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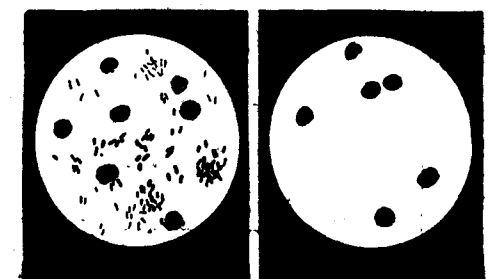
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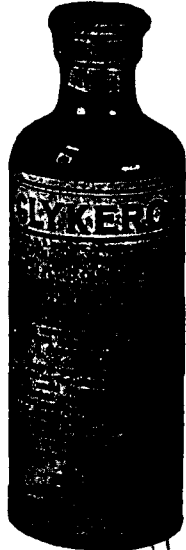
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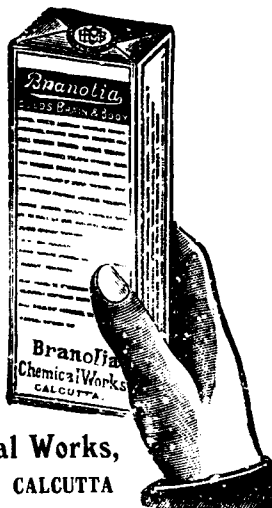
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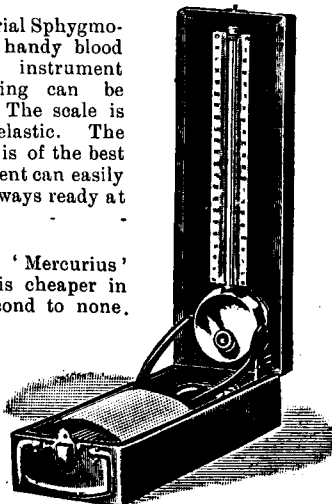


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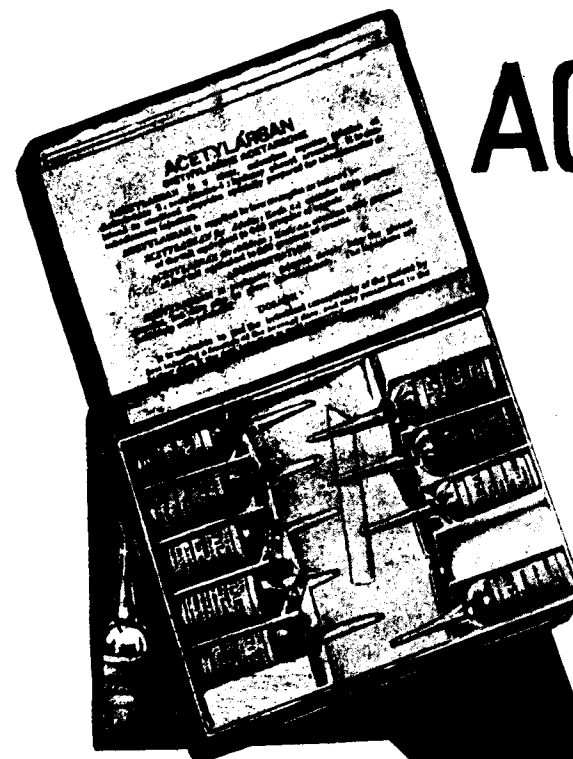
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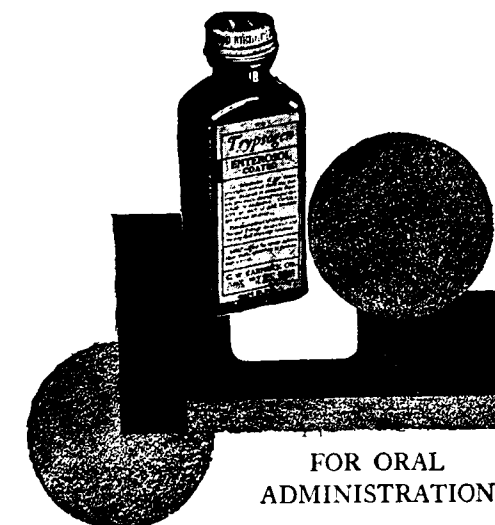
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## Original Articles

### NORMAL AND ABNORMAL STOOLS\*

BY DR. SAMUEL S. RAM SINGH, L.C.P.S., (BOM.)  
M.S.M.F., (Pb.) D.T.M., (Cal.)

*Demonstrator of Pathology, Amritsar  
Medical School*

Apparently, nature seems to be beautiful and presents an outward calmness. But under her seeming calmness there is murder, plunder, starvation and suffering!

Man is no doubt a superior being. His intelligence and inventive genius have given him power over climates and elements. Yet, there are two phases of existence from which he has not been able to free himself, viz., competition between man and man resulting in politico-economic warfare and man's fight with parasites resulting in disease.

We, as men of science, are only concerned with the latter. Most of you know the progressive attempts of medical science to free humanity from the bondage of disease. Many of the parasitic enemies of man have been discovered, their resources and limitations are better known and their tactics are better understood than a generation ago.

The Medical scientist has explored the human system with a commendable thoroughness. It has been found that many of our enemies, the parasites, are in the habit of hiding themselves in the digestive canal of man. This long, tortuous, dark and almost airless canal is the region where the female parasites rule and the males are most submissive and puny. The former are blood-thirsty and greedily search for favourable sites of existence and food. Modern methods have enabled us to detect these parasites and to realise their mischief.

Chemical and microscopic examination of the stools will reveal the nature of the intestinal parasites which produce various pathological lesions in the body. It is not my intention to bore you with technical details of laboratory work. I shall, therefore, be rest content with a brief description of normal and abnormal stools which, I venture to submit, will be more useful to the general practitioner than the dry laboratory procedures.

\* A lecture delivered at a clinical meeting of The Amritsar Branch of The Indian Medical Association on 7-9-35. Received for publication on 28-9-35. Ed. I. M. J.

Examination of stools yields data of practical value concerning the secretions, the power of absorption, and the contents of the entire alimentary tract. Really complete examination is, however, tedious and is possible only in a well equipped laboratory. Some of the Chemical tests are rather complicated and laborious. For general purposes, the stools is searched for worms, protozoa and some times for bacteria; and these seem to be sufficient for the clinical requirements of the physician. Besides, even the mere naked eye examination of stools is so interesting and instructive that I propose to deal about it also in some detail, while a passing mention will, of course, be made regarding the utility of special laboratory investigation of stools.

It must be clearly understood that the normal character of stools differs according to the period of human life. These periods can be broadly divided into:—

1. New-born period.
2. Infancy
3. Child-hood
4. Adult and old age.

1. **New-born period.**—This is the period following the birth and it may be said to comprise of 2 to 3 weeks. This period shows greatest susceptibility to upsets, as it is a period of transition between intra and extra uterine life when accommodation is proceeding. The first faecal evacuation of the new-born is called *Meconium*. It is a tarry, dark or greenish brown substance, almost odourless and faintly acid in reaction. It is passed 3 to 5 times a day during the first three days and consists mainly of cells from the intestines and the skin, minute hairs, fatty granules, cellular detritus, intestinal mucus, cholesterine crystals and other colouring substances derived from bile. Some of the peculiar constituents of meconium are explained by the fact that the foetus swallows the amniotic fluid while in the uterus. The total amount of *meconium* is about 2 to 3 ozs. When the new-born is put to the breast, the ordinary milk faeces appear. It is golden yellow in colour, ointment-like in consistency, and faintly acid in reaction. When it is given cow's milk, it is alkaline in reaction, pale yellow in colour and has a decided odour due to decomposition of protein. Well digested breast milk is almost homogeneous and has the following proportion of fat and protein. The reaction of the stools accordingly changes:—

- 3 : 1 :: Fat : Protein=Acid Stools  
1 : 1 :: Fat : Protein=Alkaline stools.

The alkaline reaction of the stools of the bottle-fed infant indicates high percentage of protein in the food of the infant. The Ph value of the stools is 4.7 to 5.6 and in diarrhoeal condition it is reduced to 4.6. Numerous small whitish balls in infant stools are normal, specially in artificially fed ones. During the first ten days of life there is a mild hyperæmia of the intestines, due to the incipient process of digestion and possibly also to bacterial invasion. Occult blood test is positive and I consider it as a normal condition in the stools of the new-born. Two to four evacuations a day are normal and later, up to the age of two, one to three in 24 hours. The constituents of the stools (24 hours collection) are roughly as follows:—

|             |                                    |
|-------------|------------------------------------|
| Breast milk | 3%                                 |
| Cow's Milk  | 4.3% (If it is given to the child) |
| Water       | 85%                                |

Greater part of the residue consist of cellular elements, mucus and bacteria. Fat is a normal constituent. Sugars are not found as they are all absorbed. A small amount of protein is detected; it is greater in bottle-fed infants. Colour is due to bilirubin.

**2. Infancy.**—This lasts about 2 years. During this period the stools become darker yellow as the diet becomes more varied. But so long as milk constitutes the main part of the food, the infantile characteristics of the stools described above continue and as the periods of childhood, youth and adolescence appear, fully formed stools are passed.

**3. Adult.**—Even a mere naked eye examination of the stools will often give us sufficient information as to the pathological changes going on in the body and their clinical bearings.

**Consistency.**—The normal stool of an adult is generally well formed and is offensive in odour due to products of decomposition, such as *skatol*, *indol* and *butyric acid*. The offensive odour is further increased if a large amount of meat is consumed or if there is an increase of putrefactive bacteria. Vegetable and fruit diets cause less offensive odour. In severe diarrhoea, in gangrenous dysentery and in the syphilitic ulceration of the colon the odour is distinctly putrid.

**Colour.**—Normally it is light or dark brown, due to *urobilin*. Some coloured foods and certain drugs change the colour of the stools, as for example, calomel makes it green. Colour is an important indication of the nature of the disease. It is usually green in the diarrhoea of children, putty like colour indicates deficiency of bile

due to many causes, putty like, but with grease on the surface of the stools points to tubercular peritonitis or pancreatic disease. Tarry black stools are due to bleeding in the stomach or the small intestines while it is dark brown or bright red if the source of bleeding is near about the rectum. In cases, however, where there is concomitant diarrhoea and hæmorrhage the stools will be bright red, even though the source of the latter may be high up in the intestines. Usually in piles, the blood streaks the motion or is a pool apart from it; sometimes clotted with intact R.B.C. Presence of mucus or mucopus betokens ulcerative lesion of the colon. Small motions attended with much straining may contain blood and mucus or mucopus when it means that the patient is suffering from dysentery. In cancer of the colon blood is uniformly mixed with mucus forming a pink jelly. In ulcerative colitis blood lies on mucus in little pools. It must be noted that when the blood comes from the proximal portions of the alimentary tract it can only be recognised by spectroscopic and chemical tests. Before doing the tests for occult blood, the patient should be asked to abstain from meat diet for 4 days and should not take drugs like iron and bismuth for the same period.

**Quantity.**—Diet and other factors influence the quantity of stools passed. As a rule, the vegetarian's is bulky while the meat-eater's is less bulky. It also depends on the degree of intestinal peristalsis. The average is about 100—200 grams.

**Frequency.**—1-2 stools a day is normal. Some people who are otherwise healthy pass stools only once in 3 or 4 days. Here individual habits play a great part.

**Form.**—Well balanced diet gives the formed stools. It is, at least,  $\frac{3}{4}$  inch in diameter, banana shaped and contains little or no gas bubbles or mucus. Variations in consistency may be due to laxative effects of certain food stuffs. Clear mucus may be present in normal stools if its passage is delayed. It is soft, mushy or liquid in diarrhoea; copious without faecal matter, serous or rice-water like in cholera; hard in the constipated; hard, rounded and scybalous in the habitually constipated indicating atony of the colon; flattened and ribbon-like in obstructions near about the rectum—these are some of the important and common abnormalities of the form and consistency of the stools.

**Mucus.**—In excess it is pathological and indicates inflammation of the bowels. It is intimately mixed with stools. If the inflam-

mation is high up in the small intestines it generally lies on the surface of the stools. Stools purely of mucus and streaked with blood is found in dysentery, ileocolitis and in intussusception. Strings or casts of mucus occur in muco-membranous colitis. These casts may be several inches long and glassy white or grey in colour. If from small intestines, they are generally bile stained and if from the large intestines, they are white. Stools of typhoid fever contains plaques of intestinal epithelium, sloughs from the necrosed ulcers, generally during the 3rd and 4th week of the disease. It should not be forgotten that mucopus and pus cells may be swallowed from nasopharyngeal and bronchial tracts and may appear in the stools. It is only when they arise from the bowels that they indicate ulcerative condition of the colon. Fresh pus in separate masses may be passed with stools in fistula-in-ano, in simple proctitis following enemas, syphilitic or gonorrhœal or tubercular proctitis or from an abscess which has burst into the lower bowel. In women, the pus may be from vulva or vagina and the possibility of blood or blood and mucus stained motions in menstruation should be borne in mind.

**Concretions.**—Gall stones and Enteroliths are sometimes found in the stools when our attention should naturally be directed towards the causes producing the same.

**Crystals.**—Charcot-leyden crystals are diagnostic of amœbic dysentery.

**Parasites.**—They are not found in normal stools. They can be broadly divided into (1) Protozoa, (2) Helminths or worms. Besides the pathogenic parasites, there are certain species of protozoa and worms which confound the average medical man. In such cases the advice of the trained pathologist must be sought. Parasitology is an absorbing study. The life histories of some of the parasites would be almost unbelievable if they had not been already scientifically established beyond doubt. Take for example, the life history of the *Ankylostomo duodenale*. The larvæ pierce, perhaps, at the dorsum of foot, enter a vein through the lymphatic vessels and then the liver, lungs, trachea, œsophagus, stomach and finally attach themselves to the mucus membrane of the duodenum or the jejunum. They take about 53 days to perform this journey during which they evolve into a state of maturity. The larvæ of *Ascaris Lumbricoides* do not utilize their first visit to the mucous membrane of the small intestines to settle there abruptly, but re-enter the tissues, to gather strength and experience so to speak,

and only later on returns to its habitat. It is a process of domicile and acclimatization and is a manifestation of the mute wonders of nature.

### Protozoa

The serious study of protozoology began with the finding of *Balantidium coli*. This is a ciliate protozoon and is sometimes responsible for a severe form of diarrhoea or dysentery. Its intermediary hosts are usually the pigs and those who come in constant contact with them are likely to get infected. The study of amœba is of great interest. Our water supplies and vegetables are swarming with amœba but not all of them are pathogenic. Sometimes, they gain access to human fæces and they are mistakenly described as *Entamoeba Histolytica*, the incriminating organism of amœbic dysentery. The life history of *Entamoeba Histolytica*, till Dobell's classic contribution in 1928, was incompletely understood and inaccurately described. In 1924, the amœba was for the first time cultured in vitro and this has facilitated the study of the intestinal protozoon and the working out of its life history in cultures. Dobell, with improved technique, has successfully worked out the different phases of its existence, and, what is more, he is able to produce at will any phase in his culture by suitable modification of the environment. The amœba have four phases:

- The vegetative phase with actively motile forms dividing by binary fission.
- The pre-cystic stage when the amœba increases in size and the cytoplasm stores its glycogen for their sustenance during the next phase.
- The cystic phase when the cyst wall is secreted, the nucleus divides into 4 or 5 daughter nuclei; protoplasmic granules are used up as food and substituted by large chromatoid masses.
- The stage of excystation.

When the amœbic cysts are passed in the fæces, their further existence is entirely governed by outside environment. They cannot live in a dry soil and under excessive heat. The ordinary water of tanks and wells forms a favourable site for their resting stage. Cysts with 2 or 3 nuclei do not survive but those with 4 or more nuclei do. The stage of excystation is entirely in man and Dobell has demonstrated that it takes place only at body temperature. What happens in this

phase of its existence is that when such cysts with 4 or more nuclei are swallowed by man through infected water or vegetables they begin to hatch, but not until all the glycogen and chromatoid substance within the cysts are used up by them. The protoplasm contracts within the cyst-wall and the young amœba tries to break and escape through the cyst wall by attacking it at various points by means of their pseudopodial protrusions. They finally escape and thus complete the life cycle. These liberated amœba may not only cause typical amœbic lesions in the large intestines but also can travel along the venules of the portal vein into the liver causing sterile abscesses, single or multiple, more often single than multiple. Clinically, it may manifest first as diarrhœa but soon ends in typical dysentery; or it may begin as an acute dysentery, become chronic, sometimes giving rise to chronic diarrhœa. Most surprising is the fact that it may damage the liver without ever producing intestinal symptoms. Stranger still, is, as Knowles points out, that it should produce in 9 persons out of 10 only symptomatic carrier state while in the 10th an acute amœbic dysentery or hepatitis. I would like to stress, in passing, that the stools of a dysenteric patient should be submitted to a rigorous laboratory examination for finding out the specific cause before beginning treatment and I stress on this, because, as you all know, that it is common to treat any kind of dysentery with emetine injections, without ascertaining whether it is due to amœbic infection or not. I would even go to the extent of calling it a malpractice. Emetine is of no use except in amœbic dysentery and to use it liberally in cases other than amœbic dysentery is likely to lead to a permanent damage of cardiac mechanism in a larger number of cases than really necessary. Knowles has noted many such cases with permanently disabled heart and while summing up his experience at the War Hospital, Bombay, said with a sorrowful sarcasm:

"It is better to learn by one's mistake than not to learn at all."

The usual types of Entamœba found in man are:

(1) Iodamœba Butshli, (2) Dientamœba Fragilis, (3) E. Coli, (4) E. Histolytica, (5) E. Gingivalis, (6) E. Nana.

There are some others which are described but not finally proved.

**Flagellate Protozoa.**—Most common of these are *chilomastix* and *giardia intestinalis*. These cause diarrhœa and the possibility of finding

them in the stools should always be borne in mind. The giardia is a very frequent cause of diarrhœa in children.

#### Parasitic worms

The economic loss and depreciation in manpower due to many chronic illnesses directly attributable to parasitic infection is indeed great; but it is almost unobserved. The detection of these parasites is easy in many cases even to the general practitioner and if there is any difficulty he may seek the aid of the specialist. *Tenia-saginata* and *solium* are easy to recognise by their segments. Their ova are not found without crushing the segments and so any diagnosis from the mere presence of ova in the stools is not reliable. A patient may harbour tape-worm and many examinations of the stools may not give any clue till the segments are passed. *Dibothryocephalus* is uncommon in our country: its ova are abundant and characteristic, so also the anæmia produced by it. In treating for tape worms, it is always a good plan to put the patient on milk alone for two days and then administer the anthelmintic and the purgative. Ask the patient to pass the motions in a vessel containing warm water and the treatment cannot be said to have been successful unless you see the head of the tape worm. Hymenolepis Nana—dwarf or rat tape worm—is a fairly common infection among children. The infection is conveyed by rat's urine. I have found the ova of this tape worm in two cases so far. It is perhaps common but not detected. The larvæ of *Strongyloides* are found in the fresh stools. They may be mistaken for the larvæ of the hook worm or for the pin-worms, if they are examined only with the naked eye. The adult *Trichuris trichuria* (whip worm) is seldom found in the stools but its ova are characteristic. Its pathogenicity is not well understood and it is hard to eradicate. *Oxyuris Vermicularis* (thread worm) is easily recognised. Auto-infection is common. *A. Lubricoides* is very common in stools and is characteristic. Diagnosis should rest more on finding the adult worm rather than the ova. *A. Duodenale*, *Necator*, *Braziliensis* are some of the species of hook-worm. The first is common in the Punjab, the second in Bengal and the third very uncommon in our country. The Ankylostome is very characteristic. Flukes are very much less in this country.

#### Bacteria

The conditions of warmth, moisture and food in the intestinal tract are ideal for the growth of micro-organisms and no wonder that

a great number of bacteria are found in the human fæces. Normally, most of them are saprophytic; but under abnormal conditions, they may invade the mucus membrane of the intestines and even find their way to general circulation and become pathogenic. As for example, B. Coli so long as they are in the intestines do not produce any untoward symptoms but when they escape either into the peritoneum or kidneys or the urinary bladder or into general circulation a definite train of local and general symptoms are observed which usually go under the name of B. Coli infection and which often baffles successful treatment. The intestinal micro-organisms are usually divided into four groups:

1. Bacteria Coliform
2. Streptococcus
3. Anærobic Bacilli
4. Acidophilic Bacilli

Most of these are gram positive organisms except the coliform group which are gram negative. Diet has got great influence on the number of bacteria in the intestines. At birth the intestinal tract is free from them, but soon they increase and at times, a third of the normal stools consists of bacteria. During the period of milk feeds the acidophils predominate. The Coliform bacteria are in abundance when a mixed diet is taken. High protein diet increases the anærobic and the coliform. Abundance of carbo-hydrates are favourable for the growth of acidophils. Diets rich in glucose increase the streptococci.

#### Pathogenic organisms in stools\*

The most important among them are the B. Typhosis, para A and para B which are most abundant during the third week of enteric fever. Bact. Dysentery (B. Flexneri and B. Shiga) are recovered from the mucopus in acute bacillary dysentery; but they are, as a rule, not found in chronic cases. The laboratory report must distinguish between the shiga and the Flexneri—the former being the cause of acute fulminating bacillary dysentery and the latter of mild and chronic forms. Para dysentery of Morgan I Type is sometimes associated with the severe diarrhœa of children. In cases of food poisoning one can isolate the Bacteria Enterides. Mycobacterium tuberculosis are often found in the fæces which may indicate a chronic bowel trouble due to Tabes Messenterica or it may be the result of swallowing the sputum of oneself suffering from

pulmonary tuberculosis. Cholera vibrios may be easily recognised in the stools under a proper and suitable laboratory technique. Staphylococci are always secondary and indicate local infection of the lower bowel. Other Bacteria, such as *B. Pyocyaneus*, *B. Proteus Vulgaris*, *B. Lactis aerogenes*, *B. Fæcalis alkaligenes* and other rarer forms are sometimes found in the stools. But these may be considered as harmless unless the contrary is proved. Perhaps, these may play some part in producing that condition which is often loosely called, *Intestinal Toxæmia*.

#### The Pathologist and the General Practitioner

Most of the pathologists' report on stools are unsatisfactory and vague because wrong portions of the stools are sent at wrong time and in wrong manner. It is disappointing to the pathologist who spends time and material in performing various tests but who cannot help submitting a vague report as under:—

260 "Dark-brown or yellow semi solid stools; acid in reaction; contains mucus, a few degenerated pus and epithelial cells; no protozoa or ova; no pathogenic organisms."

Such a report is equally disappointing to the clinician and may even mislead him. If the practitioner is to be helped by the pathologist's report he should send proper material at proper time for examination.

#### Collection of sample

Stools should be collected in a clean, preferably sterilized basin or pot, without admixture of urine. Bladder should always be emptied before the stools are passed. A chosen part of the material should be sent if it is to be examined for Protozoa, say, for E. Histolytica or for B. Flexneri or Shiga. The whole stool should be sent if it is to be examined for worms and their ova, as certain special methods are employed in the detection and counting of ova, as in Hook-worm. If it is to be examined for protozoa, it should be fresh and passed in warm basin and no antiseptics should have been used in cleaning the latter. If it is for the detection of worms, the basin may contain some warm water to enable the worms to live for sometime. If the material is very foul smelling, a little formalin or 5% phenol may be added to it to mask the smell; but the fact and the nature of antiseptic used should be reported to the pathologist along with the specimen. In very badly constipated cases, it is advisable to give some mild purgative overnight and preferably the second motion be sent for exa-

\*For fuller details vide I.M.J. Vol. XXIX. VIII 407. Ed. I.M.J.

### LABORATORY DIAGNOSIS OF PROTEINURIA

By DR. MD. K. ROHMAN L.M.P.

Assistant Pathologist and Demonstrator  
B.W. Medical School, Dibrugarh

Albumin is one of the essential constituents of blood and its commoner and better known forms are serum albumin and serum globulin. They are the natural proteins of blood and easily coagulate on boiling. It is the presence and passage in the urine of serum albumin or serum globulin or usually both that is commonly termed albuminuria. This is of utmost clinical importance. There are also other forms of protein which may appear in the urine. They are derived proteins and are of no clinical importance.

#### Derived Proteins

Following are the forms of derived proteins which either do not coagulate on being heated or redissolve before boiling point.

- (a) Albumoses and Proteoses. They are derived from hydration of proteins and normally occur as intermediate products of peptic and pancreatic activity. They are either primary or secondary. Primary forms are: proto-albumoses (not detectable in the urine) and hetero-albumoses (found along with S. albumin and S. globulin.) The secondary forms are: deuto-albumoses (found along with S. albumin and S. globulin) and peptone (rare).
- (b) Acid albumin. This may occur in hyperacid urine when mineral acid is administered.

(Continued from previous column)

mination. For bacterial investigations, a portion of the solid stools and pieces of mucus and pus should be sent in small sterilised phials. Each specimen should bear a clear label in which the patient's name, the date and time of passing the motion, the nature of examination required, a short clinical history and the full address of the Doctor should be written. If the specimen has to be sent to a distance by post, a little normal saline or 1% sodi bicarb should be added to the stools. A letter post is better than parcel post for obvious reasons and the postal instruction "Fragile, handle with care" should be boldly and invariably written on the parcel to avoid damage in transit.

(c) Alkaline albumin occurring in alkaline urine.

(d) Peptose. Its occurrence is doubtful.

(e) Nucleo-albumin. Mucin and fibrin are rare forms.

#### Albumin and the Kidneys

Normally we do not find any albumin in the urine. The epithelial cells of the glomerular tuft allow only water and certain soluble salts to pass, but prevent albumin from so doing. It is said that albumin normally escapes through the glomeruli into the tubes from where it is reabsorbed into the blood. The escape of albumin into the urine must be looked upon with suspicion, if not with anxiety.

#### Classification of Albuminuria

The escape of albumin in the urine may be temporary, cyclic or functional and organic or permanent. It may be either physiological or pathological. Strictly speaking, however, the term albuminuria means the occurrence in the urine of S. albumin and S. globulin in particular and perhaps also acid or alkaline albumins. When other than these are detected they are termed according to their constituents: *albuminuria*, *peptonuria*, *mucinuria*, *nucleo-albuminuria*, *fibrinuria* etc. So, care must be taken to distinguish these from true albuminuria. This differentiation is often of importance in Life Insurance cases.

#### Distinguishing points between temporary and permanent albuminuria

|                                  | Temporary                                              | Permanent                   |
|----------------------------------|--------------------------------------------------------|-----------------------------|
| 1. Specific gravity ...          | Normal                                                 | Abnormal                    |
| 2. Quantity of urine ...         | "                                                      | "                           |
| 3. Quantity of albumin ...       | Generally Small                                        | Higher, even up to 4 or 5%. |
| 4. Character ...                 | Intermittent*                                          | Persistent                  |
| 5. Symptoms of renal disease ... | Absent                                                 | Present                     |
| 6. Casts†                        | Not present, except hyaline casts (very rare)          | "                           |
| 7. Epithelial cells ...          | Epithelial cells of bladder and urethra may be present | Renal cells are present     |

\*Absence of albumin does not mean healthy kidneys.

†Casts are moulds of kidney tubules formed by the deposition of organic substances as fibrin, blood, epithelium etc.

#### Significance and Causation of albuminuria

**A. Temporary or functional albuminuria.**—Albumin may appear in the urine in *apparently normal* persons after prolonged exercise, cold baths and after meals (specially after breakfast). In orthostatic cases it may be most marked in the forenoon and diminishing or disappearing when the day wanes. Sometimes the condition is reversed: early morning urine may contain albumin but none when the patient is active in the day. Dietetic or digestive albuminuria is the result of excessive consumption of protein foods such as cheese, eggs (specially raw), beef etc. Febrile albuminuria is, as the term indicates, the result of febrile condition and disappears when the fever subsides. Sometimes albumin may be detected in a young person but it may disappear altogether during adolescence. Accidental albuminuria is the name given to that condition where the urine may be mixed up with albuminous secretions like pus, blood, semen, chyle, etc. What is called experimental albuminuria may be produced by the pressure upon the renal veins whereby the pressure on the glomeruli is increased; by closure of the renal artery; by ligation of the aorta below the kidney; by extirpation of the other kidney; and by causes which lead to asphyxia, as in compression of the trachea, malignant diseases of the throat etc. Causes that may lead to temporary albuminuria are:—

1. Dyspepsia, physical over-exertion, mental strain, functional hepatic disorders, excess of protein diet, anæmia, etc.

2. Renal congestion due to fever.

3. Drugs such as acid carboic and salicylic, arsenic, antimony, alcohol in large doses etc.

**B. Organic or permanent albuminuria.**—This is, as a rule, due to the morbid changes in the kidneys such as those occurring in acute and chronic inflammation, acute and passive congestion and amyloid degeneration of these organs; or to renal calculi or tumours. Other causes that give rise to permanent or relatively permanent albuminuria are trauma; obstruction below the kidney; circulatory disturbances; pulmonary, cardiac and hepatic diseases; toxins due to drugs or sepsis; certain blood diseases such as scurvy, leukemia etc.; nervous diseases such as epilepsy, tumours in the brain etc.; after ether and chloroform narcosis.

#### Necessary precautions

Attention to the following points is essential if the results of urine examination are to be usefully interpreted and understood.

- (1) The urine for examination should be clear and transparent. If necessary it should be filtered. If cloudiness still persists it may be due to bacteria and other ingredients. Clarification may be effected by using powdered manganese dioxide or carbonate, salicylic acid or saw-dust or infusorial earth and finally filtering through a double fold of filter paper. By simple filtration alone we can remove pus, mucus, spermatozoa, blood cells, etc.
- (2) If the urine is not acid in reaction make it so by adding a few drops of 2% acetic acid till the blue litmus paper turns red. Shake the test tube after the addition of each drop. Usually one to two drops are quite sufficient for this purpose. If more is added and if albumin is present, acetate of albumin or acid albumin is formed which does not coagulate on heating. It is only the addition, then, of nitric acid will coagulate it.
- (3) The possibility of pyuria being due to leucorrhœa or other vaginal discharge should be borne in mind. In case of doubt the catheter must be employed.
- (4) No case of albuminuria should be considered functional until the possibility of organic diseases has been excluded after repeated examination of urine.
- (5) The urine should be examined at different periods of the day.
- (6) Abnormal ingredients such as casts should be looked for in the sediment.
- (7) It will be of indubitable help if tests for renal efficiency are also done, especially the urea concentration test.
- (8) Should it appear that the albumin is due to organic diseases, the source and nature of albumin must be determined from the character of urinary sediments and from accompanying symptoms.

