It is generally agreed that Eosinophilia is present when there is an increase in the eosinophile cells in excess of 300 per c.mm. or 4 per cent. of the total leucocytes. The condition is common. It occurs in diseases due to infestation by animal parasites, e.g., ankylostoma duodenale, filariasis (*F. bancrofti*, *F. loa*); in diseases of the skin, and in many acute specific fevers and chronic maladies. It has also been met with in cases known as familial eosinophilia in which the eosinophile cells may be much increased in number without causing any disturbance of the general health. Idiopathic or familial eosinophilia, however, is rare.

In ankylostoma duodenale, the eosinophile cells may attain a maximum of 40 to 60 per cent. long before the clinical aspect of the disease become sufficiently marked to arouse suspicion. This would appear to show that the simple examination of a blood film may sometimes lead to other methods of investigation, e.g., the examination of stools, upon which an early diagnosis may depend. When the onset of anæmia, which is a prominent feature in the late stages of hook-worm disease, the eosinophile cells become less numerous, perhaps owing to progressive exhaustion of the formative tissue, but seldom reach the normal figure of 3 or 4 per cent. until convalescence is fully established. In a few cases, eosinophilia persists beyond the stage of recovery without any apparent cause. The reason for this is not clear.

Filaria bancrofti usually inhabits the lymphatic channels. Infection is transmitted to man through the agency of several species of mosquito, e.g., *Culex fatigans* (*Culex quinquefasciatus*). *Anopheles costalis*, etc. Microfilaria may be present in the peripheral blood stream without necessarily giving rise to eosinophilia. According to Ricot, there must be, in addition, a general reaction set up by the excreta of the adult worm comparable to that of the toxins of microbes localised in some part of the

3.—Determine the cause of the discharge. In a very large percentage of cases, the discharge is due to inflammation or infection of the cervix. In certain cases it is due to infection with *Trichomonas vaginalis*.

4.—Determine whether the cervix is lacerated. Does it bleed on manipulation? Has it any hard nodules? Is it papular or is it soft and mushroom-like? Investigate the entire cervix and not merely the vaginal portion.

5.—Inquire about any post-coital or post-douchal bleeding.

6.—If the cervix is diseased, try to pierce it by means of a sterile probe. In carcinomatous condition the probe penetrates very readily and is followed by a marked bleeding while otherwise definite resistance is offered to the probe.

7.—In suspicious cases, by all means do a biopsy, for that is the only way a positive diagnosis can be made. It is an office procedure. The fear of spreading the cancer by the use of the knife may be allayed by cauterizing the base of the cut surface, thereby sealing the lymphatics.

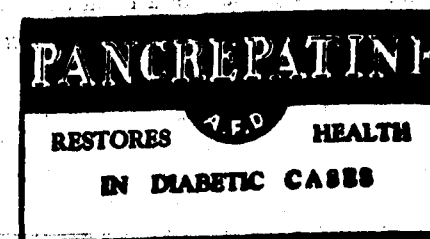
8.—In cases of bleeding from the body of the uterus, a diagnostic curettage must be done, in a hospital, and the tissues examined by a capable pathologist.

9.—Follow up the non-malignant case with periodic examinations. Remember that 95 per cent of all cancers of the cervix that are demonstrable at first examination in the office, offer an unfavourable prognosis for cure.

10.—Impress the patient with the possibility of early diagnosis of carcinoma of the female genitalia, and insist upon triannual examinations, as a prophylaxis against this dreadful disease.

11.—Treat all suspicious and unexplainable symptoms, signs and findings of the female genitalia as due to malignant disease until proved otherwise.

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



organism. In *F. bancrofti* and *F. loa* the eosinophile cells may vary from 4 to 40 per cent. Occasionally, as many as 70 per cent. have been recorded. In a series of 10 cases of *F. bancrofti*, of which only one was associated with helminthic infection, the figures were 6 to 15 per cent.; in the remaining cases, no other cause was found to account for the changes in the blood.

Although eosinophilia may be marked in diseases caused by animal parasites, it is seldom so constant a feature as in diseases of the skin. Such common affections as herpes, eczema, psoriasis, and even superficial burns of the skin, are almost invariably associated with eosinophilia, except in cases in which complications exist as, for instance, when acute inflammatory processes supervene and give rise to a poly-morphonuclear leucocytosis of sufficient intensity as to hinder, or mask, the eosinophilic reaction. It is probable, however, that cases of skin lesion occur in which eosinophilia is absent, apart from the presence of any complicating factor. Such cases may depend, at least to a certain extent, upon a lesser intensity of the lesion, or upon a smaller area of skin being affected, or both.

Eosinophile cells are also found, sometimes in enormous numbers, in the vesicular fluid of some cutaneous diseases, e.g., Durhing's disease (dermatitis herpetiformis) in which their percentage in the blood may at the same time, amount to 10 or 15 and even more.

Eosinophilia has also been observed in malignant disease, syphilis, tuberculosis, asthma, appendicitis, and other chronic affections. Its occurrence in a long-standing case of uterine disease in which it appeared and disappeared for no obvious cause is not very clearly understood.

"*The Medical Times—London June, 1934*".

Clinical Significance of the Systolic murmur.

A. R. FREEMAN, M.D., and Samuel A. LEVINE, M.D.

An analysis was made of the incidence and significance of systolic murmurs in 1,000 consecutive individuals, somewhat more than three-fourths of whom were hospital patients. From the analysis we believe

that, although systolic murmurs are fairly common and often have no importance, frequently they have a definite significance, that can be ascertained clinically and properly explained.

The intensity of the murmur was of considerable importance. In this series it was divided into six grades, from the faintest bruit, heard definitely following the first heart sound (Grade 1) to the type in which the murmur can be heard without a stethoscope and away from the chest. There were 196 cases showing a systolic murmur of grade 1 or 2; 14 with grade 3; and 5 with grade 4. There are comparatively few cases with murmurs of the intensity of grades 5 or 6.

While we agree that the average life expectancy of patients with systolic murmurs is definitely diminished, we believe that if from a series of such cases one rules out those showing the presence of such causative factors as heart disease, hypertension, hyperthyroidism, etc., there will remain a group in which this prognostic rule will not hold true.

A systolic murmur need not indicate serious disease, nor even indicate heart disease. Patients with heart disease and loud murmurs may be in better health and live longer than other patients with heart disease without murmurs or with faint murmurs; but we believe that a systolic murmur of greater than grade 1 intensity should be regarded with suspicion. We wish to speak against the prevailing opinion that systolic murmurs have little or no significance and to emphasize the fact that, although they are frequently present in the absence of heart disease, a proper interpretation of the intensity of the murmur and of the possible causative factors will aid greatly towards more accurate diagnosis, prognosis and treatment of disease. For instance, definite organic heart disease was found in 18 of 196 individuals who showed a systolic murmur of only grade 1 or 2 intensity.

Clinical Medicine and Surgery, June 1934.

Hypotensyl tablets contain the blood pressure reducing principles of Mistletoe.

CLINICAL NOTES AND PRACTICAL SUGGESTIONS.

Prophylaxis and treatment of Whooping Cough.

One of the most difficult and unpleasant tasks that the General Practitioner has to perform is the treatment of Whooping Cough. Owing to the multiplicity of symptoms and their distressing nature there is a great difficulty in finding a product which will either cure or at least improve the condition. Various preparations have been used to mitigate the symptoms but they have not been successful so far as they are not able to paralyse the smooth musculature involved in this affection. Syrup Pertussis Gabail answers the purpose to a remarkable extent because of its spasmolytic properties.

Syrup Pertussis Gabail is a compound presenting a deodorised extract of Valerian in combination with Strontium Bromide, Chloral Hydrate, Ext. Drosera liq. and syrup Rubus Idosus. It is a transparent liquid of heavy density with an agreeable aromatic odour, pleasant taste and uniform action. It can safely be recommended in prescribed doses both to infants and children without the least fear of toxic symptoms. Syrup Pertussis is potent and reliable as a cough alleviator and a respiratory anodyne and sedative. It lessens the irritability, the spasmodic character and frequency of the paroxysms and thus adds to the physical and mental well-being of the patient in this disease. Let it be understood however, that Syrup Pertussis is not offered as a specific for Whooping Cough, but it merely relieves and lessens the frequency of paroxysms, which is a very disagreeable and exhausting feature of this disease. This effect is entirely attributed to the formula of the syrup in which each item is included with sound reasons. The combination has a marked sedative effect on the excited nervous centres which cause the spasms due to the contraction of the laryngeal muscles caused by the toxic substances produced by the causative organisms. The paroxysms when checked by this means enable the patients, who otherwise suffer from nausea, vomiting and disturbed digestion, to retain the food properly.

Another value of Syrup Pertussis Gabail is that it can be given as a prophylactic for Whooping Cough when the diagnosis has not been settled. The outbreak of the illness can be prevented and the fear of further complications can be eliminated by the timely administration of this syrup. And when the disease is already there its course would be decidedly milder and the pneumonic complications would be prevented if the patient is being administered Syrup Pertussis Gabail.

As we have said before Syrup Pertussis is not a specific, in fact there is no definite specific therapy for Whooping Cough. Although treatment with vaccines prepared from Bordet-Gengou bacillus, the causal organism, is considered by some to be effective, very few pediatricians had success with it. Further, this injection treatment cannot always be carried out in the majority of cases for some reason or other and hence we have only to treat them medically. Syrup Pertussis Gabail therefore is the best remedy for symptomatic treatment as it has proved an excellent anti-spasmodic. Not only in the mild or moderate cases, but even in severe types with bronchitic symptoms this syrup is of great service. The effects show themselves in the mitigation of the spasmodic cough and reduction in the number of attacks. The retching and vomiting become progressively less. A rapid improvement is noticed in the irritability and the general condition even in the most fretful children. Exhaustion too is effectively overcome. It is necessary however to add to this treatment some form of Cod Liver Oil and Calcium preferably Pharmasol Collo Calcium in order to cope up with the spasmodic diathesis.

It will be recognised therefore that in Syrup Pertussis Gabail the medical profession is provided with a popular remedy for alleviating this most troublesome and exhaustive type of cough. Its agreeable taste enables the little patients to take it easily. It does not nauseate nor does it affect the appetite. It does not contain Opium, Belladonna or Aconite. It is not habit-forming and is perfectly well-tolerated by the stomach. Due to these advantages and due to its alleviation of the various symptoms Syrup Pertussis Gabail contributes in a great measure to the attainment of the desired results in this disease.

