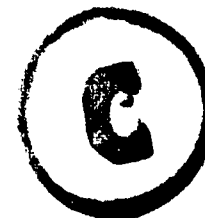


Medical Practitioner :

A monthly Medical Journal .

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The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

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CONTENTS.

	PAGE.
Original Articles :	
Carbuncles, By Lt. Col. K. G. Pandalai, M.B., F.R.C.S., (Eng.) I.M.S., ...	... 157
Alopecia, By Capt. S. Thambiah, B.A., M.C., M.R.C.P., D.T.M. & H., F.D.S., ...	... 160
Abstracts :	
Adolescent Glaucoma, By Harry Vanderbilt Wurdemann, M.D., F.A.C.S., ...	... 165
Notes on Therapeutics, Diagnosis and other Medical Subjects :	
A few Don'ts in Eye Treatment, by Dr. O. V. Muthukrishnan...	... 168
Treatment of Pneumonia in Infants and Children. ...	... 170
Editorial :	
Government Medical Officers and Nursing Homes. ...	... 173
News and Comments :	
Ophthalmologists in Conference. ...	... 175
Medical Licentiates in Conference. ...	... 176
Madras Medical College Centenary. ...	... 177
New L. M. P. Course. ...	... 178
A Downward Climb. ...	... 178
Felicitations. ...	... 178
Correspondence, Reports, etc.:	
1. Government Medical Officers and Nursing Homes, (Text of G.O.)	... 179
2. 5th Andhra Medical Conference, Vizagapatam, 3. 27th All India Medical Licentiates' Conference, Indore, 4. Treatment of Small-pox with liver, 5. Indian Institute for Medical Research, 6. The Tinnevely District Medical Association, 7. A.O. Tuberculin Vaccine.	

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* * * *

From Dr. H. V. G.....L.M. & S., Head Quarters Hospital.....The evil effects on the system of women, due to Amenorrhoea are in many instances worse than those of pregnancy. I had a case of Amenorrhoea in a young unmarried girl aged 19, the duration being six months. The unfortunate fact that the girl was unmarried and appeared to put on more flesh after the cessation of menses—evidently accumulation of fat—made the parents more anxious about their daughter and the matter was made worse when the nurse attached to my hospital who was consulted by the parents suspected Amenorrhoea to be due to pregnancy and this nurse advised the parents to use Menestrin Capsules. As one bottle of the Capsules had not the desired effect, the parents consulted me and on examination I found that the girl was not pregnant though physically appeared to be so on account of accumulation of fat in the lower abdomen, the breasts and also in the gluteal region.

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[NO. 8

Original Articles

CARBUNCLES.*

By

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CARBUNCLE is a universal disease and attacks all races. In the early stages, it is easily mistaken for a mere boil or an abscess. It is more prevalent in the hot weather when the skin perspires freely and is in a favourable condition for the onset of infection. It is a secondary disease, grafted on people predisposed to it by metabolic or other disorders. If the disease is recognized early and its seriousness understood, not only by the practitioners but by the people themselves, a great deal of unnecessary suffering and many valuable lives could be saved.

CLINICAL FEATURES.—It is a disease of early and late middle age. Generally men and women at the most useful period of their lives, when their earning capacity is at the highest, are affected.

Carbuncles are masses of devitalized tissues, occurring in most of the cases, in subcutaneous tissue. They also occur in the submucous tissues of mouth, anal canal, etc. When occurring in the neighbourhood of the two ends of the alimentary canal, mouth and anus, they are most dangerous lesions. If a carbuncle is cut into, it is found to be

a mass of slough, infiltrated with pus very much like a sponge soaked in water. In a carbuncle it is difficult to say where the slough ends and healthy tissue begins as there is no dividing line. A carbuncle does not become circumscribed but permeates subcutaneous tissues very much like malignant disease. It affects the deep fascia also, like the fascia over the pectoral muscle, fascia over the erector spinae etc. From fascia carbuncles may creep on around and along layers of muscle. In extreme cases, practically all the tissues are infiltrated except perhaps large nerves and vessels. Small vessels dilate and may be very friable, as when a carbuncle is cut out, the haemorrhage might be very serious.

Although it is true that carbuncles occur in certain young apparently healthy men and women who are perhaps specially sensitive to the staphylococcus, this is not the rule. This sensitiveness to certain organisms occurs throughout the animal kingdom. But carbuncles ordinarily occur in elderly fat and flabby individuals whose urine when tested contains sugar and ketonebodies and occasionally albumin. Cases associated with albuminuria are comparatively more dangerous.

The immediate cause of the carbuncle is the staphylococcus pyogenes aureus. The onset of streptococcal infections may perhaps be very acute and terrifying but if we compare the sum-total of the mischief wrought in the human body by the streptococcus with that by the staphylococcus, I consider the staphylococcus a more terrible

* Madras University extension lecture.

organism both by the insidiousness of its work and its chronicity.

The onset is signalled by a little local pain and slight redness, the surface is slightly elevated, tender, hot and with a tendency to spread. The colour soon changes to dark red, and a carbuncle at this stage can usually be distinguished by the absence of a central core, unlike a boil. Usually the patient makes light of it, thinks it is a mere boil and generally neglects it in the early stages. The local phenomena rapidly become aggravated, constitutional symptoms also manifest themselves. The temperature rises upto 100° or 102°; there is increase of pulse and respiration rate, the tongue is coated, there is loss of appetite and patient feels ill. There is a peculiar pallor about these cases. If left untreated, the carbuncle increases in size, the skin assumes a coppery red colour in light skinned people and gives away at more than one spot with a little discharge of pus and slough. The patient thinks that the abscess has burst, but induration remains and constitutional symptoms do not abate. The carbuncle extends in size and depth. In cases where more than one organism is present as is frequent at this stage local and constitutional symptoms are much more severe.

As regards rapidity and extent of growth, it varies a good deal. In some favourable cases the carbuncle may become circumscribed and may react to local abortive medical treatment, such as cold or hot compresses, leeches etc., which aim at producing local congestion by counter-irritation.

A favourite method with some surgeons was to inject into the core of a carbuncle such antiseptics as tincture of iodine, 5% carbolic acid or to apply pure carbolic acid on the core of the lesion with the end of a probe. Carbolic acid thus applied is rapidly neutralized by body fluids and rendered inert. Very small carbuncles can be cured by abortive treatment, such as cupping and antiseptic pastes, etc.

CLINICAL TYPES.—There are some clinical types of carbuncles which we should all recognise. There is the acute galloping carbuncle with rapid spread and severe constitutional symptoms. In such, you cannot feel sure what the patient will be like tomorrow. These are very serious and mostly fatal, rapidly passing into a state of coma. These

are cases which spread rapidly, but are arrested temporarily by treatment only to flare up again in a week or 10 days. Then there is a type of carbuncle which may be called 'Carbunclosis.' In these cases, several carbuncles are present scattered throughout the body, and in the back you may find a large central carbuncle surrounded by several smaller carbuncles. These small carbuncles should be pricked, disinfected and dressed with dry dressings.

The condition of Carbunclosis is generally fatal. It is a sort of cutaneous pyæmia, the pores of the skin being extensively involved. Then there is the variety with real pyæmia. The organism is carried in the blood stream and multiple pyæmic abscesses deep into the muscles and close to the bones develop. Each pyæmic abscess contains a piece of slough surrounded by thin milky pus. These abscesses form very rapidly overnight. They are really cold abscesses with no local or general reaction. When, in a patient who has undergone an operation for carbuncle and when he is usually expected to be gradually improving, you find that sugar is being kept up, and the wound does not heal as rapidly as it should, one should be on the look out for these abscesses which may be hidden from the patient himself. In such cases if you make a careful examination, you may find lumps in various parts of the body. When these lumps are cut into, you find some slough floating in thin white pus.

Then there is the variety, common especially in the lower extremities in which there is generalized oedema of the part. The tissues are water-logged. It is a variety of local inflammation like cellulitis cutaneous erysipelas. It is not erysipelas and is common in fat and flabby people especially those with albumen in the urine. These swellings fluctuate and resemble collections of pus and patients press you to operate, but if you incise it nothing escapes but serum. Such cases are of poor prognosis.

There is a variety which after a few days shows a band of redness in the surrounding area, a rash with a creeping edge. This is really erysipelas supervening on a carbuncle. Such cases may get better with serum, for a time but generally the patch of erysipelas recurs at a little distance from

the original site. It is curious to find in these cases a good deal of healthy tissue skipped over between the original focus and the secondary patch of erysipelas. These cases are of bad prognosis.

There is also a variety which is seen often in the buttocks. After excision in these cases the wound does not heal, the infection spreads in all directions. The organisms find no resistance and there is absolutely no reaction on the part of the patient.

In carbuncles occurring in non-diabetics, prognosis is good. Carbuncles occurring in the neck, face and scalp are very serious, because of the early spread of infection in the limited space and the tendency for the intra-cranial veins to become involved. In such cases there is considerable general reaction. Carbuncles occurring in the anal region are of bad prognosis. Carbuncles occurring on the scalp, even when operated upon early are difficult cases. It may take as long as six months for a small carbuncle of the scalp after operation to heal, and even, when the healing is complete, the newly formed skin may readily break down. In carbuncles occurring in the anal region, there may be secondary infection from gas-producing organisms and patient may die of gas-gangrene.

PROGNOSIS.—Patients with a marked general reaction, moderately high temperature and who complain of pain have a better prognosis. Cases with poor resistance have a low temperature and pain is not complained of. Generally people who are pale with a muddy complexion, anaemic, double-chinned and pot-bellied are bad subjects to treat. In these cases, the vital organs are seriously affected by the toxins especially the heart, so that it is not surprising to have sudden death in a carbuncle case which overnight was apparently in a fine state. In these fat patients, therefore it is wise to give a guarded prognosis and to specially watch the heart and lungs.

Treatment.—Treatment is divided into general and local.

GENERAL: Diet.—Anti-diabetic diet, in a case with sugar in the urine. Albumen must be controlled, if possible. In patients who have no sugar or albumen, diets need not be restricted, but in all cases stimulants such as light wine, etc., may be given. In

general the diet should not be much restricted with elderly or feeble patient.

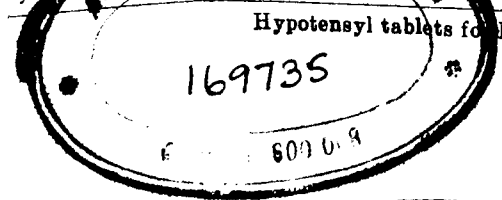
LOCAL.—In the early stages applications of counter-irritants such as antiphlogistine, or one of its modifications, heat and moisture in the form of poultices, glycerine and magsulphus, etc., are all tried before the Surgeon sees the case. Auto-vaccine is not of much value for an existing carbuncle, but it may be of help against a future carbuncle.

Face to face with a carbuncle of any size there is no wisdom in placing faith on drugs. Patients do not do well usually with these slow methods. Every carbuncle must be looked upon as an emergency and treatment started early.

Since the disease is a composite one due to infection grafted on a constitutional disorder like diabetes, the constitutional condition must also be treated. In diabetic cases insulin is very useful, but there are cases where it may not be immediately successful. When pus or slough is retained in a wound, insulin appears to have no effect on sugar in the system. Sepsis makes insulin inert. Even very large doses may be futile until the gross sepsis has been removed by operation; later insulin has a better chance.

In operating no half-measures should be employed. Operations for carbuncle should be early and 'decisive.' Then aim should be to avoid repeated operations for these repeated operations under a general anaesthetic destroy the morale of the patient and turn the scales against him. Except in such dangerous situations as the neck where a carbuncle spreads collarlike and where you cannot be too radical, in an advanced case, and where you must be content with partial excisions, in all other situations a wide excision with a healthy margin, is the ideal method for in all cases it is difficult to say exactly where the diseased tissue ends and healthy tissue begins. It is a safer procedure therefore to take away a little more healthy tissue than leave a portion of the carbuncle.

In operating, make a crucial incision, the ends of the cross being beyond the obviously indurated border. Raise the flaps and holding them well back excise the indurated mass with bold sweeps of the knife and make sure that you are going through



healthy tissue right round the carbuncles. One important point in the operation is the control of bleeding. As little blood as possible should be lost. Quick operating is a virtue here: vessels should be clamped instantly and no patient should be sent to the ward until all bleeding has been arrested by ligature. A little time spent in stopping oozing will be amply repaid. In some instances I have had to leave artery forceps on for 12 to 24 hours and this shortens the operation. Pack the wound firmly with Iodoform gauze and leave it alone for 3 days.

Such complications of carbuncle as erysipelas and pyaemia have been dealt with already. In these patients healing takes an extraordinary long time and a carbuncle of the size of the hand occurring in the back may take as long as 3 months to heal. In all fat and flabby subjects the heart should be supported by digitalis or digalen as a routine before and after the operation.

In spite of every possible precaution some cases develop coma against which no available treatment seems to be of any avail.

*ALOPECIA.

By

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INTRODUCTORY.

That the ancients were as much interested in cosmetic dermatology and hair defects as we of the present, can be clearly gauged from the amount of space devoted to these subjects in both the Papyri—Edwin Smith and Ebers. The latter has a prescription, which has the record for age, for a remedy, not for one of the great captains of death, but for baldness, prepared for Ses, mother of Teta, King of Upper and Lower Egypt, about 5,000 years ago. A bolus composed of iron, red-lead, onions, alabaster and honey was to be taken daily after pronouncing a short invocation to the Sun. Hippocratic writings and compilations have terse clinical descriptions and terminology for alopecia of various kinds as we find them to-day. But the time we

reach Aurelius Cornelius Celsus, a Roman physician of great repute, 25 A.D., we find almost all the different terms used in describing various forms of alopecia. Though the moderns may cavil at these terms, saying that refinement in terminology has gone much ahead of actual established facts, yet some of their descriptions and conclusions still remain true and unimpeachable.

Alopecia is deficiency of hair or baldness. It is derived from a Greek word "Alopekia" which means 'Foxmange.' The coats of foxes became denuded of hair in patches during winter.