#### The Qualitative Tests

**Heat test.**—Fill a test tube, three quarters full with clear and faintly acid urine and heat the upper portion thereof over a bunsen flame. The reaction consists of a white cloud at the surface and this will spread downwards settling in a soft, white flocculent precipitate which may be due either to albumin or phosphates. To differentiate proceed as follows: acidulate with a few drops of 5% acetic acid. If the turbidity clears up it is phosphates; with efflorescence, carbonates. It is better to boil the urine after each drop of acid so as to avoid an excess of it. If there is an excess of acetic acid the precipitated albumin will redissolve. Usually an acid urine shows the presence of albumin at about 75° C; if, however, there are neutral salts in

relative excess it may coagulate more readily. I would like to stress on the advisability of taking sufficient amount of urine, at least 3/4ths of a test tube, as this procedure has got many advantages: (a) Traces of albumin may then be detected. (b) We can compare the heated upper layer with the cool lower layer. (c) If urates are also present, a cloud will appear in the upper layer due to albumin; a clear layer next to it due to urates which dissolve by heating; and the bottom layer, cold and turbid. Cloudiness due to copaliba precipitates by heating but dissolves on addition of alcohol. Cloudiness which appears on heating but clearing up before boiling point is reached is due to hetero-albumoses. If cloudiness lessens on heating but does not clear up it may be due to albumin or albumoses.

**Heller's Test.**—Place  $\frac{1}{4}$  inch nitric acid into a test tube by means of a pipette: permit some urine to trickle down the side of the tilted test tube so as to permit it to become stratified on the acid: restore the tube to verticle position. In the presence of albumin a clear-cut well-defined white *ring* forms at the junction of the two fluids. Always keep it for 3-15 minutes (average 3 minutes). On standing, the layer of albumin thus formed rises into the supernatant liquid in the form of irregular columns. The larger the amount of albumin the more quickly the latter is observed. Other *rings*, however, may appear. At surface of contact a crystalline *ring* of urea nitrate may be observed or one due to resins, the latter being soluble in either. Just above this, 5-10 mm. higher, is a fine delicate ring and is probably due to urates. The albumin and urate *rings* are separated from each other by a zone of clear urine. Below the surface of contact, a reddish *ring* is due to normal colouring matter (urochrome), a mahogany coloured *ring* indicates urobilin, while a play of colour is indicative of bile and a violet colour indicative of indican. Dilution of urine to a specific gravity of 1005 tends to eliminate these non-albuminous rings. Same results may be obtained when we use saturated trichlor-acetic acid in place of nitric acid.

Heller's or acid Nitric test is less delicate than the heat test. It is subject to many fallacies which have to be borne in mind. (1) Mucin forms a diffuse haze (not opaque) at the upper surface of the urine. On heating, this haze does not disappear. On the addition of acetic acid it is precipitated but on the addition of nitric acid it dissolves. (2) Hetero-albumoses give a white opacity, often detected at the upper surface, which disappears on boiling

but reappears on cooling. (3) Nucleo-albumin gives a faint indistinct reaction occurring after sometime. (4) Uric acid, urates and urea give a crystalline layer. The layer of uric acid is often ill-defined and dissolves on heating. (5) Nitrates of urea form a layer slowly and their crystalline flakes can easily be detected microscopically. (6) Resinous drugs like turpentine, sandal wood, copaiba etc., do give a diffuse haze but clears upon heating or on addition of rectified spirits or ether. The odour of urine and history of the case will further help in the diagnosis. (7) Fatty acids also give a haze but this dissolves on adding equal volume of water. (8) The normally present urinary indigogens give violet or ruby coloured *ring* above the layer. This is increased in fevers, constipation and intestinal obstruction. (9) If the patient had been taking iodides and bromides, nitric acid turns the urine to a dark colour due to iodine or bromine. The odour of urine may give the clue; or the urine be shaken up with chloroform, the latter is then separated by evaporation and the residue tested for iodine and bromine.

**Picric acid test.**—To one inch depth of filtered urine in a test tube add  $\frac{1}{2}$  grain of finely powdered picric acid or a saturated solution of it (7 grs. to an ounce of water) when there is an immediate yellowish white flocculent turbidity, even if there is only a faint trace of albumin. This does not disappear on heating. Before applying this test, however, the following should be rigorously observed:

- (1) The urine must be clear and filtered.
- (2) It should be neutral or slightly alkaline. If strongly alkaline, the picrate of albumin is formed which is soluble in alkaline medium.
- (3) No acid should have been used before adding the reagent.
- (4) Shaking after picric acid test may dissolve the turbidity if much albumin is present but addition of excess of reagent does not dissolve the precipitate.

As in Heller's, this test also has certain fallacies. Deutero-albumoses (peptone), excess of urates, creatinin and alkaloids such as quinine, antipyrin, etc. will also precipitate the reagent but this dissolves on heating. Albumin and albumoses may occur together. In such cases, the urine should be filtered while hot when albumin remains behind as a precipitate on the filter paper. If the filtrate becomes cloudy or gives a precipitate on cooling it indicates presence of albumoses.

**Mercuric-pot-iodide test.** This reagent is prepared by dissolving 1.35 grms of mercuric chloride and 3.32 grms of pot. iodide in 64 c.c. of water and then adding 20 c.c. of strong acetic acid. If to a filtered and acidulated specimen of urine are added a few drops of this reagent, a white flocculent precipitate or opacity occurs, if there is albumin. This is confirmed, if, on further heating, the precipitate or the opacity remains.

**Salicyl Sulphonic Test.** Take about 2 inches of urine in a test tube and add 2 drops of a saturated solution of Salicyl Sulphonic acid when a white turbidity or precipitate is formed if any protein is present. This white precipitate may be due to (a) albumin (b) albumoses or (c) peptone. Now boil the solution: if the precipitate dissolves it is albumose, if of permanganate colour it is albumin and if the precipitate markedly lessens but does not clear up it may be albumin or albumose. To find out whether it is albumin or albumose, filter urine while hot when the former will be precipitated on the filter paper and the latter will be precipitated only when the filtrate has cooled sufficiently. For the detection of peptone, see below.

**Bi-urate test for peptone.** Boil the urine and filter when albumin will be removed, if present. Add powdered ammonium sulphate and shake up till no more dissolves. There is no precipitate. If precipitated, it means the presence of albumose. Filter this off and then add 1 or 2 drops of 1% cupric sulphate solution and a sufficiency of liquor potash when a rose pink colour appears if peptone is present.

**Alternate methods of determining albumoses and peptones**

- (1) Primary albumoses are precipitated by a saturated solution of sodium chloride and sulphate; whereas secondary albumoses and peptones are not so precipitated.
- (2) If an equal quantity of methylated spirit is added to urine, hetero-albumoses are precipitated while proteo-albumoses are not.

**Serum globulin test.** As globulin is not soluble in water, addition of water gives an opacity if globulin is present whereas serum albumin, being water soluble, does not.

**Sir William Roberts's test.** Nearly fill a test tube with water and add filtered and clear urine drop by drop. Each drop leaves a milky streak if a marked amount

of serum globulin is present. If, on continuing these drops of urine, the water shows a milky opalescence throughout add a few drops of acetic acid when the opalescence disappears. This is due to the fact that globulin is soluble in acid but insoluble in water. Crystalline globulin may be detected microscopically as long rhomboidal crystals with angles cut; or they may be in the form of stars or rosettes.

**Nucleo-albumin test.** Nucleo-albumin, as mentioned earlier, is largely derived from epithelial cells of urinary tract and closely resembles mucin in physical properties. It is usually distinguished from the latter by the fact that phosphates are naturally present along with nucleo-albumin and absent with mucin. It is precipitated by acetic acid and is only moderately soluble in excess of acid.

**Trichlor-acetic acid test.** Same as Heller's test. But a saturated solution of the reagent has to be used in place of nitric acid.

#### Quantitative Test

In albuminuria, the quantity present is usually well under 1%; but it may even go up to 4-5%. The following are the indispensable preliminaries for the estimation of albumin by Esbach's albumino-meter.

- (1) Urine must be fresh and clear.
- (2) Specific gravity must be below 1010.
- (3) Urine should contain not less than 0.05% of albumin.
- (4) It should be acid in reaction.

#### Technique

- (1) Take urine up to mark "U".
- (2) Add one of the following reagents up to mark "R".

#### Esbach's reagent

Picric acid 2 drms  
Citric acid 4 "  
Boiling Water 25 ozs.  
(Dissolve and cool)

#### Tsuchiya's Reagent

Phosphotungstic acid 1.5 grms.  
Concentrated Hcl. 5 c.c.  
Alcohol 95 to 100 c.c.

- (3) Close the tube with a rubber stopper, invert it a few times without much shaking and allow it to stand for 24 hours. The separation of the precipitate can be effected in a few minutes by means of a centrifuge.

## CALCIUM AND ITS POPULAR ROLE IN THERAPEUTICS

By DR. K. GOGOI, L. M. P.,

Assistant Medical Officer, Jorhat Tea Co. Ltd.,  
Kharikatia, Assam

### Calcium in the body

Calcium seems to be absolutely essential for all living matter and it is one of the most important constituents of the human system. Its presence in adequate quantity and its proper absorption are necessary for growth and healthy metabolism and any deficiency in either produces certain characteristic defects and diseases which are very familiar to the profession.

It is almost universally distributed in the body, of course, in varying but necessary proportions. It enters into the composition of bone, muscle, the liver, the thyroid gland, kidneys, blood plasma and also most of the body fluids. It is, however principally bound to the skeletal system and the skeletal structure may therefore legitimately be regarded as a *Calcium bank* to which deposits

(Continued from previous page)

- (4) The scale is graduated from 1 to 5 grams. Read off level of the precipitate. The figures on the scale represent grammes of dried albumin per litre.
- (5) If the urine is diluted previously with water, multiply the readings by the number of volumes of water added.
- (6) If the reading is divided by 10 you get the percentage of albumin and if you multiply this result by 4.375 (or  $4\frac{1}{2}$  roughly) you get the result in grains per ounce. If the total daily loss of albumin is to be ascertained you have only to multiply the grains of albumin per ounce by total number of ounces of urine passed in 24 hours.\*

I am very much indebted to Lt. Col. J. L. Sen, M.C., I.M.S., Superintendent, B.W. Medical School for kindly going through this paper.

\*Tsuchiya's reagent. The quantitative test with this reagent is usually termed *Harrover's Test*. It has got a marked advantage over *Esbach's* as it can be completed in a few minutes unlike the latter which requires at least 24 hours. Besides, it is said to be more delicate also. Ed. I.M.J.

are being constantly added and from which withdrawals are frequently made. The amount of calcium in the skeletal system may roughly be put as 21 lbs. to a man of average weight, while only a third of an ounce is distributed to the rest of the tissues. Thus calcium may be said to be present in every tissue and organ of the body with the possible exception of red blood cells.

### In what form does it exist in the body?

This is an important consideration which has to be clearly grasped for a successful Calcium therapy. Broadly, we can say that it exists in two forms; insoluble and soluble. The insoluble form chiefly consists of calcium phosphates and carbonates and is bound to the bony system. The soluble form is usually in a colloidal state and enters into the composition of organic fluids, muscles and other vital tissues. It may be protein-bound, *i.e.*, it may be bound to its constituent proteins. When protein-bound, it cannot pass through colloidal membrane and is therefore not diffusible. The non protein-bound calcium is, however, readily diffusible. The determination of Serum Calcium by modern biochemical analysis is a useful guide in estimating calcium balance and absorption in the body. Normal serum contains on an average, 5.3 Mg. of calcium per 100 c.c. in diffusible form and 4.7 Mg. per 100 c.c. in non-diffusible (protein-bound) form. The total calcium ranges between 9.5 to 11 Mgs. and in health it varies within these limits only. It must be remembered that Serum Calcium is in several different chemical and physical states. More than half of it are diffusible inorganic salts while the rest of the fraction are protein-bound and therefore not diffusible. The diffusible calcium fraction in the serum may further be divided into ionised and non-ionised portions and it is quite probable that it is only the ionised fraction of the diffusible calcium that is responsible for calcium function in the body. Calcium chloride and calcium citrate in solution are readily diffusible, the difference between these two being that the former easily splits into calcium and chloride ions whereas the latter does not dissociate into ions which is the essential factor in its ability to prevent clotting of blood. The non-diffusible calcium (protein bound) exists in the form of complex chemical compounds. Calcium phosphate is the chief among them and is usually deposited in the cartilage. It looks as if the activity of calcium phosphate is confined to tissues where calcification is required.

### Calcium Metabolism.

It seems that a mere presence of adequate amounts of calcium in the blood or bone is no guarantee against disease. Its presence in assimilable form and the extent of assimilation are essential factors in determining what is popularly known as calcium deficiency diseases. Calcium metabolism thus becomes a complicated process and depends not only on the adequacy of calcium in the body but on its proper utilization. It depends on certain extraneous factors. (1) The presence or absence of bile determines the amount of calcium absorption. Insufficiency of bile in the intestines means that the fatty acids of calcium evolved during the process of calcium digestion have no solvent medium through which they can get absorbed into the body; and sufficiency of bile means just the reverse. And for the fatty acids of calcium to be evolved, the digestive functions should be equally normal, as it is only during the acid-phase of the digestion in the upper intestinal tract that most of the insoluble calcium salts are converted into its absorbable forms such as calcium chloride, calcium hydrogen phosphate and fatty acids of calcium. In fact, the rate of absorption depends on the integrity of intestinal functions and fluids. (2) Recent investigations have given rise to another equally important consideration, *viz.*, the ratio of calcium to phosphorus present in the intestinal tract and it is said that the degree of assimilation depends on the ratio of calcium to phosphorus and *vice versa*. An optimum ratio of calcium to phosphorus has to prevail if maximum absorption of the former is to materialise. Excess of calcium aggravates the ill-effects of phosphorus deficiency and the excess of phosphorus intensifies the ill-effects of calcium deficiency. (3) Presence of vitamin D in optimum quantity seems to be fundamentally necessary to maintain what the biochemists commonly call, *the net calcium balance*, and it maintains this balance either by increasing the amount absorbed or by decreasing the amount excreted. (4) Lastly the parathyroid secretion. If this secretory gland is in a state of dysfunction or if its secretion is subnormal, whatever calcium compound one may give to make up the deficiency and in whatever form it may be given, most of it is simply excreted through urine or faeces. In other words, parathyroid secretion in normal and sufficient quantity is essential for mobilising the calcium in the tissues. The difference between the parathyroid and Vitamin D in respect of their influence on calcium metabolism is that the former mobilises the

absorbed calcium and the latter increases the absorbability of calcium. This difference in action is worth-remembering in the therapeutics of calcium.

### Physiological needs for Calcium

Apart from the needs for the bony framework of the body, calcium is essential for the performance of physiological functions of many of the tissues. The normal coagulability of blood and capillary permeability, maintenance of the rhythmic contractions of the heart and the conservation of the functions of nerves are but a few of the normal aspects of calcium metabolism. There is a constant interchange between the plasma and the deposits in the bone and between intake and excretion in accordance to the needs of the body. A normal adult requires 0.4 to 0.5 gram of calcium in the diet; woman during pregnancy and lactation and children require more. Co-tension and probably some enzyme (phosphatase) keep up the balance of interchange between the bones and the tissues while excretion is regulated by healthy kidneys and bowels.

### Disorders of Calcium Metabolism

Abnormal calcium deposits occur in various tissues of our body, mostly secondary to long-standing lesions, through various ways. If the tissues, to which calcium mainly in the form of phosphates and carbonates in solution is brought *via* blood and lymph, are in a state of malnutrition, it cannot be utilized. Not only is it then incapable of being utilized but it may also be precipitated owing to the escape of carbon-di-oxide (the solvent medium of calcium) from a retarded or a stagnant lymph stream. Thus calcium may be deposited in the tissues. Some believe that calcification of arteries, as found among aged persons, is due to deficiency of sodium chloride in the blood and the tissues which permits deposition of calcium salts. Endocrine disturbances affect the normal metabolism of calcium. Calcinosis due to dysfunction of the anterior pituitary is a familiar example. Again calcareous deposits seem to occur as in caries, osteomalacia or lymphatic leukemia owing to the upset of the *net calcium balance* in the blood referred to above. When it occurs around a joint its movement is impaired: when it occurs in an organ its function is disturbed. Sometimes, as is well known, we try to focus deposition calcium in a particular tissue for therapeutic purposes, as in caseous masses of lung in tuberculosis where calcification is a beneficial measure. When blood calcium is diminished, tetany results which



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is an expression of exaggerated nerve excitability directly due to neurogenous calcium deficiency. When the capillary permeability is raised as a result of comparative or relative, temporary or permanent deficiency of calcium, we get the phenomena of urticaria, angioneurotic oedema and some conditions of atopy and allergy, and when there is concomitant heart or kidney disease oedema and anasarca also result.

#### **Therapeutics of Calcium**

From the foregoing observations, it would have been already obvious to the reader that calcium can command a wide range of therapeutic application. But if it is to produce the desired and expected results it must be given in assimilable form, such as Dicalcium and Tricalcium phosphates and often-times in combination with Vitamin D and parathyroid extract. Oral administration is the method of choice but when quick calcium replenishment is needed, intravenous or intramuscular injections are indicated. Calcium chloride or gluconate is the drug we give intravenously (10 to 20% solution) when it is our intention to check sudden and profuse hæmorrhage; it may be usefully conjoined with intramuscular Hæmostatic serum to avoid any probable disappointment. Intramuscular injection of inorganic salts of calcium is very painful, as the calcium combines with the proteins of tissues and forms a precipitate. For that purpose, colloidal calcium is the drug of choice and I prefer Colloidal Calcium with Ostelin (which contains vitamin D). I use this preparation in capillary vaso-motor disturbances, especially acute and chronic urticaria and angio-neurotic oedema. I can bear personal testimony to the efficacy of this preparation, as I have used it on myself, being a subject of a fairly severe type of urticaria of 14 years' duration. I had been much benefitted after 10 injections and I am hopeful of a permanent cure with the help of this drug. It can also be conveniently used in pulmonary, gastro-intestinal and peritoneal tuberculosis as an adjunct to the main treatment. It can also be employed in delayed union of fractures. On account of its influence in reducing the sensibility of sympathetic nerve endings, it can be tried in various allergic states. In severe migraine it is certainly worth giving. In gonococcal epididimitis and orchitis, calcium chloride in doses of 10 c.c. of 7.5 % solution, preferably in normal saline, may be given intravenously every two to five days. Its effect is best seen in acute cases. Calcium, by reducing the capillary permeability, brings down the

inflammation and promotes healing. That is the rationale of this therapy in such cases. Calcium thiosulphate has been found beneficial in arsenical dermatitis and it is given intravenously (5 c.c. of a 10% solution). The use of calcium chloride in cholera is too well known to require a detailed mention. It is one of the ingredients of the hypertonic saline given in severe cases of cholera. In gastric and duodenal ulcer, calcium lactas is now very much preferred to bismuth and soda as the former is a truer antacid than the latter. In Rickets the drug is almost specific, provided it is given in assimilable form and in conjunction with vitamin D.

Its uses in children's bowel complaints and for preventing curdling of milk are well known.

There are a host of other conditions where calcium is indicated. The above is only a cursory review of its therapeutics. There are also certain physiological states where calcium administration is indicated eg., pregnancy, lactation, growing child and menopause.

#### **Sources of Calcium**

The main sources of calcium in food are milk, cheese, butter, eggs, green vegetables, nuts, etc. Cod liver oil is a rich source of calcium and that is one of the reasons why it is so commonly prescribed; its irradiation increases the assimilability of its calcium contents.

The following is a list of common articles forming our dietary and showing their calcium contents in Mgs. per 100 grams of each substance.

| Names of substances         | Average Ca in mgs. |
|-----------------------------|--------------------|
| Rice (milled) .. .. .       | 20.1               |
| „ (husked) .. .. .          | 66                 |
| Atta (whole wheat) .. .. .  | 24                 |
| Maida Flour .. .. .         | 18                 |
| Chana dal .. .. .           | 70                 |
| Masoor dal .. .. .          | 22.1               |
| Moong dal .. .. .           | 50                 |
| Harar dal .. .. .           | 32.5               |
| Brinjal ... .. .            | 6.8                |
| Potato ... .. .             | 7.3                |
| Milk (in 100 c. c.)... .. . | 142.5              |

(Analysis by Dr. R. N. Saha, Patna Medical College.)

## Clinical Memoranda

### BLACK-WATER FEVER IN MADRAS

By Dr. Y. SURYANARAYANA RAO, L.M.P.  
(MAD.), L.T.M. (CAL.)

Assistant to First Physician, Government  
Royapuram Hospital, Madras

The notes on the following two cases of Black-Water Fever admitted and treated in the Government Royapuram Hospital seem worthy of record. It is not often that we meet with cases of Black-Water Fever in this city.

**Case No. 1.** An Anglo-Indian aged about 18, of good physique, was admitted into the above hospital on 24.2.35.

**History.**—He was working in the hilly malarious tracts of West Coast and was subject to frequent attacks of Malarial fever. Two days previous to his admission, he came to Madras for the treatment of chronic Malaria. The night before admission, he took a dose of Quinine, as usual: but an hour later he observed that he was passing black coloured urine. He sought admission into the hospital the next day.

**Condition on Admission.**—Appeared to be in a state of severe toxæmia. Pulse frequent and small in volume. Liver enlarged to 2 fingers below the right costal margin, the spleen to 4 fingers below the left costal. Conjunctivæ and skin yellow; urine black—like Indian ink, contained plenty of hæmoglobin; no bile or bile pigments. Had severe vomiting—could not retain even water—temperature 103° F.—blood examination did not reveal any malarial parasites.

**Treatment.**—Ext. *Cassia Beareana Liquidum*, 2 drms. in 2 ozs. of water every 2 hrs. Continuous rectal saline with glucose was ordered. Mustard plaster to the pit of the stomach. Undiluted Adrenalin hydrochloride (1—1000) in 15 minim doses every 15 minutes to be dropped on the tongue to relieve vomiting. No food given by mouth except fruit and lime juice. He was not given any Quinine. The condition of the patient became worse next day—vomiting continued, temperature 103° F., urine still black and pulse very feeble. Strophanthin, Pituitirin and Adrenaline given alternately every two hours by rotation. In spite of all efforts the patient died in the evening of the next day.

**Case No. 2.** A Hindu male, aged 22 and native of Mercara, Coorg.

**History.**—He contracted Malaria while he was in his native place. He had been in this city for 5 years during which period also he used to get malarial fever, off and on. For the last 2 years he had been to his native place, Mercara, where he did not get any attack of Malaria. He returned to Madras on the first of June 1935. He got an attack of fever on 20th June 1935, i.e., after his return from Mercara where he had been completely free from fever for 2 years. In the previous attacks, the patient used to take Quinine, which, while checking the fever, gave rise to Jaundice. This time he did not like to take Quinine for fear of getting Jaundice and on medical advice he took Atebrin and Quino-Plasmoquine on alternate days for 10 days. On the tenth day he developed Hæmoglobinuria.

**Condition on admission.**—Admitted on 3.7.35: had a rigor on the previous day. Passing dark coloured urine—inky black, conjunctivæ, skin and mucus membrane of tongue and palate tinted yellow. Pain in the left hypochondrium. Severe vomiting of mucus and bile-coloured fluid—bowels slightly constipated—the colour of the stools was normal—temperature 103.6° F—Pulse 100. Respiration 26—liver enlarged to one finger below the right and spleen to 4 fingers below the left costal margin. The latter was tender and painful. Urine: Sp. gr. 1.016, alkaline, hæmoglobin plenty, no bile or bile salts, colour black; Blood, no M.P., slight leucopenia and signs of secondary anæmia.

**Treatment and Progress.**—3.7.35. Mistura Saline, 3 ozs as an opening dose. Ext. *Cassia Beareana Liq.* 2 drms in 2 ozs of water every two hours. The evening temperature rose up to 104° F.

4.7.35. Temperature 102° F. (Morning), 100° F. (Evening). Colour of the urine still dark—Ext. *Cassia Beareana* continued.

5.7.35. Developed severe vomiting, to allay which iced orange juice and glucose was given. All other food stopped. Rectal injection of 6 ozs. of 25% Mag sulph every 4 hours. Adrenalin and Mustard plaster as in case 1. Plenty of Imperial drink—in the evening the colour of urine changed from black to reddish tint. Temperature remained at 99° 5 F morning and evening.

6.7.35. Temperature normal in the morning and 99.5 in the evening. Ext. *Cassia* was stopped—vomiting much better, yet nothing was given by mouth, save glucose and orange juice. Since this day his evening temperature was 99 or 99.5° F, though normal in the mornings. Put on alkalies by mouth.

8.7.35. Colour of the urine distinctly improved to pale red—Atebrin Musonat 0.3 grm was given intramuscularly.

15.7.35 2 grains of Quinine-bi-hydrochloride orally, thrice a day.

17.7.35. Atebrin intramuscularly and repeated on 19.7.35, as the evening temperature persisted.

20.7.35. Oral dose of Quinine was increased to 5 grs. thrice daily.

22.7.35. Intravenous Quinine (3 grains. in 10 c.c. of distilled water.) Repeated on 29.7.35 but with 5 grains of Quinine. The patient was discharged cured three days later, urine and temperature being perfectly normal.

**Comments.**—As long ago as 1916, I treated some cases of B.W.F. in the Ganjam Agency Tracts where this disease is frequent. At that time, I used the same drug as for the above two cases, namely, Ext. *Cassia Beareana Liq.* with success in a good number of cases. The notes on some of these cases were published in *The Indian Medical Gazette*, November, 1918. It is significant that it is almost rare in the native population of the heavily infected malarial tracts, even though a majority of them are subject to periodical attacks of malaria and have enlarged spleens. Another fact also is significant, that Black-Water Fever occurs

mostly in such cases of Malaria which have been inadequately and improperly treated. It is well known that most of the people take Quinine when they get fever and discontinue it when it subsides. It is in such people, I believe, that Quinine precipitates Black-Water Fever. **Case 2.** is very peculiar in that he developed the disease even after a course of Atebrin and Quino-Plasmoquine which the patient took in preference to Quinine owing to his bad experience with the latter. In this connection it is interesting to note that Lieut. Col. R. N. Chopra, Drs. B. N. Sen and S. N. Bhattacharya have reported in the *Indian Medical Gazette*, August, 1935, a case of Quinine Hæmoglobinuria where the patient developed Hæmoglobinuria after Quinine and not after Atebrin and Plasmochin. They give expression to the belief that "It is possible that the substitution of Atebrin for Quinine in the treatment of Malaria will bring about a reduction in the occurrence of such cases." Another significant feature of this disease is that it sometimes develops long after the individual returns to healthy localities after having lived in malarious tracts for some-time. Manson notes the dramatic occurrence of B.W.F. in apparently healthy individuals who had arrived in England after the expiry of their duty or on leave. The theory put forward by some that administration of Quinine precipitates B.W.F. is not always true. The specific theory that it is caused by some Leptospira is now thrown out by contemporary malariologists. This disease seems to be a complication of Malignant Tertian infection, insufficiently and inadequately treated.

As regards treatment, I have found that Ext. *Cassia Beareana Liq.* is undoubtedly useful if it is given till the urine gets clear. In early cases it is effective but in the late cases with pronounced toxæmia, as in case 1, it will be of little use. The rest of the treatment is entirely symptomatic. It may be interesting to note that case 2 though he gave a history of developing jaundice every time he took Quinine, yet during the attack of B.W.F. he was able to take Quinine in gradually increasing doses up to a maximum of 15 grs. a day.

I am very much indebted to Rao Bahadur Capt., P. Krishnaswamy, M.B., C.M., M.R. C.P., Superintendent, Government Rayapuram Hospital, Madras, for going through these notes and permission to publish them.

### TRANSITORY LOCALISED URTICARIA CAUSED BY A SPECIES OF CATERPILLAR

By Dr. DAMODAR WATHOO, L.S.M.F. (PUNJAB)

Medical Officer, *Khapalu, Kashmir*

The species of caterpillar called locally *Facha Haboo* belongs to genus *chenille*. *Facha* means a bag made of the hairs of Pashmina and *Haboo* means an insect. Its body being profusely hairy—which come out in tufts—it is named *Facha Haboo* or ciliated caterpillar.

It has eight pairs of legs by which it firmly clings to any object coming in contact with the anterior three pairs which have sharp-pointed ends and the remaining five pairs which have broad saw-like ends. It widely differs from the caterpillar of the cabbages and is mainly found on the apricots, the poplars and the willows and feeds on their leaves.

**Habitat.**—Baltistan—Kashmir.

**Life cycle.**—The life cycle of this insect is very interesting. It becomes active in the later part of April and comes down from the trees by the aid of the thread that it spins or may be thrown down when the wind blows. When it attains to its full size it transforms into a butterfly. This takes place from 2nd week of June to August. The butterfly lays its eggs on the trees from August onwards. The eggs grow into larvæ and then into small insects which weave a web and enclose themselves into it.

In the April they come out again from the webs and the life cycle is thus renewed.

When this species of the so-called ciliated caterpillar comes in contact with the skin it gives rise to insatiable itching, burning sensation, redness and wheals similar to urticaria. The redness is well marked in fair-skinned people. The symptoms are of course localised to the area the insect has walked over.

If the insect is handled and the soiled fingers used to scratch the sound skin, the afore-said symptoms start at once. Hence it is imperative to wash the hands when the insect is handled.

It appears that the cause of these symptoms is probably a secretion secreted by the glands situated at the bases of the hairs of this insect.

All the above symptoms are transitory and totally abate in 24 hours.

The writer also suffered many a time from the irritative symptoms caused by this caterpillar.

**Prophylaxis.**—Remove the web from the trees in early spring and burn them. This is the cheap and effective way of destroying this insect.

### AN INTERESTING CASE OF RETAINED PLACENTA

By DR. HARIDAS DEY, L.M.F.

(Late Senior House Physician, Campbell Hospital,  
Calcutta,) Raiganj, P.O., Dinajpur

#### Short history of the case

A Hindu Bengali lady, aged 40, 7th para. No previous history of abortion. Her 5th pregnancy was an obstructed labour at full term. The present history was that she had an abortion a month back. No serious complication followed except slight uterine hæmorrhage from time to time. Suddenly one day, the patient, after some physical labour, began to bleed profusely with symptoms of collapse.

