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Original Articles

*PHYSIOLOGY IN SURGERY.

By

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Pathology is, in a sense, disordered Physiology ; and the treatment of pathological conditions must at all times take account of the normal Physiology and anatomy of the diseased part or the diseased patient, in so far as it endeavours to restore the structure or functions of the body to normal. Surgery for many centuries was the crude and often brutal companion of the empirical and superstitious individual known as Medicine ; but both are now energing into the clear air of science and reason, and at the moment both surgery and medicine show a curious mixture of knowledge and charlatanry, of the crude and the beautiful.

Surgery until very recent times consisted entirely in removal and mutilation. If an organ was diseased, and medical measures failed, it was removed, or the diseased part was removed ; and in the old days surgery was, practically speaking, the science of removal or extirpation. To a large extent this is still true ; in many diseases, such as neoplasms of all sorts, and the more severe forms of crippling and mutilation, nothing can be done except the removal of the diseased part ; to restore the body to its normal physiological condition, anatomical extirpation is the only available method. But with the advance of knowledge, the improvement of anaesthesia, and the application of laboratory lessons to the operating theatre, it is becoming increasingly possible to restore physiological function in quite a number of conditions. An analysis of all these conditions would be not merely tedious but well-nigh impossible except in a large book ; yet we may gain some help in our fight against disease by the consideration of some of the ways in which physiology guides surgery nowadays.

ACIDITY AND ALKALINITY. One of the characteristics of all normal secretions and excretions of the human body is their reaction, which in some is remarkably constant, and in others (especially those of the stomach and kidneys) is variable in health as well as in disease. But a consideration of the normal will often help us very materially in treating a patient who was not given Soda Bicarb to stop vomiting after a gastro-enterostomy operation, when the cause of the vomiting is simply the alkalinity of the bile ?—a few drops of acid in a little water, and the vomiting will stop at once. Vomiting, is, of course, caused more usually in a hyperacid stomach, and more commonly relieved by alkali ; but there are occasions very frequently, when the cause of the vomiting is the alkali, and acid alone can give it relief.

Again ; strangury and pain in the bladder may often be set completely at rest by simply changing the reaction of the urine from acid to alkaline or vice versa. The blood, too, is often at fault in its reaction ; and a sound test mixture for most cases of Asthma in this country is a strong dose of Ammon. Chlor. and Acid Sod. Phosphate, for a slight

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rise in the acidity of the blood may be all that is required for stopping the asthmatic attacks altogether. Similarly, in the after-treatment of collapsed cases after severe operations, a little Soda. Bicarb. intravenously will often save a life in danger from shock and its associated acidosis.

The Nervous system is one the physiology of which has an important bearing on surgery. To take sensory nerves, in the first place; they are the warning apparatus of the body which tells us that something is wrong; and if they fail to do this, conditions such as we see daily in leper hospitals result; perforating ulcers, and intractable sepsis in the deep tissues of the feet. The aim of all modern treatment of leprosy is to burn the disease out or destroy the bacilli before nerve trunks are irreparably damaged; and this can be done in almost every case, if it is seen early enough. The C. N. S. is isolated completely from the rest of the body by dura, arachnoid and neurilemma. Any nerve fibre which is exposed to the air or to the tissues, is at once painful, until it insulates itself once more in its closed-up system by forming isolating tissue around itself. The painful convalescence of an amputation case can be rendered almost painless by remembering this; all nerves in an amputation stump should be crushed and tied tightly with fine, strong silk; pain will be reduced to a minimum, and end bulbs will be very unlikely to form. In the great war this elementary fact was not realised, and thousands of patients suffered agony who might have been greatly relieved if the treatment given to their arteries was also meted out to their nerves. The principle of covering burns with paraffin or tannic acid is the same; the comparative insulation of the painful exposed nerve-fibres takes away both the pain and the consequent shock to the patient.

The bad results obtained from the many operations devised for the drainage of hydrocephalus are caused by the persistent attempts of the nervous system to isolate itself; we all know how soon a torn dura matter heals after a decompression of brain or of cord; and attempts to violate the insulation of the C. N. S. are almost doomed to fa[illegible]

With regard to motor nerves, little need be said save that attempts to repair damaged and severed nerves have been known to be successful up to 3 years after the injury. But it is in the matter of the sympathetic nervous system that the chief and most interesting surgical advances have been made in recent years.

The central sympathetic nervous system consists of:

(1) the cervical chain of ganglia, the stellate ganglion alone being surgically important. For all its white rami (whether distined for the cardiac plexuses or for the brachial plexus and nerves) come *upwards* to it from the thoracic region before passing to the upper cervical ganglia. (Nerves to upper limb, Thoracic roots 4—10, to ganglia 1 and 2, to brachial plexus).

(2) the thoracic ganglia, of no surgical importance save as they supply the stellate and coeliac and lumbar ganglia.

(3) the coeliac ganglia, important to the surgeon as the situation for prevertebral or splanchnic anaesthesia, and as the origin of all the sympathetic innervation of the viscera.

(4) the lumbar ganglia, which supply the lower limbs and the majority of the roots of the presacral or hypogastric plexus. (To lower limb, Thoracic 8—Lumbar 2, to lumbar ganglia, to lumbosacral plexuses.)

Sympathetic nerve surgery began in a strictly peripheral line, and so remained for many years. Sympathectomy was originally carried out by Leriche and others in cases of gangrene of the toes or fingers and in Raynaud's disease, also in some cases of causalgia. It was at first peri-arterial in character and founded on the supposition that the sympathetic fibres to the vessels accompany them throughout their length in their outer coats. Though some cases undoubtedly received benefit for a time—I have known several cases of senile gangrene, and one or two of Raynaud's disease, who were certainly benefited for a few months—yet no permanent results were obtained, and further anatomical research revealed that the more distal vessels receive constrictor fibres from the peripheral nerves, apart from those which pass down the whole length of the vessel.

The replacement of this operation by the extirpation of ganglia (stellate for the upper limb, and lumbar for the lower) has however

borne good fruit in the shape of permanent results in certain conditions: but a careful testing of the limb is required; obliterative end-arteritis is a contra-indication, whereas spasmodic conditions such as Raynaud's disease are greatly benefited and usually cured, by suitable ganglionectomy. The tonic action of the sympathetic visceral nerves is that of *inhibition* to the muscular coats of the hollow viscera *constriction* to all sphincters (cardiac, pyloric, ileocaecal, anal, vesical) *constriction* to blood vessels, especially the smaller atreries and arterioles.

Hence on administering a spinal anaesthetic, a case of obstruction due to paralytic ileus or to similar cause (that is to say, not an obstruction by bands or adhesions, nor a volvulus) may be relieved at once by the effect of relaxation of the sphincters, with contraction of the muscular coats of the viscera. This effect is often usefully applied in obstinate case of post-operative paralysis of the gut; a spinal anaesthetic is given, and in 20 to 25 minutes a motion with flatus is often passed. Moreover, owing to this action, a spinal anaesthetic is the anaesthetic of choice in cases of obstruction due to peritonitis, ileus, fæcal impaction, worms, or in fact any cause in which an urge of the intestinal contents downwards is not likely to do any harm.

Special cases for sympathectomy

Hirschsprung's disease, and extreme constipation. In these cases, the inferior mesenteric ganglion and the nerves communicating with it are removed by completely stripping the aorta in the region of, and below, the origin of the mesenteric artery. Nearly every case so far recorded has been successful. *Pyloric spasm* is relieved in many cases by removal of the bundle of fibres entering the pylorus on its posterior aspect, by stripping the pylorus and first part of the duodenum posteriorly and removing a branch of the gastroduodenal artery.

Uterine Carcinoma and certain intractable cases of idiopathic *dysmenorrhoea*, are relieved very greatly by presacral (hypogastric) neurectomy; the routine treatment in this hospital for carcinoma of the cervix, except in very early cases suitable for treatment by radium alone, includes presacral neurectomy in every case, an exploration of the uterus from the abdominal side yielding valuable information about the operability of the case, or its freedom from gland involvement. No carcinoma of the cervix can be guaranteed against recurrence; and if the patient is going to die from this distressing condition, half at least of her pain will be saved by presacral neurectomy.

The other region in which surgery has advanced especially along physiological lines is that of the abdominal viscera, notobly the stomach. For many years now the operation of gastro-enterostomy has been performed both for gastric and for duodenal ulcers, the primary object of the operation being the relief of intra-gastric pressure. But in recent years it has been increasingly realised that the ulceration is bound up with the high gastric acidity shown in these cases. Though the immediate effect of gastro-enterostomy (as seen in cases shown to-day) is a lowering, to within normal limits, of the gastric acidity, yet in some cases this lowering is only temporary; the hyper-acidity recurs, and more ulcers, usually jejunal, are formed. It is to obviate this that gastrectomy is so often done for duodenal as well as for gastric ulcers. While 2200 cases of gastro-jejunostomy were done at this hospital in the last ten years, 79 cases of gastro-jejunal ulceration were recorded, nearly 4%. In 152 cases of partial gastrectomy, in none has a recurrence of the ulceration, gastric, duodenal, or jejunal, been observed. The reason for this is at first sight rather obscure. In the stomach, the acid-secreting or oxyntic cells are confined to the cardiac end and body of the stomach; the part one takes away in pylorectomy or partial gastrectomy contains little or no mucous membrane bearing oxyntic cells. The characteristic pyloric cells have a granular substance in them, the function of which is not clearly understood; but in view of the fact that pylorectomy permanently reduces gastric acidity in every case, while gastro-enterostomy does not, it is likely that these pyloric cells form some enzyme that activates the oxyntic cells of other parts of the gastric mucosa. Partical gastrectomy for duodenal or gastric ulceration, though originally performed in order to remove, has become an operation of sound physiological principles, and is one of the most striking instances of a purely physiological operation. Personally, I do not bother about removing the ulcer if it is going to make the

operation more difficult or tedious; the results are ultimately the same whether the ulcer is removed or not. Hyperchlorhydria will be abolished, the ulcer will heal, and no further ulceration will take place. I have no doubt that in skilled hands partial gastrectomy is the ideal operation for all ulcers, gastric, or duodenal, in which the pylorus is freely permeable. Where the ulcer has constricted the pylorus or duodenum, gastro-enterostomy remains the operation of choice; but that is probably only because it takes a shorter time, and is less strain on the patient himself at the time. The convalescence of a properly performed gastrectomy is usually very favourable, and preferable to that of a simple short-circuiting operation.

A few other instances of physiological operations may be mentioned. Cholecystogastrostomy has entirely superseded cholecystotomy in this hospital, and has far better results besides offering the bile a choice of two routes and in so doing actually improving upon nature, who has arranged only one.

Similarly, pancreatic cysts can be anastomosed to the stomach, instead of being drained to the outside. The sinus is often very persistent if the pancreatic juice exists in the cyst in any concentration, and sometimes refuses to heal besides making the skin raw and painful; and anastomosis into the stomach has been tried. But it is doubtful if this is necessary, for a pancreatic or high duodenal fistula can be got to heal in some cases at least by the physiological method of giving the pancreatic juice something to eat. A case is shown here where a large, raw, and angry-looking duodenal fistula was healed within a few weeks by blocking it up with a mixture of white of egg and gelatine (agar).

Other operations may be mentioned such as Omentopexy not always successful even in hepatic cirrhosis, and invariably disastrous in ascites from most other causes. In Hemithyroidectomy for Graves' disease an attempt is made by surgical methods to strike the right physiological balance between the ductless glands. The same applies to ovarian and other grafts, which incidentally can only be successful if they are cut in very very thin slices, for only the cells in contact with the living tissues can survive, and not more than two cells' thickness in each slice can hope to preserve its function. In elephantiasis, lymphangioplasty by Kondoleon's or similar methods has been tried, the object being to gain the drainage of the skin-lymph into the deeper tissues whose lymphatics have not been blocked. This is a true physiological operation, but is seldom successful. An improved technique for it is urgently required in this country, and some of us might make it our business to conduct research towards this end.

One final word. Whether our operations be merely the extirpation of diseased organs or whether there are attempts at the repair of damaged function, we should remember that our aim in all surgery is the restoration of the smoothly-working, painless, happy organism we call man; and although we may often have to confess an utter failure to attain this object, yet if we continually keep physiological principles in mind we may attain it that is to say, bring about a real cure to our patients and a real restoration of their health and happiness—in more cases than we had believed possible.

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*A NOTE ON THE INFLUENCE OF SOCIAL AND ECONOMIC FACTORS ON TUBERCULOUS INFECTION.

