V. NO. 12 SEPTEMBER 1934

The Medical Practitioner

A Monthly Medical Journal

EDITED BY
Dr. M. S. Krishnamurthi Ayyar, M. B, & C. M.,
Retired Sanitary Commissioner, Travancore State.
AND
Dr. V. Rama Kamath,
Members, Madras Medical Council.

CONTENTS.

AN APPEAL TO THE MADRAS LICENTIATES :

THE MEDICAL PRACTITIONER was brought into existence as a result of a pledge given to the electorate by me when I contested for a seat in the Madras Medical Council in 1929. The journal has been intended for propaganda and service to the profession as a whole and especially to the Licentiate section of it; the journal has been keeping the profession informed about the activities of the Madras Medical Council. The fact that in the recent election to the Madras Medical Council a very large number of voters exercised their franchise indicates that the activities of the journal have been mainly responsible in educating the electorate and make them take more active part in the affairs not only of the Madras Medical Council but of the profession as a whole.

A large number of licentiates in addition to the other members of the profession have been co-operating with me and helping me these five years by *enlisting* themselves as subscribers. The subscription of the journal has been fixed at such a low rate of Rs. 2-0-0 a year with the sole purpose of making it reach the hands of even the humblest amongst the practitioners. This amount hardly pays the cost of the journal, yet it helps to keep the wheels going.

Last two months a good number of copies of the journal were sent with my *best* compliments to the non-subscribers of the journal with the purpose of not only keeping them informed about the election events but also to give them an *idea* of the usefulness of the journal. I hope the non-subscribers must have by now realised the necessity of a journal of the type of THE MEDICAL PRACTITIONER which not only deals with subjects of scientific importance but also discusses about topics concerning the life and prosperity of the profession as a whole.

May I appeal to my brother licentiates to enlist themselves as subscribers of the journal and indicate their willingness by filling in the enclosed post card and sending the same to me by return? The yearly subscription of Rs. 2 should be considered by my brethren as a contribution for a cause as the journal is conducted not on commercial lines but with the sole purpose of propaganda and service.

V. RAMA KAMATH.

THE Medical Practitioner

Annual Subscription { Inland Rs. 2. / Foreign Rs. 3. } Single Copy As. 4.

VOL. V.] SEPTEMBER, 1934. [NO. 12

DIRECTOR OF PUBLIC HEALTH MADRAS.

After Col. Russell left-charge of the office of the Director of Public Health Madras the appointment has been going on a begging. The vacancy caused by Col. Russell's leaving the office was filled in by the appointment of an Indian Assistant Director and after the untimely death of this officer another Assistant Director, Major Hesterlow an Anglo-Indian belonging to Indian Military Service was put in charge. Later, Major Webb (now Lt. Colonel) was brought down from Simla and Major Hesterlow was reverted to his old appointment as Assistant Director. Differences of opinion between Lt. Col. Webb and the Madras Government regarding the continuation of the services of a woman Assistant Director which post Lt. Col. Webb found to be not necessary made Lt. Col. Webb to retire earlier than he would have done otherwise. For the vacancy that arose Major Hesterlow was appointed to act. It now transpires that this officer has to go to Bombay and for the post of the Director of Public Health Madras, an Assistant Director of Public Health from Delhi, Major Ganapathi has been appointed. The appointment of the Director of Public Health has been removed from the list of appointments reserved for I. M. S. and included in the cadre of the Provincial Service. Consequently this move on the part of the Government of Madras of importing an officer from outside for a second time has created an impression that none of the Assistant Directors under their employ are competent to hold the post of the Director of Public Health. It is an indirect slur on the Government itself. Whatever might be the qualifications of an officer brought from outside the province, it is very unfortunate that past services and local experience gained in the province by their own officers did not count with the Government of Madras. It cannot be said that there was not in this province at least one who had all the necessary qualifications to be the Director of Public Health and it is an open secret that one of the most experienced Director of Public Health Col. Russell did even recommend to the Government that that person should be made to act for the Director when the latter took leave. But communal bias weighed more with the Madras Public Health Ministry than the welfare of the people under its care and and they got rid of this officer by transforming him as District Medical Officer —a most scandalous and outrageous policy which was commented upon by us in these columns at the time of this transformation. Such a policy on the part of the then Public Health Ministry has incidentally condemned the Government itself as this officer's services as a sanitarian in charge of a city municipality were recognized by the then Government who conferred on this officer the title of Rao Bahadur. There is yet another senior Assistant Director under the Madras Government who has rendered meritorious service and who was recently sent out of Public Health Office as Professor of Hygiene Madras Medical College though technically according to the existing rules thrust on by

the General Medical Council on this country this person could not hold that appointment. It looks as if the Ministry was nervous that in case this competent senior-most Assistant Director is kept on in Public Health Office it might perhaps be not possible for them to overlook his claims to the office of the Director of Public Health at any future exigency. So it is plain that local politics and not good ideals of Public Health administration is the guiding spirit of the Local Self Government in Madras.

We wish the Government were consistent with the opinions arrived at by them. They would not have an Anglo-Indian Assistant Director who belongs to the Indian Medical Service and whom they made to act twice as the Head of the Department. Amongst the junior Assistant Directors now in Public Health Office and who can stand the communal test they could not select one competent to hold this office. The Government would be well advised to abolish the posts of Assistant Directors as recommended by us more than once in these columns. They are only intermediaries between the District Health Officers and the Director of Public Health. The District Health Officers are as much qualified as the Assistant Directors and there are a few who are better qualified than the Assistant Directors. If the Director wants an Assistant he may be given one in the grade of a Deputy Director who may eventually succeed him. Granting for the sake of argument that there is a necessity of Assistant Directors there is absolutely no reason why all of them should have their Head Quarters in the city itself. The province may be divided into three divisions and each Assistant be put in charge of one division as in the case of Engineering Department where the province is divided into suitable circles under the direct charge of Superintending Engineers. The present arrangement of dividing the work amongst Assistant Directors as one in charge of Vital Statistics, another of Vaccination, a third in charge of Fairs and Festivals, a fourth in charge of Rural Sanitation and so on, is unknown and unheard of anywhere in any department. The Surgeon-General is not given an assistant to [illegible] surgical work, another for medical work and [illegible] third for obstetrical work etc. The arrangement proposed by us will enable the Assistant Directors to *gain experience* in all branches of Public Health and qualify them to hold the post of the Director without resorting to the policy of importation. It will not be out of place to mention about yet another most unhealthy tendency now prevailing in the Public Health Office in Madras. City life naturally commands freer and easier social intermingling and the Government Secretriat not being far away from the Office of the Director of Public Health it is possible for any of the Assistant Directors to have the ear of the Government and consequently an Assistant may have the possibility of dictating to his chief especially when such a person comes from an outside province. So on all counts the reform suggested by us will be most conducive. The vacancy likely to be caused by the transfer of Major Hesterlow to Bombay need not be filled in at all but a reshuffling of the duties of the existing Assistant Directors is highly desirable the senior-most Assistant Director being given executive duties in the Public Health Office and less senior Assistant Director being posted as professor of Hygiene Medical College.

Nothing can be said against the appointment of Major Ganapathi as the Director of Public Health. He has a very good record of work as a sanitarian and it is a very happy coincidence that he is not only an Indian but a native of the Madras Presidency. He comes from Coorg the native inhabitants of which are noted for their courage and uprightness. His birth and his subsequent associations are a safeguard against communal bias. He has got very trying work before him. The office of the Director and the Department have not been working satisfactorily for sometime past. One Director was found fault with as it was thought that he was entirely guided by the Manager of his office and another Director for being guided solely by an Assistant Director. Between the two evils the former seems to be the lesser. The Manager is a direct subordinate of the Director and can be punished by him, whereas the Assistant Director is not as much his subordinate and if he happens to be in the good graces of those in power, the position of the Director will be most awkward. The Assistant Directors are intended only to help the Director in his professional work, the evil arises by making all these Assistants squat in the office of the Director. It is hoped that Major Ganapathi the Indian Director of Public Health will set right matters and bring credit not only to himself but to the country of his birth. We offer him our warm congratulations and wish him a successful career.

Original Articles

THE TREATMENT OF PULMONARY TUBERCULOSIS.

III. ADJUVANTS OF IMPORTANCE.

BY

DR. C. FRIMODT-MOLLER, M.B., Ch.B., (Copenhagen).

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

In the previous articles it has been explained that the special treatment of pulmonary tuberculosis consists in a regulation of rest and graduated exercise in the right proportion in each individual case. It is this regulation which constitutes the basis for the whole treatment and in relation to which all other remedies are only adjuvants. Although this is so, various adjuvants are nevertheless of very great importance in support of the special treatment.

The "Dietetic-hygienic Treatment" which years ago was considered the most important factor in bringing about, healing will in the most of the cases not be able to secure this result. No one would think of denying the importance of diet in tuberculosis but many of the old conceptions about the direct curing effect of dieting have to be given up. If some kind of diet was especially important in tuberculosis it is likely, it would have been found out long ago as the number of diets prescribed for the disease *is legion. Even the recently so much discussed Gerson-diet has been disappointing.*

One of the old conceptions which is wrong is that the object of dieting in tuberculosis is to get the patient as stout and fat as possible. Experience has shown that overfeeding is as bad in tuberculosis as underfeeding. The great amount of fatty tissue in the overweighty patients causes an unnecessary strain on the heart for the proper circulation of the blood and therefore weakens the natural resistance of the organism already worked to its utmost capacity in combating the disease. The energy and muscle labour necessary to move the heavy and overweighty body makes the slightest exercise a burden and the fatigue caused by such exercise interferes badly with the effect of the graduated exercise and may even convert the effect from a good to a bad one.

It is in most cases a good prognostic symptom when a patient who is thin and emaciated gains in weight as it shows that the organism has some vitality, but the gaining in weight is prognostically of far less importance than the signs of improvement shown by the disappearance of fever and the other clinical symptoms or by the blood examination or X-ray photo. It is not rare to see a patient gaining well in weight, especially when first coming under treatment while the other guiding factors show an increase of the disease; and in such cases the ultimate result is bad, and the patient will again lose the weight obtained. The dieting when most successful should produce a gain in weight of ten to fifteen pounds above the patient's normal weight which is a good margin; but patients if gaining more than this, should have prescribed a diet which reduces the weight.

As there seems to be some confusion in the minds of even doctors about which diet should be used to increase the weight of a patient, it might not be out of place to mention that the so much favoured "soup" is without any nutritious value, and that a diet chiefly consisting of this fluid and of eggs and meat is exactly that which is to be used when the weight is to be reduced. That which is fattening is the carbohydrates in all forms and of course fat in form of ghee, milk and butter. Another thing is that the body gets more benefit out of the carbohydrates and fats when some protein is *simultaneously* given such as eggs and meat, but the great and very common error is to give proteins without plenty of carbohydrates and fats.

The other factor in "the dietetic-hygienic treatment" namely "the open-air treatment" has been dealt with sufficiently in the

previous article about the Principles of Treatment and the discussion of it can therefore here be omitted.

DRUG TREATMENT is often of great importance. Unfortunately the ordinary drugs used in the treatment have little or no direct action on the tuberculous lesion in setting free tuberculo-proteins to act as antigen in the body. With the exception of tuberculin and certain gold-preparations we know, at present, of no drugs which have such an action and we know of none which have the power of destroying the tubercle bacilli in the human body without doing great harm to it.

This does not mean that no other drugs than the two here mentioned are of real value in the treatment of tuberculosis. Many drugs are able to relieve certain clinical symptoms and thereby act as very valuable adjuvants giving the organism the needed rest. When a patient suffers from severe cough it is absolutely necessary to give a soothing cough mixture or an expectorant, as the case might be, as the patient is otherwise exposed to all too great physical exercise due to the severe strain of the coughing. In bringing such a patient to rest the cough mixtures are of great importance, although they themselves have no curative effect.

It is often a great help to give expectorants in the morning and during the first half of the day to clear the lungs from the sputum collected during the night and then, in the afternoon and evening, to prescribe the soothing drugs in order to give the patient rest from coughing. Codeine phosphas, in doses of one quarter of a grain, three or four times a day, is one of the best soothing drugs. As an expectorant I recommend especially a mixture consisting of a decoction of Cincohonae rubrae cortex and Tinctura senegae. When the fever becomes too high or continues too long it is necessary to give antipyretica, as the fever should be brought down.

A good way of giving such drugs is to give them an hour before the time for meals as the diminishing of the fever at that time often enables the patient to eat better. One of the best drugs against fever in tuberculosis is Pyramidon, given in doses of one or one and a half grain daily, dissolved in water. Also Phenacetin and Aspirine in five grain doses are of use, but the last drug after continuous use,often upsets the stomach and produces vague pain. Quinine is tolerated very well, even in ten grain doses, three times daily, for some days, and it is not our experience that it is apt to create haemoptysis. In closing my few remarks about drug-treatment I find it necessary to give a strong warning against the use of Sodium Morrhuate in cases of pulmonary tuberculosis. Some years ago we tried this drug in about 50 cases, with catastrophic results in a few of them, and with detrimental effect in all of them in spite of the temporary slight increase in weight seen in some of them after the injections. Since then I have observed a number of cases treated with this drug and sent to us and they have nearly all of them been very sick showing a particularly dissiminated spread of the disease in the lungs, as judged by the X-ray photos which might be due to the effect of the drug.