Men suffer from alopecia much more than women. How this comes about is not satisfactorily explained. Wearing of tight fitting and heavy hats, fez, turbans by men impede the circulation in the scalp by pressure on the temporal arteries. Ventilation is poor and light excluded. Thus the hair is not given a fair opportunity for exercising its function of protection, whereas, the hats of women are more ornamental than protective. That brain workers were liable to premature alopecia does not find general acceptance. Perhaps worry and sedentary habits of this class may act indirectly by want of a brisk circulation.

Men are very perfunctory in the matter of hair-dressing. More than keep the hair in position to keep up appearances, men pay very little attention; women attend to their hair regularly, daily, conscientiously. Anointing the head with oil and frequent shampooing is regularly practised by women as it adds to their personal appearance.

THE HAIR.

The hair is a highly modified ectodermal structure. It is divisible into a root portion contained within the follicle and a shaft extending from the surface of the skin. The bulbous end of the root of the hair is perched on the papillae—a conical structure with a good vascular and nervous supply. The papilla of the hair is the exact analogue of the papillae of the corial layer. The cells on the surface of the papillae are the germinal cells and by their proliferation the growth of the hair takes place and the hair is moved gradually outwards. The scalp hair grows at the rate of half an inch per month and in the summer a little longer

er by about an eighth or a quarter of an inch. The sebaceous glands open into the follicle at the juncture of its outer and middle thirds or slightly lower. The mouth of the hair follicle above the opening of the sebaceous glands, is formed by an invagination of all the layers of the epidermis, and below only the reticular layer remains. This difference in structure requires notice as a keratotic condition may affect the mouth of the follicle and interfere with the growth of the hair.

External and internal root sheaths are derived from the germinal cells and both these structures are surrounded by a fibrous sheath. Numerous nerve filaments can be made out ending in the inner and outer sheaths. The individual outer cells forming the cuticle of the hair point outwards and upwards while the cells of the inner root sheath, adjacent to the hair, point outwards and downwards. This arrangement together with the pilary attachment helps to keep the hair firmly enclosed in its follicle.

The span of life of the scalp hair is variously estimated as from 2—3 years. When shedding is about to take place, a fibrillary appearance is seen above the papillae and the distinct cellular arrangement is lost, and the new hair from the papilla pushes out the old hair which is slightly loosened by the shrinking of the adjacent cells holding it in position.

ENDOCRINES, SYMPATHETIC NERVOUS SYSTEM AND TOXINES.

We know that the endocrines and the sympathetic nervous system have a certain amount of influence on the pilary system as regards the growth, maintenance and shedding but just how the influence is exerted has not been satisfactorily explained.

Well-recognized cases of single endocrine disturbances show certain forms of changes in the hair. In *myxoedema* the skin is dry and desquamated in a branny form. Secretion of sweat is absent. The hair of the scalp, face and eye-brows and eye-lashes often falls out. In *exophthalmic goitre*, there is frequent loss of hair, which sometimes comes out in handfuls. Hyperfunction of the supra-renal cortex produces abnormally strong growth of hair in the body, particularly marked in the genital region. When the anterior lobe of the

pituitary hyperfunctions, hair becomes coarse and shaggy. Frolich's syndrome is marked by defective hair growth, and in Simmond's disease, hair on the scalp and eye-brows fall out. Again in Lorrain's type of infantilism, hair growth is sparse. Sabouraud noted that eunuch, did not suffer from alopecia.

Epilation by thallium acetate, in pre-adolescents, is brought about by a toxic action on the sympathetic trophic nerves. Pilocarpine series of drugs act by stimulation through the para-sympathetic and produce growth of hair.

From the foregoing, it will be evident that anything which destroys the hair follicle, or inhibits its function will become an aetiological factor in alopecia. If the follicular vascularity is well-maintained and the sympathetic trophic nerves are in good condition, the growth of the hair will not be interfered with. Certain forms of alopecia cannot be cured; certain others can only be dealt with in a palliative way, and there are others where therapeutic efforts will produce a permanent cure. An attempt will be made to bring out clearly the point, how for the patient will be benefitted by treatment.

CLASSIFICATION.

1. Congenital.
2. Symptomatic premature alopecia.
 - (a) General :
 - (i) Specific fevers, e.g. Typhoid
Pneumonia
Smallpox—eruptic fevers
Influenza
 - (ii) Cachetic conditions e.g. Syphilis
Tuberculosis
Leprosy
Diabetes
Chronic malaria
Kala-azar
 - (iii) Nervous depressions, as shock,
worry, anxiety, etc.
 - (b) Local diseases of the scalp :—
 - (i) Seborrhœic dermatitis,
 - (ii) Infection by pyo-cocci impetigo,
(Fox type) Impetigo (Bockhatt)
Boils, furuncles, Folliculitis Decalvans.
 - (iii) Vegetable parasites, favus, fungus
—Trichophytic—Epidermophytic.
 - (iv) Other diseases of scalp, as Eczema
psoriasis, Lup. vulgaris, Lup Eryth-
matosus.

* Madras University extension lecture.

3. Special forms of alopecia:

- (a) Alopecia areata (pelade)
- (b) Pseudo-pelade (Brocq)

4. Alopecia arising from pyogenic infection.

5. Senile Alopecia

6. Cicatricial alopecia—all causes resulting in follicular destruction and fibrous tissue formation.

7. Diseases of hair shaft resulting in alopecia.

CONGENITAL ALOPECIA.—True congenital alopecia is a rare condition, and varying degrees of baldness may be present. Complete baldness is met with in a few cases. This type arises from a poor development of the pilary system and other ectodermal structures are also involved as teeth and nails. In extreme cases sebaceous and sweat glands may be poorly developed or not at all. In a small percentage of these cases hair may grow eventually.

Non-hairy naevus, and alopecia resulting from amniotic adhesions in utero with deep cicatrix, birth injury to nerve trunks in in-mental deliveries, and hydrocephalic distensions of scalp are all classified under this heading.

SYMPTOMATIC PREMATURE ALOPECIA.—As the name indicates, it is always secondary to obvious causes, general or local. After long febrile conditions as typhoid, Kala-azar, tubercle, sub-acute bacterial endocarditis or pneumonia, the patient loses the hair in varying degrees either during the illness or the period of convalescence. Cachexia following chronic malaria, phthisis, leprosy, syphilis is another cause for the thinning of hair. Convalescence from eruptive fevers is attended by a defluvium; shock, prolonged anxiety and depression of spirits may result in alopecia; of the local causes, scarring lesions as tertiary syphilis, lupus erythematosus and morphea and intense inflammatory lesions from eczema, psoriasis, and erysipelas, destroy the hair follicles and, as shown above, hair growth is out of the question. In psoriasis, for many years, the growth of hair is not interfered with till the inflammation becomes intense and persistent. In the same way Keratosis and Ichthyosis interfere with the healthy pilosebaceous activity by plugging the mouths of the hair follicles.

Hypotenayl tablets contain a special hypopiesic principle of the liver.

Fungus infection of the scalp by the small spore and large spore varieties is a self-limiting disease and the patient is free from the disease even without treatment after the age of fifteen in any case. With the disappearance of the disease, a good regrowth of hair takes place. This is not so in the case of favus where permanent alopecia results from intense inflammation and cicatricial atrophy.

Of the numerous local causes, seborrheic dermatitis or seborrheic eczema will cover more cases than all the rest put together. This fact will be more appreciated when I say that early and mild cases are overlooked in those who wash their hair frequently or use regularly oily preparations for the scalp toilet. A well-known authority estimates that a large majority of the urban population suffer from the disease. Whether the disease is due to the *Morococcus* of Unna which is now considered to be identical with the *Staphylococcus albus*, *Pityrosporon* of Malassez which is confirmed by the researches of McLeod and Dowling, or yet the newly described *Schizosaccaromycetes* of Benedek need not detain us, as there is yet no unanimity among the different investigators. Both the types, seborrhea oleosa and seborrhea sicca, eventually produce baldness. The fall affects the vertex and the temples; the former area is affected earlier. Before complete baldness, the hair becomes less dense and thin, and daily combing brings out more and more of the easily shedding hair. Shed hairs are replaced by thinner ones and later they fail to appear. As pointed above, men are more affected than women: mode of living, overcrowding, poor ventilation, etc., may be contributory factors in the urban population.

3. Special forms of alopecia;

(a) **ALOPECIA AREATA**—This is characterized by the appearance of bald patches, round, oval or irregular, without any evidence of a disease process. The area has been aptly described to be as smooth and bare as a billiard ball. The periphery may show the presence of attenuated hairs of a special type, known as, "mark of exclamation hairs" (!) as the proximal root part is atrophied giving rise to this appellation. It is also considered to be of value in prognosis; when the mark of exclamation hair

is found, the process is active and when not present, there is an arrest of the fall. Regrowth takes place sooner or later or not at all. After the age of 45, a good prognosis cannot always be expected. Regrowth takes place without treatment; earlier growth is downy and may lack in pigmentation. Normal colour and texture will be restored in time. This form of baldness may affect other regions than the scalp. Beard region, eye-brows, pubic and axillary hair and the hair of the trunk and limbs may be similarly involved.

The aetiology of this condition is still unknown. Focal sepsis, diseases of the nervous system, endocrine dysharmony and reflex irritation have been suggested as cause or predisposition to the disease. That it is due to a fungus infection (*e.g.*, *Trichosporon*) or a bacterial infection is the contention of others. Epilation induced by Thallium acetate will lend support to a toxic theory. Another view is to regard alopecia areata as a condition arising from all the different aetiological factors, one or the other operating in a particular case.

(b) **PSEUDO PELADE OF BROCCQ.**—This is a form of alopecia of insidious onset arising from a destruction of the hair follicles in small patches. The individual patches vary in size from a split pea to a pie, the former dimension being commoner. The affected area is slightly depressed (absence of follicles) and the periphery may show small epidermic follicular plugs. Otherwise there is an entire absence of crusts, pustules and broken-off hairs. The alopecia is permanent and the disease is slowly progressive. When the patches are small, the scalp presents the moth eaten appearance of syphilitic alopecia; negative specific serum reaction will put syphilis out of court. Pseudo-pelade of Brocq is also one of unknown etiology: a tropho-neurosis seems probable.

4. **ALOPECIA ARISING FROM PYOGENIC INFECTION.**—Impetigo contagiosa of the Tibury Fox type accompany such scalp affections as seborrheic dermatitis, pediculosis, etc., where scratching is a prominent symptom, when the inflammation is extensive and involve the deeper parts (ecthyma), much follicular destruction and scarring takes place. Impetigo of the Bockhart type sometimes affects the scalp region. This is easily recognized by the

small pellicle of pus at the mouth of the individual hair follicle. Any one who has had a little experience with the Bockhart's impetigo in its common site of election—the legs, will find no difficulty in accepting the affection as chronic. Healing takes place when most of the follicles are disorganized and scarred. The same is also true when the affection is in the scalp.

5. **SENILE ALOPECIA.**—Our span of life, according to the Palmist, "is three score years and ten, if by reason of strength, they be four score years" But we do not get an inkling when senescence actually sets in. Some begin to look old at thirty—prematurely old, while others look young and active at sixty, blessed with a wealth of hair on their heads. Senile alopecia results when all vital powers slow down. The quantity and quality of blood supplied to the papillae become much altered and nutrition gradually fails. Senescence is brought about by some slight but cumulative deficiency of substances essential to cell metabolism.

Senile alopecia begins at the vertex, spreads to the temple and lastly to the occiput. The hairs become sparse and thin and finally cease to appear. Why the vertex should be affected first has been variously explained. I consider that, the circulation of the vertex being from below upwards, the distal and peripheral part of the circulation suffers, i.e., in the area of the vertex, where alopecia begins first. The treatment of this condition, in the very nature of things, will be unsatisfactory.

6. **CICATRICIAL ALOPECIA.**—This classification brings in all the causes where there is follicular destruction with a resultant scarring. I have dealt with this under local causes. Pseudo-pelade of Brocq may also find a place here, as the underlying pathology is destruction of the hair follicles. Infection by the pyogenic cocci will also result in follicular scarring.

DISEASES OF THE HAIR.—Such diseases as monilethrix, trichorhexis nodosa and leptothrix will have to be considered when the scalp hair keeps constantly short and stumpy. In the young, fungus infection should be excluded by careful examination. Correx filter or Wood's glass will give valuable assistance in diagnosis and in deciding the effectiveness of treatment adopted.

Such conditions as trichotillomania, loss of scalp hair in rickety children by pressure and rolling of the head on the pillow and the rubbing off the hair in acrodynia, may also be borne in mind. Idiopathic premature alopecia indicates a condition due to no detectable cause and cases falling under this grouping will become less and less when the aetiology is fully worked out. Most of the cases are really cases of Seborrhoeic Dermatitis not properly diagnosed as shown above.

TREATMENT.—A consideration of the aetiology will show which of the cases will yield results to treatment. If the follicular destruction is evident, regrowth in those areas is impossible. Congenital alopecia, cicatricial alopecia and pseudo-pelade of Brocq cannot be influenced by any form of treatment. In a general way it may be stated that all departures from normal health will require correction by improved hygiene, diets and medicine. Nervine tonics may be useful by providing a stimulus to the nerve endings supplying the pilary follicles. Alopecia accompanying or following acute infectious diseases, prolonged febrile conditions, etc., will not require any special kind of treatment as regrowth usually appears when the patient's general condition has improved.

Fungus infections of the scalp requires treatment by X-ray or thallium acetate by mouth in addition to parasiticide. As shown above one of the filters, Correx's or Wood's is useful in diagnosis and treatment. The disease becomes self-limited at the age of thirteen to fifteen; Favus is not met with in South India and I have not seen a single case. Coccal infections of the scalp will require parasiticides for local application, after cutting off of the hair over the affected parts. Auto-vaccine may be of aid and may cut short the duration of the treatment.

Seborrhoeic dermatitis precedes most cases of alopecia and careful search should be made to establish its presence. The following plan of treatment may be adopted when seborrhoeic dermatitis is present:

(1) A spirituous lotion for daily use containing a parasiticide and a disinfectant.