By

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This paper is written from the data obtained during an investigation held by me under the sanction of the Madras Government on the alleged high prevalence of tuberculosis amongst the students of a hostel in the City of Madras. On account of a scare that an unusually large number of students in the hostel were suffering from pulmonary tuberculosis a thorough investigation had to be made including a complete physical examination, Von Pirquet test and skiagraphy of the chests of all the 55 boarders. The investigation did not reveal any extraordinary prevalence of the active

* Paper read at the Medical and Veterinary Section of the Indian Science Congress—January, 1935 and specially contributed to The Medical Practitioner.

disease amongst the boarders but elicited certain interesting facts bearing on juvenile infection and the presence of the latent lesions of childhood and early adult age.

The diagnosis of early incipient tuberculosis is now admitted to be a matter of considerable difficulty. It is the chest skiagram that is now generally acknowledged to be the main factor in the ultimate decision. The interpretation of lung skiagrams, it must again be said, is by no means as easy as it may appear. It is the personal clinical study of the case that enables the clinician to place the proper interpretation, the rontgenologist being no reliable judge, not being in touch with the patient. Thus it was not an uncommon experience to have notes put up by the rontgenologist of infiltrations and extensions from the hilum in cases which were absolutely free from active tuberculous trouble and shewing no definite signs of one taken with due care and with the patient in a steady respiratory posture before correct deductions could be made from the appearances.

In the present investigation a thorough investigation of all the 55 boarders of the hostel was made including a record of family history, previous history of illnesses, existing signs and symptoms, complete physical examination of the whole body especially of the chest, the cutaneous tuberculin test, a record of the age, height, weight, temperature pulse &c., and an X-ray examination of the chest. The student boarders of the hostel belonged to the so called depressed classes consisting of youths from very poor families whose social and economic conditions at home were of the poorest, the parents and guardians being cultivators, coolies, shoemakers, mill and factory workers &c, the average income of the families being about Rs. 16 per mensem. A control series of 24 students of an adjacent High school was also examined in the same detail at the same time, these boys belonging to middle class families such as clerks, mechanics, teachers, railway servants &c., with an average monthly income of about Rs. 40.

TABLE SHEWING RESULTS OF TUBERCULIN REACTIONS AND RADIOGRAPHIC FINDINGS AMONGST THE BOYS OF THE HOSTEL AND AMONGST THE CONTROLS.

	55 Hostel Boys.	24 High school Boys.
Negative Von Pirquet reactions.	14	Nil.
Positive weak Von Pirquet reactions.	32	20
Positive, strong Von Pirquet reactions.	9	4
Advanced active pulmonary tuberculosis.	2	Nil.
Early healing tuberculous lesions in the lung.	1	Nil.
Signs of early calcified mediastinal adenitis,	27	17
Signs of advanced calcified mediastinal adenitis.	25	3
Signs of mild peribronchial fibrosis.	39	17
Signs of marked peribronchial fibrosis.	8	3

INFECTION RATE.—Of the 55 depressed classes boarders in the hostel 41 shewed a positive V. Pirquet reaction, 8 of these being strong reactors. All the 24 students in the control series of High school boys gave a positive cutaneous reaction, 4 being strong reactors. The figures are no doubt too small to draw comparative conclusions, but the percentage of strong reactors were about the same in both the series.

MORBIDITY RATE.—Of the 55 hostel boarders, one had advanced pulmonary tuberculosis during the investigation with bacilli in the sputum, one had an early healing lesion at the right apex and one who had merely enlarged hilus glands at the first examination developed 9 months later fairly extensive infiltration in his right lung with tubercle bacilli in the sputum—a morbidity rate of about 6 per 100. None of the 24 control boys had any active lesions either at the time of the examination or for the nine months following the investigation.

LATENT LESIONS IN THE MEDIASTINUM.

The most interesting results were obtained with regard to the lesions in the hilus glands

as seen in the skiagrams. Of the 52 skiagrams of the hostel boys shewing no active disease all showed enlarged and calcified hilus glands, either bronchial or bronchopulmonary, 25 of these being large in size and extensive in distribution i.e. about 48% shewed the advanced hilus glandular lesions of childhood. Of the 24 controls 20 shewed hilus glandular lesions 3 only being dense in character and wide in distribution i. e. 80% shewed hilus involvement but 125% only shewed advanced hilus glandular lesions. Similarly of the 52 hostel boys 47 shewed peribronchial fibrosis, 8 of these being dense and extensively present in both the lungs. Amongst the 24 High School boys 20 shewed such peribronchial fibrosis, 3 only being dense and extensive. Peribronchial fibrosis usually follows hilus disease and its marked presence is generally an indication of juvenile tuberculous adenopathy.

COMPARATIVE GENERAL PHYSICAL CONDITION OF THE TWO GROUPS.

The hostel boys who were maintained by public fund and Government had a much better quality of food than the High School boys, milk, meat, dhall, rice and vegetable being supplied in good quantity and suitable proportions whilst the diet of the High School boys living with their guardians was the usual one prevalent amongst the middle class families of Madras, which is rather poor in proteins, consisting mostly of rice and vegetables, meat and milk being limited in quantity. Whilst the average weight of the hostel boy was 104 lbs, that of the High School boy of the same age was 94 lbs. shewing that the hostel boys at the time of the investigation had better physique and were stronger than the control boys.

The poor social and economic conditions of childhood i.e. when the hostel boys were living as children with their poor parents in their indigent homes were therefore responsible for a higher prevalence of advanced hilus gland lesions and a greater prevalence of active morbidity amongst the High School boys, though both appeared equally exposed to infection as seen from the figures of Von Pirquet reaction and the hostel boys appeared physically better developed than the High School boys.

The results obtained confirm the general view now held that the Social and economic factors, especially during childhood and early adult age are much more important in the epidemiology of tuberculosis than infection. It might be interesting to note in this connection that a family history of tuberculosis did not prove to be of much value in tracing infection, because though such a history was elicited in 8 out of the 54 hostel boarders none of these shewed signs of active tuberculosis, the 3 cases of active disease being from families in which no history of tuberculosis could be obtained.

Abstracts

The Medical Aspects of Appendicitis

C. C. FIHE, M. D.

For the past quarter of a century the medical profession has been stressing the point that there is no medical treatment for appendicitis. There need, therefore, be no further discussion of the medical aspect of appendicitis than the diagnosis. The diagnosis made, there is but one path to follow, and that is the most direct way to efficient surgery. I say efficient surgery because any case, no matter how apparently mild, may present the most difficult problems in surgery.

ACUTE APPENDICITIS

The early diagnosis of acute appendicitis is comparatively easy in the majority of cases. The patient is acutely ill, has had no prodromal symptoms, vomits, and has a pain, more or less spasmodic, first in his epigastrium and later in the lower right quadrant, most frequently over McBurney's point. Vomiting brings epigastric ease, but the pain over McBurney's point is often so severe as to cause him to assume a protective posture on the flat of his back, his right knee flexed and his hand frequently placed over the appendix area. His bowels have usually not acted that day, or there is a history of constipation. He is apt to attribute his illness to a dietary indiscretion and tells you he has had more or less indigestion for a varying length of time, or that he has had one or more similar attacks in the past. His temperature is elevated and his pulse accelerated in proportion. Physical examination reveals no pertinent abnormality except as follows: Deep breathing is

impossible or painful. The right rectus is tense. Both epigastric tenderness and particularly tenderness over or immediately below McBurney's point are present. If abdominal tenderness is diffuse the area of relatively greatest tenderness can be elicited by sudden release of pressure made on any part of the abdomen. The white count is up and rises hour by hour, and the granulocytes out of proportion, showing hourly an increasing shift to the left. Meltzer's sign is positive in approximately 70 per cent of cases, viz : The appendix is squeezed between the finger tip and the iliopsoas muscle which is made rigid by contraction of the muscles of the right leg and extension thereof. The urine is, with exceptions to be noted below, free from blood. The attack is fulminant and its characteristic is its rapidly progressive nature, often ending in the picture of peritonitis within six to twelve hours or less.

Unfortunately, the symptoms and signs may not be so clear. Acute appendicitis may present a very mild picture without fever or vomiting, and it may present one depicting all the terrors of the obscure so-called acute abdomen. The average case, however, presents a very definite, easily recognizable symptom complex. Every case of acute abdominal pain with vomiting should be considered as one of acute appendicitis until it can be definitely ruled out by the ordinary laboratory procedures. The mildness of an attack is no guarantee of its safety, for it may become severe at any stage. Often one is mislead by the sudden cessation of pain only to find within a short time that the appendix has perforated and peritonitis resulted. On the other hand, whether mild or severe in the beginning, early operation is a comparatively harmless and safe procedure. There are few exceptions to this rule.

The pain and tenderness may be localized in the region of the right kidney in a retrocaecal appendix, within the pelvis, in one of the hypasthenic type, or in a case of transposition of the viscera on the left side. A long appendix may cause the tenderness to localize at any point within the abdomen and thereby cause confusion or error in diagnosis. Acute appendicitis may complicate an acute intestinal infection like typhoid or paratyphoid fever, or amoebic infestation.

In pediatric practice chiefly, a comparatively mild early stage of acute appendicitis may be mistaken for a stomach-ache due to the faulty dietary so frequently encountered at this period of life. Again one may lose valuable time in anticipating an en-or exanthem of one of the eruptive fevers especially of measles in which the prodromata are so often of a gastro-enteric nature. In measles, the abdominal pain and tenderness over the appendix area are often so exactly like those of acute appendicitis that a differentiation is possible by laboratory methods alone. If laboratory tests are unavailable, the differential diagnosis of appendicitis can be made by its fulminating character alone.

Acute Meckel's diverticulitis and acute diverticulitis may present identical symptoms and signs. Acute diverticulitis can usually not be identified when located on the right side unless previously found by X-rays.

Ovarian cyst with torsion of the pedicle can usually be recognized by vaginal palpation.

Dysmenorrhoea is differentiated by the history and laboratory examination. It should be noted that a chronic appendicitis frequently assumes an acute aspect during the menses; also that an appendix, the tip of which is attached to an infected ovarian tube, may become acutely inflamed by direct extension. An infected appendix may attach itself to an ovarian tube, a hernia or to the right ureter, causing blood or blood and pus to issue from the right ureter. Even without such an attachment or adhesion, acute appendicitis may cause hematuria, leading us to suspect kidney or ureteral stone. The X-rays, however, are negative and the pain is not referred to the genitalia as in stone. In stone, there is little or no fever and the blood shows either no leucocytosis or a very mild one, and there is neither the hourly rise in the number of leucocytes nor the rapid shift to the left

Dietl's crisis usually offers little difficulty in diagnosis. It occurs mostly without fever and leucocytosis. The output of urine is diminished to approximately one-half, and the size of the kidney gradually increases.

The pain of gallstone colic and of cholecystitis is usually more agonizing and epigastric, with tenderness over the gall-

bladder area referred to the right shoulder. Vomiting is followed by more complete pain relief and the patient appears less sick. Fever is rarely present It should be remembered that in Glenard's disease, in patients of the hypasthenic type, the gall-bladder occupies a position very near McBurney's point, and, unless one bears this in mind the location of gall-bladder pain in this type of patient may cause unnecessary confusion.

Acute intestinal obstruction is a-febrile in the beginning and does not show the blood picture of acute appendicitis.

In acute hemorrhagic pancreatitis, the pain remains in the epigastrium and is more continuous. The patient presenting the picture of the acute abdomen is subjected to exploratory operation and the diagnosis is usually made at that time.

The abdominal crisis of locomotor ataxia is a-febrile, and the blood pressure higher than in acute appendicitis. General examination and history reveal the distinguishing signs.

In acute perforating duodenal and gastric ulcer the history, the retracted hard abdomen and the frequent obliteration of liver dullness are characteristic.

Summary.

1. A careful, painstaking history is necessary An even more careful general examination will eliminate most mistakes in diagnosis. I shall merely mention such extra-abdominal conditions as pneumonia, pleurisy, coronary disease and angina, cardiac thrombosis and Henoch's purpura.

2. Acute appendicitis, according to Eccles, causes 70.7 per cent of the acute abdominal conditions intestinal obstruction 18.1 per cent preforations 7.2 per cent, cholecystitis 2.4 per cent, torsion of the pedicle of an ovarian cyst 1.1 per cent and acute hemorrhagic pancreatitis 0.5 per cent.

3. The characteristics of acute appendicitis are its acute fulminating character the location of the pain, the gradual rise of temperature and pulse rate, and above all, the hourly rise of the white count together with a rapidly increasing shift to the left, and normal urinary secretions.