I was called in at that time and my examination revealed as follows:

1. Patient was semiconscious with all the symptoms of collapse.
2. Uterus was palpated just above the symphysis Pubis.

I at once asked my assistant to make ready normal saline and in the meantime I injected 2 c.c. of Hæmostatic Serum subcutaneously and 1 c.c. of pituitirin (P. D. & Co.) intramuscularly. Her head was lowered and hot water bottles applied to the feet. These produced satisfactory results—the pulse was a bit improved and the bleeding became less severe. A little brandy with glucose and sodi-bicarb in a mixture was given. In the evening, when she was somewhat recovered from the effects of collapse I made a vaginal examination. The bladder was found distended which was, of course, immediately relieved. The vagina was full of blood clots. I did not like to disturb them for fear of greater hæmorrhage till my diagnosis of the cause of bleeding was finally made. I plugged the vagina tightly by means of gauze and put a bandage. Next morning I removed the gauze plug and also the blood clots to facilitate my examination of the uterus. The uterus was found filled with big clots which were removed. I then felt something adherent to the endometrium near the placental area and I removed the same after considerable difficulty. The removed placenta was *en masse* and appeared to be of the Infarct Type. After confirming that there were no pieces of placenta in the uterus by further examination, I gave a hot lysol intra-uterine douche and finally 1 c.c. Pituitirin intramuscularly and the usual ergot mixture with a little brandy and glucose. Further progress of the case was uneventful.

#### Points of interest

1. Though the placenta was retained in the uterus for a pretty long time, the patient, though a mother of 6 children, did not suspect anything wrong.
2. There was no sepsis in spite of this abnormal retention of placenta for a long time.
3. No sepsis intervened even after much internal manipulation.
4. No anæsthesia was found necessary either to plug the vagina or to extract the placenta manually.

### LANDRY'S PARALYSIS

By DR. M. M. PALADHI, L.M.F.

Lohaga Hospital, Almora

There is no doubt that this is an exceedingly rare form of acute ascending paralysis without sensory loss or sphincter disturbance. My justification for writing these brief notes is that I had treated eight such cases during the last 10 years of my practice and that I desire to record my observations thereon.

Following are the symptoms which I observed in eight of my cases.

The feeling of weakness begins in the legs and usually one leg is affected a few hours before the other. But in a short time there is a complete flaccid paralysis of both the legs which spreads upwards to the muscles of the thorax, arms, neck and face. In one of my cases, however, I noticed the paralysis spreading from the trunk to the legs. This case proved fatal. Though the muscles are flaccid, they show no electrical changes nor any signs of wasting. The tendon reflexes are lost but the power of the Sphincters is generally retained. When the paralysis spreads to the cervical region there is an imminent danger of death from paralysis of the diaphragm. Two of my fatal cases died out of such a paralysis. Failure of the muscles of deglutition makes the food liable to get into the larynx and cause trouble. In none of my cases sensation was lost and I had observed that mind remains clear to the last moment.

Following is the line of treatment which I adopted in these cases under reference:

- (1) I watch the respiration and give artificial respiration when there are slightest signs of respiratory difficulty.
- (2) I maintain the strength of the patient by injections of strychnine.

- (3) I administer Extractum Ergot Liq. orally and I had found it very useful.
- (4) An alkaline mixture is given as a routine.

Out of the eight cases I had treated, 4 died, (one of them on the second day of the disease) and the rest survived. The cases which survived regained rapidly the power of the muscles.

**Discussion.**—In none of my eight cases did I observe sensory changes or muscular atrophy, or electrical changes or any trophic manifestation. Neither was the sphincter control lost. These negative factors seem to distinguish it clearly from other spinal lesions, such as ascending myelitis, acute poliomyelitis and multiple peripheral neuritis. Another noteworthy feature is that if Landry's Paralysis is

fatal it is quickly so between 2 days to 2 weeks and if there is recovery, the patient recovers the power of the muscles completely unlike in other types of paralysis. I tried to ascertain the probable cause of this disease but in vain. In view of the rapid development of paralysis, it is reasonable to assume, at least as a working hypothesis, that it is brought about either by rapidly acting toxins from an undiscovered and cryptic focus of infection in the body or to some specific virus affecting the entire lower motor neurons. No gross lesion in the spinal cord is seen. Spittler has detected destructive changes in the peripheral nerves and corresponding alterations in the cells of the anterior horn. All my cases were adult males between the ages of 20 and 30 and it looks as if it affects more the males than the females.

## Practical Suggestions and Reminders

(Continued from the previous issue)

24. Col. Chopra recommends the following mixture in Bronchial Asthma.

|                   |     |               |
|-------------------|-----|---------------|
| Pot. Iodide       | ... | Gr. 5         |
| Tr. of Belladonna | ... | Ms. 5         |
| Borax             | ... | Gr. 3         |
| Ext. of Kuth      | ... | Ms. 30 to 120 |
| Spts. chloroform  | ... | Ms. 10        |
| Aqua ad.          | ... | Oz. 1         |

One ounce 3 or 4 times a day.

25. According to him following are the pharmaceutical actions of Ext. of Kuth:—

- (1) Depresses the Vagus.
- (2) Relieves the involuntary muscle fibres of the bronchioles.
- (3) Relieves the congestion of the bronchial mucosa by its expectorant and liquefying action on the sputum.
- (4) Reflexly inhibits the respiratory centre.
- (5) Depressing action on the central nervous system, particularly on the allergic area.

26. His classification of the types of Asthma is very useful.

- (1) *Cardiac and Renal Asthma*.—they are practically the terminal manifestations of these diseases.
- (2) *Bronchial Asthma*.—(a) *Allergic*.—due either to external allergins or internal allergins of the gut.

(b) *Bronchitic*.—where there are evidences of Bronchiectasis, Pulmonary Tuberculosis, previous attacks of Pneumonia or Whooping Cough.

(c) *Bronchial*.—due to the presence of a gram negative bacilli in the sputum, the morphology of which is still undetermined.

27. The above types may roughly be inferred as follows:—

- (a) If the Arneth's Index\* is high and the blood and sputum eosinophilia is low, it is probably bronchial in origin.
- (b) If the Arneth's Index is high, as also the eosinophilia it is probably due to the gram negative bacilli referred to above.
- (c) If the Arneth's Index is normal but if there is a high eosinophilia it is probably allergic.

28. *Infantile Asthma*.—Following is my plan of treatment:—

- (a) Grey powder overnight and saline next morning.
- (b) Strict dietary given at fixed intervals. Avoid overfeeding, milk and butter-milk.
- (c) Glucose D about 2 ozs. a day.
- (d) Maintain regular evacuation of the bowels by liquid paraffin preparations.

\*Vide I.M.J. Vol. XXIX. VI. P. 310.

This has given good results in my hands. I give no drugs. No detailed dietary is mentioned for the obvious reason that it requires no more than an adjustment of the usual diet to which the particular family is accustomed. Principles underlying such dietary are (1) easy assimilation (2) avoidance of roughage and overfeeding, (3) elimination of foods that cause intestinal stasis and putrefaction.

29. *Soamin*.—I know of a doctor who has made a name as an Asthma Specialist—of course among the laity—by giving Soamin injections (a total dosage of 10 grs. of Soamin for the full course). Though he claims to have cured many cases, I find in my practice that only a few cases are cured with this drug. It is interesting to note that Soamin by mouth is not so efficacious as when given intramuscularly. I use Soamin Tablets of B.W. & Co.

30. Acute lymphangitis, orchitis, epididymitis due to filariasis are almost invariably associated with staphylo and streptococcal infections. I have therefore used the staphylo and streptococcal serum with considerable success. If the case is very severe, as shown by toxæmic symptoms, I use the combined serum (15 c.c. each intravenously; if moderately severe, subcutaneously). In subacute infection, I use vaccines. The results are quick and satisfactory. If this septic inflammation is left untreated at its onset, it recurs frequently and ends in the fibrosis of the area concerned. This materially augments the fibrosis induced by the blocking of the glands by the adult worm. There is, at present, no recognised specific treatment for filariasis and if, therefore, its chief and ugly complication such as elephantiasis is to be avoided, the secondary infection has to be treated vigorously by vaccines if chronic and by serum if acute. When the elephantiasis is established, injection of the heart-muscle extract is recommended to reduce the fibrosis. Late Col. Acton seemed to have had some good results with this preparation in the treatment of filarial fibrosis. Further trials are necessary to hazard a definite statement regarding its fibrolysing properties.

31. Treatment of epilepsy: Bromide is still the sheet anchor, though it is by no means a specific. Sodium bromide is better than potassium bromide. Bromides act better and only a smaller dose is required, if the patient is given a salt-free diet. Besides, such a procedure lessens bromism. Medinal is effective but should not be continued for a long time. Luminal also is used.

A. V.

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DECEMBER 1935

## ABOLITION OR REFORM

We had often written in these columns and the All-India Medical Licentiates' Association had still more frequently made representations to the Central and Provincial Governments urging them either to reform the existing Medical Schools in conformity with the modern standards of medical education or to abolish them altogether if the former is not possible or feasible due to chronic perversity of understanding or to financial exigencies of the Government. Matters have come to such a pass in recent times that the authorities cannot and should not shirk this responsibility any longer. They owe it to themselves, to the students in the 26 Medical Schools of India and to the public that they should decide either to abolish these schools or reform them to the extent necessary. And this responsibility is peculiarly their own because all the 26 medical schools of India, with the exception of two in Bengal, one in Madras and another in Bombay are owned and conducted by the Provincial Governments and any stigma of inferiority on the alumni of these schools is by implication a reflection on their ability to run these institutions in a manner suited to the needs of medical progress. The tragic irony of the situation is that the Provincial Governments themselves give open expression to the opinion that the diplomas granted by the medical schools and by the Examining Boards of their own choice and creation are inferior! That is what the majority of the Provincial Governments said when the Central Government consulted them on the advisability of including the diploma of L.M.P. in the schedule of recognised Indian medical qualifications. If their opinions had been actuated by no other motive than the expression of truth in which they believed it is up to them to act up to their opinion to its logical conclusion—to abolish or to reform the Medical Schools under

their charge. The one or the other has to be done and done as expeditiously as possible if the future Medical Licentiates are to be spared the shame and disabilities of their predecessors.

## The role of the Provincial Medical Councils

It is within the scope of the Provincial Medical Councils to dictate to the Government either to close down the Medical Schools or to reform them in such a way as to deserve their recognition. It is a mystery, however, that they had not taken action so far, especially in the face of the opinion of the Provincial Governments that the diplomas of the Licentiates are not fit for recognition by the All-India Medical Council. If rejected by the All-India Medical Council they cannot be upheld by its satellites, the Provincial Medical Councils. It is rather a strange phenomenon, almost freakish in nature and ominous in significance, that these Provincial councils too should have fallen in line with the expressed opinion of the Provincial Governments that the Medical Licentiates are unfit to be included within the scope of the Indian Medical Council. That was the *considered opinion* which the majority of the Provincial Medical Councils gave when they were consulted by the Central Government as to the Status of the Indian Medical Licentiates with reference to their inclusion in the All-India Medical Council. We ask, with due deference, why, if that had been their opinion about the qualifying examinations of the Medical Licentiates, should they themselves cognise them for registration in the Provincial Register? Such a bare-faced inconsistency ill befits the dignity and prestige of a council enacted by Local Legislature which enjoined on it certain duties. We affirm with a full sense of responsibility that Provincial Medical Councils have hopelessly failed to perform one of the most important of their duties, viz, to recognise only such qualifications as are deemed fit for registration and to take such steps, when

the deficiency is brought to their knowledge or is existing to their knowledge, as to demand the setting right of such a deficiency; or to have retorted that the alleged deficiency was not true in fact. If these Provincial Medical Councils exist to safe-guard the public for which express purpose they have been established by Legislative Statutes and not to degenerate into a mutual admiration society or to walk rough-shod upon one of the *classes* of medical men who form the legal part of their register, they owe it to themselves and to the public that they should have immediately advised the Provincial Governments that their allegation was wrong and, if right, to have urged the need of improving the curriculum of studies in medical schools and set a reasonable time limit for the Government to do so; failing which they should stoutly refuse to recognise the qualification which both they and the Government have tacitly and openly admitted as inferior. It is a thousand pities that neither the Provincial Medical Councils nor the Provincial Governments take the necessary initiative for reasons best known to themselves. If the Vizag Medical College is not recognised by the All-India Medical Council, there is the kind and generous Sir Frank Connor to run to the Government asking for about 17 lakhs for improving the efficiency and equipment of that College. Medical Schools of India seem to have no such allies or generous-hearted friends who would move the Government for such a grant either out of sense of duty or justice or mercy. The non-recognition of 26 Medical Schools had created no flutter nor drawn a tear from the heads of the medical administration while the three colleges which were perversely refused recognition by the All-India Medical Council seem to have engaged the sympathetic attention of the respective Provincial Governments. We do not at all mean or insinuate that these colleges should not be improved but write only to point out the glaring partiality of treatment.

#### The Annual Average output

We give below the number and names of Medical Colleges and Schools in India, their annual average total strength on rolls and the average annual numbers that finally qualify out of these institutions, with a view to impress on the Government and our readers certain legitimate and inevitable conclusions *per se*.

Table I. Medical Colleges (11)

| Serial Number | Names of Colleges                                            | Average Number of pupils on rolls in all classes (per year) | Average Number finally qualified (per year) |
|---------------|--------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------|
| 1             | King Edward Medical College, Lahore ...                      | 450                                                         | 80                                          |
| 2             | Lady Hardinge Medical College for women, Delhi ...           | 140                                                         | 22                                          |
| 3             | King George's Medical College, Lucknow ...                   | 240                                                         | 40                                          |
| 4             | Prince of Wales Medical College, Patna ...                   | 260                                                         | 40                                          |
| 5             | Medical College, Calcutta (including M.M.F.) ...             | 740                                                         | 90                                          |
| 6             | Carmichael Medical College, Belgachia (including M.M.F.) ... | 640                                                         | 65                                          |
| 7             | Grant Medical College, Bombay ...                            | 600                                                         | 70                                          |
| 8             | Seth Gordhandas Sunderdas Medical College, Bombay ...        | 360                                                         | 25                                          |
| 9             | Madras Medical College ...                                   | 580                                                         | 50                                          |
| 10            | Medical College, Vizag ...                                   | 200                                                         | 30                                          |
| 11            | Medical College, Rangoon ...                                 | Not known                                                   | Not known                                   |
| Total         |                                                              | 4210                                                        | 492                                         |

N. B.—This table refers only to M.B.B.S. examination of the above Colleges. The average is only approximate and is the mean of the actual figures for the years 1932, 1933 and 1934.

Table II. Medical Schools (26)

| Serial Number | Names of Schools                              | Average Number of pupils on rolls in all classes (per year) | Average Number finally qualified (per year) |
|---------------|-----------------------------------------------|-------------------------------------------------------------|---------------------------------------------|
| 1             | Medical School, Amritsar ...                  | 400                                                         | 60                                          |
| 2             | Punjab Medical School for Women, Ludhiana ... | 120                                                         | 22                                          |
| 3             | Medical School, Agra ...                      | 300                                                         | 61                                          |
| 4             | Women's Medical School, Agra ...              | 100                                                         | 15                                          |
| 5             | Medical School, Darbhanga ..                  | 210                                                         | 25                                          |
|               | Orissa Medical School, Cuttack ...            | 180                                                         | 25                                          |
| 7             | Campbell School, Calcutta ...                 | 555                                                         | 100                                         |
| 8             | Lytton School, Mymensingh.                    | 230                                                         | 35                                          |
| 9             | Ronaldshy School, Burdwan.                    | 180                                                         | 20                                          |
| 10            | Chittagong School ...                         | 170                                                         | 10                                          |
| 11            | Jackson School, Jalpaiguri ...                | 175                                                         | 5                                           |
| 12            | Bankura Sammilani School.                     | 220                                                         | 25                                          |
| 13            | National Medical Institute, Calcutta ...      | 400                                                         | 50                                          |

| Serial Number | Names of Colleges                                  | Average Number of pupils on rolls in all classes (per year) | Average Number finally qualified (per year) |
|---------------|----------------------------------------------------|-------------------------------------------------------------|---------------------------------------------|
| 14            | Dacca Medical School ...                           | 440                                                         | 65                                          |
| 15            | Calcutta Medical School ...                        | 440                                                         | 50                                          |
| 16            | Robertson Medical School ...                       | 260                                                         | 40                                          |
| 17            | King Edward Medical School, Indore*                | 300                                                         | 50                                          |
| 18            | B. J. Medical School, Poona...                     | 310                                                         | 45                                          |
| 19            | " " " Ahmedabad                                    | 180                                                         | 18                                          |
| 20            | Medical School, Hyderabad (Sind) ...               | 115                                                         | 10                                          |
| 21            | National Medical College, Bombay ...               | 280                                                         | 25                                          |
| 22            | Stanely Medical School, Madras ...                 | 300                                                         | 120                                         |
| 23            | Lady Willingdon Medical School for women, Madras . | 95                                                          | 20                                          |
| 24            | Missionary Medical School for women, Vellore       | 100                                                         | 20                                          |
| 25            | Berry-white Medical School, Dibrugarh ...          | 245                                                         | 25                                          |
| 26            | Burma Government Medical School, Rangoon ...       | 170                                                         | 25                                          |
| Total         |                                                    | 6465                                                        | 965                                         |

N. B.—The above table refers only to the qualifying examination for diplomas variously styled in different Provinces, *E.g.*, L.C.P.S., L.M.P., L.M.F., M.P.L., etc., though in effect and status all these mean one and the same kind. The average is only approximate and is the mean of the actual figures for the years 1932, 1933, and 1934.

#### The Lessons of Figures

The following conclusions, direct and indirect, can be arrived at if the above tables are scrutinised from different point of view:—

- (1) The number of students trained in and of the finally qualified from the medical schools is roughly twice that of the medical colleges. For every single medical graduate, two medical licentiates are produced each year.
- (2) While there are only two medical colleges in Bengal and Assam, there are 9 medical schools in this area which mean that the need for medical men in these two Provinces are greater than in other provinces and that the largest amount of medical relief is sought to be given by employing the medical Licentiates; or it may mean, which we are informed as true, that there has been a

\*This school coaches the students for L.C.P.S. (Bom.), L.M.P. (Nagpur), & L.M.F. (Calcutta) examinations.

thoughtless increase in the number of medical schools at the cost of efficiency, (The Bengal and Assam Branches of the A.I.M.L.A. have been time and again protesting against this increase at the expense of efficiency).

- (3) Out of the total of 1457 annually qualifying medical men, nearly 1000 of them are medical licentiates. In other words, it is on the licentiates that the main burden of medical relief in this country falls, either through State Service or Private practice.

- (4) That for a population of 400 millions (latest census) this annual output of 1457 doctors is obviously and strikingly incommensurate to its medical needs, not to reckon its probable future growth. This means that the Government, if it cares for the health of the people cannot, without dire results, reduce this number still further—rather it should try to fortify the health of the people under its charge by a greater number of medical institutions.

#### Are The Medical Licentiates Really Inferior?

We have till now granted for purpose of argument the statement of the Provincial and Central Governments that the diplomas of the medical Licentiates are inferior to the medical degrees of the Indian Universities, merely to controvert that if they are deficient or defective there is no understandable reason why they should annually fecundate foredoomed imbeciles. It is impossible for them to escape this charge of inconsistency.

Sir John Anderson, the Governor of Bengal, while opening the Jalpaiguri Hospital extensions on 7-11-35 said:

"I understand that so far as examinations are concerned the results of the Medical School have hitherto been on the whole satisfactory, but the arts of Medicine and Surgery demand more than formal qualifications . . . ."

It looks as if the Government is capable of performing the impossible—blowing hot and cold at the same breath. On one side, they say that the medical licentiates have done yeoman medical service in times of peace and war and epidemics; they employ a large, correspondingly larger number of them than the medical graduates, to man their dispensaries and hospitals and on the other side they say that they cannot be treated as equals to the Graduates when the fidgeting Licentiates claim a

status which is due to them by law, education and achievements. In no part of the civilised world is one section of medical men with legally registrable qualification treated differently from the rest of that fraternity. Will this be tolerated for a day in Great Britain?

The truth is all too obvious. The diplomas of the Medical Licentiates are not inferior. The label of inferiority is merely placarded behind their backs in order that the Government may be free from certain political and financial embarrassments. We strongly believe that the Government would have done them justice but for the interfering propensities of the G. M. C. of Great Britain. The latter wants massive buildings, I.M.S. professors, and whispering humbleness on the part of the Indian Medical Profession to entitle our degrees and diplomas to be recognised by them. When our own Government yields to the threats of the G.M.C. we can only cry like an anguished child deserted by its mother. The other incubus is financial—that is, the Government is under the impression that if the status of the licentiates is equalised with the rest of the medical groups, the cost of medical administration will be doubled and that it would be impossible for it to shoulder this responsibility. While we are not foolish enough to deny the truth of this statement we have to say at the same time that it is only partially true and that circumstances have so changed that it can get as many Graduates on the existing scale of Sub-Assistant Surgeon's pay as medical Licentiates. Here is what Sir Malcolm Hailey said : \*

"There is an increasing tendency on the part of our local bodies to utilize the services of the graduates of the Lucknow Medical College, on the ground that they can now be obtained at the salaries available."

This is true not only of U.P. but of all Provinces and recently the I.G.C.H. of Punjab had advertised for Graduates for the post of temporary Sub-Assistant Surgeons. The cost of medical administration is top-heavy and disproportionate. The I.M.S. officer is paid 3 or 4 times more than the Assistant Surgeon and the latter twice or thrice that of the Sub-Assistant Surgeon. If a reasonable maximum and minimum scale of pay is fixed, the cost of the medical administration will be materially reduced. It will still further be reduced if the Government extends the Honorary Medical Service which some Provincial Governments are trying with striking success. The money so saved can be usefully utilized for the improvement of Medical Schools.

\*I.M.J. Vol. XXVIII. V. P. 283.

We realise that these cannot be done in a day but a beginning ought to be made seriously. A change of heart, at least, is needed for the immediate present.

#### The Burden of the Song

The leaders of the All-India Medical Licentiates' Association anticipated, even two decades ago, that the Licentiates, notwithstanding the lip-praises to which they were gullible, will one day be landed in a *cul-de-sac*. In spite of their precautions this has happened to-day. They knew that for the ostensible reason of want of a five-years' curricula of studies the Licentiates would be denied the rights and privileges which others of the fraternity are enjoying. They therefore claimed, and even now claim, the formal introduction of a five-years' course in all the medical schools of India. They prayed, petitioned and went in deputation for this five years' course. The Provincial Governments were sympathetic but pleaded financial inability—the burden of the song. When the Bengal Licentiates went in deputation to the Governor and when the latter's attention was drawn to the fact that Madras was already having a five-years' course he advised the deputationists to study the financial resources of Bengal and compare them with Madras. The reply only meant, in a plainer language, that there was no will and therefore there was found no way for solution. The tale from U.P. was different. The Provincial branch of the U. P. Medical Licentiates' Association went even so far as to say to its Government that it will collect the necessary funds for the additional expenditure, if that was the impediment to the increase in the course of studies. The branch collected sufficient money but it has to be returned to the donors as there was no response from the authorities. The other Provincial Governments sang the same monotonous song—financial inability. The Central Government refuses to interfere because Medicine is a transferred subject. But they have conveniently brushed aside this constitutional principle and enthusiastically and successfully sponsored the All-India Medical Council Bill. Was it because that bigger fries were in the frying pan?

#### The Position

Could the Medical Schools be abolished? The Government say they are deficient yet they do not abolish them. The Licentiates are overpowered by the philosophy of despair, borne out of disgust and disappointment and demand abolition of schools if reforms are not possible. But we sincerely believe that

abolition is neither desirable nor practicable. The fact that the Government have not abolished them is very significant and they know, more than any body else, that such an abolition means the withdrawal of a large amount of medical relief which they are now able to give to the teeming millions of India through the Medical Licentiates.

The Hon. Sir B. P. Singh Roy, Minister for Public Health, Bengal, while proposing a vote of thanks to His Excellency, The Governor of Bengal when the latter opened the extension of the Jackson Medical School, Jalpaiguri on 7-11-'35 said.

"The genesis and object of the improvement scheme have been fully explained to you by Mr. Robertson. When the recommendation of the Bengal Retrenchment Committee was placed before you, sir, you at once decided that the closing down of the school was out of the question both in the interest of Medical relief and medical education in this part of the province and inspired your advisers with an optimism which enabled them to undertake a rather ambitious scheme for the expansion and improvement of the hospital necessary to avert disaffiliation of the school by the State Medical Faculty."

That is the reason why the Government is sitting on the fence; but this attitude is indefensible. As they know that abolition is impossible, they must make serious attempts to reform the medical schools up to a level which they think as necessary and which will spare the Licentiates the odium of being incompletely trained for which, if it is true as they say, they alone are responsible. The talk of abolition is moon-shine. It is not practical politics. The medical Licentiates have made a mark in the medical history of India since the days of the East India Company. Their growth cannot be hindered nor can they be rooted out. If only our Government can extricate themselves from political subservience to the British Medical Council and look at the medical Licentiates with dispassion and with the view-point of medical interests of India they will feel sorry for having till now assailed the latter with the trumpery charge of their ineligibility to the legal and fundamental rights of the medical profession. They can by a mere stroke of the pen exercise their inherent power to raise the status of the medical schools and Licentiates and undo the century-long injustice. If, however, they honestly feel that the medical schools have to be reformed to entitle the Licentiates to the status which they demand, we have no objection nor the All-India Medical Licentiates' Association. But the poignant truth is that the Association has been clamouring for reforms and it is only the Government that are postponing them. They have to do it one

day or other for the simple reasons explained earlier. We say and suggest: why not do it in time, save the agony and the shame of the Licentiates and get credit for having done the right thing at the right time?

#### TENDENCIES OF MODERN SURGERY

The extra-ordinary development of modern surgery may lead one to believe that its aim is to extend its scope of application and to trespass into fields of medicine. Nothing, however, is farther from truth and if we had read aright the trend of its developments surgery has always been trying to restrict itself. An James Walton\* said: *Medicine will ultimately progress so that Surgery reaches its true aim—that of its own abolition.*

Broadly speaking, it may be said that surgical treatment covers three distinctive grounds, viz., injuries, infections and tumours. Surgery began its career with treatment of injuries and its progress in this direction, especially after the Great War of 1914, was as great as it was satisfactory. But it owed its success, not merely to the improvement in technique but to the co-eval progress in bacteriology and bio-chemistry. The effectiveness of anti-tetanic serum as a routine prophylaxis in the treatment of wounds is an instance of the tendency of Surgery to restrict itself. Considerable progress has been made in the treatment of fractures. Prophylactic inoculations against subsequent infection, the help of X ray in determining the seat and extent of fracture, the improved methods of fixation by a dexterous arrangements of special splints have all tended to make the fractured patient comfortable in his sick-bed, to minimise his period of invalidism and to restore him early to active work. The economic gain due to the modern treatment of wounds is indeed great and from this point of view alone Surgery can proudly and justifiably claim its due meed of praise. Orthopædic Surgery is honestly trying to shrink itself and this shrinkage has been in direct proportion to the expansion of successful relief given by therapeutic measures of modern medicine. Forty years ago hospitals all the world over were used to be full with children suffering from tuberculous bones and joints and the surgeons of the last generation were requisitioned for correcting deformities due either to tuberculosis or rickets. Straightening of bones of a ricketty child and the plaster of Paris jacket for fixing the spinal column in a case of Pott's disease are now but

\*Lancet, May 4, 1935.

memories of a recent past. Preventive medicine, better social conditions, better food supply and the immense care which modern States take in health propaganda and in prevention of disease have contributed not a little to the limitation of surgery in this respect. If the ideal of surgery, namely its own limitation and abolition, has not yet been reached it is due to circumstances beyond the purview of the surgeon.

In the treatment of certain infections by special surgical procedures, surgery has saved many lives and narrowed the period of suffering. If it has not shrunk itself more than what it has been able to do in recent years it is because there is not yet discovered more reliable methods of relief than with the surgeon's knife. A boil on the finger, an acute necrosis of the bone and abscess in the brain or chronic inflammation of the appendix need his dexterity and he will gladly retire the very moment when the physician takes upon himself the responsibility of treating these infections successfully. The degree of surgical interference in the treatment of infection depends on the progress and achievement of specific immune therapy. If it is possible to discover specific anti-toxin to each and every kind of infection and if the discovered anti-toxin is able to undo the mischief which an infection plays, then is the day for surgeon's self immolation. He is not to-day anxious to treat diphtheria but appendicitis, because he knows that anti-diphtheritic serums will do what his knife cannot do while in the latter he is sure that his knife can do much better than any anti-toxin sera yet discovered. He has gracefully retired from many functions which he had, till lately, been performing because better and surer methods of treatment by medical means have been evolved. Tropical abscess of the liver caused by *Entamoeba Histolytica* is a disease which has entered the domains of medicine except in cases where suppuration is more extensive than can be effectively dealt with by medical means. Amputations for gangrene of the limbs have been astonishingly decreasing owing to effective therapeutics by means of anti-streptococcal and anti-gas-gangrene sera. In fact one may be justified in the optimism that, ere long, specific immune therapy will cover a wider field than it has been possible now and still further limit the surgeon's scope.

There has been very little evidence of the recession of surgery in the treatment of tumours except perhaps in a certain state or type

carcinoma where X-ray and radium do what surgery was doing two decades ago. The reason is not far to seek. The causation of both malignant and benign tumours are more in the nature of anatomical aberrations of cell disposition than of pathology of infection. Here there is no question of overcoming the morbidity by anti-toxins but by setting right the abnormal growth by excision. Besides the multiplicity of places in which the tumours occur make their diagnosis and treatment essentially surgical and the physician has necessarily, at least for the present, to play but a secondary role in this connection. Even where X-ray and radium are likely to be effective, as they certainly are as in skin and breast cancer, yet if cancer occurs in situations which would not allow easy access to radium or X-ray therapy the surgeon has perforce to enter and do what he could under the circumstances with or without the help of radium. Recent researches on nutrition and vitamins, notably by Col. MacCarrison (now retired) in India, have revealed the possibility of preventing the formation of tumours by putting the infant from its very birth on a diet which would supply the demands and the needs of the body. If stone in the bladder or kidney, and cancer of the skin or of the internal organs can be experimentally produced—as they had been in some notable laboratories—by a diet suspected to be specific in the production of such tumours we can confidently point this out as the silver lining in the cloud. When that is satisfactorily accomplished and in a scale capable of mass application, the surgeon will retire even from this field of his activities which, at present, seem to be peculiarly his own.

Thus, the tendencies of modern surgery tend towards its own extinction and the extent of this extinction entirely depends on the progress of science in finding out medical ways and means of eradicating such diseases which at present require surgery for their relief.

There have been tremendous advances in modern surgery, not from the point of view of extending its scope but from that of perfecting itself in its technique where its services are required. Surgery of the brain, of the thorax and of the abdomen have been made possible and safe by the improved skill of the surgeon, by better and more delicate instruments, by improvements in anaesthesia—local and general and even rectal (Avertin) and by the close co-operation of the pathologist and the physician.

