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NOVEMBER & DECEMBER 1935

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,
Member, Madras Medical Council.

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NOVEMBER 1935.

[NO. 2

Original Articles *TOXAEMIAS OF PREGNANCY.

BY

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(Continued from last issue.)

PRE-ECLAMPSIA or Eclampsism is essentially eclampsia without the convulsions. These patients usually show the same picture as eclampsia except that convulsions are absent. The patients are acutely ill with a large amount of albumin and some casts in the urine and a high blood pressure. After delivery there is a prompt return to the normal blood pressure level and the urine soon becomes albumin free. Pre-eclampsia probably a manifestation of the same disease entity as eclampsia, and differs from it only in so far as convulsions and coma do not occur.

Symptoms: The disease develops usually during the last two months of gestation, and its onset may be quite abrupt, as is so often the case in eclampsia. The first danger signal, especially where there has not been any prenatal care, is frequently a complaint of headache, sharp epigastric pain or failing vision. Within a short time the blood pressure has climbed to a high level, usually around 190 systolic and 110 diastolic. The

urine contains from two up to 10 or 20 Gms. of albumin per litre. The signs and symptoms often become rapidly more pronounced, the patient being on the verge of an eclamptic attack. One sometimes even observes twitching of the fingers and toes. The outstanding characteristic of the disease is the sudden development of hypertension and albuminuria, which may be quite marked. As in eclampsia, the face and extremities may be very oedematous.

There are no very marked changes in the blood and urine. Examination of the eye grounds may show oedema of the retina, retinal haemorrhages or even detachment of the retina but no albuminuric retinitis. According to Mills, the eyes are involved in about 90% of all cases as a result of a physiologic enlargement of the pituitary gland. Different degrees of contraction of the visual fields by pressure on the optic commissure and tracts are the result of this enlargement. He believes that the symptoms of pre-eclampsia arise from local intra-cranial pressure of the enlarged hypophysis as well as from increased function of this gland.

Treatment: The danger in the pre-eclamptic patient is the fact that the condition may suddenly eventuate in eclampsia. The rational treatment therefore should consist in taking steps to prevent the outbreak of eclampsia.

The pre-eclamptic patient should of course always be admitted into the hospital as soon

* Elizabeth Matthai University Lectures 1935.

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MENESTRIN CAPSULES.

How do Menestrin Capsules prevent pregnancy?

This question is often asked by some members of the medical profession. The capsules contain Quinine, Iron, Manganese, Ovary and Thyroid and a few other ingredients belonging to the indigenous system of medicine, so combined as to produce temporary hyperaemia in uterine mucous membrane which causes tonic contraction of the uterus and the resulting menstrual flow washes the uterine cavity. This plain answer was put to test by eminent physicians who are to-day prescribing the capsules to their lady patients who dread pregnancy.

To be sure of action the capsules should be taken on the very day when the expected menses did not appear.

The Therapeutic indication for prescribing Menestrin Capsules for Amenorrhoea is quite evident from the action of all its ingredients, a combination of which has been curing patients suffering from inveterate Amenorrhoea due to any causes functional or otherwise.

A VALUABLE OPINION

From a Gynaecologist.

I had some hesitation to use Menestrin Capsules in my lady patients who dreaded pregnancy. The explanation submitted to me by O. R. Laboratory, regarding the unique way in which the Menestrin Capsules bring about menstruation cleared my doubt and I have since been using the capsules extensively advising my patients to take them on the very day when the expected menses did not appear.

I am glad to say that in almost all patients who used the Menestrin Capsules from the day when the expected menses did not appear, had no disappointment at all.

There cannot be any hesitation to use the capsules in cases of inveterate Amenorrhoea as all the ingredients containing them are rationally indicated for the treatment of Amenorrhoea.

They could find no evidence of increased toxicity of the blood serum proteins in the latter. Obata was also unable to demonstrate any increased toxicity in eclamptic serum. So far no satisfactory evidence has been adduced to prove the existence of a "toxin" in the blood of patients suffering from eclampsia.

2. FOETAL ELEMENTS—fragments of chorionic villi.

3. FOETAL METABOLIC PRODUCTS—disturbed function.

4. PLACENTA THEORIES (YOUNG)—infarction of placenta—placental auto-lysis. Young and Miller state that the placental degeneration is due to interference with its blood supply, and that absorption of the placental poisons occurs through portions of the placenta attached to the uterine wall. They believe the toxæmia to be associated with placenta-*prævia* or premature separation of the placenta and that eclampsia is due to the absorption of broken liver cells possibly other cells which are killed by the poison coming from the placenta. In cases of eclampsia where there is no visible placental infarction, they think the changes in the placenta are so minute that they cannot be detected, but, nevertheless give rise to sufficient toxin to cause the disease. Williams believes that placental infarcts, when present in cases of eclampsia should be regarded as accidental findings or, at least, as secondary to the toxæmic condition and not as its cause.

5. INFECTIONS: No organism has been identified neither is the disease transmitted from patient to patient.

6. ENDOCRINE: Thyroid and Corpus luteum.

15. Oxygen deficiency: Some believe that deficiency of oxygen is the immediate cause of eclampsia. While others regard eclampsia as an acidosis due to lack of oxygen and have demonstrated that a lowered bicarbonate reserve in the blood can be raised after exposure to ultra violet light.

In summary it must be stated that no convincing and conclusive proof has been adduced in support of any of the proposed theories regarding the ætiology of eclampsia. We are wholly ignorant as to the cause of this disease although information which

may ultimately prove of real value is constantly being gathered by a list of investigators and I hold that every large maternity centre in India should have separate department for Toxæmias of pregnancy for investigation and treatment.

TREATMENT OF ECLAMPSIA: Prior to 1870, the treatment of eclampsia consisted mainly in venesection, sedatives, cold packs or baths, but no obstetric interference. From 1870 to 1890 the treatment was still expectant, and narcosis diaphoresis and pilocarpine played a great part, while venesection was abandoned. In the latter part of this period the teaching was to effect the promptest possible delivery, by means of accouchement force or instrumental dilatation of the cervix. The maternal mortality during this period was over 30% where statistics were available. Dührssen in 1890 advocated vaginal Caesarean section as the routine treatment for all cases of eclampsia, urging that the operation be performed as soon as possible after the first convulsion, and from thereon radical treatment of eclampsia was generally followed.

At about the beginning of the present century more conservative methods of treating eclampsia were introduced but there is still a great deal of controversy as to the relative merits of the two methods of treatment the operative or radical and the medical or conservative.

Prenatal care is an important factor in preventing the occurrence of eclampsia as well as in reducing maternal mortality. Every obstetrician has his quota of toxæmias in patients whom he has supervised from the onset of pregnancy. The fundamental thing to be recognized is that adequate prenatal care will permit the physician to anticipate serious complications and therefore, prevent serious complications. And no where in the range of medicine there are the rewards so gratifying as in the late toxæmias. We will always have toxæmias of pregnancy but proper rest, elimination and diet will reduce the incidence of eclampsia. Pre-conceptional, prenatal and postnatal care are of utmost value in lowering the incidence and mortality of toxæmias.

To-day almost every one has agreed that the incidence of eclampsia has been markedly reduced during the past 20 years

by the rigid application of adequate pre-natal care of the mother. The anxiety of the patient is decreased and she faces the ordeal with a lessened nervous strain by her confidence in her medical attendant.

The frequent routine checking of the blood pressure, of the urine, weight increase, and of the patient general condition undoubtedly leads to the early recognition of a pre-eclamptic state or an eclampsia that may be pending. Although prophylaxis alone cannot entirely prevent the outbreak of eclampsia, it is a great aid in reducing the incidence and the maternal mortality of the disease.

CONSERVATIVE TREATMENT: Plass, in an excellent review of the subject studied the results in over 10,000 cases treated by the radical and conservative methods. He found that in the 4607 cases treated radically, the mortality was 27.07% as contrasted with 11.1% in 5976 cases treated conservatively. In India out of 1052 eclampsia cases the percentage of mortality after conservative treatment found is 15.96.

There are various methods of conservative treatment—Veratrum Viride, Venesection, Kidney decapsulation, lumbar-puncture to relieve the oedema of the brain, serum obtained from former eclamptic patients, liver extract—(Heparmone) to neutralise the toxins.

MAGNESIUM SULPHATE: Since Einar in 1907 suggested the possible therapeutic value of magnesium sulphate in the treatment of eclampsia, it has been employed quite extensively, especially by Lezard and his co-workers, Ruchers and Alton and Lincoln. Lezard has treated a large series of eclamptic patients with this drug, with fairly good results, and is enthusiastic about its use. Others have not been convinced that the results obtained by the administration of magnesium sulphate, either intramuscularly or intravenously warrant its use in the treatment of eclampsia. Schwartz and his associates report that the most constant single finding in their study of eclampsia patients has been a blood concentration. They have also noted a striking relationship between relief of this blood concentration and clinical improvement of the patient, with the result that the treatment they now employ, is concerned primarily in establish-

ing and maintaining hydration of the blood within normal limits. To this end intravenous glucose solution has been employed to very good advantage in exceptionally obstinate cases; where neither blood dilution nor diuresis could be effected with glucose, it has been found that gum acacia solution was successful. The explanation of this latter clinical fact is probably to be found in the advantage of a colloid over a crystalloid in water-binding properties.

TREATMENT OF PULMONARY OEDEMA: To prevent aspiration of saliva into the bronchi and to retard the development of pulmonary oedema, it is customary in many clinics to have the foot of the bed elevated about 10 inches above the floor and to have the patient lie on her side with special instructions to the nurse to swab out the patient's throat whenever necessary and I well remember Tweedy making his patients stand on their heads to allow the saliva to gravitate out. But I find raising the head of the bed to one foot helps greatly to reduce the oedema of the lungs and brain and the patient soon shows a different picture altogether. The swollen neck and puffy face disappear and the lungs soon clear up; for, I believe it is more a static congestion than increase of secretion of the lungs that causes oedema of the lungs.

Mussey suggests the use of ammonium chloride. He states that its use is generally followed by prompt diuresis, disappearance of oedema, marked loss of weight, lowered blood pressure, and improvement of the patient and that improvement is usually greater and more lasting than that obtained by dietary methods. He believes that the increased excretion of urine and the decrease in the oedema with resulting loss of weight following its use, probably carries off from the tissues a sufficient amount of toxin to improve the condition.

TREATMENT IN ACIDOSIS: One of the most characteristic features in certain cases of eclampsia is a true acidosis developing immediately after a convulsion. A persisting coma following a convulsion should make us suspicious of acidosis. It must be apparent that we have as yet no satisfactory way of combating this dreaded disease whose average maternal mortality is from 10% to 30% with a foetal mortality of approximately 51.5%. We do not know the

cause of the disease, and consequently our treatment is entirely empiric. Frequent blood analysis will reveal the presence or absence of a developing acidosis.

The best results I find, are obtained by following a conservative treatment along the lines indicated in a modification of the Stroganoff method. The use of morphia and chloralhydrate with magnesium sulphate intramuscularly or intravenously. The avoidance of any obstetric interference, unless indicated in the second stage of labour. The prevention of aspiration pneumonia of œdema of the lungs and the constant look out for a true acidosis are the essentials in this treatment. In the event of the eclamptic attack subsides following such conservative methods and the patient has not fallen into labour, I have allowed the patient to go to term rather than induce labour and have so far not found any untoward results. Some believe it safer to induce these patients after definite improvement or recovery from the eclamptic outbreak than to allow them to proceed to term.

SUMMARY: From all the foregoing facts we find there is no cure for any of these toxæmias and I would reiterate what I have already stated that although we may not wipe out toxæmias altogether yet by proper pre-natal care we could almost succeed in making eclampsia a more rare condition. When I was in Vienna in 1930, I enquired as to the treatment of eclampsia and I was told that they had no true cases of eclampsia, that is, they had no patients who had worked into convulsions during the last twelve years. They had some pre eclampsia cases but no eclampsia and this was due to the good antenatal care the patients had. It was incumbent that every case attended the antenatal clinic from the 12th week onwards if not earlier, and the poor were awarded a benefit of 40 shillings after confinement if they continued attendance and treatment till term.

In ante natal care in addition to weight, blood pressure, testing of urine etc., for the prevention of toxæmia and lessening infant and maternal mortality due to toxæmia, I would emphasise a sensible and well chosen diet throughout pregnancy. Granting that the foetus is essentially a parasite that takes from the mother's blood only that which it needs for its development it follows that the

pregnant woman who has sufficient and proper nourishment in her blood stream to supply the needs of the rapidly developing foetus would endure the strain of pregnancy with a minimum amount of damage to her own tissues.

DISEASES DUE TO DEFECTIVE DIETS IN INFANTS.

By

DR. T. V. MUTHUSWAMI CHETTIAR, F.M.P.

These diseases may be classified as follows:—

- (1) Non-specific under-nutrition,
- (2) Protein deficiency,
- (3) Dehydration,
- (4) Vitamin "A" deficiency (giving rise to retardation of growth and xerophthalmia etc.),
- (5) Vitamin "B" deficiency (giving rise to beriberi).
- (6) Vitamin "C" deficiency (giving rise to scurvy).
- (7) Vitamin "D" deficiency (giving rise to Rickets).
- (8) Vitamin "G" deficiency (giving rise to Pellagra).
- (9) Avitaminosis and disturbed calcium and phosphorus metabolism (giving rise to dental caries).
- (10) Nutritional anaemia arising from avitaminosis and disturbed calcium and phosphorus metabolism.
- (11) Infantile tetany and spasmodophilia arising from disturbed calcium and phosphorus metabolism and Vitamin "D" deficiency.
- (12) Non-specific Vitamin deficiency arising from an insufficiency in the diet of the substances from which hemoglobin is produced.
- (13) Peptic Ulcer.
- (14) Deficiency of inorganic salts.