Experiences with Bacte-Rhino-Phage.

It is common knowledge that the nose and the throat are the principal entrances for pathogenic bacteria to transmit various diseases to the lungs and the pharynx. Even serious infectious diseases such as diphtheria and scarlet fever find their way into the organism through the oral cavity. In view of this it is advisable to prevent the development of the pathogenic bacteria giving rise to all these diseases by destroying them—at the very entrance. The only effective means of doing this is the use of Bacte-Rhino-Phage by means of an atomiser. Apart from this prophylactic action it acts as a specific in the various topical affections produced by different pathogenic bacteria.

Numerous clinical observations and laboratory experiments have demonstrated the bactericidal power of Bacte-Rhino-Phage. It is reliable both in the treatment and prophylaxis of various infectious diseases. Bacte-Rhino-Phage being a mixture of various strains of Bacte-Phages, affords an excellent means of obtaining rapid bactericidal action. It is useful as a specific in the various affections of the upper respiratory tract as the different strains in this Phage are selected from the different bacterial species isolated from the affections of the nose and the pharynx. It therefore rapidly destroys cultures of such bacteria as staphylococci, streptococci, pneumococci, enterococci etc., which are usually found in the affections of these regions. The symptoms are soon alleviated, the inflammation is subdued and the condition is soon relieved without the least harm to the organism. No other drugs or local antiseptics are needed in Bacte-Phage treatment.

The menace constituted by Rhinitis or common cold and its relatives can be easily brought under control by spraying once or twice a day ampoules of this Bacte-Rhino-Phage. Favourable results from the use of these sprays in the treatment of colds has been the experience of various physicians. Many of these patients experience prompt relief forty-eight hours after the use of this Phage and the majority of them are entirely free from symptoms by the third day after the treatment is instituted.

It offers the best and most prompt results in the treatment of colds. The Bacte-Rhino-Phage therefore is a powerful prophylactic against diseases of the upper respiratory tract since it effectively deals with Rhinitis or Colds which are precursors of serious infections such as influenza, pneumonia, Bronchitis etc. Incidence of these and other infectious diseases can be lowered by the timely application of this remedy. Furthermore, this Phage is capable of affording immunity to colds for varying periods of time if used at weekly intervals stretched over long periods of time.

Sinusitis, either frontal or maxillary, is amenable to treatment by this Phage as the infecting organisms in these cases are commonly pneumococci or streptococci. It may at times be a mixed infection. Bacte-Rhino-Phage being a mixture of these various strains acts as a specific in these cases. Pain, tenderness and discharge, the usual symptoms of these affections are soon brought under control by the regular spraying of this Phage once or twice a day according to the severity of the trouble. Many persons are benefitted by this line of treatment, where scraping and puncturing of the sinuses have failed to bring about any amelioration. It is a safe, convenient and effective method of dealing with these troubles.

Spraying of this Phage has been a greatful application in Bronchial Catarrh specially when it is accompanied by fever and headache. It affords an excellent means of allaying irritation, soothing the inflammation and relieving cough and difficulty of breathing.

Another indication in which Bacte-Rhino-Phage can be effectively sprayed is Coryza. Two or three days of its regular use will stop the profuse muco-purulent discharge as well as running of the eyes. The frontal headache and the febrile symptoms if any will also be relieved promptly. This disorder being microbic in origin yields easily to this Phage which helps to destroy the various bacilli that the nasal cavities harbour. Although it is not a serious disorder, its repeated occurrence may lead to such trouble as Otitis Media or even Bronchial Catarrh. It is therefore very important to

about the disease once it has set in by vigorous treatment with Bacte-Rhino-Phage.

The nose, throat and the tonsils, it is well-known, are the starting-points from which the bacilli of Influenza penetrate into the system and attack the various organs. Although the Pfeiffer's bacillus plays an important role in the beginning of the attack, the whole infection soon becomes a mixed one, haemolytic streptococci predominating. Usually the routine treatment of salicylates is given without paying any heed to the bacilli that thrive in the oral cavity. It is possible to destroy the bacilli at their seat of attack by means of Bacte-Rhino-Phage. It is proved beyond doubt that the growth and the development of Influenza and other bacilli that are the causative agents of the disease are made impossible by the regular and timely spraying of Bacte-Rhino-Phage. It is a powerful antiseptic. It permeates all the crevices of the throat, penetrates into all the folds of the mucous membrane of the nose and unlike antiseptic gargles remains for a long time in contact with the infected areas. All these actions are brought about without causing any sort of irritation to the cells of the organism, as it acts exclusively and selectively on the bacilli. Bacte-Rhino-Phage is not only a strong therapeutic remedy but is an effective prophylactic against Influenza. Its regular use at the proper time cures the disease and also prevents its further spread into the lungs and development into real toxic influenzal state.

The outstanding effect produced by Bacte-Rhino-Phage therapeutically is the relief it affords in certain cases of asthma which are due to hypersensitiveness to proteins derived from germs inhabiting the upper respiratory tract. Its action is slow but none the less sure. Spraying this Phage or plugging the nose with cotton soaked in it often suffices to keep the patient free from attacks. Nasal sprays of this Phage have a greater utility than any other medicine in the treatment of this allergy.

In Bacte-Rhino-Phage we have an efficient therapeutic agent which not only successfully and promptly relieves common colds and other affections of the upper respiratory tract, but prevents their extension into the lungs. The treatment can be given for prolonged periods as the toxicity

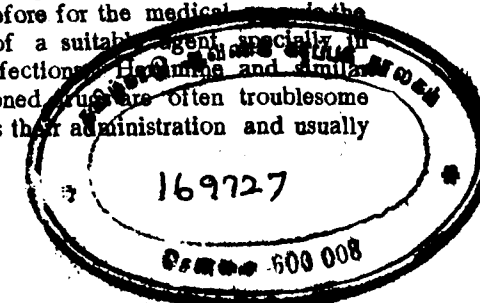
is very low. It has therefore a decided advantage over vaccine treatment. As this Bacte Phage has no effect on the cells of the organism, there are no contraindications to its use at all. Its effects are more rapid than any ordinary vaccine. On account of the absence of any protein content in it, the Phage hardly causes any reaction. Again, spraying can be repeated two or three times a day which is an obvious advantage over vaccines in acute infections. All things considered Bacte-Rhino-Phage has proved itself extra-ordinarily successful and at the same time absolutely harmless in the affections mentioned above.

The following case is typical of many and will illustrate quite well what has been said above regarding Bacte-Rhino-Phage.

A middle-aged woman was suffering for a long time from severe chronic Rhinitis and Sinusitis. It appeared from the terrible headaches that she had specially over the eye-brows, that frontal sinuses were involved. The nasal discharge was profuse and at times of the foetid type. During this long period of suffering she had received all sorts of palliative treatments and according to her history had also been operated upon. I suggested Bacte-Rhino-Phage, one ampoule of which she sprayed in the nose twice a day. The spraying was continued for four weeks. She was feeling very much better after this. The treatment was continued and the discharge after six weeks was very much less, it had become of a serous nature and had lost its foetidity. Headache had also disappeared. Two months of this treatment had completely cured this patient who had suffered long from this complaint. Later on I gave her injections of Pharmasol Collo Calcium (12 in all) intramuscularly and there has been no recurrence of the trouble so far i.e., about six months now.

An easy method of combating B. Coli infections.

Urinary antiseptics is a problem of great importance to all clinicians and it is on account of this that the need for a reliable urinary antiseptic asserts itself. The problem therefore for the medical man is the selection of a suitable agent, specially in B. Coli infections. B. Coli and similar old-fashioned bugs are often troublesome as regards their administration and usually



do not attain the end we have in view. They cannot be relied upon entirely, and in many respects they fall far short of the qualities essential for rendering the urinary tract anti-bacterial. The outstanding features that should distinguish a reliable urinary antiseptic particularly in cases of B. Coli infections is that it should be stable, non-toxic and non-irritating. Again it should be in sufficient concentration to exert an anti-bacterial action and at a rate by which the action will be maintained and continued for a sufficient time. The last but not the least important factor about such a product is that it should be administrable by the mouth. One product at least fulfills all these desiderata and that is Bacte-Coli-Phage.

This is a sort of vaccine preparation to be given internally. Whereas vaccine treatment must necessarily be uncertain, lengthy and tedious and even if successful at times there is every possibility of the recurrence of the trouble, this Bacte Phage therapy is easier of application and more certain and rapid in its results. Bacte-Coli-Phage, moreover, possesses the property of tissue penetration thus reaching the submucous area where the pathogenic process is at its maximum. Bacte-Coli-Phage is an effective bactericidal agent against micro-organisms of the cocci type, particularly the B. Coli. It is also of service in mixed infections of the genito-urinary tract.

Bacte-Coli-Phage is presented in the form of ampoules of 2 cc. for ingestion and subcutaneous injection. Ampoules of 10 c.c. are available for irrigation and instillation. Each cubic centimetre of the sterile solution contains one billion bacteriophages capable of destroying different strains of pathogenic B. Coli and paracoli. This Phage remains potent for a long time and it is non-toxic and non-irritating but it exerts its anti-bacterial action only in alkaline medium and it is always necessary to give large quantities of Soda-Bi-Carb, a drachm per dose, to the patient to alkalise the urine. Bacte-Coli-Phage shows a strong anti-bacterial action towards several types of Cocci and the B. Coli communis. In addition to its strong anti-bacterial action this Phage is highly capable of penetrating into the tissues and of markedly stimulating

the proliferation of the epithelial cells. These latter properties explain its successful use in chronic cases of Bacilli Coli infection.

In the treatment of Cystitis of B. Coli origin Bacte-Coli-Phage has now become an established remedy. Its employment by the increasing number of clinicians, who testify to its efficacy, shows that it is a reliable therapeutic agent in this disease. Whether the infection is acute or chronic this Bacte-Coli-Phage ingested twice a day, once on an empty stomach and once at bed-time 3 hours after the last meal in half a glass of Vichy water or ordinary lukewarm water, will prove of immense benefit. The dosage may be increased according to the individual necessities of a case. In addition to this Phage therapy, confinement in bed, hot fomentations, hot sitz baths, liquid diet, local irrigations are all necessary for effecting a rapid cure and easing the patient. In chronic cases it is better to adhere to this therapy alone. In the majority of cases this treatment brings about rapid and admirable results by soothing the mucous membrane and reducing pain and frequency of micturition. By stimulating the epithelial cells it tends to bring about healing of the inflamed mucous membrane and by its ability to penetrate the tissues it exerts its anti-bacterial action even on the B. Coli lodged in the submucous layers. This Bacte Coli Phage is well tolerated and hardly causes any reaction. Its effects are rapid and soon after its administration for some days the number of organisms tend to become less and less until they vanish altogether, pus is reduced and the symptoms disappear entirely.