A very helpful drug is Sanocrysin. It is not possible here to write in detail about the indications for its use, its dosage the dangers of it, and the good results obtained by it. I may be allowed to refer the reader who would like detailed information to the June issue, 1934, of the "Indian Medical Gazettee" page 380 where Dr. P. V. Benjamin has written about our experiences with this gold preparation and the great help we have found by using it.

THE COLLAPSE THERAPY is undoubtedly, as it has been said, the greatest development in the treatment of pulmonary tuberculosis since the introduction of sanatorium treatment about fifty years ago.

When complete rest in bed cannot prevent a too strong flow of tuberculo-proteins and toxins from the lesions in the lung and the fever continues and rapid destruction of the lung can be expected by cavity-formation, nothing is then more rational than to try to bandage the lung itself inside the chest. The collapse therapy is simply a further development of the principle of creating the least possible circulation of the blood through the lesions.

THE PNEUMOTHORAX-TREATMENT is the chief and the best of the different kinds of collapse-therapy and should always be tried first. If not well tolerated, it can

be stopped, and the lung will expand as before without the condition being altered from the time before this treatment was given. In other kinds of collapse therapy there is no going back, if the collateral lung is not able to stand the strain to which it is being subjected on account of having to take over the most of the respiration.

In all cases of unilateral tuberculosis, or almost unilateral,with formation of cavities, pneumothorax-treatment should be given if not directly contraindicated on account of the presence of such adhesions which would prevent the collapse of the diseased part and create an all too high pressure. In such cases it is of no use to continue the treatment, for it will be very detrimental to the patient.

In recent years the whole pneumothorax-treatment has been modified. Previously it was considered that the more the lung was compressed the better. Experience has shown that this is a completely wrong conception. The aim is now to collapse only the diseased part, leaving the healthy part to be used, which procedure has been called "selective collapse". In other words the aim is to obtain the maximum result with the least pressure with which this can be done. This pressure is of course not a constant one but varies both with the individual and with the changing condition of the patient.

The result of pneumothorax-treatment is often quite dramatic with the fever disappearing completely within one or two weeks. But even if the improvement is not so spectacluar, it is remarkable how many patients in the most advanced stage benefit by it, and obtain a permanent improvement and full working capacity.

The treatment is dangerous even in the hands of experienced specialists, but now nearly as dangerous as during the first years after its introduction. We have treated 1045 patients with pneumothorax and have given about 15,000 refills where statistically the most disasters happen, and we have had only one case of embolism and two alarming cases which soon recovered.

It is necessary to point out that pneumothorax should never be given without a pro-per manometer. By the reading of the manometer only it is possible to know whether the needle is really inside the pleural cavity or whether it is where it should not be such as outside the pleura, or inside the lung or the abdominal cavity, not to speak of being in an artery or a vein. It is absolutely wrong to open for the inflow of the air until the manometer shows the proper reading. The manometer is our eyes, without which the operation is performed blindfolded and may in that case be exceedingly dangerous or harmful or useless. The pressure should always be negative during the first weeks or months of treatment, and it is a mistake to give more than 300 c.c. to begin with unless in a case of acute haemoptysis where a great amount of air should be given the very first time, if possible.

The other operation now much used in collapse therapy is the Phrenico-exairesis Operation with evulsion of as much of the phrenic nerve as possible. The operation which should be used in strictly unilateral cases gives often a good result, although sometimes only after a month or more after the operation. We have found a real improvement in about 50 per cent of cases having treated 268 patients with the phrenico-exairesis operation.

THORACOPLASTY is a very serious and big operation and should only be done after pneumothorax or phrenico-exairesis have been tried without result and only when the patient's general condition is still good. In many cases the effect of the removal of the ribs and the application of a strong compression against the now movable chestwall is very striking and curative, an experience we also have had.

There are still other adjuvants which it would be worth while to mention, such as ultra-violet light treatment in cases complicated with intestinal or laryngeal tuberculosis, or such adjuvants as tuberculin in carefully selected cases, but the space will not allow this to be done.

In closing this series of articles about the treatment of pulmonary tuberculosis I cannot but again emphasize that the whole basis for the treatment of this disease is not rest, not "open-air-treatment", not dietetic treatment, not drug treatment, not operative treatment, but rest and graduated exercise, under open air conditions in the right proportion in each individual case. All the other treatments, however useful and

necessary they may be, are nevertheless only supplementary to the only real curative one that one of which many doctors have so often lost sight, or with which they have not been acquainted.

HEREDITARY DISEASES.

BY

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

Superintendent, Government Ophthalmic Hospital, Madras.

(Continued from previous issue.)

Mention has just been made of the association of consanguineous marriages with retinitis pigmentosa in South India. It may also be noted as recorded in the Eugenics Laboratory Memoirs XXI "Treasury of Human Inheritance Nettleship Memorial Volume" Vol. II Part I by Julia Bell edited by Karl Pearson, that with an increase in the percentage of consanguinity there appear to be an increase in the defect resulting. For the most part we find it practically impossible to follow up pedigress or even verify the incidence of an abnormality in the same generation. Sometimes a defect appears in several siblings of the same generation without any trace of its occurrence in previous generations even when circumstances favour a careful investigation. For the most part, the affections we see show themselves in siblings of both sexes. Recently we met with an interesting familial affection in a family of three brothers and one sister in which the three brothers showed macular degeneration with progressive diminution in vision and dementia and marked dolicocephaly. At first sight the eldest boy about 17, age the impression of tower skull with lateral compression and elongation, but it was not a true oxycephaly. The appearances at the maculae were those previously referred to as of the "beaten brass," or "tarnished metal" type. The female was unaffected. No evidence of such a disorder could be found in the previous generations, the grandparents also were free. It is possible that in this case the condition was transmitted by unaffected females, the males only being affected, complying with the law of Nassee. This law holds for certain conditions like Haemophilia, Leber's hereditary optic atrophy, certain forms of nystagmus, colour blindness, megalocornea. There is no hereditary condition known however in which the female alone is affected and the defect is transmitted by the healthy male. It would appear that in heredity Kipling is right, and that "the female of the species is more deadly than the male."

For the purpose of these lectures nothing more need be said to emphasise the importance of hereditary blinding diseases and the part they play relative to the other chief blinding diseases of childhood. While I was yet collecting records on this subject and thinking of the part played by heredity in connection with our blind problem it interested me greatly to see an article by Bickerton in the British Medical Journal of of January 1934 on "The Menace of hereditary blindness." He illustrates his article with a number of interesting pedigrees and makes out a case for checking these conditions which appear to play a prominent part in the causation of the total blindness of England and Wales by a number of means for improving environment and heredity, including sterilization. The article should be read by those interested.

Prevention: In Madras we have heard a great deal about birth control in the last year or so. The opinions of all and sundry have been aired at length; clerical and lay, Protestant and Catholic, male and female. Nearly all are the opinions of those who have not made an intimate study of the various population problems involved, and applied to them the acid tests of historical records, statistics and eugenics including modern views on heredity. They make wonderful copy, and on account of the sex problems involved attract a wide range of readers. The reading too is sometimes very amusing. There is no certain knowledge however that if it were feasible to introduce birth control by Stopean methods, such as those suggested, on a scale commensurate with the object in view and in such simple forms as to be adopted intelligently by the uneducated masses, it would have any material effect in checking the undesirable increase of population. One has only to look at the history of population figures in Japan, Ireland, France, Italy, Great Britain to realise that there are factors at work so profound that their effect

would hardly be influenced over a few generations by the methods of birth control so much discussed in the past few years if attempted in India. The practical essay of the various forms of Stopean technique by the uneducated villager conjures up the most comic situations in the medical mind. Nor is difficulty in acquiring technique by any means confined to the country cousin as every medical man knows.

However we are not now concerned with the humorous side of a partially impractical and purely hypothetical measure for influencing the birth rate as a whole. The matter was very well summed up not long ago by one of our leading medical journals in a report dealing with the conference on birth control in Asia held at the end of last year under the presidency of Lord Horder. Referring to the data before the conference it says, "about these facts and about similar facts pointing to over-population in China, there was hardly any controversy. But though in proposing a remedy everybody was anxious to put the cart before the horse, nobody, as is common in sociological discussions, could distinguish for certain or agree entirely with anybody else as to which was which."

Suppose for a moment we agree that birth control in some form in certain circumstances is desirable, might we not reasonably consider that the certainty or strong probability of a man or woman being the parent of a potentially blind child, is one good reason for the application of stringent birth control. If this be admitted, might we not also consider what is the best and only certain method of control under such circumstances. When I first started thinking of the hereditary conditions in connection with preventible blinding diseases, I knew that there was a movement afoot to approach the Minister of Health in England with regard to the sterilization of the unfit. In June 1932, the Minister appointed a Departmental Committee on sterilization. That Committee went into the subject in great detail and its report was presented to Parliament on January 18th this year. The difficulties which had to be contended with can only be appreciated by reading details of the report.

To quote from a leader in the British Medical Journal:—"Before coming to a conclusion as to the justification for sterilization the Committee considered first the question of compulsion. Interpreting its reference as asking it whether there was on scientific grounds, an unassailable case for sterilization, it came to the conclusion that in the present state of knowledge the case for compulsory sterilization could not be established."....."With regard to voluntary sterilization the Committee did not entertain the same doubts and unanimously recommended that voluntary sterilization be sanctioned, on the grounds that enough is known, to be sure that inheritance plays an important part in the causation of mental defects and disorders.....and that mentally defective and mentally disordered parents are, as a class, unable to discharge their social and economic liabilities or create an environment favourable to the upbringing of children;" ".....with the rider that there is reason to believe that the opportunity for sterilization would be welcomed in some cases by the patients themselves." In other words the Committee recommended legislation of voluntary sterilization subject to safeguards. The Ministry is now in consultation through the Board of Control with the Medical Research Council, and the Registrar-General as to the best course of action concerning the recommendations in the report. It is interesting here to note that the British Government sometime does consult experts before embarking on legislation in relation to highly scientific problems.

Meantime it may be noted that in Germany sterilization of defectives has been legislated for in a less conservative spirit than that indicated in the British Report. There is in fact a world-wide tendency to come to grips with this important problem of preventing defectives begetting defectives. It would *prima facie* appear to be the best and at which to begin in any composite scheme for lessening the number of births. We might in any such programme include the sterilization of those suffering from hereditary disease productive of blindness. I wonder how many of those who have put up a fight for the modern contraceptive birth control would be anxious and willing to resort to sterilization should they discover that they were the potential parents of children likely to become blind because of a hereditary taint. Retinitis pigmentosa is so common in Southern India that it is more than likely that some of our birth con-

trol protogonists suffer from it. If so they might set a good example by publicly embracing the only certain method of birth control known, namely, sterilization.

A word as to sterilization. My friend and colleague, Lt.-Col. V. B. Green-Armytage I.M.S. (Ret.) London (formerly of the Eden. Hospital, Calcutta) who has had an extensive experience in this connection and published methods in detail, assured me in the course of discussion, that sterilization in the female is a simple undertaking. Permanent ligation of the tubes is an easy operation which should be possible for any competent gynaecologist to perform per vaginam. The patient should be out of bed by the fifth day and home by the seventh. The same case of performance holds good for the general surgeons with regard to the cords in the male; it should be possible to do either procedure rapidly under local anaesthesia. Neither operation interferes in any way with the individual, sexual activity is not lessened, but subsequent reproduction is impossible. No doubt many reasons may be given against it by those opposed to the sterilization of known carriers of hereditary blinding diseases. A very practical one here in India is that owing to the difficulty of tracing relatives, carriers who do not themselves present the disease, may be missed in the previous generation. But one has only to look through some of the hundreds of pedigrees published in ophthalmic literature to be prejudiced in favour of sterilization. For instance the Risley pedigree recently brought to mind by Bickerton's illustrated article in the British Medical Journal of January 20th this year in which one man blind with aniridia had thirteen children similarly affected, sixty-one grand children affected out of sixty-three, and thirty-nine great grand children out of forty two. This single individual in the course of three generations was responsible for producing 113 cases of blindness.

The prevention of Blindness Committee of the Union of Counties Association for the Blind (Great Britain) issued an interesting report last year on hereditary blindness. It points out that data recorded over a long period of years have been analysed by genetic experts and reports issued by the Galton Eugenics Laboratory. For technical reasons it cannot be estimated with any degree of accuracy to what extent blindness as a whole could be prevented by limitation of parenthood in individual cases.

The British Medical Journal says with reference to these reports:

"There are diseases of the eye which result in defective vision and others which cause blindness. Taking both groups it may be held by the eugunist: (a) That any man or woman who had had aniridia, congenital cataract, glioma of the retina, hereditary opacity of the cornea, or ectopia lentis, microphthalmus, or retinitis pigmentosa, and of whom either parent had been similarly affected, is likely to transmit the defect and should abstain from parenthood. (b) That any normal parents who have more than one child affected with one of the above-mentioned diseases, or with buphthalmus or total colour-blindness should have no more children, and such children as they have should abstain from parenthood—whether they themselves are affected or not. Even if the parenthood of such children does not lead at once to the manifest reproduction of the disease, it inevitably adds to the latent defect in the population, which becomes manifest when two people carrying such latent defect marry and have children. (c) That if, in all stocks in which Leber's disease (hereditary optic atrophy) has occurred more than once the sisters of affected males were to abstain from parenthood, the disease would be almost exterminated, except for sporadic cases of no genetic significance. In general, there is no risk to the descendants of men who are suffering from Leber's disease; the instances in which they transmit the disease are very rare, but should be borne in mind, and if one such case in a family has occurred all other affected members of that stock should be regarded as liable to transmit."