(2) Pomade for use in the night preceding the morning shampoo and

(3) A simple shampoo. The spiritus lotion may be made up as follows:

Hydrargyri perchloridi ...	grs. 20 to 30.
Chloral hydrate ...	1 dr. to 1½ drs.
Spt. Cologne ...	2 ozs. and
Rectified spirit ...	1 pint.

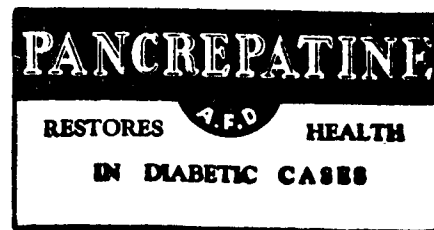
The lotion may be put up in a sprinkler-top bottle for ease in daily use. I have found a lotion containing sulphur precipitate 1 dra, acid salicylic 1 dr. in 4 ozs. of Bay rum to be equally effective for daily use. Pomade may be made as follows:

Sulphur precipitate ...	grs. 30.
Acid salicylic ...	grs. 20.
Unguentum aqua rosæ ...	oz. 1.

This should be rubbed in small amounts into different parts of the scalp after parting the hair seriatim, so that the whole scalp is gone over once fairly well. The morning shampoo for use is made up by digesting 2 ozs. of Saponis Mollis in 1 ounce of spts. rectificatus. The addition of a 2 or 5 grs. of thymol may make it more effective. Two to three drachms of the Soap spirit will be sufficient for a shampoo.

Alopecia areata patch may be painted daily with Tr. iodine or ordinary vinegar till growth appears. Good results are also accomplished by painting the bare area with pure carbolic acid as recommended by Bulkley. The re-painting can only be done after the inflammation has subsided. Aolan may be injected intradermally once or twice a week. All these measures aim at producing a peri-follicular vascularity. This may be attained by a regular massage of the area for ten minutes both morning and evening. U. V. L. may be used to effect the same and keep the patient in touch with the modern craze. The hair will grow in most of the patients under 45. It may not acquire the proper colour and texture, and so the patient may have a pie-bald appearance.

The lecture was demonstrated by epidiastic pictures.



Hypotensyl tablets contain a special hypopiesic principle of the spleen.

Abstracts

ADOLESCENT GLAUCOMA

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It is the consensus of opinion that senility seems to be the important factor in the production of chronic, non-inflammatory, simple glaucoma. Elliot says, "Without doubt, the advance of life stands in a strong causal relation to glaucoma."¹ This is likewise the case with arterio-sclerosis and general vascular hypertension; but the intraocular tension of the eyes does not seem to bear any direct relationship to that of the arteries for the reason that the venous pressure in its variations is more closely connected with the intraocular pressure than is the arterial. Hence it follows that a local interference with the venous return readily gives rise to a glaucomatous attack, according to Duke-Elder,² and he further says that it is a manifestation of a local vascular crisis.

Aside from traumatism, intraocular growths and secondary glaucoma, a malignant permanent rise in the intraocular pressure with symptoms such as loss of the central visual acuity, changes in the visual field, haloes and discomfort, and subsequent enlargement of the eyeball with glaucomatous excavation of the optic nerve, is comparatively rare in young persons and without these signs, a diagnosis of glaucoma in youth is open to dispute.

It is my impression that three varieties of glaucoma may be differentiated; the one is anterior and infantile in which the changes in the eyeball largely occur through the stretching and thinning of the cornea, producing the type known as buphthalmos.

Then the ordinary medial glaucoma of late adult and senile type in which the cause is largely due to closure of the iridic filtration angle. However, there are indubitably other causes; such as, changes in the consistency of the aqueous and vitreous and the secretions of the ciliary body, enlargement of the lens, etc. These are not treated here, nor is the acute inflammatory type, nor that due to traumatism or intraocular growths.

The third, or posterior, type is from

causes in the posterior portion of the eye due to a local interference with a venous return causing deficient filtration through the lamina cribrosa of the optic nerve and the chorioidal plexus. Then comes on a myopic lengthening of the eye-ball with thinning of the sclera, and the optic nerve is forced back from the scleral ring from the pressure, with the production of a cupping.

In this type there may not be any diminution of the circumferential space as shown by transillumination. The anterior chamber may not be shallow and there may not be a typical glaucomatous pupil; and if such eyes could be sectioned, it would be found that the canal of Schlemm and spaces of Fontana are not appreciably occluded and that the lens and ciliary body are practically normal. However, the posterior lesions are here pronounced. Salzmann³ says, "The lumen of the central vein is progressively narrowed, even to cause occlusion. This constriction is due to a sharp bend in its course from the base of the glaucomatous cup into the axis of the optic nerve. The higher arterial pressure compresses the vein on the nasal side with an inflammatory process accompanying, leading to complete closure. Collateral circulation may occur with the chorioidal vessels meeting with the central vein proximal to the occlusion." Likewise, collateral circulation may occur with the deep scleral and episcleral vessels with large tortuous veins showing externally on the eyeball which were well marked in all six cases here presented.

To come back to the age, out of the several thousands of cases of glaucoma I have seen in forty-five years, I can recall only six which developed under the age of thirty years, and very few between thirty and forty. The majority of my cases have been after the fiftieth year of life. This general observation corroborates the statistics of others; for instance, the last series is that of A. Pillat⁴ who, in four years of practice in China, had 12,933 cases, with 144 of glaucoma in men. In these, there were 107 chronic cases and 14 acute inflammatory cases; 11 were younger than 45, 17 between 45 and 55, 42 older than 55. In women, 13 were under 45, 18 between 45 and 55, and 48 older than 55.

This likewise compares with the earlier

Read at the Western Ophthalmological Association, Butte, Mont., July 19, 1934.

reports of Priestley-Smith⁵ in 1912, and Kagoshima⁶ in 1915. Haag,⁷ in 1,032 glaucoma cases, found 4 under 10 years, 16 under 20, 26 under 30, 74 under 40, 176 under 50, 88 under 60, 329 under 70, 116 under 80, and 3 older.

CASE 1

The earliest case I remember was about the year 1900 in Milwaukee, in which I had Casey A. Wood for consultation. This occurred in a girl of 19 years of age who had progressive myopia with dilated scleral vessels, hypertension and cupping of the optic nerves. Operated on by iridectomy in both eyes with stoppage of the process so far as I know. The case history reports in this instance are not at present available. However, the following are on record.

CASE 2

Mrs. A.E.S., Seattle, Wash., age 27 years, Sept. 19, 1927. Referred to me by Dr. Robert G. Reese of New York who operated on her by double Elliot trephining in October, 1924. She had been under observation by him since November, 1908, when she was eight years of age. At that time she had a physiological excavation in both nerves. There was a pulsating artery in the nerve of the left eye. Her fields were then normal and her mother suffered from chronic glaucoma. Her vision then was 20/20 in each eye with -1.50 sphere.

In April, 1912, she had tension of 35 Schiotz in each eye. May, 1912, iridectomy performed in each eye. January, 1914, second iridectomy performed in the right eye. April, 1914, a trephine operation on the right eye. Since that time she has had normal tension in each eye. The fields of vision in both eyes have remained normal and she has normal blind spots. There has been, however, an increase in the myopia during these years and in May, 1926, she had 20/20 vision in the right eye with -4.50 combined with -2.00, 90°; 20/20 in the left with -3.50 combined with -1.00, 90°. Dr. Reese considered this a cured case of glaucoma.

At the time of my examination, the myopia had further increased to:

Right—5.50 combined with -2.00, 90° V=20/40.

Left—4.50 combined with -1.00, 90° V=20/40.

Both optic nerves are fully cupped, typically glaucomatous. The retinal circulation, however, is normal. The visual field in the right eye is concentrically contracted to 60° while that in the left is practically normal. These conditions have remained the same to my last observation, in May, 1934. At this time, she is carrying her third child at about seven months pregnancy, having already had two caesarean deliveries with living children, and expects this one also to be surgically born.

In this case, the anterior portion of the eyes is perfectly normal; large perilental spaces, freely moveable pupils; and the myopia is axial, not attended by any stretching away of the choroid or the formation of posterior staphyloma. There are likewise enlarged episcleral veins which, however, are not as prominent as in the other cases following.

CASE 3

C. R. L., Washington, age 27 years, negro, July 2, 1928.

The vision of the left eye has been failing for six months. Nine years ago he had treatment for what was then said to be "hardness of the eye" in the postgraduate school clinic in Chicago.

Vision right eye=20/20; left eye=20/80.

The right eye+1.00; left eye-75.

There was a contracted visual field in the left eye down to less than 10°; i.e., tubular vision, with hypertension of 55° Schiotz, glaucomic cup of 5 D. He was first treated by miotics and then, in August, 1928, a double Elliot operation was done in both eyes with results when last seen in 1933 of 20/20 vision in the right eye and 20/60 in the left. The visual field has increased in the left eye to a somewhat contracted field of approximately 50° with full color vision. In this case, too, there were no anterior glaucomic lesions, the effects of the hypertension being restricted to the optic nerve and posterior portion of the globe shown in the glaucomic cup and the moderate myopia. The episcleral veins in the left eye were likewise tortuous and prominent and have remained so despite the operative work and the favorable progress of the case.

Hypotensyl tablets reduce Systolic Blood Pressure.

CASE 4

Miss L. P., Salem, Oregon, then age 40 years, March 7, 1930.

Had gradual loss of vision for at least 20 years, it having been diagnosed as chronic simple glaucoma more than 10 years before in Chicago, Ill., Portland, Ore., and Seattle, and had been under miotic treatment for a long time.

This case was not myopic but had previously worn stronger plus lenses. In the right, the refraction was: R+1.50 combined with +1.27, 10°, V=20/100; left, +4.00, V=20/100.

There was lateral nystagmus and an early arcus senilis. The visual fields were concentrically contracted; the right to approximately 30° for form and less than 14° for color, the left to 60° for form and 30° for color. The optic nerves were both characteristically cupped and especially noted was the angulation of the central veins and the pulsation of the arteries. Tension: right=110, left=50.

March, 10, 1930, double Elliot operation with full iridectomies was made. This case has been under observation since that time with no further deterioration of vision and the visual fields have improved. In 1933 she had a sinus operation done on the sphenoids and ethmoids. At this time she was frightened about her eye condition but neither before nor since have I found any reason or indications for having had this operation performed.

CASE No. 5.

Mrs. L. D. O., Bellingham, Wash., age 28 years, April, 10, 1934.

Came in with a blind right eye, scarcely seeing light. The left had vision of 20/40; tension right=+75, left=+40. Both eyes myopic—2 D. Great glaucomic cupping in the right eye and a large physiological cup in the left. Visual field of the right, such as could be taken, restricted to a small spot downward and inward; in the left, somewhat contracted. There was small re-entrant angle upwards in the left eye. Low blood pressure: 108/80.

Operation double Elliot with iridectomy in the right and buttonhole in the left, May, 3, 1934. Normal progress, healed afterwards. May 12, 1934, the finger tension was normal and the patient comfortable.

In this case there is exceptional engorgement of the external ocular vessels, almost as much as is sometimes seen in the case of pulsating exophthalmos, due to a varix in the orbit.

CASE No. 6.

F. J. W., Bellingham, Wash., brother of Case 5, age 26 years, April 20, 1934.

Vision R. E.=20/200 with a somewhat contracted visual field. Left eye=20/20 with almost the same field.

Refraction right—1.25 combined with—50, 90° V=20/60; left +.50, 180° V=20/20.

In the right eye there is an enormous glaucomic cupping. However, the retinal circulation is full and the patient has not had any of the ordinary symptoms of glaucoma, despite the fact that his tension in the right is 60 and in the left, 40. Here, too, there is an enormous congestion or enlargement of the episcleral vessels of the right eye. In both case 5 and 6, the father is reported to have large blood vessels in his eyes but no loss of vision. This case has been placed upon miotic treatment until he makes up his mind to have the operation of trephining done in both eyes.

RESUME.

It will be noted in five of these cases that there was progressive myopia and in one, lessening of the hyperopia, with contraction of the visual fields and production of glaucomic cups, without any of the signs of anterior or medial glaucoma. There have been no serious inflammatory attacks and that in all of them there has been a pronounced engorgement and enlargement of the scleral and episcleral vessels. It is contended in this article that these cases are due to a local posterior stoppage of circulation which has caused an intra-ocular hypertension with formation of glaucomic cup and loss of vision, a condition which certainly is not generally recognized and must be very rare in late adult and senile life. It is likewise to be commented upon that these cases were not relieved by miotic treatment but that the process has been stopped by operation in the five surgical case.

BIBLIOGRAPHY.

1. R. H. Elliot, Glaucoma, 1918.
2. Duke-Elder, Tr. Oph. Soc. Jn. King, 1913, and Recent Advancement in Ophth., 1918.
3. Salzmann, Zeitschr. f. Aug. 15, 1933.
4. Pillat, Arch. of Oph., 129-299, 1933.

5. Priestley-Smith, Glaucoma, 1891.
 6. Kagoshima, Nippon Gankakai-Zashi, Sept. 1915, and Ophthalmology, July 16, 1916.
 7. Haag, Klin. Mon. of Aug. 133, Idv. 1915, 320 Stimson Building, Seattle, Wash.
- The Eye, Ear, Nose and Throat Monthly*
March, 1935.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

*A few Dont's in Eye Treatment.

By

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I first hesitated to take up this sort of a subject before a body of experienced medical men, for what I have to say is most common place and might be superfluous to most of you. But, in our experience, we have found that there are certain things overdone or omitted by general practitioners which had been responsible for some serious defects to the eye, that we thought we should present a paper on what we had seen and which might be useful to a few of you atleast. We know we cannot expect one engaged in general practice to deal with the eye cases he is forced to treat, in the same delicate way as a specialist. He can only remember some common routine treatment. We have a lot of text books on Eye, but there is no simple, practical book on the market, useful for the general practitioner, particularly for conditions in India. It is only in what the general doctor is doing now, I want to point out where he is usually making mistakes, which though negligible in most of the cases are certainly harmful in some.