In Pyelitis including that found in pregnant women and children Bacte-Coli-Phage when taken regularly, after rendering the urine fully alkaline by means of large doses of Soda-Bi-Carb, helps to mitigate the pain and frequency of micturition and to perceptibly reduce the amount of pus in the urine. This it does by its strong anti-bacterial action and deep penetration. If it is necessary to carry out bladder lavage 10 cc. ampoules meant for instillation may be used with benefit. This Bacte Phage is markedly useful in the treatment of Pyelitis during pregnancy in which condition it is

not at all contra-indicated. It can also be employed with benefit in Pyelitis which often follows operations.

In Pyelo-Nephritis Bacte-Coli-Phage shortens the course of the disease and alleviates in a notable manner such symptoms as irritability and frequency of micturition and reduces the amount of pus in the urine. This result is attained because this Bacte Phage penetrates deeply into the tissues and organs which are not accessible to other similar preparations.

Bacte-Coli-Phage exhibits marked bacteriostatic action against B. Coli Communis and is therefore specially serviceable in Endometritis, Salpingitis and Prostatitis caused by the same organism. It is found highly satisfactory in these conditions which are usually resistant to other treatments and its internal administration will often obviate the necessity for any sort of local treatment.

As a prophylactic before and after operations Bacte-Coli-Phage can be given internally or instilled locally as it would undoubtedly lessen the tendency to sepsis. It is thus of great service in various operations on the urogenital tract.

The Bacte-Coli-Phage is distinguished by the following characteristic features and advantages:

1. It possesses powerful anti-bacterial action against the cocci type of organisms.
2. It has no toxic effects and does not cause any reaction.
3. It penetrates into the tissues and stimulates the proliferation of epithelial cells.
4. It lessens pain and inconvenience to the patient.
5. It prevents complications.
6. It can be administered orally.

Details of one case which had come within the experience of the author will be of interest to the profession.

I was called to see an elderly lady who had high temperature 104° with a pulse-rate of 130. She was complaining of severe pain in the hypogastrium. Micturition was frequent and painful. The urine on examination showed a large number of B. Coli and a heavy deposit of pus. She gave history of previous attacks of this nature for the last five or six years at the interval of 8 or 12 months. These cleared up after 15 or 20 days. The present infection was one

such and I at once prescribed B. Coli. Phage. I injected 2 cc. of it subcutaneously at the very start and asked her to take one ampoule in half a glass of Vichy water every four hours leaving some interval between this and her nourishments. She was having Soda-Bi-Carb in drachm doses about four to six times per day. After four days of this routine her temperature was normal but there was very little relief from the urinary symptoms. At the end of ten days however there was some progress as could be seen from the very little pain that she suffered during micturition which also was not as frequent as before. There was absolutely no tenderness over the hypogastric region and her general condition was decidedly improving. The urine also was much more clear and free from pus and only showed isolated B. Coli on examination. The dose of the Phage was accordingly reduced, she was having the contents of one ampoule on waking in the morning and one at bed time. After about a week more of this routine the urine was found absolutely sterile on culture.

It may be noted here that whereas Hexamine and alkaline line of treatment although apparently clear up the attacks, there is every tendency for these latter to recur. With Bacte-Coli-Phage not only is there every possibility of getting rid of the attacks but there is hardly any chance of their further recurrence.

Diagnosis and treatment of Lumbago.

Lumbago may be defined as pain in the lumbar muscles. The term is loosely applied to any kind of backache irrespective of its location and hence for the speedy cure of the complaint accurate diagnosis of the etiological factor is absolutely necessary.

Lumbago covers a multitude of conditions, real and referred. We do not propose to deal here with referred pains and those due to organic conditions, but only those in which lumbar muscles are involved. This latter is a definite and a real clinical entity, although it is not well-defined pathologically. Lumbago is frequently met with in general practice and is considered one of the common non-articular manifestations of either Rheumatism or Gout. It is very often a painful crippling condition

and is sometimes associated with fibrositis, either acute or chronic, of the various structures in the loin. Males of all ages are more frequently affected than the females.

The complaint very often varies in its onset. Sometimes it comes on suddenly with great violence and immediate incapacity. At other times it is gradual and it persists with such tenacity that the patient gets worn out.

In the acute attack, although fibrotic, no fibrous thickenings or nodules can be detected on palpation. The patient complains of intense pain in the lumbar region and the movements are also very much restricted and painful. When the attack becomes chronic the pain is more localised and careful palpation may enable us to detect either nodules or plaques of fibrous tissue. These fibrous thickenings may be prevented by careful and judicious treatment during and subsequent to the acute attacks. If they are once formed and allowed to persist any exciting cause may flare them into activity with the result that there will be an attack of Lumbago. Among the exciting causes may be enumerated exposure to cold, trauma, strain or over-exertion, septic focus, colitis, intestinal toxæmia, food idiosyncrasies and allergic conditions.

When we come to the treatment of this complaint we cannot dissociate several aches and pains in other muscles and joints which are usually labelled "Rheumatic" Lumbago as these pains also have their origin from some infective focus somewhere in the organism, from which the toxins circulate in the system with the result that this complaint and a whole host of similar conditions arise. This chronic septic focus may be present in the teeth, tonsils or sinuses and the removal of this focus may result in marked improvement. Ascribing all these conditions to these septic foci is somewhat an exaggeration, as is found from several cases in which very little or no benefit is derived even after removal of the foci. However it is essential in these conditions to examine the mouth and any signs of pyorrhoea or caries in the teeth, if detected, should be vigorously and radically treated and this might end in a cure of Lumbago. Tonsils are the next to attract our attention. Sometimes tonsils which

appear quite innocent exude a good deal of pus when pressed. The enucleation of such tonsils means eradication of the root cause of the disease, which in turn means complete cure. Any form of infection in the nose or naso-pharynx or the accessory sinuses should be next looked for and if present should be treated with Bacte-Rhino-Phage and surgical measures. Endocrine deficiency particularly of the Thyroid is considered in some cases as giving rise to this trouble. Any signs of Seborrhoea in the scalp or any other parts of the body or any evidence of hypo-thyroidism should be found out and if present should be treated with Opocrin Thyroid. That would result in permanent benefit to the patient and no recurrence of the trouble need be feared afterwards. Another system that needs investigation is the alimentary tract. If there is any inherent atony of the intestines or inhibitory condition due to intestinal stasis, Mycol treatment is called for, which will deal effectively with the atony or the stasis of the intestines and thus not only relieve the patient of the trouble but will protect him from future attacks of this recurring illness. If there is any evidence of Gout or Gouty diathesis treatment with Urogenine is indicated. This will diminish uric acid formation, lower uric acid from the blood and increase its excretion through the kidneys. Allied with this, diet restriction of proteins and foodstuffs of high caloric value and purin content is necessary. Salines and diuretics in order to flush the intestines and the kidneys are also valuable. Some cases of Lumbago are attributed to food idiosyncrasies. Pain and stiffness in the lumbar region following certain articles of food should best be treated by avoiding them. When lumbar pain is associated with Oxaluria careful dieting together with the administration of Urogenine will remarkably aid the pain and stiffness to subside. Salines and diuretics may advantageously be given in the acute stage.

Pain should be relieved in the acute stage by complete rest in bed combined with application of heat. Anodyne applications should be well massaged into the lumbar region in conjunction with heat.

Drugs which can be beneficially given are Salicylates, Bromides in combination with Salines and diuretics. The therapy of

this complaint has been greatly improved owing to the discovery of Iodaseptine and Salicylated Iodaseptine. While the latter is effective in acute and subacute attacks, the former can be continued during the intervals to prevent and later entirely stop the recurring attacks. Salicylated Iodaseptine possesses the advantage over the classical Salicylates of prolonged administration in active doses with no ill-effects such as giddiness, tinnitus or sweating. This Iodaseptine is prepared in a suitable form for intravenous injection. Iodaseptine and Salicylates, the two most powerful agents, are so combined that increase in therapeutic effect is observed in greatly reduced doses. When given intravenously this Salicylated Iodaseptine has the most remarkable effect of relieving pain of Lumbago of whatever origin. Its action in this muscular or even articular rheumatism of acute or subacute variety is certain, prompt and enduring. Permanent cure is usually effected after the course of 6 to 8 injections. Pain usually disappears after the second or third injection. In order to avoid the possibility of a relapse it is desirable to inject after the acute stage simple Iodaseptine. This will prevent further outbreaks of acute attacks or at least diminish their severity and frequency. In chronic cases of Lumbago where partial mobility indicated that the affection was confined to soft parts, increased movements followed by complete cure is the result of Iodaseptine injections. In acute and subacute cases Salicylated Iodaseptine is of great benefit while simple Iodaseptine is valuable as a curative and prophylactic in chronic cases.

The numerous advantages that Salicylated Iodaseptine offers over the ordinary salicylates commend its employment in these cases. It is well-known that treatment with Salicylates act on the blood-corpuscles and has a depressing effect on the heart because of the disturbance of the ionic equilibrium. Salicylated Iodaseptine permits its continuation for prolonged periods without any ill-effects and with the best of toleration. Again, Iodaseptine is a good cardiac tonic and resolvent, and an efficacious stimulant of defensive mechanisms and eliminatory organs. Salicylates when given in high doses upset the stomach, while this Salicylated Iodaseptine when given intravenously is not in the least injurious. Iodaseptine has

without any of its disadvantages. It achieves a more rapid and a more powerful action of Iodine without causing any of the symptoms of Iodism. When Iodaseptine is administered, either intramuscularly or intravenously, there is easy and uniform splitting off of free iodine and it is therefore borne locally as well as generally much better than of the inorganic or organic salts of Iodine. Iodaseptine can be employed with great advantage in all the indications of iodine therapy. All physicians who have had the occasion to use it are unanimous in their verdict concerning its efficacy, safety and freedom from symptoms of Iodism even if it is administered daily for some length of time. Intramuscular or intravenous injections are well tolerated and do not cause any irritation or pains. The treatment of Lumbago and other allied affections with injections of Salicylated and simple Iodaseptine is a great advance on the classical therapy of salicylates because of its permanency of effects, least discomfort to the patient and facility of employing high dosages.