These recommendations would appear to be essentially sound, but the words "abstain from" are perhaps a little conservative. In view of my experiences of the criminal carelessness of certain parents, I would feel more inclined to substitute " be restrained from." There is no doubt a great difficulty here is South India in obtaining accurate information, but I personally feel that nothing but good could result from the sterilization of all those known to be affected with, or to be potential sources of, hereditary blinding diseases.

Abstracts

INDICATIONS FOR RADIATION THERAPY IN CARCINOMA OF THE CERVIX UTERI.

By

HENRY SCHMITZ, M. D., CHICAGO, ILL.

Professor of Gynecology, Loyola University School of Medicine.

At the end of 1928, 662 private cases of carcinomas of the female genitalia had been treated with radiations. The charity cases, which were included in all former reports, have been omitted as they have been transferred to the tumor clinics of the Mercy Free Dispensary and the Cook County Hospital. Among the 662 cases were 502 primary and 160 recurrent carcinomas. Table I shows the number and percent of the cases for the various regions of the genital tract. It is seen that 80 percent of the carcinomas were in the cervix. Therefore control of malignant diseases of the female genitalia must be centered in the early recognition and immediate, adequate treatment of cervical carcinomas.

TABLE. I.

NUMBER AND PERCENT OF CARCINOMAS OF THE FEMALE GENITALIA FOR PRIMARY AND RECURRENT MALIGNANT TUMORS.

REGION.	Primary Carcinomas.		Recurrent Carcinomas		Total Carcinomas.	
	Number	Percent	Number	Percent	Number	Percent
Vulva ...	20	3.98	6	3.75	26	3.95
Vagina ...	7	1.39	2	1.25	9	1.16
Cervix Uteri ...	398	79.28	129	80.63	527	79.61
Corpus Uteri ...	38	7.60	5	3.13	43	6.50
Ovaria ...	39	7.7	18	11.31	57	8.78
Total ...	502		160		662	

Statistics prove that early, localized carcinomas, adequately treated, have a five-year curability rate of 80 to 90 percent. Clinical research, comprising the earliest tissue changes leading to malignancy and the symptoms and signs of early beginning cancer nodules has brought about greater progress in the diagnosis and prognosis of cancer than have all other investigations. The results of clinical research and the consequent improved methods of diagnosis should become the common property of the entire medical profession. The control of cancer can be achieved only by wholehearted co-operation between the general practitioner and the specialist.

The treatment of carcinomas of the uterine cervix may be surgical, radiologic or medical. Surgery is indicated when the entire growth can be radically removed. Irradiations are employed when it is possible to apply an adequate radiation tissue dose to the entire malignant growth. An adequate radiation tissue dose means a known radiation intensity, homogeneously distributed within the entire tumor-bearing area and capable of arresting or destroying the tumor cells. Medical treatment is necessary to prepare the patient for treatment, to enable the patient to pass safely through the period of treatment, and to assist the patient during the convalescence to a

speedy recovery. Further, should the carcinoma have advanced so far that surgery and radiologic treatment are useless, then palliative treatment should be given, which consists in medical management of infection, toxemia and so forth, and radiologic and surgical procedures for the relief of pain.

DIAGNOSIS.

The selection of remedial measures, whether surgery or radiology, depends mainly on the extent of the growth, but also on local and general systemic complications. The extent of the growth can be elicited by answering the following questions by a physical examination:

1. Is the cancer clearly localized? A growth about 1 cm. in diameter and normal mobility of the uterus are the two characteristics of a clear localization of the cancer. Normal mobility of the uterus is tested by traction on a tenaculum forceps attached to the cervix. If the cervix can be displaced downward to the vaginal outlet without any distress to the patient then mobility of the uterus is normal.

2. Does doubt exist as to localization? An edematous consistency and loss of elasticity of the paracervical tissues are felt on recto-abdomimal palpation. The uterus cannot be displaced downwards to the introitus by traction on the cervix.

3. Are the parametria are regional lymph nodes involved and is the tumor, as a whole, movable or fixed? Recto-abdominal palpation is required to determine parametrial involvement. The patient should be anesthetized and the anus dilated to enable the examining finger to reach the brim of the pelvis at the bifurcation of the common iliac, to palpate the hypogastric and external iliac lymph nodes.

4. Have extensions or metastases occurred in the bladder, the rectum and vagina? They can be elicited by bimanual palpation, cystoscopy, proctoscopy and vaginoscopy.

5. Have distant metastases occurred? They are determined by the history, general physical examination and diagnostic roentgen-ray procedures.

The answers to these five questions permit a clinical grouping of the carcinomas, thus: Clinical Group I, the clearly localized growth; Clinical Group II, the doubtfully localized growth; Clinical Group III, the invasive growth, characterized by parametrial and gland invasion (however, the tumor mass is not fixed); Clinical Group IV, the fixed and disseminated growth, including (a) the "frozen pelvis"; (b) invasion or metastazation of vagina, bladder or rectum; (c) distant metastases.

Inflammatory infiltration and tumors of the adnexa may complicate a cervical carcinoma. Nodular infiltration of the parametria, continuation of the cervix tumor with the parametrial masses, absence of displacement of the uterus either upwards, downwards or sidewards, are characteristic for cancer. Uniform induration of the adnexa, with a line of demarcation between the uterus and the inflammatory mass, early fixation and gradual resolution with return of mobility are indicative of adnexitis. Ovarian, ligamentous and uterine tumors may cause displacement of the uterus and loss of mobility, though the carcinoma may be in the clearly localized stages.

INDICATIONS.

The clinical grouping determines the indicated method of treatment. Clinical Group I carcinomas may be subjected to radical panhysterectomy or to radical radiation treatment. Clinical Group II cancers indicate radical radiation treatment. Clinical Group III carcinomas indicate radical radiation treatment. Clinical Group IV carcinomas are treated palliatively. Radium may be inserted for the arrest of bleeding: From 1,800 to 2,400 mg. element hours of radium are used in the crater; roentgen-ray therapy may be used to relieve pain; while presacral sympathectomy may arrest otherwise intractable pains, caused by pressure on or invasion of the pelvic nerves. Local cleanliness nourishing food, sunshine and medical management are equally important in all the clinical groups. Radical radiation treatment comprises the use of radium locally and of roentgen-rays distantly, to at least two fields: an anterior pubic and a posterior sacral field.

Operability depends upon the following factors: (1) normal mobility; (2) patency of the cervical canal; (3) afebrility; (4) sterile uterine and vaginal secretion, and (5) good surgical risk.

The determination of mobility has been given. Patency of the cervical canal is tested by dilatation. The escape of serous, hemorrhagic or purulent fluid is evidence of a retention due to atresia or stenosis of the cervical canal. Afebrility means absence of infectious processes, either local or systemic. Corroboration of infection is obtained by a high leukocyte count and a rapid sedimentation time of the red blood corpuscles. The pathogenicity of the cervical secretion is tested by the inoculation of 5 cc. of defibrinated blood obtained from the patient's arm vein with the cervical secretion, and incubation for four hours. The growth of colonies of bacteria is evidence of the presence of pathogenic bacteria. Bad surgical risks depend upon many factors, such as metabolic disturbances, renal, cardiac, hepatic and pulmonic diseases, severe degree of anemia, and so forth. The presence of any one of these complications contraindicates surgery. Some of the conditions may be overcome by proper medical management and operation may then be performed.

Radiation therapy is contraindicated in the presence of: (1) General emaciation, cachexia and toxemia due to absorption of waste products. Rediation almost invariably aggrevates these states; (2) anemia with a red cell count below 3,000,000, a hemoglobin percentage below 50, and a leukocyte count below 3,000. Radiations may cause an increase in these conditions to a danger point; (3) impaired nitrogen metabolism. Radiations may produce a rapidly increasing N retention due to the liberation of proteins, especially in advance cases. This may assume dangerous proportions in the presence of an already impaired N metabolism; (4) invasion of the urinary or rectal tract. Radiations, especially radium, lead to a rapid destruction of cancerous tissues and subsequent formation of fistula; (5) the presence of infection. Local manipulations contribute to a spread or reactivation, especially when radium is used. Roentgen-rays, however, may be applied, but should be stopped if a rise in temperature ensues.

The rules given in the preceding paragraphs have been carefully observed. Since 1917 operations have been discarded entirely. In this year a survey of the three-year end results showed that clearly localized carcinomas, treated with radiations but contraindicating surgery, had remained well anatomically and subjectively. Hence operations were entirely discarded. The five year good end results tabulated in the following table therefore represent the result of radiation treatment in carcinomas of the cervix.

It is evident that the good results of treatment could be increased at least three fold if patients came for treatment during the early, or Clinical Group I and II, stages. These however, can only be discovered by a careful pulvic examination of every woman patient coming to a physician's office. Stated re-examinations after infections, abortions and labors, until involution is complete and chronic tissues changes have been adequately treated, and periodic health surveys including examination of the pelvic organs, preferably on the client's birthday, are the only means to prevent cancer and to discover it in the early so-called silent stage.

TABLE 2.

GROUP	I	II	III	IV
Number of Cases...	36	53	180	126
Percent of Total Number of Cases...	9.27	13.25	45.23	32.25
Five Year Good End Results ...	31	25	33	1
Percent of 5 Year Good End Results..	87.87	47.17	17.78	0.78

Total Number of cases is 398.
Total Number of 5-year cures is 90 or 22.67 percent.

Chronic cervicitis is the precursor or carcinoma of the cervix. It should be adequately treated whenever found, whether it causes or does not cause symptoms. Routine microscopic examination of all the tissues obtained during operative procedures on the cervix is the only safe method to determine the true nature of the pathologic process.

CONCLUSIONS.

The treatment of carcinoma of the cervix should be based on the extent of the growth. Surgery is indicated in the clearly

localized carcinomas which can be radically and completely removed by operation. All other cases should be treated by adequate radiation therapy. Due to the delay in consulting the physician and to the avoidable delay in making an immediate diagnosis, more than 90 per cent of patients have clear indications for radiation therapy, as the tumor has grown too widely for surgical eradication.

The recognition during routine physical examinations and the adequate treatment of chronic cervicitides which result from infections, abortions and labors, will remove the chronic tissue changes which almost invariably precede malignant tissue changes.

Periodic health examinations, best at six-month intervals, will enable the physician to detect early and therefore curable cancers.

The rational treatment of chronic cervicitides and the discovery of early cancer nodules by periodic health examinations and their immediate and adequate treatment are the only means to attain control of carcinoma of the uterine cervix, as about eighty per cent of the early, silent and clearly localized carcinomas show five-year good end results from radiation treatment.

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

Notes on Treatment of Diseases.

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

Pancreatic Disease: The three drugs known to be secreted by the Pancreas are Aspirine, Hexamine, and Soda salicylas and they may be tried in the treatment of Pancreatic Diseases.

Paralysis (of birth) if due to Endocrine deficiency, pluriglandular treatment is called for.

Paralysis Agitans: Arsenic in the form of Fowler's solution, Hyoscine Hydrobromide 1/200-1/150 grain hypodermically and scopolamine are useful.

Pseudo-Hypertrophic Muscular Paralysis: Vitaminous food; large doses of calcium and milk. Ephiniphrine either hypodermically or under the tongue and massage. If due to hypertropy of the Pineal gland, Pineal gland 1/10 grain to be given for 3 weeks and then Thyroid gland and then Pituitary and Orchitic substance as the patient gets older.

Palpitation: Tincture Digitalis drs. 2. Spirit Ether Nitrosi oz. 1., Liquor Ammonium Acetatis, oz. 6., a dessert spoonful thrice a day. Or, Pot. Citras, drs. 2., Infusum Digitalis oz. 2., Aqua. Menth Pip oz. 6., a table spoonful thrice a day.

Paronychia: If a thick layer of mercurial ointment is smeared over the finger and kept on for one week, the pain rarely lasts more than a day. Silver Nitrate grs. 5., Spts. Ether Nitrosi oz. 1., to be painted once a day. Silver nitrate 5% solution may also be applied under the nail fold or a dressing of Iodum gr. 1., Pot. Iodide grs. 5, water oz. 2.

Paraphymosis: Application of solution Adrenalin chloride in 1000 with Cocaine hydrochloride solution 2 to 4 p.c. reduces the swelling in 15 minutes.

Parotitis: Injection of Diphtherial antitoxin is very efficacious provided it is given immediately after the onset of the disease. Application of radium is the best treatment.

Pelagra: Arsenic is good. Picric acid to be applied externally and given internally. Tomato diet is good. Fruit and milk diet will bring about a change of intestinal flora and improve the condition of the patient. Meat and yeast may also be tried. 50 cc. of watery extract of rice husk or the preparation of rice husk called "oryzania" is good. Sodium thiosulphate intravenously may be tried (about 20 to 60 injections).

Perinial Skin Thickening: Salicylic acid 6% in 50% of alcohol may be used as a paint.

Pemphigus: Arsenic by mouth or Sodium Cacodylate by injection. Hypodermic injection of Coagulin. For local application Carbolised Calamin lotion.

Peritonitis: To check vomiting, Aectanilide 2 grs. every 2 or 3 hours in brandy or ice. For bringing down the temperature, a dessert spoonful of Epsom salt every 15 minutes until the bowels move.

Peritonitis (Tubercular): Vaccine treatment must be had recourse to. Mercurial or guaiacol ointment is effective, (Guaiacol dr. 1, in Lanoline oz. 1); The ointment should be rubbed over the abdomen which should be bandaged with flannel. For Ascitis, Novasurol should be given intravenously every two or three days.