From this it is clear that there are various states of under-nutrition in infants. Congenital Pyloric stenosis leads to under-nutrition on the basis of mechanical obstruction to the Pylorus and Pyloro-enterospasm on the basis of disturbed neuro muscular control of the gastro-intestinal tract. Protein and Vitamin deficiency lead to well recognised diseases in infants. Similarly under-nutrition may arise from a number of causes some of which are probably due to dietary deficiencies,

some of which are the result of digestive upsets dependant on food unsuitable for infants and others are the result of the infections. The age and constitutional factors of the infant play an important part in the genesis of these conditions. Though the causes of under-nutrition are many and varied, its effect on infant are quite similar and can be described from a clinical point of view.

(1) The clinical picture of non-specific under-nutrition in infants may be divided into three stages, all of which merge imperceptibly into one another, viz.:—

(1) Dystrophia, in which growth takes place in a slower rate than normal and subcutaneous fat is present in reduced amounts.

(2) Atrophy, in which growth has ceased and subcutaneous fat is practically gone.

(3) Malignant under-nutrition, in which in spite of apparently adequate intake of food, the weight does not increase but it tends to decrease.

These are not three separate diseases. These are the three progressive stages of under-nutrition leading on to death.

Clinical characteristics: The loss of subcutaneous fat occurs early in all types of under-nutrition or loss is gradual in infants, it is slower still in older babies. Subcutaneous fat disappears from the various storage depots roughly in the following order—abdomen, shoulders, arms, legs and buttocks. The fat of the face remains fairly long and that of the sucking pads is preserved until death.

Along with the loss of subcutaneous fat, the skin loses its colour, appears more translucent than usual, and through it the veins are apt to appear prominently. In atrophy, elasticity of the subcutaneous tissue is reduced. In malignant stage, dehydration aggravating loss of skin turgor, always occurs.

The muscle tone diminishes early, abdominal wall is less resistant. While certain cases of pyloro-enterospasm develop under-nutrition, it seems true that certain cases of under nutrition simulate pyloro-enterospasm, the interior abdominal wall appearing hypertonic. In such cases, the child cries continually and regurgitates the food, taken.

The underfed baby is apt to be irritable and cries a good deal, it being difficult to

make him smile. Later, apathy and somnolence occur between spells of crying. The cry becomes weak and whining, the infant lying in semi-stupor, with eyes half-closed or fixed in a disinterested stare. The cry of hunger is recognised by the hands of the infant moving towards his mouth and by the fact that feeding the child stops crying.

When unaccompanied by or uncomplicated by infection, dehydration, or specific vitamin deficiencies, the appetite is usually good. In the 3rd stage, even this disappears.

Disappearance of the subcutaneous fat is significant chiefly as it indicates that the body has already begun to draw upon the more essential stores as well. Loss of tissue occurs in muscle, lymphoid tissue, thymus, gonads, adrenals and liver. The tissues of the heart, brain, and parenchymatous tissues are preserved. Liver glycogen becomes minimal. Nitrogen retention diminishes, ceases, and becomes negative.

In the third stage, accelerated loss of weight results due to dehydration of tissues and loss of sodium and potassium. Diarrhoea usually terminates the course of events.

Changed reaction to infection is the result. Resistance to infection is lowered. Trifling infections produce major disturbances and infections tends to spread i.e. complications are the rule. This is more so in Dystrophia and Atrophy, as diarrhoea develops invariably. In the malignant stage, severe diarrhoea results.

Resistance to infection is the best index of the state of nutrition as diminished resistance to infection persists often; a gain in weight leads to an inference that recovery is taking place, in short baby may present all the appearance of a return to health, when an infection may quickly reduce him to his former dystrophic or atrophic state.

The average healthy baby can withstand a day of starvation with little or no loss of weight. In dystrophia, a day of starvation leads to failure to gain for several days. In atrophy there is a great loss of weight. In the third stage the loss of weight with dehydration is alarming.

Feeding disturbances are nil in dystrophia; are easily overcome in atrophy; are greatest in malignant under nutrition.

Tolerance relative to the needs are limited in dystrophia. It is close to the maintenance value and gain in weight is difficult to be maintained at first. As recovery takes place

the rate of recovery is accelerated. In the third stage, even a maintenance diet leads to vomiting, diarrhoea and loss of weight accelerated, loss of tolerance results accompanied by diarrhoea and dehydration. Dehydration may occur in the absence of diarrhoea.

Tolerance to food is influenced by the kind of food and its relation to the body's needs; among premature infants, the younger the infant, the narrower the margin of safety. Though normal infants tolerate raw cow's milk, this is not the case among underfed babies. Cow's milk is better tolerated, if it is altered by boiling, evaporation, souring, alkalisation, peptonisation etc.,

In fever, tolerance to food is almost always reduced. To avoid adding the danger of dehydration to those of relative starvation and to avoid untoward symptoms, the food given must be reduced in quantity and given well-diluted.

PATHOGENESIS: Under-nutrition may be brought about by (1) quantitatively insufficient intake of an otherwise suitable food due to (a) an insufficiency in total intake, or (b) an insufficiency due to vomiting, congenital pyloric stenosis etc., (2) qualitatively defective food with indefinite calories e.g.; deficiency in protein, carbohydrate or vitamins. (Minimal requirements of fat are always present and so true fat deficiency never occurs) (3) defective digestion as in celiac disease and pancreatic insufficiency (4) constitutional inadequacy. The baby needs rest and quiet to thrive. Babies one to six years of age refuse to eat food thrust upon by their parents. In babies aged three or four months this same type of reaction may be present. Frequently this difficulty starts from the time solids are added to the child's diet. In such cases, the parents are of a neuropathic constitution (i. e. they are greatly worried if the child does not eat well) and this attitude of the parents towards their children should be corrected.

TREATMENT:—(1) First find out the state of under-nutrition. In one to three months old babies slow gain in weight, which is consistently below four ounces per week for a few weeks may indicate the onset of dystrophica.

Atrophy is accompanied by loss of subcutaneous fat.

In malignant degeneration, there is failure

of growth, loss of subcutaneous fat and dehydration.

Failure to gain in weight after six and a half months does not necessarily mean the onset of dystrophica, if the baby is fat.

(2) Find out the cause of under-nutrition: whether it is due to infection, constitution or food. Treatment must be directed to overcome these handicaps.

(3) The urine should be examined for evidence of Pyuria, and appropriate treatment instituted when found.

(4) The food should be modified and rendered easily digestible. It must be adequate in all respects. If vomiting occurs reduce the fat content. Underfed babies should receive undiluted milk, and water offered in small quantities at frequent intervals. Babies experience trouble in holding enough food in their stomach to supply their needs. The question being one of capacity to lodge the volume of food required. The daily regimen must be divided into several parts and given at frequent regular intervals. In healthy normal babies feeding must be carried on once in every four hours and in week or premature babies once in every three hours.

In babies who regurgitate their food, frequent small feedings are quite useful. Premature and weak babies should be fed on breast milk only. For older and normal babies if breast milk is not available cow's milk may be given.

Vitamin deficiencies in the diet must be rectified. To supply vitamin "A" give Cod or Halibut liver oil; to supply vitamin "D" give Visterol and sunbathe the baby for $\frac{1}{2}$ to 1 hour in the forenoon between 7-30 A. M. and 9-30 A. M; to supply vitamins "B" and "G" add dried yeast or wheat germ. After the baby has attained the sixth month of age, give fresh liver and egg yolk in small quantities, depending upon whether the child is able to digest the same. To supply vitamin "C" give orange juice.

In atrophy and in most cases of dystrophica with infection one or two blood transfusions 20c. c. per Kilogram of body weight may be given. In malignant under-nutrition give blood transfusions combined with saline and intravenous glucose. Subcutaneous injections or physiological saline, infusions of glucose and transfusion of citrated blood are often useful.

MADRAS MEDICAL COLLEGE CENTENARY.

The Madras Medical College Centenary was celebrated on the 4th November at the College premises under the presidentship of His Excellency Lord Erskine, the Governor of Madras. Lady Marjorie Erskine was also present. There was a large gathering of medical practitioners besides past and present students of the College; Sir Muhammad Usman, President of the General Committee of the College Centenary celebrations accorded a cordial welcome to His Excellency Lord Erskine and Lady Marjorie Erskine. He briefly narrated how the Madras Medical College which was originally a school developed into a college and earned a high reputation as one of the most efficient institutions imparting medical instruction in the Empire. He said that the medical College supplied these hundred years thousands of trained and qualified medical practitioners who brought to the people of this Presidency and the adjoining Indian States well being in scores of ways maintaining a high standard of accuracy and thoroughness. It was gratifying he said that the celebration had not been confined to medical men alone but was extended to obtain the valuable support of the general public also. He expected that the public would pronounce their verdict of appreciation by making generous response to the call of funds for the advancement of post-graduate research in the College as a fitting monument of the unique event, the Centenary. He also announced that for the purpose of collecting funds the General Committee had decided to keep open the funds for one year till 3rd November 1936.

Lt. Col. Newcomb the Principal of the College then addressed the gathering reviewing the progress of the College which was founded under the order of the Government dated 13th February 1835 and began as a school on the 1st July of that year. The object of the school in the words of this order was "to afford better means of instruction in Medicine and Surgery to Indo-British and Indian youths entering the medical branch of the service in this Presidency". The curriculum of studies extended over two years and the staff consisted of four members—a Superintendent, an Assistant Superintendent and two Assistants. In

1850 the school was raised to the status of a College. In 1852 the College was granted for the first time the privilege of issuing Diplomas to students and enjoyed that privilege for about 15 years, when its Diplomas became merged into the degree of the University of Madras. During this period the College was responsible for several grades of medical instruction, a senior department for training of candidates for the University degree, a junior department for the training of Apothecaries, and a third department for the instruction of candidates for the grade of Hospital Assistants. In 1863 the privilege of granting Diplomas to the higher class of medical students was transferred to the University. The Medical College after its affiliation to the University was recognised by the Royal College of Surgeons and by the Faculty of Medicine of the University of Edinburgh. In 1875 the Medical College admitted lady students to qualify for degrees in the Madras University and the Madras Medical College was the first College in India to open its doors to women students. Lt. Col. Newcomb mentioned the name of Mrs. Scharlieb who afterwards was known as Dame Marie Scharlieb, the famous women practitioner in Medicine at the time. In 1902 the third department of the college for the training of Hospital Assistants was transferred to the Royapuram Medical School. The College which at the time of its inception had a staff of only 4 developed in 1867 to 8 departments with five Professors and various Assistants and in 1901 to 17 Professors and Lecturers and qualified Assistants and to-day after hundred years of progress, it is a well equipped institution with a staff of Professors, Assistant Professors, Lecturers, Assistant Lecturers, Demonstrators and Tutors etc., making up 90 as its staff. The college buildings underwent extensive alterations from time to time and recently new block of buildings were erected at a cost of 12 lakhs. Hand in hand with the improvements to the College there have been excellent improvements to the institutions to give clinical training to the medical students, the General Hospital, the Women and Children Hospital, the Ophthalmic Hospital, and the Mental Hospital. All these institutions had been under-going rapid improvements consistent with the advancement of the Scientific methods of treatment. In reviewing the last annual report of the Medical College the Govern-

ment expressed its opinion that the period of the existence of the college was a century of sustained effort and marked progress, and the appreciable advancement of medical knowledge in South India generally, was mainly due to the efficiency maintained by this institution during its long period of existence. "It is our hope that the progress which has been made in the past may be continued in the future and that the College will continue to advance from strength to strength so that it may be said of its Alumni that there are no better products of medical education in India or elsewhere."

His Excellency Lord Erskine then addressed the gathering as follows:—"Sir Muhammad, Mr. Principal, Ladies and Gentlemen, Speaking on behalf of Lady Marjorie Erskine and myself, I should like first to thank you for the kind welcome which you have given us this afternoon, and to tell you how much we appreciate this opportunity of sharing in so happy an occasion as the centenary of this College. We deem ourselves fortunate that so memorable a date should have fallen within a year of our coming to Madras, and have been looking forward to it with very pleasurable anticipation. For everyone knows that medical colleges, no less in this country than in my own, are homes of good cheer, and the medical student, a hilarious fellow who uplifts a merry voice in our streets and displays himself to great advantage on the field of sport. I confess I find the reason for this hard to understand. It passes my comprehension why to spend a major portion of one's time dabbling in the insides of very dead frogs should be conducive to hilarity; or how eyes accustomed to spend long hours searching for unmentionable things through microscopes can be equally skilled at watching the flight of hockey balls. But such is the reputed effect of medical schooling, and if ever there were an occasion for cheerfulness, it should be this.

It is the custom the world over to shower congratulations upon the centenarian, but all too often the recipient of those congratulations is some mere decrepit mortal who can at best anticipate the dragging out of a few more years of useless and unhappy existence. Not so this college. Here we have a centenarian not only in full possession of his

faculties, but actually showing every sign of increasing strength and vigour and with every right to look forward confidently to many hundred years yet of healthy life and growth. Surely this is nothing less than another of those miracles of modern medical science.