Clinical Application of Crystalline Ovarian Hormone.

A great amount of work has been carried out in recent years in investigating the complex endocrine system which controls the female sex organs. Probably the most important discovery resulting from this research, and one which offers immense possibilities, is the isolation of folliculin or oestrin, the ovarian hormone, which appears to be the hormone which exerts the greatest influence over the genital functioning of woman between puberty and the menopause.

That a certain amount of doubt exists regarding the therapeutic value of ovarian hormone preparations is readily understood, when we recollect that most important discoveries are accompanied by an immediate attempt to utilise the newly discovered product before the necessary minimum knowledge regarding the substance has been acquired.

Oestryl however is a preparation containing the ovarian hormone Oestrin which has been carefully standardized and which is constant in activity, furthermore, the concentration of this hormone in Oestryl is such that it closely corresponds to woman's actual physiological requirements.

A factor which has greatly impeded oral administration of Oestrin or folliculin pre-

parations is the destructive action of the gastric secretions on folliculin resulting in a great diminution of its activity, rarely leaving more than 20-25 per cent in an assimilable condition.

Research has however resulted in the discovery of a derivative of folliculin, closely resembling it in chemical composition but which possesses the valuable property of not being destroyed when administered orally, also when given in the same dosage it is equally as active as the oily solution of folliculin administered parentally. Oestryl for oral administration contains this folliculin derivative which has been thoroughly standardised, thus providing us with a preparation which may be administered orally without fear of destruction from the gastric secretions.

An important point to be borne in mind when considering ovarian hormone preparations and their administration is that recent research has definitely revealed that the quantity of follicular hormone elaborated by normal woman greatly exceeds the amount originally thought, hence the necessity of using a preparation of a potent, constant and standardised activity.

A brief review of symptoms which may be treated with Oestryl reveals a wide range of application.

Due to its folliculin content it is capable of increasing the flow of blood in the uterus, also certain cyclical changes in its mucous membrane. The hormone folliculin passes from the ovaries into the blood stream and exerts an influence on the whole system. Thus where a deficient secretion of folliculin is present, the resulting effects are evident not only locally but throughout the whole system, and in support of this we must bear in mind the most important factor in connection with endocrine functions i.e. a definite balance exists between the endocrine glands, and any interruption of the normal function of one will probably affect the remainder, or at least the majority.

The serious symptoms which arise from a breakdown of the endocrine balance are fully evident in the changes which occur at the Menopause. At this stage we find a change over from an active to a passive sexual life, which is accompanied by a reduction in folliculin secretion, and from

evidence obtained it appears that this diminution in folliculin secretion is responsible for upsetting the endocrine balance and causing onset of the various symptoms.

This change affects the normal metabolism and induces both physical and psychical changes. Among the physical changes we find flushings of heat and cold, and numerous symptoms arising from disturbance of the vasomotor system, among which we may mention, certain affections of the eyes, ears, kidneys, nausea, menopausal rheumatism etc. We also find certain skin affections such as pruritis, eczema, erythema etc. The psychical changes vary exceedingly in character and intensity.

These symptoms should be treated at the onset, the objective being to lessen the severity of the transition from one mode of life to the other, and to accomplish this we have a valuable remedy in Oestryl, which by virtue of its folliculin content which is of a constant and standardised activity is capable of largely rectifying this breakdown of endocrine balance caused through insufficient folliculin secretion.

Oestryl may be used with great benefit in treating the symptoms following surgical or radiological castrations. Both these operations produce symptoms similar to those occurring at the Menopause, but of much more rapid onset and greater severity. The severity of these symptoms can be greatly reduced and frequently prevented by administration of Oestryl, preferably by injection, since it supplies the hormone folliculin the natural source of which has been abruptly removed during castration resulting in a severe breakdown of endocrine balance.

Folliculin is probably the chief secretion concerned in controlling and activating the menstrual flow and generally absence or suppression of the menses clinically termed Amenorrhoea and Hypomenorrhoea are due to hyposecretion of this hormone. In these cases Oestryl regime is followed by a marked improvement producing a return of normal and regular menses, at the same time improving the nervous and physical symptoms associated with such disturbances.

Delayed puberty accompanied by infantile uterus and precocious obesity, when

arising from hyposecretion of ovarian hormone can be most suitably treated with Oestryl. The polliculin content of this preparation supplements the deficient natural secretion and promotes development of the uterus and onset of puberty, at the same time overcoming the secondary symptoms which accompany delayed puberty.

Adiposo-genital syndromes frequently found in young women may arise from deficient folliculin secretion. These women generally suffer from irregular menses, also obesity which is frequently rather marked. Such cases will be found to respond well to Oestryl, this treatment reducing the obesity, promoting regular menses, and improving the general condition of the subject.

Oestryl will generally be found effective in subduing the pernicious vomiting associated with pregnancy, also in abolishing the nausea present in these cases, due to these symptoms mostly arising from ovarian dysfunction.

Another important application of Oestryl is in supplying the maternal hormone to a prematurely born child. Towards the end of pregnancy there is a relatively high proportion of folliculin in the maternal blood and since this circulates in the foetus it will be readily realised that the sudden interrup-

tion which occurs in premature birth is exceedingly detrimental to the infant, but this can be alleviated by the administration of Oestryl. This hormone folliculin also appears to exert a controlling influence on growth and nutrition and where an infant suffers from defective growth and nutrition Oestryl should be included in the treatment.

In considering the therapeutic value of Oestryl we must bear in mind that its administration is indicated for symptoms in which the primary causative factor is deficient ovarian hormone secretion. In these cases the symptoms are numerous and varied in character and arise through the hormone deficiency causing a breakdown of the endocrine balance, thus the object of Oestryl administration is the restoration of this balance, and to accomplish this successfully it is essential that treatment should be commenced early in order to prevent the system becoming partially adapted to a new endocrine balance which is totally unsuitable for the well being of the subject. If these points are borne in mind it will be found that Oestryl is a valuable preparation constant and standardised in activity—for treatment of the various symptoms arising from deficient folliculin or ovarian hormone secretion.

CALCIUM THAT IS ABSORBED

THE daily adult requirement of calcium amounts, according to highest authority, to 0.45 gram (7 grains) per day. It can be predicted that the intake of a very large proportion of patients is far below this requirement. Our great interest in Cod-Liver oil, violet rays, vegetable diets, etc., should not blind us to the fact that after all they contain little or no calcium. The satisfactory use of lime requires a number of considerations, such as (1) acidity of the upper bowel (2) alkaline metabolic end products, (3) a balanced administration of phosphorus, magnesium and the alkaline bases. These considerations are fully met in

CALCIONATES

Three teaspoonfuls = the lime of 1 pint of milk
Calcionates is supplied in 4 ounce bottles.

Manufacturers: **The UPJOHN COMPANY, U.S.A.,**

For particulars and literature apply to sole agents:

T. M. THAKORE & COMPANY,

111, Nainiappa Naick Street, P.T., Madras.

Head Office: **43, Churchgate Street, Fort, Bombay.**

TREATMENT OF CHOLERA

Though Cholera is a specific disease due to a specific bacteria, the history of cholera epidemic must have convinced the medical profession that apart from the infection by the Coma Bacillus, there should be other disturbances in the human system to bring about a regular attack. The most important organ that guides and controls the gastric and intestinal flora is the Liver and if this organ functions normally no disease bacterial, constitutional or due to other causes can upset the stomach and intestines. The 'ONE HERB SPECIFIC' a preparation prepared from only one Indian plant has been tried and found very useful not only in preventing cholera but in curing the same, being a specific for correcting the dysfunction of the Liver.

Preventive Treatment. When cholera rages in a locality give a teaspoonful (adults) in an ounce of water morning and evening if there be any gastric or intestinal disturbance. Children may be given proportionately smaller doses depending upon age, basing on the formula $\frac{\text{Age}}{\text{Age}+12}$ i.e. a child of 4 years old should be given $\frac{4}{4+12} = \frac{1}{4}$ the adult dose, dissolved in 2 teaspoons of water.

Curative Treatment. As soon as a patient starts vomiting or purging or both, stop all diet even water for six hours and give the following mixture:—

One Herb Specific	...	...	drs.	2
Tint. Zingiberis fort.	...	...	mms.	13
Spt. Chloroform	...	...	mms.	15
Spt. Ammonium Aromat	...	...	mms.	15
Spt. Aether Nit.	...	...	mms.	15
Spt. Camphor	...	...	mms.	5
Glucose	...	...	drs.	2
Aqua add	...	...	oz.	1

Such a dose should be given every 2 hours till the symptoms abate and then at longer intervals. The patient should be kept warm, wrapped in woolen clothing and hot fomentation given to the loins and abdomen. If the extremities are cold and clammy they may be rubbed with brandy or turpentine or both mixed and hot water bottles applied. After 6 hours the patient may be given thin Arrow-root gruel sweetened with glucose and flavoured with lime juice in small quantities and later preferably after 48 hours milk may be added to the Arrow-root gruel without lime juice.

We are having very good reports from medical practitioners from Madras, Bihar and some parts of Bombay presidency where the Cholera epidemic is raging. The specific is supplied only to the members of the medical profession for a special net price of Rs. 1-0-0 per bottle.

THE ORIENTAL RESEARCH LABORATORY, Vepery, Madras.

News and Comments.

Poisons' Act: We understand that the Commissioner of Excise, Madras, has made a reference to the Registrar, Madras Medical Council asking his opinion regarding the advisability of controlling all kinds of transactions in the following preparations as this subject was under the consideration of the Council of the League of Nations:—(1) preparations of Esters of ecgonine and of their salts; (2) Preparations of dihydromorphine; (3) Preparations of esters of dihydrohydroxycodine of dihydrocodoinone, of dihydromorphinone, of acetyl dihydrocodoinone, of dihydromorphine and of their salts; (4) Preparations of morphine-N-oxide, (Gonomorphine); (5) Preparations of morphine-N-oxide derivatives and of the other pentavalent nitrogen morphine derivatives; (6) Preparations of ecgonine, theboine, benzylmorphine and other ethers of morphine and of their salts except (methylmorphine and ethymorphine and their salts. The Registrar Madras Medical Council has under the direction of the President been gathering the views of the individual members of the Council.