Pharyngitis (Acute): Local application of 1 per cent solution of Salicylic Acid or a solution of Silver Nitrate grs. 30 to 60 to oz. is useful.

Pharyngitis (Chronic): Paint the part with 5 per cent solution of Silver Nitrate once a week and give the patient a bland gargle.

Pleuritis: Injection of gas into the pleural cavity is useful. For pain Aspirine or Bromide may be given. In exudative variety Calcium chloride a tea spoonful every two hours (16 grams per day); Soda Salicylas in enema containing 2 grams in 10 to 20 c.c. of warm water. Salt free diet is advised. For the effusion paint the chest for 3 to 10 days with a solution of Tr. Iodine, Guaiacol and Mythil Salicylate each 8 c.c., Liq. Petrolatum 120 c c. Thyratoxine (A.F.D.) may be given for the resolution of the fluid.

Plague (Bubonic): Adrenalin Chloride 1 in 1000 mms. 40. Tr. Digitalis mms. 30, Spt. Ammon Aromat mms. 30. Aqua oz. 1, to be given every two hours to prevent heart failure. Anti-Plague Serum 40 to 60 c.c. should be given intravenously morning and evening till the temperature comes down. To guard against Anaphylaxis inject 1 or 2 c.c. first hypodermically and then give the intravenous injection. For buboes hot fomentation, after which apply the pigment containing Icthyol, Belladonna with Glycerine. Mercurochrome intravenously is said to have good effect and also, Bin-Iodide of Mercury $\frac{1}{5}$ to $\frac{1}{2}$ gr. in 15 mms. of water intravenously.

Placenta: To detach the placenta run in a pint of Saline solution into the Umbilical vein.

Poliomylitis: Anti-Streptococcus serum offers the only rational treatment and to be effective, it should be given before the paralysis sets in.

Anterio-Poliomylitis: Horse Serum and that of Petit of Paris are found to be very effective.

Pitryasis Vascular Nigra: Spirit lotion 4% containing Salicylic acid followed by mild Mercurial ointment such as White Precipitate grs. 10 to 15 to oz. 1, of Vasceline is all that is desirable.

Prickly Heat: Use a dusting powder containing Sulphur part i, Camphor part i, Starch part iii Zinc Oxide part ii and Boric Acid part i.

Pemphigus: Use Una's Paste consisting of 1 oz. of prepared Chalk, Sulphur, Oxide of Zinc, Linseed Oil and Lime water.

Notes on Therapeutics, Diagnosis and other Medical, Subjects.

Deferring old age through the Endocrines.

By

J. S. LANGFORD, M.D.,
San Antonio, Tex.

Life is glorious in youth when the rich blood flows tumultously and stirs the body and mind into thrilling action. The mind is alert; the heart is full of hope; ambition lures and life is great. It seems that no obstacle can come that cannot be surmounted by energetic and imperious action. Even when difficulties arise, handicaps, disease, discouragement, still life is sweet and precious at this age when the body is young and buoyant and the endocrine glands are functioning generously.

The thyroid secretion energizes the brain into action and its function is to turn activated by the suprarenal secretion, with the gonads also playing a part. Mental capacity and achievement depend upon the proper functioning of these important glands. If they are up to a high standard and well balanced in their inter-relations, the youth passes on into mature years with good prospects of a successful life. If function is poor and unbalanced, the chances are against a profitable existence in health and mental achievement, in spiritual values and in happiness. If there is great abnormality, there may be borderline insanity and the individual is, in part at least, incapaciated erratic, queer, unsuccessful and may be a menace to his family and neighbours. If function is greatly impaired he may be frankly psychotic.

One important thing, therefore in deferring old age, is that the endocrine system

shall be studied by a competent physician in youth, the deficiencies and excesses controlled, and the body brought through the adolescent years in the best possible condition. It is surprising what may be accomplished by the proper care of the endocrine system in the growing years by indicated organotherapy and by the proper regulation of the habits of life and everything that will promote the functioning power and the proper balance of these glands. Then, when active business life begins, there is a fair chance for success. The best time, therefore, to defer old age is in youth when, by temperate and correct habits of life and by developing a splendid and beautiful body by physical training, diet and wholesome thought, preparation can be made for service and happiness.

Therapeutic Abortion.

By

W. C. TENERY, M.D., F.A.C.S.

It is my opinion that too many therapeutic abortions are done without thorough analysis of the condition of the patient. The complications incident to producing abortions are decidedly more hazardous than the average individual is willing to admit.

Hyperemesis is perhaps the most common condition in which we have to make a decision. After the patient has been placed in hospital and all methods of controlling the hyperemesis have been tried, if the patient is rapidly losing weight, with a temperature constantly above 100° F and an irregular pulse rate consistently above 110, with mental disturbance, then abortion should be performed.

Regarding tuberculosis, the poorly nurished woman with pulmonary tuberculosis, who already has a number of children and who is not financially able to place herself under proper management, should be considered a fit subject for therapeutic abortion.

In the case of heart disease, patients with sortic lesions and myocardial insufficiency without broken compensation, with proper supervision throughout pregnancy and carefully avoiding unnecessary physical exertion, can usually go to term without any particular risk.

Concerning the patient with nephritis, at the end of about two months' observation, if there is an appreciable rise in nonprotein nitrogen or lowering of the phenolsulphonephthalein output, with a sharp rise in the blood pressure an increase in albumin and casts in the urine and evidence of optic neuritis, the patient should have a therapeutic abortion.

Clinical Medicine and Surgery, June, 1934.

Cancer of the Prostate.

Palpation of the prostate, by rectum, should be a part of every physical examination of men over fifty. Many cases of prostatic and rectal cancer would thus be detected early. The cancerous prostate is stony hard, may be smaller than the average gland and, unless accompanied by hypertrophy (as it often is,) is not obstructive until a late stage.

In early stages, radical removal of the prostate and vesicles is frequently curative; and even in the late stages, prostatic resection plus irradiation is helpful.—

Dr. Frederic L. Hoffman, in New Eng. J. of M., March, 8, 1934.

The Sex of Unborn Children.

A new method of foretelling the sex of unborn children, which has correctly forecast 242 boys and 156 girls, was described in an announcement at Boston University, Massachusetts.

If the baby to be is a boy, a small pink spot appears on the mother's forearm after a slight hypodermic injection has been made of an extract taken from the glands of bulls.

The colour in the case of girls is white, which means virtually that no reaction appears after the needle is used.

The test has been devised by Dr. Max Davis, instructor in obstetrics and gynecology at the School of Medicine.

The total prospective mothers tested were 468. The accuracy in respect of this number was 82.3 per cent. for male children and 89.6 per cent for females. The best period for accurate forecasts is said to be after the fifth month.

Times of India.

CLINICAL NOTES AND PRACTICAL SUGGESTIONS.

Enuresis and its Treatment.

Enuresis or bed-wetting, though a physiological condition in infancy, becomes very troublesome when it persists after two and a half years. In male children the habit continues for a longer time than in the female, because the former develop more slowly. Enuresis is mainly a symptom of infantilism. Sometimes this condition of Enuresis is seen as late as puberty and in such cases puberty is usually delayed and there is a slow development of secondary sexual characteristics. As soon as puberty is reached this condition automatically disappears.

This unpleasant affection arises from various causes. Persistence of nocturnal enuresis is sometimes attributed to heredity. There is no doubt a certain hereditary predisposition in some children in whom some signs of degenerative type are always present. The enuresis in these children always implies some delayed or interrupted mental development. Some of these children not infrequently have some kind of spinal lesions. At times we meet in these cases general nervous symptoms, such as disturbances of sleep, fears, abnormal sleepiness or exhaustion during day-time, nausea etc.

Another factor that has an important bearing in this condition is that when there is delayed or interrupted physical and mental development the elaborate mechanism of complicated conditioned reflexes is also interfered with. Such children therefore have no control on their sphincters and the bladder is emptied as soon as it reaches a certain degree of fullness.

Some local conditions or lesions either on the outer or the inner part of the urogenital system cause nocturnal enuresis Bed-wetting then is a symptom of this local affection. Phimosis, balanitis, stone in the bladder or congenital strictures are some of the conditions which need investigation in such cases. These lesions cause local irritation, which in turn may cause atonia of the sphincter Vesicae or cramp of the detrusor.

Very often no organic cause can be traced and then this condition is mostly of a psychological nature.

In passing, we may mention a few rare causes of symptomatic enuresis, Diabetes, Nephritis and Epilepsy. Sometimes nocturnal attacks of epilepsy manifest themselves through enuresis.

It is generally believed that there is no treatment that is invariably successful in this condition. Good results can be obtained in the initial stages by giving Adrenalin (1 in 1000) solution and large doses of Belladona combined with Bromides. Five minims of Adrenalin solution is to be dropped under the tongue and retained there as long as possible before swallowing. This is done because Adrenalin is usually destroyed in the stomach. The usual precautions of emptying the bladder before going to bed and two hours after are to be adopted. The mixture of Belladona with Ammonium or Sodium Bromide usually helps matters to a great extent.

When the possibility of an organic affection of the urogenital system has been eliminated, then the treatment must be based entirely on the child's neuropathic constitution. In the beginning the child should be awakened two or three times and induced to pass water. The child must be fully awake and conscious before it passes water. The first wakening must be done in the early part of the night as this is the most likely time for enuresis to occur. Later, wakening can be reduced and can be stopped entirely after three weeks. A quiet suggestive treatment is very important in this affection. The child's diet should be rich in vitamins, albumen and fats. It should not contain carbohydrates or salt. This sort of diet would greatly reduce the quantity of urine in the night. Rest, physical education and if necessary light-therapy are other factors in the successful treatment of this affection. The child must sleep in a well-ventilated room with fresh clothes at night. The bed linen must be frequently changed. In enuresis of neuropathic type some sort of calcium treatment per oz is specially desirable. In this type enuresis is chiefly a symptom of increased irritability of the neuro-muscular terminal apparatus in the bladder. Pulmo Calcium is best suited for this purpose as it is able to decrease the

irritability of the neuro-muscular terminals in the bladder and elsewhere without diminishing the function of the cortical centre as is the case when Bromides are administered. In addition to this Pulmo Calcium has an excellent sedative action in such children who usually suffer from disturbances in sleep. The influence of this remedy on the general nervous irritability is also beneficial. Pulmo Calcium regulates the vegetative nerve-tone and due to this fact there is great improvement in the psychic factor in enuresis. The affected reflexes are well adjusted and the activity of the organism is thus regulated. It acts as a sedative on the autonomic nervous system and it also restores sound and normal sleep. The great advantage of Pulmo Calcium is that it can be indicated even in those children whose digestive organs are weakened. It does not produce gastric irritation nor has it got any bad taste. It is therefore most suitable for children. They tolerate it well. The superiority, however, of this preparation lies in the fact that it is easily assimilated and that its calcium contents are fully utilised by the organism. In Enuresis Pulmo-Calcium is specially indicated as it establishes the normal humoral equilibrium of calcium with other salts so effectively that it can be considered even superior to other anti-spasmodic sedatives. Again it has another advantage of being absolutely harmless.

Lastly we have to take into consideration the belated or impaired physical and mental development which is usually present in these children. This calls for a restorative treatment, which can be best done by the administration of Fer-Ma-Pho. Not only does it restore the vital functions of the organism but it replenishes certain reserves of the nervous system. It is a specific for the nerves and due to the ingredients in it, it is admirably suited as a general restorative to improve the physical and mental development. This general treatment viz., association of Fer-Ma-Pho with Pulmo Calcium is more important and more successful than the local, as it is not advisable to unduly direct the attention of the little patient to the sexual region. The beneficial influence of this combined treatment soon becomes evident. The general irritability is much reduced, there is sound and restful sleep and the patient soon assumes a cheerful appearance. The general condition improves and the child begins to develop both physically and mentally in a rapid manner. Enuresis diminishes and after a time disappears completely. This composite treatment can be applied over any length of time as it has hardly any harmful effects on these children.

The Cure of Malaria with Quinarsine.

Whereas for the actual treatment of acute Malaria reliance should be placed on that old and tried remedy Quinine, the after-treatment and prevention of recurrence of the attacks should be carried out by Quinarsine. It fulfils a great demand as there exists no such product which serves as an effective treatment for chronic Malaria and for the prevention of relapses. Quinarsine, when administered either before or after the attacks, effectively removes from the blood the gametocytes which are the cause of recurrent attacks of Malaria. Quinarsine treatment represents an effective method of combating Malaria and preventing its transmission. It is therefore of great value from a curative as well as prophylactic point of view, because it acts on the schizonts of the tertian and quartan Malaria. Due to the combination of Quinine with the Arsenic, Quinarsine acts to greatest advantage and is able to cope with the most obstinate cases of Malaria both clinically and parasitologically.

While Quinine when used alone as a prophylactic and preventive involves a lengthy and debilitating course of treatment followed at times by relapses, Quinarsine injections reinforced in certain grave and chronic cases by pills, tends to effect a complete cure within a month without any of the by-effects of the continuous administration of Quinine. Quinarsine is a compound of a double salt of Quinine and of Arsenic. It combines the action of Quinine, which must form the basis for any anti-malarial treatment, with that of Arsenic, which has proved besides Quinine, as the only active and energetic drug capable of destroying Plasmodium vivax as well as Plasmodium Malaria. This action is further reinforced by Sodiianyl Cinnamoarsinate which is contained in the other ampoule supplied in the box of Quinarsine. It has been clinically proved beyond doubt that this combination is more active than either of the substances employed separately and that it is an effective remedy for combating all forms of Malaria.