So far we have considered the early stage of acute appendicitis only. The purpose of this symposium and of this meeting is to remind us of the fact that we are losing too many cases of acute appendicitis. May I then as an internist suggest at this point that it is high time that we accept the verdict long since rendered, that the early diagnosis of acute appendicitis is necessary. Otherwise, it is obvious that an early operation cannot be done. If after a thorough examination, one is still in doubt, it is better to err on the side of safety than of danger if the patient refuses to follow your advice or if he has called you late in the disease if he has treated himself with castor oil or other cathartics, the responsibility is his and not yours. It is, however, our duty to give the message to the people, to consider every case of acute abdominal pain with vomiting as one of acute appendicitis, until that condition can be positively ruled out, and that if it cannot be ruled out appendectomy should be done at once. The later stages of acute appendicitis: perforation, abscess, peritonitis, septicopyemia can not be discussed in the allotted time. They ought to be as rare among us as is typhoid fever. They usually signify that some one has erred The error was made by either the patient or his doctor.

Chronic Appendicitis

The pathologist does not accept the term chronic appendicitis. Nevertheless, there is a clinical syndrome characteristic of certain degenerative processes of the appendix (atrophy and fibrosis) which for want of a more acceptable term we still call chronic appendicitis. The diagnosis of chronic appendicitis often presents serious difficulties and rests on the following points:

1. Digestive disturbances more or less mild, frequently referred to as "indigestion" or "dyspepsia," or previously diagnosed as gastric or duodenal ulcer.

2. Vague discomfort, distress or actual pain and tenderness—one or both—in the right lower quadrant.

3. The history of a previous acute attack.

4. X-ray findings as follows:

(a) Failure to visualize the appendix by means of a barium meal, combined with

(b) Tenderness over the head of the caecum, or

(c) Immobility of the caecum, or

(d) Ileal stasis;

(e) Fixation of the tip of the appendix;

(f) A break in the continuity of the barium column, found after two or more examinations with repeated barium meal;

(g) Spasticity and other deformity of caecum and colon.

In practice it is a mistake to allow the diagnosis to rest solely upon an X-ray diagnosis. The X-ray examination should be evaluated merely as positive or negative laboratory evidence. It should never be taken as the criterion upon which to base the diagnosis of chronic appendicitis. These findings should be correlated with the history and other physical signs.

The differential diagnosis in chronic appendicitis is the same as in acute appendicitis. The error in diagnosis arises most frequently from:

1. The failure to obtain a good history.

2. Incomplete examination of the patient.

3. The failure to recognize such conditions as neurasthenia, Glenard's disease, certain endocrine disturbances, or even sacro-iliac pain.

I should like to stress the following points: The necessity of a careful general examination and in particular a careful examination of the gastro-intestinal tract: Test meal, barium meal, occult blood test of the stools, and a Wassermann, catheterization of the ureters, vaginal and rectal examinations. Quoting Moynihan's admonition, "the commonest site of gastric ulcer is in the right iliac fossa."

Exception may be taken to the statement that every case of chronic appendicitis should be treated surgically I make it, nevertheless, in so far as I assume that my patient has come to me for relief from symptoms which I have found are not due to another organic or functional disease. A senile atrophic appendix is probably not a very dangerous one to keep. Fibrotic appendix is more so because of the fact that it may contain islands of fairly well preserved mucous membrane which when inflamed is more apt to become gangrenous than one which contains no fibrotic or bands.

(The Journal of Medicine, May, '35.)

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Dosage Above the Pharmacopoeial Maximum.

The following are extracts from the address delivered by Dr. F. Hurst at a meeting of the Pharmaceutical Society, Great Britain. The information presented in the address about a few most important drugs largely prescribed by practitioners will be of considerable interest to the profession.—Ed.

I can best introduce the subject of my lecture by quoting the following paragraph from the introduction to the British Pharmacopœia of 1932. It very clearly summarises the principles which guided the Commission in expressing the dosage of the drugs it contains.

"It must be clearly understood that the 'doses' mentioned in the Pharmacopœia are not authoritatively enjoined as binding upon prescribers. They are intended merely for general guidance, and represent the average range of quantities which are generally regarded as suitable for adults when administered by mouth. The maximal doses mentioned may, as a rule, be repeated three or four times in twenty-four hours, but it must not be assumed that they indicate the greatest amounts of drugs that may be given by repeated administration. The medical practitioner will exercise his own judgment and act on his own responsibility in respect of the amount of any therapeutic agent he may prescribe or administer. When, however, an usually large dose appears to have been prescribed, it shall be the duty of the pharmacist or dispenser to satisfy himself that the prescriber's intention has been correctly interpreted".

As I am frequently asked by dispensers whether a prescription of mine containing a dose of a drug greater than the maximum given in the Pharmacopœia is correct, it seemed to me that I could not do better than choose the subject of dosage above the Pharmacopœial maximum for the address which your secretary was kind enough to invite me to give you this evening.

The dosage given in the British Pharmacopœia represents the average dose given to adult patients. Experience shows that under certain conditions very much larger doses of certain drugs can be given with advantage. In some instances, as in the

case of atropine, this is due to the great variations in individual susceptibility, the same therapeutic effect being obtained in a very susceptible individual with a dose which may be only half or a quarter of the dose required for a patient who is usually resistant to the action of the drug. In other cases recent therapeutical investigations have led to the discovery that a more powerful and sometimes quite different effect can be obtained with a dose very much greater than that given in the Pharmacopœia; the larger dose has then generally to be administered with special precautions. In such cases it would only be safe to alter the official dosage if it were possible at the same time to add a note as to the method of administration.

Iron in Anæmia.

In spite of the large amount of work which has been done in recent years on the treatment of anæmia, and the admirable accounts published by Dr. L. J. Witts on the indications and dosage of iron, it is surprising to find how little care is often taken in deciding whether a case is one which will benefit with iron or with liver, proprietary preparations combining the two together being very popular. The dosage of iron is generally quite insufficient, complicated organic preparations are too often ordered instead of the simple inorganic preparations, which are also the most effective, and iron injections have not yet passed into the oblivion they deserve.

Anæmia as a cause of symptoms is far more common than is generally recognised, and many middle-aged women with chronic ill health, which is often ascribed to the menopause, are really suffering from an easily curable anæmia. The vast majority of cases, including those which follow hæmorrhage respond with great rapidity to efficient treatment with iron. When I first came to Guy's in 1901 the popular *Mist. Ferri Arsenicalis* contained five grains of iron and ammonium citrate with five minims of *Liquor Arsenicalis*. When I was Dr. Beddard's clerk in the out-patients' department he told me to double the dose of iron and have that of arsenic. Later I increased the dose of iron to fifteen grains and then to twenty grains and Dr. Witts has shown us that we should increase it still further to thirty grains. It is unsafe to give much larger doses, as one patient of mine almost died from acute iron encephalopathy following the administration of forty grains four times a day for three weeks.

We now know that arsenic is useless, and that iron given by injection is quite inert; the popular and expensive ampoules of such solutions may have some effect on the mind, but they have none on the blood. When thirty grains of iron and ammonium citrate are given three times a day the hæmoglobin generally increases by about 1 per cent. a day, and still more rapidly if the anæmia is severe. For example, a youth aged 20 years with splenic anæmia, who came in with 14 per cent. of hæmoglobin, was prepared for operation by giving him this dose of iron, his hæmoglobin percentage rose to 76 in forty five days.

Though there is a popular notion that iron causes indigestion and leads to constipation, there are very few people who cannot take thirty grains of iron and ammonium citrate in half an ounce of water three times a day after meals for weeks or months without unpleasant result. The anæmia which is always present after hæmorrhage from an ulcer, and which delays healing if left untreated, rapidly responds to this treatment, and so far from irritating the gastric mucous membrane, the iron appears to have a directly favourable action on the ulcer and the associated gastritis. In a recent case the hæmoglobin percentage, which two months after a hæmorrhage was only 48, rose to 87 in twenty five days.

The anæmia in carcinoma of the stomach and colon often improves very quickly, and no case should undergo operation with less than 80 per cent, hæmoglobin. Only if the hæmoglobin is very low is it necessary to hasten matters by one or more preliminary transfusions. Liver and stomach preparations are useless in all anæmia except Addison's (pernicious) anæmias and some closely allied megalocytic anæmias, such as that of sprue and they should be reserved for such cases.

Hydrogen Peroxide and Hydrohcloric Acid in Achlorhydria.

Achlorhydria is a common sequel of chronic gastritis, and is present in about 15 per cent., of all patients suffering from abdominal symptoms, as well as in about 4 per cent, of perfectly healthy young adults, in

about 75 per cent, of cases the power of secreting acid can be restored by dieting, removal of septic foci from the mouth and throat and lavage of the stomach when fasting in the morning with dilute hydrogen peroxide (half oz. to the pint). The hydrogen peroxide acts as a mild antiseptic and dislodges the mucus adhering to the mucus membrane. The treatment is repeated daily until washings are clear. In many cases a fortnight is enough to restore the secretory activity of the stomach, but in some cases the patient has to continue the treatment himself for several weeks.

Since I began using hydrogen peroxide lavage for gastritis eight years ago, only about one quarter of the patients to whom I should fomerly have given hydrochloric acid now require this drug. It should never be used except as a temporary measure until a second test-meal after a course of lavage has shown that achlorhydria is still present as it is obviously infinitely more satisfactory for a patient to provide his own acid than to have to take it from a bottle. When the gastritis is so severe that all the acid-secreting cells are destroyed, and when the achlorhydria is due to an inborn error of secretion, as it is in the rare cases of constitutional and familial achylia gastric, hydrocloric acid should be given.

When one drachm of dilute hydrochloric acid is mixed with five ounces of water it is only slightly weaker than natural gastric juice. Thus diluted, with the additional of the juice and pulp of an orange and some sugar, it makes quite a pleasant beverage, which should be taken before breakfast and with lunch and dinner for the rest of the patient's life. The usual dose of dilute hydrochloric acid is quite inadequate. This was first clearly shown by some experiments made in cases of Addison's (pernicious) anæmia, a condition which is almost invariably associated with incurable achlorhydria, by Dr. Maurice Shaw when my house physician in 1922. He found that one drachm of dilute hydrochloric acid, suitably diluted and sipped during the hour following a test-meal, was rarely sufficient to neutralise the alkaline contents of the stomach, so that no free acid appeared. Occasionally one and a half drachms produced a normal curve, and two drachms a hydrochlorhydric curve, but more frequently two drachms were required to produce a normal curve of acidity. In rare instances even two drachms did not lead to the appearance of any free acid.

Hexamine as a Billiary Antiseptic.

It has been known for many years that hexamine is excreted by the bile, but Dr. Knott was the first to prove definitely that it acts as a biliary antiseptic in spite of the bile being alkaline, although in the urinary tract it is inactive unless formaline is set free by the acid urine. Pure bile obtained through a duodenal tube has no antiseptic action, but if large doses of hexamine are given, the bile which can be shown to contain unaltered hexamine, is strongly anticeptic and bacteria which are present in it before the treatment having disappeared. Formerly the maximum dose of hexamine which could be given with safety was limited by the supposed necessity of keeping the urine acid. But hexamine is just as efficient a biliary antiseptic when sufficient alkaline is given to make the urine permanently alkaline; under such conditions no formalin is set free and enormous doses can be administered without causing any bladder irritation. A mixture containing 60 grains each of sodium bicarbonate and sodium citrate in 2 ounces of water is given after breakfast, after tea, and last thing at night after drinking a glass of milk or water. The reaction of the urine is tested every time it is passed; as soon as it is found that the urine is constantly alkaline, if necessary after the dose of the alkalis has been increased, 100 grains of hexamine is added to the mixture, so that 3000 grains are taken a day. The treatment can be continued for periods of six weeks. The hexamine sterilises the bile ducts and gall-bladder and when combined with non-surgical biliary drainage by means of Epson salts, it results in the cure of most cases of cholecystitis. This treatment should be given for a week or two before and after operation on the gall-bladder and bile ducts in order to guard against septic complications. In cases of severe infective cholangitis with jaundice, high temperature and rigors, it has sometimes appeared to save the life of the patient.

Hexamine is excreted into the cerebro-spinal fluid, and has been found by experiment to prevent the development of poliomyelitis in monkeys inoculated with emulsion of the spinal cord from fatal cases. I think therefore that large doses are worth

giving, in the manner I have just described, to contacts in poliomyelitis epidemics, and possibly also during the acute stages of encephalitis and for the cerebral complications of ear and sinus disease.