This is another phase of the Poisons' Act about which we commented in our last issue referring to the hardships of the members of the profession in U. P., where the Government have introduced certain regulations under the Poisons' Act with regard to drugs like Aconite, Atropine etc., and their preparations. All the preparations mentioned in the letter of the Commissioner of Excise, are rarely used by the members of the profession. Even if it were otherwise, there is no necessity of any control for any kind of transactions by the Registered Medical Practitioners as the Medical Council has efficient control over the conduct of the Registered Practitioners with regard to sale of poisons, any practitioner offending the existing rules regarding the sale of poisons being liable to have his name erased from the Medical Register. We trust that the members of the Madras Medical Council will give their unanimous opinion that there is no need for any department to interfere with the rights and privileges of the Registered Medical Practitioners.

Primary F.R.C.S. Examination in India: We welcome the well thought of arrangement by Lt.-Col. Wright the Officiating Principal Madras Medical College, in

organising Tutorial classes for coaching up the candidates appearing for the ensuing F.R.C.S. Examination which will be held in Madras in the third week of December next. The candidates will be given lessons in Anatomy, Physiology including Bio-Chemistry at the Madras Medical College, outside regular working hours, the fee for each subject being Rs. 100, for Physiology and Bio-Chemistry (together) Rs. 150. It will be an excellent idea if Col. Wright were able to get the services of doctors as Tutors who have recently undergone the F.R.C.S. ordeal themselves. It is essential that those who tutor should know what is expected by the examiners from the candidates. Mere knowledge of the subjects however thorough will be of no avail for the candidates to pass the examination. It is not known when the classes will begin working. The last day for the receipt of applications for these classes is fixed as the third September.

A New Hospital at Sholapur: His Excellency Lord Brabourne, Governor of Bombay opened a Hospital at Sholapur on 14-8-34 organized by the Medical Relief Association at Sholapur. The Sholapur Municipality gave Rs. 5,000 and the Wadia Charitable Trust gave Rs. 10,000 on condition the Hospital was named after the late Mr. N. M. Wadia. Other donors helped with Rs. 7,000. With this initial help the Association built the hospital and they are confident of public support to complete the project. Drs. Tilak and Kaikini and other local practitioners have volunteered their professional services to the hospital. The Governor expressed his appreciation of the unofficial and voluntary efforts to promote the cause of medical relief in Sholapur but regretted the inability of the Government to help the institution financially as there was a well equipped Government hospital in Sholapur and expected that the Sholapur Medical Relief Association would not relax their efforts to make the institution useful to the locality. We congratulate the Sholapur Medical Relief Association on their achievement. They would have certainly been encouraged if the Governor of Bombay made a small gesture by announcing at least a very small grant as a token of appreciation of the disinterested work of a private body. It is very unfortunate that the system of medical administration has

been mainly responsible in not encouraging voluntary private medical institutions though philanthropy and public spirit are not wanting in this country. The award of titles and medals to such of those philanthropists who wish to get the appreciation of the Government for their charities has been the main cause for the dwindling of true charitable disposition on the part of those who can afford charities, so much so that no charitable institution is being encouraged by the public unless persons of the position of Governors and Viceroys have something to do with these institutions. It should be therefore the aim of the Government to encourage voluntary medical aid. Then only the question of medical relief of the masses could be solved more satisfactorily than now.

The Rich to pay for Treatment:

The Bombay Municipal Corporation recently adopted a resolution regarding the advisability of charging well-to-do patients attending municipal hospitals and dispensaries in the City of Bombay. The reasons put forth by those who opposed the resolution were far from convincing. One member said that the rich were contributing towards the municipal revenues and hence should not be debarred from getting free medical relief. Another said the rich would not visit the hospitals and dispensaries and at the most they would be 5% of the total number that went to hospitals for relief. While a third, a medical man himself argued that no rich man would wait at the hospitals from 8 A.M. to 2 P.M. to get his medicine.

It is certainly a very wrong principle that medical relief only should be free. Why not the poor get free relief with regard to engineering, legal and such technical matters from public bodies and the most reasonable relief would be with regard to food and clothing, a real necessity for life which will even ward off illness. If the rich do not care to attend the charitable institutions and even if their number is very small, why not prohibit even this small number. The process of tipping which the rich only could afford helps the rich to get themselves attended to without waiting from 8 A.M. to 2 P.M. On the other hand this process is the cause of inordinate delay

which the poor are subject to in getting relief at charitable institutions. If the well-to-do are prevented from getting free medical relief at charitable institutions, private hospitals will certainly increase in number and they will be equipped to meet the demand of various classes of well-to-do people as is the case with ordinary households which cannot be of one uniform type each one having to build a house and equip it according to his means. This is the law of nature which if followed in the matter of medical relief can never be a hardship either to the rich or the poor, who will look after themselves much better than they are now looked after by municipal or Government medical institutions. In all civilised countries especially in Great Britain every hospital has in its staff an officer called the Almoner who is not a medical man and who controls admission to the charitable institutions. He has a list of the well-to-do in the area served by his hospital and he refuses admission to the well-to-do. The Government and the Municipal bodies who collect revenues and taxes from the public can in this country also have a list of the well-to-do which list they can supply to all charitable institutions. The appointment of Almoners will surely be an economic measure in hospital administration and it will not be difficult in Bombay to realise this as in that city quite recently an experiment was tried in some hospitals where a lay secretary was appointed for hospital-administration and it was found that such institutions were more economically managed than they were before. We would suggest that in institutions such as the K. E. M. Hospital, Bombay where the entire staff is honorary the Bombay Corporation should charge a reasonable amount towards the Hospital stoppages and also a fee in addition, the former to be credited to municipal funds and the latter paid to the honorary staff. In Government institutions where the staff are amply paid, the fees received from the public should also be credited to Government treasury. If the medical profession and the public co-operate and bring about the reforms suggested by us neither the rich nor the poor will have any grievance with regard to medical relief and the medical profession will be more uniformly con-

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."

tended and the question of medical relief solved to the entire satisfaction of all concerned.

A Retrograde and Inconsistent Policy: We learn that Lt. Col. Pandalai I. M. S., the Officiating Superintendent, of the Government General Hospital Madras, is on leave and that Capt. Alexander, a junior member of the staff of the General Hospital has been made to act as the Superintendent. The name Superintendent, implies one who supervises the work of others. Such a man should in all fairness be the senior most amongst those over whom he exercises control. It is true that Capt. Alexander belongs to I. M. S. service which service was considered to be a superior service to the Provincial service and perhaps basing on this principle the temporary appointment was made superseding the existing senior members of the Provincial service now working at the General Hospital. Such a policy though untenable might have been justifiable in the past. Now we find in other Government Departments seniority of officers and not nature of service being taken into account by the Government in making appointments and senior members of the Provincial Civil Service are being appointed as District Collectors and such Officers have control over the junior members of the Indian Civil Service. It is so in other departments also. In the Medical department itself quite recently a senior member of the Madras Provincial Medical Service has been appointed to act as Principal, Medical College Vizagapatam though that institution had a member of the Indian Medical Service in the staff. The fact, that even in the matter of appointments of temporary Governors in this and other provinces in India, seniority was recognized by His Majesty The King Emperor, ought not to have been forgotten by those who were responsible to overlook the claims of seniors, at the Government General Hospital Madras. We trust such an injustice will not recur again.

Better late than never: We missed to congratulate Dr. T. S. Tirumurti on his appointment as the Acting Principal, Vizagapatam Medical College in our last issue. We had some misgivings at first as there was more than usual delay in the Gazette-Notification about this appointment. The ways of the Government are at times

very mysterious and those under them have to be thankful even for small mercies. Dr. Tirumurti had acted as Principal more than twice before. He is the senior most in the staff of the Vizagapatam Medical College. The Andhra University has honoured him twice by appointing him as the Vice-Chancellor. Yet the Government could not find its way to make him the permanent Principal of the Medical College when that opportunity came. Whatever might be the past happenings, we are glad that Dr. Tirumurti got some justice during the regime of the Hon'ble The Raja Sahib of Bobbili and we believe that Major-General Sir Connor had his share in the recognition of the merits of Dr. Tirumurti.

A Correction: Our readers might remember our comments on page 204 of the May issue of the journal under the caption "Culpable Neglect". Our object was not to apportion blame on anybody much less on the Bernard X-Ray Institute but to point out that the patients from the Government Tuberculosis Hospital were put to great inconvenience on account of the want of a X-Ray plant at the Tuberculosis Hospital itself. We are informed that the patients usually leave the Hospital at or after 11 A.M. and not 8 A.M. as mentioned in our comments. We are sorry our original information was not correct and hasten to correct the mistake. We are also informed that it is quite likely that the Tuberculosis Hospital will have an X-Ray plant of its own in the near future. We thank our esteemed informant for giving us an opportunity for correcting the mistake and also for the glad news that the Tuberculosis Hospital will soon own an X-Ray apparatus.

Public Functions serve their own purpose: Social functions at times serve very good purposes and the public come to know of facts which are not only interesting but are very useful. There were two such functions at the Madras Medical College recently. The first on 13-8-34, was a farewell party to the Medical Graduates who passed the final examination this year and the second on 29-8-34 was the distribution of prizes at the same College. The principal speakers on these two occasions were Mr. Littlehales, the Vice-Chancellor of the Madras University, Major-General

Sir Connor, the Surgeon-General with the Government of Madras, and Lt. Col. Wright the Acting Principal, Madras Medical College. Mr. Littlehailes presided over the party to the Graduates and Major-General Sir Connor took the Chair on the prize distribution day. Lt. Col. Wright served the host on both the occasions. Mr. Littlehaile's speech as reported in the newspapers was as brief as it was pithy. He stressed on the social side of the University life and referred his audience to the Convocation address of Mr. Ratnaswami and said that "as qualified doctors they have to move with people who know absolutely nothing of medicine, yet who talked much about it" and advised the graduates to have patience with such people.