## Current Comments

We draw the attention of our readers to one of the resolutions tabled to be moved by Dr. Gianchand Blaggana in the Punjab Medical Council (*see our column: Medical Councils*). His resolution asks for three elected seats; at present the strength of the licentiates in that Council is two elected and one nominated. In our opinion, it is too modest a resolution; he could have asked for more seats without being accused of greed or inconsistency. We wish him every success; but we wonder whether he would succeed. Others had failed before him. Anyhow he is discharging his duty. God speed him!

We had said, he would not succeed even with this modest resolution which is no inconvenience even to the vested interests of the Provincial Medical Councils. We are not pessimistic. We know the situation. It is such that it will allow no quarters to the medical Licentiates, as far as it lies in the power of the Medical Councils. And they have the power. Let our readers judge from what we write below.

If they had carefully perused our comments in this column in our June, July and August issues, they would have realised and felt the iniquity of Medical Council elections on *Caste lines*. Let it be known that such a procedure is a direct negation of the principle of medical registration. Compartmental registration according to degrees and diplomas and communal election are not in the constitution of Medical Councils in any other civilised countries except in our unfortunate country.

We will now discuss whether even within this freakish constitution of our Medical Councils there is any sense of proportion for assigning seats for their constituents. We shall exclude for the present the question of the excess of nominated seats. That is a subject apart, in which the more we say the less will be done. We may even be misunderstood by the authorities.

May we ask our readers to oblige us a little by turning to page 92, I.M.J. Vol. XXVIII. II

wherein they will find an excellent and instructive table regarding the Provincial Medical Councils prepared by the General Secretary, A.I.M.L.A. Every Indian Medical Practitioner may as well set it up in his consulting room to remind him of the insignificant and shameful position he occupies in the Medical Councils of his country.

Look at the Punjab figures, for example. The total number in its register (1932) is 3618 medical practitioners out of whom 2406 are medical Licentiates and the rest are composed of medical graduates with Indian or British qualifications. (We use the word *Graduate* to include the medical diplomas of Great Britain also). Only two elected seats are made available for the former while for the latter five seats are thrown open. What is the meaning or motive behind this franchise?

Is it according to the importance of the degree or diploma or is it consistent with the principle of medical registration? It is obvious that the value of numbers is not taken into consideration—that is to say, in political parlance, the allocation of seats is not on population basis.

If the election to the Medical Councils is run on the basis of a general, or at least of a joint electorate in which any registered practitioner can vote for any other registered practitioner, irrespective of the greatness of his degree or diploma and of the caste which State service has christened him, the medical Licentiates would not be so fool-hardy as to demand for more representation. When such is not the position it is but natural that they urge the claim for more number of elected seats. If proportional representation cannot be instituted for fear of the Licentiates swamping the Councils and voting down the retrograde and the anti-Licentiate propositions by mere strength of numbers, there should at least be sufficient minimum representation to voice their interests and influence its deliberations in their favour. Though in every Provincial Medical Council more than half and in some more than three fourths (as in Assam where out of 716, 600 are Licentiates) of the medical practitioners in its register are Licentiates yet the allotted seats are utterly inadequate; neither are they uniform. Out of the 8 Medical Councils, 6 of them give but 2 seats while only 2 give three elected seats. What is

the reason for want of uniformity. God alone knows.

\* \* \*

There is no general or joint electorate. There is no value given to numbers. There is no visible sign or mark of a popular system. The accepted principles of election and franchise on the numerical strength of the constituency are not followed. The present system is set to make the Indian Medical Profession divided and mutually intolerant. Those with British qualification can vote only for Part I candidates and live in a narrow world of their own greatness and glory. The Indian Medical Graduates who can only vote for Part II candidates live in a world of expansive delusion. The Indian Medical Licentiates who are eligible to vote only for part III candidates live in a world of self-satisfied sorrow.

\* \* \*

Why are the Licentiates not given representation proportional to their number in the Medical Register? For very good reasons! They would vote down all reactionary resolutions. They would not sign their own death warrant. They would have made these Medical Councils really representative. They would have compelled the Government to improve the Medical Schools and Colleges in this country. They would not kneel down at the feet of the British Medical Council with bated breath or whispering humbleness.

\* \* \*

These are the good reasons why the poor Licentiates are left in the back-ground with a very meagre representation. The medical councils could have very comfortably denied even these two or three seats but for the bare-faced inconsistency that would arise which they could not escape in spite of all the sophistry for which they are so famous and in which they are so perfect.

\* \* \*

Could these Medical Councils, if the Licentiates had their due and legitimate share of representation there-in, have said or done against;

- (1) the inclusion of Medical Licentiates in the All-India Medical Council.
- (2) the increase of the course in Medical Schools from 4 to 5 years.
- (3) compelling the Government to make no distinction between registered

medical practitioners for the purpose of State employment?

\* \* \*

Or could they have tolerated so long:

- (1) the compartmental classification of their registered medical practitioners.
- (2) the disproportionate number of seats allotted to the different groups of the profession.
- (3) the apathy of the Government in improving the medical schools in their charge to the extent necessary for modern medical studies.
- (4) the official preponderance in the Council.
- (5) the nominated instead of the elected president?

\* \* \*

These are the few but by no means exhaustive reasons why the medical Licentiates are denied their due share in the deliberations of these Medical Councils. These Councils, as they are at present, are mere ornamental institutions, appendages of wrong convention and constitution, anachronisms that have unfortunately escaped the prudent ravages of time and citadels of reaction. This Medical Feudalism survives and thrives in this country alone. *In a sense we deserve this, because we are disunited. If the soil had not been favourable these types of Medical Councils would have died of inanition long ago.*

## Notes and News

### OUR BERLIN LETTER

(From our Special Correspondent)

#### Surgery in Germany

At this year's meeting of the Deutsche Gesellschaft für Chirurgie at Berlin it became evident which themes of surgery are in the foreground of interest to-day. Above all it is the

#### Cancer

König of Würzburg dealt with the question whether the cancer may be considered a purely local disease. He answered the question in the negative—as much as he made the action of the surgeon more difficult thereby in principle. Experi-

ence has taught that apart from the local disposition other factors must still be present that are responsible for the origin of cancer, such as constitution, age and heredity. Also with the cure of the disease general factors are consequently playing an important role.

Klein of Ludwigshafen has found as a cause of cancer, apart from the local damage, a cell ingredient that produces cancer when transmitted to animals by inoculation. He has worked out a method for the diagnosis of cancer disease by means of which he has been able to make 90% correct diagnosis of cancer. Also Kirsener of Heidelberg has found the correct diagnosis with the acid of the Klein cancer reaction in 82% of 600 cases of cancer. For the time being, the method is slightly interfered with by fever of the patient, X-ray treatment, and prescription of medicaments; such cases should, therefore, be excluded from the test.

Baur of Breslau and V. Mikulicz of Königsberg reported on

#### Indication and Technique of Sterilisation

Out of about 45,000 sterilised cases of men and women, more than 96% concerned had grave mental defects. Counter-indications against sterilisation must be investigated carefully and, if need be, reported to the Court. To this category there belong general illnesses increasing the danger of operations in an undue manner. Special complications including such of psychological nature, have not manifested themselves after the operation. The mortality of 1.15% must be termed very low. The practical application of the law on sterilisation has not led to any difficulties. From other quarters it was suggested to carry through the sterilisation of lunatics in the lunatic asylum instead of in the surgical clinic.

A principal source of care for surgery is to-day the

#### Increase of cases of embolism

after operations. Sticht of Göttingen considers this increase of embolism and thrombosis to be seeming one only; older lives are being preserved now-a-days and consequently more operations are being carried through with elderly people, where there is in itself a disturbance of circulation present. The occurrence of such disturbances may be prevented by various measures. They include gentle operating, timely therapeutics of the circulation, early exercise of movement and early rising after the operation, also influencing the composition of the blood by medicaments.

Payr of Leipzig applies X-ray treatment successfully with such cases of thrombosis. Ritter of

Düsseldorf does not want any intravenous injections to be applied before the operation; the main cause of thrombosis after operations seems to him to be too generous an application of anodynes and dormitives. Other observers were able to reduce the number of cases of thrombosis after operation by systematic application of medicaments strengthening the circulation; particularly *sympatol* was repeatedly named in this connection. Also early rising after the operation was emphasised frequently.

According to the great interest in all question of heredity a lecture was held by Schloessmann of Bochum on the

#### Hemophilia as an hereditary disease

The disease is hereditarily anchored in all cells of the body. Consequently a cure is impossible, though an improvement can be attained. With all observations of the effect of different medicaments not only the beginning of the blood coagulation should be communicated, but also its end; otherwise great deceptions are unavoidable.

Batzner of Berlin reported on narcosis with *evipan*. The experiences made with more than 1½ millions of such narcosis have been reported now. Among them approximately 60 fatal cases have become known which had been caused almost exclusively by wrong dosage. If correctly applied, the remedy is quite harmless; the doses should never exceed 1.0 gr. Sauerbruch of Berlin takes objection to cerebral surgery being specialised too much. Great parts of cerebral surgery must be well known to any surgeon. The operation of cerebral tumors should, however, be conveniently reserved to specially trained cerebral surgeons. Co-operation of the surgeons with the neurologist is of great value.

A further main theme at the Surgical Congress was the

#### Operation of the prostate

Voelcker of Halle who reported on it pointed out that the carcinoma of the prostate did not lend itself to radical operation; it should be subjected to Roentgen treatment. Various quarters reported on advantages of electro-operation with hypertrophy of the prostate, etc.

Beside the main lectures, a great number of lectures was held on special surgical themes showing the many-sidedness of interest and of the special domains of research.

#### Robert Koch Celebration

The 25th anniversary of the death of Robert Koch, the great German bacteriologist, gave rise to a series of commemorations. Among others his bust was

unveiled (simultaneously with that of Roentgen) in the Hall of Honour of the Deutsches Museum of Munich.

#### Obituary Notices

On May 10th the Director of the Staatliches Institut für experimentelle Therapie (State Institute for experimental therapeutics and Chemo-therapeutic Institute of Research) of the Chemotherapeutisches Forschungsinstitut of Frankfurt on the Main, Geheimrat Prof. Wilhelm Kolle, died at Frankfurt on the Main. He had been one of the collaborators of Robert Koch, and later on he had taken over the Frankfurt Institutes as the successor of Paul Ehrlich. His works concerned the most varied infectious diseases, above all typhoid fever and cholera, bacterial problems, the improvements in the treatment of the spirochete diseases, such as syphilis. His opinions which he stated in the Hygienic Committee of the League of Nations, enjoyed great attention.

In Berlin the specialist for internal diseases Prof. A. Goldscheider died, the former director of the ambulatory clinic, and then the Second Medical Clinic. The Berlin Medical Society honoured the memory of their president of 1930-33, G.V. Bergmann holding the obituary speech. Goldscheider was a representative of the strictly natural-historic, non-mystic school in Medicine which is very frequently attacked recently. He had been a pupil of Leyden. Physical and dietetic forms of therapeutics played a very important role in his field of work.

#### Sterilisation and Heredity

The question of sterilization, such as are in part embodied in the new German legislation, is meeting with great interest abroad. In a recent edition the "Deutsche Medizinische Wochenschrift," has compiled a series of essays dealing with this subject scientifically. Matzner of Berlin discusses the *Hereditary Health Court* and its proceedings. There are 209 Hereditary Health Courts and 29 Hereditary Health Supreme Courts in Germany. For each chamber four medical pairs of judges have been nominated, consisting of one Governmental Physician and one non-governmental Physician each. Every physician is obliged to give notification of every case of illness covered by the law, even if a further amphigamy of the person suffering from the hereditary disease is unlikely. When succession may not be expected, sterilisation may be dispensed with. There are two questions to be answered: where is sterilisation possible? and, where is it

unavoidable? Matzner personally advocates the latter.

Gohrbrandt of Berlin reports on the *sterilisation of males*. Gohrbrandt thinks that here the vasectomy (resection of a piece from the spermatic duct) has found general introduction. It is the duty of the surgeons to provide for the sterilisation being carried through with absolute certainty and for the operative interference being made as small as possible. To effect an immediate and complete sterilisation, a liquid is injected into the end of the vas deferens nearest the spermatoceysts. This liquid enters the spermatoceysts and kills the spermatozoa present there (Rivanol 1:1000). Gohrbrandt never noticed any signs of irritation. The piece of the vas deferens removed should have a length of at least 6 cm. In general, the operation is to be considered small and harmless. A few complications are discussed.

Ottow of Berlin deals with the legal *sterilisation of women*. In his hospital 850 sterilisations have been carried through up to now. All the 850 women have been dismissed as cured. Ottow further discusses a series of view-points and possibilities. There are still some open questions and unsolved problems every-where, as he says.

A Schlegel of Berlin reports on the castration as a measure of sterilisation and safety against dangerous *sexual criminals*. As established in the legislation, the castration is not intended to be a punishment, but a measure of safeguarding against dangerous sexual criminals. In the Moabit hospital 160 cases of castration have been operated upon so far, all of them under local anaesthesia. Following up castration, no disturbance of the feeling of comfort or any other spiritual disorders were noticeable with the men in question. The healing process went smoothly almost in every case, and also the general condition of the patients was good. The ability of working was re-established within a fortnight. The mental capability did not suffer. In some cases outbreaks of sweat occurred. In 90 cases out of 100 the sexual impulse had disappeared after four weeks, with the rest it was weakened, with a few it only disappeared after four months. An absolutely sure statement of the effect of castration can only be made, when the prisoners are free again. Up to the present, 22 castrated criminals have been dismissed; no case of relapse has been reported so far.

#### More protests against the All-India Medical Council Act

**Jhansi Medical Association.**—"That this meeting of the medical profession under the joint

auspices of the Jhansi Medical Association and the Jhansi Branch of the All-India Medical Licentiates' Association condemns the Indian Medical Council Act of 1933 and calls upon the members of the Legislative Assembly to take early steps so as to provide, among other things, a more suitable arrangement for reciprocity, a larger number of elected members and the inclusion of Licentiates."

**Indian Medical Association, Amritsar Branch.**—"Resolved to request the Government to so amend the Indian Medical Council Act of 1933 as to include the Licentiates and that for purposes of reciprocity with foreign Universities their diplomas should be recognised."

**Birbhum.**—"This meeting of the Registered Medical Practitioners of this town emphatically protests against the Indian Medical Council Act of 1933 and respectfully urges on the Government to amend it in such a way so that the medical Licentiates are recognised by the Indian Medical Council."

**Indian Medical Association, Sailkot Branch.**—"Resolved to request the Government that the Indian Medical Council Act of 1933 should be so amended as to include the Licentiates and their diplomas should be recognised for purposes of reciprocity with foreign Universities."

**Hoogly.**—"This meeting of the registered practitioners of Hoogly condemns the Indian Medical Council Act of 1933 which has excluded the medical Licentiates who form the majority of the medical profession in this country and without whom any Medical Council will be a farce and therefore resolves to urge the Government to amend the Act in such a way that the diplomas of the Licentiates are recognised by the said Council."

**Indian Medical Association, Gujranwala Branch.**—"Resolved to request the Government that the Indian Medical Council Act be so amended as to include the Licentiates and that for purposes of reciprocity with foreign Universities their diplomas should be recognised."

**Asansol.**—"This meeting of the registered medical practitioners emphatically protests against the Indian Medical Council Act of 1933 and respectfully urges on the Government to amend it in such a way as to include the Licentiates within its purview."

**Saran.**—"This meeting of the medical men of Saran District emphatically protests against the constitution of the Indian Medical Council and requests the Governor-General in Council and the Members of the Assembly to amend it to provide for

- (1) the inclusion of medical Licentiates,
- (2) an elected president,

(3) a larger representation to independent medical profession."

**Baroda Branch of the All-India Medical Licentiates' Association.**—"This meeting unanimously records its strong protest against the All-India Medical Council Act of 1933 and requests the Government of India to amend it as to include the deserving class of Licentiates within its purview."

**Burdwan.**—"Resolved unanimously that this meeting of the registered medical practitioners of Burdwan enters its emphatic protest against the Indian Medical Council Act of 1933 and urges on the Government for its immediate amendment enabling the medical Licentiates who form the majority of the medical profession in this country and whose qualifications are registrable in the Provincial Register and who have been unjustifiably kept away to be brought within the purview and scope of the said Act."

**Muzaffarnagar Medical Association.**—"This Association urges upon the Government of India the necessity of amending without further delay the Indian Medical Council Act so as to include the Indian Medical Licentiates within the scope of the Act and requests the present members of the said council to take necessary steps to move the matter in the Council and press upon the Government of India to remove the injustice which has been done to the deserving class of the Indian Medical Licentiates by their exclusion; and this association appeals to the members of the Legislative Assembly to take up this question in right earnest."

**Jorhat.**—"This meeting of the members of the medical profession of Jorhat regrets that the degree of some of the Indian Universities and the diplomas of the Licentiates have not been given recognition in the Indian Medical Council and therefore lodges its most emphatic protest against their exclusion and requests the present members of the Indian Medical Council to find out ways and means to get them recognised at an early date; this meeting invites also the attention of the Members of the Assembly and the Council of State and requests them to take up this matter earnestly and undo this great injustice."

**Bhandara Branch, All India Medical Licentiates' Association.**—"That this branch strongly protests against the Indian Medical Council Act of 1933, since it tries to ride rough-shod over the rights and privileges of the qualified medical Licentiates by wantonly ignoring their claims; therefore, this meeting requests the Governor-General-in-Council to amend the said Act at once and incor-

porate the demands made by the Licentiate through the A.I.M.L.A."

**Gauhati Branch, A.I.M.L.A.**—"This meeting emphatically protests against the Indian Medical Council Act of 1933 and respectfully appeals to the Government of India and the Members of the Assembly to amend it in such a way so that the medical Licentiate are recognised by the Indian Medical Council."

**24 Parganas Branch, A. I. M. L. A.**—"This branch records its emphatic protest against the exclusion of the medical Licentiate who form 80% of the qualified practitioners in this country from the Indian medical Council."

**Meerut Branch, A.I.M.L.A.**—"This meeting of the members of the medical profession practising at Meerut records its emphatic protest against the defective constitution of the Indian Medical Council which is absolutely subservient to the G.M.C. of the United Kingdom: this meeting therefore requests the Government and the Indian leaders to so amend the Indian Medical Council Act as to secure the following provisions there-in, consistent with the function and the dignity of the Council:—

- (a) maintenance of a *Register* of qualified practitioners,
- (b) inclusion of medical Licentiate who form nearly  $\frac{3}{4}$ ths of the profession,
- (c) securing of uniform minimum standard of qualification in the Government Medical Schools of India along with the University Colleges,
- (d) recognition of non-Indian diplomas and degrees on principles of reciprocity only,
- (e) adequate representation of the medical Graduates and Licentiate of every Province with a majority of elected members,
- (f) election of a non-official president."

**Mariani Branch, A.I.M.L.A.**—"This Association strongly protests against the All-India Medical Council Act for excluding the Licentiate who form the greatest bulk of the medical profession with registrable qualifications from within its purview; this association entirely endorses the editorial comments of the I.M.J. that the name *All-India medical Council* is a misnomer, it has a very few of the normal functions of a real medical council, it is a result of adroit and audacious trespass of the G.M.C. of Great Britain into our precincts, it is not the result of our willing endeavour or acceptance."

**Late Dr. Sarju Pershad.**—Condolence resolutions from the following branches of the A.I.M.L.A. have been received: Gujrat, Bombay, Family Fund, Kolhapur, Bhandara, Nagpur, Amritsar and Burma. All of them express their affectionate regret and sense of irreparable loss to the association at the demise of their most beloved leader. The full text of the resolutions will be duly published under Association Notes.

**M.S.M.F. Course in the Punjab.**—We understand from a reliable source that the medical Licentiate are not very enthusiastic to join this course for the simple reason that the instruction imparted is unsatisfactory and not up to the standard. When this was brought to the notice of the I.G.C.H., Punjab by the 18th Punjab Provincial Conference of the medical Licentiate (1934) he echoed the Master's voice of the Principal of the King Edward Medical College that the instruction imparted was both complete and satisfactory. If so, how is it that no one has applied for it during the last two years? This requires elucidation and the whole situation should be investigated by an impartial committee. An ostrich-like attitude is highly detrimental to the interests of sound medical education in that province. Will the I.G.C.H. kindly look up to this affair and ease the just dissatisfaction of the Punjab Licentiate?

**Nagpur Conference of the Indian Medical Association.**—We heartily congratulate the I.M.A. for its wise election of Dr. U.Rama Rao as president of its coming annual gathering, this Christmas. This shows which way the wind blows. The unity of the profession is real and not stage-managed as Sir Fazali Hussain once said. It is indeed a happy augury of the times. We invite the attention of our readers to a brief biographical sketch of the President-elect published elsewhere.

**Burma Independent Medical Practitioners.**—They recently waited on deputation to the Governor of Burma and laid bare their disabilities, on account of which, the deputationists pointed out that they are in a very precarious condition and fast becoming a class of unemployed men for want of sufficient paying work and want of influence due to the lack of patronage by the Government and Local Bodies. They said, among other things, that:

- (1) they have to face competition with paid Government Officers who, though whole time, engage in practice by opening consulting rooms or nursing homes.

- (2) Numerous patients are admitted into the hospitals through these consulting rooms and these become the favoured ones and get the best of the comforts provided in the hospital. Cases sent by private practitioners are refused admission for alleged want of accommodation and admitted only when very serious or moribund.

They sought redress and suggested that the private practitioners should be subsidised for medical and public health work on a small honorarium which will be more effective and economical than what it is

really at present. (*From Our Special Correspondent*).

**U. P. Poisons' Act.**—The Viramgam Medical Association held a meeting on 18-9-35 and passed a resolution lodging an emphatic protest against the recent amendments to the above Act and requesting the Government to rescind the same, as it is a slur on the qualified practitioners.

## Medical Conferences

The Sixth annual provincial conference of the Assam Branch of the All-India Medical Licentiate's Association was held at Dibrugarh on the 26th and 27th October 1935. Delegates from all the Assam branches of the A.I.M.L.A. and many distinguished visitors graced the occasion. C. S. Gunning Esq., Deputy Commissioner, Lakhimpur, opened the Conference. Sjt. N. C. Bardoloi, M.L.A. presided and Lt. Col. Sen conducted the scientific section. The conference expressed itself strongly on the unenviable position of the medical Licentiate and their unjust exclusion from the All-India Medical Council. After the usual formalities, the provincial Secretary Dr. K. C. Purkayastha read the following annual report which was very much appreciated for its brevity and for the unvarnished version of the activities of the Assam Branches of the A.I.M.L.A.

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President, Brother Delegates, Ladies and Gentlemen,

Another 2 years have elapsed since we met last at Gauhati in 1933. The onerous task of presenting before you the report on the working of the Association since the last conference has fallen upon me. It is a matter of great regret that our Provincial President Dr. B. Mazumdar and the most energetic Secretary Dr. L. K. Barooah had to tender their resignations in 1934 owing to unavoidable reasons. All efforts for the withdrawal of their resignation proved abortive. The executive committee in its meeting elected me as Provincial Secretary and at last I had to take over the charge of the office on the 10th April last. So it is obvious that all the credit of the work of the Association goes to my predecessors for the efficient discharge of their duties. Gentlemen, I know it fully well that it would have been better if this choice has fallen on some one more able than myself, but as an humble worker in

the cause of the Association, I had no other alternative but to bow down to the wishes of my colleagues. I thank you, gentlemen, for the honour conferred on me and with the blessings of Almighty, I will do my best to keep the lofty tradition of the office in tact.

Ladies and gentlemen, before entering into the details of the working of the Association, please allow me to convey the sincere and heartfelt sympathy of the Association to the sufferers of appalling and unprecedented havoc that nature has wrought in Behar and Quetta. Our members have ungrudgingly opened their pockets to the succour of Behar. And now also the members of the Association are showing great eagerness to extend their helping hands to the needy of Quetta. Then again coming to our own Province, we know fully well how the flood has ruined Nowgong and some parts of Sylhet. We offer our sympathy to the sufferers in these places also. In this connection too, our members did their utmost in helping the relief works by sending both men and money. I take this opportunity to extend our heartfelt thanks and gratitude to various benevolent personages and organisations within and outside the Province who helped us in our distress.

Gentlemen, on behalf of the Association, I join the universal rejoicings upon the completion of Their Majesties' Silver Jubilee. May the Almighty Father grant Their Majesties and Their children long years of health and happiness!

Turning now to the business of our Association, I wish to express my thanks to the members of our Dibrugarh Branch to whom the credit of this session is entirely due; specially because they took the bold stand to shoulder the responsibilities of inviting the conference while other branches could not manage to do so on account of various difficulties. This is our sixth session and happens to be the third

time that the Association meets at Dibrugarh, a matter which my colleagues of this branch may genuinely feel proud of. Dibrugarh can also claim the honour of being the place where the foundation of the Association was laid in its first session in 1928.

Since its inception in this province, not quite long ago, our Association met at general conferences at the following places under the patronages and able guidance of the following illustrious persons of the province. On behalf of our Association, I cannot but join my predecessors in expressing again our deep debt of gratitude to these persons whose valuable support and sympathy have all along been affording us great facilities in various ways.

The following is the list of places of the conference and their presidents.

A glance at the list will show how, inspite of all our limitations, our Association has gradually grown in popularity and been able to enlist the support of all right thinking public of the province, both official and non-official. In my humble opinion, this constitutes a very great achievement in view of the fact that the association is still anything but mature and is yet to work under heavy odds.

Gentlemen, the foremost of all handicaps referred to above is the comparatively slow response from our profession. I am extremely pained to have to refer to this, but I feel I shall be failing in my duty if I do not give prominence to the bare facts. *It is true that the list of our members has gradually increased from year to year, but considering the objects of our Association and the amount and nature of strenuous work that has to be launched*



Delegates and Visitors to the Sixth Provincial Conference of the A. I. M. L. A., Assam Branch

| Sessions | Place      | Date                         | President                                                                                     | President, scientific section                                        |
|----------|------------|------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| 1st.     | Dibru-garh | 14th & 15th Feb. 1928        | Col. G. Hutcheson, I.M.S. I.G.C.H.                                                            | Lt. Col. D. L. Graham M. B., I. M. S., Supdt., B. W. Medical School. |
| 2nd.     | do         | 26th & 27th May 1929         | Mr. E. S. Roffey, Attorney-at-Law M. L. A. Secretary Assam Branch, All India Tea Association. | Major C. McIver, I. M. S. Supdt., B. W. Medical School.              |
| 3rd.     | Silc-har   | 24th & 25th May 1930         | Babu H.C. Chakravarti, Dy. President, Assam Legislative Council.                              | Major J. L. Sen, M.B., M.C.D.M. R.E., I.M.S. Civil Surgeon.          |
| 4th.     | Now-gong   | 3rd & 4th April 1931         | Rai Bahadur Kanak Lal Baruah, Minister of Local Self Govt. Assam.                             | Dr. K.K. Roy, Offg. Civil Surgeon Now-gong.                          |
| 5th.     | Gau-hati   | 15th, 16th & 17th April 1929 | Mr. T. R. Phukan, Bar-at-law M. L. A.                                                         | Major J. L. Donnelly I.M.S., Civil Surgeon, Kamrup.                  |

*upon and maintained in attaining the same, there remains a great deal yet to be fulfilled.*

Ours is a Body that has for its aim the uplift and well-being of its members in their various fields of activities, the amelioration of their grievances and the improvement in their status; and for that purpose it exploits all the available avenues, and the Association in doing good to itself incidentally tries to do good to the public with whom our people are most inseparably linked more than any other learned profession of the world. You are well aware, gentlemen, that it is only those children that cry loudest receive the greatest attention and caressing from their parents and in this world of struggles for existence and competition, only the strongest survive and reach their goal. Our claims are just and legitimate—we clamour only for what is due to us. What we pre-eminently require now is the acquisition of sufficient strength for concerted all-round action, persistent zeal and an unflinching tenacity of purpose. As our strength, particularly in this Province, remains yet far short of expectations, I would like to take advantage of this opportunity to extend my earnest appeal to every member of our

profession, wherever and in whatever circumstances he is, to shake off his lethargy and join us in our struggles for the attainment of our rights and privileges. I like also to appeal earnestly to my colleagues present here today to give their very serious consideration to this state of affairs and to exert all their influence in enrolling as many of our brothers as possible. This, in my opinion, should form the very primary work of every branch Association and of every individual member if we wish to be adequately attended to by the authorities. I appeal again to all the rank and file of our fellow Licentiates to shake off their silent apathy which is daily eating into our very core and prospects and I do hope that my most earnest appeal will not fall on deaf ears.

As for the working of the various district branches hitherto in existence, it is gratifying to note that inspite of the unavoidable difficulties created by frequent transfers of their members, many important meetings were convened at fairly regular intervals and many important issues discussed. There are, to this day, 14 branches in this Province. A good number of scientific papers were read and discussed in these meetings and many important resolutions covering the entire field of progress of our brotherhood have been introduced and adopted. I have, however some cause for complaint in this connection. I had to note with regret that many of the branches failed to respond promptly or fully to my letters and circulars seeking for the various statistics and details of their working. This failure on the part of some of the branch associations, as also the unfortunate but unavoidable necessity for me to have to assume office comparatively late in the course of the year, offered me many difficulties in compiling this report. While I offer my sincere apologies for all my personal inabilities and short comings, I would like to urge all the branch associations to give me prompt and ready co-operation in all matters in future.

160 new members have been added to our strength since we met last but side by side with it names of 192 members had to be struck off for various reasons. This, as I have referred to at the outset, is extremely unfortunate and regrettable and should set every one of us seriously, a-thinking. Such retardation must be checked at all costs. Previously there used to be complaints regarding the regularity and conducting of the journal and withdrawal of many of the members was popularly ascribed to this; but after the recent transfer of the office of the journal from Calcutta to Madras under a very able and learned

Board of Editors, most of whom are specialists in their respective sections, this plea can no longer hold good. A glance at the list of Editors will convince any one of us about the maintenance of strict regularity and high standard of the journal in future.