I should like to suggest that in the next issue of the British Pharmacopœia, explanatory notes should occasionally be given under the head of dosage. Thus in the B. P. 1932 the dose of hexamine is given as 10 to 30 grains. But 5 to 15 grains is the correct dose when it is used as a urinary antiseptic, and 50 to 100 grains as a biliary antiseptic. For the former acid sodium phosphate or similar drug must be given to keep the urine acid, and for the latter alkalies must be given, to keep it alkaline. The higher pharmacopœial doses—15 to 30 grains—are too small for billiary antisepsis and too large for urinary antisepsis as if given alone, and especially if given with acid sodium phosphate, they would be liable to cause severe hæmorrhagic cystitis.

Atropine in the Treatment of Ulcer.

There is no doubt that the presence of free acid in the stomach is an essential factor in the development of gastric duodenal and anastomatic ulcers and such ulcers tend especially to develop in individuals with the hypersthenic gastric constitution in which more than the average quantity of acid is secreted. Successful treatment largely depends upon choosing a diet which calls forth little secretion as possible and has a high neutralising power. Alkalies are given to neutralise still more of the free acid, and olive oil, atropine to inhibit its secretion. It is a familiar fact that some people are much more susceptible to the action of atropine than others. Its influence on salivary secretion is approximately parallel to its influence on gastric secretion. In order, therefore to obtain a maximal effect on the stomach, the dose should be increased until the largest quantity is given which does not make the mouth unpleasantly dry. I give 1/200 grain of atropine sulphate dissolved in a drachm of water before three of the feeds and a double dose last thing before going to sleep, as it is particularly important to inhibit the continuous secretion of acid during the night when there is no food in the stomach which can partially neutralise it. Both doses are then increased by ten minims of the mixture—*i.e.*, 1/200 grain—every day until the patient complains of unpleasant dryness of the mouth or paralysis of accommodation. After being reduced by ten minims the doses are continued throughout the period of treatment. As the atropine dries the mouth, it may be assumed to dry the stomach, and actual tests have shown how effective it is in reducing the quantity of free acid present. It is impossible to guess beforehand what will be the adequate dose in any given individual. Occasionally a patient cannot take more than the initial 1/200 grain three times a day and 1/100 grain at night; majority can take about 1/100 grain, whilst occasionally as much as 1/40 grain is found to be the correct dose for the day and 1/40 plus 1/200 for the night. It is important to increase the dose in this way, as I believe that 1/200 grain would be without any effect on the last patient, though sufficient for the first, in other words, 1/200 grain in one individual is equivalent to 1/40 grain in another.

Hyoscine, Stramonium and Pilocarpine in Paralysis Agitans and Parkinsonism.

About twenty five years ago I found that the dose of hyoscine which could safely be given to patient with paralysis agitans could be increased greatly by combining it with pilocarpine. The pilocarpine prevented dryness of the mouth and paralysis of accommodation without in any way diminishing the calming effect on the tremor, a fact which had been discovered about 1895 by Erb. It was consequently possible in most cases to give 1/50 grains of hyoscine hydrobromide, in many cases 1/20 grain, and occasionally as much as $\frac{1}{8}$ grain three or four times a day, without any troublesome dryness of the mouth, paralysis of accommodation or other unpleasant symptom being produced. I have had many patients who were thus enabled to take large doses continuously for several years. Though the tremor was not often completely controlled, it was almost invariably rendered much less trying, the effect being considerably greater than with the maximal doses of hyoscine given by itself in the usual way.

In view of the close resemblance of some of the post-encephalitic disorders to paralysis agitans, it was natural that hyoscine should be tried for the former. Quite unexpectedly it was found to have comparatively little effect on the tremor which is generally a much less prominent symptom than in paralysis agitans, but to exert a favourable influence on the rigidity of paralysis agitans. It may remain completely unaffected by the drug, even when given in large doses with pilocarpine in the manner I have described. Observations carried out by Hall with belladona and by Carmichael and Green with stramonium showed that these drugs are even more effective than hyoscine.

It occurred to me in 1928 that a combination of pilocarpine with hyoscine or stramonium might make it possible to give a larger dose of the latter drugs, and thereby obtain a more favourable effect in post encephalitic parkinsonism, as well as in paralysis agitans. The result has been most satisfactory. In every case improvement has occurred, and in some, the whole life of the patient has been made infinitely more happy as result of overcoming a good deal of the muscular rigidity. One patient who had been completely bed ridden for over a year was able to get about again within a fortnight, and some who were completely unable to dress and wash, can now carry out all the essential activities of life without help.

I begin by giving the patient 15 minims of tincture of stramonium in 1/2 oz. of water on waking, after lunch, and after tea. If the stiffness causes disturbed nights by preventing the patient from turning over in bed, an extra dose is given before going to sleep. One drachm is added to each of the three doses of the mixture on alternate days, so that in eight days, the total dose is doubled. The gradual increase in the dose is continued until the patient begins to complain of unpleasant dryness of the mouth or paralysis of accommodation. Pilocarpine nitrate 1/10 grain is then added to the last dose of stramonium, and the mixture is prescribed in $\frac{1}{2}$ oz. of water. One drachm is again added to each of the three doses of the mixture on alternate days until sufficient relief is obtained or slight toxic symptoms appear—the most common being paralysis of accommodation – in spite of the added pilocarpine. By this time the dose is generally at least 60 minims of tincture of stramonium, with perhaps, 2/5 grain of pilocarpine nitrate. The exact proportion of pilocarpine and stramonium may require modification. Finally, a prescription is given for the full dose of stramonium and pilocarpine in a single dose in half oz. of water.

Morphine for Incurable Pain.

In spite of all the modern advances in therapeutics we must still often rely upon morphine for the alleviation of pain. Inoperable cancer is not necessarily very painful but when it involves the spine and also in many cases of carcinoma of the liver and of the pelvic organs, the pain is excessively severe. By the fearless use of morphine it is always possible to keep a patient with this terrible disease comparatively happy and completely free from pain. There is obviously no need to fear the development of a drug habit in a dying patient, but most doctors are curiously averse to giving the huge doses which may be required in such cases. I do not think that the various substitutes for morphine have any special advantage. The dose should be found by experiment which when given at sufficiently frequent intervals keeps the patient completely free from pain. As the tissues quickly develop the power of destroying increasing quantities of morphine, so that only a small proportion is left to exert its analgesic effect, the dose has to be increased steadily in order to remain adequate. The dose required during the last week of life in patient who survives for an unusually long period may be huge—as much as 50 grains a day. But it should be remembered that this is really equivalent to about one grain a day at the onset of treatment, most of the morphine being destroyed in the liver and other organs. Many patients with secondary cancer of the liver and spine live for many weeks and even many months, and I am inclined to think that the morphine often delays death—its one disadvantage though this is more a disadvantage to the unhappy relatives than to the sleeping patient. For a proper dose is one which keeps the patient in a continuous state of twilight sleep; the sleep is often dreamless, but when dreams occur they are generally happy ones. The patient is easily roused three or four times a day to take a little nourishment, but he only wakes sufficiently to smile and murmur a few words.

pubic region. The temperature was at this time 101°. The quantity of urine voided during 24 hours was nearly normal. The specific gravity was 1024 and upon standing the urine left a heavy precipitate. On microscopic examination many leucocytes were seen, a few red blood cells were present and a great number of small and large epithelial cells.

Frequent micturition, pain in the suprapubic region and tenesmus all these were fairly characteristic of acute cystitis and the probable organisms responsible for this were B. Coli and Staphylococci.

At the start an injection of B. Coli Phage (2 c. c.) was given subcutaneously and the patient was asked to swallow one ampoule of the same Phage (2 c.c.) in a glass of Vichy water on an empty stomach, both in the morning and evening. She was asked to take complete rest in bed and was advised bland liquid diet. Hot fomentations over the bladder and the loins were recommended. By the end of the third day of this treatment the patient suffered little or no inconvenience. Fever disappeared, pain and tenesmus were relieved and frequency of micturition no longer annoyed her. Although she was practically free from the complaint after four days she was asked to remain in bed until the seventh day, from which time onwards the convalescence was quite uninterrupted.

Some interesting clinical reports

A male patient aged about 40 sought medical advice for pain in the shoulder-joint. The history was that he got up one morning and found that any movement of the right arm produced acute pain in the inter-scapular region. The pain used to come in paroxysms on movement of the arm. He had taken a lot of aspirin, but still the pain persisted and at last he had to seek medical aid. On examination it was found that gentle passive movements were possible, but there was continuous dull pain in the upper part of the back and the patient complained of acute pain on the least movement of the shoulder-joint. He had no temperature and the heart and lungs were quite normal. Abdomen was supple enough and deep pressure evoked no pain. I tried to find out some septic focus but nothing abnormal either in the throat, mouth or nasal passages was detected. Diagnosing this as rheumatic fibrositis I gave him a good dose of calomel at the start and then prescribed saline aperients with diuretics and salicylate of soda. This prescription with rest in bed and fomentations etc., was continued for three days, but no sensible amelioration was obtained. On the fourthday in addition to the above line of treatment I injected one ampoule of Iodaseptine 5 cc intravenously. This did not improve matters much, so next day I again injected one more ampoule of the same dosage by the same route. After this the pain become less acute but more diffuse. I continued the same line of therapy and after six injections the relief in the pain of the shoulder and the interscapular region was very marked. In all, eight injections were administered and the pain at the end of this course had distinctly disappeared. He was able to move the arm and the shoulder without any pain or discomfort. The patient left his bed and was able to resume his usual occupation after about 10 days.

2. This was a case of a patient who was an intelligent girl of nineteen. She had menstruated for the first time at the age of thirteen. At that time menstruation occurred regularly every month, but later on the intervals became irregular, increasing sometimes even up to six months and the loss of blood was becoming more and more scant. Amenorrhoea had distinctly set in and this was followed by increase in weight. Examination of the external genitalia showed atrophic labia with sparse hairs. On rectal examination, as vaginal one could not be done due to the intact hymen, a short, atrophic, narrow and rigid uterus could be palpated. The breasts were flaccid with gland tissue developed and the nipples drawn in. This was a case of ovarian insufficiency and Opocrin Ovary (A.F.D,) with injections of the same preparation were prescribed. She took six opocrins per day and one ampoule of the same was injected subcutaneously every other day. After six weeks of this routine there was marked improvement. The nipples were no longer retracted in fact unlike before they were

erectile. Montgomery's glands, which were previously not visible, were seen to come out. There was no secretion however. Spontaneous appearance of menstruation followed, which subsequently became very regular. There was reduction in her weight also. After two months of this treatment her menstrual function became normal and regular. It may be noted here that Opocrin Ovary not only stimulates building up of the endometrium but influences the secondary sexual characteristics also.

Sarcoptol in Scabies.

Scabies is perhaps the commonest skin affection that the general practitioner is called upon to treat. Although it appears to be a harmless disease, it is apt to be very troublesome both on account of its recurrence and consequences. Cases of temporary insanity and extreme cachexia have been met with as an outcome of long-standing scabies. Acute and definite eczematisation have been seen following scabies, especially in subjects who are susceptible to eczema.

Scabies is a severely itching disease of the skin due to Acarus Scabisi. It is the adult pregnant female acarus that plays the important role in the production of disease. The male lives on the surface only and dies soon after mating, while the female after fecundation burrows itself deep into the layer of the skin, known as stratum corneum. Roughly from 15 to 20 eggs are laid in this layer after which the female dies. After five or six days the eggs are hatched and the tiny larvae bore their way through the thin layer and soon become adults. Impregnation follows and the young females make their way into the stratum corneum where in their turn the eggs are laid. The cycle is thus repeated.

Scabies are usually transmitted by pregnant female acari from an infected person or object. Transmission usually occurs at night because the parasites are nocturnal in their habits. The infection occurs through bed-fellows who have got the disease or through their clothes. Formerly it was considered to be a disease of the poor or the unclean but at present it is met with in all ranks of society. Children or adolescents usually suffer from it, although no age is immune.

The chief symptom complained of by the patient is intense itching, worse at night, because the parasite is nocturnal in its habits. The lesion is most characterstic having a dark grey ridge or line with a small pearly vesicle with the acarus embedded in it at the distal end. Sometimes these ridges or lines are difficult to detect because of the presence of pustules. The diagnosis is then very difficult due to the entire absence of itching.