I must confess, ladies and gentlemen, that in matters of medicine and surgery I am the merest layman. I am aware that there are certain portions of the human anatomy which, for reasons partly known to the medical profession but best known to themselves, are accustomed from time to time to go wrong and to have to be removed. I believe, too, that the human body is a mass of tiny organisms, so extraordinarily small as to be quite beneath one's notice, if it were not for the fact that they frequently make their presence felt in sundry unpleasant ways. I am afraid that you will not consider the extent of my knowledge very great, but this I do know, that man, being the unreasonably frail and complicated animal that he is, is in constant need of skilled medical attention, and that for the training of his skilled attendants there is no finer school than the Medical College, Madras.

At the time of the foundation of this College, Medical Science can scarcely be said to have been in existence. There was practically no certain knowledge of the causation of disease and the results obtained by the methods of treatment at that time in vogue were not unnaturally equally uncertain. Medicine was then an art, not a science, and was learnt as an art by apprenticeship. I think I may say that there is still quite a lot of art in it, but it is now much more a science and the method of its acquisition very different. Then the would-be physician picked up his knowledge from washing his master's medicine bottles, and the budding surgeon shareopened the kitchen chopper which was about to hack off a limb. In the absence of anaesthetics and antiseptics none but the most rudimentary operations were possible, and those, apart from being too horrible to contemplate, were very often fatal. The very existence of bacteria as the cause of disease was unsuspected. Indeed, it was not until some years after the foundation of this College that the great discoveries in these fields were made which gave to

medical science an impetus which it has never since lost. The College cannot, I fear, take credit to itself for those discoveries, but it was not slow to take advantage of them, and much valuable research work has been done here in addition to the practical instruction which has been imparted. We may point with pride to the discovery in 1903 by Donovan, a Professor of this College, of the parasite of one of the then most deadly diseases prevalent in South India—Kala-Azar, paving the way for the subsequent introduction of a treatment which has reduced the death-rate of that disease from 100 per cent to almost nil. The progress of medical science in the second half of the last century was indeed rapid, and no less rapid since 1900. With every step forward its complexity has increased, and parallel to it has been the growth of this College. The history of the College is in fact the history of medicine in South India, until to day it stands a noble monument to one hundred years of steady and devoted service in the interests of humanity. Attached to it are a wide range of clinical institutions as up-to-date and efficient as any in India, and amongst those in charge of them are men whose repudiations are world-wide. At the recent F. R. C. S. examination, held for the first time in India at this College, Madras candidates secured better results than their fellows from all parts of India, and I may fairly claim that the repudiation of our medical profession is second to none. A word, too, of congratulation to our lady students. For is it not the fact, and justly so, that they who first stormed the citadel of male prejudice here in Madras are still able to hold their own in competition with the so-called sterner sex.

Ladies and gentlemen, we are met to day in an institution of which any city in the world might well be proud. It is an ever-growing institution and this fine building in which we now find ourselves is the latest addition to its requirements. But its needs are many yet. I think I am entitled to say that my Government have in the past dealt generously by the College, and I would now urge that the College deserves generously at the hands of the public. That the Madras public can be generous is shown by the example of a lady who has within the last few days offered an endowment of Rs. 50,000 for the institution of scholarships tenable in this college. I refer to Mrs. Kamala Ranga

chari, and it gives me great pleasure to take this opportunity of expressing to her the gratitude of my Government for her munificent gift. The President of the Centenary Celebrations Committee has informed you that a Centenary Fund has been opened and will be kept open for a year from this day. I understand that subscriptions to it already total Rs. 14,000 apart from Mrs. Rangachari's gift. I warmly sympathise with this undertaking and I confidently appeal to you and to the public at large to give it your generous support, for no worthier object for your charity could be found.

In conclusion, ladies and gentleman, I would like to assure you that the interest taken by Lady Marjorie Erskine and myself in this College is deep and abiding. This afternoon will long remain amongst our happiest memories of Madras. We wish the College and its Centenary Celebrations all possible success."

An enjoyable Tea Party followed and the Centenary Celebration came to a close that day.

Centenary Exhibition.

The Centenary Exhibition was opened at 10 A. M. on Tuesday the 5th of November by Lt. Col. Newcomb, the Principal who also unveiled portraits of some of the past members of the staff Major H. Kirkpatrick, Major A. C. Ingham, Rao Sahib K. Vasudeva Rao, Bahadur M. C. Koman, Rao Bahadur C. B. Rama Rau, Lt. Col. R. E. Wright, Dr. P. S. Chandrasekhar and Col. A. J. H. Russell. The exhibition was kept open for four days till the 8th evening. Admission was by tickets (4 as. each). All the departments of the College put up very interesting exhibits. They were divided into many sections.

Medical Students' Dinner.

The old students of the Medical College arranged for a dinner under the auspices of the Centenary Celebrations. Dewan Bahadur Doctor C. Natesa Mudaliar M. L. C. presided on the occasion. Covers were laid for nearly 300 persons.

Dewan Bahadur Dr. C. Natesa Mudaliar proposed the toast of His Majesty the King-Emperor.

The toast of 'Our Alma Mater' was proposed by Rao Sahib N. Ramaswami Naidu, the oldest student of the College. In the course of his speech he said that he was

about eighty years of age and that he joined the College in the year 1865. His father was also a medical man and served in the Army. In his day the Medical College was located in a couple of rooms attached to the General Hospital and he was glad to see the modern palatial buildings of the College.

Lt.-Col. Newcomb, the Principal, replying, said :—

"I feel perhaps it would have been more fitting that one of the real sons of this Alma Mater should have responded to this toast rather than an adopted son—as I hope I may consider myself. To many people the College means the buildings and indeed I often feel that it means buildings more than anything else to the inspectors who come from time to time to have a look at us.

The buildings are merely the outer husk. The College, properly understood, is the company of men and women who work here. In them we can all take a legitimate pride. We have now a very highly qualified staff and what are commonly called the bad old days are gone, when men were put in to teach largely on account of seniority and other considerations and with little thought to their knowledge of the subject they had to teach. I think it is remarkable how successful the teachers were in those bad old days and this serves to confirm my idea that the personality and general culture of a teacher are of as much or more importance than his specialist knowledge."

Rao Sahib Dr. U. Rama Rao then proposed the toast of the medical profession. In doing so, he observed that it was a rare honour and privilege to propose the toast of the medical profession. He paid a tribute to the Indian Medical Service for all that they had done for India. While he was a student, he observed, the professorial classes were managed by the members of I. M. S. only. But now there was a number of Indian Professors on the staff.

Lt. Col. Wright replied to the toast in a short speech. He observed that the profession was divisible according to him into two great groups, the profession as it existed for him and the world at large, and the profession as it existed for him and the country, more particularly this Presidency of his adoption.

Dr. A. Lakshmanaswami Mudaliar proposing the toast on behalf of the guests ob-

served that it was a red-letter day in the annals of the medical profession in Southern India, and the first occasion when a real old students' rally had taken place.

Continuing, he said : We are pleased to have amidst us the Hon'ble the Minister for Public Health to day. In medical dinners this is not the first occasion when the representative of the Government has graced the occasion with his presence. In 1913, I am able to recollect the first dinner I attended. Sir Alexander Cardew the member of Government was present.

He then paid tributes to the great services rendered by Sir Alexander to the advancement of medicine in this presidency. The next great administrator of medicine was the late Raja of Panagal. Col. Russell was also referred to by the speaker as one of the persons who was responsible for the Medical College as it was to day. He thanked the elected representatives of the new students of the college and the lady students. He referred to the achievement of Mr. Alva the Assistant Secretary of the students' representatives in his being able to start and run a hostel for the students which was entirely self supporting. In this connection he recalled the demand made for a medical hostel and the Government's promise about thirty years ago.

He concluded by expressing thanks on behalf of the executive committee of the centenary celebrations to all present and gratitude to Col. Newcomb for the active interests he had taken in the celebrations.

Dewan Bahadur S. Kumaraswami Reddiar replying to the toast said that Dr. Lakshmanaswami Mudaliar had spoken a great deal about the professors who were old students of the college. He referred to the election of representatives by the college students and said that the day would come when medical men would turn out to be politicians and hold their own portfolio as Ministers. (Cheers.)

In conclusion, he observed that the Old Students' Association, though it was only a few months old, had been doing active work as was evident from the day's function. He wished the Association long life and a bright future.

CLINICAL NOTES AND PRACTICAL SUGGESTIONS

Ovarian therapy.

As a result of scientific research and experiment during the last twenty years Ovarian therapy has become one of the best developed and most effective methods of treatment. With the advent of exact knowledge of the follicular or female sex hormone it was comparatively easy to evolve a satisfactory method of standardising preparations containing these hormones. Accurate animal experiments thus became possible, and on these, clinical application of these hormone-containing preparations were based. All this knowledge has resulted in therapeutic possibilities now at our disposal with the ovarian glands. There are two hormones in the ovary, the follicular hormone and the luteal hormone. Some believe that there exist in the ovary other hormones, which are at present unknown, which may be termed metabolic hormones which play a decisive role in the formation and maintenance of the female secondary sexual characters, and the normal internal economy of the female organism. It is often difficult to find out from the clinical symptoms what particular hormone or hormones are deficient and the administration of the extracts of the entire ovary is therefore always desirable. Opocrin Ovary (A. F. D.) is such a product and it is prepared from the ovaries of freshly slaughtered animals under conditions which observe all precautions necessary for scientific research, for the production of pure ovarian preparations of the highest quality.

Opocrin Ovary is the safest and simplest remedy for the relief of disorders due to the cessation of the ovarian functions. It compensates for the hormone derangement by means of substitution. Its action is rapid and definite. It exercises a profound influence on the function and development of the infantile sexual organs and the castrated and senile females. It has also a favourable tonic influence on the female organism as a whole. The hormones in this Ovarian preparation remain effective even when it is orally administered, because the hormones are not destroyed by the gastric juice or the digestive ferments. It is necessary however

to prescribe large doses for a long period of time if specific effects are desired. Besides the oral administration of these Opocrins we have ampoules for parenteral exhibition. The preparation can be injected subcutaneously without causing any infiltration.

The field of application for Opocrin Ovary therapy is a broad one. Ovarian insufficiency forms an important indication for this therapy. In these cases menstruation is regularised, the mammary glands become fully developed and the sexual characteristics assume the usual mature form. The Opocrin therapy has proved valuable in the treatment of this condition. It is a rational and effective treatment for those cases of hypo-ovarian function with inadequate follicular development and varying degrees of uterine atrophy. These cases respond quickly to this line of oral treatment, supplemented by the injections of the same preparation.

Climacteric disturbances and cases of Ovariectomy from other important indications for Opocrin Ovary therapy. Through the application of this treatment we are able to avoid the general bodily disturbances, usual at this stage due to the acute deficiency of the ovarian hormones and to adjust the organism to this diminishing supply. There is great relief of the vaso-motor disturbances. Mental changes such as psychic depression etc., complained of by these patients are benefitted, due perhaps to the generalised tonic effect of the treatment. All the menopausal discomforts of vaso-motor or nervous character are done away with by the regular intake of Opocrin Ovary. Thus eczema, pruritus, neurasthenia or melancholia, the usual concomitants of the climacteric are avoided by this means. Opocrin Ovary is of particular value in the artificial menopause caused by the total extirpation of the ovaries. The patient goes through the distressing period of climacterium if she is on Opocrin Ovary regime, without feeling any discomfort of hot flushes, irregular hæmorrhages, sweating, headache etc.

In cases of amenorrhœa of long duration Opocrin Ovary is of great benefit. The menses appear promptly and become quite regular. This action resembles ovarian transplantation. The function of the ovaries is soon brought into action and later continues to be normal.

Hypotensyl tablets reduce Diastolic Hypertension.

In cases of menorrhagia or metrorrhagia the results with this therapy are satisfactory. The bleeding becomes normal and regular by prolonged administration of Opocrin Ovary, supplemented if necessary, by the injections of the same.

Opocrin Ovary is the rational treatment of dysmenorrhoea as many of these cases are due more to the defective neuromuscular mechanism of the uterus than the abnormalities in the cervix. This therapy restores this mechanism to normal and remedies hypoplasia of the myometrium. Thus by maintaining the constant supply of the necessary hormones, the menses become free and regular without causing any discomfort to the patients.

In obesity due to the deficient ovarian hormones Opocrin Ovarian therapy is of proved value. By supplying the necessary hormones it improves the defective metabolism and soon restores it to normal. Reduction in weight takes place gradually and at the same time secondary sexual characteristics attain their normality.

In skin diseases such as eczema, pruritus, acne etc. which can be traced to disturbances of the ovarian function Opocrin Ovary is of immense value. If in addition to skin diseases there is amenorrhoea, infantilism of the genitals, under development of the mammary glands or immaturity of the sexual characteristics, then we should take it for granted that there exists close connection between the ovary and the skin trouble. Such cases can be successfully treated by means of this Opocrin medication. Complete disappearance of the skin lesions takes place after the regular use of these Opocrins for two to six weeks according to the severity of the case.

Remarkable improvement is noticed in cases of Rheumatic Arthritis dependent on the hypo-secretion of the ovaries if Opocrin Ovary is administered along with the injections. Decrease in swelling of the joints takes place after a short time and they become free from pain and fit for use. This improvement is seen one or two weeks after the administration of these Opocrins, and it continues if the therapy is carried on until the next period, when it is likely that acute exacerbation may occur. It is there-

fore highly essential to continue this Opocrin medication for long periods in order to free the patient completely of this troublesome complaint.