I am quite fully conscious of the fact, gentlemen, that I do not place before you a long list of substantial attainments in various spheres of our activities over which we can rejoice; but I hope you will understand me when I say that this has been so because of circumstances beyond our control. For, who is not aware that our destiny is ordained by those who have scant sympathy, if any, for us and for every privilege, big or small, that we want to realise for ourselves, we have but one means—begging and appealing which are oftener than not turned down with contempt? The story is still fresh in our mind of the enormous magnitude of work, struggles and appeals extended over a period of many years which our Association had to pass through in obtaining such small concessions as the alteration of the disgraceful epithets of *Native Doctors, Hospital Assistants Hospital Mates, Indian Doctors, Doctor Babus* etc., to more acceptable courtesy titles of doctors, *Sub-Assistant Surgeon, Resident medical officer* " or *Assistant medical officer* " and yet these involved no expenditure or sacrifice on the part of the sanctioning authorities. With such experience in a matter in which financial question does not arise you will realise, gentlemen, what tremendous lot of work, suffering and despair remain ahead of us and what vast amount of strength, determination and popular support we must have to acquire if we are to realise our bigger objectives. Our activities have so far remained confined within the narrow sphere of scientific discussions and adoption of resolutions—things within our reach; but it is high time that we formulate a very sweeping programme and that very early too and try to work it out to the last word of it. Born nearly a century ago, we have remained where we had been as regards status and recognition; to quote the eminent doctor B. C. Roy's words. "*The caterpillars of the profession still waiting to see the light of the day—despised by more fortunate brothers of our profession, neglected by our superiors and unrecognised by the public for whom we live and die. How long more we should remain like this! I would wish that either we receive our due place in the entire human race or the whole structure of our body be pulled down and*

*demolished, leaving not a soul amongst us to groan eternally under pressure."*

Gentlemen, *The Indian Medical Council Bill* has made us the untouchables of the profession, more distinctly so than we used to be treated before in the various registers of provincial Councils. We have been given a special brand and in service we still remain to be "Subs" and "Assistants" in every respect imaginable—whatever be the length and record of meritorious service. You know, gentlemen, that the 20th September last has been observed as All-India Anti-Indian Medical Council Day throughout India to protest against the All-India Medical Council Act of 1933. To fight against the shameful treatment meted out to us, we have to demand and capture our due and proportionate seats in the various legislative and administrative bodies and for this purpose we have by all means to win the support and sympathy of all people high and low of the land and I am quite confident that if we can duly represent our cause and prove our fitness they will not fail to give us a quick response.

I cannot conclude this report without stressing on the urgent need for the reform of the present medical education. The existing curriculum of the medical schools is definitely congested and has to be run through within a period which is far too short. The course does not allow any facility for specialising in any subject, it does not provide for the all important Post-graduate training which is very reasonably given due prominence in the curriculum of the foreign medical schools. We should have to press for a thorough overhauling of the system of medical education of this province and urge the Government to lengthen the course of studies from 4 to 5 years in the Berry White Medical School, an innovation which has already been inaugurated in some of the medical schools of India. A four years' medical studies with one subsequent year for Post-graduate studies for gaining the necessary experience and aptitude for the efficient handling of human life and sanitation would have far-reaching results. The public will find in us efficient and experienced healers, the moment we emerge from the academic course and would readily and unhesitatingly throw themselves to our care and attention. I do not say that an increase in the course of training by a year would directly raise us in the estimation of the public, nor that the authorities concerned will immediately lift that time-honoured practice of indifference and apathy, but what I wish to stress is that an increased proficiency will afford us immensely greater chances

of being recognised and appreciated by the public at large for whom we are and who in turn should be for us. Any frequent change in the teaching staff adds immeasurably to the inconvenience of the scholars and hampers their progress. So every care should be taken in selecting suitable staff.

Coming now to the condition of this Association, I regret to note that it is far from satisfactory. Unless means are devised soon for the financial stability of the Association, no substantial work can be expected to be done in the province. I, therefore, earnestly request that all the branches will co-operate and pay off their subscription regularly.

Gentlemen, I do not like to tax your patience any more, as many other important issues have to be discussed by the Chairman, Reception Committee. I have detained you long for which I crave your indulgence and putting the report before you, I resume my seat.

Mr. Nabin Chandra Bardoloi, M.L.A., the president-elect rose amidst cheers and delivered the following address:

LADIES AND GENTLEMEN,

Not knowing anything concerning medicine or the medical profession I am quite unfit to preside over this meeting mainly composed of scientific men. The heartiness of the invitation of my young friends obliged me to accept this proud position although with a great deal of misgivings. I do not know that I shall be able to guide your deliberations with all these limitations fastened upon me. Any way let me thank you with all sincerity for conferring upon me this unique distinction. Unworthy though I am I shall try my utmost with your kind help and co-operation to bring this sitting to a successful termination.

Medical system took its origin in India when the world was in its infancy. The great Rishis and the sages of old established a system of medical science apparently not with the help of the present day highly developed scientific apparatus but with the help of their great esoteric power or yoga. Makardh-waja which even the most highly scientific savants have not been able to produce as efficiently as it is done by the crude methods prescribed by the sages of old is now acknowledged by the most scientific medical men to be wonderful and most efficient medicine. In my own humble and superstitious way I ascribe it to the great wisdom derived by the yogis by the yoga system. I once read in Bhaba Prakash and Bhaisajya Ratnavali as to how to make a medicine by the name of *Troilokya Chintamani*.

The different operations described therein extend over months. I have seen the efficacy of this medicine in one case. Was it all foolishness on the part of the Rishis? No, it is an evidence of great wisdom generated by ages of *tapashya*, generation after generation.

Medical science is a progressive science. The system of yoga and the organisation was forgotten and it gave place to empiric quack treatment. At this stage the western system of medical treatment was introduced in India. The Hindus could not get over the prejudice of dissecting human bodies and for a long time that stood in the way of taking to this system of medicine. Yet even to-day, in spite of the introduction of English system of medicine all over India and the production of hundreds of doctors annually, the Ayurvedic and Unani systems still cater for the medical needs of the greater portion of India's population.

The first Hindu to operate upon a dead body was Goodeve Chakrabartty who joined the medical college at Calcutta. This occasion was marked by a salute of several guns fired from Fort William at Calcutta. Today we are having any number of doctors of all grades all over India and with the present day standard of living, barring those who are employed in service whether Government or private and those who are doing well as private practitioners, the rest are virtually unemployed and that is one of the reasons why medical men formed into associations all over India according to their grades with a view to ventilate their grievances and to better their prospects. I do not find doctors of any grade satisfied with their lots. In Government service, specially, the heart burning is chronic due to various causes. The most principal of the causes is that the members of the Indian Medical Service who are always placed at the top of the Medical department in every District boss over able and well versed Indian medical men although for all practical purposes the I.M.S. may be a man of inferior abilities; the difference in emoluments and power, the arrogance of treatment naturally cause dissatisfaction in the minds of the subordinates. On the top of it, the actions taken by the general medical Council of Great Britain in a high handed manner accentuated this discontent.

Since the last 29 years, the All-India Medical Licentiate's Association has been struggling to raise the course of study from 4 to 5 years and thereby improve the course of training. They insist that the minimum registrable standard should be prescribed and the curriculum of studies in medical schools should be standardised and systematised all

throughout India. Before dealing with the subject at length, let me give you an idea of the General Medical Council of Great Britain. It was established in order that persons requiring Medical aid should be entitled to distinguish *qualified* from *unqualified* practitioners. The system of keeping a Medical Register was introduced and the effect was striking. Its function was to see that the name of no person is entered therein as qualified unless he has had an adequate professional education and to remove therefrom the names of qualified persons who are no longer entitled to public confidence. Degree, therefore, was not so much of importance as the appearance of a name in the Register.

British Medical Act was invested with the authority of refusing to grant recognition to Medical degrees in India since 1886, if the standard of education does not entitle the holder to prosecute post-graduate studies in Great-Britain. It is now past history how the General Medical Council of Britain in trying to restrict the Indians from going to compete for the I.M.S., began to exercise stricter control: how the universities of Madras and Bombay were inspected and the Calcutta university refused to be so inspected, with the result that the degrees of Bombay and Madras were recognised whereas those of Calcutta University were not; and how subsequently recognition was restored temporarily on promise of good behaviour. To crown all the insults and indignities, the General Medical Council proposed that a permanent Commissioner for Medical examination should be appointed and who should function till such time as an All-India Medical Council was created. The Legislative Assembly however turned this proposal down and punitive action was taken by General Medical Council of Great Britain by withdrawing recognition from all the Indian Universities. This caused great resentment all throughout India and the scheme of evolving an All-India Medical Council began to take shape. The first scheme was brought forward by the Government in 1919. But in 1922 the matter was shelved on financial grounds. In 1926 a private bill was introduced in the Council of State and the discussions therein made the Government aware of the eminent need of setting up in India a Central organisation which will make India autonomous in the recognition of her own standard of medical qualifications and the determination of the terms on which qualification acquired abroad should be recognised in India. Two conditions in that bill were arbitrarily rejected by the Government. The first

was the representation and the registration of the Licentiates of India and the second was the exclusion of the practitioners registered under the Medical Act of the provinces who have been on the teaching staff of an institution in independent schools or methods of medicine. Accordingly, Government prepared another bill, but the heads of Medical Department from provinces and Ministers turned down the entire proposal for the formation of an All-India Medical Council. After many vicissitudes, the Government of India again took up the question of creating an All-India Medical Council in 1930, and called an official conference at Simla in June 1930, composed mostly of Government servants. A draft bill was made in 1931. The preamble of this bill stated as follows: "Whereas it is expedient to establish a Medical Council in India and to provide for the maintenance of a Register of qualified practitioners of modern scientific medicine in order to establish a uniform minimum standard of qualification in medicine for all provinces so that persons attaining thereto shall be acceptable as medical practitioners throughout British India." The question is who are the *qualified practitioners*? Those men whose names are in the Provincial Register and who are dealing with the lives of thousands of sick persons daily and giving them relief when big doctors are catering only to the needs of the rich, I say, the main question is whether these persons are qualified practitioners or not. If they are not, why is the Government inflicting their services on the bulk of the Indian population and why are they turned out with diplomas entitling them to practice medicine knowing fully well that they are not qualified? On the other hand if they are qualified why are they excluded from the All-India Register? The mischief of the whole thing is that, before the All-India Medical Council came into existence, those medical practitioners who were registered in the Provincial Register were accepted as medical practitioners in India, as reciprocity exists between the various provincial councils. Can anything be more illogical than that of confining these men to Provinces only?

Referring to the entire exclusion of the Licentiates, renowned medical men state that it is a great mistake to divide the profession into entirely water-tight compartments by excluding this class of practitioners altogether from the purview of the Indian Medical Council. If necessary, the standard of medical examination in medical schools throughout India should be raised and the period of instruc-

tion should be 5 years after matriculation. It is said that the medical Graduates in the country are fewer in number in comparison with the vast member of Licentiates and so, if both classes of doctors are enrolled in the same register, there will be no chance for the former to get into the All-India Medical Council. Eminent doctors including Col. Gidney, Dr. Jivraj Mehta and others regret that watertight compartments in this profession are introduced by the short-sighted policy of the Government. Both the Graduates and the Licentiates belong to the same profession and both of them should feel that they belong to the same noble profession working shoulder to shoulder for the amelioration of the pains and diseases of the suffering humanity. Eminent physicians and surgeons who have made All-India reputation belonging to this class are denied representation in the All-India Council. Dr. Jivraj Mehta suggests that the better method would be to maintain one electoral roll for all the medical graduates in the country and also a similar one for the Licentiates. The advantage will be that the representatives of the Licentiates will also find a few seats in the All-India Medical Council wherein they shall be able to sympathetically deal with the subject of the improvement of the status and qualifications of Licentiates all throughout India. Another advantage would be that the representatives of the profession would not think provincially, so that the chance of a clash between the interests of the different provinces would be reduced to minimum.

The next point to be considered is the status of the Licentiates. Not only have they been excluded from the All-India Medical Council, thus confining them to the Provincial Council and Provincial status alone, they have been also strictly put down to the Subordinate positions with which they begin their career. An Assistant Surgeon may someday aspire to be a Civil Surgeon but a Sub-Assistant Surgeon has no chance of being an Assistant Surgeon within measurable time. Col. Sir Henry Gidney M.L.A. has been crying hoarse over this affair. He deprecates compartmentalism and deplors the policy pursued in India, that once a man is subordinate he is always a subordinate.

Gentlemen, the history of the British people shows that this race with all their willingness to be fair are very hide-bound in their ideas. They feel their superiority in every walk of life. They have the British Licentiates registered in Britain and so automatically registered in India. But when it comes to the case of the Indian Licentiates it is very

difficult to drive home this idea into their very hard heads. So, ideas are to be hammered on and on and someday the great *Kumbhakarna* will wake up!

As regards your pay and prospects in Government services and in other services, your Chairman of the Reception Committee has enumerated your grievances fully and I need not dilate on them now. *My only object in delivering this speech is to bring home to those who care to peruse this speech the great injustice done to the Licentiates without whom the medical profession would not be worth mentioning and quack treatment and empiricism will again create havoc in the country. These doctors, who work the hardest in the most difficult places should not be treated in this manner. In Cholera and Kalazar duties, it is they who toil ceaselessly and fearlessly amidst dirt and infection whereas the members of the superior services only supervise their work and roll on arm chairs in rest houses and Dak bungalows. Should not these self sacrificing and hard working men get their dues? Should they be ignored eternally?* In the All-India Medical Conference held at Delhi in December 1934 Col. Bholanath, the President-elect, stated in his forceful address as follows:—

"The tyranny of the Czars is coming to an end at Simla as it has disappeared elsewhere. The time is not far off, when Sir Rice Edward's underdog will be coming to his own, and it will not be long when they will lick the hands of the underdog."

"The other man whom the Czars are trying to divide from you is the Licentiates. Don't desert the poor man; he has done the pioneer work of the profession. There are over 25,000 of them all over India who are doing most useful work in urban and rural towns. The uniformity of education and qualification is only a device to create division in your ranks. The Licentiate is a part of you."

He further stated regarding struggling private practitioners as follows:

"You should demand that the undue and the unfair competition which is going on at present between the struggling private practitioners and the salaried state medical men should cease by confining the latter to his consulting practice only."

"This, gentlemen, is writing on the wall and this is my vision of the future progress of the medical profession in India."

Gentlemen, old order is changing giving place to the new. The orthodoxy and conservatism of British Government notwithstanding, affairs must march on progressively. The unsatisfactory arrangements everywhere must give place to orderly progress. Time is not far off when your own people will actually take control of affairs in spite of the present impediments doggedly and senselessly imposed. Do not relax your efforts and do not

cease to try to improve your qualifications and attainments—God will crown you with success, in spite of men's short-sighted actions.

Thanking you all once again for giving me this opportunity of presiding over this assembly of learned and wise men, I am resuming my seat. May God make your deliberations fruitful! May you all prove to be worthy sons of our beautiful Motherland! Bandematram.

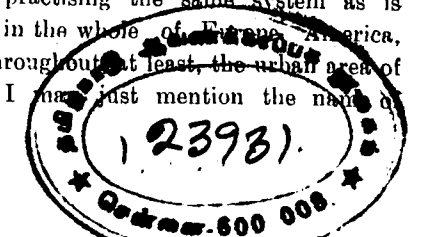
The Second United Provinces Medical Conference was held at Cawnpore. Dr. S. N. Sen, the Chairman of the Reception Committee, while welcoming the delegates and the President-elect, Major Ranjit Singh, stressed on the need for a greater number of private hospitals and nursing homes, and that medical associations all over the country should bestow their attention on this urgent problem of medical relief through institutions of their own. He thanked the Meerut Branch for its valiant fight against the recent amendments to the U. P. Poisons' Act and urged the imperative need for stopping quackery by suggesting practical schemes for the benefit of the public. He recommended strongly Dr. Naidu's plan of medical relief adumbrated by him in his Presidential Address at the Lucknow Conference of the Indian Medical Association. Continuing he said: *all this work can be done only when we are united as an organized body, but our selfishness and want of discipline stand in the way of its attainment.*

Major Ranjit Singh then rose to deliver his presidential address who said in the course:

"No body present here is more conscious of the enormous responsibility that rests on the president of such a body, specially in these days when our profession is in the great danger of being encroached upon not only by an army of quacks but by various other systems most of which I am not prepared to criticize adversely. And according to the old maxim of preserving our own order first, I must take the cudgels of the modern system of the medical profession as it is practised to-day. I have purposely avoided to call it western as we find that the greater part of the civilized world is practising the system to which we have given our allegiance. It is well-known to most of you that not only in the West that great researches have been made but there are brethren in the Far East also who are carrying on the campaign of research and practising the same system as is practised to-day in the whole of Europe, America, Australia and throughout at least, the urban area of British India. I may just mention the name of

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Prof. Kitasato of Japan who is the first discoverer of plague bacillus and Ehrlich and Hata, the German and Japanese workers respectively, who were the inventors of Salvarsan, our great sheet anchor against Syphilis, and who, I am sure, are well-known to you. Going centuries back, we all know that the principle of vaccination from cow-pox was really started from and was known to India long before the West claimed its discovery.

Coming to organo-therapy, which is acknowledged as the Scientific branch of our treatment, and which has its basis on Koch's postulates as against the rest, which is after all more or less empirical, we Indians can point out with great pride, indeed, that our ancestors knew and used it extensively. Having been fortunately a student of the Unani system of medicine and having studied the original text-books in Arabic, I know it personally that organo-therapy was also extensively practised and is practised even to-day by the Unani Physicians although in a more or less modified and crude form as compared with the modern system. The task before us is not to sit and to harp the tune of our ancestry but to take a practical view of things confronting us as they affect our profession.

#### Medical Education

The big question that I would like to place before you is the great question of medical education in the province. We have at present two main teaching institutions. (1) The King George's Medical College at Lucknow and (2) The Medical School at Agra, the former turning out M.B.B.S. and the latter L.M.F.S. I had been a member of the State Board of Medical Examinations from its inception until the time it merged into the State Medical Faculty, to which I had not the honour to be elected—not because I did not carry the confidence of the independent medical profession but because the Government ruled that even the representative of the private medical profession had to fall back on the votes of men of the Provincial Medical Service. I know the great heart burning that exists amongst our brethren of the Agra Medical School about the invidious distinction that exists in their after-lives, the most glaring one of which is their not being recognized eligible for registration by the British Medical Council, and to crown all these, your brethren have been altogether ignored by the new Indian Medical Council, which fact is well known to us all and for which I have all sympathy with those brethren. In

my humble opinion the time has long arrived when there should have been one minimum qualification for registration by the British Medical Council as well as the Indian Medical Council. We are all aware of the difference which exists between the Graduates of the universities of England and a Licentiate or diploma-holder of the Joint Board of the Royal College of Physicians and Surgeons, yet it is a well-known fact that both are entitled to compete for the highest service under the State whereas in our country our Licentiate brethren are deprived of such privileges. Having deep convictions in the efficiency of our system and realizing the general inability of the State to provide sufficient medical aid to the teeming millions of the land, I deplore any delay that is being allowed in raising the standard of the Medical School of Agra which has been recommended strongly for many long years and brought to the notice of the Government through the efforts of the All-India Licentiates' Association, and personally I would strongly advise you to give the subject your serious and mature consideration and send a strong resolution supporting the idea. Perhaps I may explain this point a little further. The origin of the Agra Medical School dates back to the time when medical assistance was sorely needed chiefly for the military and the Government. It was at that time that medical School was started on a small basis and we are satisfied that the students received sufficient training to work as sub-assistant surgeons and to help the medical officers attached to the army. Much water has flown down the Ganges since then and it is high time that the State should realize its responsibility towards supplying proper and qualified medical aid to the masses who suffer owing to the want of sufficient number of men trained in the system of allopathy as well as a sufficient number of Hakims and Vaidas turned out by recognised and modernized institutions. The other medical institution which is catering for the supply of medical aid is the King George's Medical College where the admission has become as difficult as one that exists in entering the Provincial or even the Indian Civil Service. I was horrified to find that a very deserving student was kept back from being admitted, because having suffered from fever lately he was unable to compete in a race. Ladies and gentlemen, I admit that we should see that a person entering the medical line is possessed of a good and strong physique, but I fail to see why he should be kept back if he has failed to compete in a race, which qualification I thought was more suited for the military or the policeman.

#### Medical Administration

The other great question about which I have to make a few observations is the question of medical administration. This again dates back to the time of the East India Company when they had to import their doctors along with their armies and after their getting hold of the territory they had to expand a system of medical administration for their service also. The Indian Medical Service (to which I had also the honour to belong during the Greater War, although I am proud to say I did the service in an honorary capacity) used to be specially pleaded for owing to the needs of the State during the time of War. The late War has, however, proved it beyond all doubt that with all their claims they were unable to cope with the need of the military and they had not only to fall back on the Civil Medical Service, but they had also to throw open the doors of the I.M.S. by giving temporary commissions to our graduates, many of whom, I am proud to say, were fortunate enough to be decorated with Military Crosses and D.S.O.'s, and were mentioned in despatches. The intelligent opinion of the country has already expressed that there are no sane grounds for maintaining this old order of things and continuing the I.M.S. as a military service as well as for civil administration. I do not want to be misunderstood and I am personally aware of the great and solid work done by the I.M.S. officers who were mostly responsible for imparting education in our colleges so far; but even from this point of view is it not rather ironical to think that after a lapse of more than a hundred years they have failed to produce men who may be looked upon as being equivalent to the medical officers imported from foreign land. Here again, gentlemen, I say with a great deal of pain that it is again a question of vested interests and there is nothing but pure *Zid* on the part of the administration to continue the I.M.S. in its present shape and then, to make the matters worse, by reserving big stations for European Members of the Service on the main plea of the officers' claim to be treated by medical officers of their own nationality. I would only point out the fact of there being several hundreds of Indian medical practitioners who have a large and lucrative practice in London and in other towns of the United Kingdom to-day, a few of them having even entered the ranks of specialists in Harley Street and there are also some amongst us who have been preferred by high European Officers such as Chief Justice, Commissioner of a division and Governor of a province who have freely availed themselves of the consultation and treatment by pure Indian medical officers on many occasions in prefer-

ence to medical officers of their own nationality. It is all very well to talk of a British Commonwealth but when the questions comes to rupees, annas and pies it is a question of heads I win, tails you loose.

Even from a point of efficiency of medical administration, I am of opinion that the Civil Medical Service should be made entirely independent of the military element. I have already said that during the last war, the State had to fall back on the civil side of the medical profession. I, therefore, suggest that we can meet with the plea of the State during the time of war by making military service obligatory to all the civil medical officers who may be, by turns, trained in the military hospitals, and thus be available to the military side during the time of an emergency. I would, therefore, suggest that appointments to the civil side of the medical administration should be thrown open to all qualified medical practitioners for whom there should be one minimum qualification for the whole province and the posts be awarded by competitive examination which will give the best material available. This will mean that there will only be left one class of medical officers viz., the provincial medical service and it may be said that this will rather be impractical to have one class of men for the different charges such as subdivision and divisional head-quarters. This difficulty, however, can easily be met with by grading the pay according to the seniority and an efficiency bar. This much for the existing medical service. I have another point which I would very much like to put before you and that is this. Why is it that now, when we are turning out between 30 to 40 qualified medical graduates every year, we cannot run our public hospitals on the same lines on which they are not only run in the United Kingdom, but also practically in the rest of the civilized world. In the years gone by when I happened to be a member of the local Legislature, I had nearly moved a resolution attacking the present system of medical administration and suggested a system of running our hospitals by honorary medical officers, but before I had done so I was unfortunately misunderstood by my brethren in the service. It was far from my mind to attack the vested interests and if the system that I am advocating is ever allowed to see the light of day it goes without saying that vested interests will always be protected. At this point I would like to appeal to my brethren in service to look at the question from the point of view of the good old saying and precept, '*institutions before men and not men before institutions.*' Imagine the vast amount of saving that would be possible by avoiding the

large amount of money spent in salaries and last and not the least important of all, imagine the efficiency we would be adding to the work. Let me explain this further. In these days of specialization, draw the picture of a man and his plight who sits down with a register and has to cope with three to four hundred patients in an ordinary Government hospital daily. These patients consist of cataracts, refractive errors, polypi in the nose, adenoids, bad throats, typhoid fever, tuberculosis, pneumonia, malaria, accidents and various other kinds of surgical complaints. Compare this to a hospital where three to four qualified honorary medical officers are attached who, perhaps, may be given a small honorarium and conveyance allowance and who will divide the work and give individual attention to the patients. I do not think any other arguments are required to establish the point.

#### Unemployment

May I now take up the general question of unemployment that is facing us in general and our younger brethren who are facing the question in common with our countrymen in other walks of life? But we as medical practitioners have to take to account a number of facts which, in my humble opinion, are by no means helpful towards bettering the prospects. I have already mentioned that our medical colleges and schools are turning out not less than 50 to 60 medical practitioners every year, who during the time of their student career in the colleges, specially during the last decade or so, have raised their standard of ordinary comforts unfortunately unnecessarily high and like their colleagues of other departments of education, they become more or less alien to their village folks which is a great national loss. With all humbleness, I suggest that by doing so they are losing great chance of not only providing themselves with a modest and decent living but keeping back their kinsmen from the advantages of their scientific attainments. It is said that our village folks have to fall back on the more obsolete system of medicines, because they are cheap and because the practitioners of those systems are easily available to them, being members of the same society. Let our young practitioners give up the false notions of prestige and dress simply and go even with a limited armamentarium to the headquarters of a Tehsil and live there and I am sure they will soon establish themselves and earn a living easily than they can do in bigger towns even after a number of years. I appeal to my brethren to face the struggle for existence and not to waste time. I believe it is time when we should recognize our

indigenous systems and organize them. Let our brethren carry on their work and depend on the efficiency of their scientific methods which are sure to win in the long run and they will find that they have better chances of becoming popular. I now wish to make a few observations on the encroachment made upon the profession by a number of charitable and other voluntary medical institutions. **It has come to my notice that the public who were rich enough or earning enough to pay for a doctor look upon a charitable institution as a matter of right, forgetting that the public subscriptions and Government aid to run these institutions were never meant for them at the sacrifice of the indigent population for whom they were really intended.** Great respect that I have for such institutions such as Seva Samiti or the mission hospitals, I beg to point out to them that in these days of unemployment they should not allow themselves to overstep the rights of other professional workers in their zeal for philanthropy.

Before concluding, I would also point out to the absence of medical element in the local legislature and also in our local boards. **In matters of public health, our country has not even attained the 18th place in the world.** Is it not therefore absolutely necessary that our legislatures should be expected to give some representation to this important section? As President of the Allahabad Medical Association, I know how useful our representative of the local municipal board has been and I suggest to you to make a representation to the Government to allow different branches of medical associations representation on the local boards and also on the local Legislative Council. The latter may perhaps be a little late after the announcement of the changed constitution, but I appeal to the intelligent public to try and send at least a few representatives of the medical profession to the Legislature and as an example I may point out the case of my esteemed friend, Dr. Deshmukh of Bombay, who is doing such solid and good work in the Legislative Assembly.

A word about the Poisons' Act and I will conclude. The subject has been discussed threadbare in many district medical associations and I leave it to you to dispose it off by a special resolution. I consider it unfortunate that His Excellency the Governor did not allow our deputation to wait on him, which perhaps means that we have not become vociferous enough and let me, therefore, hope that before another year passes every district in the United Provinces will have a regular and recognized branch of our provincial association.

## Biography in Brief

### DR. U. RAMA RAO

Dr. Rama Rao's position in the medical politics of India is unique in that he is popular among both the medical Licentiates and the medical Graduates and is a peace-maker between these two groups of medical men whose objects and methods of work are often at variance. It was thus possible for him to get elected unanimously as the president of the All-India Medical Licentiates' Association once in the year 1916 and again in 1932 and also as a vice-president of the Indian Medical Association for a number of years. To day he has been elected to preside over the Nagpur Conference of the Indian Medical Association, certainly a significant event in the current history of the Indian Medical Profession. This is indeed a favourable omen which betokens that the day of disunity and division amongst ourselves is fast dying out and that better days are in store for us. This unity and combined endeavour mean that no more, nor any longer, could the Licentiates or the Graduates be used as a pawn to stave off the consolidation of the profession, so essential for our progress and high destiny. The government of India may usefully note the significance of this event.

Born on the 17th September 1874 at Udupi in South Kanara, of a humble but respectable parentage, he received his general education in the now famous Madras Christian College. He joined the Medical College in the year 1896. Even as a student he was noted for his intelligence and industry which won for him many medals and prizes. He was marked by his teachers as one full of promise for the future.

Thus 36 years ago, in the year 1899, soon after he qualified himself as the *hospital assistant* of the old order he chose to enter into private practice in preference to government service. He was probably the first medical man in Madras to have dared to venture *practice* amidst circumstances which might have easily baffled a lesser man and to have achieved a distinction which is the envy of the younger generation. Slowly and steadily, he built up a *busy practice* and his kindness, tact, gentle manners

and jovial disposition attracted the poor and the rich alike, though in Madras he was popularly called, *the poor man's doctor*. He was, and is even now, really the poor man's doctor; the absence of ostentation, the desire to serve the poor and his readiness to be at their call have endeared him to many a poor family in this city. Dr. C. B. Rama Rao, a famous physician of the Madras General Hospital, now retired, used to characterize him as a perpetual moving machine while Drs. Clarence Smith and Nair requisitioned his services to assist them in their surgical operations.

Private practice is no heroic affair now-a-days; but 35 or 40 years ago, our medical men put a high premium on Government service and believed (of course wrongly) that best talents found a suitable

field only in State service and that alone was the means to fame and greatness. If Rama Rao had yielded to this raging temptation of his day, he would, perhaps, now be an insignificant pensioner drawing Rs. 30/- per month and growing brinjals for sale to supplement this income in the obscurity of a village corner. He had made his choice rightly at the beginning and he has now become a famous physician of Madras. When the delegates of the Far Eastern Association of Tropical Medicine came on their southern tour, he had the unique distinction of presiding over the

dinner given to them by the medical men of this province. This was in acknowledgement of his position in the profession. That position he holds it even to day.

It was only just six months ago that he resigned his seat in the Madras Medical Council with a view to retire from active work. Since its very inauguration in the year 1914, he held an elected seat therein and this almost unopposed successful election at every term denotes the affection and esteem with which the medical Licentiates of this province hold him. He was also for a number of years, till he lately retired, the elected vice-president of the council which again shows the esteem and regard of the other groups of medical men, official and non-official, the I.M.S. and the Indian medical Graduate.



When the Government of India consulted this Council regarding the inclusion of the Licentiates within the purview of the All-India Medical Council, rumour has it that it was he who influenced its deliberations in their favour with the result that this council was one of the few of its kind opposing their exclusion.

Rama Rao's ambition did not stop with the satisfaction of a successful and roaring practice. His zeal to serve the profession and the public has led him to fields in which he had acquitted himself brilliantly and on account of which he had now gained ample recognition and appreciation.