The main sites of the skin that are affected are the opposed surfaces of the fingers and toes, particularly the webs where the skin is most delicate. The palm of the hand, the front of the wrist, the axillary folds, glans penis, buttocks and nipples and areolæ in women are common areas of predilection. In children lesions are found all over the body and they are soon converted into pustules. The face, scalp and the neck are never affected, which factor is a great help in diagnosis.

As regards the diagnosis an uncomplicated case presents no difficulty; but when the case is complicated by secondary infections such as inflamed papules, pustules, impetiginous and eczematous sores etc. then the diagnosis becomes very difficult. The original clinical picture is thus marked. Whenever we come across polymorphic skin eruptions with intense itching affecting specially the region of the hands, wrists, genitalia or breasts we should always suspect scabies. The most characteristic symptom of scabies is nocturnal itching.

Our aim in the treatment of this troublesome skin affection should be the destruction of all the acari and their eggs. To avoid recurrence complete disinfection of all the articles of clothing or bed-clothes should be enjoined. Another point that should be borne in mind is the avoidance of secondary infections which are very often intractable and which prolong the disease unnecessarily. Sulphur ointment is a time-honoured remedy for this complaint and it has not yet been displaced. But it requires great caution on the part of the physician, as its indiscriminate use, or individual susceptibility or hypersensitiveness to it frequently causes irritable dermatitis. This latter sometimes misleads the doctor who imagines that the trouble is not properly eradicated and who [illegible] the strength of the [illegible] Sarcoptol is an excellent remedy [illegible] all these troubles [illegible]

ADRENALINE IN ASTHAMA.

The pharmacopœial dose of adrenaline is both too large and too small. It is too large for habitual use in ordinary cases of asthma, and too small for use in the exceptional cases of status asthmaticus. In spite of recent advances in our knowledge of asthma, it is comparatively rare that a patient is given such complete relief that he never has another attack. It is, therefore, necessary in almost every case to devise some treatment for the asthmatic paroxysm itself.

In the treatment of the asthmatic paroxysm the prepondering activity of the vagal over the sympathetic nerve supply to the bronchi can be overcome by means of drugs, such as atropine, which paralyses the vagus, or by adrenaline, which stimulates the broncho dilator fibres of the sympathetic. The inhalation of fumes from powders containing stramonium or belladona, which was formerly the universal method of treatment, has the great disadvantage of causing chronic bronchitis by irritating the bronchial mucous membrane. This treatment should never be used, as the opposite method of restoring the balance by means of adrenaline has no such disadvantage and is also more promptly and more constantly effective. The patient should be taught to inject the adrenaline solution himself, as if he does this at the first sign that an attack is developing it will be aborted, and one or two minims will often be sufficient though 5 minims or more would have been required had he had to wait for a doctor or nurse to give the injection at the height of the attack. This small dose gives rise to none of the unpleasant symptoms often caused by larger doses, which sometimes make a patient prefer the asthma to the adrenaline. Adrenaline does not raise the blood pressure and there is no danger of damaging the arteries.

Its use has in many cases the further justification of making good a deficiency in the secretion of adrenaline, just as thyroid preparations do in myxœdema. The treatment also reproduces the way in which relief may on rare occasions occur under natural condition. If an individual during a severe attack of asthma comes under the influence of sudden fear or anger the two emotions which as Cannon shows stimulate of secretion of adrenaline—the attack immediately ceases, the patient having had an "autogenous dose" of adrenaline. We may hope that the time will come when asthma will be curable, but until that consummation has been attained, the proper use of adrenaline deprives asthma of most of its terrors and makes it possible for every asthmatic to live a life of moderate activity. The patient should be provided with a pocket case containing a small bottle of adrenaline, a special small all-glass hypodermic syringe with very fine bore, so that minims and half-minims can be accurately measured up to a maximum of 7 minims, an "iodine pencil" and two spare needles.

The rare condition of status asthmaticus, in which severe asthma continues uninterruptedly for days or weeks, and may end in fatal exhaustion, can always be arrested by the method of continuous adrenaline injection, which I first used about ten years ago. The needle is kept in position with a full syringe, and after an initial injection of a dose which is known to cause no unpleasant symptoms, one or more minims are injected every fifteen, thirty or sixty seconds, according to the patient's reaction the rate being varied until it is found how frequently the injection can be made without any unpleasant symptoms arising. The injections are continued, if necessary, for even half an hour or more; relief always follows and generally manifests itself by the patients falling into a deep sleep, which may be the first he has had for several days.

Anaphylaxis can also be most efficiently treated by this method of injecting adrenaline, which is far more effective than occasional injections of larger doses. If adrenaline is always at hand when a patient is given serum or other injection which may cause anaphylactic reaction, the latter should never prove fatal.

CLINICAL NOTES AND PRACTICAL SUGGESTIONS.

Experiences with Bacte-Coli-Phage.

Of the many measures adopted for combating B. Coli infections of the genito-urinary tract none of those commonly employed has been found perfectly reliable urinary antiseptics, bladder irrigations, intravenous injections and vaccine treatment have all fallen short of our usual expectations, particularly in chronic infections. Definite success has, however, invariably attended the exhibition of Bacte-Coli-Phage in such conditions. Bacte Coli Phage given by the mouth is of distinct service as a urinary antiseptic and it obviates the inconvenience of employing local measures. It is remarkably free from toxic effects and is able to exercise a continuous antiseptic action. Its strong anti-bacterial property towards B. Coli, Paracoli and several types of cocci is of great value even in mixed infections. When taken internally it has the property of penetrating the tissues without causing any sort of irritation. Being anti-bacterial it soothes the tissues, relieves pain and stimulates proliferation of epithelial tissues. Thus it ensures proper healing of the inflamed mucous membrane. On account of its potent antiseptic action it acts specifically on inflammations of the mucosa, and by experience it has proved a most effective agent in getting rid of B. Coli and Paracoli infections.

The main characteristic of the action of B. Coli Phage in the treatment of infected urinary passages is the rapidity of its effects. The clouded urine becomes clear and sterile a few days after its administration. As a rule one ampoule of 2 c.c. of the Phage in the morning in half a tumbler of water and the same dose repeated in the evening, if continued for some days, brings about a radical cure.

Bacte Coli Phage therefore fulfils all the desiderata of a reliable antiseptic in B. Coli cases. On account of this marked action against these organisms it can be employed with advantage in Cystitis, pyelitis and pyelo-nephritis.

The chief method of administering B. Coli Phage is by the mouth, one ampoule of 2 c. c. twice a day. At the outset a subcutaneous injection of 2 c. c. is given, after which the patient is asked to swallow one ampoule in half a glass of water, preferably Vichy water, on an empty stomach. The patient is prescribed Soda Bicarb which should be taken in drachm doses so that the urine becomes distinctly alkaline. The Phage acts better in an alkaline medium. Vegetable diet should be recommended. By means of this Phage the affected tract is permeated with the drug which gradually weakens and destroys the infectious agents in the tissues. Local treatment in addition, when indicated, consists of irrigations of 10 c. c. of the Phage diluted in 50 c.c. of lukewarm boiled water. The irrigations may be given twice or thrice a week according to the severity of the inflammation. Daily irrigations are fatiguing and hence should be avoided.

The following are typical cases under the writer's care :—

1. The patient was a female aged about 25 suffering from pain in the right kidney region. She complained of burning sensation during micturition. The complaint was of one week's duration. The urine was cloudy and albumen and numerous pus cells were present in it. Staphylococci and B. Coli were detected in the specimen. Diagnosing this as Pyelitis due to B. Coli she was started on B. Coli Phage therapy, one ampoule in the morning and one in the evening. A subcutaneous injection of 2 c.c. was given at the beginning and Soda Bicarb in drachm doses was prescribed. Light diet, mainly vegetable, was advised. A week of this regime cleared her urine. The albumin disappeared and there were few leucocytes. All the symptoms of pain, burning etc., were no longer present. The leucocytes became less and less until no staphylococci or B. Coli were found. The lady completely got rid of her complaint in a fortnight's time with this Phage medication.

2. This patient, a girl of about 22, complained of severe discomfort in the lower portion of the abdomen and in the loins, and frequent micturition. The quantity of urine voided each time was not large but micturition was accompanied by a certain degree of tenesmus. There was headache, chilly sensations, anorexia and general malaise. The severe discomfort after two days gave place to dull pain in the supra-

ed from extensive experience of several dermatologists, a specific for scabies.

Sarcoptol if properly used and with careful attention to details will free the patient of this troublesome and recurring ailment in the shortest possible time. Sarcoptol is a colloidal sulphur compound, the energetic action of which depends on the fineness of the colloidal particles in suspension. It combines in it complete absence of irritation of the skin with a strong parasiticidal and analgesic action. Its soothing action on the itching skin takes place soon after application. If it is correctly applied scabies can be rapidly and completely cured. The chief characteristics of Sarcoptol in the treatment of scabies are that it is clean and pleasant to use, that it does not stain or irritate the skin, that it is speedy in effect and that it immediately allays itching. It is noticed that during Sarcoptol treatment the frequent complications of scabies such as inflamed pustules, impetiginous inflammations or eczematous sores are avoided, or if they occur, they are quickly healed. Sarcoptol is absolutely effective and simple for use and is perfectly free from odour. It does not produce toxic by-effects, nor does it stain the linen.

The usual line of treatment adopted for scabies is to ask the patient to have a warm bath with free application of soap, preferably soft soap. The soap should be rubbed thoroughly especially into all the areas affected. A bath is absolutely necessary as it helps softening of the skin. After the bath the skin should be dried with a soft towel and Sarcoptol should be applied in the concentrated form on the affected parts. Continuous friction should be employed so that the liquid may be completely absorbed. In the application of Sarcoptol special attention should be paid to the areas of predilection. Usually a single thorough application will bring about a cure but sometimes three to four applications are necessary before a complete cure can be obtained.

The bed-linen as well as the underwear should be disinfected every day to prevent reinfection and a hot bath should be taken on the fourth day and no medication should be applied on the day. This is the best line of treatment particularly for patients who object to the smell of sulphur. When secondary infections persist, Pharmasol Manganese, a colloidal manganese dioxide preparation is very valuable. Iron tonics internally, preferably Fer-Ma-Pho, are of great service in such cases.

To avoid reinfection all bed-clothes and under-linen should be thoroughly disinfected after the attack has passed off. The best method of disinfection for cotton clothes is boiling, while flannels and woollen clothing should be soaked in a solution of cyllin and then washed in cold water.

A typical case:

A lady aged about 25 was suffering from scabies of the right nipple off and on for the last three years. Although it was ameliorated by treatment, it never healed completely. She had delivered about two years back and during lactation the scabies had disappeared but there was severe relapse after the lactation period was over. At this time the original infection was complicated by eczematous inflammation. Application of Sarcoptol in concentrated form was advised. This was done after the affected part was cleaned by soft soap and completely dried by friction with towel. Sarcoptol was rubbed in for some time until it was thoroughly absorbed. Five days of this routine, which was repeated twice a day, brought about complete healing, leaving only brown pigmentation. The first day crust formation ceased and the secretion decreased. Itching entirely stopped after two days. The ulcers became dried on the third day and the whole lesion completely healed up after five days.

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THE SCHOOL OF INDIAN MEDICINE.

Soon after the Government of Madras, Local Self-Government Department issued a G. O. in February 1933 making provision for the registration of practitioners of Indian Medicine we pointed out how the power assumed by the Government for this purpose was totally misconceived. An executive G. O. has taken the place of a Legislative Bill by a short cut and the principal of the School of Indian Medicine has been in a manner constituted into a departmental head, occupying the place of Surgeon-General with the Government of Madras so far as Indian Medicine is concerned. We have nothing but regard for the qualifications of the principal who is a distinguished product of the Madras Medical College and who has made endeavours to acquaint himself with works on Indian Medicine since his posting to the School of Indian Medicine. But it is obviously too much to claim that he can be regarded as an authority on Indian Medical System just as the Surgeon-General with the Government of Madras can be regarded as an authority on Western Medical System. But, even the Surgeon-General cannot effect registration of Allopathic Practitioners without the aid of legislation. Furthermore it is not quite easy to justify the place that has been assigned to the principal of the School of Indian Medicine in regard to questions entirely outside the scope of the school and relating to practitioners of various branches of Indian Medicine and their order of merit as such practitioners.

Ever since the G. O. referred to above was given effect to with regard to the registration of practitioners of Indian Medicine, there has been great discontent among the practitioners of Indian Medicine who individually and through conferences protested not only against the method of training the practitioners of Indian Medicine at the Government School of Indian Medicine, but also against the method adopted by the Government for the registration of practitioners of Indian Medicine. Elsewhere we have published the views expressed by a well-known journalist on this controversial topic, which will give an idea of the public feeling on this subject.