Acute conjunctivitis or Catarrhal Ophthalmia as it is commonly called, is a condition which I am sure every one of you has been called upon to treat. It is a simple condition no doubt, and I dare say you have had no difficulty in tackling those cases successfully, but it is here in the management of this condition that I have to point out a number of small mistakes which you can easily remember to avoid.

The first common mistake, one usually observes, is in the indiscriminate use of the

Silver Nitrate Solution. No doubt, it is an excellent and most efficacious drug for acute conjunctivitis, but when not used properly, it leads to dire results.

I have very often seen, especially in the mofussil dispensaries, this solution being simply dropped into the eye, and that, generally by the ward attendant. It should not be done so. You get the best effect only by a brushing of the conjunctiva of the everted lids. And this, should be done by the doctor himself, as far as possible. When you drop in the solution, not only you don't administer an efficacious application over the whole infected area, but you also run the risk of irritating the epithelium of the cornea and exciting small ulcers there.

The next mistake commonly committed is the continuous use of this drug every day. You should not use it for more than two or three days successively. When the discharge has stopped, which is generally the case after two or three applications, there is no indication whatever for continuing it. What the eye needs then is a weak antiseptic emollient ointment for the healing of the tender condition of the inflamed conjunctiva. If the discharge is persistent, you have to give rest to the eye with this ointment for a day or two and then start Silver Nitrate solution.

I have seen some doctors increasing the strength of the solution every day if the discharge does not stop. Never do that. Silver Nitrate acts best on the conjunctiva as a 2% solution and in a higher strength, it is an injurious irritant and caustic.

For the same reason, prepare your solution atleast every fortnight. In long kept solutions, owing to evaporation, the strength becomes more than 2% sometimes. Moreover, if you use freshly prepared solutions, you prevent the formation of irritating precipitates in the drug. Don't use at all a solution more than a month old.

The same is the case with the much used Argyrol. Don't use an Argyrol solution more than two weeks old. A more freshly prepared solution is less irritating.

Never apply the Silver Nitrate solution in the evenings. It is always best to do it in the mornings. Its application excites a

profuse discharge and when you use it in the evening, there is an accumulation of the pus inside the eye during sleep, which is not a desirable thing.

Never apply the solution more than once a day.

Don't prescribe Argyrol for indefinite use. It stains the conjunctiva and makes it resistant to further treatment.

Don't give hot fomentations to a case of acute conjunctivitis even when the patient complains of pain. You thereby increase the congestion and worsen the condition.

Don't overlook a case of frequent or intractable sore eyes, especially in the young. It might be Trachoma. You know it is a very insidious disease and its symptoms come out clearly, only when the disease is well established. If you detect it and have it treated early, you might save the child a lot of suffering and impairment of vision in later life.

Don't advise goggles for conjunctivitis, or as a matter of fact for any case with discharge in the eyes. Good ventilation to the eye, aids the healing in these conditions.

Don't also bandage an eye with discharge.

If it is possible, don't forget to protect the other children in the house if one child is having acute conjunctivitis. Don't also allow that child to be sent to school, lest the other children in the school should get the infection.

Foreign body in the cornea is a condition which a general practitioner especially in the mofussil frequently comes across.

I can remember many an eye that was lost merely by mishandling the case. In his anxiety not to injure too much of the corneal substance—for he has learnt in the text-books a corneal scar never disappears—the practitioner tries to dig up as close to the foreign body as possible. In eye surgery, accuracy and steadiness are very essential and where these are lacking or deficient, what the operator does is to simply push down the foreign body, especially if it be a sharp thing. I have known cases where a superficially lying foreign body had been pushed into the anterior chamber, or where the operator himself had opened the chamber in trying to dig out the foreign body. It is very likely because the cornea is transparent and you may not know how deep you are going. A safe way of taking it out is

to start a little away from one side of the foreign body—say 1 or 2 mm. away according to your steadiness go a bit deep and towards the foreign body, and then elevate its edge and thus gradually lift the whole piece out. If you do it that way, you will never fail to take it out. Where you are not quite sure, use a magnifying loupe. And, always have a good illumination.

In all your manipulations, avoid scarifying that portion of the cornea which lies over the pupil. A safe plan is to direct the movements of your instrument from the centre to the periphery and never from the periphery towards the centre. Even the faintest scar over the pupillary area will cause a considerable disturbance of the vision and dazzling.

When a patient complains of something having fallen into the eye and if you don't find it on the cornea or bulbar conjunctiva, don't be digging for it in the fornices. Just evert the upper lid and you will invariably see it in the furrow just beneath the row of eye lashes.

Atropine is another drug that is indiscriminately used by many. There are cases which have gone blind from glaucoma, excited by the dilatation of the pupil with Atropin. Any irritation or ulcer tempts some doctors to put in Atropin immediately. Unless you are sure of the purpose for which you drop it and there are no contra-indications for it, please don't deal with that drug lightly. In any case, I would strongly advise you not to use Atropin for any one over 35 or 40 years of age, unless advised by a specialist.

Corneal ulcer is another frequent condition which a general practitioner usually comes across, especially in the rural areas. My advice will be, don't attempt to treat that case if that can be sent to any eye practitioner nearby. Treatment of a corneal ulcer is a condition which baffles even experts and no routine specified treatment helps all cases uniformly. One has to treat every case according to its particular condition which a general practitioner cannot be expected to detect and treat. Among the various causes for the appalling amount of preventable blindness in our country, corneal ulcer stands almost foremost. For want of proper early treatment, many an eye is lost, especially in the rural parts. Where we see

* Read before the monthly meeting of the Trichinopoly District Medical Association on 23rd March, 1935.

the cases early, we are able to check the course of the ulcer and preserve some vision at least, but when we see them late, even though we may be able to stop the progress of the ulcer, the sight is irrecoverably lost. If, soon after patients with corneal ulcers, approach a general practitioner, he sends them to the nearest specialist, he will be doing a service to humanity and society by saving those useful eyes giving them the benefit of expert treatment.

I should like to say the same thing—perhaps with greater emphasis—concerning that dreadful disease, Gonorrheal Ophthalmia, whether in children or in adults. It is a condition where hours and perhaps even minutes count. It is a most destructive disease and it requires prompt, energetic and proper treatment to check its destructive course. When you see a case, hurry it up to a specialist immediately, whether in working or non-working or out-of-hospital hours. The hearty and quick co-operation of the general practitioner, will be appreciated by both the patient and the specialist.

Don't neglect the eyes in a case of small-pox. A small attention to the eye every day will mean its safety. I know the case of the daughter of a medical man, where the eyes were irrecoverably lost under his very nose. If he had only taken care to bestow a little hygienic attention to the eye, not caring for what old folks would say regarding Mariamma getting offended, the girl should never have gone blind.

In head-aches, where you cannot see any organic cause, don't fail to eliminate the eye as a possible cause. You will thereby save a lot of suffering to the patient and worry to your own self.

Never push on Arsenic in syphilitic or other conditions, if the patient is complaining of failing vision. The dimness may be due to a starting optic atrophy and in nearly all cases of optic atrophy, whether syphilitic or non-syphilitic, the atrophy is made worse by the administration of arsenic. Idiosyncrasy to Arsenic itself may start an optic atrophy, even when given in such small doses as in Iron and Arsenic mixture or pills for anaemia. Where, after the administration of arsenic the patient complains of slight blurring of vision, don't fail to note it. You may have to stop the Arsenic

immediately and send him on for an expert consultation before continuing it again.

Lastly, in all cases of failing vision, you would do best, to advise an expert consultation, unless you are quite sure of the diagnosis. Scores of eyes have been lost from glaucoma on account of their being diagnosed as cataracts most ignorantly and innocently and the patients being advised to wait till the cataract is ripe. Dimness of vision in later life may be from any cause and not due to cataract alone, and when your patient complains of gradually failing vision, don't fail to get at the correct cause, so that if it be from any other cause than cataract it might be treated in time and the patient's valuable sight saved.

Treatment of Pneumonia in Infants and Children

The treatment of this condition presents many pitfalls, and there is the danger of treating the disease rather than caring for the patient. This condition demands the most meticulous attention to so called "little things." Pneumonia must be considered as a contagious disease and children having it must be isolated. A nurse, doctor or attendant who has the slightest upper respiratory infection has no business in the room of a sick child.

One thing that is very important in the treatment of pneumonia is sleep and rest. The child should not be disturbed very often and even a physician's examination should not be repeated more than once a day. A quiet room, few examinations, exclusion of all visitors, and the omission of every therapeutic measure for which there is no cogent reason helps at arriving at complete rest.

In the case of uncomplicated pneumonia which is a relatively short disease, one need not pay great attention to diet. But if the illness extends to beyond 10 days then certain factors must be considered. The diet in pneumonia must be from the standpoint of furnishing quickly available energy, of preventing dehydration, and acidemia, and of minimizing gastrointestinal irritation. It is desirable to furnish as large a proportion of sugars and starches as is consistent with freedom from intestinal upsets and for this

purpose a combination of dextrins and maltose is most suitable. Infants over six months of age should be given 2 to 2½ ozs. of fluid per pound of body weight; and from one to two years 2 ozs. per pound of body weight; from three to six years of age between three and four pints, and past six years at least two to three quarts. A diet from which to start all children who are not on formulas is: one pint of milk with an added ounce of sugar; a mixture of 8 ounces of orange juice, 8 ounces of water, and an ounce of sugar plus 1 pint of plain or alkaline water or weak tea. To this may be added cooked cereals, gelatin, junket, custard, greated egg yolk, double toasted bread, plain crackers and plain puddings.

The administration of salines hypodermically or intravenously are very valuable. Normal saline or 4 per cent. glucose up to 20 cc. per pound of body weight may be given hypodermically or up to 10 cc. per pound body weight intravenously when there is fluid need or threatened or actual collapse. Intravenous glucose is usually given in 5 to 10 per cent. solution, the stronger concentration is specially indicated when the kidney function is distinctly impaired.

Oxygen should be used immediately there is the slightest blueness round the lips or the fingertips. If mild, one can use a nasal catheter intermittently or continuously. Cocaine, epinephrine or ephedrine nasal drops help to clear the nose.

Transfusions are of great use and are being used daily more and more. They are distinctly valuable in cases of children who do not present particularly good risk and often throw the balance in the right direction. There is no need to fear an embarrassment of the circulation. A single transfusion of 10 cc. per pound body weight may be given but a greater amount than 250 cc. should not be given at a time.

Drugs should be chosen with due regard to dosage, indications, and the possibility of causing gastric upsets. One drug at a time is a very good rule to follow in children. For cough, codeine can be depended upon. Acetylsalicylic acid alone will reduce the fever and relieve distress in the first hours as well as any other combination. One grain for each year, every three or four hours, may be given for not more than five

doses. Atropine is extremely useful in presence of copious secretion or bronchial spasm. Compound tincture of benzoin in steam inhalation must be used at times for laryngeal spasm or stridor but when much mucus is present it should not be used continuously.

The mouth should be kept clean and moist with sodium perborate. Digitalis should not be used routinely. In chronic carditis or heart failure it should be used and in vasomotor collapse although it is now quite generally conceded that the heart itself is not at fault so frequently as has been imagined in the past.

Pneumonic specific serum is useful and should be utilised. The total amount of serum in the first 24 hours will vary from 200 to 800 units per pound body weight. A safe starting dose for infants is 2 cc. and for children over 5 years, 5 cc. Subsequent doses and intervals will depend on the drop in temperature.

Regarding routine care one daily bath with soap and a daily emptying of the bowels are necessary. The latter can be done either by giving routinely milk of magnesia, or a mineral oil, preferably flavoured in jelly form or when necessary a low enema of 4 to 6 ounces of sodium bicarbonate or plain water. Change the position of the patient if he does not do so himself and avoid sitting up whenever possible. Take the temperature at three-hour intervals and order a tepid sponge if it is over 104° F. Apply cold only to the head. Cold applications to the skin defeat their own purpose by further limiting an already lowered evaporative power of the skin.

In cases of delirium, chloral hydrate and sodium bromide by rectum; 6 to 10 per cent. glucose intravenously. Tepid sponges. For vasomotor collapse transfuse or give 6 per cent. glucose intravenously, Epinephrine, camphor or caffeine hypodermically.

During convalescence, cod-liver oil, heliotherapy, proper food, and change of climate are important. Iron and liver extract for a short period is not infrequently necessary. To get small children to breathe deeply, blow bottles or balloons can be tried.

(*The Medical Clinics of North America*, November, 1934, p. 881.)

ZAMA

Sure remedy for all skin diseases, such as Eczema, Itch and many others accompanied by itching, watering and formation of pus.

Eczema and the allied skin diseases are generally the result of indigestion in children; in females the causes are generally menstrual disorders and pregnancy; in males gout, diabetes and diseases of kidney and liver, while sedentary habits, unhygienic surroundings; anæmia, debility, and scrofula are among the internal constitutional causes in all phases of life.

TREATMENT.

The persistent external application of Zama, as described below coupled with suitable internal treatment for the constitutional causes mentioned above is the ideal treatment to be adopted. Bowels should be free having recourse to occasional doses of castor oil in hot sarasaparilla decoction once or twice a week. Habitual use of purgatives is condemned. Constipation is to be cured by the use of proper food. Salty preserved food, such as fish and pork, greasy food, such as bacon and fried dishes, pastry and cheese should be avoided. Food difficult of digestion be struck off the bill of fare. If debility, anæmia be present, take cod-liver oil or Iron tonics; for indigestion take pepsin in combination with hydrochloric acid. Kidney and liver diseases should be treated if present.

CAUTION.

In acute cases of Eczema or itch and allied skin troubles use of soap in any form is harmful. The part is to be cleaned in the early acute stage with thick gruel prepared of finely powdered rice, arrowroot, or any such starchy material. Later on with this may be added a little soap and at any stage soap alone should not be used.

DIRECTIONS TO USE ZAMA.

Wash the part once a day in the manner described above and after drying the parts with a soft towel, apply a thin coating of Zama. There will be marked improvement after 3 or 4 days' use. If you find the part a little irritated after use, especially in infants with tender skin, dilute Zama before applying with half or equal quantity of Cocoanut oil or Vaseline. When healing takes place there will be a sensation of itching when you should not scratch the parts with your nails but should take a little Zama and rub on gently.