He founded *The Antiseptic* in the year 1904 and the medical men of India are too familiar with it to need any detailed comment on its position as one of the leading medical journals in this country. His great friend, late Dr. T. M. Nair and himself were editing this Journal with conspicuous ability and success; after the demise of his colleague he has been fortunate enough to get the devoted help of his son, Dr. U. Krishna Rao who had richly inherited the brilliant intellect and the industry of his father. Both the father and the son serve the profession through the medium of *the Antiseptic* and let it be said to their credit that they had not allowed its pages to be used for sectarian claims or for helping the stronger against the weaker. They also conduct another popular monthly, *the Health*, with a view to educate the lay public in matters of hygiene and health: apart from its English edition, it is issued in all the chief vernaculars of this province.

Nor did Rama Rao fought shy of his civic and political duties. He served as a municipal commissioner for 6 years and in conjunction with his colleague, Dr. T. M. Nair, was able to effect many salutary civic reforms and through his *guide to rate-payers*, published monthly in English and Tamil and distributed free, he educated them and roused their civic conscience. He conducted health propaganda among them by means of lectures on temperance, first aid, and health problems through lantern slides prepared at considerable expense. When the great war of 1914 broke out, he organised ambulance classes, trained thousands of people and sent them to the front for service. He published a series of booklets on "First Aid in accidents" and their sale proceeds were handed over to the War Funds. In recognition of this service during the War, he was awarded the title of *Rao Sahab* and later a *Kaiser-I-Hind* medal. He was made the divisional superintendent of the St. John Ambulance Corps Overseas, Madras district, and was decorated

with a silver Donat badge of the order of St. John of Jerusalem, the highest distinction to a non-Christian in the gift of His Majesty the King Emperor.

The Montford reforms brought him to the Madras legislative council to which he was returned with an overwhelming majority from one of the city constituencies. Here he was instrumental in the inauguration of the Rural Medical Scheme, in improving the medical inspection of schools and in trying to effect reforms in the administration of the General Hospital and the Medical College. When his term expired he was again elected by his native constituency of South Canara.

At this stage of his political career, he fully identified himself with the politics of the Indian National Congress. That great political organisation nominated him for a seat in the Council of State as its candidate and was, of course, elected ultimately as such. Here, he and Dr. Lohakare tried to introduce a Bill for the establishment of an All-India Medical Council. But as every one knows it died before it was born and that the Government of India was responsible for this fœticide. We have to day in its place a Medical Council about which the less we say the better. He finally resigned his seat in the Council of State in 1930 at the mandate of the Congress.

His political career was marked throughout by constructive statesmanship and by splendid loyalty to the Congress. During the days of Civil Disobedience, he organised the Madras Congress hospital: he and his hospital were the only popular means of medical relief to the unfortunate victims to the lathi and the bullet. He is not a noisy politician but a silent builder.

The secrets of his success are his prodigious industry and penetrating intellect which he brings to bear not only in the performance of his duties as a medical man but also in the discharge of his other public duties referred to above. If he is convinced that a certain thing is to be done he overcomes all the obstacles and accomplishes it successfully. His polished politeness, his exquisite manners and his enthusiasm for the cause on hand are the secrets of his personality. Possessed of tact and sympathy, master of debate and fully conversant with its technique, sweet in disposition and without affectation, quick in understanding the needs of society and the needs of the profession to which he belongs and of which he is one of the best products he has become deservedly the leader of men. He richly deserves the exalted position of the presidency of the Indian Medical Association.

## Correspondence

### An appeal for a Fitting Memorial to late Dr. Sarju Pershad Tiwari

To

THE EDITOR,

THE INDIAN MEDICAL JOURNAL

Sir,

Allow me to make this appeal to the members and office bearers of the All-India Medical Licentiates' Association through your columns:

Today our Association is in mourning. One of its illustrious sons has taken eternal rest. Rai Bahadur Dr. Sarju Pershad,—its life and soul—is dead. No more will his wise counsel and cool judgment guide our deliberations! No more will his towering personality adorn our meetings and conferences!

He was in the forefront of the Association ever since its inception. His love for the Association was deep-seated in his heart. His devotion to duty was very great: on one occasion, not minding his broken health he proceeded to attend a meeting of the Association and en route, only a "Stroke" could take him back and force a rest on him. His selflessness and attachment to the Association for which he gave the best of a quarter century of his life was too evident to those who had the unique opportunity to see him at his residence at Indore during the last Conference. It was a tragic sight to see our dear Sarju Pershadjee propped up in bed, gasping for breath, but all the same, coolly suppressing his agony (due to the diseased heart and kidney), directing, instructing and guiding his lieutenants with an iron will to make the Conference a huge success that it was. Verily he died in harness; he laid his life serving his Mother Association.

Dear Colleagues! Rai Bahadur Dr. Sarju Pershad Tiwari is dead; but let him live for ever in our hearts; let us—one and all—try to emulate his noble services to our cause. In this connection, I can only place before you his stirring appeal, his pious wish, uttered as early as on the 6th of January 1910, full 25 years ago, as Chairman of the Reception Committee of the 4th Conference of our Association held at Indore. He said, "I hope in the years to come, the Association will wander all over India making its home in every city, in every town, and even in important villages, where a Hospital Assistant is present and a dispensary exists."

Brethren! What greater honour can we bestow on him than by carrying out his life's ambition for a cause for which he lived and died? What more befitting memorial could we erect on his grave than by fulfilling his heart's desires?

It is for those of us who remain in the fighting line to redouble our efforts and to enlist further strength and support for the Association. It will be a tribute to the memory of the departed that he himself would have chosen.

I would therefore propose to observe the month of December, as "*Rai Bahadur Dr. Sarju Pershad Memorial Month*." During this period, I would ask all our Provincial Secretaries to programme an intensive propaganda tour in their respective areas; I would request all the branches to hold a meeting, pass condolence resolutions and send them on to—Rai Bahadur's son, Mr. Ram Bharosa Tiwari, Tukoganj, Indore, C. I. and also to suggest a suitable memorial for placing before the next Conference. During the month they should approach each and every Licentiate in their jurisdiction with a view to enroll them as members of the Association. To each and every individual member of the Association, I have a special appeal to make. I would earnestly request them to solemnly resolve that they would induce at least one of their non-member friends to join the Association during this month. It is a very small request which is not at all difficult to comply with, and the combined results will be astounding. I am sure my appeal will not have been made in vain.

May Rai Bahadur's soul rest in peace.

Bombay  
31-10-35

U. B. NARAYAN RAO,  
General Secretary, A.I.M.L.A.

### The Silver Jubilee Fund in India

To

THE EDITOR,

THE INDIAN MEDICAL JOURNAL

Sir,

I have read with much interest your valuable suggestion in the *Notes and News Column* of your esteemed *Journal* of October 1935 issue, under the head "The Silver Jubilee Fund in India", that part of it may be given to help some of the languishing research department while the rest may be usefully spent in organising an extensive scheme of Rural Medical Relief throughout India. Rural Hospitals are needed more than the city General Hospitals.

I do fully endorse your most valuable suggestion, having much experience of Rural Medical Relief

organized by the Government. Inaugurated by the benign Government four years back, it is doing much useful work as is clear from the Government reports published from time to time.

The Rural Medical Relief Scheme is put into action on different lines in different provinces. In the Punjab about 325 Rural dispensaries are opened and maintained by a Government Grant-in-aid.

The Government have still much to do for the improvement of these dispensaries. But on account of financial stringency they had to cut short even the grant-in-aid. Thus these Rural dispensaries are to-day no better in equipment and accommodation than when they were started. These are working practically in half-starved condition as the supply of medical and surgical requisites is accommodated within the narrow budget that is practically the Government grant-in-aid.

The Local bodies who are entrusted with the control of these dispensaries are not contributing anything towards their maintenance on the plea of "Want of funds". Thus the usefulness of the rural Service is marred to a great extent simply for want of proper funds, though it is an admitted fact that a Rural dispensary is really a boon to the rural public.

A Rural dispensary does not only serve to administer to the needs of the sick but also it serves as a useful medium of educating the rural public on health matters.

Besides, the Rural Medical Officers in charge of these dispensaries have their own grievances. They are stationed in remote areas where even the most primary amenities of civilized life are not available. In spite of many handicaps they are directing all their honest efforts to achieve the useful purpose viz., ameliorating the sufferings of the sick. But they are given no encouragement in their work; rather they are discouraged. In some instances their annual increment is stopped; in others 10% cut on salaries is applied.

Thus the lack of funds stands in the way of effecting improvements to these much useful institutions and in giving the needed relief to the Medical Officers in charge of them by way of better pay and prospects.

If your editorial suggestion is given effect to, it will be in the best interests of the rural masses (the poorest of the lot); and it will relieve much of the sufferings of the rural doctors devoted to the service of the poor and illiterate masses. May it receive the best consideration of the Government for which it

shall win the everlasting gratitude of the people of this country.

S. L. RAWAL

Medical officer,

Rural Dispensary Agroha, Hissar

29-10-35

### Training in Pharmacy in India

To

THE EDITOR,

THE INDIAN MEDICAL JOURNAL

Sir,

I shall feel much obliged if you will kindly publish my humble letter in your most esteemed journal.

With great pleasure I read the speech recently delivered by Col. Chopra in the Rotary Club, Calcutta. 'Man' like him cannot but think of the deplorable condition of the entire Drug Trade and the profession of Pharmacy which vitally affect the health and the purse of the public. He is not only the Founder and Father of Pharmacy in India but also the Friend of the poor Compounders. My joy knows no bounds to see that the public also have sympathy with the improvement of the Drug Trade and the Pharmacy. India is the only civilized country in the world where the Drug Trade and the profession of Pharmacy are uncontrolled and uncared for and anybody and everybody can deal with it as he likes.

All-Bengal-Compounders' Association was changed into "Bengal Pharmaceutical Association" in 1934 under the presidency of Col. Chopra whose object is to build up the profession of Pharmacy on scientific and ethical basis, and to protect the public from the grave danger to which it is constantly exposed due to the scandalous way in which the Drug Trade is carried on in the country. In all other civilized countries in the world, the Drug Trade and the Profession are controlled by laws. But unfortunately in India, the Profession of Pharmacy is practically ignored and the Compounders who represent the Profession of pharmacy are in a horrible condition. No systematic training is given to them throughout the whole country and above all there is total absence of laws to control their qualifications. The training imparted to them is so very inadequate that they become wholly unequal to discharge their responsible duties. In other countries their professional brethren are thoroughly conversant with the science of Pharmacy and are only engaged for this particular work. But in India the Compounders are not only meant

for dispensing medicines but they also have to perform the duties of dressers, operation assistants, anaesthetists, nurses etc. The chaotic condition of the compounders who are unjustifiably designated as such instead of Pharmacists or Chemists and Drug-gists is fully discussed in the Report of the Drugs Enquiry Committee (1930-31) and calls for stringent measures to cope with it urgently. Bengal Pharmaceutical Association drew the attention of the authorities concerned towards the miserable plight of Compounders and the result was that the State Medical Faculty of Bengal had appointed a Sub-Committee to revise their Syllabus. Col. Chopra I.M.S. was its Chairman. The Committee finished their task and submitted their Report along with a thorough and comprehensive syllabus properly drawn up by them in the meeting of the Governing Body of the said Faculty held on the 17th February, 1934. It was approved of and unanimously passed in the said meeting. The Committee strongly recommended its early introduction. It is a matter of great surprise that though two years elapsed it is lying unapproved

by the Government of Bengal. We do not know the fate of it. I dare say if the new curriculum be introduced, the development of pharmaceutical industry will considerably be helped by the newly trained Compounders (Pharmacists). Without well trained personnel the serious situations created by the adulterated drugs cannot be improved.

Under these circumstances I beg leave to draw the special attention of the Government of Bengal for the introduction of the new syllabus, at any rate by the next session for the training of the Compounders (Pharmacists) as a preliminary action for the prevention of sale of spurious drugs and as an essential part of the legislation proposed. I also urge both the Provincial and Central Governments to give effect to the recommendations of the Drugs Enquiry Committee as early as possible which are so vital to the well-being of the country and its people.

KARUNA KUMAR ACHARJEE.

Member, Bengal Pharmaceutical  
Association Standing Committee.

## Reviews

Modern Treatment in General Practice, Volume II Edited by Ceil P. G. Wakeley, D., Sc., F.R.C.S., F.R.S.E., Fellow of King's college, London and Editor of "The Medical Press and Circular." Published by Messers Butterworth & Co. (India) Ltd., Post Box 251, Calcutta, Price Rs. 7/14/-.

"This Book is Born of Popular Demand" was the prefatory remarks by its Editor to the first volume and there is no doubt in our mind that both the volumes had amply justified the statement. They are popular because the articles appearing there-in are authoritative, accurate, reliable and up-to-date, being written by men who are masters on the subject with which they are dealing. The first volume presents 56 articles, mostly medical and the second volume under review presents 40 articles, mostly surgical and thus these two volumes cover a wide and valuable survey of the latest advances in medicine and surgery with particular reference to therapeutics and diagnosis—the two chief needs of a busy practitioner. And we do hope that these series will be continued so that the excellent service which its Editor renders to the general practitioner may be complete and exhaustive. There is yet another feature which makes these volumes remarkable and that is, they are readable

without boredom. We know what an amount of physical patience and intellectual concentration are necessary to read through an ordinary but compendious text-books of medicine or surgery and we doubt whether even a most laborious and painstaking student has ever read such a book completely. That is, of course, inevitable with text-books which aim more at the quantity and quality of facts than their literary presentation. The volume under review, just like its predecessor, presents the dry facts of science in an attractive, pleasant and variegated style; and as Dr. Johnson said of Goldsmith, the dry scientific facts have been converted into a *Persian Romance* by the charming literary grace and diction of its many contributors without any loss of accuracy or veracity. We have no doubt that the general practitioner will find in these volumes profit and pastime—a safe, sure and certain guide to his practice. It is fully illustrated, its get-up is excellent and let us hasten to assure him that Rs. 7/14/- is almost a cheap bargain for the pleasant and true material it offers.

The Medical Guide for India and Index of Treatment by E. J. O. Meara, O.B.E., Lt., Col., I.M.S. (Retd.), F.R.C.S. (Eng.), D.P.H. (Cantab.).

Fourth Edition, 1935—completely revised, enlarged and fully illustrated. Publishers, Messrs Butterworth & Co. (India) Ltd., Avenue House, Calcutta, Price Rs. 15/-.

This is the fourth edition of this well-known book and is for the first time illustrated. It was first published in 1920, reprinted twice within two years and has passed through three successful further editions since 1924. That speaks for its popularity as a valuable book of reference to all classes of practitioners in this country. Many of the sections have been entirely re-written to keep pace with modern advances in medical science and section XI which deals with Pharmacology has been completely recast in consonance with the new edition of the British Pharmacopoeia, 1932. The Author has also been able to enlist more specialist-collaborators than in the former editions. A book of this nature and for the purpose for which it is intended—both as a guide for practice and index to treatment—is not easy to compile. We can easily imagine the infinite labour, extra-ordinary patience, the enormous time and extensive experience necessary for the production of a book of this kind. We have no doubt that Col. O' Meara has exercised these qualities in a pre-eminent degree. The selection of his collaborators is happy as it is fitting. The result is that we are having a book which can be used with full confidence and benefit by all and sundry of the profession—be he a physician, surgeon, gynecologist or obstetrician. The book is really a guide in the best sense of the word and will lead the practitioner to gain more definite information on a particular thing he wants or to clear a doubt or uncertainty under which he is labouring. It deserves to be on the table of every doctor and it will serve him faithfully and truly in times of need. It is a closely printed and voluminous book of 1234 pages, neatly bound and presented by Messrs Butterworth & Co. at Rs. 15/- which is not too high a price for the service it is bound to render him when it is most needed.

**The Most Vitalising Of All Measures.**—is the name of a handy brochure issued to the profession, free of cost and obligation, by Messrs. Hanovia Ltd., Bath Road, Cippenham, Slough, (For India, Malgham Bros., Bombay), and deals briefly, yet effectively, about Actinotherapy and other physical resources in general practice. A hundred clinical references are given in this booklet and the practitioner who fights shy of these modern physical therapeutics, either out of ignorance or prejudice, will

find here-in an ample food for thought and deliberation. If he is to give the best relief to his patients, especially when they are suffering from chronic ailments like tuberculosis, endocrine dysfunction and skin lesions, he will have perforce to use physical therapy, at least as an useful adjunct to medication by drugs and specific biological preparations. A perusal of this brochure will put the practitioner on a new modern tract of therapeutics and reveal to him its untold possibilities.

**Diabetes, The Malady of our Time. A Manual, Etiology, Course and Treatment of "Diabetes Mellitus".** By Dr. Levy-Lenz and Dr. Heinz Schmeidler, sh. 4/6 (Rs. 3.)

Whilst the diagnosis of diabetes mellitus is hardly in the nature of a medical problem, its etiology, symptoms, therapy (especially dietetic) are still encumbered by many unsolved questions. Although the discovery of insulin has, to a large extent, robbed diabetes of its pernicious character, we are still confronted by the question whether injection treatment cannot be replaced—at any rate, in mild and moderate cases—by oral treatment; which would also do away with the noxa caused by injections.

The present book, written by two well-known authors, represents a compendium of diabetes mellitus for the general practitioner. With great thoroughness and due consideration of recent research everything of importance as regards diagnosis and therapy, is clearly set out in this work. It contains detailed and lucid information on diagnostic methods, such as the tests for sugar, acetone, diacetic acid in the urine; and the determination of the blood-sugar, the distinction of symptoms in diabetic coma and insulin-shock, and the difference of treatment are also described. Of special importance are the chapters dealing with the treatment of mild, moderate and severe cases, the question of diet in each being minutely discussed and a table of calories added. The maximum of attention will be aroused by the passages on oral treatment. The writers have come to the conclusion that no beneficial results can accrue from insulin given by mouth, but that this is otherwise in the case of *guanidin*, since the action of oral doses of this substance and its derivatives is very similar to that of insulin. The authors give it as their experience that combined oral remedies give the best results, as the *Pancreaslets*. Natural curative methods (exercise, sun-baths, abdominal bandages, autoserum) are fully described as are preventive measures.

## Notes on drugs and New Preparations

**Dextrosol (Glucose Powder).**—Manufactured by Corn Products Refining Co., New York, N. Y., U. S. A., Dextrosol is a white crystalline substance resembling sucrose or cane sugar, but only about three-fourths as sweet. It is readily soluble in water. Dextrosol requires no digestion and is the form into which all other carbo-hydrates must be converted before assimilation, and, being identical with the sugar of the blood and tissues, it is immediately available as a source of energy. It is the finest quality of medicinal glucose showing on analysis a purity of 99.9%. The exceptional purity and low moisture of Dextrosol permits of its use in the preparation of solutions for purposes of injection as well as for oral administration. It can be administered orally or rectally in those conditions involving a carbohydrate deficiency. This is an ideal carbohydrate for building up and maintaining sugar reserves in the treatment of:—

|                       |                      |                       |
|-----------------------|----------------------|-----------------------|
| Asthma                | Surgical shock       | Toxic Infections      |
| Acidosis              | General Malnutrition | Gastric Ulcer         |
| Cyclical vomiting     |                      | Infantile Eczema      |
| Vomiting in pregnancy | Sea-Sickness         | Acute Specific fevers |
| Nervousness           | Ketosis              |                       |
|                       | Hepatic Toxaemias    | Pneumonia.            |

A booklet entitled "Remedial uses of dextrosol (glucose powder)" which succinctly deals with the history and methods of administration is issued to the medical profession. It can be had free on application to Corn Products Co. (India) Ltd., P.O. Box 994, Bombay; P. O. Box 2191, Calcutta.

**Myeladol.**—A product of the Upjohn Laboratories containing Super D Cod Liver Oil with red bone marrow extract, iron and ammonium citrate and Malt.

Myeladol is a palatable, nutritive, reconstructive tonic which presents a logical well rounded formula supplying a high content of four vitamins (A, B, D, and G.) plus iron, copper and manganese. These are combined with a proven factor valuable in the treatment of anæmias of secondary origin. It constitutes a high grade tonic with a strong clinical and scientific background and as such has a broad field of usefulness. Complete literature and samples can be had from the sole agents T. M. Thakore and Company, 100, Nainiappa Naick Street, Madras (Head Office: 48, Churchgate St. Fort, Bombay.)

**Syrup Guakofom.**—is a palatable preparation by the Bharat Laboratory and Chemical Works and is one of the best cough syrups in the market; its value lies in its sustained antiseptic action and in its power of thinning the bronchial secretion and thus facilitating expectoration. Besides, it is also laxative and does therefore help digestion and appetite. As it contains no narcotics it can be given to children with perfect safety and good results.

**Santuben:** Lt. Col. F. E. Glinter, D.S.O., R.A.M.C. (Retd). Physician to Margaret Hospital for Consumptives writes:

I HAVE been a firm believer in the value of tuberculin, both in diagnosis and treatment for some years. My reasons for this have been dealt with in book form—"Tuberculin in Practice"—and I do not propose to discuss this matter here. Last November I published an analysis of 100 cases treated at Margaret Street Hospital, under the title "Is Tuberculin Worth While?" in THE MEDICAL PRESS AND CIRCULAR. I pointed out in the article that in cases of T. B.—ve, and in tubercular asthmatics the results were excellent, but that in T. B.+ve they were apt to be disappointing. I also pointed out that, other things being equal, the more sensitive the cases were to tuberculin the better the results, but the more careful you had to be; for tuberculin when administered by injection is a double-edged tool, and if given without due caution can do actual harm. For this reason I was delighted when Santuben came on the market, and determined to give it a trial.

And he had later on published his cases treated with Santuben ointment which contains a specially activated Tuberculin. This method of introducing Tuberculin into the body seems to possess more advantages and safety than its intradermal injection. To augment the effects of inunction, Santuben Tablets (guaicol-Silicium) may be administered at the same time. Thus, the treatment for pulmonary tuberculosis may be carried out by external and internal means and is popularly called "The Santuben Treatment".

**Glyceroidine.**—is a stable and standardised 5% Colloidal preparation of Iodine in Glycerine prepared and presented by the Indian Chemical and Pharmaceutical works, Meerut. As it is a viscid preparation, the hypodermic needle should not have a narrow calibre and a subcutaneous injection is the method of choice. It is practically painless and can be administered in all cases where Iodine medication is indicated. It has been found specially useful in plague.

## Medical Councils

Extracts from the proceedings of a meeting of the Medical Council of India held on 29th October, 1935, under the presidency of Major General C. A. Sprawson. 26 members were present.

After the names of new members had been read out by the Secretary, the Council considered the Reports of the Inspectors on certain Universities and decided to recommend to the Governor General in Council that Medical Qualifications of Bombay and Lucknow Universities should remain on Schedule I of the Act.

The Council resolved to direct its Secretary to send to the General medical Council of Great Britain now and in future, the name of Universities and their medical qualifications which after inspection had been found by the Council to be 'sufficient'.

Regulations and Bye-laws of the Council were then with a few amendments passed. The Secretary read out a Notification of the Governor General in Council nominating Major General Sir Frank Connor as officiating Director General, Indian Medical Service and President of the Council vice. Major General Sprawson who has resigned on account of his departure on leave.

The Council adjourned until next day.

30th October 1935

The Medical Council of India resumed its deliberations to-day at 10 a.m. under the presidency of Major General Sir Frank Connor.

With reference especially to States and Countries the medical qualifications of which are not already included in the Second Schedule of the Act, the Council decided to request the Executive Committee to consider the whole question of reciprocity with other countries and to put up proposals at the next meeting of the Council.

Certain amendments to the Recommendations on Professional Education of the Council were referred to the Executive Committee for careful consideration, the Committee being asked to examine at the same time the 'Report on the Medical Curriculum' recently issued by a Conference of the representatives of the Universities of Oxford, Cambridge and London and certain other bodies, and to bring their proposals before the Council as early as is practicable.

It was decided by a majority that the meeting of the Council should continue to be held in New Delhi or Simla and not in rotation at different Provincial or University centres.

Certain other minor items were dealt with and, February 17th, 1936, having been confirmed as the date of the next meeting, the present session was dissolved.

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The following is a summary of the proceedings of the meeting of the Bombay Medical Council held on 3rd September 1935, :—

The Council proceeded to consider the application of the Rangoon University for the acceptance of the L.M. & S. of that University for registration under the Bombay Medical Act, 1912, and decided that Government be asked to add the L.M. & S. of the Rangoon University to paragraph 1 of the Schedule to the Bombay Medical Act.

The council proceeded to consider the application from the Director, Medical and Sanitation Department, H. E. H. the Nizam's Dominions, for the acceptance of the M.B., B.S. degree and the L.M. & S. diploma of the Osmania University, Hyderabad, Deccan, for registration under the Bombay Medical Act, 1912, and resolved that the matter be referred back to the Executive Committee of the Council for further consideration in the light of the information since received from the Director, viz, that the medium of instruction at the Osmania Medical College, according to the regulations of the Osmania University, is Urdu.

The Council proceeded to consider certain papers received from Government relating to the question of recognition, for registration under the Bombay Medical Act, of the medical graduates of American "A" Class Universities on certain conditions, which had previously been under discussion, and it was decided that, in view of the recent establishment of the Medical Council of India and the functions entrusted to it, it should be suggested to Government that the question be referred to that Council.

The Council considered the reports on the First L.C.P.S. Examination received from the Visitors appointed by the Council to attend and be present at the Professional Examinations for the L. C. P. S. and it was decided that the reports be referred to the College of Physicians and Surgeons of Bombay for the necessary further action.

The Council proceeded to consider an appeal from Mr. U. H. Sadarangani, M.B., B.S., of Karachi, regarding a resolution of the Executive Committee of the Council, laying down that the size of his

signboards be reduced to the minimum and that, at the least, a 4 feet board be substituted for the existing 8 feet board, and it was decided to accept the resolution of the Committee.

The Council proceeded to consider the papers received from Government relating to the application of Mr. K. P. Deshpande for permission to be registered under section 7(3) of the Bombay Medical Act, 1912, and decided that, in the opinion of the Council, Mr. Deshpande may be given the permission applied for.

The Council proceeded to consider the question of the instructions to be issued to the Visitors appointed by the Council to attend and be present at Professional Examinations and it was decided that, as the last visits of the Visitors to the Professional Examinations for the L.C.P.S., Bombay, had only recently been completed, a further inspection of them this year is not necessary.

The Council resumed consideration of the application made by Mr. S. P. Lulla, M.B., B.S., for the restoration of his name to the Bombay Medical Register and resolved that his name be restored to the Register as a special case.

The Council proceeded to consider again the application of Mr. Motiram Tirithdas Ramchandani, M.B. B.S., for the restoration of his name to the Bombay Medical Register and resolved that some more time should elapse before Mr. Ramchandani's application is entertained.

The Council proceeded to consider the application of Mr. Narayan Krishna Panse, L.C.P.S., for the restoration of his name to the Bombay Medical Register and resolved that, in view of the short time that has elapsed since the removal of his name from the Register, his application for the restoration of his name to the Register should not be entertained yet.

The Council proceeded to consider the application of Mr. Ganpat Subrao Kasyapi, L. M. & S., for the restoration of his name to the Bombay Medical Register and resolved that, in view of the short time that has elapsed since the removal of his name from the Register, his application for the restoration of his name to the Register should not be entertained yet.

The Council considered a motion made by Mr. M. N. Talati, L.C.P.S., (1) that, in the absence of the benefits of a Provident Fund, the staff of the Bombay Medical Council be given a reasonable amount of bonus for the financial year 1934-35, and (2) that steps should be taken at a very early date to establish

a Provident Fund for the benefit of the staff of the Council with effect from 1st April 1935, and it was resolved that only the proposal to institute a provident Fund for the staff be accepted and that the necessary further steps to work out the details be taken.

The Council proceeded to consider a motion made by Mr. R. A. Amesur for the creation of a separate cadre of teachers for the three Government Medical Schools in the Presidency and for the proper equipment of the laboratories and museums provided for them and eventually it was decided to invite the attention of Government to the reports of the Visitors appointed last year to visit the examinations for the L.C.P.S. and to the necessity for the introduction of a special teaching cadre and better equipped laboratories and museums for certain Departments of the Medical Schools.

Extracts from the Minutes of the Bengal Council of Medical Registration held on the 18th February 1935.

1. The remarks offered by the authorities of the undermentioned medical schools on the Inspection Committee's observations recorded on inspection were referred to the Committee for consideration.

- (i) Ronaldshay Medical School, Burdwan.
- (ii) National Medical Institute, Calcutta.
- (iii) Bankura Sammilani Medical School, Bankura.

2. It was reported that nomination papers were issued to the members of the Council for the election of a representative of the Council on the Bengal Nursing Council and as a single candidate Dr. Bidhan Chandra Ray, M.D., M.R.C.P., F.R.C.S., was nominated for this election he was reported as elected. The action taken by the office was approved.

3. Government Resolution announcing the appointment on the Bengal Sanitary Board of Dr. Taraknath Majumdar, L.M.S., D.T.M., D.P.H., F.C.S., and Dr. Abdul Majed, M.B., D.T.M., D.P.H., representatives of the Bengal Council of medical Registration and the State Medical Faculty of Bengal, was recorded.

4. Report on the inspection of the Campbell Medical School was adopted.

5. Report on the inspection of the Jackson Medical School, Jalpaiguri, was considered and adopted and it was decided that the authorities of the school should be asked to stop admissions and that the question of its disaffiliation be considered by the

Council at their next meeting and that Government be informed of the decision taken.

6. Government letter authorising the entry of the title "Fellow of the State Medical Faculty" in the Register of Registered Practitioners as an additional qualification was recorded.

7. The consideration of the report on the revision of the Appendix to the Annual Medical List was postponed.

8. Government notification announcing the acceptance of the recommendation of the Council that the M.B., B.S. degree granted by the Andhra University be recognised as registrable under section 18 of the Bengal Medical Act, 1914, was recorded.

9. It was decided that the qualification D.B. (London), be entered as an additional qualification against the name of Dr. Ganapati Panja, M.B. in the Register of Registered Practitioners.

10. The consideration of the application of Dr. M. R. Tren, M.D., (Cologne University) for registration of his name under the Bengal Medical Act 1914, was postponed for the next meeting.

11. Government notification announcing the election of Dr. Bidhan Chandra Ray, M.D., M.R.C.P., F.R.C.S., under clause (c) of Section 4 of Bengal Medical Act, 1914, was recorded.

12. On an application from the Registrar, Andhra University, it was decided that a report be made to the local Government under section 18 of the Bengal Medical Act, 1914, recommending that the L.M.S. diploma granted by the University be recognised as registrable in Bengal.

13. On an application from the Registrar, University of Rangoon, it was decided that a report be made to the local Government under section 18 of the Bengal Medical Act, 1914, recommending that the L.M.S., diploma granted by the University be recognised as registrable in Bengal.