We have thus seen that Opocrin Ovary gives positive and discernible effects in the various indications mentioned above. It fills a definite place in the treatment of various conditions resulting from deficient functions of the ovaries. It can be confidently prescribed in them without fear of any harmful by-effects resulting from it. As regards the action of these Opocrins it is far superior to any similar preparation as is evident from its therapeutic effects, and specially its influence on metabolism. It is in short an effective casual and symptomatic remedy for the treatment of all disorders arising out of ovarian dysfunction.

The following is a selection of a case effectively treated with Opocrin Ovary.

This patient aged about 42 came to me complaining of hot flushes, insomnia, globus major and irritability—all of three years' standing. There was marked digestive disturbance. Menstrual intervals had been regular, but the flow was very scanty. Recently she had put on weight very rapidly. She had extreme depression and frequent hot flushes. Opocrin Ovary was prescribed together with injections of the same. Injections were given on alternate days and she took six Opocrins daily. After twelve injections and one month's regime of the Opocrins, she began to get distinct relief in her symptoms. The flushes had disappeared and she began getting sound sleep every night. The injections were continued, so also the Opocrins. A month later irritability, the feeling of globus major and digestive disturbances had completely gone. The menstruation had become regular and complete and there was distinct reduction in weight. Five months of this treatment which consisted nearly of 40 injections and six bottles of Opocrin Ovary made her feel absolutely all right. There were no flushes, no irritability and she began to get a normal four-day menstruation. She is feeling quite fit at present and is much reduced in weight also.

Cryogenine:

The introduction of Cryogenine according to the opinion of several distinguished clinicians is a distinct advance in the realm of therapeutics. It is metabenzamido-semicarbazide and unites in itself valuable properties of the pyrazolon derivatives, also it has a very synergistic effect. It is a white crystalline powder with no smell or taste.

Cryogenine has been found to have a prompt antipyretic action. In various kinds of fevers it reduces the temperature in a decisive manner where other similar preparations have failed. This fever reducing action of Cryogenine sets in slowly, but is of long duration. Its analgesic action displays itself in influencing the central sensation of pain. Hence Cryogenine constitutes a powerful analgesic, absolutely innocuous and remarkable in the constancy of its effects. Cryogenine presents a combination of pronounced analgesic and antipyretic properties. Extensive pharmacological and clinical experience has confirmed the value of this remedy. Its effects are characterised by rapidity of action, intensity and duration of analgesia and freedom from by-effects.

Cryogenine has proved itself an exceptional antipyretic in all cases in which it is employed. The fall in the temperature follows promptly with quite moderate sweating. This antipyretic effect lasts from 8 to 10 hours and then the temperature may rise again, but it never reaches the original height and comes down to the normal in a relatively short time. From clinical experience stretched over long periods of time, the impression has been gained that the oral administration of powders in 5 to 10 gr. doses every 3 to 4 hours, three or four times a day has very soothing and remarkable antipyretic effects. The fall of temperature is always by lysis and not crisis. Even in sensitive patient and those affected by vomiting no disturbances of the gastro-intestinal tract have been observed with this oral method of administration. Due to this reliable antipyretic action of Cryogenine there are no limits set to its administration.

In addition to its antipyretic action Cryogenine displays marked analgesic effects. Frequently an hour or two after the administration of Cryogenine the pain begins to abate. In neuralgia of whatever nature definite remission of pain is always obtained

if Cryogenine is continued, specially in large doses. The rapid and lasting analgesic effects of this preparation has always been its great striking feature. On account of this conspicuous and rapid therapeutic effect, particularly rapid abatement of pain, Cryogenine has displaced other pain-relieving remedies and even Morphia.

The principal fields for the application of Cryogenine are internal diseases. It is the remedy of choice in all fevers, in acute neuralgia and in painful conditions of every nature with very few exceptions. Cryogenine can be used as an antipyretic in almost all fevers due to any cause. It promptly reduces the temperature without causing any harm. Improvement in the subjective symptoms is soon observed in the majority of cases. In pneumonia, influenza, pleurisy, enteric fever etc., besides reduction of fever, diaphoresis is brought about in a favourable manner. In typhoid even a certain and lasting remission of fever has occurred in several cases. Cryogenine is valuable in phthisis also. The results in these cases are only temporary but still favourable, as besides the subsistence of temperature a subjective well-being is definitely perceptible, specially in the initial stages of the disease. These effects are more marked in children. In pyrexia due to sepsis the preparation renders valuable service. Although the temperature in these cases cannot be reduced to normal, still it can be kept one or two degrees lower and the subjective condition of the patient can be considerably improved.

The analgesic action of Cryogenine is equally effective and for this reason it has been used in pains of every description. The relief of pain is not narcotic in character but a sort of relaxation. This latter follows cessation of pain and then a sound and restful sleep results. This sleep is not, however, obtained in each and every case but a well marked euphoria, mostly psychic in character due to the relief of pain, is observed in almost every patient. Hence it is valuable in headaches of whatever origin. In cases of neuralgia such as intercostal neuralgia, trigeminal neuralgia, the pains often cease promptly enabling the patient to take a good restful sleep. In dental practice Cryogenine is an ideal medication on account of its rapid action of alleviating pain and the absence of any secondary effects. It is specially valuable after extractions and other

interventions, in dental periostitis, pulpitis, neuralgias of the trigeminal nerve etc. It is necessary for analgesic effects to give Cryogenine in large doses. In colics, whether biliary, renal or intestinal, Cryogenine is of special value in view of its effective analgesic action and absence of danger. In cases of sciatica not only do the pains abate, but if it is continued long, no recurrence of the trouble ever occurs. Cryogenine is used successfully for alleviating pain during menstruation but for this purpose large doses are always essential. From all this we can deduce that Cryogenine fulfills a great need in therapeutics for effecting rapid relief of pain, thus eliminating the need to resort to habit producing alkaloids.

The outstanding quality of Cryogenine is its freedom from any injurious by effects. So far nobody has come across a case of drug-rash due to its use even for long periods. Its excellent tolerability has assured it a permanent place in therapeutics. No disturbances of the heart or the vascular system has ever been observed. The blood-pressure remains unaltered after the administration of this preparation. The urine always remains free from albumin and sugar. Cryogenine is absolutely harmless and there is no question of habit-formation due to its use. Hence it is of immense value in the relief of pain.

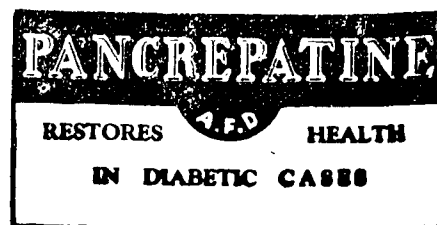
The results obtained with Cryogenine are so encouraging that we can assert with confidence that it has completely fulfilled the expectations formed of it. Due to the fact that it can be employed in a variety of complaints the general practitioner will find it of great use in his daily work.

Cryogenine has rendered signal service in numerous cases at the hands of the author and the following is typical of them:

A young woman about 25 years of age was suffering from a severe type of Dysmenorrhoea. Every period was a time of great torture for her. She was prescribed Cryogenine tablets, 2 of which she took every 3 hours. These tablets kept her very comfortable and she was able to do her usual work during the periods without the least discomfort. Her periods are now entirely free from pain, as she has always at hand a bottle of Cryogenine tablets.

An Interesting Case Report.

1. A young man of 30 came to me for his Asthma of about two years' duration. When he came to me he was in a very bad state of health and extremely thin. He told me that a cold in the nose and head invariably preceded the asthmatic attack. He complained of absolute incapacity to mount any stairs. The attacks of dyspnoea were repeated pretty often. These were at times very violent. Sneezing and coryza was very frequent. There was oppression in the chest with tachycardia. His general health was very much shattered, there was emaciation, anorexia and insomnia. On auscultation over the lungs I found sonorous rhonci and subcrepitant rales all over. There was nothing abnormal about the heart except that the sounds were somewhat feeble. All the usual treatments have been tried without much success. They only temporarily relieved the condition. Biocalcium injections were at once started and for the acute attacks Felsol was prescribed. The first three injections of Biocalcium did not show any perceptible change, but after the fifth injection his breathing became very much better. Injections were continued every other day. After ten injections were given the improvement in his condition was simply remarkable. The patient was able to breathe well and he had no longer any discomfort. There was no fatigue, no oppression in the chest and he was able to climb the stairs without being obliged to stop. He was able to sleep well, his strength was returning rapidly and he had very good appetite. The lungs on examination were found to be quite clear. The cure has lasted for nearly three months, which period was completely free from anything, even slight coryza. His strength has returned and he is capable of doing a day's hard work without the slightest discomfort. This complete cure has been obtained by three courses of ten injections of Biocalcium. No other treatment was given in this case.



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Abstracts

NOTES ON THE MEDICAL SCHOOLS OF INDIA.

BY THE DIRECTOR-GENERAL, INDIAN MEDICAL SERVICE

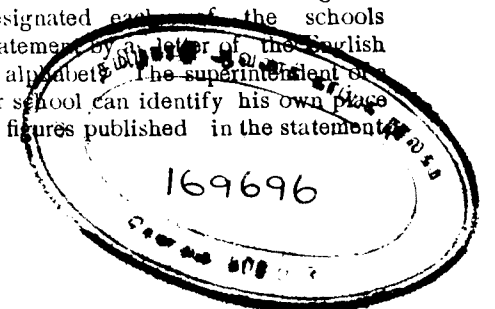
1935

In the course of journeys throughout the greater part of India, entailed upon me by service in different provinces and by my present appointment, I have taken the opportunity to visit many medical schools where education of the licentiate medical standard is given. There cannot be many medical officers whose duty will have led them to visit many of these medical schools in widely distant provinces and whose training can qualify them profitably to note on their observations: so it has occurred to me that remarks upon the medical schools of India as a whole considered with information about each school should be of aid to the teachers and superintendents of these schools and to the Governments and other bodies who control them. Indeed it seems to me that the collection of such information is a necessary prelude to a general improvement in the standard of licentiate medical education.

There are 28 medical schools in India, including one in Burma: they are under provincial or other local control with but little centralising influence and the staff of one school have no direct knowledge of what is being done in distant schools outside their own province. No one can have visited many of these schools without being struck by the difference in standard amongst them, by the variations in buildings, equipment and staff. There is much more difference between the best and the worst medical school than there is between a good medical school and a medical college affiliated to a University. The reason for this is not difficult to see. There have been stronger centralising and equalising influences at work among Universities and Medical Colleges than among Medical Schools. For one thing the medical colleges have of recent years had more attention paid to them and by reason of their past association with the General Medical Council of Great Britain a minimum standard for higher medical education has been arrived at, a standard that it will be the work of the Medical Council of India to

sustain and improve. The standard of education in medical schools is under the eye of provincial medical councils, who consider local needs; but these schools are without any central co-ordination. Whether such co-ordination is necessary or not, it is advisable that the various schools should have some knowledge of what the schools in other provinces are doing and some means of comparison. It has been suggested that a single inspecting body should visit the schools and report on them. Since these 28 schools are placed all over India and Burma, such inspection would obviously be expensive and lengthy and is outside present consideration. But meanwhile something can be done and to this end information has been collected on some essential points in medical education at the schools and some of that information is given here. Certain details have been obtained from the annual reports of the medical schools and questions on other practical points have been sent to the school authorities to enable this information to be enlarged. Here I take the opportunity of thanking those authorities, whether of Government or private schools, for sending me their reports and the answers to my questions. The parts of this information that lend themselves to tabulation are given in a statement at the end of these remarks and some explanatory notes and comments of my own precede the statement.

I wish it clearly understood that there is no criticism here of any individual school. From what I have seen of the schools I believe that they are all doing their best with the sometimes poor means, financial or otherwise, at their disposal, and much credit is due to their superintendents and their staffs for having done as much as they have. But the staffs of these schools will be the first to admit that there is room for improvement. When they study the tabulated statement here they will identify their own school and see what other schools are doing and they may be able thereby to induce changes in certain items in their own schools. If so, that will be all to the good; and they can be assured that the figures relative to their own school are confidential. To ensure that being so I have designated each of the schools in the statement by the use of the English or Greek alphabet. The superintendent of a particular school can identify his own place from the figures published in the statement.



with which he has furnished me; but no one else is likely to recognise his school from these figures.

It is not suggested that the figures here given can show a complete picture of the school's condition. Many questions, pertinent to the efficient instruction of medical students, have not been asked. For instance no enquiry has been made whether the hospital attached to the school possesses a radiological section, or has a proper staff of nurses or a Nurses Training School. All these, and other things, are items which most of us regard as necessary for the complete training of medical students; but we know that several of these hospitals do not possess these things, and this first enquiry is only into the points we regarded as more essential.

In the comparative statement we have not tabulated replies to all the enquiries made, though the replies on other points are also interesting. Enquiry was made as to the cost to the educating authority per student per annum after laying down for the sake of uniformity certain principles on which this calculation should be made. The average cost seems to be about Rs. 300 per annum per student, though schools for women only usually cost more, probably because of the fewer number of students in comparison with the number of staff to be paid. There is, however, extraordinary variation in the replies received. Thus in School J the cost is only Rs. 60 per annum and 80 per cent of the students are private, and in School F the cost is Rs. 62 per annum and all are private; while in School N, a women's school, the cost is Rs. 960 per annum and none are private, and in School V, where the sexes are mixed, the cost is Rs. 952 for a stipendiary and Rs. 564 for a private student: presumably reckoning without the student's fees the cost would be Rs. 952 for every student. This difference in cost per student is apparently reflected in the standard of instruction because School N certainly compares well with others.