Apart from the foregoing considerations there is the bigger question of the utility of the School of Indian Medicine as run at present imparting instruction in systems of Indian Medicine and in portions of Allopathy. It has been rightly contended that this method is not likely to produce either finished products of Ayurveda or of Allopathy and is by no means calculated to revive the system of Ayurveda for which purpose the school was originally started. The system of giving notes on Ayurvedic subjects in English or Tamil without the students having to read the text books and being taught Ayurveda in the way in which it should be taught according to Ayurvedic methods, is more likely to do a disservice to Ayurveda than otherwise. If the object of the school is to resuscitate the Ayurvedic system, then the Government should be content to have Ayurveda taught entirely by Ayurvedic practitioners in full accordance with Ayurvedic methods, without attempting to make the institution a school for producing a hybrid class of practitioners with a smattering knowledge of Ayurveda and Allopathy.

It is not possible to impart the minimum knowledge of the indigenous systems of medicine and the Allopathic system within a period of four years. In fact the Government School of Indian Medicine has been responsible to bring into existence a class of practitioners ill-equipped in both the systems and so the action of the Government in getting recognition by means of registration to the practitioners, trained in the Indian School of Medicine has been rightly resented.

The Government would have done better justice to the public as well as to the medical profession if instead of creating a separate registration for the practitioners of indigenous systems of medicine they brought into existence a Licensing Board to grant licenses to the practitioners of all systems of medicines who cannot be brought within the purview of the existing Provincial Medical Act thus prohibiting those who do not hold a license from treating the public. Such a measure would have gone a good way in checking quackery and the consequent danger to the public. The most rational method for the revival and growth of indigenous systems of medicine will be to create special chairs in the existing Allopathic schools and Colleges to teach students indigenous systems of medicine.

We do not believe that the Government can afford to be indifferent to these fundamental questions relating to the School of Indian Medicine. We know that the Surgeon-General with the Government of Madras is least desirous of interfering in these matters. But we consider he owes it to himself to advise the Government on matters which affect the public health and which are incapable of rational justification on the very face of what is taking place.

News and Comments.

The Fifth Andhra Medical Conference: The Andhra Medical Association held their 5th Annual Conference at Vizagapatam, in the Jubilee Town Hall, on the 8th instant, in the afternoon and continued the sittings for two more days following. Dr. B. S. Moonjee who should have presided having suddenly fallen ill, Dr. B. Tirumala Rao Chairman of the Reception Committee, had to discharge the duties of the President as well. Extracts of the address delivered by Dr. Tirumala Rao have been published in the correspondence columns. Dr. Tirumala Rao attributed the upheaval of his brethren in Andhradesa to the lasting influence of the Medical School which existed in Vizagapatam for three decades and later was transformed into the existing Medical College. He impressed on the audience the cultural value of medical science and admitted with gratitude the part played by the Western Scientists in the development of scientific system of medicine in this country. He did not tolerate the idea of training medical practitioners in the way it was done at the Madras Government School of Indian Medicine. His remarks on this subject are worth the consideration of the Government, the public and the medical profession and are identical with the views expressed by us in the Editorial columns of the current issue. Affairs of the Vizagapatam Medical College formed a part of the subject matter of the presidential address. Dr. Rao regretted that the Vizagapatam Medical College was not recognised by the Indian Medical Council and that the Madras University would not allow the students of the Vizagapatam Medical College to appear for M. S. and M. D. degrees. The non-registration of this College by the Indian Medical Council is only a passing phase; and there are signs that this blot on the good name of this institution will soon be removed. But it is rather surprising to learn from the address that the Madras University which had been conducting the examination of the Vizagapatam Medical College did refuse admission to the medical graduates of the Andhra University to appear for M. S. and M. D. degrees. This attitude on the part of the Madras University is highly reprehensible. Now that the Andhra University is itself conducting the examinations of the Vizagapatam Medical College, we trust that the Andhra University will lose no time to meet the legitimate aspirations of its Medical Graduates.

We congratulate the organisers of the 5th Andhra Medical Conference on their having successfully conducted the proceedings of the conference in spite of the absence of the President of the conference. We find that the officiating President of the Conferference did not preside over the Annual Meeting of the Andhra Medical Association.

We presume that the official position of Dr. Tirumala Rao must have prevented him to discharge this duty as the meeting had to discuss medical politics. All the same we are glad to learn that most cordial feelings prevailed between the Government Medical Officers and the members of the independent medical profession both of whom seemed to have vied with each to make the conference a success. The feelings of contentment displayed in the presidential address regarding the present emoluments, status of the Government Medical Officers and the unanimity that prevailed in the passing of the resolutions such as those pertaining to the prohibition of private practice to state paid medical practitioners, indicate that such of the Government Medical Officers who participated in the activities of the conference, agree to forego their privileges in the interest of the growth and prosperity of the independent medical profession. Before closing, we wish to suggest to the Andhra Medical Association the advisability of making Vizagapatam the permanent venue for holding their annual conferences in future. Vizagapatam being the seat of the Andhra University, will afford exceptional opportunities to the members of the Andhra Medical Association on account of the existence of first rate University teaching institution, in getting the benefits of up to date scientific knowledge which will help them a good deal to relieve human sufferings.

Ophthalmological Conference: We are obliged to an eminent ophthalmologist who attended the last session of the Ophthalmological Conference at Madras for having sent us his "impression" of the Conference. It has been published in the correspondence columns and we draw the attention of the Ophthalmological Society to the various suggestions made by this ophthalmologist who is a member of the Ophthalmological Society from its very inception.

Is it a Canard? It is usual in political circles to give publicity to a canard with an idea to fish out correct information from the camp of the opponents. The recent G. O. prohibiting Government doctors from running nursing homes has been a subject of adverse comments in one of the Madras dailies. The 'Ooty Correspondent' of a daily in Bombay has sent news to the effect that, "Government have been urged to reconsider their order banning nursing homes run by medical men in their service. It is contended that the homes were being run only after the necessary permission had been obtained, and that the ban was imposed without inquiry being made. A modification of the ban is sought or the grant of sufficient time for the closing of the homes." Since the same news has also been published in the Madras daily which wrote notes on this subject in its editorial columns we have to presume that the source of information is from one person. Some of these correspondents of news papers are extraordinary beings. They can read the mind of the Government even from outside the walls of the Secretariat.

Private Practice to be defined: Abuses of the privilege of private practice allowed to Government medical officers are on the increase in direct proportion to the increase in the number of private practitioners. About 20 years ago when there were very few private practitioners the private practice of Government doctors consisted in visiting the patients in their own houses and receiving fees for the services rendered. This service included operations also. Later when the private practitioners came into existence they equipped themselves with dispensaries to dispense medicines prescribed by them. A few Government doctors followed suit. Some of the fortunate Government doctors employed in the teaching cadre in the city who were not disturbed by transfers like their less fortunate brethren in the mofussil started private dispensaries on a small scale in their own houses and dispensed medicines to their patients. A few others were either employed by professional chemists and druggists equipping them with consultation rooms in their premises where consultation was given free as was done by the private practitioners in their consultation rooms. While a few at the top who could command large practice started professional chemists and druggists shops and had attached to them bacteriological laboratories. During the period of the Great War when some of the I. M. S. officers in the city hospitals were replaced by officers in Provincial Service, one amongst the latter who was commanding large surgical practice opened a private hospital and employed an assistant under him from amongst the private practitioners. The then

first Surgeon of the General Hospital thinking perhaps that a private hospital was an advantage in private practice took permission of the then Surgeon-General and started a private hospital and had it run with the help of Assistant Surgeons serving under him. The then second Surgeon followed the first Surgeon. He went a step further and built a pucca private hospital with the permission of the same Surgeon-General who granted permission to the first. Still later smaller private hospitals cropped up, owned by Government officers in Provincial Service. Such of them who started these private institutions for medical relief without the permission of the Surgeon-General must have argued within themselves and those who took previous permission must have discussed with the Head of their Department that if they could treat private patients in the houses of the patients they could do the same in their private hospitals where the patients could command better facilities. The humbler officers running chemists and druggists shops or who were in the employment of chemists and druggists must have, as logically satisfied themselves that supplying of medicines and other requisites to the patients was part of the duties of a doctor who is treating his patients.

The Government who have been conniving at these abuses so long, have at last issued a G. O. prohibiting the running of private nursing homes by Government doctors. What about the other abuses and many more to follow? In para 140 of the latest Civil Medical Code a list of Government appointments are given, all of them are not allowed private practice. Only two appointments are permitted consultation practice. Does the service of operating on qrivate patients amounts to consulting practice? There would not have been a need for this and similar queries if the Government were pleased to define the term 'private practice' as it appears in the Civil Medical Code.

L.G.O. Diploma: A new diploma styled L.G.O. meaning—Licentiate in Gynaecology and Obstetrics has been recently instituted by the Government of Madras and the circular on this subject sent to us for information by the Superintendent, Government Hospital for Women and Children, Madras, has been published in the correspondence columns. During these days of specialisation this new diploma will be most welcome. It is mentioned in the circular that there will be tutorial classes to those who wish to qualify themselves for this Diploma. This is a distinct improvement over a similar course at the Government Ophthalmic Hospital where no special tutorial classes are held for those who undergo the course for the L.O. Diploma. The fees of Rs. 100 for the first quarter and Rs. 50 for the subsequent quarters compares favourably and even cheaper than the fees charged for the L.O. course. So far so good, but it is very unfortunate that this Diploma should have been attached with an inferiority complex by the introduction of of a conditional clause that the Diploma is meant only for the Medical Licentiates. No where in the civilized part of the world courses of medical studies have been set apart for a particular class of medical practitioners. The Medical Licentiates have been groaning and agitating by all possible ways to get out of the inferiority complex with which they are looked upon by other members of the medical profession. Those who are interested in building up a harmonious and organised profession in this country should not countenance anything that is likely to widen the gulf already existing in the profession. We are aware that for the medical graduates a special diploma has been instituted by the Madras University. This cannot justify the inclusion of the objectionable clause referred to above. The inferiority complex attached to L. G. O. looks more glaring in comparison to the L. O. Diploma which is free from all complexes.

A splendid opportunity: We learn that the representatives of the Coimbatore District Silver Jubilee Fund Committee have decided in consultation with the Surgeon-General and the Director of Public Health to establish a Tuberculosis Sanatorium at Perundurai, Coimbatore Dt. It is said that the Coimbatore District will get a lakh of rupees out of which Rs. 50,000 will be utilised for the sanatorium where provision will be made for 40 beds 20 for adults and 20 for children.

This is a splendid idea consistent with the purpose for which the collections were made from the public for the Jubilee Fund. Tuberculosis has been spreading in this country with little or no check on its ravages due to apathy on the part of public. The present system of medical administration by the Government is wholly responsible for the callousness on the part of the public in not taking active interest in medical relief as is the case in other civilised countries where almost all public institutions for medical relief are managed exclusively by the public. We have been repeatedly mentioning in these columns and elsewhere that it is not possible for any Government to render adequate medical relief to the public from out of the public revenue and that the Government should whenever opportunities arise, entrust non-official agencies to run institutions for medical relief. So far our suggestions have fallen on deaf ears. A few months ago when His Excellency the Governor of Madras presided over the annual meeting of Y M.C.A., His Excellency remarked that unlike in other countries India depended solely on the Government for medical relief. Utilisation of the Jubilee Funds is a splendid opportunity for His Excellency for making the public realise their responsibility with regard to medical relief. The proposed Sanatorium for Coimbatore is one of them. We would earnestly request His Excellency to advise his departmental heads to act merely as advisors on any scheme of medical relief to be started with the help of the Jubilee Fund, entrusting the whole management professional as well as administrative to voluntary agencies.

While going to the press we learn that the sanatorium at Perundurai is to be entrusted to a society to be registered as Tuberculosis Society and a constitution has been framed with a provisional committee to manage the affairs of the Sanatorium at present. We shall revert to this subject once again after knowing further details of the proposed Tuberculosis Society.