Quinarsine fulfis the conditions required of any anti-malarial remedy. It is not effective during the course of fever and it does not relieve the symptoms, but it has been noted that after the full course of injections the asexual parasites in the blood diminish and disappear. Most cases are negative for ring forms after the full course. The administration is simple and the toxicity is low. Its effects as a preventive and a prophylactic is remarkable and its introduction therefore marks a new era in the therapy of not only malignant tertian, but tertian and quartan forms of malaria. Though Quinine cures acute attacks of Malaria, it actually favours recrudescences and the patient does not acquire an immunity. Quinarsine, on the other hand, has proved its superiority in that no recrudescence has occurred after the full course has been taken. This shows that the patient gains immunity through its use.

It is now generally recognised that in order to entirely stamp out Malaria all the parasites from the patient's blood must be destroyed. Quinine only destroys the asexual forms leaving the sexual forms in the blood, which become a great source of infection to other persons. Quinarsine acts much better in this respect. It is able to wipe out the sexual forms of the parasites from the blood and is particularly well-tolerated. It can be employed in all cases of Quinine idiosyncrasy. It even destroys the gametocytes of subtertian Malaria. Although it does not cure the fever it effects a full sanitary cure due to its anti-gametocyte action. Thus according to clinical observations Quinarsine is considered to be a powerful anti-plasmodic having an excellent therapeutic action in every form of Malaria. It exercises a particularly destructive effect on the subtertian ring forms and the tertian ring and pigment forms. In most of the cases it causes the crescents to disappear.

During the quiescent periods the administration of Quinarsine intra-muscularly supplemented by the pills helps to destroy the schizonts and gametocytes of tertian and quartan Malaria. In subtertian Malaria, Quinarsine sometimes fails to destroy the gametocytes but is capable of eradicating the ring forms from the blood. These results are usually found at the end of the course of 12 injections of Quinarsine. In some cases it is necessary to undergo another course together with the oral administration of Quinarsine pills. No matter what form of Malaria we have, we can safely employ Quinarsine by the injection method which controls and prevents the disease with surprising rapidity. Its effective action in small doses without any of the by-effects makes it possible for us to use it for prolonged periods. Splenic enlargement is also favourably influenced. One out-standing feature about Quinarsine treatment is that it produces remarkable and surprising improvement in the general condition of the patient. As the clinical signs and symptoms progressively diminish until they disappear altogether, the strength of the patient rapidly returns, appetite is restored and the body-weight increases in a most satisfactory manner. It is therefore very serviceable in all cases manifesting signs of weakness, debility, emaciation and anaemia resulting from chronic Malaria. These results are possible because the tonic effects of Quinine are reinforced by Sodiianyl Cinnamorasinate much more effectively than either cacodylates or other forms of Quinine.

Quinarsine is also of great value as a prophylactic because it influences the sporozoites transmitted by anopheles. It is thus able to prevent the clinical outbreak of an infection. The injections followed by daily administration of Quinarsine pills prevent latent patients from becoming carriers of gametocytes, and thereby becoming a source of infection for anopheles. It breaks the cycle, from man to mosquito and from mosquito to man, and protects the individual and those around him from infection by anopheles. Besides its specific action the fact that Quinarsine exerts a stimulant and haemopoietic action on the system raises its value as a prophylactic. The organism thus innervated is better able to resist the infection.

According to the clinical reports received from various quarters it is found that after the full course of Quinarsine it is rare to find malarial parasites in the blood. The chief and the greatest advantage of the treatment is that it is safe, short, simple and effective. The injections are painless and they do not cause any infiltration of the tissue. The pills are not unpleasant to take, and they do not leave any depressing after-effects. They are well-tolerated by all, even by pregnant women and young children. Treatment with Quinarsine has decided advantages over ordinary Quinine. There is no tinnitus and the digestive organs are not upset. Relapses are rare after Quinarsine treatment. The toxicity of Quinarsine is low. It has a wide margin between the therapeutic and the toxic dose. No case of haemoglobinuria has ever been observed after prolonged treatment with Quinarsine, in fact it is not contra-indicated in cases which have developed haemoglobinuria. From all these advantages we can conclude that Quinarsine is a powerful preventive against Malaria. Not only are those treated with it rid of Malaria, but they also become completely non-infective to the people around them.

The following case is one amongst the many illustrating the efficacy of Quinarsine:

A young adult Hindu aged 30 came to me with a history of malarial attacks for over a month. He looked anaemic with a weak and slow pulse. He complained of severe headache always. Spleen was palpable half an inch below the costal margin. Blood film revealed tertian and subtertian rings in large numbers. Blood cells showed parasites. The percentage of haemoglobin was 60. Quinarsine injections were at once started. A and B injections were given alternately every other day in the deltoid muscle. He was kept on Quinarsine pills and no other drug was prescribed. After a course of 12 injections his condition was greatly improved. No spleen was felt and his general condition looked better. No headache was complained of and the improvement in the appetite was marked. Another course of 12 injections was given after an interval of a fortnight. At the end of the treatment the blood film showed hardly any rings either tertian or subtertian and cells were absolutely devoid of parasites. Haemoglobin percentage was raised to 80. After the completion of the treatment he was no longer anaemic. He has had no relapse now for months after the full course of this treatment.

Pharmasol Manganese.

It is unnecessary at this stage to emphasise the general medical acceptance of the numerous advantages that colloidal products possess over their molecular equivalents. These advantages have received ample recognition and their widespread employment in a variety of indications conveys the conviction that in Pharmasol preparations we have at our disposal potent remedies for various conditions which are rebellious to treatment, and which are a source of anxiety and trouble to those responsible for the conduct of the cases. Pharmasol Manganese, one of the earliest of the Pharmasol group, has still maintained its peramount position as an effective weapon to cope with Staphylococcal and Streptococcal infections. It forms therefore a remarkable addition to our armamentarium for dealing with all kinds of suppurative processes.

The success following the introduction of Pharmasol Manganese for the trearment of Staphylococcal infections induced clinicians to use it more widely in other infections, such as Gonorrhoea and its complications, and its efficacy in these has proved that this colloidal substance is a rapid and harmless measure for dealing with these infections. Moreover its action depends both on its power of killing the micro-organisms and its ability to increase the resisting power of the host.

Pharmasol Manganese has in suspension ultra-microscopic particles of Manganese Dioxide. It contains one part of Manganese in 400 of the solution (0.25 per cent). Its action is due, it appears, to the power of the particles to act as catalytic agents and to play the part of oxidises or oxidising enzymes. When taken internally, or when it comes in contact with the tissues the Manganese Dioxide in this Pharmasol helps the absorption and release of the ions

essential to bring about the resisting power of the serum proteins and thus to deal with the invading micro-organisms.

The treatment of Furunculosis and other staphylococcal infections with vaccines has been entirely displaced by Pharmasol Manganese. While with vaccines the results are in the majority of cases most disappointing, improvement may be looked for almost immediately with a course of Pharmasol Manganese injections. In addition to its power of arresting suppurations Pharmasol Manganese has definite hemopoietic properties which enables the patient to overcome anemia usually associated with this condition. The result is that the patient is not only free from his complaint, but feels much better in general health. Injections of Pharmasol Manganese also give excellent results in carbuncles. The pain is relieved, the suppurative process is arrested and the carbuncle soon shrinks and heals in a remarkable manner. The general health is improved and recurrences are prevented.

Various skin-diseases such as eczema, dermatitis herpetiformis, psoriasis etc. have been found to yield rapidly to Pharmasol Manganese injections given twice weekly, intramuscularly in doses of 0·5 cc. increased to 1.5 cc. or even 2 cc. It has also given good results in Seborrhoeic Eczema. It helps the removal of masses of crust and heals the pitted and inflamed surfaces. All these types of skin-diseases of intractable and chronic nature answer well and rapidly to a full course of Pharmasol Manganese injections supplemented by the administration of the same orally.

In suppurative acne Pharmasol Manganese injections give better results than any other line of treatment. Improvement begins rapidly after three or four injections and the effect on suppurative processes is quite marked. The face becomes quite clear at the end of the treatment and no pits or blackheads are found on it, as is usually the case with other lines of treatment.

Pharmasol Manganese has proved of great service in acute, subacute and chronic gonorrhoel urethritis. It is considered at present a decided advance over former methods of treatment. The relief obtained by these injections together with local irrigations is really striking. Even when the disease has taken a thorough hold and complications have set in these injections have proved beneficial. The value of Pharmasol Manganese seems to lie in its power to raise the resisting capacity of the host against all coccic infections, and herein lies the explanation of its remarkable success in acute cowperitis, in acute and chronic prostatitis and epididymitis In gonorrhoeal arthritis great relief is obtained by a course of these Pharmasol Manganese injections together with local application of heat. The pain ceases, the temperature falls, and after massage and passive movements the joint can be soon restored to its normal condition.

A considerable percentage of cases of Urticaria which are most intractable to other lines of treatment respond well to Pharmasol Manganese. Very often practitioners come across cases of Urticaria for which no cause can be assigned. In such cases, besides the usual purgatives and calcium salts Pharmasol Manganese injections help to clear up the condition in a remarkably rapid manner. The particles of colloidal Manganese Dioxide increase oxidation and by stimulating the protein colloidal particles in the serum help in the dispersion of these particles so that the surface exposed to the invading protein or other toxic particles becomes greater. The increased oxidation together with the enhanced activity of the protein particles of the tissues and the serum bring about destruction of the invading proteins or toxins. This is the explanation on which the utility of Pharmasol Manganese is based in Urticaria. Being non-toxic and non-irritant this Pharmasol can be given either internally or injected intramuscularly with absolute safety. There is complete disappearance of symptoms without any possibility of recurrence.

There are several other indications in which Pharmasol Manganese both in oral and parenteral form can be usefully employed. Certain cases of middle-ear trouble, erysipelas and various septic blood-conditions can be treated with considerable success with this remedy as an adjunct to other lines of local or general treatment. Great relief is afforded, and pain and discharge put a stop to in Ethmoid disease by injections of Pharmasol Manganese, or even by the oral liquid preparation.

Injections of Pharmasol Manganese have hastened cure in many a case of muco-

purulent conjunctivitis of Gonorrhoea. The discharge stops, pain disappears and the congestion is rapidly relieved.

In the treatment of Sinusitis we have a specific in Pharmasol Manganese. Cure can be brought about in the majority of cases either by injections or internal administration of this Pharmasol.

Pharmasol Manganese has become an established routine method of treatment to control pustulation. This it is able to effect by powerfully increasing the resistance of the tissues and acting as a potent bactericide. It also improves anemia commonly associated with all suppurative processes. It is therefore an excellent remedy for the indications mentioned, and is a valuable adjunct to the surgical treatment of suppuration.

An illustrative case:

A male adult was suffering from boils on axill, thighs and buttocks. The infection was of three months' duration. He complained of awful pain, fever and malaise. Vaccines had been used with no result. I started him on the combined Stannoxyl and Pharmasol Manganese treatment. He was taking Stannoxyl tablets, 8 per day and Pharmasol Manganese was injected twice weekly. I began with 1 cc. for a dose and gradually increased it until he had 2 cc. The boils, which had proved refractory and which recurred when the vaccine treatment was carried on, were subsiding and hardly any fresh boil cropped up. This result was apparent in the second week when four injections were administered. The smaller boils were aborted, and the larger and the indurated ones ceased to give any pain, and later the core came away without much trouble. At the end of the treatment all the boils had cleared up and malaise also had disappeared. The patient was looking much better because of the improvement in the general health. There is no recurrence of the trouble so far.

Some interesting Case-notes.

FROM PRACTITIONERS' DIARY.

1. A young woman of rather a stout build and of 29 years came to me complaining of Dysmenorrhoea associated with scanty, irregular menses. During the periods she used to have intense abdominal pain, tenderness, rigidity and nausea. She has been quite well otherwise except that she has been inclined to be nervous. Sometimes even after the periods she used to feel nausea and she complained of pain in the lower abdomen some days after the menses had stopped. There was also constant headache and on account of the pain in the abdomen she was at times unable to walk very well. No amount of uterine sedatives or antipyretic drugs ever relieved her condition. When she came under my charge I decided to try only Ovaro Pituitary Co. All other medication was stopped and I gave her one ampoule of Ovaro-Pituitary Co. A. F. D. intramuscularly. I repeated this injection every other day. This was supplemented by the Opocrins of the same preparation. She took six of these daily. By the time the fourth injection was administered, her pains had ceased, nausea was almost gone and she had an excellent appetite. When six of these injections were finished all her symptoms entirely stopped. Headache disappeared, she could walk much better due to the lessening of abdominal pain and her nervousness entirely vanished. The flow was normal in quantity and duration and was absolutely painless. In all she was given a series of 12 injections which she took willingly, as the trouble grew progressively better after each injection. The injections caused no pain nor was there any local trouble. She is now having regular periods without any of the previous troubles. She is still continuing the Opocrins.

2. A Hindu patient aged about 48 sought my advice for Diabetes from which he was suffering for the last five years. He used to pass sugar in his urine as much as 50 grms. for every 35 or 36 ounces of urine. Polyuria was very troublesome. The urine for 24 hours measured about 150 ounces. There was intense thirst and appetite and the patient complained of neuralgic pains in the legs and hands. Severe itching all over the body worried him much. Patellar reflexes were absent. The general condition was very bad and the patient had commenced losing weight. Having stopped all other medication I kept him solely on Pancrepatine, prescribing the necessary diet. He took in the beginning 8 globules per day along with his food and increased them to 12 later on. After nearly two months considerable improvement in the general condition began to show itself. There was diminution in glycosuria, only 15 grms of sugar could be found in about 35 ounces of urine. Polyuria had lessened. Although there was still some glycosuria the patient felt strong enough. He was able to move about and carry on his usual routine. The appetite and thirst was less and he was able to put on flesh. A certain amount of glycosuria still persisted but his general condition was excellent. Pancrepatine treatment was still continued.