Question was asked also on the preliminary standard of education before entry to the medical course. In all provinces the Matriculation or School Leaving Certificate is the standard usually taken, though one province is obtaining an appreciable number of Intermediate-passed entrants. Another province accepts women students at a lower entrance standard. I believe this to be a mistaken

policy. It can be defended by representing the need for women doctors and the lack of applicants unless the entrance doors are widened: but it is doubtful if a woman who has not attained Matriculation standard can take with profit a medical course, and at any rate the time has now come when a higher demand should be made on women entrants. We should have women doctors of satisfactory standard or not at all. This leads naturally to the much bigger question whether we should try to educate a large number of students in an inferior manner or fewer students in a comparatively satisfactory manner: whether we should have many inferior schools or a few satisfactory ones. Because we cannot have it both ways. There are only a few places in each province with hospitals large enough to provide clinical material for a medical school. Further, the cost of the school and hospital buildings, and the cost of the equipment necessary to instruct students properly both in school and hospital are such that no province would be prepared to provide a correct standard of buildings and equipment for more than one or two schools. Perhaps more important still is the matter of the teaching staff. Except in the two largest cities where the services of a well-qualified staff can usually be obtained on a voluntary basis, there is not yet in any province a sufficiency of medical men, highly qualified enough to be considered of medical education standard, to staff more than one or two medical schools in addition to the medical colleges. If, therefore, we multiply medical schools they must, at any rate for the present, be inferior in several respects. It is a matter of policy to be decided therefore whether we should have several inferior or a few satisfactory schools and different provinces have followed different lines, while the same province has apparently changed its policy with the times. The Madras Presidency formerly had 6 or 7 medical schools, but now has only 3, two Government and one private. The Bengal Presidency has 9 schools, 6 Government and three private, and some of them of recent establishment. Which is the correct policy? It may be argued that many cheap doctors are wanted for the villages, to replace inferior practitioners or supply some sort of medical aid where none exists; that it is no good sending expensive doctors there because the people cannot pay them, that it is better to send out registered medi-

cal men with some sort of qualification, however inferior, than to leave the rural population to ignorant and unqualified practitioners. It has even been said we should multiply compounders and send them to the villages since doctors will not go and cannot get a living. This question was considered at length in Madras in 1929 when a Medical Education Committee was established that decided that the Presidency did not so much need more doctors as better doctors. Experience seems to show that the average medical man, if not properly educated, when he is let loose on the world to practise his profession, himself tends to degenerate and to become hardly better than the man he is intended to replace. It is only the exceptional man who, without a satisfactory education, can make good and educate himself until he becomes a really good doctor. If that is so, it certainly seems better to have a few satisfactory schools rather than several inferior ones and that seems to be the generally accepted policy, because the average number of medical schools per province or State area works out to about 2½.

One method that has been used in the past to economise equipment and teaching staff is to have a medical school in the same building as the medical college and using the same hospital. This is not satisfactory: both college and school are likely to suffer, and the experience of the past has led generally to the abandonment of this plan. There is only one place where this is still done.

Before examining the tabulated statement we may consider what standard in certain respects we should try to attain. From what has been said above it will be expected that most of the medical schools will be overcrowded with students, and indeed that is so, except in the case of a few schools for women. This is certainly regrettable, because overcrowding of students in proportion to laboratory accommodation and equipment, amount of clinical material, and number of teaching staff, are the most potent causes of inefficiency of education. The province with the largest number of schools has them even more overcrowded than the other provinces.

Here I propound seven standard rules to which I consider a school should try to attain. All these rules are concerned with

the proportion of patients and certain equipment to the number of students. There are doubtless other rules of proportion: I am suggesting only a few that experience has taught me are important. If anyone thinks that these standard rules tend unduly to restrict the number of students I can only give it as my experience that lower numbers tend to better education.

Standard Rules.

Let x = Total number of students in the School.

and y = Number of students admitted annually.

Where the instruction is a 4-year course it will generally be found that $x = 4\frac{1}{2}y$, and in a 5-year course that $x = 5\frac{1}{2}y$ or a little more. This allows for failures in examination and for some students abandoning the course. If these numbers are not approximately in this proportion, and a study of the tabulated statement will show that they are often not so, then there must be some other factor dislocating the proportion, such as an unusual admission number in one or more years, or an exceptional number of students abandoning a medical career.

(i) The sanctioned number of beds in the hospital or hospitals, including special departments, should be not less than $5\frac{1}{2}$ times y .

(ii) The number of beds in the hospital should be not less than x .

(iii) The daily average of in-patients should be not less than 5 times y .

(iv) The daily average of in-patients should be not less than x .

(v) The average annual number of confinements available for teaching students should be not less than 10 times y .

(vi) The numbers of microscopes available for teaching physiology should be not less than $4/3y$.

(vii) The number of microscopes available for teaching pathology should be not less than $5/4y$.

I will not stop to explain why I have fixed on these arbitrary numbers except to say they are the result of experience. I have fixed on the item of microscopes because they are the most expensive articles of equipment a student uses and they form a fair gauge of the general adequacy of laboratory education. I do not regard a microscope as fit for physiology teaching unless it

has 2/3 and 1/6 objectives, nor for pathology teaching unless it has 1/12 oil immersion in addition to the other two. Deficiency in microscopes is the only item in which every medical school is below the standard of these Standard Rules and the real reason is the expense. The methods different schools employ to obviate this deficiency are numerous; the explanations given are, that the students do not require to prepare specimens themselves, but are shown those prepared by demonstrators; that the students do their practical classes in batches; that two or more students share one microscope; that microscopes are used in common between physiology and pathology; that microscopes are borrowed from the medical college. All these methods are unsatisfactory. A microscope is an individual article of equipment that should be in the care of one student during the course of the practical classes. Although no school attains what I consider the correct standard so far as microscopes are concerned, the deficiency of some schools is deplorable. How can School H with 50 students admitted annually teach pathology with only 4 microscopes and School I with 115 admissions with only 8 pathological microscopes? School K has only 5 and School L but 2, while School U has only 3 microscopes for physiology, and Schools X and Y have but 3 and 2 respectively for pathology. These are notable deficiencies.

My figures are still more arbitrary when I come to assess the numbers and qualification of the various staffs and it should be recognised that I am but expressing a personal opinion based on the lists sent. I have taken 5 marks in each case as a maximum to represent adequacy of the numbers of staff allotted to teaching and clinical work, and to the special qualifications of the staff as a whole for the work they have to do. Obviously a paper estimate cannot be really satisfactory; and in assessing the arrangement of duties among a staff, usually inadequate in numbers, another 5 marks has been allotted. In some cases the teaching of more than one subject falls to one member of the staff, and we see such combinations as surgery and hygiene, anatomy and medical jurisprudence, gynaecology and ophthalmology, pathology and radiology. The assessment in this respect is therefore largely dependent on the number of staff available.

The percentage of marks necessary to obtain a pass varies in many schools in different examinations: so the figures here given are those of the final examinations only. Most schools have a 40 per cent. standard, and it is good to see that now there are more with a 50 per cent. standard than there are with only 33 per cent.

In assessing the adequacy of the methods for appointment of examiners, the appointment of external examiners, men of recent teaching experience, to examine in conjunction with the internal teachers, is considered satisfactory; while the appointment of the school's teachers alone, or in conjunction with local practitioners, who are not teachers, is considered unsatisfactory. A member of the staff of one school represented to me that examiners at one school should be appointed from among the staff of other schools and that by so doing knowledge of the conditions in different schools would be disseminated as well as the appointment of unbiassed examiners secured. This would certainly be a better method of appointment than that employed in his own school; but in most schools examiners are appointed by an Examining Board or by a Medical Faculty and the selection made is satisfactory.

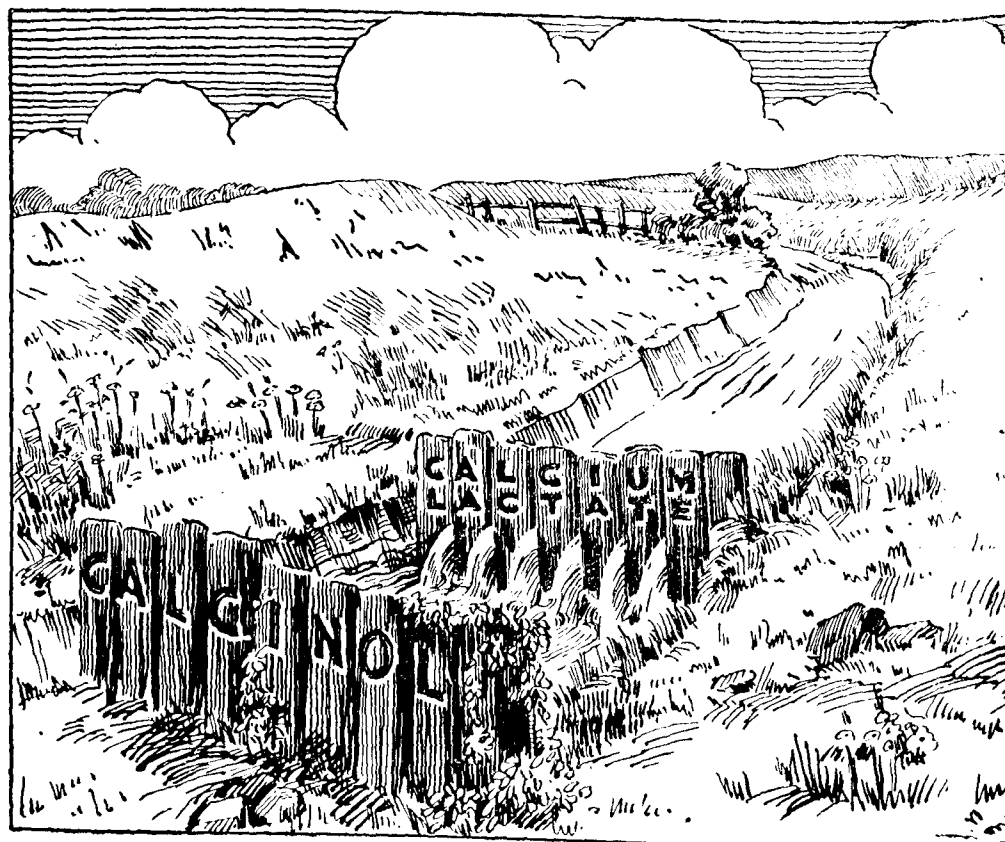
The number of labour cases available for training students varies greatly with the different schools. Some of them have special maternity hospitals attached. Schools teaching women only are as a rule abundantly provided for; but some of the schools teaching both men and women cannot be teaching much practical midwifery to either sex. The hospitals attached to Schools C and L have only 14 and 9 labour cases in the year; but in most cases the deficiency is realised and the school authorities are doing their best to remedy this.

From what has been remarked above it is evident that the two principal defects in most medical schools are overcrowding and deficiency of equipment. If the communication of the few facts here given is held to be a step in the right direction and if further advance is considered feasible, the next step in such advance should be in my opinion a central and so far as possible all-India meeting of representatives of the various schools and of their controlling bodies, Government and private.

Sex of Students.	Staff. Maximum marks under each head.				Maximum No. of annual admissions.	School.			Arrangement of duties.	Percentage marks necessary for pass at final examination.	Satisfactory "S."	Unsatisfactory "U."	No. of beds in attached hospital.	Daily average of in-patients.	Annual number of consultations.	Number of Microscopes for teaching.		Length of course in years.	Conformity with Standard Rules.
	Numbers.	Qualifications.	Numbers.	Qualifications.												Physiology.	Pathology.		
A	62	1	2	2	1	1	2	2	1	33	U	U	236	197	247	12	17	4	Deficient in all 7 rules.
B	305	1	2	2	1	1	2	2	1	50	U	U	216	199	93	20	18	4	" Ditto.
C	276	1	2	2	1	1	2	2	1	50	U	U	109	88	14	7	10	4	" " in all but Rule ii.
D	180	1	2	2	1	1	2	2	1	40	U	U	117	454	342	32	28	4	" " in all 7 rules.
E	580	1	2	2	1	1	2	2	1	40	U	U	288	174	254	18	17	4	" do.
F	799	1	2	2	1	1	2	2	1	40	U	U	150	115	125	16	8	4	" do.
G	434	1	2	2	1	1	2	2	1	40	U	U	146	122	41	12	8	4	" do.
H	199	1	2	2	1	1	2	2	1	40	U	U	83	63	54	12	4	4	" do.
I	222	1	2	2	1	1	2	2	1	40	U	U	261	259	144	48	8	4	" do.
J	490	1	2	2	1	1	2	2	1	40	U	U	112	96	34	14	4	4	" do.
K	238	1	2	2	1	1	2	2	1	40	U	U	109	85	47	19	5	4	" do.
L	168	1	2	2	1	1	2	2	1	40	U	U	101	85	9	13	2	4	" do.
M	171	1	2	2	1	1	2	2	1	40	U	U	354	389	2,722	88	23	4	" do.
N	503	1	2	2	1	1	2	2	1	50	U	U	120	175	2,109	32	9	5	" in i, ii, iii and vii.
O	20	1	2	2	1	1	2	2	1	50	U	U	250	146	284	15	15	5	" in vi and vii only.
P	108	1	2	2	1	1	2	2	1	50	U	U	176	200	17	30	32	4	" in all 7 rules.
Q	416	1	2	2	1	1	2	2	1	50	U	U	240	175	1,068	19	10	4	" in ii, vi and vii.
R	128	1	2	2	1	1	2	2	1	40	U	U	131	187	46	29	17	4	" in all 7 rules.
S	241	1	2	2	1	1	2	2	1	40	U	U	218	181	62	12	6	4	" in i, ii, iii and vii.
T	199	1	2	2	1	1	2	2	1	40	U	U	296	258	243	33	25	4	" in all except i.
U	309	1	2	2	1	1	2	2	1	40 & 33	U	U	155	113	1,124	3	6	4	" in ii, vi and vii only.
V	100	1	2	2	1	1	2	2	1	40 & 33	U	U	540	379	2,310	10+	6+	4	" in vi and vii only.
W	168	1	2	2	1	1	2	2	1	40	U	U	300	225	803	24	30	4	" in all except i.
X	318	1	2	2	1	1	2	2	1	40	U	U	220	233	215	13	3	4	" in all except ii and iii.
Y	174	1	2	2	1	1	2	2	1	40	U	U	144	120	41	12	2	4	" do.
Z	119	1	2	2	1	1	2	2	1	40	U	U	250	225	90	7	10	4	" in rules i, vi and vii.
AA	46	1	2	2	1	1	2	2	1	40	U	U	250	250	623	12	10	4	" in ii and iii only.
BB	233	1	2	2	1	1	2	2	1	40	U	U	75	61	157	14	...	4	" in all 7 rules.