Medical Council Elections: Recently two election proceedings were conducted in this province, one for a seat which fell vacant in the Indian Medical Council on account of the death of Dr. T. Krishna Menon and the other in the local Medical Council due to the expiry of the term of office of Dr. U. Rama Rao. There was competition for the former election between Dr. T. Satakopan and Dr. T. S. S. Rajan. Dr. T. Satakopan was declared elected, having secured 251 votes more than his rival. Rightly or wrongly an impression prevailed that of Dr. T. Satakopan was a nominee of the Government or atleast of those under the employ of the Government. It might be remembered that Dr. T. Satakopan competed for an elective seat to represent the graduates in the Madras Medical Council which suddenly fell vacant a few months ago on account of the death of Dr. M. S. Krishnamurthi Aiyar, Dr. U. Krishna Rao being another aspirant for the same and that the Government of Madras nominated Dr. T. Satakopan to a seat in the Madras Medical Council which fell vacant on account of the death of Dr. T. Krishna Menon who was the nominated member of the Madras Medical Council. This nomination looked not only curious but extraordinary and lot of surmises were afloat why the Government should nominate a person to the Madras Medical Council when the same candidate was seeking entrance by election and that during the course of the election proceedings itself. The announcement by Dr. Satakopan that he was seeking election to the Indian Medical Council was made almost the very day when his nomination to the Madras Medical Council was rumoured. The effect of this coincidence that was brought about must naturally be the cause of surmises referred to above. The fact that a prominent member of the I. M. S. had been taking keen interest with regard to canvassing of support for Dr. Satakopan added more strength to the surmises and a false fear was created amongst the voters who were Government servants, that the voting procedure not being a secret ballot enjoining on the voter to put his signature on the counterfoil attached to the voting paper, it was likely that the Surgeon-General who was the Returning Officer for this election was likely to know who voted for whom. This fear found expression in a communication addressed to the Editor of a daily in the city of Madras wherein this communication was published. Those who know the present Surgeon-General at close quarters would not only laugh at this idea and even put it down as base calumny. But unfortunately what actually transpired at the Indian Medical Council with regard to the ap-

pointment of its Secretary as Inspector when the late Dr. T. Krishna Menon gave his vote for the first time against the appointment of Secretary as Inspector and later changed his mind, was quite fresh in the minds of the electorate most of whom being in service got credulous and openly and solidly voted for Dr. Satakopan. We mean no disparagement to Dr. Satakopan who richly deserves to be a representative of the graduates in the Indian Medical Council. But it is our duty to let know all concerned the effect of the Government having gone out of the way—may be with the best intentions, in having nominated Dr. Satakopan to the Madras Medical Council under the circumstances mentioned above. We also wish to point out that the canvassing of votes by officers of the Government is an election offence according to the existing law. It is therefore desirable that either the law has to be amended or serious notice should be taken by the Government against their officers who engage themselves in canvassing, or else the Government will be brought into contempt by its own officers however much such an illegal action might otherwise help the Government. We cannot blame Dr. Satakopan for what has happened and we congratulate him most heartily. His future activities in both the Councils will, we trust be such as to nullify the effects of the rumours that were afloat during the stages of his nomination and election.

The result of the another election to the Madras Medical Council was announced on the very day of the receipt of the nomination papers. Dr. Y. Suryanarayana Rao of Tanuku being the only nominated candidate, he was declared elected to the vacant seat. Dr.Suryanarayana Rao is very lucky indeed. The decision of the Madras Medical Council arrived at its last March meeting, not to send individual precepts to the voters intimating to them about election proceedings as was done ever since the Madras Medical Registration Act came into existence, did materially add to the luck of the candidate who has been returned unopposed in a constituency which has nearly 4,000 voters. We are told that under certain circumstances customs and conventions assume the force of law. It is quite open to any voter to raise an objection against the procedure followed by the Madras Medical Council. All the same we congratulate Dr. Y. Suryanarayana Rao. The entry of an Andhra to the Madras Medical Council will be welcome as there was an impression amongst atleast some of the medical licentiates in the Andhra province that they had no representation in the Madras Council ever since it came into existence.

This seems to be a season for Medical Council elections. Far away in the Punjab Dr. Gian Chand Blaganna has come out successful against his rival Dr. R. B. Hariram who, we are told, was the sitting member ever since the Punjab Medical Council came into existence. Three years ago there was competition between the same two caudidates and Dr. Gian Chand Blaganna was defeated by a narrow minority. We admire the spirit of perseverence in Dr. Blaganna. We send him our felicitations.

A Notable Coincidence: Lt. Col. E. W. C. Bradfield I. M. S., who left Madras Service as first Surgeon and Superintendent, Government General Hospital and Major A. M. V. Hesterlow, who, before his transfer was acting in Madras as Director of Public Health have been appointed respectively as Surgeon-General with the Government of Bombay and Director of Public Health, Bombay. We congratulate both and wish them a bright and useful career as the Heads of the Medical and Public Health Departments of Bombay Presidency. It is really a notable coincidence that both these officers who served major portion of their official lives in Madras Presidency are made to bestow the benefit of their ripe experience earned in Madras Presidency, to another sister Presidency and that at one and the same time.

The policy now followed in all provinces in importing Heads of Medical Department from outside cannot be said to be conductive towards progress excepting in a few instances where such importation may be justifiable. Till about 1925, the senior most member of the I.M.S. in a particular province was made the head of the Medical Department and the next senior possessing public health qualification, was promoted as Director of Public Health. Vested interests could not permit the Government in this country to promote a senior most Indian I.M.S. Officer as Surgeon-General when his turn came and consequently the policy of importation was adopted to bring in a more senior I.M.S. officer to a province where the

Indian I.M.S. was senior most officer but junior to one that was imported. Madras was the first province where such a change of policy was introduced. Advantage of this new policy is now taken by the Ministers when they wish to get rid of an officer whom they do not wish to have under them and at times they are forced to have recource to this policy from outside influence in the interests of officers from outside their own provinces. A combination of the above two circumstances is said to be the cause of Madras losing two of its officers in the I.M.S. one of whom ought to have been the Surgeon-General and the other Director of Publlic Health. All the same we are glad that Col. Bradfield and Major Hesterlow attained the positions which they richly deserved.

A Vicious Principle: We learn that the Madras Government have recently passed orders enhancing the fees for special courses in the city hospitals in case of those coming outside the Madras Presidency. There is no justification for such an unreasonable and exorbitant demand. Indians have been rightly complaining against discrimination made by foreign universities regarding admission of Indian students. But so far the foreign institutions did not charge Indian students more than they did for the natives of those countries. Preferential treatment regarding admission into teaching institution where there are only limited number of seats may to a certain extent be justifiable on the principle 'that the man who paid the piper had a right to call the tune.' The Madras infection has quickly spread in Bombay. The Bombay corporation inspite of strong opposition from some of the councillors decided, at one of its meetings held last month to increase the fees at the Ghordhandas Medical College by Rs. 20, per term for students coming from outside the city of Bombay and the Bombay Suburban Districts but from within the Bombay Presidency, and by Rs. 40, more per term for students coming outside the Bombay Presidency over and above the usual fees of Rs. 67 per term, charged for the resident students of Bombay. It is an unfortunate irony that during these days of advancement and socialism invidious distinctions are made by those in authority between a province and a part of a province and between sister provinces. The logical sequence of such distinctions will be most disastrous indeed.

Plague in Borsad: Mr. Vallabhai Patel with the help of Dr. Patel had organised a Plague Relief Camp at Borsad, Kaira Dt. of Bombay as he found that Government measures for the relief of plague stricken people were very unsatisfactory. There have been Government communiques and counter-communiques from Mr. Vallabhai Patel one blaming the other. But fortunately for the plague stricken people this controversy proved a boon to them. In addition to the relief measures from a non-official philonthropic agency, the Government machinery is made to move quicker than usual and Borsad and the surrounding plague infected areas are having much better attention now. The Government and the local bodies would have been wiser and would have discharged their responsibility to the benefit of the people under their care if they co-operated with the non-official agency in combating plague. But they seem to value their prestige more than the lives of the people especially so as the relief measures at Borsad were started by a devotee of the Indian National Congress. We do not wish to go into the details of this controversy. Suffice it to say that the Director of Public Health and the District Collector are now doing the work at Borsad entrusted at one time to a Vaccination Inspector and a Mamladar. Inspite of the heavy toll paid by Indians in the mortality rate of preventable diseases,the Government,not only in Bombay but throughout India, have not realised their responsibility in concentrating their attention in preventing diseases and have been spending fabulous and proportionately large amounts of money on curative medical relief,starving the Public Health Department. The benefits and at times even the existence of the Public Health Department is not felt by the public especially during the prevelance of epidemics. This department is not provided with funds to the extent of the magnitude of work they have to deal with and when an epidemic prevails in a locality this prevention department is forced to do actual curative work and that too, in a haphazard way. We are glad that Congress men of the position of Mr. Vallabhai Patel are interesting themselves in public health measures. Time does not seem to be far when Congress men will take active part in the Government of this country. We hope they will then realise the

necessity of organising Public Health Department on much sounder basis so that this department may do the work expected of them to the entire satisfaction of the public.

Progress: We congratulate Dr. T. S. Shetty on the rapid progress evinced at his private Eye, Ear, Nose and Throat Hospital which institution was brought into existence by Dr. Shetty soon after he returned from Vienna specialising in Eye, Ear, Nose, and Throat diseases. On 14-6-35 the newly constructed extensions of this hospital were opened by M. P. Mr. Pai, M.A., I.C.S., Sub-Collector, Devakottai.

Dr. Shetty started his life as a medical officer of a small public hospital founded by one of the philonthropic Nattukottai Chetty at Kanadukathan where Dr. Shetty made a mark as a skilful surgeon. As the benefits of post-graduate studies are denied to the medical licentiates of India in Great Britain and as there are much better opportunities for specialising in any branch of medical science at Vienna, Dr. Shetty specialised in the treatment of Eye, Ear, Nose and Throat at Vienna and soon after his return to Kanadukathan he found the need for a special hospital for the treatment of the diseases in which he has specialised and started an institution of his own at Kanadukathan in September 1933. The fact that within two years, new extensions were required for this institution shows the popularity and the quality of work turned out by Dr. Shetty inspite of the existence of two well-equipped free hospitals within a radius of a mile and a half from Dr. Shetty's Hospital.

We are sure that Dr. Shetty will be a source of encouragement to other members of the independent medical profession, especially the medical licentiates, skilful amongst whom should realise during these days of advancement of medical science that hospitalisation is an ideal service to the public more than dispensing practice.

A Request : Lt. Col. C. M. Ganapathy, Director of Public Health, Madras has sent us a communication received by him from the General Secretary of the Far Eastern Association of Tropical Medicine, who has requested the Director of Public Health to collect papers on the subject of Nutrition from the members of the medical profession in this province. It is needless for us to say that Nutrition forms the most important subject with regard to the welfare of a nation and India more than any other country needs a solution of this problem. Nobody could tackle this question more efficiently and usefully than the members of the medical profession who should have an intimate knowledge of various foods in preventing and curing human ailments. We appeal to the members of the medical profession in this province and outside to take keen interest on this subject and co-operate with the organisers of the Far Eastern Association of Tropical Medicine in their efforts to solve the important problem of Nutrition.

Correspondence Reports, Etc.

The Fifth Andhra Medical Conference, Vizagapatam.

The fifth session of the Andhra Medical Conference was held at Vizagapatam on the 7th, 8th and 9th of June 1935.

The Conference was opened by Mr. B. Venkatapathi Raju, B.A., B.L., C.I.E., who took the opportunity to refer to the step-motherly treatment given by the Madras Government to the Vizag Medical College and hoped that the Government would soon afford better facilities to medical students at Vizag and effect the improvements urgently required by the Medical College and Hospital. He urged the conference to extend its sympathy to all systems of medicine. Long before there was any scientific knowledge in Europe, India had perfected a system of medicine called Ayurveda. In conclusion, he opined that the day would soon dawn when allopathic practitioners would devote part of their time to investigate and bring to light the many hidden truths in Ayurveda.

In the unavoidable absence of Dr. Moonjee, Dr. B. T. Rau was requested to take the presidential chair. He then delivered a stimulating and learned address touching practically on every one of the major issues that confronted the Medical profession in the Andhradesa.

Dr. A. Lakshmipathi of Madras opened the Pharmaceutical exhibition. He referred to the great mineral and vegetable wealth of India. Drugs abundantly found here are being exported to Europe for refinement. These finished products return to India in a new garb and are sold at very heavy cost.

The delegates and the visitors after going round the exhibition adjourned to the King George Hospital, where Dr. B. T. Rau entertained them at tea.

The Scientific section then opened its proceedings and a number of lectures were delivered for the benefit of the doctors that gathered.