3. A Hindu lady aged 45 had frequent attacks of articular rheumatism of the shoulders. When she came to me the articular stiffness of the left shoulder-joint was very much pronounced and painful, rendering impossible all spontaneous and passive movements of the left arm. The stiffness was so much that the left arm could not be moved either forward or backward. Her general condition was anything but satisfactory. She passed sleepless nights on account of the pain. There was troublesome anorexia. I gave Cryogenine powders (10 grs. dose) for relieving her pain and kept her on the following mixture:

Sodii Salicylas	gr. xv
Pot Iodide	gr. iii
Vin Colchicii	m. x
Tr Gentian Co	m. xx
Aq ad	ounce i

1 dose after food.

As she had Pyorrhoea her teeth were attended to by a dentist. The joint was massaged with Lint Methyl Salicyl. This treatment had very little effect in the beginning, but later on the pain subsided a little. I started after a fortnight giving her Aurothysin injections. One ampoule (0·05 gm.) was injected in the gluteal muscles. There was absolutely no reaction and she had very good sleep on that day. The pain in the joint was decidedly better, although the stiffness remained. Another injection was repeated after six days, the dose being 0.10 gm. This time she had a little temperature. In all five of these injections were given. They were very well borne by the patient. She got very good sleep after these injections. After the fifth injection the pain no longer existed. The general condition improved but a little stiffness still remained in the joint. I have been giving her Iodalose by mouth at present and the movements of the shoulder after one month have become almost normal. The cure still persists and now there is absolutely no pain in the shoulder-joint. There is remarkable improvement in the general condition.

4. A Hindu male about 38 came to me complaining of impotency. For the last six months he was noticing that he had incomplete erections and untimately ejaculations. He was very much addicted to alcohol. He admitted having indulged in sexual excesses, but I could not elicit history of either syphillis or gonorrhoea. His bowels were constipated. He was lethargic and had no appetite. Signs of nervous debility were quite evident. He told me that he was feeling quite "Out of Sorts" and was not inclined to do any work. Examination revealed an enlarged liver, about a finger's breadth below the costal margin. It was tender and painful. Urine report showed nothing abnormal and blood was absolutely serum-negative. In the beginning I kept him on Sodium Salicylate mixture for this hepatitis. All kinds of alcoholic drinks were interdicted. When the patient became free from this complaint I decided to treat him for his impotency with Homovir and Hypercytol injections. These were given alternately every day until twelve of each were administered. At the end of this first series the patient said that he was feeling much better although not entirely free from the complaint. Another series of 12 injections of each were administered after a fortnight's rest period during which he took only 3 Homovir tablets per day. After the completion of this series the patient was decidedly improving. He had regained full power and potency and he was able to enjoy life and concentrate on his work. There was no aversion for food, he ate well, enjoyed good sleep, had regular motions and was quite fit sexually. There were no longer any symptoms of nervous debility. He was very much eased as regards his mental state and was extremely gratified with the results. I prescribed Fer-Ma-Pho tonic after this which he has been taking regularly with good results.

5. A child of twelve months was brought to me for treatment of severe diarrhoea

of seven days' duration. The child was passing watery, slimy and foul-smelling stools for one week. The general health of the child was anything but satisfactory. After giving the child at the start Oleii Ricini mixture, and after careful dieting I kept it on Thoroxyl treatment. The child took 6 tablets per day with the nourishment which mostly consisted of diluted milk and fruit juice. The number of motions was reduced after a couple of days, and five days later improvement definitely set in. Vomiting which so much troubled the child stopped entirely. There was good appetite and the motions soon assumed the typical homogenous yellowish brown appearance. The general condition of the child showed a remarkable improvement and its weight also was on the increase. After eight days the treatment was stopped and the child is faring much better. There has been no relapse as yet.

3. A young man of 30 was suffering for more than a year with chronic rhinitis and sinusitis. The nasal discharge was very profuse and of a foul odour. On examination by a specialist it was found that there was marked involvement of the frontal sinus. He was always complaining of severe headache and foul discharge, so much so, that he was worried with life. He had received all sorts of palliative treatment and has been once operated upon. There was absolutely no relief. I decided to try Orargol treatment in his case, both local and general. He was advised to purchase an Orargol outfit which he did, and he was instructed to use the Orargol solution provided with it, in the nose, specially in the upper turbinate region and the posterior nares. An attempt was made to reach all the possible infected areas. Internally he was having Orargol solution morning and evening, about 2 drachms per day. At the same time I gave him one injection of Orargol intravenously once a week. After about 5 weeks of this routine the patient felt a little better and his headache had stopped entirely. After one more week he felt that he was distinctly improving. The discharge which was of a foul and purulent nature had become only serous and had lost its offensive odour. I stopped the intravenous injections after this, but continued the internal and the local treatment. There was practically no discharge and headache had entirely stopped. He was able to sleep well and enjoy life in every other respect. Except for occasional coryza which troubles him, he is absolutely free from this complaint which worried him for well nigh a year.

News and Comments.

Diehards at Work: His Majesty's Government in England had under its consideration the subject of continued recruitment by the Secretary of State to the Superior Medical and Railway Service in India with a view to include its recommendations regarding this subject in the White Paper proposals. In the meanwhile a Committee was appointed in India to consider the re-organisation of the Military Medical Services. It is also said that the Government of India appointed a senior officer on special duty to examine and report on the question of the future medical services in India having regard not only to the impending constitutional changes but also to the recommendations of the committees appointed earlier both in India and England to go through the same question. The special officer mentioned above is now understood to have submitted his report with his recommendations. The subject matter of the report is treated confidential. All the same it is surmised that the report has a considerable bearing on the future of Medical Services in India. In the meanwhile retired members of the Indian Medical Service are at work in England and are engineering a campaign against Indianisation of Medical Service and quite recently Lt. Col. C. L. Dunn formerly Director of Public Health in the United Provinces has written an article in the July number of the English Review under the caption "The Menace to India's Health." Lt. Col. Dunn asserts that Indianisation has brought about serious deterioration of the Medical and Public Health departments in India. Although he admits that a few Indians are good professionally he opines that the majority of them are inferior to the British medical men especially in their standards of hospital management. There is no doubt that political events in India since 1919 have affected Medical Services but the fault is entirely due to the indifference shown by the Provincial Heads of the Government in almost all the provinces in India, who many a time on account of political reasons allowed the Ministers to have party considerations with regard to the appointments to the Superior Medical Services in India. If there could be found inefficient medical men in charge of Medical and Public Health departments it is not because there were not able and efficient medical men in the country but because the Government made bad choice. Our readers are aware that we did on more than one occasion comment in these columns and even in the Editorial columns of the current issue, have pointed out how the Madras Governor winked at the appointments made by the Minister of the Public Health and Medical departments and permitted him to appoint an officer who spent the major portion of his service in the Public Health Department and who was even recommended to the highest post in that department but who was made a District Medical Officer and allowed to practice medicine and surgery. Yet another who was a professor of Chemistry in a medical college, was made a Civil Surgeon. There may be such instances in other provinces as well. The Governors of the provinces are mainly responsible for the development of political parties in this country. If the Governors of the provinces encouraged the growth of political parties on sound and rational lines as obtaining in the country of their birth and in other civilised countries Lt. Col. Dunn or other Diehards belonging to the Churchill's school of thought would not have had opportunities to write in the way some of these Diehards have chosen to do with the set purpose of a campaign against the grant of political reforms to India.

British Pharmacopoeia : Preparation and publication of British Pharmacopoeia is one of the statutory functions delegated to the General Medical Council and each time the Pharmacopoeia is published, a commission consisting of experts is appointed by that Council. The last edition of the British Pharmacopoeia was published in 1932 and there have been considerable criticisms on the last edition. The General Medical Council have therefore appointed another commission which is expected to sit for seven years and publish another edition in 1941. A laboratory has been newly equipped to carry on chemical and pharmaceutical investigations. The new commission has commenced its work and it is reported that committees have been brought into existence in the respective Dominions to co-operate and help the Commission. Such a Committee must have been necessarily

appointed in India though the profession in India does not know the place where the Committee is constituted and its personnel. Evidently it must be purely an official body somewhere in Delhi or Simla. The Surgeon-General with the Government of Bombay had made a reference to the Bombay Medical Union requesting them to make suggestions as to the special requirements in India. The Commission is prepared after investigation to include any new drug or preparation which the Committee in the Dominions suggest to the Commission. We in Madras are so far ignorant of the activities of the India Committee. Perhaps the officials in the medical department are dealing with it.

It is an irony that the General Medical Council have not as yet made up its mind to recognise the Provincial Medical Councils though almost all of them came into existence as early as 1915. India has been denied its right to have its own Pharmacopoeia in spite of the fact that facilities are now available in this country for publishing such a book. Though the Government of India brought into existence in this country an All India Medical Council at the instance of the General Medical Council the latter body did not seem to have suggested the idea of delegating to this body duties and functions which that body enjoys. Even in a matter like the publication of Pharmocopoeia which affects the whole profession they would not mind to have the co-operation of the Provincial Councils which defective as they are, now represent the medical profession. Why should not the Surgeon-General with the Government of Bombay refer this subject to the Bombay Medical Council instead of the Bombay Medical Union which Union has only 316 members. Such a reference will only serve the purpose of an eye-wash. We trust the heads of the Medical Departments in all the provinces in India who are the Presidents of the Provincial Medical Councils, will not be discourteous to the bodies over which they preside but would refer the subject of the revision of the British Pharmacopoeia to the respective Medical Councils and honour those bodies and thus honour themselves.

Quacks and Bogus-Degree Holders: There is a feeling amongst the members of the profession that the Medical Councils have not been guarding their interests against quacks and Bogus-Degree holders. This feeling seems to us to be justifiable in a way. Though the scope of the existing Medical Acts is very limited and the Councils are quite helpless to prevent quacks from practising, the Indian Medical Degrees Act of 1916, gives powers to the Provincial Medical Councils to prosecute (with the previous sanction of the local Government) all those who voluntarily and falsely assume or use any title or description or any addition to their names implying they hold a degree or diploma, licence or certificate conferred, granted or issued by any authority recognized by the Governor-General in-Council or in case they practise Western Medical (Allopathic) Science. The complaint of the profession is not against the quacks practising indigenous system of medicine or Homeopathy. It is against the quacks practising Allopathic system of Medicine including Dentistry and also the Bogus-Degreeholders. We have come across many such Bogus-Degree holders in the city and quite recently have sent to the Registrar Madras Medical Council for necessary action a handbill widely circulated by one such Bogus Degree holder who has added the title F. R. C. S. behind his name. The Medical Councils have been very indifferent so far in not dealing with the Bogus-Degree holders. As referred in these columns, the Punjab Medical Council has been recently taking steps against these and we have not heard of any other Medical Council following the lead of the Punjab Medical Council. The Senior Editor Dr. M. S. Krishnamurthi Ayyar has given notice of a resolution which he would move at the October Session of the Madras Medical Council pointing out the necessity of taking necessary action against the Bogus-Degree holders and those unqualified persons practising the Allopathic System of Medicine. We trust that the Madras Medical Council would pass the resolution unanimously and take active steps to do away with the Bogus-Degree holders and unqualified practitioners of Western Medical Science who are a danger to the public as well as to the profession. We hope that the Medical Councils in other provinces also will not lag behind in protecting the qualified profession from quacks and Bogus-Degree holders.

U. P. Licentiates in Public Health Service: We have published an appeal from the Honorary Secretary of the U. P. Public Health Branch of the All-India Medical Licentiates' Association to his colleagues in the subordinate Public Health Department of the province. It is praiseworthy that these ill-paid hardworking members of the U. P. Public Health Department, have organised themselves not only to improve their lot but the lot of those in rural areas entrusted to their care. We trust that the appeal of the Honorary Secretary will attract due attention not only of those for whom it is intended but others in U. P. and other provinces in Public Health Service, who will do well to follow the example of their brethren in U. P. who, though not favoured by fortune are no less sincere in their zeal to serve the public while serving themselves. We congratulate the Honorary Secretary on his having taken the initiative of organising a conference which if conducted on the lines suggested in the programme will bring about very healthy results.

South Kanara District Medical Association: The Secretary has sent us a report of the proceedings of the Annual General Meeting and also a copy of the Annual report. The proceedings are published in the Correspondence Columns. From the perusal of the report we find the Association has been steadily progressing both in its strength and activities. South Kanara District Medical Association was the first in breaking the *mamool* of having always the District Medical Officer as the President of the District Medical Association, and we are glad to note that the Association has been getting active co-operation and help from the District Medical Officer and his staff and the feelings between the Government paid practitioners and private practitioners have been very cordial. It is very satisfactory to note that with the steady increase of honorary appointments there is proportionately as steady a progress in the growth of fraternal feelings amongst medical men in the moffussil stations. This is as it should be. Medical Associations not only help the practitioners to gain scientific knowledge but infuse in them a spirit of brotherhood which will in course of time do away with the evils of unfair and unwholesome competition in the profession. We trust Madras city which is naturally looked upon as an example, will lead the moffussil instead of being lead by them. The actual brunt of work in conducting the affairs of an association successfully usually falls on the Honorary Secretary and we congratulate Dr. K. R. Kini on his being elected as the Secretary for the fifth time continuously which honour the Association must have conferred on him in appreciation of the disinterested work of the energetic secretary. Dr. Kini would not have been able to do much but for the hearty co-operation he was having from his colleagues—the members of the Committee not to mention of the leadership of Dr. M. Shiva Rau. The Association did well in recognizing the services of their Managing Committee by re-electing them unanimously with Dr. Shiva Rau as the President.