N.B.—Under the first column "Sex of Students" after "Z" AA and BB have substituted for the Greek letters mentioned in the Note.

* Since lowered to 35.
+ S 31 from College.
‡ S 44 from College.



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[NO. 2

MADRAS NEEDS A STATE MEDICAL FACULTY.

We learn that the examiners referred to in the Editorial on the above subject appearing in these columns last month, are not selected by the President Board of Examiners, but are recommended by a Committee of which the President Board of Examiners is the Chairman. We regret the error. We need hardly point out that our only object in writing the Editorial on the above subject was to show that the teaching in the Women Medical Schools was not unsatisfactory as might be thought in some quarters and to suggest the need for a State Medical Faculty in this province. The Editorial was not meant to cast any reflections on anybody.

MEDICAL SCHOOLS OF INDIA.

Major-General C. A. Sprawson, the Director General of Indian Medical Service has recently published a booklet with a title "Notes on the medical schools of India" The purpose of this publication seems to be in the words of the author "that remarks upon the medical schools of India as a whole considered with information about each school should be of aid to the teacher and superintendents of these schools and to the Governments and other bodies who control them. Indeed it seems to me that the collection of such information is a necessary prelude to a general improvement in the standard of licentiate medical education." The notes of Major General Sprawson have been published in the Abstract Columns of this issue. There are at present 28 medical schools in India including one in Burma. The province which

has the largest number of medical schools is Bengal and the schools in this province seem to be more crowded than those in other provinces. Major-General Sprawson has very ingeniously devised a formula containing seven standard rules and rightly considers that the schools which do not satisfy the seven rules cannot be fit to impart medical education of the type expected by the present standard of medical education. He bases his formula on the strength of the school and he is particular that each teaching institution should have a clinical hospital containing beds whose sanctioned number should not be less than $5\frac{1}{2}$ times the number of students admitted every year and the actual number of beds not less than the total number of students in the school. Regarding the teaching of mid-wifery his formula demands an average annual number of confinements not less than 10 times the number of students admitted annually. Major General Sprawson's standard demands also a sufficiency of equipment in the supply of materials for practical training in Physiology and Pathology, two very important subjects enabling the medical student the condition of the human system in health and in disease. It is his considered opinion that a medical school should be equipped with microscopes for the teaching of Physiology not less than $\frac{4}{5}$ th of number of students annually admitted and for Pathology not less than $\frac{5}{4}$ th of number of students admitted annually. Out of 28 schools none come up to the standard demanded by General Sprawson. Exactly half the number are deficient in all the 7 rules. Only one school satisfies 6 rules, three schools 5 rules, three schools 4 rules, two 3 rules, two 2 rules and three only 1

rule. Major-General Sprawson's formula is a hypothetical one. He himself does not claim that it is perfect and not free from flaw. He mentions that the formula adopted by him was with regard to essential items and he did not conduct an enquiry regarding other details, such as equipment of radiological department, nursing staff, etc., which items should also be considered as necessary for the efficient and complete training of medical students.

It looks as if the non-inclusion of the medical licentiates who are trained in the medical schools, within the purview of the Indian Medical Council Bill, seems to have pricked the conscience of Major-General Sprawson, who as the head of the Indian Medical Council must have realised the desirability of not only maintaining a uniform standard of medical education for the licentiates throughout India, but also the need for a central authority to control over such standard. General Sprawson was quite right in saying that "the standard of education in medical schools is under the eye of provincial medical councils" but the qualifying sentence "who consider the local needs" coming after the word "councils" cannot be considered to be justified by actual facts. There is lot of difference between the words "under the eyes" and under the control and we presume General Sprawson used the former expression guardedly; for it must be within his experience as the ex-President of two provincial councils, of the United-Provinces and of Madras, that there is a provision in the Provincial Medical Acts for the supervision of the standard of medical education not only in Schools but also in Colleges. But the majority of the Provincial Councils have not been so far functioning towards this end nor did the Provincial Governments have been taking any notice of the existence of the Provincial medical councils with regard to their policy concerning the medical education in schools. They were solely guided by the advice of heads of the medical departments and there have been instances when the heads of the medical administration retarded necessary reforms in the curriculum of studies in the medical schools. Major-General Sprawson must be aware that the College of Physicians and Surgeons Bombay, who conduct

examinations for the L.C.P.S. diploma in Bombay Presidency suggested to the Government the necessity of increasing the course of studies of medical education of the licentiates to five years instead of four, and if our information is correct the State Medical Faculty in the United Provinces, who are in charge of the medical education of the licentiates and conduct examinations for granting diplomas to them, did also recommend to the Government of the United Provinces to increase the course of studies of the licentiates to five years; but it is reported to us that in both these provinces the heads of the medical department came in the way. Major-General Sprawson is convinced and rightly so that the course of training for medical licentiates should be for a period of five years and that the qualification for the entrants should be of the Intermediate Standard. It was possible for him when he was the Surgeon General with the Government of Madras to persuade the Government to increase the course of studies for the licentiates to five years, and in spite of the then existing financial stringency in the province, the Madras Government did not lag behind and acted on the advice of their immediate adviser. What has been possible in Madras may be made possible in other provinces also. Major-General Sprawson occupies the most advantageous and enviable position as the Director of the Indian Medical Service and also the President of the Indian Medical Council and if he makes up his mind, he can advise the heads of the medical departments in other provinces to bring about reforms in the medical education of the licentiates in the way designed by him in his book under reference. Whatever might be the purpose of the controversy initiated by the General Medical Council in objecting to the inclusion of the medical licentiates within the purview of the Indian Medical Council Act, it is quite possible for Major-General Sprawson to have an unbiased mind and judge for himself whether the objection raised by the General-Medical Council is not imaginary devoid of any sensible reasoning. It is beyond comprehension how and why the inclusion of the control of the medical education of the licentiates in this country by the Indian Medical Council, may defile the uniform standard of the medical education of the

graduates, if the Indian Medical Council prescribes the uniform standard of medical education in India both in schools and colleges as is the case in Great Britain where the education of the medical graduates and other medical diploma holders is under the control of one and the same medical council. If the foreign degree holders, the Indian medical graduates and the Indian medical licentiates, could be under the purview of the provincial medical acts why should they not be under the purview of an all Indian Medical Act. Major-General Sprawson is aware and did certify to that effect when he presided over the all-India Medical Conference of the licentiates in Madras a few years ago, that there was no well organised medical profession in this country on account of the existence of water-tight compartments in the medical profession. So knowing as he does that the profession and the public are at present helpless to bring about necessary and urgent reforms in the medical education of the licentiates in India we appeal to him that soon after his return to India after the expiry of his leave, he should take upon himself the task of visualising his own aims demonstrated in his book let. Then only his preaching will have the effect of precept.

News and Comments.

Ourselves: After going to the Press we thought it was desirable to keep abreast with the time and so to make up for the delay of 15 days in publishing the journal we are sending this issue out as a combined issue for November and December 1935, so that we may be able to publish the January 1936 issue in time.

New Year Greetings: On 15th October 1935 The Medical Practitioner has commenced the 7th year of its existence. We are highly indebted to our subscribers for their support and co-operation which has been encouraging us to serve the profession in a variety of ways through the columns of the journal. The scope and aim of The Medical Practitioner are concentrated in levelling up the medical profession in India where due to various causes for which the government of the land has been mainly responsible the profession could not thrive and prosper. The Government in this country

is so constituted that it has been able so far to float public opinion. After the introduction of the new constitution, it is hoped that India would have real provincial autonomy and that popular ministers will be able to press the views of the public on the Government. How for this hope is to be realised on account of the "safe-guards" introduced in the new constitution, time alone can judge. But it has to be said that the new constitution is sure to give much better opportunities for the peoples' representatives in the legislature to control the policy of the Government and if the medical profession fully rises to the occasion by educating the public in favour of reforms the profession may hope to advance in every way. Self help is the best help and union is the best strength. Both these commodities could be had in the profession itself. So it should be the aim of the members of the profession to unite to their full strength giving up petty differences for a rituous cause. No member of any other profession can influence public opinion so efficiently and so easily as one belonging to the medical profession. So it is incumbent on the members to take lively and abiding interest in the affairs of the Government whether provincial or federal with the hope of successfully pressing the will of the people on the government. If this is achieved reforms are guaranteed. The coming year is full of hopes and possibilities and we appeal to the profession to bestir itself for the common good of the country they live in and commence their activities in this direction right earnestly in the coming year. The columns of The Medical Practitioner are always at their service as they have been in the past. May the new year bring more unity and with it more prosperity and contentment to the members of the profession is our sincere prayer while sending to the readers of the Medical Practitioner our New Year Greetings.

Madras Medical College Centenary: Those who have been responsible for celebrating the Centenary of the Madras Medical College were not justified to call it the Centenary of the Madras Medical College as could be seen from the history narrated by Lt. Col. Clive Newcomb, the Principal of the Madras Medical College on the Centenary day. The period of one hundred years denotes more correctly "a sustained effort and a marked progress and

the appreciable advancement of medical knowledge in South India generally". The Medical College came into existence on 1st October 1850 and correctly speaking the centenary of the College as such should be in 1950 exactly 15 years hence. The School was founded in 1835 under the order of the Government and though in 1850 the institution was raised to the status of a College the Medical School was kept merged into it till 1903 when the school department had a separate existence of its own as the Royapuram now Stanley Medical School. The Committee in charge of the Centenary celebrations, did have the guidance, leadership and co-operation of the non-medical men, keeping perhaps in view the need of funds for having a suitable commemoration of the Centenary. The Medical School as it existed merged in the Medical College till 1903 and as a separate entity after 1903 and the Medical College, are owned by one master, the Government. Both the institutions should have celebrated the centenary of the development of the medical profession in this Province and not the centenary of the Medical College. We regret that the Centenary Committee did not realise the desirability of associating the Stanley Medical School in the activities and festivities of celebrating a centenary of the growth and development of scientific system of medicine in the Madras Presidency. A splendid opportunity was thus lost for the unification of the medical profession in this Province. We were very much disappointed to learn on the eve of the Centenary Celebrations that neither the old nor the present students of the Stanley Medical School were invited to participate in the festivities of the Centenary. It was said that the newly built hall in the College could not accommodate more than 1200 and that the Committee was very much handicapped for want of accommodation to invite more than 1200. The Medical College has an extensive open ground which might have even accommodated 10,000 audience and the occasion of the Celebration of the Centenary which only a few fortunate could witness in their life time, ought to have been witnessed by the largest available section of the public, including amongst them almost all the members of the medical profession. From a practical point of view of collecting funds to commemorate the Centenary, it would have been more sagacious to

invite as many as possible certainly not excluding the members of the medical profession.

The Centenary Celebrations were conducted on a grand scale as could be seen from the report published elsewhere in this issue and all concerned who were in charge of the Centenary Celebration, have to be congratulated on the splendid programme organised by them to educate not only the profession but also the public. It is rather discouraging that the funds so far collected including the money realised by tickets at the Exhibition comes to Rs. 18000 or very near this amount. For realising the legitimate ambition of the Centenary Committee to organise research and post-graduate study lakhs will be required and not thousands, and we trust the Committee will continue their efforts in realising the need and we appeal to the public that contributions towards the funds for research and post-graduate study for the benefit of the members of the medical profession, is a sound investment for ensuring the health and hence the prosperity of the public. We hope that any organisation for research and post-graduate study that is to be started by the Madras Medical College Centenary Committee, will be on democratic lines and not restricted to a particular class of the members of the profession. We did comment on this subject a few months ago in these columns and have shown the practicability of conducting post-graduate studies through the existing University.