SAFETY ASSURED.

Zama may be used quite safely in any part of the skin including that on the head and private parts at all ages from infancy to infirmity. It is not poisonous if a baby licks it accidentally; but care should be taken that children do not swallow the Zama in large quantities.

CAN BE HAD FROM ALL RESPECTABLE CHEMISTS OR

THE ORIENTAL RESEARCH LABORATORY,
VEPERY, MADRAS.

CLINICAL NOTES

AND

PRACTICAL SUGGESTIONS.

Rational therapy of Obesity.

Obesity, whether generalised or secondary to other processes, is a disease of metabolism. The generalised variety is usually unassociated with other pathological conditions and is very difficult to treat, while the secondary one is frequently amenable to treatment.

Obesity is classified into two types, endogenous and exogenous. Endogenous obesity is based upon some fundamental characteristic of metabolism, whereby food is more easily converted into fat than energy. There is some sort of disturbance of the process of combustion and food storage irrespective of food intake; in fact the organism is not able to regulate properly between its energy requirement and storage of food-stuffs. The organism continues to store fat despite the most limited and carefully chosen diets quite disproportionate to the generation of energy.

Exogenous obesity, on the other hand, is the result of faulty relation between the food intake and energy requirement. The metabolic process in these cases is normal, but there is excessive intake of food beyond the body requirement. Besides the large quantity of total food ingested the fats and carbohydrates greatly predominate in the dietary. Both fats and carbohydrates are fat producers. Adequate restriction and right selection of diet, exercise etc., are of real value in this type.

It has been found out that the main difference between metabolism of the obese and the normal individual is that the former derives less energy from fat than others and that he uses larger quantities of carbohydrates and permits excessive storage of fat. Obesity in almost all cases is attributed to a qualitative anomaly in metabolism which means that carbohydrates are converted into increased amount of fat. That there is a definite relation between the percentage overweight and the respiratory quotient has been found out, subjects with overweight having a particularly low respiratory quotient and those with less overweight having a normal or nearly normal respiratory quotient.

The chief characteristics in the metabolism of the obese are therefore lowered utilisation of fat in the food as a producer of energy, thus allowing storage of fat or a tendency to convert abnormally large quantities of carbohydrate into fat. It seems almost certain, although it is still a controversial subject, that deposition of fat is always associated with lowered basal metabolism.

The importance of endocrine elements in Obesity is presumably much greater than hitherto recognised. Mild degrees of hypofunction of the closely related thyroid, ovary and pituitary may be sufficient to change normal metabolism to one of obesity-producing character.

Hypothyroidism for instance is always attended by obesity. There is always sub-oxidation and lowered metabolism. Thyroid in such cases acts as a general non-specific stimulant of metabolism of all types of tissues. Similarly obesity and hypovarianism go together. Amenorrhoea is always associated with obesity. Menopause is frequently followed by obesity. In these cases the diminished ovarian secretion brings about diminution in the general metabolism of the body. Hyposecretion of the testes also gives rise to obesity. It is therefore clear that thyroid, ovarian and testicular hypofunction gives rise to generalised obesity. Deficient function of the pituitary produces a characteristic type of obesity, wherein the mammae, the hips and upper thighs show fat deposits.

The endocrine gland products, as we have seen above, should therefore play an important and interesting part in the treatment of obesity. Many drugs containing thyroid extract have been used from time to time, some of which are effective but they carry enormous risk to health, specially when used indiscriminately and without any supervision of the physician. It is therefore essential that a safe and efficient fat-reducing remedy should be at the disposal of the profession. Such a one is Iodobesin. It contains extracts of all the glands such as liver, pituitary, testes, ovaries, thyroid, supra-renal, besides Iodalbumen. A combination of these extracts offers a safe and efficacious treatment for obesity. Iodobesin acting as it does on the glandular system causes the production of those elements of

internal secretion which are lacking for the proper oxidation of fats. Thus it brings about the desired reduction in body-weight in a rapid and harmless manner.

As much importance, and rightly too, is attached to the internal secretions in the etiology of obesity, this pluriglandular preparation is much in evidence at present in the treatment of this condition. Looking at the different factors in the causation of obesity it has been the experience of many that pluriglandular therapy gives much better results in the majority of cases. Iodobesin, on account of its combination, is a rational remedy in markedly reducing the body-weight without any changes in pulse-rate or blood pressure. The thyroid extract in it stimulates metabolism and the oxidation of fats takes place as a part of the general effect. Most of the cases of obesity are associated with pituitary deficiency and hence pituitary extract finds a place in Iodobesin. The thyroid and the pituitary are closely related to the sex-glands i. e., when one gland is malfunctioning the others also are disturbed and hence ovarian and orchitic extracts are included in this preparation. Supra-renal extract is present in Iodobesin because of its property of raising the metabolism rate and the respiratory quotient. The role of orchitic and ovarian extracts on basal metabolism is well-known. The increase in metabolism which affects the whole organism is due to the intense organ-specific effect of the sexual hormones. The hepatic extract is there because some of the obese patients belong to the anaemic type. This type of patient is pallid and weak and cannot undergo this pluriglandular treatment without harm. He can neither take violent exercise nor can he be rigidly dieted. In order therefore to maintain strength and build up haemoglobin, hepatic extract is added to this combination. Iodalbumen a colloidal form of protein is also present in Iodobesin as it effectively makes up for the excessive protein metabolism brought about by the various extracts.

The underlying principle of the combination in Iodobesin is therefore most rational, and based upon considerations and etiological facts of obesity. The successful result obtained with it are due to the syn-

ergistic effects exhibited by the various gland extracts. Iodobesin treatment is a powerful but harmless method of reducing over-weight. This form of therapy, unlike thyroid preparations, can be carried out without the patient being under medical observation, as it does not produce any toxic symptoms. Nervous and cardiac disturbances are completely eliminated and the clinical results always come up to our expectations. Experience has shown that it is well-tolerated and the dosage can be increased gradually without any disturbances or side-effects. Iodobesin does not show any change at all so far as thyroid effects are concerned, which possibility constitutes a grave danger when thyroid gland-products are administered. No case has yet been reported showing any dangers arising during the administration of Iodobesin for the purpose of reducing weight. Several cases of endocrine imbalance resulting in overweight demand an extended course of Iodobesin administration. In such cases this preparation can be used with impunity and it brings about the long-sought for weight reduction, where other treatments fail.

The treatment of obesity, however, is not confined to merely prescribing this remedy, but a well-balanced diet must be outlined for the patient limiting his caloric intake according to the circumstances. In exogenous types, for instance, due to over-eating and little exercise, limitation and careful selection of the diet is usually effective in reducing the fat. Along with this graduated exercises are essential. The extent to which these should be carried should depend upon the general condition of the patient and his work. Walking is useful and should be made part of the daily routine. Swimming and salt water bathing is of great value. A systematic and well followed plan of at least several months is more valuable than spasmodic periods of exercise and diet. The weight of the patient should be regularly taken and attempts at rapid reduction should be avoided. Heart and vascular system should be examined from time to time. As regards the diet the total daily intake should be reduced, the reduction upto 1800 to 2000 calories being sufficient. Both carbohyd-

rates and fats should be curtailed but sufficient proteins may be given. Vegetables, particularly green vegetables are valuable as giving bulk.

Despite the efficiency of Iodobesin the reduction of obesity usually requires strong determination on the part of the patient. In most of the cases habits of life must be radically altered. Limitation of quantity and change in character of food is accomplished only with considerable effort. Habits of easy living should be replaced by systematic work coupled with adequate exercise. With co-operation of this sort from the patient along with the application of Iodobesin, the practitioner can offer real hopes of success in the majority of cases.

The following case report is typical of many successfully treated with this product.

A female aged about 43 came to me for treatment of her obesity. She weighed 203 pounds and her height was 5' 3½". She was of sedentary habits. Her pulse was 78 and blood pressure, 142 systolic and 104 diastolic. There was nothing abnormal about the urine. She was given two opocrins of Iodobesin daily for 10 days and her diet was approximately reduced to 1800 calories per day. After 10 days of this treatment the condition was almost the same. During the next 10 days the dosage was increased, she was having 4 opocrins daily. After this period her weight was found to be 196 and her blood pressure was 135 systolic and 100 diastolic, the pulse remaining the same. She was given complete rest for the next 10 days. Then the treatment was again continued with 4 opocrins daily. Her weight was brought down appreciably after 20 days, the weight now being only 182. Thus the treatment was continued with 4 opocrins per day for every three weeks, at the end of which she was having rest for one week, during which period she took no treatment but adhered to the diet. When this routine was continued for four months her weight was reduced by about 30 pounds. The dietetic restriction was quite moderate. There was no change in the pulse rate and the blood-pressure was brought almost to normal. The patient reported of an increased feeling of well-being. Her dullness and lethargy gave place to regular and systematic work. She

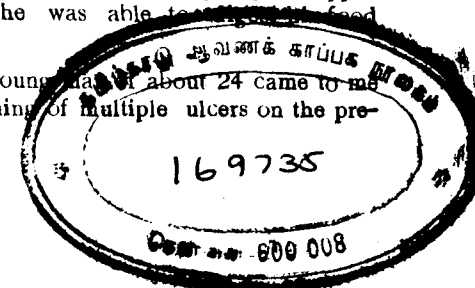
is still under treatment and she weighs at present only 168 pounds.

Some interesting case reports.

1. A male patient, aged 30, came to me for treatment of fever and dysentery. The stools were frequent and mixed with blood and mucus. There was pain in the abdomen and tenesmus for the last four days. Anorexia, abdominal pain and diarrhoea were marked symptoms. The number of stools varied between 10 and 40 a day and they were small in quantity and consisted mainly of mucus, blood and serum. There was extreme prostration and intense thirst. The pain was localised near about the umbilicus. Each bowel evacuation was accompanied by tenesmus which was extremely distressing. Fever was of irregular type and fluctuated between 99° and 101°. On palpation of the abdomen tenderness could be elicited along the whole course of the colon. Heart impulse on auscultation was found to be a little feeble and the pulse was weak and increased in frequency. The urine was scanty, of high specific gravity and there was trace of albumin in it. He was under treatment for two days somewhere where I presume he must have had the usual anti-dysenteric therapy. I started him at once on Bacte Dysenteric Phage. He was having one ampoule of 2 c. c. of the Phage every 4 hours in half a tumbler of cold water. All other treatment was stopped and he was kept on barley water and tea. After twenty four hours the abdominal pain, the rectal tenesmus and the general symptoms progressed for the better. The same treatment was continued the next day and remarkable improvement in the condition of the patient followed. Blood and mucus were no longer seen in the stools and pain was entirely relieved and the number of stools were reduced to three. On the third day there was no fever and the patient was very much better and passed only two well-formed stools. The phage therapy was continued, the patient having only 3 ampoules of 2 c. c. per day. After a week the patient had recovered completely and was able to attend to his work. He had developed good appetite and he was able to eat and sleep properly.

2. A young man, aged about 24 came to me complaining of multiple ulcers on the pre-

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L. M. A. J. S. B. B.

puce. He repudiated any sexual indiscretion and there was no reason to disbelieve him as I knew him well. The patient, I was aware, was subject to Herpes Labialis and there was a crop of vesicles on his lower lip when he came to consult me. The lesions on the prepuce were in the form of multiple vesicles at first, and appeared on reddened and slightly swollen areas of the skin. These used to burst after a day or two. The ulcers thus formed were clean and caused much itching, pain and burning. Having diagnosed this as Herpes Genitalis I gave him for local application Acid Boric mixed with Salicylic acid and for pain I prescribed Cryogenine in 10 gr. doses. He was instructed to avoid irritation of any kind for at least two months. Next day I started Sulfarsenol injections, 12 ctgr. dose dissolved in one ampoule of Arseno Solvent. Improvement was clearly evident after the first injection, as was found by the disappearance of the pain, burning and irritation. Another injection of 18 ctgr. was given intramuscularly after three days. The ulcers were almost healed. The next injection of the same dosage was repeated after four days and the ulcers had completely disappeared. Pain, irritation and burning were entirely relieved. Intramuscular injections were made entirely painless due to the Arseno Solvent medium. The patient was entirely free of this troublesome and recurring complaint within a fortnight's time.

3. A young boy of 22 came to me suffering from severe catarrhal jaundice. The complaint, he said, started 8 days back after a heavy meal. Next morning after the meal he got up with severe vomiting, epigastric distress, mental dullness, headache and hebetude. All these symptoms pointed to acute gastritis. He was not able to attend to his work as he was feeling very dull. The third day after these symptoms he began to pass, according to him, yellow urine and his eyes too were yellow. General examination revealed slight yellowing of the skin. He perspired profusely due to which his clothing was bile-stained. The conjunctivae

were jaundiced, the tongue was heavily coated and the buccal cavity contained a lot of saliva. On palpation the patient complained of tenderness over the liver, although the organ could not be felt below the costal margin. The urine was bile-stained but contained no albumen. The faeces were clay-coloured and emitted an abnormally offensive odour. The diagnosis arrived at was catarrhal jaundice secondary to acute gastritis. The following two mixtures were prescribed and he was advised to take them, the first half an hour before meals and the second half an hour after meals.

Soda Bicarb.	dr. $\frac{1}{2}$
Tr. Nucis Vom.	mms. 30
Pot Citras.	drs. $1\frac{1}{2}$
Spt. Ammom Aro.	mms. 30
Tr Card Co.	drs. $1\frac{1}{2}$
Spt. Chlorof.	dr. 1
Aq. Menth Pip.	ounces 6

1/6 part to be taken $\frac{1}{2}$ hour before food

Ammon Chloride.	dr. 1
Sodii Sulph.	drs. 4
Sodii Phosphas.	drs. 4
Liq Hydrarg. Perchlor.	drs. $1\frac{1}{2}$
Spt Chlorof.	dr. 1
Succus Taraxaci.	drs. 3
Glycerin.	drs. 4
Aq. Cinnamomi.	ounces 6

1/6 part $\frac{1}{2}$ hour after food.