Major-General Sir Frank Connor gave wholesome advice to the Medical Graduates on both the occasions and it is noteworthy to observe in the two speeches that there was not a single instance of the repetition of advice though he addressed the same audience consisting of the Medical Graduates. In his first address Sir Connor advised the graduates not to be exalted "that they know everything of medicine as humility would soon come to them in actual practice and they were sure to realise how elusive was their wisdom in medicine". He advised them to have a spark of ambition as without which they could not progress far unless fortune favoured them. Continuing, Sir Frank Connor said, "Government appointments were becoming fewer in number. In the mofussil there was more than enough room, but fees were low. It was often said that opportunities made a man. That was, of course, true. But it was also true that man could make his opportunity. He knew of Major Smith better known as Jhullunder Smith. He went to Jhullunder. Major Smith within two or three years, made that place the surgical Mecca of the Punjab. That was an instance of a man making his opportunity." Speaking on what their relations ought to be with the public and with brother medical man, Sir Frank Connor, pointed out how powerful the British Medical Association was and asked them to join the Association and said, "They should remember that their profession was a noble one and should avoid unhealthy competition. In medico-legal work, when they

were being questioned by lawyers, they should remember that they were experts in their own field. Another thing to remember was that doctors should stand by one another." Speaking on the question of a hostel for the Medical College, Sir Frank Connor said that he felt that there was scope for not only a hostel but also for a medical college run by a private agency.

On the second occasion when Sir Connor presided over the function of the distribution of the prizes to the successful students of the Madras Medical College he said "the study of man in health and in disease, was their work and they would find it the most interesting of pursuits. The doctor had to thoroughly examine a patient and after the examination, he should be able to know the patient both internally and externally. Many of them would be placed in surroundings where they would be the only persons knowing Science. In many rural parts the doctors would be the centres of all scientific knowledge and that was a proud position to hold.".....Addressing the graduates, Sir Frank Connor asked them to make up their minds as early as possible whether they were going to practise medicine or surgery or carry on research. They should have a sense of inquisitiveness. That was the way to find out the secrets of Nature. A doctor began his real work in the out-patients department and he would advise them to observe well the patients. They should listen to the statements of the out-patients with patience and sympathy. Fortunately for them the speaker continued, the profession was one in which they saw a daily advance. They should acquire more knowledge and try to be up-to-date." "Addressing the lady students, Sir Frank Connor said that it had been stated that the profession would make them less womanly. He could not understand why it should do so. The profession should bring out the best qualities of womanliness, gentleness and sympathy for the suffering. Here in India there was great need for women doctors particularly to attend on women who would not come out to hospitals and who had objection to men doctors attending on them."

Lt.-Col. Wright, the Officiating Principal of the College presented the report of the working of the college in 1933-34. There was nothing very special in the report excep-

ting the fact that the Regulation by which the L.M.Ps. were given a chance to qualify for higher degrees was in accordance with the recommendations of the Committee on Medical Education who emphasised that what was needed was not more doctors but better doctors, and regretted that very few seats were allotted by the Government to the L.M.Ps. and therefore numerous applicants with good qualifications had to be refused admission.

Apart from the valuable and the sound advice which Sir Connor gave to the graduates we were very pleased to note his desire to have another medical college in the city run by private agency. If Sir Connor makes up his mind it is quite possible for him to transform the Stanley Medical School into a medical college run by honoraries; or he can at least help the independent medical profession to run the Stanley Medical School themselves under a Charter similar to that of the Royal College of Physicians and Surgeons in Great Britain raising the standard of medical education to a level in no way inferior to that of the college. Then and then only the recommendations of the Committee on Medical Education referred to by Lt.-Col. Wright in his speech on the day of the annual distribution of prizes could be realised. It is not quite correct to say that the Madras University passed the regulation by which the L.M.Ps. could qualify for higher degrees in accordance with the recommendations of the Committee on Medical Education. As far as we know, Doctors Guruswamy Mudaliyar and Lakshmanaswamy Mudaliyar were mainly responsible for the regulation under reference, which they did perhaps on account of the agitation conducted in our columns and elsewhere for enabling the L.M.Ps. to get University qualification. Before closing we wish to refer to the advice given by Sir Frank Connor to the graduates to enlist themselves as members of the British Medical Association. It is essential nay, imperative that medical men should enlist themselves as members of useful medical associations. It is quite true that the British Medical Association is a very influential body and has been doing lot of good to its members by constitutional agitation, but the experience has been that the activities of this association in this country serve only a particular service, though in the

country of the birth of this association every thing was done and is being done to help the growth of the profession as a whole. Moreover it is certainly too costly a bargain for an average member of the medical profession to become a member of the British Medical Association. Sir Connor would have been much more appreciated if he advised the graduates to enlist themselves as members of the existing useful associations in India.

A Children's Hospital for Madras

—His Excellency Sir George Frederick Stanley, Governor of Madras laid the foundation stone of H.R.H. Prince of Wales Children's Hospital on 20-8-34, at the site behind the Government Victoria Caste and Gosha Hospital, Madras. This Hospital is intended as a permanent memorial of H.R.H. the Prince of Wales' visit to Madras in 1921. It will be a fifty bed hospital and serve as an adjunct to the Government Victoria Caste and Gosha Hospital and will be utilised for an intensive study of the problems connected with children's diseases.

The hospital is intended to serve as a memorial for a distinguished member of the Royal family, the future Emperor of India and as such this institution ought to have had a separate entity unconnected with any existing institution. It took nearly 14 years for the memorial committee to give a practical shape to their intention to have a children's hospital and it is certainly a matter for disappointment that they with the help of the Government could not procure a better site for this memorial hospital. The building is likely to be an imposing one but the surroundings bounded on all the three sides with existing buildings such as the Victoria Caste and Gosha Hospital and a student's hostel connected with the Presidency College with little or no open ground in front of it, would detract the grandeur of the memorial and the location of this memorial as an adjunct to a Gosha Hospital will certainly limit the scope of the intensive study of the problems connected with children's diseases as male doctors cannot have an access to this institution though we hope the male children will have the benefit of this memorial.

A Tragie Incidence: It is reported to us that about a couple of months ago a patient was admitted into one of the nursing homes run by a Government official in

V. Ranganatha Rao to whom I talked about election months before the stage of nomination, promised his whole-hearted support for my candidature. Dr. T. V. Ranganatha Rao's nomination has a history of its own. I am gathering facts and hope to publish the same if possible after the election results are out. The only nominated candidate whom I was very particular to meet was Dr. S. V. Rama Rao one of the leading practitioners at Rajahmundry and a staunch nationalist. I ran up to Rajahmundry but instead of going to Dr. Rama Rao's, went straight to the house of Dr. Gurumurthi, also a leading practitioner and a sincere public worker in the Andhra Desa, with the intention of knowing the views of this friend independent of Dr. S. V. Rama Rao and to my joy found Dr. Rama Rao at Dr. Gurumurthi's both of them seriously discussing about the election and as to the advisability of Dr. Rama Rao's retiring from the field in my favour. Soon after I met these two friends I told them that I was surprised and even grieved that I should be opposed by a nationalist friend from Andhra Desa from where I was reckoning solid support. Dr. Gurumurthi and Dr. Rama Rao immediately retired to an adjoining room and came out and said that Dr. Rama Rao had after deliberate consideration decided to withdraw in my favour and Dr. Rama Rao gave me a letter to THE HINDU requesting the Editor to publish that he had withdrawn in my favour. He also gave me another letter to the Returning Officer intimating to him about his withdrawal. Dr. Rama Rao was requested to contest the election by some of his friends not at all with the purpose of opposing me but to satisfy a sentiment that Andhra Desa should be represented in the Madras Medical Council. My appeal to a nationalist did not fall on deaf ears. I convinced my friends that the medical profession cannot have castes and creeds nor can identify itself with any locality or province. I told them that I did not neglect anybody or any place and did propaganda and service through a journal and tried to satisfy all. But I did anticipate the sentiment expressed by my friend Dr. Rama Rao and with this purpose moved a resolution at the Madras Medical Council to allocate four seats to represent the practitioners in Part III of the Medical Register. Just when I was about to part these friends wished me

to take a message from them to Dr. Dakshinamurthi at Bezwada requesting him also to withdraw in my favour. I did meet Dr. Dakshinamurthi. He said he was not very particular to contest the election. He did not even see anybody at Bezwada except the two practitioners who nominated him. This was quite true as evidenced by a few practitioners whom I met at Bezwada. All the same this candidate felt peculiar to withdraw but his indifference could be counted as withdrawal. Dr. A. Dhanraj is another candidate a rural practitioner of scarcely two years standing. I was informed by the practitioner who nominated him that he did so for fun. I was rather amused at this practical joke and later learnt that the practitioner who nominated Dr. Dhanraj asked him to withdraw and Dr. Dhanraj had withdrawn. His and Dr. Venkappa's names appear in the voting papers as these had not intimated to the Returning Officer about their withdrawal in time before the voting papers were despatched to the voters. Though at first I was rather uneasy of an opposition not at all out of any nervousness about the verdict of the electorate in my favour as I knew the hearts of the majority of them. Uneasiness at elections is a natural human weakness. I now find that the opposition has served a very good purpose of educating not only the electorate but also myself. I have had exceptional opportunities of knowing many practitioners personally and through letters, some of whom have sent me lists of their individual grievances which in the case of the medical profession serve as the grievances of the profession as a whole. Besides this the magnanimity indicated by Dr. Rama Rao by withdrawing himself from the contest and Dr. T. V. Ranganatha Rao's persisting to contest the election in spite of his not being keen has lessons of their own and I shall take the earliest opportunity to let know the electorate what these are after I have learned them myself.

In the meanwhile may I earnestly request the voters to cast their votes in my favour and send the voting papers by Registered post to the Returning officer part III Madras Medical Council, Mount Road, Madras. Such of them who did not receive the voting paper may apply to the Returning officer to send the same. The last day for the receipt of voting papers is 15th October, 1934.

V. RAMA KAMATH.

Correspondence Reports, Etc.

District Medical Association, W. Godavari.

On 29-8-34 there was a meeting of the District Medical Association W. Godavari at Palacole. About 30 members were present. After the reading of the last meeting's proceedings Dr. E. Dixit spoke about "Opacity of cornea" its causation and treatment and Dr. C. Ramanujayya, the President gave out some salient points regarding operation of Hernia. He also introduced the first publication of the District Medical Bulletin which he just began to edit for the Association. Appeal was also made for donations for the library just started for the Association. Rs. 70 were immediately subscribed and Rs. 20 paid on the spot. The Palacole medical profession whose guests the District Medical Association were gave a hearty dinner and a nice tea party.