Col. Bhola Nath :—Col. Bhola Nath, C. I. E., I. M. S. (Retd.) President, The Indian Medical Association has been touring in the Madras Presidency as a propagandist for enlisting members to The Indian Medical Association. He has taken upon this responsibility himself and has been spending his own money for the expensive journeys, maintaining his prestige and status as a Colonel though retired. He began his work in his own province, the Punjab. He then toured in the neighbouring United Provinces and established branches of The Indian Medical Association. Later he visited Bihar and Orissa and started branches in that province also. A brief history of his life is likely to interest our readers. Col. Bhola Nath is a Rajaput. He had his medical education in England where he qualified for M. R. C. S., L. R. C. P.

in 1893. In 1894 he entered the Indian Medical Service and belonged to the Madras cadre. From 1897 to 1898 he was doing duty in North-West Frontier. In 1899 he went to England on furlough and returned to India in 1901. He was then posted to Kamptee (Central Provinces) from where he was transferred to Belgaum where he served till 1902. From 1902 to 1904 he was in Somaliland from where he was re-transferred to Belgaum in 1905. After serving at the last station till 1908 he took furlough for post-graduate studies. In 1909 he was posted to Aurangabad. Later he went to Persia and after serving there till 1913 returned to India and took furlough. He was recalled for duty while on furlough on account of the great war and served in Rangoon and Burma from 1914 to 1915 when he had to go to Mesopotamia and was there till 1919. He was mentioned in the despatches for his meritorious services during the war and was honoured by the Government with the C. I. E. title. He was the chairman of the war-economy committee appointed during the war. He also served on the Lovatt Committee and was promoted to the rank of Colonel in 1919. From 1919 to 1924 he served on the selection committee for the Indian Medical Service. He was the Secretary of the Red Cross Society and St. John Ambulance Association. It will not be out of place to mention an incident during the official career of Col. Bhola Nath. In 1902 he received a telegraphic communication to take charge of the Madras Government medical stores. But when he arrived in Madras the person who was in charge of the medical stores at the time, informed him that another military officer had been posted and that Col. Bhola Nath got the telegraphic communication by some mistake. He was then asked to report himself for Civil duty to the Surgeon-General with the Government of Madras. Col. Bhola Nath accordingly saw the Surgeon-General. But before accepting civil duty he requested the Surgeon-General to assure him that no European I. M. S. officer would be given preference either in the matter of posting to good civil stations or to positions of responsibility. The Surgeon-General would not give him such an assurance and Col. Bhola Nath preferred to be in Military duty till the rest of his career. This incident shows of what stuff Col. Bhola Nath is made of. He enlisted

himself as a member of The Indian Medical Association in 1927 and ever since has been taking lively interest in its affairs. At his instance, the All India Medical Conference, held every year under the auspices of the Indian Medical Association, was invited to Lahore in 1929 December, and he was the chairman of the Reception Committee of the Conference. Last year the Association honoured him by electing him as the President of the Association. Ever since Col. Bhola Nath has taken upon himself the most laudible task of strengthening the Association and we are glad to observe that the medical profession has been receiving him most cordially and responding to his appeal. It was so in the Madras Presidency and it will not be a surprise that Madras which unjustifiably still retains the name, the most benighted province, will prove to the medical profession as it has done in other public activities that it is second to none in its progressive ideals when once it is convinced the usefulness of such activities. From the reports we have been reading in the news papers Col. Bhola Nath has very good reception wherever he went and his appeal to the members of the profession in service as well as in private practice seems to have been equally well responded. It is a very pleasant irony that the independent medical profession in India has to depend entirely upon the guidance and leadership of their brethren in service whether it be concerning education, exercise of the medical profession and even in activities concerning the welfare and prosperity of the profession. It cannot be otherwise even with regard to the affairs of The Indian Medical Association. Though the idea of starting an All-India Medical Association was first initiated in Calcutta as early as 1918 there was little or no encouragement for this movement till about 10 years ago and but for the ardent zeal and perseverance of Doctor K. S. Ray who has been continuing as one of the Honorary General Secretaries of the Association, the Association would not have progressed to the extent it is now. Till 1933 all the Presidents of the association were members of the independent medical profession ever since they entered the profession and yet none could take up the work which Col. Bhola Nath has undertaken to do and that at his own cost. The fact Col. Bhola Nath is now 70 years old should

convince all about the depth of love Col. Bhola Nath has for his younger brethren. The most sad event, of Col. Bhola Nath losing his loving life partner about a month ago, had not detracted him from continuing his work. Even the most cynical being cannot say that Col. Bhola Nath expects any reward or even appreciation from the members of the profession. From what we could observe from the speeches made by Col. Bhola Nath in Madras and elsewhere his only ambition seems to be to establish in India a strong well organised medical fraternity on the lines of the British Medical Association. The fruits of labour of Col. Bhola Nath are to be reaped by the younger generation and is it too much to expect that those for whom Col. Bhola Nath has been serving will rise to the occasion and prove worthy of the zeal displayed by the true veteran in his 70th year.

Doctor U. Rama Rau honoured: Col. Bhola Nath, the retiring President of The Indian Medical Association, will soon decorate Doctor U. Rama Rau with the mantle of responsibilities he has been wearing for one year most fittingly, as Dr. Rama Rau has been elected as the President for the coming year. The August ceremony is to take place during the coming Christmas week at Nagapur. It is a most happy coincidence that Col. Bhola Nath has made a practical demonstration in Madras Presidency of what he conceived to be his duties as the guiding spirit of the medical profession in India in his capacity as the President of the Indian Medical Association at an opportune time when The Indian medical Association honored Dr. Rama Rau by electing him as the President to succeed Col. Bhola Nath. Doctor Rama Rau did not lag behind to indicate his worthiness to succeed Col. Bhola Nath as was demonstrated by his earnestness to strengthen The Indian Medical Association. The reception organised by him to his predecessor on 2-12-35 at the Gokhale Hall where a most representative gathering of the members of the medical profession met to honour Col. Bhola Nath, is an earnest of the varied activities which Doctor Rama Rau is likely to undertake on behalf of The Indian Medical Association. Doctor Rama Rau is now busy canvassing members and by the time he has to throw his mantle on the shoulders of

his successor next year, the members of The Indian Medical Association in Madras Presidency will, we hope, outnumber those in other provinces. Doctor Rama Rau needs no introduction to the profession. He has been a pillar of strength to the independent medical profession in Madras and but for his career as the pioneer practitioner in the city, Madras would not have had such a large number in the independent profession. His success in life has been a distinct encouragement for many others to start private practice, and if Madras contains many successful practitioners, a large number of whom being licentiates it is due to the lead given by Doctor U. Rama Rau. Doctor Rama Rau has had the good fortune of being peoples' representative in many capacities. He was a councillor of the Madras Corporation. He entered the Madras Legislative Council soon after Mont-Ford Reforms were introduced in this country and before his term of three years expired he competed for a seat in the Council of State and got elected. He had to leave the council due to the congress ban. He represented the Registered medical practitioners in the third group of the Madras medical register from 1915 to 1935 when he retired making room for others. He is now free, having placed his worthy son on the gadi of his business. He has been keeping exceptionally good health and it may be surprising to many if we say he has completed his 60th year. We congratulate Dr. Rama Rau on the honour conferred on him by The Indian Medical Association and trust he would discharge his duties to the entire satisfaction of the profession in this country.

All India Medical Conference : The Indian Medical Association have summoned the All India Medical Conference at Nagpur on the invitation of the Nagpur Medical Association. The Conference is open to all registered medical practitioners irrespective of their being members or non-members of The Indian Medical Association. The members of The Indian Medical Association are charged Rs. 5 as delegate fee whereas the non-members have to pay Rs. 8. With only this difference with regard to delegate fee the non-members and members of The Indian Medical Association have equal rights in participating with the activities of the conference.

This is the XI All India Medical Conference, the conference met last year in Delhi. The effect of the annual gatherings of the representatives of the medical profession has not made any tangible impression on the medical profession in India. It is mainly due to the fact that little or no propaganda was done by those concerned to strengthen The Indian Medical Association which has on its roll only 1533 members while the total strength of qualified practitioners in this country is reckoned to be roughly 40,000. Col. Bhola Nath laid special stress in the presidential address delivered by him at Delhi last year that for redressing the grievances now laboured under, by the profession in this country. The Indian Medical Association should concentrate its activities (1) for the removal of the Military Service from the Civil Medical Department (2) for amending the Indian Medical Council Act in such a way as to enable India to fix her own standard of medical education, independent of outside authority and (3) for securing the solidarity of the medical profession. The plan suggested by Col. Bhola Nath if worked out will get at the root causes of the grievances of the profession. Col. Bhola Nath has played his part well. We are told that there has been an appreciable increase in the strength of the Association and if the work commenced by Col. Bhola Nath is being continued by successive Presidents of The Indian Medical Association for a few years more, the solidarity of the profession will be assured to a great extent. And if consistent with the solidarity the caste system now prevailing in the profession is done away with the Indian Medical Association is sure to wield the required influence to be able to carry out necessary reforms in the medical administration to the entire satisfaction of the medical profession and the public. Hand in hand with propaganda for strengthening the association, the association should show constructive work conducive to the welfare of the profession. Nothing has been done so far in this direction excepting the passing of pious resolutions. We trust the Indian Medical Association will bestir itself and conduct persistent agitation so that the resolutions passed at the All-India gathering are given effect to. Year after year we have been elaborately mentioning in the columns of

The Medical Practitioner about the important urgent reforms which are likely to bring contentment and prosperity to the profession consistent with the satisfactory solution of the huge problem of affording medical relief to the public. We do not wish to reiterate what we have been mentioning all these years. The most important problem of all these confronting the profession, is the Rural Medical Relief. The Indian Medical Association appointed a committee some years ago to go through this question but nothing has been done in this direction so far. Rural Medical Relief has been prevailing more conspicuously in the Madras Presidency than in other provinces and the President-elect of this year's conference is from Madras Presidency and therefore The Indian Medical Association has exceptional opportunities of reforming the Rural Medical Relief Scheme under the guidance of Doctor U. Rama Rau who being the President also of the Madras Rural Medical Practitioners' Association, will be able to give necessary materials to work out a scheme which while affording satisfactory medical relief in rural areas, will also materially solve the problem of unemployment in the medical profession. If the Indian Medical Association concerns itself with only this problem and nothing more and solves the same to the satisfaction of the public and the medical profession they can certainly be proud of having attempted and having achieved something tangible. One thing at a time and that done well is certainly more laudible than the discussion about various schemes and doing nothing. So, apart from discussing about current topics concerning the profession and passing resolutions, the Association should take up schemes, such as Rural Medical Relief, Health Insurance etc. one by one every year and give a good record of constructive work.

Medical Profession honoured: Rau Bahadur Doctor T. S. Tirumurti, Professor of Pathology, Medical College, Vizagapatam, was asked by His Excellency the Governor of Madras in his capacity as the Chancellor of the Andhra University to deliver the Convocation Address of that University on 28-11-35. This is the first time to our knowledge that a member of the medical profession was requested to address the graduates on the convocation day of a

University in this province. Doctor Tirumurti rightly says in his address that His Excellency was perhaps desirous to give an opportunity to a member of every profession so that the public and the students who took their degrees might have an idea as to how the various problems connected with education and welfare of the country are viewed by persons belonging to different professions. The honour conferred on Doctor Tirumurti should be considered as the one bestowed on the medical profession.

Doctor Tirumurti's learned address concerned itself entirely on the problems of preservation of health. He dealt at length how Public Health questions are treated in other civilised countries and how they were neglected in India and narrated briefly the history of public health policy in India and endeavoured to impress the importance of preventive medicine and justified the need of including the study of Nutrition, Mental Hygiene and Biology in the school and college curriculum as was the case in Japan, America and Soviet Russia. Doctor Tirumurti's profession would not but tempt him to concentrate his whole address on the problems of health, a subject always neglected in this country both by the Government and the public and the justification of the lead taken by Doctor Tirumurti was in a way anticipated by His Excellency Lord Erskine when his Excellency addressed the students of the Government College Mangalore on the prize distribution day while on tour in South Kanara District. His Excellency said amongst other things that "Education does not merely mean stuffing one's brain with facts; it means that, in order to be able to use those facts, one must keep healthy, so that he may be able to make use in future life all the knowledge and learning that he may get when he was at school or college".

Local Bodies and Rural Practice: Subsidised rural practitioners were brought into existence in the province of Madras and in some other provinces as well, to encourage medical practitioners to settle in villages so as to afford scientific medical relief in rural areas. Though the subsidy given to the medical practitioners was a very meagre amount many junior members of the profession took advantage of this scheme and have settled in the villages. Politics is said

to exist for the welfare of a country but unfortunately many local bodies in the Madras Province are using it for the benefit of the individuals in the local bodies. The subsidised rural practice scheme is for the mutual advantage of the public and the medical profession. It enables the local bodies to give cheap yet efficient medical relief to the masses with little or no strain on public revenue. In spite of this some of the local bodies have been adopting a suicidal policy by converting the subsidised dispensaries to pucca dispensaries, and in some districts starting subsidised dispensaries in villages where a subsidised practitioner already existed. The purpose seems to be to provide employment for persons in whom any individual member of a local body is interested. We have been agitating and pointing out to the Government that if such practices were allowed the subsidised rural practitioners' scheme would end in failure and disrepute. The Government did pass orders prohibiting local bodies from starting subsidised dispensaries in villages where a qualified practitioner had been practising and advised the local bodies that in a place where they wished to establish a pucca dispensary and where there existed a subsidised dispensary the subsidised medical practitioner of the place should be appointed as the medical officer of the pucca dispensary. After the abolition of the Taluk Boards a fresh order was passed by the Government to the effect that wherever District Boards established pucca dispensaries the subsidised practitioners of the district should be preferred in case they apply for the posts of the medical officers to be in charge of those dispensaries. We are informed that the Government is the final authority to decide the need of any new appointments of a District Board. We therefore request the Government not to encourage District Boards to start pucca dispensaries under them as this is not only against the interests of the development of rural medical relief scheme but also a bad financial proposition. It is also desirable in the interest of discipline that the Government insists on the District Boards to give preference to subsidised practitioners regarding the appointment of medical officers to be in charge of pucca dispensaries already started by the District Boards. We suggest to such of those subsidised practitioners whose claims were overlooked by the District Boards to

appeal to the Government through the proper channel or channels.