He was recommended light diet. The treatment was continued for some time but showed very little improvement. After the fourth day Boldine pills A. F. D. were added to this line of treatment, the patient having 8 per day. This improved matters remarkably. Two days later the urine was clear and the faeces assumed a good brown colour. The treatment was continued for four more days and there was entire disappearance of yellow pigment from the skin and the conjunctivae. He was feeling more active and was able to digest his food remarkably well. Eight days after the institution of Boldine treatment he completely recovered and was able to resume his work.

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GOVT. MEDICAL OFFICERS AND NURSING HOMES.

Last March we mentioned in the News and Comments columns that we would, in a future issue, deal with the speeches made by the members of the Madras Legislative Council on the cut motion in connection with the Budget Estimate for Medical Services and the reply made by the Chief Minister, the Raja of Bobbili. We have to reserve discussion on this subject in a future issue, as we have to deal in detail about the private Nursing Homes run by Government Medical Officers, one of the most important items referred to by the Chief Minister in his reply to the criticisms levelled against the Medical Administration. The Raja Sahib said amongst other things that the running of the Nursing Homes by Government Medical Officers, was most objectionable and that he would take necessary action to stop such abuses in future. Accordingly an order has since been issued by the Government prohibiting Government Medical Officers from running Nursing Homes. We congratulate the Raja Sahib on his having taken prompt action against the abuse brought to his notice and which abuse was connived at by his predecessors in office though pointed out repeatedly by a few members of the Madras Legislative Council. The text of the order has been published in the Correspondence Columns. Ever since The Medical Practitioner came into existence it has been agitating about the abuses of private practice enjoyed by the state paid Medical Officers such as, running of chemist shops, laboratories, soliciting practice through chemist shops etc. All these abuses have been subjects for interpellations or discus-

sion on the floor of the Madras Legislative Council, since 1930 during the Budget Session. It took five years for the Government to realise that running of private Nursing Homes by the Officers under the control of Government was equivalent to engaging in trade and that contravened Rule 15 of the Government Servants' Conduct Rules. If the Government could now conceive that the running of private Nursing Homes by their officers contravenes the Rule 15 of the Government Servants' Conduct Rules, it will not be difficult for them to comprehend that the running of chemist shops, laboratories, soliciting private practice through chemists and druggists come under the purview of the Rule 15 and we trust the Government will be consistent in their new policy if they issue another comprehensive order prohibiting their officers from engaging themselves in trade more offensive, in the light of Rule 15, than the running of the Nursing Homes. It is also desirable to request the Surgeon-General to obtain periodical returns from all Government Medical Officers in order to satisfy himself that these officers are strictly observing such an order.

We are rather surprised that The Madras Mail has come forward with arguments criticising the Government for passing the prohibition order which it says was done "in haste without regard to the long controversy over the propriety or otherwise of Government Medical Officers running Clinics". The Madras Mail goes a step further and makes insinuations on the Government for casting "upon the Surgeon-General the duty of issuing orders to the concerned persons instead of doing it themselves." It looks as if The Madras Mail has had the

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required inspiration for justifying the running of Nursing Homes by Government Medical Officers from the "concerned persons" who are affected by the recent order. At the outset, The Madras Mail agrees with the reasonableness of the Government order as it serves to check undue competition between the Government medical officers and the private doctors but the inspired imagination seems to have gained the upper hand when The Madras Mail puts forth most frivolous arguments against the G.O. All these arguments are based on the inspired presumption that the Government doctors are running private Nursing Homes to supply the needs of the "poorer middle-class" who are unwilling to seek admission into state hospitals "on account of rigorous rules and regulations apart from other considerations." This unwarranted assumption is followed by an ingenious advice to the Government that the whole question should be considered "not from the point of view of the Government doctor but from that of the public". The public need and that, only in the city of Madras, is made so much of by this paper that it goes to the extent of making a destructive suggestion to the Government not to mind the bigger question of supplying "the deficiency of skilled medical attendance from which the country is suffering." The Madras Mail then attacks the members of the independent medical profession in the Presidency on as imaginary and as unjust evidence that they have not supplied facilities to the "poorer middle class" for skilled treatment outside state hospitals. It then compares their lot with those of their more fortunate brethren in the cities of Bombay and Calcutta and avers that the competition in the profession in these cities is between members of the independent medical profession itself and not between the later and the Government doctors. After quoting a doctor in a neighbouring Indian State that there is at present only one doctor for a population of 15,000. The Madras Mail makes a very subtle suggestion, "that independent practitioners may as well be driven to rural areas to take advantage of opportunities of rural practice" and finally it finishes its arguments with a sermon on Rural Practice by saying: "The pecuniary rewards of such practice are not great but it provides a career of service such as open to few in other countries. It also provides

the experience from which, it is claimed independent medical profession is now largely debarred."

We read and re-read the G.O. Nowhere could we find any suggestion, direct or indirect that the Government have passed the G. O. to encourage independent medical practitioners. It was very unfair on the part of The Madras Mail to make the independent medical practitioners a party and level against them most unjust *ex parte* criticisms and that, to uphold an abuse which has no parallel in any other civilized country where whole-time officers of the Government in the medical or any other department are allowed to carry on trade. The Madras Mail would have done better service to itself and to the cause which it wishes to uphold, in case it restricted its criticisms to the subject matter of the G.O. as was published by the Government. The gist of the G. O. is that in the opinion of the Government the running of private Nursing Homes is equivalent to engaging in trade and this contravenes Rule 15 of the Government Servants' Conduct Rule. The Madras Mail at first justified the running of private Nursing Homes by Government doctors as such facilities to the "poorer middle-class" were not afforded by the independent medical practitioners and after a couple of days brushes aside the main issue by saying that the private clinics are not private Nursing Homes and clinics do not come under the category of trade. Any clever and ingenious advocacy on the part of The Madras Mail would have been appreciated by all concerned much more by the Government, if The Madras Mail adduced arguments and proved that clinics, as run by Government medical officers in the city of Madras, do not tantamount to trade as decided upon by the Government.

Private hospitals would have been a proper denomination for the institutions now run by Government Medical Officers in the city. It will not be far wrong to call them private Nursing Homes but the word, clinics does not correctly indicate the nature of work done in these places. The correct meaning of a clinic is—teaching of medicine or surgery at hospital-bedsides or a class or institution so taught or conducted. None of the clinics now run by the Government Medical Officers in the city are teaching institutions but places where patients are

admitted for treatment only and such patients are charged for the services rendered including operation and subsequent nursing. Trade is a loose term meaning—business carried on as means of livelihood or profit. The Government doctors may not depend upon the so-called clinics for their livelihood but these clinics certainly bring them profit and hence come under the category of trade.

Medical relief is not the only item of expenditure to the 'poorer middle-class'. They may require much greater help in the matter of house construction, legal advice, items of expenditure, certainly far more costly than medical relief and the whole-time officers under the Government in the Judicial and Engineering Departments are not allowed to render cheaper service to the "poorer middle-class." It may be argued that the Government doctors are allowed private practice. Private practice was originally allowed to them, in the interest of the public to popularize Allopathic system of medicine when it was first introduced in this country soon after the advent of the British Government and the Hospitals were established to render medical aid to the public in these institutions when and where the public could not afford the same at their houses either for want of funds or facilities. Gradually as the Allopathic system grew popular the public were charged fees depending upon their income for treatment in these institutions. It is therefore clear that the Government expected that their Medical Officers should admit and treat the members of the public in the Government institutions where all facilities are provided according to the means of the patient, in case they could not afford skilled and scientific treatment in their own houses. If the existing "rigorous rules and regulations" in the city hospitals complained of by The Madras Mail prevent the "poorer middle-class" to seek admission in the Government Hospitals, it ought to have agitated in its columns to make them less rigorous. This specious argument advanced by The Madras Mail cannot be seriously considered when it is known that the very officers who were and are responsible to initiate these 'rigorous rules and regulations' for admission of patients into the Government Hospitals were and are running the private hospitals. The coincidence that the rates charged for

patients at the city hospitals have been on the increase ever since the private clinics came into existence, should not be lost sight of by those who favour the running of private clinics by Government Medical Officers. So, if the hospitals are not popular to-day for whatever reason, the blame is on those who are at the head of these institutions. Attempts should be made by all interested in hospital administration to make these institutions popular by finding out and removing the causes at work, which have made these institutions unpopular, instead of putting obstacles in the way towards wholesome reforms in this direction. We would appeal to them to consider dispassionately if the running of the private hospitals by the Superintendents of Government Hospitals, in the city, who have been doing so utilizing the services of the subordinate staff under them, will not lead to demoralization and corruption, and bring the state hospitals into disrepute.

News and Comments

Ophthalmologists in Conference:

The Fourth Conference of the All-India Ophthalmological Society was held in Madras on 22-4-35 at the Medical College. The Conference was presided over by Lt. Col. R. E. Wright, Superintendent, Government Ophthalmic Hospital, Madras and was opened at 2 P.M. by Sir Mahomed Usman, Ex-Hon. Member, Madras Government. Our Editor being ill at the time, he could not attend the conference and we had therefore to depend upon the news paper reports for our information of the proceedings of the Conference. Usually the organisers of professional conferences, send reports of the proceedings to the professional journals for publication. Having not received such a report we wrote to the Joint Hon. Secretary of the Ophthalmological Society requesting him to be good enough to send us a copy of the report of the proceedings. Having had no reply so far we are led to believe that the official report of the Conference is either not ready or the organisers are satisfied with the publicity of their activities in news papers.

The President of the Conference is an Ophthalmologist of international fame and reputation. The organisers of the Conference would have done a great service to the

profession and through the profession to the public if they published the thought-provoking presidential address with the proceedings of the Conference as a special supplement to all the existing journals in this country at least. The ideals enunciated by Lt. Col. Wright in his address are of very high order. The gist of Lt. Col. Wright's address was that the Government Ophthalmic Hospital in Madras was the third Eye institution started in the British Empire, that the experience gained in the practice of Ophthalmology cannot be got from the books nor could an Ophthalmologist be too proud of the work done by him. There was vast amount of material available in India for utilising to improve practice and gain considerable experience and there was no reason for Indian Ophthalmologists to take a back seat in the practice of their art. According to his estimate well-nigh 50,000 cataract operations are being performed in India and this he considered to be a creditable achievement in a country which had over 6 lakhs of blind people, yet his ideal did not permit him to elevate those who have performed cataract operations in bulk, to a prominent place as Ophthalmologists. He did not consider such persons as useful as even the lay exponents of blind relief as they could not turn out the quality of work required for prevention of blindness.

Evidently Lt. Col. Wright had a picture of Ophthalmologists of his position and eminence when he mentioned that, "there is no reason for us to take a back seat in the practice of our art nor are we doing so." The experience of his predecessor, the President of the Third Ophthalmological Conference had been quite to the contrary and all young medical graduates, who have been attending ophthalmic hospitals run by Government either in Madras Presidency or outside including those in Indian States, have been lamenting that they had little or no scope for practical work in these institutions irrespective of the fact whether they worked under a stipendary or an honorary ophthalmic surgeons.

If Lt. Col. Wright, the Ophthalmologist transforms his ideals into action as the Superintendent of one of the finest ophthalmic hospitals in the British Empire and trains his staff and through them "the visiting ophthalmologists" and post-graduates who seek admission into the ophthalmic hospitals for study, giving them facilities

to attain the ideals set forth by him in his address, he would be able to visualize the high standard expected by him from Ophthalmologists of the type he would like to associate himself with. Every Ophthalmologist has to begin his life as such, as a 'carpenter' surgeon. Preventive work is appreciated by the credulous public especially in India, if the person who does this has a good record of curative work. The Government Ophthalmic Hospital of Madras, much less Lt. Col. Wright could have been able to command the reputation which they now enjoy but for the large amount of curative work turned out in this institution. Cataract is the only disease where an ophthalmic surgeon can hope of tangible appreciation from his patients. Lt. Col. Wright did acknowledge the importance of 'carpenter' surgery which has been able to remove blindness in 50,000 human beings in India. All those who contributed their share in the 50,000 Cataract operations cannot come to the standard of an Ophthalmologist. At least a few of them will be the members of the All India Ophthalmological Society. Lt. Col. Wright does not count much on 'carpenter' Eye Surgery for the prevention of blindness. Very few of these 'carpenter' surgeons can evolve as Ophthalmologists for want of facilities of practice and if the Ophthalmologists of the eminence of Lt. Col. Wright, who are in charge of the Government Ophthalmic Hospitals indicate a compunction to convert 'carpenter' surgeons into Ophthalmologists, much cannot be expected towards the advancement of Ophthalmic Science without which no tangible work could be done for preventing blindness in any country. So, if the All India Ophthalmologists Society wishes to continue their work of usefulness not only to themselves but to the society at large, they should seriously ponder over the presidential address delivered by Lt. Col. Wright and find out means and methods to turn out more Ophthalmologists of the type Lt. Col. Wright wishes to have.

We could not get further details of the proceedings of the Conference than what was published in news papers. In case we are lucky in getting any further information about the activities of the conference we shall revert to this topic once again.

Medical Licentiates in Conference: We have published in the Correspondence Columns extracts of the proceedings

of the 27th All India Medical Licentiates' Conference, sent to us by the General Secretary of the Association. We congratulate the Medical Licentiates of Indore on their having successfully conducted the Conference in spite of the illness of their beloved leader Rai Bahadur Dr. Sarju Parsad Tiwari. The fact that the new drafted rules and regulations of the Association which awaited sanction by the general body of the Association for over six years, were passed at Indore indicates that either the warring elements were absent or the Licentiates at Indore were more sagacious than their brethren either at Bombay or Madras, the venues of the last two conferences and where these drafted rules and regulations could not get the sanction of the general body for some reason or other. The important changes brought about in the rules being quite healthy and salutary, we trust that the affairs of the Association will in future be conducted more smoothly than before. The representation of the delegates from the Branches to the annual conference of the Association is made to depend upon the strength of the members in each branch of the Association and the delegates will not in future be paid traveling expenses for attending the conference. This is as it should be. The future conferences will be attended by delegates who are really interested in the welfare of the Association. The President of the future conference is to be one from amongst the members of the Association. The Association was primarily started for redressing the grievances of the Licentiates and hence it was thought that this object could be satisfactorily solved in case the heads of the Medical Departments were made to preside over the annual gatherings. Times have since changed and that rapidly; the Licentiates in private practice have now outnumbered those in services and fight for the rights has taken the place of begging. So this reform though belated, will also be most welcome and so also the appointment of a paid Editor and Manager for the official journal of the Association.