More News about F. R. C. S. Examination in India: We learn that the students and graduates of the Andhra University are denied the privilege for applying for the Primary F. R. C. S. Examination to be conducted in Madras in the third week of December. We are also informed that Dr. MacRae who is in charge of the arrangements for conducting the examination at Madras has protested against the decision of the Council of the Royal College of Surgeons though Dr. MacRae does not believe that his protest will have any effect on the autocratic and unjustifiable attitude displayed by the Council of the Royal College of Physicians and Surgeons.

Professors William Wright and John Mellanby are the examiners appointed by the Council of the Royal College of Physicians and Surgeons for holding the examination at Madras. The two professors with Mr. Horace Rew, Director of Examinations of the Royal College of Surgeons will fly to India arriving on 18th December at Madras. It is also said that two Indian surgeons would be identified with the examiners in their work.

Dentistry College for Punjab: It will be welcome news that at least one Provincial Government that is the Punjab Government made up their mind to start a Dental College at Lahore. Admission in the first instance has been limited to the medical graduates who will be required to undergo two years' post-graduate instruction at this institution. But it is hoped that

early arrangements will be made with the Punjab University for the admission of medical licentiates also. A four year course in Dentistry will be instituted and the college has been named De Montomorency College of Dentistry. Dentistry in India is at present in the hands of quacks and the Government of India or the Provincial Governments have not as yet shown any concern to prevent the growth of Bogus Dental institutions where boys and girls with little or no preliminary general educational qualifications are given farcical training for a few months and let loose on the credulent masses for the practice of Dentistry. If the Punjab Government could start a Dental College why should not other Provincial Governments follow suit? There is a well equipped Dental College at Calcutta run by private agency and the Calcutta University would be well advised to recognise this institution imposing necessary conditions consistent with the dignity of the University education.

Medical Certificates: The baneful and unethical practice of countersigning the certificates of private practitioners by the Government medical officers has been substituted by a yet more objectionable procedure of taking a second opinion. Though the Government have notified that the second opinion should be obtained as early as possible by the Heads of the Departments, the patients are usually sent very late to the Government medical officers by which time the disease complained of is either cured or takes a different aspect and the purpose for which the second opinion is sought for gets frustrated. In many cases the Heads of the Departments prejudice the mind of the Government Medical Officer by sending him confidential reports against the person applying for leave. In the code of Medical Ethics published by the Provincial Medical Councils there is a rule according to which the practitioner occupying the official position should as a matter of courtesy whenever practicable communicate with the practitioner in attendance so as to give him the option of being present and the Government official should scrupulously avoid interference with or remarks upon the treatment or diagnosis that has been adopted. In spite of this rule it is almost regretable that men of the position of District Medical Officers do not observe the rules of etiquette. We understand that practitioners both in the moffussil and the city have complained to the authorities concerned against the discourtesy shown to them by the Government Medical Officers in not consulting them as required by the rules of Medical Ethics before they issue certificates in contravention to the opinions arrived at by the private practitioners. The procedure of taking the second opinion has certainly most disastrous effects on the prestige of the private practitioners and it is highly desirable that the Medical Councils should interfere in the matter in the interests of the medical profession as a whole and do away with this baneful practice of taking a second opinion.

Police Zulum: We have received a complaint from a moffusil medical practitioner that a Police Sub-Inspector has been threatening him not to perform operations. One has to be very cautious in dealing with the Police. They are guardians for maintaining Law and Order. We have no idea under what authority this Police Sub-Inspector intends taking action against the medical practitioner who, being registered can practise Medicine, Surgery and Midwifery. The only authority which has disciplinary control over the members of the medical profession is the Medical Council. We have forwarded the complaint to the Inspector-General of Police and trust that the members of the profession will not have any occasion to complain against the Police for such and similar unwarranted interference.

A Parting Present: A few days ago we read a letter in the Hindu about the creation of a new post called "Medical Superintendent, Bernard X-Ray Institute" General Hospital Madras and on enquiry learn that the new post got the sanction of the Government with the lightning speed. It is said that the "Medical Superintendent" is to be in the grade of Civil Surgeon and it is also strongly rumoured that an assistant surgeon now working at the Bernard X-Ray Institute is to be promoted to the grade of Civil Surgeon and made the Medical Superintendent.

There is little or no justification for the creation of this new post except it be to favour a particular Assistant Surgeon who in the ordinary course of events would have taken several years to reach the grade of Civil Surgeon. We have been pointing out to the Government through the columns of this journal that the policy followed by them in the past of converting junior assistant surgeons into Civil Surgeons superseding the Senior Assistants on the plea of such juniors holding special appointments, would bring about demoralisation and discontent in the Provincial Medical Service. Of late it was made possible for Assistant Surgeons with special qualifications to be in charge of special departments such as the Venereal, the Skin and even to act as Physicians and Surgeons in the University teaching institutions without transforming them as Civil Surgeons. Was it not possible to style an Assistant Surgeon as Medical Superintendent of the X-Ray Institute without raising him to the status of a Civil Surgeon? Apart from the haste with which the post was sanctioned the prefix "Medical" to the designation of this officer will look superfluous at least to those who are not aware that the director of the X-Ray Institute is a non-medical man. Evidently the purpose of those who created this new post was to distinguish the holder of the new post from the non-medical Director. We mean no disrespect either to the Bernard X-Ray Institute or the persons holding the posts of the Director and the new Medical Superintendent when we say that the naming of the institute and much more the creation of the new post would commemorate the action of the Government of Madras who made it possible for a non-medical man to be in charge of a medical institution having under him Registered Medical Assistants in contravention to an existing statute which prohibits medical men from associating themselves with unqualified persons in the exercise of their profession. The strange coincidence that this post was sanctioned by the Government on the eve of the expiry of the term of office of the last Deputy Secretary in charge of Local Self Government would make it appear as if it is a parting present unless the selection of the candidate to the post is made by the Public Service Commission as is usually done for all new posts.

Dr. M. S. Krishnamurthi Ayyar: has given notice of the following resolutions which he will move at the October session of the Madras Medical Council.

1. That in the interests of the Public and the Medical Profession, it is highly desirable that candidates that pass out successfully from the medical colleges and schools, undergo a practical course of training in Medicine, Surgery and Obstetrics, in the Government or recognised Medical Institutions for at least a period of one year, before they become eligible for registration.

2. That a committee of not less than three local Members of the Council be appointed to make suitable arrangements for the location and equipment of the office of the Council.

3. That the Government be requested to affiliate the Medical Schools to the Universities.

4. That the Council do take active measures against persons holding Bogus Medical qualifications.

Dr. Kamath expresses Gratitude: Before expressing my heartfelt gratitude to my brethren who took part in the recent Medical Council Election and returned me with a majority nearly amounting to unanimity, I should apologize with all humility at my command to the readers of The Medical Practitioner for not being able to publish the journal in time. I did apologize to them once before when the condition of my health was far from satisfactory, for my inability to publish the journal as punctually as I have been doing ever since the journal was started. My health is not normal still and the election campaign has retarded the progress to some extent. I request the readers to bear with me for a couple of months more within which time I hope to regain the retarded speed.

Coming to the topic of the Madras Medical Council Election, I am not justified in reporting the news of my success in the September issue of the journal as this event took place in October. But I crave the indulgence of the readers and beg to be excused as the circumstances were beyond my control myself having to spend anxious days, certainly not due to any uncertainty of success. I knew that the heart of the electorate was with me and the election results had proved the fact most tangibly. What troubled me most and kept me musing at times with a certain amount of uneasiness was the concern shown by a few licentiates employed at the Government teaching institution at Royapuram who knowing as fully as I did, and even expressing their opinion publicly that I commanded the confidence of the electorate, yet, dragged to the election field a candidate who was not himself keen to compete. A

rumour which was current not without foundation that a high official connected with the teaching institutions at Royapuram was also interesting himself with the election, puzzled me and kept me musing still more as this person was not himself a voter. The unfortunate circumstance that a final year student of the Stanley Medical School the son of my Madras rival was active in the election field naturally lent more colour to all sorts of rumours. The history of nomination of Dr. T. V. Ranganatha Rao, my rival in the city of Madras revealed and the result of the election proved that the purpose of getting me opposed was not for a contest in the interests of the electorate. Any opposition with whatever motive troubles those who are keen to serve and as much those who desire to have a faithful sincere worker to serve them. The lesson to be learnt from the recent election is that honesty of purpose has its own reward in spite of any unholy propaganda by self-interested people.

I do not claim any credit for the splendid result in the recent election. Over 1500 voting papers reached the Returning Officer and he had to reject nearly 150 papers as these were sent by ordinary post. Never in the annals of the history of the Madras Medical Council Election there was such a good record of polling. I got 1258 votes, Dr. T. V. Ranganatha Rao 66 votes and Dr. J. Dakshinamurti 4 votes; 27 votes were invalid and out of the 150 votes received by unregistered post my share must have been not less than 140 votes basing on the ratio of the published results. The electorate have thus kept me under a deep debt of gratitude which debt I can only attempt to repay by my service to them. I have been receiving heaps of letters congratulating me on my success and I take this opportunity of thanking most sincerely one and all my friends and the wellwishers of the cause I have been serving and assure them that I am always at their service. As The Medical Practitioner reaches all of them I have not written to them individually.

V. RAMA KAMATH.

Correspondence Reports, Etc,

The South Kanara District Medical Association, Mangalore.

The fourth Annual General Meeting of the above Association was held on 22nd September 1934, in the premises of the Wenlock Hospital Mangalore at 5 P. M. A large number of Medical Practitioners both local and from up country attended the meeting. After reading letters and telegrams from medical men who were unable to attend the meeting, the secretary read the Annual Report, statement of Accounts and the budget estimates for the year. The Executive Committee of the previous year was unanimously re-elected. After this light refreshments were served, the caterers being the Taj Mahal Hotel. Then the toast of the Association was proposed by Dr. M. Umesha Rao, L.M. & S, in which he requested the secretary to hold some meetings of the Association in the mofussil stations as such meetings would combine the benefits of a clinical meeting and a picnic. Next Dr. L. P. Fernandes, B.A., L.M. & S., spoke a few words about the Association and what good it has done to the profession. He expressed his inability to take more active part in the Association on account of his old age. He closed his speech by conferring his choicest blessings on the Association. The toast was suitably replied to by Dr. C. P. Kamath M.B. B.S. The president in his closing remarks thanked the District Medical Officer and his staff for giving the Association all their help during its meetings. The meeting terminated after the usual vote of thanks from the Secretary.

The Nuzvid Medical Practitioners' Association.

The monthly meeting of the Association was held at Nuzvid in the Local Government Hospital on Sunday the 30th September at 2 P.M. Many cases of clinical interest were discussed after which a resolution was passed conveying the heartfelt thanks of the Association to the Government of Madras for re-instating Dr. N. Rama Rao in charge of the Subsidised Dispensary at Gollapalli after a period of five months when Dr. Rama Rao had to undergo a lot of inconvenience and mental suffering.

District Medical Association, West Godavari.

On invitation from the Taluk Medical Association, Tadepalligudem, the General Body of the above association met at Tadepalligudem on 2-10-34 at 3 P. M. Dr. C. Ramanujayya presiding. The Managing Committee passed the accounts and some bills and then sanctioned the printing of the Bulletin and the purchase of 4 books for the Association Library. Dr. C. Ramanujayya, welcomed the members, introduced new members and appealed for better cooperation in sending association news, case notes and reports to the Bulletin. Dr. H. V. J. Sarma, the General Secretary, read the proceedings of the last meeting and requested the members to promptly pay up their subscriptions and return books in circulation.

A condolence resolution was then passed regarding the untimely death of Dr. P. Venkaiya of Palacole. Another resolution was also passed thanking the President and Managing Editor of the Bulletin for their offering to meet half the printing charges of the Bulletin.

Dr. Sivaramakrishna of X'Ray Institute of Bezwada, then read an essay on radiation in treatment of Human Organism. A case of anurism of the left popliteal artery was demonstrated with Specific History. Dr. M. Narayanamurty of Pentapadu read a lengthy article on "Puerperal Fever".

The Trichinopoly District Medical Association.

A monthly meeting of the above Association was held at 5 P.M., on Saturday the 25th August 1934, in the Government Hospital, Trichinopoly, when about 50 Members were present. Dr. Mrs. D'Costa was "At Home" to the members.

Dr. Balammal occupied the chair on account of the unavoidable absence of Dr. C. E. R. Norman, the President of the Association.

Dr. S. Padmanabha Sarma, M. B. C. M., District Medical Officer, and an old President of the Association was welcomed back to the Association by a formal resolution. Dr. Kalamegham, B.A., M.B.B.S. spoke on "Some Middle Ear conditions".

* * *

A monthly meeting of the above Association was held on Saturday the 29th September, 1934, at 5 P.M., in the Government Head Quarter's Hospital, Trichinopoly when about 35 members were present. Dr. Edward Paul Mathuram was "At Home" to the members. In the absence of Dr. C. E. R. Norman, the President, Dr. M. Balammal, M.B.B.S., presided.