A Glaring Vagary again: We learn that the President District Board, East Godavari, has sent a circular to the teachers employed by the Board in Elementary Schools that in future the teachers should obtain medical certificates from "degree holders not lower in rank than a L. M. & S. or Assistant-Surgeons, other wise they will be granted leave without allowance." We are not tired in bringing to the notice of the Government and also of the Madras Medical Council the vagaries of those in authority, who violate the principles and spirit of a Statute passed under the very authority of the Government. In the September issue of The Medical Practitioner we pointed out the baneful effect of an order of the President Taluk Board, Koraput (Agency tract). We are authoritatively informed that the Madras Medical Council passed a resolution at its October Session requesting the Government to make their orders regarding issuing of medical certificates applicable to local bodies also. Some time ago the same Council passed a resolution requesting the Government to do away with the distinctions showed by them between Government Medical Officers and private practitioners with regard to the granting of medical certificates. The agitation conducted by us in these columns with the help of some of the members of the Madras Medical Council did make the Government yield to the extent that the medical certificates issued by registered practitioners are accepted generally and in exceptional cases such certificates are sent for a second opinion to a Government Medical Officer in case of those employed under Government. The Order of the President District Board East Godavari, is as insulting as it is unreasonable and we suggest to the aggrieved practitioners majority of whom are members of the East Godavari District Medical Association, to table a resolution at the next meeting of their association, bringing to the notice of the Government the vagary of the President District Board, East Godavari. It will serve a double purpose, as it will prove in addition that the medical profession is one fraternity which does not recognise invidious distinctions amongst them regarding their rights and privileges.

Correspondence Reports Etc.

Primary F. R. C. S. Examination in India.

The council of the Royal College has again acceded to the request of the Director-General of the Indian Medical Services to conduct the primary examination for the F. R. C. S., in India in December.

The examination was held for the first time in India last Christmas at Madras, when 60 candidates were examined, and of these, 31 passed the examination, which is generally recognised as the most exacting test in the medical world.

This year, the examination is to be conducted at the Medical College, Calcutta, owing to the courtesy and co-operation of the authorities of that University. Sixty seven candidates have entered for the examination, which began on December 19, and, as last year, the Royal College has sent out two examiners to conduct the examination.

The two examiners who have consented to act for the Royal College have both had very considerable experience, having each served for ten years on the Board which conducts the primary examination in London. The examiner in Physiology is Professor G. A. Buckmaster, M. D., F. R. C. S., Emeritus Professor in Physiology at the University of Bristol. Captain B. T. Krishnan, M.B., Professor of Physiology at Madras University is Professor Buckmaster's Assessor.

* Mr. G. Gordon-Taylor, O. B. E., M. S., F.R.C.S., who will examine in Anatomy, is the second Senior Surgeon at the Middlesex Hospital, where he is also a Lecturer in Surgery and Surgical Anatomy in the Medical School. He is accompanied by the Director of Examinations of the Royal College of Surgeons (Mr. Horace H. Rew). Professor L. M. Banerji, F.R.C.S., L.R.C.P., Professor of Surgery at Calcutta University will be Mr. Gordon-Taylor's Assessor.

The First All-India Obstetric & Gynaecological Congress, 1936.

The first All-India Obstetric and Gynaecological Congress will be held in Madras, at the Museum Theatre, Egmore, on the 2nd, 3rd and 4th January 1936. Dr. Miss Ida Scudder, M.D., D. Sc., Principal

of the Women's Medical School, Vellore, has been elected the President, and H. L. Lord Erskine, Governor of Madras is opening the Congress at 10.30 A.M. on Thursday the 2nd January.

In connection with the Congress, a medical and scientific Exhibition has also been arranged, in which some of the leading firms—dealers and manufacturers of medical and surgical appliances, drugs, etc.,—are participating.

The sessions of the Congress will be divided into three sections—Obstetrics, Gynaecology and Maternity & Child Welfare—and the programme for the 3 days is as follows:

2nd Jan.—10.30 a.m. Opening of the Congress and Exhibition by H. E. the Governor, Chairman's welcome address, election of President and vote of thanks.

1.30 to 4.30:—Obstetric section—reading of papers.

3rd Jan. 10 A. M. to 1 P. M.:—Obstetric Section—Discussion on "Pelvic Disproportions."

2.30 to 5 P. M. Gynaecological section—reading of papers.

4th Jan. 10 A.M. to 1 P. M. Gynaecological Section—Discussion on "Displacements of the uterus."

2.30 to 5 P.M.:—Maternity & Child Welfare section—Reading of papers and discussion.

Social. 2nd Jan., 4-4.5 P. M. Tea for the President and Delegates.

3rd Jan. 8 P. M. Subscription dinner for the Delegates. (Delegates wishing to participate in the Dinner are kindly requested to communicate to the chairman, Reception Committee sufficiently early).

Visits to places of interest and other hospitals in Madras, and excursions to interesting places near Madras will also be arranged. There are no special fees for Delegates.

Delegates who wish to contribute papers to any of the three sections are requested to communicate to the Chairman, Rec. Committee.

Further particulars may be had from Dr. A. Lakshmanaswami Mudaliar, Chairman, Reception Committee, Govt. Hospital for Women and Children, Egmore, Madras.

A. L. MUDALIAR,
Chairman, Reception Committee.

The East Godavari District Medical Association, Cocanada.

A meeting of the East Godavari District Medical Association took place at Peddapuram on 23rd November 1935. Captain J. S. Mc. Millan, F.M.S., presided. The Peddapuram group of members were at home to the Association. 42 members from all over the district attended. There was an enjoyable tea party. Dr. P. Lakshminarayana of Peddapuram read a paper on "Surgical Shock". Dr. P. C. Jaju of Peddapuram read some case notes on the "The Toxic effects after the injection of Organic Arsenical Compounds". Dr. V. Venkataramayya of Veerapuram read some case notes on "Rat-bite Fever".

Capt. J. S. Mc. Millan, F.M.S., explained the cause of Rat-bite fever and said that among rats some are infected with a disease caused by the *Spirillum minus*, producing in the rat a disease in 3 stages like Syphilis and when an infected rat, bites the human being and if there be mucous patches in its mouth it conveyed the infection to man. The disease in addition to the other symptoms was characterised by a fever running a course like relapsing fever with the difference that whereas in relapsing fever, the relapses stopped with two or three, rat-bite fever relapses went on and on and for months unless Salvarsan was administered in some form. Diseases so rare because few rats were infected in this country. *Spirillum minus* was a very small spiral with 2, 3 curves, demonstrable on making a smear of fluid extracted from an inflamed lymphatic gland. It was not found in blood smears as in relapsing fever. Inoculation of a rat with human blood would show the spirillum in rats' blood.

Capt. Mc. Millan, brought to the notice of the Association that a case of "Cerebro Spinal Meningitis" was admitted recently into the Head-Quarter Hospital at Cocanada and warned that every medical man should be on the look out for more and explained that the disease is very dangerous and characterised by intense head-ache going on very quickly into unconsciousness with signs of meningitis. Lumbar puncture centrifugalising the fluid and staining a smear with Leishman would show the Cocci unmistakably and intrathecal administration of serum and persisting in it daily even after consciousness was regained until all Cocci disappear.

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ed from the spinal fluid was the line of treatment.

Capt. Mc. Millan made a speech on the need for the organisation of Red-Cross Society all over the district and formed an advisory committee consisting of local doctors to organise a branch at Peddapuram. Dr. T. Kanakaraju of Ramachandrapuram read a paper on "Honorary Medical Officers and State Hospitals.

After an enjoyable dinner the guests dispersed.

Chettinad Medical Association.

There was a special meeting of the Chettinad Medical Association at Karaikudy on 7-12-35 in honour of the visit by Col. Bhola Nath, I. M. S., C. I. E. About 50 doctors from Pudukottai and Ramanad District were present. After tea arranged by the hosts, Col. Bhola Nath gave a lecture on the comparative positions of the medical profession in the western countries and in India. He said it was in a deplorable state in our country without any unity, uniformity and with almost no invention to its credit in spite of our 150 years existence. He there fore urged the necessity of an all India Medical Association open to all doctors both in the Government service and in private practice with whatever degrees or diplomas so long they possessed registrable qualifications in India. He advised the doctors to sink all their differences and to work with one aim of bettering the prospects and position of the noblest of all the professions. It was resolved that the Chettinad Association be affiliated to the Indian Medical Association and individual doctors consented to join as members. With a vote of thanks the meeting terminated. Col. Bhola Nath on his way visited Doctor Shetty's Nursing Home.

The Tinnevely District Medical Association, Palankottah.

The Tinnevely District Medical Association held its monthly meeting on Saturday 23rd November 1934 at Srivaikuntam a holy place of this District. Members numbering 15 including two lady doctors gathered from all parts of the District. Some of the officials and non-officials were also present.

Members also attended the Health Exhibition organised by the District Health Officer. The meeting began under the presidentship of Lt. Col. T. S. Shastri, I.M.S., at 11 A.M. The Secretary read the minutes of the Centenary Celebration of the Madras Medical College along with the monthly meeting of the Association held on 4-11-35 at Palamcottah, which were passed. Discussion about the scheme of meetings for the next year [1936] was taken up and will be concluded at the next meeting. The following resolution proposed by Dr. P. Janardhana Rao, L. M. & S. and seconded by Dr. S. Kanthimathinathan, L. M. & S. was unanimously passed:

"Resolved to request the Government that they may be pleased to consider the period of absence of medical officers from their stations, viz from the 1st to 5th January 1936 both days inclusive for attending the First All India Obstetric and Gynaecological Congress at Madras as duty even though travelling allowance may not be paid".

An enjoyable Dinner was served to all present at 12 noon. After sweet music and rest, the meeting again began at 2 p. m. Dr. S. Kanthimathinathan, L. M. & S. of the Municipal Hospital, Tinnevely, delivered an interesting lecture on 'Dyspnoea'. Dr. S. Venkatachlam, L.M.P., of Srivaikuntam, read a paper on 'Splenomegaly in the Tropics'. A case of Caesarian section for Placenta Previa Centralis which was operated on by Lt. Col. T. S. Shastri, was read by Dr. Mrs. A. Brown of the Women & Children Hospital, Vannarpet, and the detailed treatment of the serious complications that ensued viz. B. Coli infection, Thrombosis of both the lower limbs, and puerperal Insanity was explained. The woman was discharged cured after a stay of 2½ months in the Hospital. The President offered thanks to Dr. Govinda Menon, the Sub-Assistant Surgeon of the Local Fund Hospital, Srivaikuntam, who is to retire shortly and his fellow-members of the area for their splendid hospitality. The President conveyed to Dr. Menon, the best wishes of the Association for his happiness and prosperity after his retirement. The meeting ended after tea and an exhibition of some thrilling feats of physical strength by a local 'Sandow' at 5 P. M.

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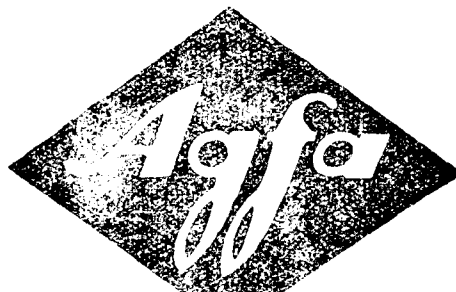
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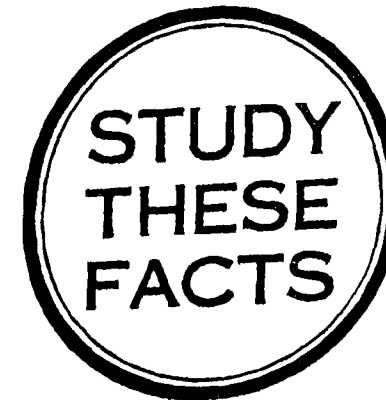
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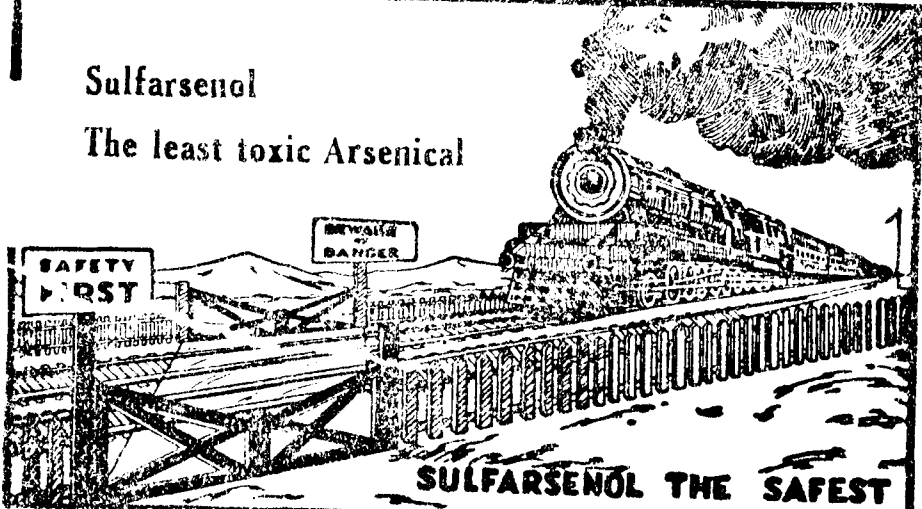
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