The General Secretary would have done better service to himself and the Association and justice to his office if he gave a brief account about the affairs of the Association with regard to actual number of members on the roll at present compared with previous years, number of branches, and the

financial condition and such details. The Association is an All India concern depending upon its success not on one individual. The Secretary in his youthful zeal has taken upon himself the responsibilities of a president of an annual gathering and has thus justified the necessity of having in future a president from amongst the members themselves.

Madras Medical College Centenary: Our readers might have read the letter addressed to us by an old student of the Madras Medical College published in the correspondence columns of our April issue regarding the proceedings of a meeting called by Lt. Col. New-Combes, Principal of the Medical College to discuss ways and means for celebrating the Centenary of the Madras Medical College. This correspondent complained and rightly so that in the Centenary Committee that was elected, members of the independent medical profession ought to have been included so as to make this committee a representative one. We have been pointing out in these columns more than once when we discussed matters connected with the teaching institutions in this Presidency that there was always an inherent feeling amongst the staff of these institutions that even in matters connected with the social functions of these institutions they should have the predominant control. This mis-directed zeal is likely to be misunderstood by the members of the independent profession who have as much right, even more to identify themselves in the affairs of the teaching institutions especially in connection with the celebration of the functions like the Centenary of the Madras Medical College. Having invited the past students of the Madras Medical College Lt. Col. New-Combes ought to have found his way to advise the members of the Medical College Council or at least suggest to them that it was quite in fairness of things that those who have been invited ought to be made a party not only for conducting the meeting of that day but also for carrying out decisions arrived at the meeting. Centenary is an occasion of festivities which are to be participated by all those connected with the institution and the past students of the College ought to take more lively interest than the present staff of the Medical College persons who being in Government service cannot claim more interest than those of the birds of

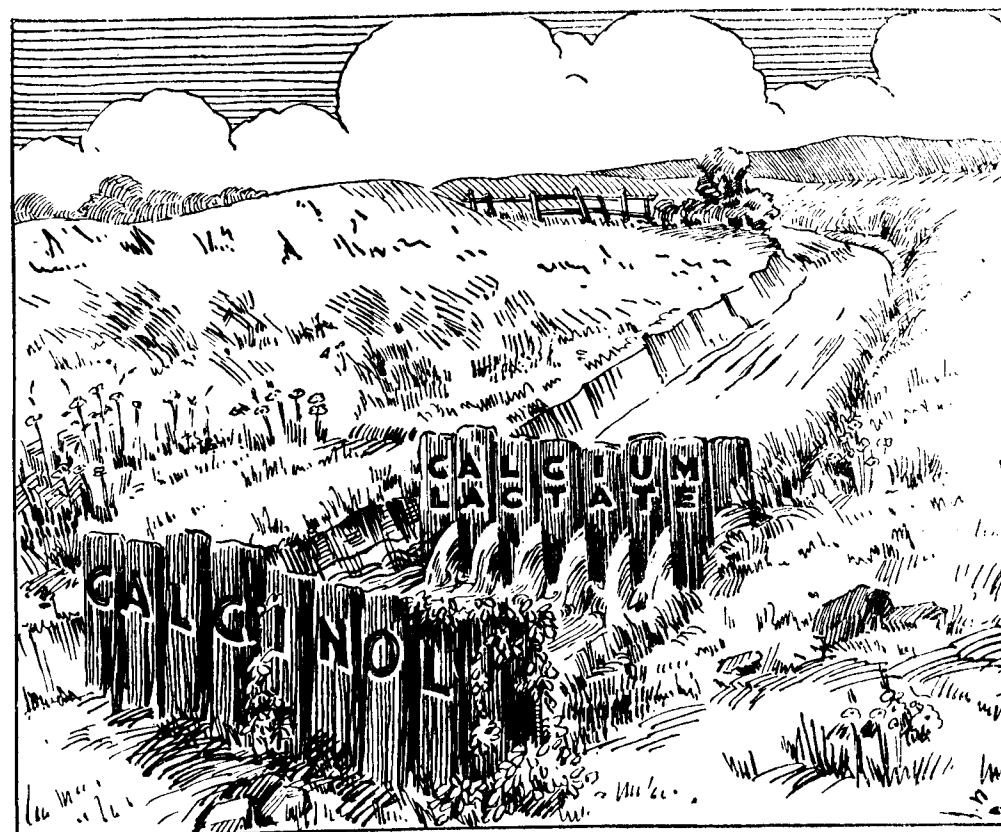
passage. But the past students of this College will continue to be such till their life time. There was yet another practical sagacity which seem to have been overlooked. A pretty big amount of money will be required for making the Centenary a success and the large number of students who have passed out of the College, now thriving as private practitioners both in the city and mofussil would have more liberally subscribed towards the fund of the Centenary if they had adequate representation in the Centenary Committee. We are told that there will be yet another meeting in July to consider further about the details of the Centenary and trust that Lt. Col. New-Combes, the convener of the meeting will meet the wishes of the past students of the College and appeal to them to give liberal support to make the Centenary a real success. Before closing we wish to point out to the organisers of the Centenary Committee that their suggestion to start a college of Physicians and Surgeons will be outside their scope. The Madras Medical College is an University institution training students for University Degrees and as such the same institution cannot start another institution which is likely to be its rival however laudible and necessary it may be to start a College of Physicians and Surgeons either in the interest of medical profession or of the general public.

New L. M. P. Course: Under this caption we published a letter addressed to us by the Secretary of the All India Medical Licentiate's Association Madras Branch who while pointing out to the Government the necessity to raise the preliminary educational qualification of the candidates seeking admission for the L. M. P. Course, observed that the results of the L. M. P. Examinations were very poor both in the Lady Willingdon Medical School and the Vellore Medical School for Women, as the lady candidates admitted into these schools were of a lower calibre regarding their preliminary educational qualification. On the contrary, we learn that what was alleged by the correspondent was not quite correct and the cause of failure could be attributed to many other causes which were beyond the control of the Superintendents of the Medical Schools for Women. There are always two sides for a question and we are thankful to our correspondent in bringing to our notice one side of it. We are now trying to know the other

side to the best of our knowledge and shall deal with this important subject in one of our future issues.

A Downward Climb: Those who were responsible to import Dr. McRae to the Indian Medical Council as its Secretary, will, we hope, realise that they were not wise to depend upon an outsider even to run a show thrust on the Indian Medical Profession by a foreign body. The Government of India would not mind the protest of the Medical Profession in India when they appointed Dr. McRae and later introduced indiscipline in the Indian Medical Council by forcing this council to have its Secretary as an Inspector and made the council swallow its own decision by having recourse to an illegal step—the rescinding of the resolution first passed by the Council against the appointment of the Secretary as Inspector. Retributive justice has now been rightly meted out to the Government by its own servant who dictated terms to his masters. One of which was that he should move with the Government between Simla and Delhi and this was agreed to. The other that he should deal with the authorities direct without the intervention of the President of the Council, was not accepted by the Government with the result that a Secretary without whom the Government of India thought that the Indian Medical Council could not be run, resigned and made the Government to climb down. They have now appointed Lt. Col. Gerald Tyler Burke, M.D., M.B.B.S., M.R.C.S., I.R.C.P., F.R.C.S., I.M.S., Professor of Medicine, King George Medical College, Lucknow. Was this candidate possessing much higher qualifications than his predecessor, not available two years ago?

Felicitations: We heartily congratulate Major G. R. McRobert, Professor of Medicine, Madras Medical College and Physician of the General Hospital Madras on his being elected as Fellow of Royal College of Physicians, London. This is the first occasion when a Professor of Medicine of the Medical College of Madras has been so honoured. The fact that Major McRobert got this most coveted qualification at a relatively early age indicates that the recipient is held in high estimation by those who are responsible in electing him to the Fellowship. Major McRobert has so soon endeared himself not only to his patients but also to the students under his care and his future career is bound to be very useful to the public.



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PANCRESALETs

A REMEDY FOR DIABETES ?

While the invention of insulin prevented danger to life in severe cases of diabetes, it must not be forgotten that insulin is not really a cure. It can only be used by way of injections, which are mostly necessary several times a day, being accompanied by numerous dangers for the patient. This was referred to only recently by Prof. Dr. E. Wiechmann, Head of the Medical Clinic of the Municipal Hospital in Magdeburg-Sudenburg, in an article in *Fortschritte der Therapie*. Prof. Dr. Wiechmann wrote: "Insulin does not cure the disease, but only replaces what the diabetic patient lacks." In the same publication, Prof. Dr. Otto Hess, of the State Infirmary, Bremen, wrote of the injury done by insulin.

In bad cases of diabetes, insulin injections cannot be avoided, for coma, one of the complications to which the diabetic is liable, would be fatal without them. But to resort to insulin injections in slight or moderately bad cases would be tantamount to treating headache with injections of morphia.

It is a remarkable fact that other German medical periodicals published articles simultaneously, dealing with the treatment of diabetes mellitus by means of taking preparations. A treatise by Dr. Maurer, which appeared in Nos. 15/16 of the *Arztliche Korrespondenz* (1934), is of special importance. It gave details of experiments on diabetic patients in the Munich-Pasing District Hospital. Dr. Maurer discussed the question as to whether it was possible to replace insulin injections by a preparation to be taken.

The experiments were made with the Pancresalets tablets of Dr. Richard Weiss, and the result was successful. One of the patients, a man of 78 years of age, who has for years had two insulin units injected daily, was treated with Pancresalets, whereupon the sugar discharge was considerably reduced. A diabetic woman of 54 took Pancresalets for some ten days, with the result that the sugar disappeared from the urine.

In the *Allgemeine Medizinische Zentral-Zeitung*, Dr. Gleichmann reports on a number of diabetics who were effectively treated with Pancresalets. Dr. Gleichmann gave voice to the decision that an extremely effective pancreas-vitamin preparation is to be found in Pancresalets, which he further described as a good means of fighting diabetes, without any harmful by-effects, the result being prompt, and the reduction in sugar discharge certain.

The German Industrial Echo, (March 1935.)

Pancresalets are available at:

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Correspondence Reports, Etc.

Govt. Medical Officers and Nursing Homes.

TEXT OF GOVERNMENT ORDER.

The Government of Madras have issued the following order concerning Government medical officers and the running of nursing homes:

Under Paragraph 29 of the Memorandum regarding appointment to and conditions of service in His Majesty's Indian Medical Service forwarded by the Government of India in the Army Department with their letter No. 718 - Medical A. D. 5 dated 18th April 1934, Officers of the Indian Medical Service with the exception of the Administrative Officers, Military or Civil, and Officers holding certain special appointments are not debarred from taking private practice so long as it does not interfere with their proper duties.

Under paragraph 279 of the Madras Civil Medical Code, Vol. I, 1929, edition, all Executive Medical Officers are permitted to afford professional assistance to persons unconnected with the Government service so long as their own departmental duties are not thereby neglected. The exceptions to this rule are specified in paragraph 140 of the same code. It has been brought to the notice of the Government that certain Government medical officers are running private Nursing Homes of their own. The Government have, after very careful consideration, come to the conclusion that the running of private nursing homes by Officers under their control is equivalent to engaging in trade and this contravenes Rule 15 of the Government Servants' Conduct Rules. The Government have therefore decided that the running of such homes should not be permitted any longer. The Surgeon-General is accordingly requested to issue immediate orders stopping the business wherever it is being done by Government Medical Officers. He may, if necessary, allow a reasonable time to the officers concerned to abolish or dispose of their Nursing Homes.

2. If any Government Medical Officer owning or running a private Nursing Home, attempts to evade the orders in paragraph 1 above by a nominal transfer of his interest therein to another person while in reality he retains such interest in the business, he will

render himself liable to severe disciplinary action. The Surgeon-General is requested to obtain periodical returns from all Government Medical Officers in order to satisfy himself that the orders in paragraph 1 above are being strictly observed. Any remissness on the part of Medical Officers in strictly abiding by the orders of the Government in this matter should be brought to the notice of the Government.

Fifth Andhra Medical Conference Vizagapatam.

INVITATION TO THE MEMBERS OF THE PROFESSION.

The Fifth Andhra Medical Conference will be held this year at Vizagapatam on the 7th, 8th and 9th of June 1935 and we cordially invite you to participate actively in its deliberations.

Arrangements are being made for an exhibition of Medical and Surgical Appliances and Drugs.

Members of the Profession are earnestly requested to contribute to the success of the Conference by attending as delegates and by sending papers containing original ideas bearing on Modern Medicine and Surgery and on new methods of treatment. Clinical demonstrations are also solicited. Titles of papers should reach the secretary, Scientific Committee by 1st June.

Copies of resolutions intended to be moved and scientific papers should reach the Secretaries before the 1st of June 1935. The delegate fee is Rs. 3 which may be sent in advance to the Reception Committee or paid at the Conference.

We specially request all the Doctors and the Public of Vizagapatam District to enroll themselves as members of the Reception Committee and help to make the Conference a success.

We hope that through your co-operation, we may be able to advance the cause of Medicine and promote the interests of the profession, by decisions arrived at the conference.

M. V. KRISHNA RAO, } Joint Secretaries.
V. V. KRISHNA RAO, }

27th. All India Medical Licentiates' Conference, Indore.

The 27th. Annual Session of the All-India Medical Licentiates' Conference was held at Indore in a specially arranged pandal in the compound of the King Edward Hall on 17-4-35 in the afternoon, Sir James Roberts, Kt., C.I.E., (I.M.S. Retired) Member of the Council, Dewas Sr. presided. A number of delegates from different parts of India attended the Conference. The distinguished guests included Col. J. R. J. Tyrrell, Inspector General of Hospitals, Holkar State, Lt.-Col. Nicholson, Residency Surgeon, Indore and Rai Bahadur Dr. S. H. Pandit.