The following resolutions were passed unanimously :—

"This Association requests the Commissioner of the Trichinopoly Municipality to suitably combat the dust menace which is a great danger to the Public health of the inhabitants by watering the roads twice morning and evening and thus conduce to the sanitary improvement of the Town".

(2) "It also brings to the notice of the commissioner the baneful influence of vending openly sweet meets and other articles of diet without suitable Hygienic safe-guards against infection and contamination."

Then there was a demonstration of clinical cases of interest.

Dr. Narasimhalu Naidu of Siruganoor, demonstrated a case of chronic Middle Ear disease in a boy aged 18 who has discharge from the ear since birth, the peculiarity in this case was that an anterior cervical gland was soft, swollen and suppurating. Dr. V. Subramanyam, Hony. Dental Surgeon demonstrated a case of a small boy aged about 12 suffering from cyclic vomiting due to Acetonuria and who improved remarkably under Glucose and Insuline. Dr. S. Padmanabha Sarma, gave his experiences of Acetonuria, particularly in children and impressed on the need of examining the urine in intractable cases of restlessness and vomiting in children. Dr. R. Gopalan demonstrated a case of Peptic Ulcer in an old woman of about 60 who was improving very well under medical treatment, chiefly alkalies. Dr. R. Kalamegham and Dr. S. Padmanabha Sarma explained the danger of administering Sodium Bicarbonate promiscuously and said that after neutrlising the acid, it stimulated more secretion of HCL and said Bismuth and Calcium carbonate were the ideal antacids. Dr. R. Sambasivan, M.B.B.S., demonstrated a case of Haemophilia. This

patient who had a serious accident involving face injuries during infancy recovered normally then. Even last year when he was operated upon for a Haemotoma on the right calf muscle recovered naturally. But when a similar Haemotoma was operated upon at the same place about fortnight back bleeding started immediately and could not be controlled by vigorous treatment with lot of calcium lactate by mouth, Hamostatic serum, calcium chloride injection and application of local steptics such as Zinc-chloride, Tr. Ferri Perchlor, etc., but suddenly stopped after a fortnight without any apparant specific treatment. Dr. M. R. Bhat of Pulivalam demonstrated a case which he had treated a year back for Scoliasis.

All India Medical Licentiates' Association.

APPEAL FROM DR. I. N. SAXENA,

Secretary, U. P. Public Health Branch.

Dear Doctor,

You would permit me to state that response to my appeals dated November, 6, 1933 and January 16, 1934 and subsequent reminders to nonmembers was really encouraging and that there are only 22 more L. P. H. Officers who have still not joined the Branch. I shall therefore take this opportunity of appealing to these colleagues of mine to join the Association forthwith, so that I shall have the proud pleasure of informing the authorities that our Branch represents all the Licentiates in public Health Service in the Province. The impression which such a strength and solidarity in our ranks, will give both to the public and to the Government, will carry us a long way in redressing the still unredressed grievances of our service. I sincerely hope that you will not hesitate any more for any reasons whatsoever to join the Branch and that you will thus give an opportunity for announcing at the next annual conference that the membership of our Branch is complete both in number and strength of our demand.

I have the pleasure to inform you that our second annual conference will be held at Lucknow in October 1934, and that the D.P.H., U.P. has been addressed to accept the Presidentship which he is likely to do so.

I therefore urge you to make the conference a great success by your attendance and by informing me any proposals or resolution which you would like the conference to adopt. The scientific section, which is a very important part of our conference, will organise reading of scientific papers, and will give us an opportunity of exchanging views on research work and new methods of prevention of diseases before a distinguished gathering who will assemble at the conference. Any Public Health subject may be chosen by you and as suggestion, I give below, the following few subjects on which you may write. As there is plenty of time, I would request you to prepare the paper on the subject you are interested in and send me a typed copy in advance to allot time for the reading of those papers. Our journal, the Indian Medical Journal will publish the accepted papers and will furnish the usual number of reprints to the writer.

1. Practical improvements in village sanitations and hygiene.

2. The importance of medical inspection of school boys in relation to the prevention of preventible diseases.

3. Practicable Malarial prophylaxis in U. P.

4. Bacteriophage in the prevention of an epidemic cholera.

5. The incidence of Tuberculosis in U.P. and suggestions to reduce such an incidence.

6. Practical methods in the prevention and prophylaxis of plague as would be applicable to U. P.

These are only suggestions. You can of course choose your own particular subject. The paper should not be long, not more than 10 typed pages, should be of a practical nature and should bear distinctive marks of originality, merit and usefulness. The papers read at the last conference, were very much appreciated by those who were present and were published and favourably commented upon in our journal. Such exhibition of our professional ability and attainments will not only raise us in the estimation of the Public Health Officers, but will also be a deciding factor in the redress of our grievance which we bring to the attention of the Government. You may therefore send to my address the resolutions and scientific papers so as to reach me on or before the 1st October 1934. Any suggestions to make the conference a success and an effective medium for ventilating our particular grievances will be thankfully received by me.

The old members whose subscriptions are due, and the new members to whom I confidently expect this appeal will go home are also requested to remit their subscription to the Honorary Treasurer of our Branch, Dr. R. N. Tandon, Mir Jan Lane, Latouche Road, Lucknow, without any delay. The actual date and programme of our next conference will be duly intimated to you and of course, leave of absence to attend the conference will also be obtained from the authorities as usual.

We, who are under a heavy load of grievances, should show our determination to get them redressed. It may be that many of our grievances laid before the authorities in the form of resolutions and through deputation remain wholly or partly unredressed. But as in the case of other Associations and as constitutional method involves, sustained and continuous pressure of this nature will inevitably bring fruitful results. I would therefore appeal to you with all the emphasis of sincerity and love towards our class to join our Branch in greater number, to muster strong at the conference, to give the benefit of your personal advice and guidance and to continue to put forth sustained efforts for our redemption, despite temporary setbacks and failures which under present circumstances are unavoidable.

Drug that "Acts like a charm."

FIFTY DEATHS RECORDED.

A drug that " acts like a charm " is sold under the various trade names and has been associated with 50 recorded deaths was mentioned at a Birmingham inquest. The inquest was on Herbert Hulme, aged 31, a works electrician of Birmingham. It was disclosed that he was suffering from sciatica and gout and was prescribed atophan, a drug composed principally out of quinine and carbolic acid, which cured him after an accident in which he was burned. Jaundice developed, and he died. Dr. K. Douglas Wilkinson, Professor of Pharmacology at Birmingham University, said he used the drug fairly frequently, but with considerable caution.

It was sold under various trade names was very useful and acted as a charm, so much so that patients were likely to fly to it and recommend it to all their friends.

There had been about 50 recorded deaths, but there must be more cases, because it was not generally recognised as likely to do damage to the liver in certain cases. Dr. Neuman, medical director to the manufacturers, said 68,000,000 tablets of the drug were consumed last year.

The coroner said he thought the drug ought at once to be put on Part I of the the schedule of Poisons. At the present moment anyone could obtain as much as he wanted from the chemists. The medical evidence was that death in this case was due to acute yellow atrophy of the liver, and a verdict of death by misadventure was returned.

(*Times of India.*)

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

No.	Names of Sub-Asst. Surgeons.	From.	To
1	Dr. C. Padmanabha Menon	Mental Hl., Calicut	L. F. Dy., Omalur.
2	,, T. S. Subramania Ayyar	Leave	L. F. Dy., Rajapalayam.
3	,, T. R. Srinivasa Iyengar	L. F. Dy., Rajapalayam	Spl Police Force Dy., Sivakasi.
4	,, S. N. Nilakantan	Sp. Police Force Dy. Sivakasi	L. F. Dy., Tiruvadanai.
5	,, N. Krishnaswami Iyer	Agency Duty, E. Godavari	Govt. Hl., Conjeevaram.
6	,, C. Manicka Mudaliar	Govt. Hl., Conjeevaram	L. F. Dy., Poonamallee.
7	,, M. Gopala Menon	L. F. Dy., Poonamallee	L. F. Dy., Nachiarkoil.
8	,, J. Satyanarayanamurthi	Govt. Hd. Qrs. Hl., Guntur	L. F. Dy., Mangalagiri.
9	,, S. Sriman Narayanamurthi	L. F. Dy., Mangalagiri	L. F. Dy., Porumamilla.
10	,, A. Krishna Rao	Leave	L. F. Hl., Razole.
11	,, K. Rajamannar	L. F. Hl., Razole	Govt. Hd. Qrs. Hl., Cocanada.
12	,, P. V. Anantanarayana Iyer	Leave	L. F. Dy., Edappadi.
13	,, K. Krishna Rao	Leave	King George Hl., Vizagapatam.
14	,, Mrs. Sarah J. Souri M.B B.S.	Leave	Govt. Hl., Hospet.
15	,, Mrs. L. Anandan	Govt. Hl., Hospet	Govt. Hl., Madanapalle.
16	,, M. A. Seshan	Leave	L. F. Dy., Andiyur.
17	,, R. P. Narayanaswami Iyer	L. F. Dy., Andiyur	L. F. Dy., Kottur.
18	,, V. V. Kannan Nair	L. F. Dy., Kottur	L. F. Dy., Kannambra.
19	,, Miss. C. E. D'Silva	Presy. Jail for Women Vellore	Govt. Hl., Tindivanam.
20	,, Miss. G. Gnanaprakasam	Govt. Hl., Tindivanam	Govt. Hd. Qrs. Hl., Madura.
21	,, Mrs. C. H. Selvanayagam	Govt. Hd. Qrs. Hl., Madura	Govt. Hl., Srirangam.
22	,, K. Tyagarajan	Leave	P. W. D. Dy., Thekkadi.
23	,, A. Susaimarian	P. W. D. Dy., Thekkadi	L. F. Hl., Melur.
24	,, H. Govinda Gadiyar	L. F. Hl., Melur	L. F. Dy., Tirumangalam.
25	,, G. Venkataramayya	Govt. Hd. Qrs. Hl., Masulipatam	L. F. Dy., Pamarru.
26	,, K. Sriramamurti	L. F. Dy., Pamarru	Govt. Hd. Qrs. Hl., Masulipatam.
27	,, A. Tyagarajan	L. F. Dy., Uttiramerur	Agency Duty, Ganjam.
28	,, A. Pichakuppu Sastri	Leave	Police Hl., Coimbatore.
29	,, Vasa Narasimham	L. F. Dy., Surada	L. F. Hl., Aska.
30	,, P. Satyanaraya Rao	Govt. Hd. Qrs. Hl., Kurnool	Establishment of Special Chenchu Officer, Atmakur.
31	,, N. Murti Sarma	Establishment of Special Chenchu Officer, Atmakur	Govt. Dy., Dhone.
32	,, A. Narasimhalu	Govt. Dy., Dhone	Govt. Hd. Qrs. Hl., Kurnool.
33	,, Dr. J. T. Moses	L. F. Dy., Tirupanandal	Govt. Hd. Qrs. Hl., Ramnad.
34	,, Mrs. Leela Samuel	Leave	Govt. W. & C. Hl., Salem.
35	,, Miss. V. Kalyani Ammal	Govt. W. &C. Hl., Salem	Govt. Hl., Udipi.
36	,, T. M. Sundari Bai	Govt. Hl., Udipi	Govt. Hl., Puttur.
37	,, S. Ponnuswami Iyer	R. M. Dt. Hd. Qrs. Hl., Tanjore	L. F. Dy., Kulitalai.
38	,, A. Kandaswami Pillai	L. F. Dy., Kulitalai	R. M. Dt. Hd. Qrs. Hl., Tanjore.
39	,, K. P. Chidambaram	Govt. Hd. Qrs. Hl., Trichinopoly	L. F. Dy., Marungapuri.
40	,, T. Ramadoss	L. F. Dy., Porumamilla	Govt. Hl., Palmaner.
41	,, N. C. Govindaswami Pillai	Leave	Govt. Hd. Qrs. Hl., Cuddalore.
42	,, K. Govinda Menon	Leave	Govt. Hd. Qrs. Hl., Coimbatore.
43	,, C. Raman M.R.C.S., L.R.C.P.	Police Hl., Coimbatore	L. F. Dy., Mettupalayam.
44	,, A. M. Ethirajulu Nayudu	Govt. Hd. Qrs. Hl. Guntur	L. F. Dy., Vetapalem.
45	,, V. Lakshminarayana	L. F. Dy., Vetapalem	L. F. Dy., Surada.
46	,, P. Chokkalingam Pillai	Leave	Govt. Hd. Qrs. Hl., Trichinopoly
47	,, C. Kameswara Rao	Govt. Dy., Harpanahalli	Govt. Hl., Adoni.
48	,, T. Sitaramayya	Govt. Hl., Adoni	Govt. Dy., Harpanahalli.
49	,, M. V. Ganesan	Govt. Hl., Bezwada	L. F. Dy., Bantumilli.
50	,, M. Sridharamurthi	Agency Duty, E. Godavari	Govt. Hd. Qrs. Hl., Nellore.
51	,, K. A. Subramaniam	L. F. Dy., Edappadi	L. F. Dy., Uttangarai.
52	[illegible]iah	L. F. Dy., Uttangarai	L. F. Dy., Palakodu.
53	,, S. Arunachal[illegible]	Leave	L. F. Dy., Uttiramerur.
54	,, P. Lakshminarayanamurti	Police Training Hl., Vellore	L. F. Dy., Arni.

Reg. No. M. 2528.

Printed at THE INDIA PRINTING WORKS, "Sri Nivasam" Mylapore and Published by the Managing Editor, Dr. V. RAMA KAMATH, 147, Purasawalkam High Road, Vepery, Madras.