14. An application from the Principal, Ludhiana Medical School, praying for recognition of the school as an institution eligible to train and send up candidates for the Licentiate Examinations of the State Medical Faculty of Bengal up to the Intermediate standard was refused as there was already a Medical Faculty in the Punjab.

15. It was decided that the Dacca Medical School and the Lytton Medical School, Mymensingh, should be critically inspected during the next 6 months.

16. The consideration of the Returns submitted by the recognised medical schools was postponed for the next meeting.

17. With regard to the publication of the Annual Medical List it was decided that it should hence forth be corrected up to the date it goes to press.

18. With regard to an application from the authorities of the Medical Bulletin, Bombay, it was decided that copies of such proceedings and resolutions as are intended for the medical press may be supplied for publication in the Bulletin.

19. The undermentioned gentlemen were re-appointed members of the Penal and Ethical Cases Committee for the year 1935 :—

Lt. Col. T. C. Boyd, D.P.H., F.R.C.S., I.M.S.

Dr. J. N. Moitra, M.B.

Sir K. N. Das, Kt., C.I.E., M.D., F.C.O.G.

Dr. P. Chatterjee, M.B., F.R.C.S.

Dr. A. D. Mukherjee, L.M.F.

20. Considered two reports of the Penal and Ethical Cases Committee.

21. Dr. J. C. Chatterjee, L.M.S. was re-appointed as a member of the Managing Committee of the Provident Fund of the Office.

22. Dr. K. S. Ray, M.A., B.Sc., M.B.Ch.B., was appointed as a member of the Inspection Committee vice Dr. Mrigendralal Mitra, M.D., F.R.C.S., deceased.

23. With regard to an application from Mrs. Kusumkumari Majumdar, L.M.P., L.M., praying that her M.D. (Berne), qualification be entered against her name in the Register of Registered Practitioners as an additional qualification it was decided that particulars regarding this degree should be obtained from the University.

24. Entry under section 21 of the Bengal Medical Act, 1914, of the qualification D.T.H. and H. (England) against the name of Dr. Francis John Copeland, M.B.Ch.B., was approved.

25. The raising of the fee for registration of an additional qualification from Rs. 5/- to Rs. 25/- and the Price of the Annual Medical List from Rs. 3/- to Rs. 5/- per copy was agreed upon.

26. The following motion of Dr. Amulyadhan Mukherjee, L.M.F., was referred to the Inspection Committee :—

"This Council is definitely of opinion that in institutions recognised by this Council each subject excepting Medical Jurisprudence and Hygiene must be taught by separate teachers as is done in the Medical Institutions of Calcutta and Dacca".

**Resolutions proposed to be moved by Dr. Gian Chand Blaggana, in the Punjab Medical Council on the 9th Nov. 1935.**

1. That in the event of election to the Punjab Medical Council the ballot papers of voters known to reside outside India be sent by Airmail wherever possible.

2. That this council recommends to the Government of the Punjab to so amend the Punjab Medical Registration Act (2) of 1916, as to allow 3 members to be elected to the Punjab Medical Council by the registered Practitioners who hold a diploma from a local government declaring them to be qualified to perform the duties of a sub-Assistant Surgeon to rectify the meagre representation allowed them at present.

3. A. That this council recommends to the government to so amend the Indian Medical Degrees Act as to prohibit the use of title "Doctor" by persons not possessing any recognised registrable qualification entitling them to practise as Physicians, Surgeons, Ophthalmologists, Dentists and Veterinary surgeons, exempting, however, from the operations of this proviso persons entitled to call themselves Doctors on the strength of their scholastic attainments.

B. Also that persons not possessed of registrable medical qualifications be prohibited from prescribing and treating with Pharmacopoeial preparations.

## Notices

### IMPORTANT

All members of the ALL-INDIA MEDICAL LICENTIATES' ASSOCIATION are requested to remit their subscription for the year 1936 to Dr. A. N. Khosla, Hony. Treasurer, Shah Kot, Dist. Jullundur (Punjab) by the 1st of January, 1936. V.P.P. cards for Rs. 4-4-0 will be issued to those whose subscription will not be received by that date, which may please be honoured.

The Scientific Committee of The All-India Medical Licentiates' Association has decided to award two prizes of the value of Rs. 50/- and Rs. 25/- for two best papers in each of the following subjects :—

1. Incidence of Protozoal infections of the intestines and the methods of their eradication.
2. Blindness in India, its causes and how to prevent it.
3. Causes and treatment of chronic enlargement of Tonsils in children.

*The papers must be based on writer's own observations and only the members of the All-India Medical Licentiates' Association shall compete for these prizes.*

The papers must reach the Secretary at least ten days before the next Annual Conference.

In the award of these prizes, the decision of the Scientific Committee shall be final and the members of the Committee present at the Conference shall form a quorum for this purpose.

The Committee shall reserve the right to withhold any of the prizes, if in its opinion no paper merits distinction.

The competitors may, if they like, present themselves at the Conference (of course at their own expense) to reply to the criticism on their papers.

**For further particulars a reference may please be made to the Honorary Secretary, Dr. Chhabildas, Civil Hospital, Ludhiana, (Punjab).**

**The Society for The Promotion of Family Hygiene.**

The aim of the above society is, broadly, to help in increasing happiness in the martial and family relationships and ensuring a general improvement of the human race. The family is here the central agent. As the value of all advice on sexual life depends wholly on scientific research, this society will organise research on the subjects covered by the term, *Family Hygiene*, and institute scholarships and endowments to achieve the same. Propaganda, periodical conferences, supplying available advice to the members of the society will be some of its chief features. The membership is open to adults of both sexes: Ordinary members to pay Rs. 10/- a year, Fellows Rs. 15/- a year and Life members and Life fellows Rs. 100/- and Rs. 150/- respectively. It is also proposed to have in course of time Associates, chiefly students, paying Rs. 5/- only a year. Only the Fellows, Life Fellows and Life members can vote on matters relating to the constitution of the society, etc. All of them are, however, entitled to free copies of *Marriage Hygiene* published quarterly at Bombay, free advice by post, the use of the Library and attendance at lectures. **For rules and further particulars apply to its General Secretary, Kodak House, Hornby Road, Bombay.** The society is expected to function from about the end of November 1935. The following well-known persons have already agreed to serve on the All-India Committee: Sir V. Ramesam, (Madras), Col. Berkeley Hill (Ranchi), Dr. Ruth Young (Delhi), Dr. Radakamal Mukerji (Lucknow), Prof. Gyanchand (Patna), Lt. Col. Chatterjee (Calcutta) and Dr. Khanlokhar (Bombay).

## Service Notes

### LIST OF CHANGES AMONG SUB-ASSISTANT SURGEONS IN THE PUNJAB DURING THE MONTH OF SEPTEMBER, 1935

Dr. Shah Muhammad, on expiry of leave, relieving Dr. Ram Narain Wadhwa transferred to General Duty, Civil Hospital, Multan, to Sutlej Valley Project Dispensary, Shergarh, Multan District.

„ Dhan Singh, General Duty, Civil Hospital, Gujranwala, to Sohawa Dispensary, Jhelum District, Vice Dr. Amar Nath Marwaha whose services have been placed at the disposal of the Agent, N. W. Railway.

„ Murli Dhar, on expiry of leave relieving Dr. Saudagar Singh Gill transferred to General Duty, Civil Hospital, Multan to Canal Dispensary, Rashida, Multan District.

„ Ghulam Muhammad, General Duty, Banga Dispensary, Jullundur District, to Lohian Khas Dispensary, in the same district, vice Dr. Shankar Das granted one month's leave.

„ Gurbakhsh Rai, General Duty, Civil Hospital, Gurgaon, services placed at the disposal of Agent, N. W. Railway.

„ Gopal Das, General Duty, Civil Hospital, Lyallpur, granted two months leave.

„ Khushal Chand, General Duty, Civil Hospital Gujranwala, to Kila Didar Singh Dispensary, Gujranwala District, vice Dr. Sahib Singh transferred.

„ Sahib Singh, Kila Didar Singh Dispensary, Gujranwala District, to Mian Channu Dispensary, Multan District, vice Dr. Raja Ram promoted to the rank of Assistant Surgeon.

„ Sham Singh Bedi L.T.M. (Cal.), General Duty, Civil Hospital, Gurdaspur, to Canal Dispensary, Tarkhani, Lyallpur District.

„ Ram Lal, Sutlej Valley Project Canal Dispensary, Qutabpore, Multan District, to Jehania Canal Dispensary, Multan District, vice Dr. Udho Das granted leave and transferred.

2nd Class Senior Doctor Sadhu Singh, on expiry of leave vice Doctor Atma Ram Sharma transferred to the Police Hospital, Ambala, to Mahilpur Dispensary, Hoshiarpur District.

„ Lal Singh Randhawa, General Duty, Punjab, Dental Hospital Lahore, to Pindi Bhattian Dispensary, Gujranwala District, vice 1st Class Senior Doctor Arjan Singh proceeded on 4 months leave.

„ Saudagar Singh Gill, Canal Dispensary, Rashida, Multan District, to General Duty, Civil Hospital, Multan.

„ Ram Narain Wadhwa, Sutlej Valley Project Dispensary, Shergarh, Multan District, to General Duty, Civil Hospital, Multan.

Dr. Ram Narain Wadhwa, General Duty, Civil Hospital, Multan, to Kabirwala Dispensary, Multan District, vice 1st Class Senior Doctor Bura Ram proceeded on 4 months leave.

„ Diwan Chand Chopra, General Duty, Civil Hospital, Sialkote, to City Branch Dispensary Sialkote, vice Dr. Ram Lal Malik granted one month leave.

„ Asa Ram, General Duty, Civil Hospital, Rohtak, Services placed at the disposal of the Chief Medical Officer, Delhi Province.

„ Saudagar Singh Gill, General Duty, Civil Hospital, Multan, to Canal Dispensary, Kanya, Lyallpur District, vice Dr. Sundar Das granted one month and 15 days leave.

„ Bhagwan Singh, General Duty, Civil Hospital Dharamsala, to Hajipur Dispensary, Hoshiarpur District, Vice Dr. Chuhar Singh transferred.

„ Bishen Das, on return from leave vice Doctor Amar Singh Grewal transferred to General Duty, Civil Hospital, Ambala, to Canal Dispensary, Fazilka, Ferozepore District.

„ Gokal Chand, General Duty, Civil Hospital, Sargodha, Shahpur District, to Canal Dispensary, Kandiwala, Shahpur District, vice Dr. Sidh Das proceeded on one month's leave.

„ Bakhtawar Lal, on return from leave, to Police and Jail Hospitals, Gurgaon District, vice Dr. Kalyan Singh Makhania, D.T.M., transferred to General Duty, Civil Hospital, Gurgaon.

„ Uttam Chand, General Duty, Civil Hospital, Multan, to Narnaund Canal Dispensary, Hissar District, vice Dr. Rajindar Nath granted two months leave.

„ Nihal Chand, on return from leave, to Police and Sub-Jail Hospitals, Sargodha, Shahpur District, vice Dr. Nanak Chand Lakhanpal transferred to General Duty, Civil Hospital, Sargodha, Shahpur District.

„ Mul Chand, Juan Dispensary, Rohtak District, to Hassanpur Dispensary, Gurgaon District, vice Dr. Ram Nath Sood transferred to General Duty, Kaithal, Karnal District.

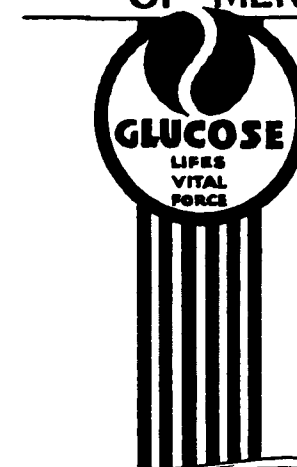
„ Atma Ram Sharma, Mahilpur Dispensary, Hoshiarpur District, to Police Hospital, Ambala District, vice Dr. Labhu Ram transferred to Balachaur Dispensary, Hoshiarpur District.

„ Sohawa Singh, General Duty, Civil Hospital Karnal, to Kotgarh Dispensary, Simla, vice Dr. Hukamat Rai granted two months leave.

„ Sher Singh, L.T.M. (Cal.), General Duty, Civil Hospital, Dharamsala, to Hydro Electric Dispensary, Jogindarnagar, Kangra District, vice Rai Sahib Doctor Hans Raj Bhambi proceeded on leave for 6 months and 25 days.

„ Ghulam Muhammad, General Duty, Civil Hospital, Amritsar, to Majitha Dispensary, Amritsar District, vice 1st Class Senior Doctor Behari Lal Khara proceeded on 21 days leave.

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.. Labhu Ram Puri, Police Hospital, Ambala, to Balachaur Dispensary, Hoshiarpur District, vice Dr. Harbhagwan Das transferred to the N. W. Railway.

.. Umrao Singh, on return from leave, to Juan Dispensary, Rohtak District.

.. Ram Gopal Bhatla, on return from leave, to General Duty, Civil Hospital, Jhelum.

.. Muhammad Zaka Ullah, General Duty, Civil Hospital, Amritsar, to Anaesthetist, Civil Hospital, Amritsar, vice Dr. Ali Hassan transferred.

.. Basheswar Nath, Dharmkot Dispensary, Ferozepore District proceeded on 7 days leave.

.. Tirath Ram, 1st Class, on return from leave, to Qilla Gujar Singh Dispensary, Lahore.

### LIST OF P.S.M.S. OFFICERS, U.P., TRANSFERRED AND GRANTED LEAVE DURING THE MONTHS OF APRIL, MAY AND JUNE 1935

Dr. Badri Prasad, from Leave, to Reserve Gorakhpur.

.. Badri Prasad, Reserve, Gorakhpur, to Barhaj Gorakhpur.

.. Ambika Prasad Sinha, Barhaj, Gorakhpur, to Reserve Gorakhpur.

.. Bhagwati Sahai, from Leave, to Police Bareilly.

.. Sundar Lal Varma, from Leave, to Reserve Allahabad.

.. Sojan Lal Kapoor, Sadr Muzaffarnagar, to Central Jail Bareilly, cancelled.

.. Mohd. Shafi Siddiqi, Central Jail Bareilly, to Pihani Hardoi.

.. V. W. Clifford, Sadr Sultanpur, to Reserve Lucknow.

.. Mukat Behari Lal, from Leave, to Reserve Bijnor.

.. Bishambher Nath Kapur, Reserve Jhansi, to Rath, Hamirpur.

.. Sidh Nath Sharma, Reserve Lucknow, to Sub-charge Fyzabad.

.. Raj Bahadur, Sub-charge Bareilly, to Ramnagar Naini Tal, cancelled temporarily till 1st week of June 1935.

.. Raghubir Saran Garga, Ramnagar, Nainital, to Sub-charge Bareilly, cancelled temporarily till 1st week of June 1935.

.. Ali Abdulla Jafri, Reserve Pilibhit, to Jail and Police Pilibhit.

.. Mor Mukat Vaish, Kosi, Muttra, to Nagina, Bijner.

.. Mohan Lal Chaube, J. and P. Jhansi, to Kosi, Muttra.

.. Rasik Behari Lal, from Leave, to Katra, Shahjahanpur.

Dr. Jamil Ahmad Khan, Katra, Shahjahanpur, to Reserve Bareilly.

.. Hari Sanker Mathur, from Leave, to J. and P. Bahraich.

.. Jai Krishna Lal Arora, J. and P. Bahraich to Reserve Lucknow.

.. Narain Dass, Reserve Etawah to Police Etawah.

.. Dewan Chand, Police Etawah, to Purwa, Unao.

.. A. N. Vyas, Purwa, Unao, to Reserve Lucknow.

.. Kanhaiya Lal Sharma, Reserve Budaun, to Misrikh, Sitapur.

.. Dewan Singh, Under suspension at Meerut, to Reserve Lucknow.

.. Pearey Lal Gupta, Mehndawal Basti, to Shohratgarh Basti.

.. Manni Lal, Shohratgarh Basti, to Mehndawal Basti.

.. Sunder Lal Saxena, Bisauli, Budaun, to Mental Hospital Bareilly.

.. Jagat Narain Varma, Mental Hospital Bareilly, to Bisauli, Budaun.

.. Kashi Prasad Khare, Moth, Jhansi, to Tuberculosis Jail Sultanpur, Postponed for 2 months, till 14-7-39.

.. Murli Manohar Narain Mathur, T. B. Jail Sultanpur, to Moth, Jhansi.

.. Sunder Lal Varma, Reserve Allahabad, to P. and Mental Hospital Benares.

.. Lal Mohan Nath, P. and Mental Hospital, Benares, to Police Hospital Lalitpur, Jhansi.

.. Jagdish Lal Jagota, P. Lalitpur, Jhansi, to Chirgaon, Jhansi.

.. Lalit Mohan Saran Varma, Chirgaon, Jhansi, to Reserve Jhansi.

.. V. W. Clifford, Reserve Lucknow to, I/c Sadr Hospital Fatehpur.

.. Durga Prasad, from Leave to J. and P. Banda.

.. Gur Saran Lal Kacker, J. and P. Banda, to Reserve Cawnpore.

.. Dewan Singh, Reserve Lucknow, to Central Jail Bareilly.

.. Jagdamba Prasad, J. P. Sitapur, to Ghaziabad, Meerut.

.. Abdul Rahim, Ghaziabad, Meerut to Jehangirabad, Bara Banki.

.. Basdeo Sahai, from Leave to Reserve Farrukhabad.

.. Shiv Dayal Agnihotri, from Leave, to Sujauli, Bahraich.

.. S. Zahid Ali, Sujauli, Bahraich, to Reserve Bahraich.

.. Jai Krishna Lal Arora, Reserve Lucknow, to Sub-charge Cawnpore.

.. Devi Sahai, from Leave, to Khalilabad Basti.

.. Shiam Lal Mathur, Khalilabad Basti, to Moongra Badshahpur, Jaunpur.

Dr. Ram Narain Saxena, Moongra Badshahpur, Jaunpur, to Pokhrayan, Cawnpore.  
 .. Khushal Singh, Pokhrayan, Cawnpore, Retires.  
 .. Sadhu Saran Pande, Reserve Gorakhpur, to Utraula, Gonda.  
 .. Abdur Rahman Khan, Utraula, Gonda, to Kakori, Lucknow.  
 .. Abul Hai, Kakori, Lucknow, to Reserve Lucknow.  
 .. Murli Manohar Agarwal, Saidpur, Ghazipur, to J. and P. Unao.  
 .. Prem Shanker Varma, J. and P. Unao, to Saidpur, Ghazipur.  
 .. A. N. Vyas, Reserve Lucknow, to J. and P. Jhansi.  
 .. Jamil Ahmad Khan, Reserve Bareilly, to J. and P. Shahjahanpur.  
 .. Murli Dhar Diwari, J. and P. Shahjahanpur, Dismissed.  
 .. S. Nisar Ahmad, Puranebahr, Bareilly, to Police Moradabad.  
 .. Butter Guwan, Police Moradabad, to Puran-shahr, Bareilly.  
 .. Mukat Beharilal, J. and P. Jhansi, to Reserve Allahabad.  
 .. Abdul Haque Qureshi, Reserve Agra, to Central Jail Agra.  
 .. Janki Prasad, C. Jail Agra, Under suspension.  
 .. Jai Narain Mathur, Gawan Budann, to Reserve Lucknow.  
 .. Sohan Lal Kapur, Reserve Muzaffarnagar, to Reserve Dehra Dun.  
 .. Jai Narain Mathur, Reserve Lucknow, to Karchana, Allahabad.  
 .. Ram Dass Bhatia, Asstt. Lecturer in Medical School, Agra, to Mahsi, Bahraich.  
 .. Govind Lal Dutt, Mahsi, Bahraich, to Asstt. Lecturer in Medicine, Agra Medical School.  
 .. Gur Saran Lal Kacker, Reserve Cawnpore, to Kitcha, Nainital.  
 .. Sri Nath Singh, Kitch, Nainital, to Fatehpur, Bara Banki.  
 .. S. C. Sen Gupta, Fatehpur, Bara Banki, to Reserve Lucknow.  
 .. Hari Shanker Saxena, Reserve Cawnpore, to Dadon, Aligarh.  
 .. S. Murad Ali, Dadon, Aligarh, to Reserve Aligarh.  
 .. Ambika Prasad Sinha, Reserve Gorakhpur, to Chakrata, Dehra Dun.  
 .. Shyam Lal Vidyarthi, Chakrata, Dehra Dun, to Kasia, Gorakhpur.  
 .. Mohd. Iqbal Rathor, Reserve Agra, to Ramnagar, Nainital.  
 .. Lalit Mohan Saran Varma, Reserve Jhansi, to J. and P. Ballia.  
 .. Mohd. Umar, J. and P. Ballia, to Dist. Jail Moradabad.

Dr. Dalsat Singh, from Leave, to J. and P. Pilibhit.  
 .. Ali Abdulla Jafri, J. and P. Pilibhit, to Hasan-ganj, Unao.  
 .. S. Ahimad Khan, Hasanganj Unao, to Reserve Lucknow.  
 .. S. C. Sen Gupta, Reserve Lucknow, to Sujauli, Bahraich.  
 .. S. Zahid Ali, Sujauli Bahraich, to Reserve, Lucknow.  
 .. Har Sahai, from Leave, to sub-charge Fyzabad.  
 .. Sidh Nath Sharma, sub-charge Fyzabad, to Reserve, Fyzabad.  
 .. Prem Kishore Varma, from Leave, to Rath, Hamirpur.  
 .. Bishambhar Nath Kapoor, Rath, Hamirpur, to Reserve Jhansi.  
 .. Sher Singh, from Leave, to Reserve Bijnor.  
 .. Lall Bahadur, from Leave, to Reserve Bareilly.  
 .. Rasik Behari Lal, Katra, Shahjahanpur, leave 1 month a. p.  
 .. Damoder Singh, Palia Kheri, leave 2 months.  
 .. Shanker Deo Varma, Fatehabad, Agra, leave 2 months.  
 .. Daya Nand Misra, C. Jail Lucknow, leave 3 months.  
 .. Lall Bahadur, Police Hopt. Bareilly, leave 3 months.  
 .. Kanhaiya Lal Gupta, Pihani, Hardoi, leave 6 months.  
 .. Prem Kishore Varma, Rath, Hamirpur, leave 2 months 10 days.  
 .. Har Sahai, sub-charge Fyzabad, leave 2 months 21 days.  
 .. Hukam Chand, Dhaurelna, Kheri, leave 3 weeks.  
 .. Ganga Saran, Opium Factory, Fhazipur, leave 6 weeks.  
 .. Dalsat Singh, J. and P. Pilibhit, leave 4 months.  
 .. Ram Chandra Saxena, Misrikh, Sitapur, leave 3 months.  
 .. Sher Singh Nagina, Bijnor, leave 2 months.  
 .. Radha Mohan Misra, Bazpur, Naini Tal, leave 14 days.  
 .. Mohd. Ismail, Kadipur, Sultanpur, leave 3 weeks.  
 .. Mohd. Yar Khan, Karchana, Allahabad, leave 3 months.  
 .. Ram Saran, Jais Rao Bareilly, leave 21 days.  
 .. Murad Ali, sub-charge Cawnpore, leave 4 months.  
 .. Beoti Prasad, Karhal, Mainpuri, leave 15 days.  
 .. Shishu Lal Mathur, Khatilabad Basti, leave 15 days.  
 .. Ram Archa Saran Bhatnagar, Shahganj, Janpur, leave 15 days.

Dr. Raj Bahadur, sub-charge Bareilly, leave 2 months.  
 .. Mukat Behari Lal, Reserve Allahabad, leave 4 months.  
 .. Pratap Singh, Hawett, Dehra Dun, leave 4 months.  
 .. Syam Sunder Shukla, Maudha, Hamipur, leave 8 days.

**STATEMENT SHOWING THE TRANSFERS  
LEAVE AND POSTINGS OF SUB-ASSISTANT  
SURGEONS OF ASSAM MEDICAL SERVICE (JN.)  
DURING SEPTEMBER AND OCTOBER 1935**  
(Through the courtesy of Dr. S. C. Barooah)

Dr. Ruchi Narayan Sarma, Malariology training, Shillong, to Lokra A. R. Hospital.  
 .. Charu Chandra Mazundar, Lokra, to Longai, (Sylhet).  
 .. Pulin Behari De No 1., Longai, (Sylhet), to Supernumerary, Sylhet.  
 .. Md. Easin Ali, Malariology training, Shillong, to Nongpoh (K. and J. Hills).  
 .. Suresh Chandar Das gupta, Nongpoh, (K. and J. Hills), to Supernumerary, Shillong.  
 .. Hiranmoy Bhattacharya, Malariology trining, Shillong, to Supernumerary, Shillong.  
 .. Sashi Mohan Pal, Malariology training, Shillong, to Supernumerary, Shillong.  
 .. Prakash Chandra Mazundar from Leave, to Supernumerary, Dhubri.  
 .. Upendra Chandra Palit, Leave extension 2 months.  
 .. Abdul Jabbar Choudhary, (S. grade), Bhunabir, (Sylhet), Leave 3 months 24 days.  
 .. Stephenson R. Marak, Leave extension 2 months.  
 .. Sashi Mohan Pal, Supernumerary, Shillong, to Nongtalang (K. and J. Hills).  
 .. Sotri Mohon Diendoh, Nongtalang, to Leave 2 months.  
 .. R. K. Khuala, N. Cachar Hills Trav. Dispensary, Leave 16 days.  
 .. Abbaya Charn Das, leave 2 months after his training at the School of Tropical Medicine and Hygiene, Calcutta.  
 .. Upendra Chandra Dutta, Supernumerary, Shillong, to Clinical Research Hospital attached to the Pasteur Institute, Shillong.  
 .. Naresh Chandra Roy, Clinical R. Hospital Shillong, to Pasteur Institute Shillong.  
 .. Haralu from Leave, to Wokha (Naga Hills).  
 .. Neilhouzhie Angami, Wokha (N. Hills), to Trav. Dispy. Naga Hills.  
 .. Abdul Matlib (S. grade), Golaghat, to Leave 4 months.  
 .. Dakshinas Ranjan Sen No. 1, Supy. Jorhat, to Golaghat.  
 .. Suresh Chandra Das Gupta, Supy. Shillong, to Leave 2 months.

Dr. Bongshidhar Bora, Supy. Tezpur, to Leave 2 months.  
 .. Hirendra Chandra Endow, Supy. Sylhet, to Supy. Silchar.  
 .. Nazibur Rahaman, from Leave to Dibrugarh, Jail and Police Hospital.  
 .. Deveswer Bhattacharyya, Dibrugarh, Jail and Police Hospital, to Supy. Jorhat.  
 .. (Mrs.) Plentysibon Rynjah, Shillong Dispensary, to Dibrugarh Dispy.  
 .. (Miss) Premalata Sahu, Dibrugarh Dispensary to Gauhati Dispy.  
 .. (Mrs.) Henrimai Siemlieh, Gauhati Dispensary to Shillong Dispy.  
 .. Stephenson R. Marak, Leave, to Supy. Duty Garo Hills.  
 .. Prakash Chandra Mazunder, Leave extension, to 2 months.  
 .. Dharanidhar Bhuyan, Itinerating Duty, Sadiya, to Denning (Sadiya).  
 .. Dharani Kanta Baruah, Denning, to Nizam-ghat out post, (Sadiya).  
 .. Pulin Behari De No. 11, Supy. Sylhet, to Supy. Silchar.  
 .. Joel Sarwan, Confirmed with effect from 16th April '35 and his services placed at the disposal of P. H. Dept.  
 .. Ram Chandra De, Supy. Lakhimpur Dist., to Krishnai, (Goalpara).  
 .. Bhabani Charan Patwari, Krishnai, to Sairang (Lushai Hills).  
 .. Sashi K. Deb Lashkar, Sairang, Leave 3 months.

**Public Health Department**

Dr. Pratul Chandra Das, Nowgong Town, to Doboka, (Nowgong) Tempy.  
 .. Subodh Chandra Gogai, Doboka, to Hojai (Nowgong).  
 .. Saradananda Das, Chapanalla, to Doboka (Nowgong).  
 .. Pratul Chandra Das, Doboka, to Kuaritul (Nowgong).  
 .. Surendra Chandra Chakravarty, Sylhet Dist., Leave extension.  
 .. Naresh Chandra Dutta, Sylhet Malaria Duty., Leave 3 weeks.  
 .. Surendra Chandra Deb, Services at the disposal of I. G. C. H with effect from 20-9-35.  
 .. Md. Abdul Bari, Epidemic unit, Goalpara, Leave 2 months.  
 .. Binoy Bhuson Gupta, Sylhet Town, to Chik-nagool (Sylhet) Malaria duty.  
 .. Ishaque Ali Choudhary L. M. P. appointed as Tempy. S. A. S. and posted at Sylhet.  
 .. Bhim Karna Rai, L.M.P. appointed as tempy. S. A. S. and placed at the disposal of I.G.C.H. from 1-10-35.

Dr. Bimala Charan Pal, Nowgong District, Leave 1 month.  
 „ Jagannath Sarma Barua, Nowgong District, Leave 1 month.  
 „ Hafizuddin Ahmed, Nowgong District, Leave 1 month 15 days.  
 „ Miftahul Hussain, Malariology training, Shillong, to Doom Dooma, Malaria Duty.  
 „ Amiruddin Ahmed, Malariology training, Shillong, to Gauhati, Malaria Duty.  
 „ Kanak Chandra Gogoi, Malariology training, Shillong, to N. Lakhimpur, Malaria Duty.  
 „ Muhammad Ali, Malariology training, Shillong, to Morigaoi, Malaria Duty.  
 „ Dhirendra Kumar Das, Malariology training, Shillong, to Nowgong, Malaria Duty.  
 „ Benoy Bhushan Gupta, Malariology training, Shillong, to Sylhet, Malaria Duty.  
 „ Gopiroman Bhattacharyya, Malariology training, Shillong, to Gauhati, Malaria Duty.  
 „ Kajiram Das, Epidemic Unit, Kamrup, Leave 2 months.  
 „ Dinesh Chandra Chakravarty, Doom Dooma, to Dibrugarh, Malaria Duty.  
 „ Pratul Chandra Das, Nowgong, to Hojai (Nowgong).  
 „ Trittheswar Sarma, Hojai, to Morigaoi (Nowgong).  
 „ Chittaranjan Dutta, Morigaoi, to Baithalangsoo (Nowgong).  
 „ Bimala Charan Pal, Singimari (Nowgong), to Chapanalla (Nowgong).  
 „ Sadananda Das, Chapanalla, to Dobka (Nowgong).  
 „ Subodh Chandra Gogoi, Dobka, to Kuaritol (Nowgong).  
 „ Rahmat Hussain, Kuaritol, to Barthol.  
 „ Satish Chandra Purayastha, Sylhet District, Leave 6 weeks.  
 „ Subimal Chandra Roy, Shillong, to Gauhati.  
 „ Nurul Huda L.M.P., appointed as a Temporary S.A.S., at Gauhati.