Welcoming the delegates, Dr. G. D. Khandekar, Chairman of the Reception Committee, referred feelingly, in the course of his speech, to the illness of Rai Bahadur Dr. Sarju Prasad, to whose tireless energy and unremitting zeal the Association owed its inception and expressed the fervent hope that he would before long be restored to normal health so as to give the Association the benefit of his devoted guidance and ripe experience. The chairman, in reviewing the manifold activities of the Association alluded to the ceaseless endeavours to remove the stigma of inferiority which had unfortunately attached itself to the class of Licentiates. He then surveyed the work turned out by the Association in raising the standard of education in Medical Schools and bring it to much higher level. Dr. Khandekar referred to the insult offered to the Licentiates on account of the Indian Medical Council Act and deeply grieved over the loss sustained by the Association on account of the sad untimely death of Dr. K. D. Lohakare M. L. A. who would have championed their cause in the Legislative Assembly. Concluding Dr. Khandekar stressed the need for a properly equipped school of Pharmacy where the medical youths could, with advantage, learn the art of manufacturing drugs of requisite standard. Apart from providing suitable scope for exercise of their talents, the vast and unexplored field of Industry and Research in this branch of science would effectively stop the colossal drain of money from this country.

Dr. U. B. Narayanarao, the General Secretary in presenting the annual report of

the association referred to the work which had been done by the members of the Association in affording relief to the people afflicted by the earthquake in Bihar. Over Rs. 3,500 were subscribed to the Relief Committee Funds and 12 Licentiates were sent for relief work. He referred to other important activities of the association such as the drafting of new rules, propaganda for canvassing more members, conducting discussions with the Indian Medical Association about the possibilities of federation or amalgamation with that body, formation of an Information bureau to supply full particulars to members regarding post graduate studies in British Empire and other foreign countries.

He said that The Indian Medical Journal was a dispair of the Association and suggested the appointment of a paid Editor and Manager and also the creation of a permanent Secretary with adequate staff to conduct the affairs of the Association. He concluded his report by referring to the need of reforms for uniform standard of medical education, employment of Licentiates as honoraries in State Hospitals, the invidious distinction shown by the Insurance Companies with regard to the employment of Licentiates as medical examiners, the un-ethical procedure adopted by the Government of obtaining counter signature of Government Medical Officers on the certificates issued by the independent Medical Practitioners, redressing of the grievances of the Licentiates in service, reform of the Medical Councils for securing proportionate representation to the Licentiates and the prohibition of quakery. He also advocated starting of Trade Unions, Defence Societies, Sick Benefit and Accident Insurance scheme.

Dr. G. B. Motiwale, Secretary Family Fund in the course of his report announced that Rai Bahadur Dr. Sarju Prasad had communicated his desire to donate the entire amount due to him from the Fund for being utilised in the award of prizes.

Sir James Roberts made an *ex tempore* speech in the course of which he said that he was pleased to find himself amongst old friends and old students. When he first came to Indore they had only hospital assistants and there were no hard and fast rules governing admission to the Medical School. Sir James informed the audience that he

had done his utmost to raise the standard of education in the medical school, and had taken steps to see that Government recognised the medical Licentiates. He sympathised with the Licentiates in their protest against the invidious treatment meted out to them by the Indian Medical Council said that they had been treated unjustly by people, who knew nothing about the education of the Licentiates. He exhorted them to press their case on the attention of Government until their grievance was redressed. They should strive for this recognition as that was theirs by education and qualification. Everything has a small beginning and he said he remembered how when he first came to Indore in 1901 the school was small and how it grew in importance by the efforts of the staff and how much had been done by that great man Rai Bahadur Dr. Sarju Prasad, whose absence that day they deplored and by the late Rai Bahadur Dr. Bhandarkar. He said that the Association which was started in Bombay with a humble beginning had grown to be an influential body of medical men who were claiming what was theirs by right; either a man is a doctor or he is not; there can be nothing in between. In conclusion Sir James wished the Association every success.

The second day commenced with a group photo. The scientific section then conducted its deliberations where papers were read and discussed under the presidentship of Col. Nicholson.

The Open Conference met in the noon on the 19th (third day) and approved of the rules, elected office bearers for the year and passed a number of important resolutions already approved by the subjects Committee.

The main changes in the rules are (1) representation of delegates in proportion to the number of members in each branch (2) abolition of travelling allowances to delegates (3) election of the Conference President from amongst Licentiate members of the Association, (4) appointment of a paid Editor and Manager to the Indian Medical Journal.

The following Office bearers were elected for the year: (1) Patron: Rai Bahadur Dr. Sarju Prasad Tiwari, (2) President: Rai Sahab Dr. R. N. Lal, (3) Vice-President: Dr. Jamiatram B. Desai, (4) General Secre-

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tary : Dr. U. B. Narayan Rao, (4) Joint General Secy.: Dr. Manhorlal Kapoor (6) Treasurer: Dr. A. N. Khosla, (7) Finance Secretary : Dr. A. D. Mastakar, (8) Editor and Manager: Dr. A. Vishwanathan,

Amongst the resolutions of importance were those requesting (1) the Government to (a) increase the course of Licentiates to 5 years in all Medical Schools (b) include them within the Indian Medical Council Act (c) give increased representation in the Provincial Medical Councils (d) and to enunciate definite policy regarding Honorary appointments in Hospitals; (2) the Indian Medical Association to work for the statutory recognition of the Licentiates and to bring about uniformity of medical qualifications in India; (3) the Universities to allow the Licentiates to appear for the M. B. B. S. Examination without the restrictions laid as in the Madras University and (4) the Insurance Companies to remove the distinction they make between the Licentiates and the Graduates regarding the payment of fees for Medical Examination. The Conference concluded its deliberations at 6 p. m. on 19th April.

Treatment of Small-Pox with liver.

I have found injectable liver extract useful in the treatment of small-pox. It modifies the course of the disease, shortens the duration, aborts the eruption at all stages and avoids the consequent disfiguration from deep scarring and pitting. It also controls the toxic symptoms, improves the general health and well being of the patient and prevents the development of the usual complications of untreated cases of small-pox as boils, subcutaneous abscesses, toxic rash, phlebitis, thrombosis etc.

The treatment proper consists of daily intramuscular (intragluteal) injections of liver extract till the eruptions desiccate and incrust. Five c.c.s. of the extract should be given for the first two or three days according to the severity of the case, followed up by two c.c.s. daily for the remaining period. The extracts used by me were (1) campolon of Messrs. Bayer-Meister-Lucius and (2) Injectable liver extract of Messrs. Bengal Chemical and Pharmaceutical Works Ltd.

For full particulars please refer to the article entitled "Treatment of small-pox

with Liver" in the Journal of the Indian Medical Association, July 1935.

King George Hospital, V. GOVINDAN NAIR
Vizagapatam, M.R.C.P., F.R.F.P.S.,

The Indian Institute for Medical Research.

41 DHARAMTALA STREET CALAUTTA

The Indian Institute for Medical Research, for which an appeal for funds was issued sometime ago, was started at 41, Dharamtala Street on the 1st of January last. The Institute could only open the Departments of Bacteriology and Protozoology and the Diagnostic section with the funds available at present. Besides the paid staff a few honorary workers are also engaged in researches on the determination of Vitamin C values of Indian foodstuff, the immunological studies on Typhoid and Cholera, and the therapeutic value of Leishmania vaccine. It is contemplated that research work on Tuberculosis, Indigenous Drugs, Immunochemistry, and Biochemistry will be taken up as soon as adequate funds are available.

Dr. H. Ghosh, M.B., M.S.P.E. (Paris) and Dr. J. C. Ray, M.D. (Berlin) have been placed in charge of the Departments of Bacteriology and Protozoology respectively and, they have been giving their wholtime services to the Institute in an honorary capacity since the starting of the Institute.

The Diagnostic department affords facilities for standardisation of laboratory techniques as well as for obtaining materials for research work. The present staff consists of 2 Directors (honorary), 8 medical men (two honorary), 2 Biochemists (one honorary), 3 laboratory assistants and 5 menials. The nett income from the Diagnostic Laboratories is wholly spent in meeting the expenses of the research departments.

The following papers have already been published viz. A preliminary note on the treatment of cholera with a new anti-cholera serum (published in the British Medical Journal), and Oriental Sore Vaccine (Indian Journal of Pediatrics). One paper on the Vitamin C content of some Indian foodstuff has been sent for publication to the Indian Journal of Medical Research.

The Tinnevely District Medical Association.

The Tinnevely District Medical Association had its monthly meeting on 26th May 1935, at Tiruchendur one of the most sacred and salubrious seaside resorts of the Presidency on Sunday the 26th May 1935. Members numbering 38 including some lady doctors gathered from all parts of the District. Some of the local officials and visitors were also present. Refreshments and visitors were also present. Refreshments were served to all present at 5 P.M. One of the local residents gave sweet music on the Harmonium.

The meeting began at 6-30 P. M. under the Presidentship of Lieut. Col. T. S. Shastri, I.M.S. The Secretary read the minutes of the last meeting which were passed.

The following resolution was moved from the chair which was carried unanimously:—

The last Sunday of every month will be the meeting day of the Association herein after in view of the Surgeon-General's suggestion to hold it on Government holidays.

The President moved that the following

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THE MANAGER.

Dr. K. S. Narayanan, L.C.P.S., (Bombay), L.D.Sc. (Cal), Z. L. O. (Vienna), gave an interesting demonstration and lecture on Endoscope which was very much appreciated. The President thanked Dr. Narayanan for his very good lecture and demonstration and Dr. Srinivasa Prabhu, L.M.P., and his co-workers for their kind and generous hospitality.

Then a very enjoyable seabath and a grand dinner brought the modest function to a close late at night.

K. KALYANARAMAN,
For Secretary & Treasurer.

A. O. Tuberculin Vaccine.

The above vaccine is a preparation of tubercle bacilli originated by Arima, Aoyama and Ohnawa in Osaka Japan and licensed by the Japanese Government in 1927. According to the originators, AO is made from Tubercle bacilli of the human type. It is sterile, consists of the native protoplasm of the bacilli, is easily

absorbed, is completely innocuous, is derived from strongly immunizing strains of bacilli, and has a uniform potency. It is sterile and there is no danger of infection. As it consists of the native protoplasm of the bacilli, it is able to immunize the inoculated organism in the same way as the organism is immunized by infection with live tubercle bacilli. As it is easily absorbed, it acts quickly as an antigen by causing the production of antibodies in the inoculated organism. The easy absorbability is brought about by the autolytic changes which, during the long cultivation, take place in the bacilli, which are devoid of waxy substances. AO is innocuous, as its use in 4000,000 patients in different parts of the world up to the end of 1932 shows. No ill effects have resulted from its administration up to the time of writing. Because this vaccine consists of specially selected, strongly immunizing strains of bacilli, it is remarkably effective. Its potency is constant, as its efficacy is measured by a special immunobiologic method and is expressed in antigen units (A.E.). The application of AO is threefold: it may be used for prophylaxis, diagnosis and therapy. Further particulars can be had from the sole agents:

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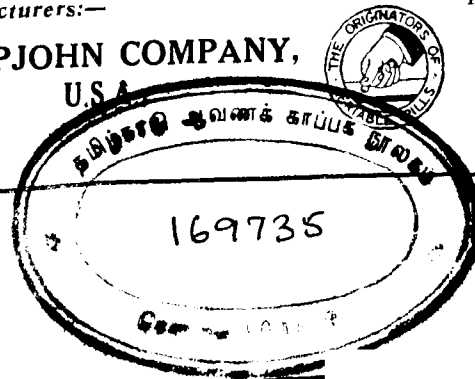
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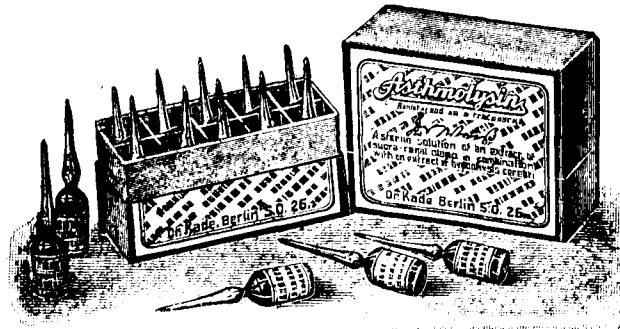
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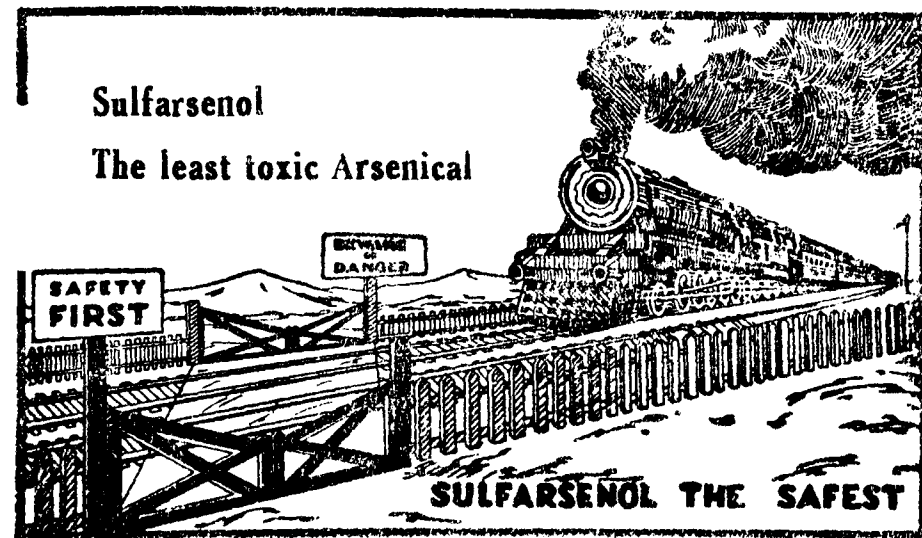
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