The Medical Practitioners Association, Nuzvid.

An ordinary meeting of the above Association took place at Kanumole at 3 P. M. on Sunday the 26-8-34. The Medical officer of the Government Hospital Nuzvid presided over the occasion. The Secretary Dr. N. Rama Rao after reading the minutes of the last meeting, read a paper 'Migraine, its incidence Aetiology and treatment'. Mr. P. Anjalal Naidu reported about the story of a patient with general anasarca of a very severe type for over 8 years who is accustomed to drink his own urine to relieve him from suffering. This year that did not give him any relief and therefore submitted himself for treatment. He was given colossal calcium subcutaneously and internally diuretics which could reduce him to a skeleton within only 5 days. Several other cases of much clinical interest were discussed.

After light refreshments offered by Dr. S. S. Rama Rao, the local Rural Medical practitioner the meeting came to a close by 5.30 p. m.

The Tinnevely District Medical Association.

The Members of the above Association met at Curtallam on the invitation of Dr. S. Kanthimathinathan on Saturday the 18th

August '34 at 5-30 P.M. Dr. K. Srinivasaraghava Iyengar presided on the occasion. Dr. K. Gopal Rao read a paper on Epilepsy. There were twenty members present. Dr. S. Kanthimathinathan was "At Home" to the members on the occasion. After a very pleasant evening the members dispersed at 8 P.M.

The Trichinopoly District Medical Association.

A monthly meeting of the above association was held on Saturday the 30th July 1934, at 5 P.M., in the Government Hospital Trichy when about 40 members were present. Dr. S. Balavelayudam Pillay, L.M. & S., Assistant District Medical Officer presided. The following resolution was moved from the chair and passed unanimously.

"The Trichinopoly District Medical Association places on record its heartfelt sorrow at the sudden and untimely demise of Lt. Col. N. M. Mehta I. M. S., District Medical Officer, Trichinopoly, a member of the Executive Committee and its first President."

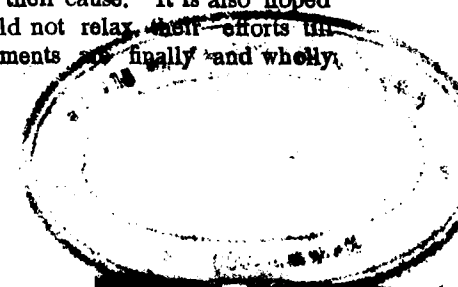
The President of the Association be authorised to Communicate this resolution to his son and to the press.

A. I. M. L. Association, Jhansi.

The following are amongst the important resolutions passed at their meeting held on 27-6-1934.

Resolved that the Jhansi Medical Licentiate Association, while whole heartedly supporting the memorandum regarding Poisons Act drawn up by the Meerut Medical Association and submitted to Government for consideration emphatically reiterates its protest against the said amendments and hopes that the Government will yet see its way to rescind the obnoxious and humiliating provisions of the said amendments.

This association also expresses its hearty thanks to the members of the U. P. Legislative Council, particularly to Rai Bahadur Babu Vikramajit Singh Sahib and Mr. C. Y. Chintamani for ventilating the genuine feeling of resentment of the qualified medical profession in the province and for espousing their cause. It is also hoped that they would not relax their efforts in these amendments are finally and wholly rescinded.



Madras city. A fee of Rs. 300 was settled for an operation in addition to the usual daily charge of Rs. 5 for diet and nursing. The patient was kept under observation and in the course of observation the patient got a few hypodermic injections. Later the patient got convulsions and from the description given to us we are led to believe that the patient must have developed Tetanus. Naturally the patient's relations and friends got anxious but were assured by the medical officer in charge that the convulsions were due to mere fright. But the patient was shifted to the Government General Hospital and admitted in the sheds from where he was discharged in a moribund condition only to die in a friend's house. The tragedy has a history of its own which if enquired into by those in authority will not only purify the medical administration but teach a valuable lesson to the profession as a whole. The head of the Medical Administration has in this country a dual function being the nominated president of the respective medical councils and it is much easier for this officer to wield disciplinary control over his subordinates who being registered practitioners cannot escape the notice of the President of the Medical Council also. Though we know the patient's name and the friend who narrated us this tragic story, we have refrained from publishing these names for obvious reasons. We have no cause to serve except that of the profession and the public and we are ever ready to help them if our services are requisitioned in public interest.

Nominations to Medical Councils: As discussed in our Editorial Columns some time ago, the medical councils in this country are not utilised and worked out in the manner they are in other civilised countries. If the scope of these councils was realised by the Government of India they would not have brought into existence yet another all India Medical Council. Though the Provincial Councils cannot be said to be democratic consisting as they do of an overwhelming majority of nominated members, the local Governments seem to bestow little or no care even in making nominations to the Councils. Persons and not interests are being represented by nomination in all the councils. Medical Councils exist primarily to control Medical Education. Yet all the Superintendents and Principals of existing medical schools and colleges respectively

do not find a place in the Councils though the representation of all existing teaching medical institutions is a statutory obligation in the General Medical Council Great Britain from where the Medical Acts in this country were copied. In Bengal and Bombay there are several medical schools and two medical colleges respectively for each province but all the superintendents and principals do not find a place in the medical councils of those provinces. In Madras, matters are not better. The Lady Willingdon Medical School is not represented and also the Vizagapatam Medical College. The nomination of the Lady Superintendent of the former institution would serve a double purpose in having in addition a representation for women practitioners. Another principle seems to have been forgotten by the Madras Government and that is representation for a minority group of the Registered Practitioners. The Third Group in the Madras Medical Register consists of all the medical licentiates of this province and outside, those who hold the qualification of the Diplomat of medical colleges in India (Military Assistant Surgeon) and those holding foreign qualifications not registered in the British Medical Register. This is the largest section in the Medical Register consisting as it does as many as 4,000 registered practitioners and yet the Medical Registration Act provides only two seats to be filled in by election by the III Group in the register. At the instance of Dr. V. Rama Kamath a resolution was passed by the Madras Medical Council some time ago to increase the seats to four to represent the practitioners in part III of the Register but we have no idea if the resolution has ever reached the Government and if it did reach whether the Government are prepared to amend the Medical Act to bring about this reform. There will soon fall vacant three or four seats to be filled in by nomination by the Government and there is a splendid opportunity for the President, Madras Medical Council to bring to the notice of the Government the desirability of nominating a Diplomat of the Medical Colleges in India for the first vacancy which they have been doing ever since the Medical Council came into existence and which they omitted to do when a vacancy occurred in 1932 due to Major F.W.A. Coshan I.M.D. taking up the office of the Registrar Madras Medical Council on account of a sudden

vacancy arising due to the resignation of the then permanent incumbent. The second vacancy may be filled in by nominating the Lady Superintendent of the Lady Willingdon Medical School and the third by nominating one holding foreign qualification not registered in the British Medical Register, and the fourth by nominating the Principal, Vizagapatam Medical College when the permanent incumbent returns to duty. It will not be out of place if we bring to the notice of the Government that while nominations are made to represent teaching institutions they should be done in the names of the office and not in the names of the officer holding the appointment. Sometimes it may happen that the Principal or Superintendent of the medical college or school respectively may be transferred due to the exigencies of service and such institutions may go unrepresented. We have made these suggestions in the interest of the harmonious working of the Madras Medical Council and not in the interests of any individual and trust our suggestions will be appreciated by the President, Madras Medical Council and the Government in the spirit in which they are offered.

Doctor Kamath meets his Rivals: As expressed in these columns and elsewhere the readers of THE MEDICAL PRACTITIONER, will, I trust remember that the Journal was primarily started by me to let know the members of the profession the affairs of the Madras Medical Council and bring about such reforms in the working of the council, which will bring more contentment and with it harmony in the medical profession as a whole. Virtually I have dedicated the journal to the medical profession and have been serving the profession to the utmost of my capacities and resources and determined to do so not in my individual interest but in the interests of the profession as a whole till I am physically unfit to serve them. In this self-imposed task of mine I have been fortunate to get the collaboration of one of the most senior and revered brother in the profession—I mean my senior colleague Dr. M. S. Krishnamurthi Aiyar. The readers are aware that quite recently his services and merits were recognized by the medical graduates in this province who unanimously returned him to the Medical Council and by so doing have strengthened the cause served by THE MEDICAL PRACTITIONER.

Thus The Medical Practitioner being an organ of the profession and myself its servant, I trust I am justified in taking advantage of the columns of the journal for letting its readers know the different stages of the ensuing election for which I am one of the candidates. After the scrutiny of the nominations in connection with this election and even a few days before the scrutiny, I began seeing my rivals in the field being anxious to know whether they found me wanting, in serving the Licentiates and others who are in the III Part of the Medical Register and also the profession as a whole. The first candidate I saw even before he was nominated was Dr. D. V. Venkappa, my old rival in 1929. He certified that I did excellent work in the council. When I requested him to propose my nomination, he hesitated, and said he wished to consult his friends who might wish him to contest the election. But after a heart to heart talk with him for nearly an hour and a half, he proposed my name in one of the nomination papers. Later I was rather surprised that Dr. Venkappa was one of those in the list of the valid nominations. Still later he announced in THE HINDU that he had withdrawn from the contest but he did not intimate his intention to the Returning Officer and on enquiries, I learn that the Returning Officer was written to by him about his withdrawal on or about 20-8-34 when the voting papers were despatched by this officer to the voters. The candidate whom I saw next was Dr. T. V. Ranganatha Rao about whose nomination I heard from one of the Sub-Assistant Surgeons at the Government Royapuram Hospital which Sub Assistant Surgeon told me that a colleague of his, working in an adjoining institution sent him a nomination paper, his colleague having proposed the name of Dr. T. V. Ranganatha Rao and having sent the paper with the son of Dr. T. V. Ranganatha Rao, a final year student at the Royapuram Medical School. Dr. T. V. Ranganatha Rao was plain and frank. He said he had been forced to stand by his friends though he was convinced that he would not be able to do so as much work as I was doing in the Medical Council and went even further and said that he was not keen and would not worry himself but circumstances were such that he could not withdraw from the field. It will not be out of place if I were to mention here that Dr. T.