## Quetta Relief Fund

| Amritsar                       |     | Rs. | A. | P. |
|--------------------------------|-----|-----|----|----|
| Dr. Munshi Singh               | ... | 5   | 0  | 0  |
| „ Paiare Singh                 | ... | 4   | 0  | 0  |
| „ A. R. Khan                   | ... | 4   | 0  | 0  |
| „ S. R. Issar                  | ... | 2   | 0  | 0  |
| (The above paid to V. Q. Fund) |     |     |    |    |
| „ Sayed Ali Khan               | ... | 4   | 0  | 0  |
| „ Wazir Singh                  | ... | 10  | 0  | 0  |
| „ Kundal Lal                   | ... | 2   | 0  | 0  |
| „ S. Ram Singh                 | ... | 2   | 0  | 0  |
| „ Mohd. Sherif                 | ... | 5   | 0  | 0  |

Dr. Harpas Khan ... 8 0 0  
 „ Mohd. Din ... 5 0 0  
 „ Harbans Singh ... 5 0 0  
 (The above paid to different funds).

### Ludhiana

„ Barkat Ullah ... 5 0 0  
 „ Jagir Singh ... 10 0 0  
 „ Khan Sahib, Dr. Rustam Ali ... 5 0 0  
 „ Subedar Dr. Kamaluddin ... 5 0 0  
 „ Chhabildas ... 5 0 0  
 „ Shanti Swarap ... 2 0 0  
 „ Ashan Ullah Raq Minhas ... 5 0 0  
 „ Pyare Lal Varma ... 2 0 0  
 „ Asha Ram Mahindra ... 5 0 0  
 „ C. Bhan & Co., ... 8 0 0  
 „ Hari Mohan Rai ... 1 0 0  
 „ Meghi Ram Chopra ... 2 0 0  
 „ M. A. Azad ... 2 0 0  
 „ Lajpat Rai ... 5 0 0  
 „ Balak Ram ... 2 0 0  
 „ Mohd. Umar ... 1 0 0  
 „ Shiv Das ... 2 0 0  
 „ Medhi. Hussain ... 5 0 0  
 „ Faquir Chand ... 8 0 0  
 126 0 0

Amount already accounted for Vide  
 I.M.J. Vol. XXIX. XI. 604 ... 882 10 0  
 Total Rs. ... 508 10 0

## Association Notes

(Proceedings of Branch meetings should be sent for publication through the General Secretary only. ED. I. M. J.)

### Standing Committee Resolutions

*Reference circular No. 17.*—Resolved that the standing Committee of the All India Medical Licentiates' Association appoints a sub-committee consisting of Drs. R.N. Lal, U.B. Narayan Rao, A.D. Mastakar, A. Viswanathan, S. L. Sharma, Ahmed Hussain and Kunj Behati, Lal Varma to launch a vigorous propaganda against the amended Poison Rules in U.P. till they are totally withdrawn. Resolved further that Rs. 100 be sanctioned for its expenses.

*Reference circular No. 18.*—Resolved that Rs. 86/5/- the amount spent by the Patron of the Association for the establishment charges in 1935 be sanctioned as a special case.

*Reference circular No. 19.*—Resolved that the amount of Rs. 45/- for the pay of the Ex-Editor's clerks be sanctioned as a special case.

*Reference circular No. 21.*—Resolved that the Standing Committee sanctions the proposal of allowing the old members who have become defaulters to be readmitted to the Association on payment of

# THE INDIAN MEDICAL JOURNAL

(ORGAN OF THE ALL-INDIA MEDICAL LICENTIATES' ASSOCIATION)

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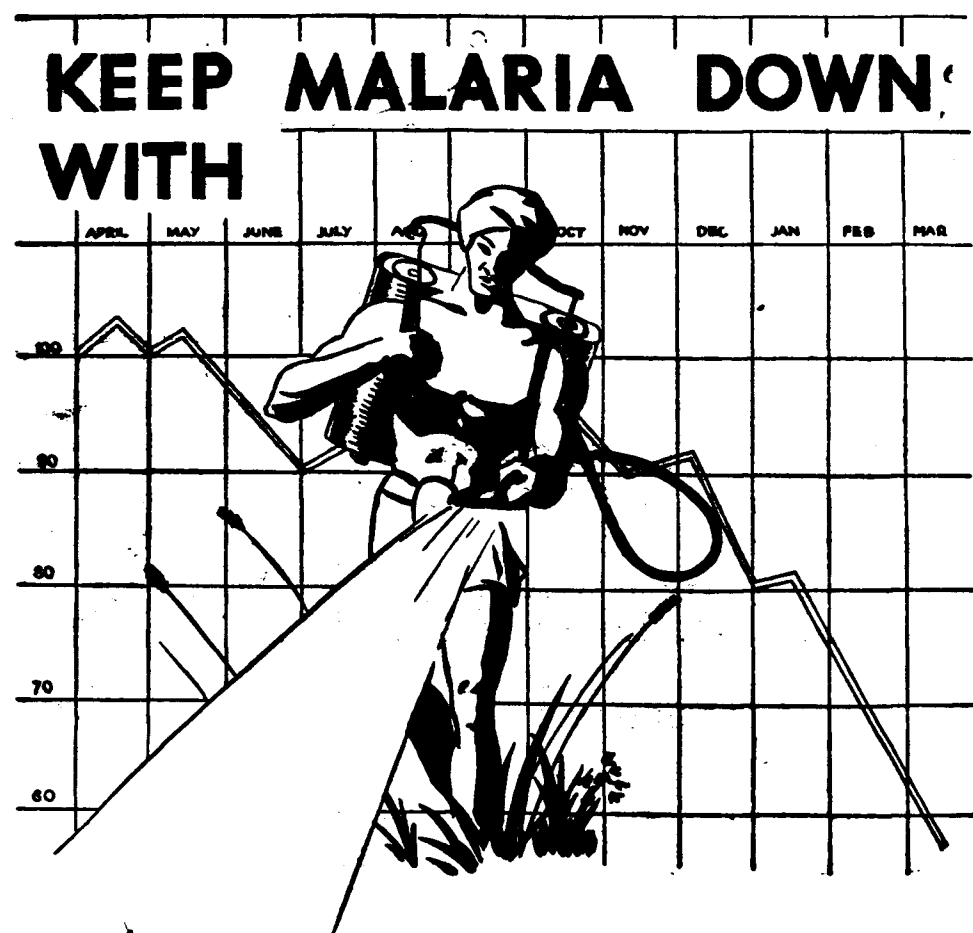
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the usual annual subscription of Rs. 4/- a year. The question of charging admission fee be relaxed in such cases, subject to the sanction by the Conference. Replies received 19—18 for and 1 against.

#### Fyzabad Branch

An inaugural meeting of the Fyzabad branch of the A.I.M.L.A. was held at Dr. Qureishi's residence on 11-7-35. Dr. Qureishi was in the chair. The following persons were present.

Doctors 1. S. L. Sharma of Aligarh, 2. S. A. Qureishi, 3. Bhagirath Pershad Jain, 4. Basant Lal, 5. Har Sahai Saxena, 6. Dinesh Varma.

Dr. S. L. Sharma explained the necessity of forming a branch because no society can progress in the world without organisation. Moreover the recent promulgation of the obnoxious Poison rules is a great menace to the independent Medical profession. Some suitable measures should be adopted at once to have the above rules rescinded and that can only be possible through the unanimous support of the medical profession as a whole.

1. Resolved that the following office bearers be elected. 1. President—Dr. S. A. Qureishi, 2. Vice President—R. S. Dr. Brij Mohan Lal, 3. Secretary—Dr. Dinesh Varma, 4. Joint Secretary—Dr. Har Sahai Saxena, 5. Treasurer—Dr. Basant Lal. Members of the executive committee:—Drs. 1. Bhagirath Pershad Jain, 2. S. S. Gangwar, 3. Dharam Pal Gupta, 4. Har Nath Tandon, 5. C. L. Gupta, Medical Officer of Schools.

2. Resolved that a party be given tomorrow evening at 5 P.M. in honour of Dr. S. L. Sharma, President U.P. Branch at Dr. Qureishi's place.

3. Resolved that a Committee of the following members be formed to fight out the obnoxious Poison Rules with a power to co-opt: Doctors S. A. Qureishi, B. P. Jain, Dinesh Varma.

4. Resolved that the Secretary be requested to enroll the Medical Licentiates who are in private practice or in service as members of the Association in the District of Fyzabad.

5. Resolved that a copy of the proceedings be sent to the General Secretary, A.I.M.L.A., 94 Girgaon Road, Bombay No. 4 and to the Editor, Indian Medical Journal, 131 Coral Merchant Street, Madras and to Rai Sahib Dr. Ram Narain Lal, President, A.I.M.L.A., Ram Niwas, Mussoorie.

6. Resolved that a local subscription of annas four per month be realized to meet the expenses of the branch from every member.

With a vote of thanks to the Chair the meeting dispersed.

Resolution passed by the Fyzabad branch on 81st August, 1935, at Qureishi Medical Hall, Fyzabad.

(a) "That this meeting of the members of qualified Licentiates held under the auspices of the Fyzabad branch of the A. I. M. L. A., strongly protests against the obnoxious Poison Rules recently promulgated by the U.P. Government as per their Government order No. 1000/vi—1776—1930 dated

15th April 1935 and published in the U.P. Gazette of 18th May 1935 whereby undue restrictions have been placed on all the Registered Medical Practitioners in the Province by the said rules and requests the U.P. Government not to enforce the said rules, as they are likely to entail great hardships upon the Medical practitioners of the Province.

(b) Resolved that a copy of the above resolution be forwarded to the U.P. Government and to the Secretary, All India Medical Licentiates' Association, Bombay, and also to Dr. S. L. Sharma, and to the Editors, Indian Medical Journal, Leader and Pioneer.

#### Bareilly Branch

An inaugural meeting of the Bareilly Branch of the A.I.M.L.A. was held on 15-7-35 at 7 P. M. Dr. S. L. Sharma was proposed to the chair by Dr. R. S. Garga and seconded by Dr. Bhagwati Sahai.

The following doctors were present:—S. L. Sharma, Lal Bahadur S.L. Saxena, Bhagwati Sahai, M. Irripatti (Lady Doctor), R. S. Garga, J. N. Saxena, and K. N. Johri.

Dr. S. L. Sharma explained in a short speech the advantages of having an organisation of the Association in a place like Bareilly and narrated the advantages of membership in the Association.

The following office bearers were elected for the year 1935:—Doctor Krishna Sahai-President, Dr. Nanshe Ali-Vice President, Dr. R. S. Garga-Hon. Secretary, Dr. J.N. Saxena-Jt. Secretary, Dr. Bhagwati Sahai-Treasurer.

Executive Committee:—Doctors S.L. Saxena, K. N. Johri, Blenchfield, M. Irripatti (lady doctor), S. B. Gupta, G. Gaman and G. S. Bhatnager.

The following Sub-Committee with power to co-opt was formed to effect amendments to the newly amended Poison Rules recently formulated by the U.P. Government:—Doctors 1. Shiam Behar Gupta, 2. Lal Behar Gupta, 3. Lal Singh, 4. Lakshman Swarup, 5. Ram Charan Anan, 6. Nanshe Ali.

4. That all the registers required under the rules of the Association be prepared immediately by the Secretary.

5. That this branch is thankful to Dr. S. L. Sharma who so kindly took the trouble of coming to this place to revive this branch which had been inactive since a long time.

6. That a copy of the proceedings be sent to the General Secretary, Indian Medical Journal and the President U.P. Branch, for information.

With a vote of thanks to the chair the meeting dispersed.

A monthly meeting of the Bareilly branch was held on 11-8-35 at 6 P.M. at the residence of Dr. R. S. Garga. Dr. Lakshman Swarup was in the chair. The following were present:—Doctors Lakshman Swarup, Syed Murad Ali, J. N. Saxena, and R. S. Garga.

Resolutions passed:—

1. The proceedings of the last meeting were read and confirmed.

2. Read General Secretary's circular No. 14/35 and resolved that this should be put in the next meeting for consideration, as there is only a small number of members present owing to the rains.

3. That the contingent bill of the branch for the month of July be passed and sent to G.S. for payment.

4. The letter of Dr. Krishna Sahai, President, was read, as he could not attend the meeting owing to serious illness of his niece.

5. With a vote of thanks to the chair the meeting ended.

A monthly meeting of this branch was held on 12th September 1935 at 6 P.M. Dr. Babu Ram was in the chair. The following members were present:—Doctors Babu Ram, L.M.P. Retd. P.S.M.S.; Raj Bahadur, L.M.P.; R.S. Garga, M.S.M.F. J.N.; Saxena, L.S.M.F.; H. H. Blenchfield, L.P.H.; K. N. Johri, L.S.M.F.

Resolutions passed:—

1. The proceedings of the last meeting were read and passed.

2. Resolved that this branch in conformity with the resolution No. 7 passed at the 27th Annual Conference of the A.I.M.L.A. at Indore (copy below) urges upon the authorities for the immediate necessity of expediting the action proposed therein.

Resolution No. 7 runs:—"This Conference urges upon the Government of India the necessity of amending without any further delay, the Indian Medical Council Act, so as to include Indian Medical Licentiates within the scope of the Act and requests the present members of the said council to take necessary steps to move the matter in the Council and press upon the Government of India to remove the injustice which has been done to the deserving class of the Indian Medical Licentiates by their exclusion from the scope of the Act. And this conference appeals to the members of the Legislative Assembly to take up this question in right earnest."

3. Resolved that the Standing Committee of the U.P. Provincial Branch be invited to hold its session for transacting the business here.

4. Resolved that the contingent bill as presented by the Secretary be passed and forwarded to the G.S. for payment.

5. Resolved that a sub-committee consisting of the following members be appointed with power to co-opt for the purpose of making the arrangements in connection with the meeting of the S.C. and every medical Licentiate of the District be requested to contribute Rs. 2 each to meet the necessary expenses.—Doctors 1. R. S. Garga (Convenor), 2. Raj Bahadur, 3. J. N. Saxena, 4. H. H. Blenchfield.

6. With a vote of thanks to the chair the meeting dispersed.

#### Dibrugarh Branch

Proceedings of the monthly meeting of the above branch of the A.I.M.L.A. held on 22-6-35 at 4 P.M. in the premises of the Out-door Dispensary, Dibrugarh State Hospital.

Dr. K. N. Biswas was in the chair. Members present:—Doctors K. N. Biswas, D. Bhattacharjee, Md. K. Rohman, S. P. Nath, P. Ganguly, M. Barooa, K. Chakraborty, R. Dey, K. K. Dutta, B. D. Barakoty and H. D. Nath.

1. Proceedings of the last meeting were read and confirmed.

2. Accounts for the month of May 1935 were passed.

3. Circular No. 8 from the General Secretary and the Provincial Secretary, Assam, was read and it was resolved unanimously that the Branch has got full sympathy and that it will contribute its mite, through the local Government Fund and that this branch will try to send doctors for help, though at present there is none to volunteer for the purpose.

4. A letter from the Secretary, Assam Branch, Indian Tea Association, was read and it was resolved that the members of the local branch express their gratitude for his very kind and prompt action.

5. A letter from the Inspector General of Civil Hospitals, Assam, regarding proceedings of an emergent meeting of the executive committee of the Dibrugarh Branch of the A.I.M.L.A. held on 26th February 1935, was read and the Provincial Secretary is requested to make necessary correspondence to clear the point of usual tenure of service of the Demonstrators of the B. W. Medical School, Dibrugarh, and communicate the reply to the Branch in due course.

6. A letter from the President of the Dibrugarh Branch was read and resolved that the President be requested to reconsider his resignation of Presidentship and continue his office till the end of the session.

7. Resolved unanimously to send an appeal to those members of the local branch, who have not paid up their branch subscriptions, with arrears, if any, to clear off their dues at an early date.

8. The meeting terminated with a vote of thanks to the chair at 5-30 p.m.

Proceedings of the monthly meeting of the above branch of the A.I.M.L.A. held on 25-5-35 at 5 P.M. (local) in the premises of the B.W.M. School, Dibrugarh.

Dr. D. Bhattacharjee was in chair. Members present:—Doctors 1. M. Barooa, 2. D. Bhattacharjee, 3. Md. K. Rohman, 4. B. Dey, 5. K. C. Chaudhary, 6. B. K. Goswami, 7. S. R. Das, 8. P. K. Sen Gupta, 9. H. D. Nath, 10. K. L. Ghose, 11. R. Dey, 12. S. P. Nath.

1. Minutes of the last meeting were read and confirmed.

2. Accounts for the month of April 1935 were passed.

3. T. A. bill of Dr. K. L. Ghose, an elected delegate of the branch to the A.I.M.L.A. Annual Conference held at Indore, amounting to Rs. 105-11-0 was passed and forwarded to the Parent body for favour of payment.

4. Dr. K. L. Ghose gave a brief note of the splendid success of the A.I.M.L.A. Conference held at Indore in April 1935.

5. Resolved that the members of the Dibrugarh Branch of the A.I.M.L.A. offer their hearty thanks to Col. C. E. Palmer, I.M.S., Inspector General of Civil Hospitals, Assam, for kindly promoting Rai Sahab Dr. Gongsesh Ch. Dass to the cadre of the Assam Medical Service Sr., and also offer their hearty congratulation to Dr. G. Ch. Dass for his promotion to the present cadre.

6. Resolved that the resignation of Dr. K. C. Choudhary (on transfer to Manipur) be accepted and Dr. S. R. Dass appointed as Auditor in his place.

7. A letter from the Honorary Secretary, Reception Committee of the 6th Provincial Conference was read and discussed, and resolved unanimously to select their Presidents for election as follows:—

1st: Rai Bahadur P. C. Dutta, C.I.E., 2nd: Sjt. N. C. Bordoloi, Advocate, M.L.A., 3rd: Sir Sayed Md. Saadulla, Kt., M.A., B.L. Advocate.

8. Resolved that the Secretary be empowered to invite the attention of the Civil Surgeon, the Chairman L.B., and the Secretary A.B.I.T. Association, Dibrugarh, to our resolution No. 4 of the monthly meeting of the 28th April 1934.

9. The Secretary proposed a vote of thanks to the Chair and the members present and the meeting came to a close at about 7 p. m.

Proceedings of the monthly meeting of the above branch of the A.I.M.L.A. held on 21-7-35 at 4 p. m. (local) in the premises of the B.W.M. School, Dibrugarh.

Dr. D. Bhattacharjee was in the chair. Members present:—Doctors 1. D. Bhattacharjee, 2. M. Barooa, 3. Md. K. Rohman, 4. H. D. Nath, 5. K. L. Ghose.

1. Minutes of the last meeting were read and confirmed.

2. Accounts for the month of June 1935 were scrutinised and passed.

3. (a) Letters from the Honorary Secretary, Red Cross Society, Lakhimpur District branch and Rai Sahab G. C. Dass were read and filed.

(b) A letter from the Honorary Secretary, Reception Committee of the 6th Provincial Conference was read and resolved that the members be requested to contribute their mite as early as possible and exert their earnest effort to make the Conference a success.

(c) A resignation letter from Dr. K. N. Biswas, President of the local branch was read and accepted.

The meeting terminated at 5 p. m. with a vote of thanks to the chair.

#### Nadia Branch

A monthly meeting of the above branch, A.I.M.L.A. was held on 30-6-35 at 7 P.M. in the house of Dr. Kulaja Ranjan Ray, Amimbazar, Krishnagar.

Members Present.—1. Dr. H. Sen in the chair, 2. Dr. J. Sharkel, 3. Dr. L. K. Pramanik, 4. Dr. K. Ray, 5. Dr. M. Sammadar, 6. Dr. T. Bagchi.

I. The proceedings of the last meeting were read and confirmed.

II. The circular No. 8 and 9 dated 6th June 1935 from the General Secretary were placed before the meeting and discussed.

III. The circular Nos. 10, 11 and 12 dated 22nd and 28th June 1935 from the General Secretary were placed before the meeting and discussed thoroughly. The Secretary of this branch is requested to send a copy of the register of members to the General Secretary at an early date.

IV. Scientific discussions on Malaria and the treatment of Kala Azar with Urea Stibamine were held by the members.

V. The meeting dissolved after a vote of thanks to the chair and the host at about 10 P.M.

A monthly meeting of the above branch was held on 30-7-35 at 7 P.M. in the house of Dr. Monoranjan Sammadar, Jail Hospital, Krishnagar.

Members present:—Doctors H. Sen (in chair); J. Sharkel; B. Bhadra; L. Pramanik; M. Sammadar, K. Ray; B. Ghosh and T. Bagchi.

Proceedings of the last meeting were read and confirmed.

It is resolved to request the Mother Association to publish the list of members province-wise for purpose of ready reference and enlistment of new members. Though this may cost a little at the outset, it will ultimately be a gainer.

Scientific discussions on skin diseases were held amongst the members present.

The meeting dissolved after a vote of thanks to the chair and the host.

A monthly meeting of the above branch was held on 30-8-35 at 7 P.M. in the house of Dr. Harshnath Sen, Police Hospital, Krishnagar.

Members present:—Doctors H. Sen (in chair); L. Pramanik; B. Bhadra; M. Sammadar; T. Bagchi; Ghosh and Dr. K. Ray.

1. Proceedings of the last meeting were read and confirmed.

2. The letter No. 356 dated 28th August 1935 from the Provincial Secretary with the defaulters list and the list of Medical Licentiates of Nadia District were placed on the table and the members had gone through the list to find out ways and means to enlist new members in future and to induce the defaulters to be re-enlisted if practicable.

3. The members of this branch are very glad to announce that Dr. Tara Prasad Bagchi has been enlisted as a member of this Association.

4. Scientific discussions on Microscopical examination were held by the members present.

5. The meeting terminated with a vote of thanks to the chair and the host at about 9 P.M.

\*

A monthly meeting of the above branch was held on the 20th September 1935 at 7-30 P.M. in the house of Dr. Bimal Chandra Bhadra, Aminbazar, Krishnagar.

Members present:—As the President and the Vice President were absent Dr. Kulajaranjan Ray was voted to the chair and the following members were present.

Doctors B. Bhadra; L. Pramanik; T. Bagchi; B. Ghosh and N. Biswas.

1. Proceedings of the last meeting were read and confirmed.

2. Scientific discussions on Gynecological and Obstetric cases were held by the members present with great enthusiasm.

3. The meeting dissolved after a vote of thanks to the chair and the host at about 9 P.M.

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#### Habiganj Branch

A special meeting of the Habiganj branch of the A.I.M.L.A. was held at Habiganj on 4th July 1935.

Members present. Doctors 1. H. Rohaman, 2. S. C. Datta, 3. P. C. Roy, 4. D. N. Madak, 5. A. Haque and 6. A. C. Das Gupta.

2. Dr. S. C. Datta was voted to the chair.

8. Circular No. 10 dated 23rd June 1935 from General Secretary, A.I.M.L.A. was read and discussed and resolved that the subject matter of the circular be discussed in the ensuing Provincial Conference to be held at Dibrugarh on the 27th July 1935 and measures be adopted.

4. Resolved that one of the undermentioned gentlemen be selected as the President to the 6th Provincial Conference to be held at Dibrugarh on 27th July 1935 and the preference of this branch goes to the first. i. Sjt. Brindaban Chandra Goswami, M.L.C., ii. Khan Bahadur Mawli Abdul Matin Chaudhury, M.L.A., Ex-Deputy President, Legislative Assembly, P.O. Bhaderwar Dt. Sylhet, iii. Sjt. N. C. Bardoloi.

5. Resolved that Dr. S. C. Datta be elected as a delegate to the 6th Provincial Conference to be held at Dibrugarh on the 27th July 1935.

6. Resolved that the following resolutions be moved in the Provincial Conference.

(i) That the D.P.H. Assam be requested to abolish the present artificial distinction in two transferable sections of the S.A.S. of P.H. Department in regard to their pay and to a uniform time scale or a special pay if the present system is to continue.

(ii) In view of the hard nature of the work of S.A.Ss. on Epidemic unit, P.H. Depart-

ment, whose work is admittedly harder than those in charge of dispensaries (General P.H.D.) and as they have to be constantly on tour over an extensive area incurring heavy expenses, resolved that authorities be requested to grant the S.A.Ss. on Epidemic unit a special allowance over those in general P.H.D., if the present practice is to continue.

(iii) Resolved that P.H.D. Assam be requested to fix the period of services of Sub-asst. Surgeons, Epidemic unit, and on the completion of the term they may be offered the charge of the P.H. Dispensary, taking into account their whole length of service with regard to the special pay.

(iv) Resolved that Local Boards be requested to change the designation of Doctors from L. B. Dr. to Medical Officer and use the courtesy title of Dr. instead of <sup>Bahn</sup> ~~Maulvi~~ before the names of L. B. Doctors as followed by the Government.

7. Circular No. 8 dated 6th June 1935 from the General Secretary was read and discussed and resolved that contribution to Quetta Earth Quake Relief fund be made through the official relief committee that is going to be formed by the Local Government.

The meeting terminated with a vote of thanks to the chair.

\*\*

#### Karnal Branch

The annual meeting of the Karnal Branch, A.I.M. L.A., was held on 7-7-35 at 11 a.m. in the King Edward Memorial Hospital waiting room under the presidentship of Dr. P. L. Tandon, P.C.M.S., the Civil Surgeon of the District.

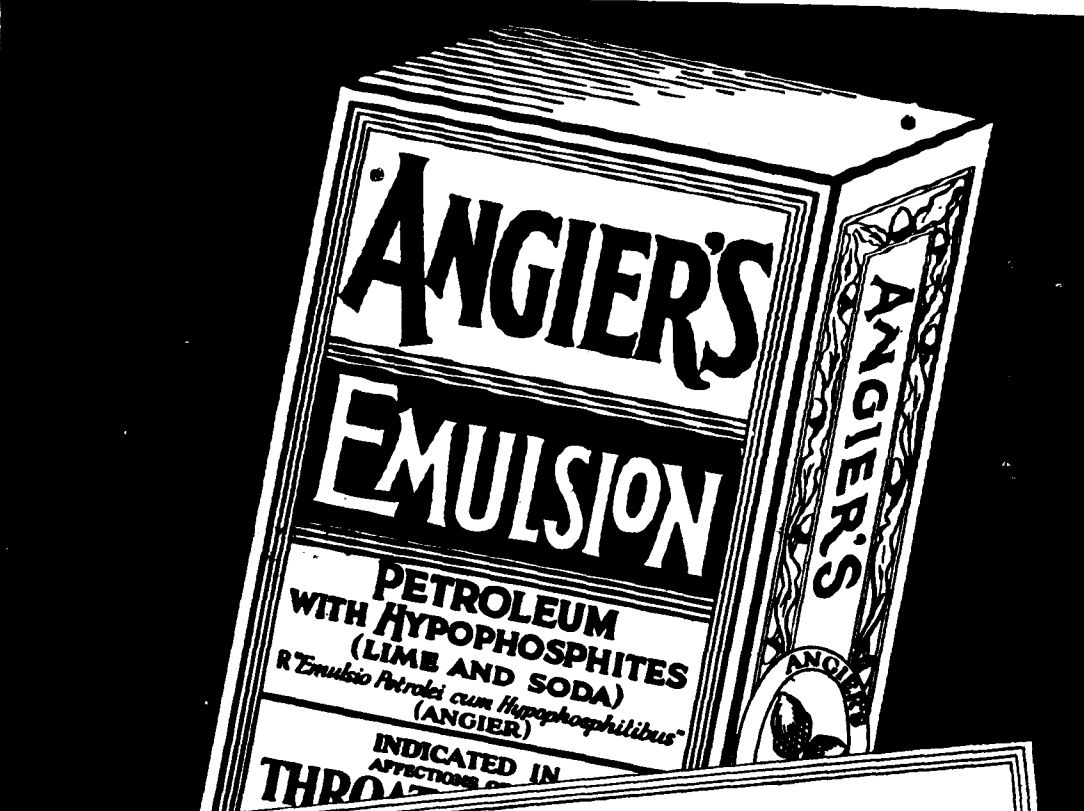
The members and the non-members were all invited, but the number that attended the meeting was much below expectation. The cause is unknown, Possibly the hot weather.

The Hon. Secretary read the annual report of the branch and discussed fully the necessity of more members joining the Association. The report was well received. The Honorary Secretary later on read the General Secretary's circular Nos. 8 and 9 dated 6-6-35. The circular No. 8 needed no further discussion as action was already taken. Circular No. 9 which gave a brief history of the A.I.M.L.A. was keenly heard by the house and appreciated. After that, Dr. L. P. Kapoor, M. O. Baputi, read two papers on the following subject.—

1. Application of Ichthyol-Belladonna-Glycerine in Otitis Media.

2. Interesting case notes.

Both the papers were much appreciated.



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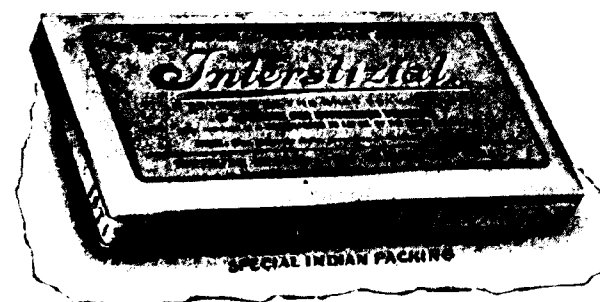
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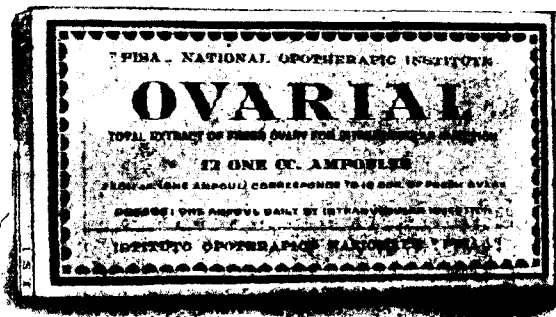
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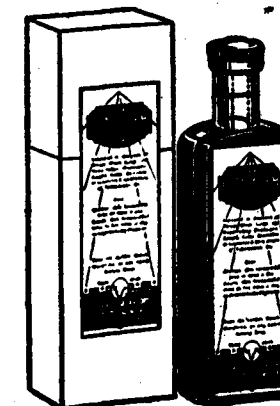
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