The question of 5 years course at Agra Medical School was considered in the light of H. E. The Governor's observation, and the Branch after full consideration of the situation resolved as follows:—

(i) That the memorandum presented to H. E. The Governor, U. P., on behalf of the U. P. Medical Licentiate's Association contained certain demands which were really absurd and extremely unreasonable.

(ii) That the matter contained therein besides the demand of introducing 5 years course at Agra Medical School, was inopportune and undesirable.

(iii) That Dr. Sharma, the author of the memorandum, did great disservice to the cause of 5 years' course, to include other unnecessary demands in the memorandum and thus giving a set back to our

scheme of having a 5 years' course at Agra.

(iv) That no attempt was made to publish the Governor's reply in the Medical Press till now and no reply to the adverse comment appeared in the Lay Press on H. E.'s reply was given on behalf of the author of the memorandum. This omission on the part of Dr. Sharma weakened our case for 5 years' course and created wrong impression on the public about our claims for 5 years' course.

(v) It was also resolved that the subscription paid by the members towards the funds of introducing 5 years' course should be returned to the donors forthwith and the expenditure incurred in the collection of such fund should be borne by the provincial Branch of A. I. Medical Licentiate's Association.

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

No.	Names of Sub-Asst. Surgeons.	From.	To
1	Dr. K. V. Rajagopal	Borstal School Palamcottah	Govt. Hl., Coonoor.
2	„ R. Venkatakrishnayya	Govt. Hl., Rajahmundry	L. F. Hl., Razole.
3	„ K. Rajamannar	Agency Duty	L. F. Hl., Razole.
4	„ M. Gopalacharya	L. F. Dy., Indurpet	c/o Agency Surgeon, Koraput
5	„ J. R. Moses	Agency Duty Vizagapatnam	c/o P. W. D., Nellore.
6	„ S. Tbiyagaraja Chetty	Leave	L. F. Dy., Arantangi.
7	„ Mrs. Surah J. Souri M.B.B.S.	Leave	L. F. Hl., Gooty.
8	„ Miss. L. Borges	L. F. Hl., Gooty	W. & C. Hl., Bellary.
9	„ Miss. T. Timothy	W. & C. Hl., Bellary	Govt. Hl., Madanapalle.
10	„ V. Sitarama Iyer	L. F. Hl., Bapala	L. F. Hl., Sulurpet.
11	„ V. Jagannatha Rao	L. F. Hl., Bobbili	Govt. Hl., Anakapalle.
12	„ R. M. Patro	Govt. Hl., Anakapalle	L. F. Dy., Chetput.
13	„ K. Tyagarajan	Leave	L. F. Dy., Tirumangalam.
14	„ N. Isaac	L. F. Dy., Tirumangalam	Govt. Hd. Qrs. Hl., Palamcottah.
15	„ V. Sivasambu	Govt. Hd. Qrs. Hl., Palamcottah	Agency Duty Koraput.
16	„ S. V. Ramaniab	L. F. Dy., Chetput	L. F. Dy., Tiruttani.
17	„ T. B. Panchapakesa Pillai	L. F. Dy., Tiruttani	Agency Duty, E. Godavari.
18	„ J. Satyanarayanamurthi	Leave	Govt. Hd. Qrs. Hl., Guntur.
19	„ A. M. Ethirajulu Nayudu	Leave	Govt. Hd. Qrs. Hl., Guntur.
20	„ K. P. Chidambaram	L. F. Dy., Marungapuri	Govt. Hd. Qrs. Hl., Trichinopoly
21	„ P. S. Ramaswami	L. F. Dy., Arantangi	Govt. Hd. Qrs. Hl., Trichinopoly
22	„ C. E. D'Silva	Leave	Queen Mary's College Madras.
23	„ P. Chokkalingam Pillai	Leave	Govt. Hd. Qrs. Hl., Palamcottah.
24	„ Miss. R. Mathew	Leave	R. M. Dt. Hd. Qrs. Hl., Tanjore.

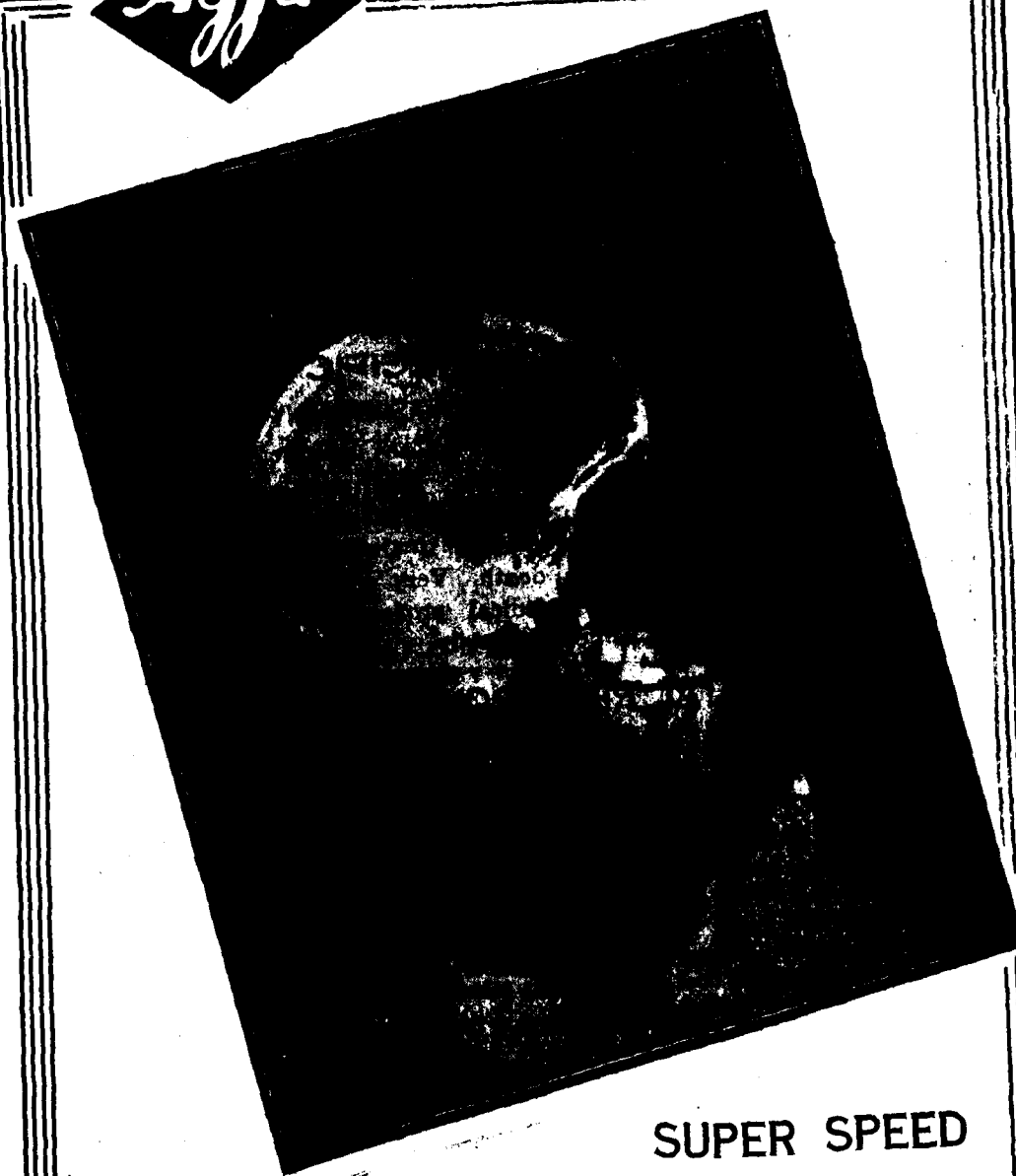
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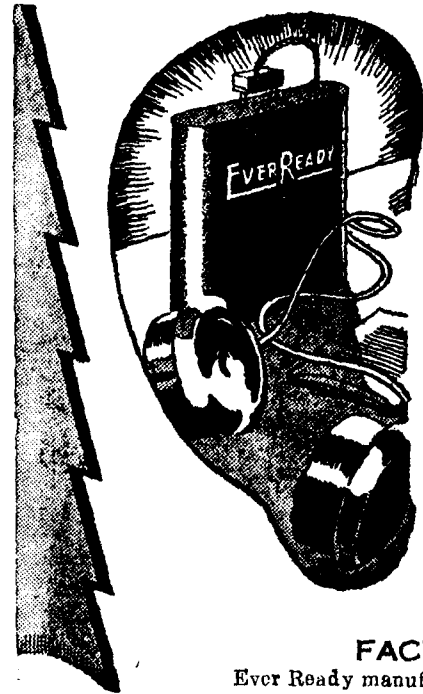
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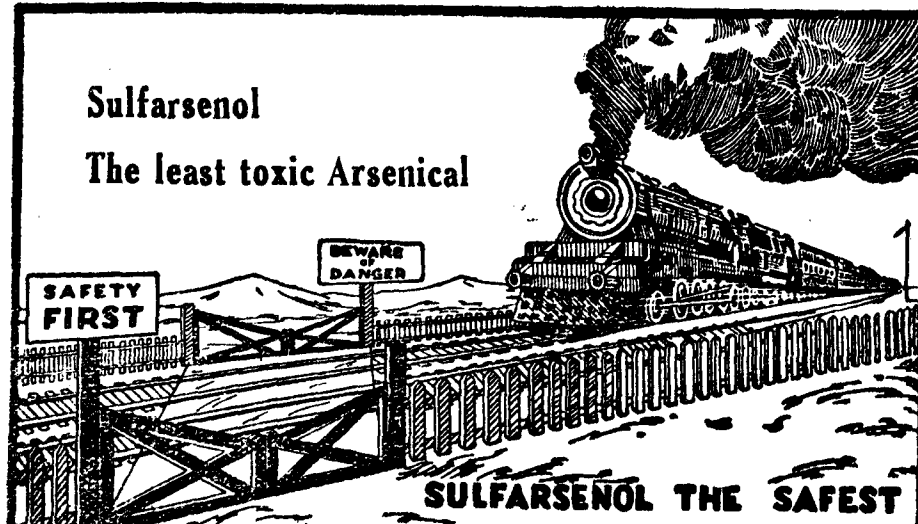
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