Dr. Trasi, Professor of Obstetrics, Vizag Medical College read a paper on 'post-partum haemorrhage'. He referred to the percentage of incidence in various countries, emphasized the importance of ante-natal prophylaxis and discussed the comparative merits and demerits of the various methods advocated by different authorities. He gave in detail a technic which in his experience was the most satisfactory one to arrest post-partum haemorrhage.

Dr. Dinker Rao, Professor of Medicine, Medical College, Vizag next lectured on Hypertension'. He gave a comprehensive, list of the current theories of causation and emphasised the clinical and bio-chemical investigations which would help the doctor in diagnosing this disease from apparently similar conditions and drew attention to clinical features which were important in prognosis.

The next day, the delegates after visiting the Andhra University and the Mental Hospital, Waltair, again assembled in the Pathology Block to hear lecture demonstrations.

In the absence of Dr. B. T. Rau, Dr. T.S. Tirumurti took the chair during the morning session.

Dr. P. Ramachandrarao Asst. Professor of Pathology, Vizag Medical College showed a large collection of post-mortem specimens and slides collected from atypical fatal cases of malaria and discussed in detail the microscopic changes noted in these cases.

Dr. Kini Surgeon K. G. Hospital gave a lecture demonstration on 'some surgical aspects of joint disease' showing cases, photos and Xray films, illustrating the condition and functional capacity before and after certain operations.

Dr. R. Viswanadhan Lecturer in Tuberculosis dealt with 'bronchiectasis' illustrating his lecture with case records and Radiograms.

Dr. Ch. S. John of Nidadhavole read an interesting paper on 'sterilisation in men.'

The Conference assembled in the Town Hall in the afternoon with Dr. B. T. Rao in the chair when Dr. P. Kutumbiah, Physician K. G. Hospital, Vizag, gave a clinical lecture on 'neurosyphilis'. He referred to the incidence, classification and clinical diagnosis of the disease and read out case reports illustrating different types of Neurosyphilis.

Dr. Abbu Mudaliar, Professor of Opthalmology, Medical College, Vizag read a learned paper on 'The recent advances in the diagnosis and treatment of Trachoma.'

Dr. A. Lakshmipathi read an interesting paper on the 'Therapeutics of Indian Medicines." He prefaced by giving a brief statement on the Tridhatu theory, which formed the foundation of Ayurveda. Disturbed conditions of three-dhatus known as Tridoshas were reduced to normal by giving drugs having opposite qualities. As an instance of the valuable, though somewhat out of date methods, he discussed the therapeutics of the eight urines (Ashta-mutras) viz., those of the buffalo, goat, sheep, cow, horse, camel, elephant and ass. He dealt with the various uses to which these urines could be put and instanced number of cases, where one or other of the eight urines had been used with considerable success.

Dr. N. T. S. Yazulu Vizianagaram read a paper on 'Indigenous drugs' and made some suggestions for the improvement of indigenous drugs

After the visit to the harbour and King George Hospital, the Scientific Section resumed its proceedings with a lecture demonstration by Dr. Kesavaswami on 'Interpretation of X-ray films.' This was followed by a cinema film taken in the King George Hospital showing the characteristic gaits in different nervous diseases. Another interesting series of films on 'Harmones' were shown by Bayer & Co. The first paper for the day was by Dr. G. V. Subbarao of Tenali on 'The village call' narrating his experiences when summoned to see emergent cases. The next paper related to

physilogical problem concerning the human parotid saliva. Mr. T. S. Ramachandran read out the results of a bio chemical assay of different kinds of saliva, while Dr. Baseer described the results of inoculating animals with saliva. He seemed to suggest a relation between some as yet unidentified harmones as in saliva and the gonads. Dr. Trasi made a few comments from the point of view of a gynaecologist, while Dr. Krishna Rao offered some criticisms as a morphologist.

The paper by Dr. Seshacharyulu, which dealt with 'The human heart in action' suggested a few lines of investigation and study on what he called the dynamic physiology and pleaded far greater attention to human machinery than to rats and rabits.

The scientific section closed with a paper by Dr. Govinda Nair on 'the new treatment for small-pox' wherein he gave his experiences with the liver extract injections which if given sufficiently early, appeared to reduce the amount of pustulation and scarring in the latter stages.

About ten papers from various parts of India by specialists in their line had to be taken for read for want of time. Among them were three papers from the Indian Institute of Medical Research, Calcutta, one from Dr. Naidu of Haffkine Institute, one from Dr. Sundararao of Calcutta School of Tropical Medicine,

The Medical Conference passed the following resolutions :—

(1) The Andhra Medical Conference has heard with deep sorrow the great calamity that has befallen the people of Quetta and North-west Frontier Province and conveys its heart-felt sympathy to members of the bereaved families and exhorts all the members of the medical profession in the Andhradesa to contribute liberally towards the relief funds that are started in the country for the help of the distressed people.

(2) The Andhra Medical Conference urges on the Government of Madras and the Andhra University authorities the necessity and the urgency of getting the Andhra University M.B., B.S., degree recognised by the Indian Medical Council by effecting immediately the necessary improvements required by the Inspection Commission in the King George Hospital and the Medical College, Vizagapatam.

The President in his concluding remarks expressed the hope that the varied activities of this conference would give impetus to the profession to organize themselves for better professional and scientific work and that a spirit of co-operation and emulation would pervade all ranks of the profession.

A number of delegates spoke thanking the reception committee for the arrangements and demonstrations organised for the benefit of the conference.

After a vote of thanks to the numerous individuals and public institutions, that co-operated in making the Conference a success, the Conference was brought to a close.

The same night, there was a farewell dinner at the delegates camp, where the gathering was entertained to delightful music. The Doctors from various parts established new contacts, renewed old friendships. The gathering broke up with a fealing that they had spent three days usefully and happily.

Andhra Medical Association.

ANNUAL SESSION.

The annual session of the Andhra Medical Association for the year 1934-35 was held at the Town Hall, Vizagapatam, along with the conference, which met on the 7th, 8th, 9th instant under the presidency of Dr. A. Lakshmipathi, B. A. M. B. & C. M.

Among the amendments made in the draft rules of the Association was one to the effect that 10 per cent of the collections of the branches shall be paid annually to the Central Council.

The Association passed a number of resolutions the following being some of them:

The Association resented the Government attitude requiring a second opinion from Government Medical Officers on certificates issued by private practitioners, as this procedure is against the dignity of the independent medical profession. (2). It resolved that doctors in Government service should not be allowed private practice unless it be of a consulting nature. (3) Protested against the non-recognition of the Andhra Medical degrees by the Indian Medical Council and appointed a committee to investigate and agitate about the non-recognition of the Andhra Medical degrees and thanked Sir S. Radhakrishnan, Vice-chancellor of the Andhra university and Major Ebden, I.M.S. Principal Medical College, Vizagapatam for their efforts to improve the Vizag Medical College. (4) Recommended the use of Khaddar and Indian made articles and medicines as far as possible. (5) Urged that appointments in the Vizag Medical College should be given to Andhras as far as possible. (7) Pointed out the necessity of instituting of M. D. and M. S. degrees in the Andhra University. (8) Recommending the starting of a central pharmaceutical laboratory in Andhradesa by the Association either by private efforts or through the agency of the Government. (9) Urged the need for paying a minimum of at least Rs. 800 per year to rural medical practitioners. (10) And requested the Government that medical men in the local boards and municipalities should be given the same scale of pay that is granted to men in Government service.

Office-bearers for the coming year were than elected with Dr. D. S. Ramachandra Rao as President, Dr. S. V. Ramarao as Vice-president and Drs. M. V. Krishnarao and C. Suryanarayanamurti as Secretaries, the latter being also the Treasurer.

An advisory board consisting of Dr. Pattabhi Seetharamayya, Dr. D. S. Ramachandrarao, etc. was constituted to bring out a journal.

Dr. Lakshmipathi, in his presidential address, remarked that he was pleased to find that the bridge between Allopathic and Ayurvedic practitioners in the Andhra country was quickly closing up, that the untouchability of the Ayurvedic physician was removed by the Government opening the school of the Indian Medicine under its control and that the progress of medicine in the country depended upon the young and enthusiastic graduates, who should study the subjects from all points of view. He added that, though he was a strong supporter of Ayurvedic system, he was not against the introduction of the western scientific methods.

Continuing he said that he was struck by the remarkable spirit of co-operation and friendliness shown by the students, the graduates and the Professors of the Vizagapatam Medical College in conducting the session. He exhorted the Andhra medical practitioners to organise themselves strongly by the establishment of branches of the Association in all the District and Taluq head quarters and promote the interests of independent medical practitioners.

Far Eastern Association of Tropical Medicine.

Hon. Act. General Secretary
W. F. Theunissen.
Act. Dir. Publ. Health Service of
The Netherlands Indies.

Batavia (Centrum)
1st May, 1935.
Parapattan 10.

To

The Director of Public Health,
Madras.

Dear Sir,

During the second Council Meeting of the ninth Congress of the Far Eastern Association of Tropical Medicine at Nanking, Dr. de Langen (Batavia) proposed, seconded by Dr. Kuno and endorsed by Col. Russell, that the question of nutrition on its widest sense, being of such very great importance in the Far East, should be specially brought before the next Congress, as a main subject. Dr. de Langen had had no time to discuss the matter beforehand with Dr. Rosedale, but would do so on his return to Netherlands India, and proposed that two or three raporteurs should assemble material dealing with this matter and send it in before the next Congress.

This proposal was agreed to unanimously.

Consequently, the following resolution was passed:

That in view of the importance of the food-factor in diseases, a section of Food Problems be added to the programme of the next Congress.

The outcome of the discussions between Dr. de Langen and Dr. Rosedale has been the composition of a circular letter, a copy of which you will find enclosed herewith.

In order to obtain good co-operation I wish to suggest that you have the circular letter published in the local medical periodicals of your country.

(2)

INSTITUUT VOOR VOLKSVOEDING
Institute for Nutrition Research.
BATAVIA (Java).
SECRETARIAT: V. HEUTSZBOULEVARD 12.

At the next Congress of the Far Eastern Association of Tropical Medicine it is proposed to hold a round-table discussion on nutrition, and we have been asked by the Council to make preparation for it.

Papers are invited upon Nutrition from the widest point of view and we should be glad if you will be so good as to ask trained observers who are working on any aspect of the subject in your country, whether they will kindly contribute to the discussion by reading a paper on their work under any of the sub-headings below?

If suitable support is forthcoming, it may be possible to combine the papers received and the discussions in a volume, which would constitute an up-to-date account of Nutrition as concerns the East.

It is hoped that some indication of the support which may be expected from your country may be received during 1935, though it will not be necessary for titles of papers to be sent in until a later date which will be notified in due course. Such co-operation will enable the Council to know how much time should be allotted for the discussion.

It has been proposed to divide papers under three headings as follows:—

I. ECONOMICS. to include such aspects as Agriculture in relation to human nutrition, e.g. improvement of yield and quality of food crops; horticulture; fruit-growing; stock raising; dairy problems; institutional feeding; food surveys; storage; cooking, &c. &c.

II. CHEMICAL AND PHYSIOLOGICAL. to include food analyses in the widest sense; vitamin, mineral, fat, protein studies &c; metabolism, basal metabolism, energy requirements, specific dynamic action.

III. CLINICAL: Studies of disease in relation to food and diet, the feeding of infants during the first year with special reference to development (height and weight); children's diseases in relation to food; nutritional oedema, atypical beriberi; the course of infectious diseases under the influence of food; liver cirrhosis; anaemias; skin diseases in relation to food and vitamins; ulcers of the leg; leprosy in relation to food; constitutional diseases, diabetes, obesity, gall-stones, gastric ulcer, &c.; clinical value of certain foods &c.

It should be understood that the above provisional programme is intended to be as wide as possible, and that additional suggestions from those able to make them will be welcomed. It is hoped that the subject of nutrition will receive emphasis from the general and normal point of view as well as from the point of view of disease.

(Signed) C. D. de Langen
J. L. Rosedale.

N. B.—Lt. Col. C. M. Ganapathy, M.C., I.M.S., Director of Public Health, Madras requests the members of the medical profession, both official and non-official to contribute and send him articles on the subject of Nutrition to be forworded to the General Secretary of the Far Eastern Association of Tropical Medicine.—Ed.

All India Ophthalmolcgical Society

AN IMPRESSION.

The fourth conference of the above society was held in Madras on April 22, 23 and 25. The first and the last days' sessions were held in the Medical College Library Hall and the second day's in the Government Ophthalmic Hospital. The attendance was moderate consisting mostly of people from Madras and the States around. Many of the other Provinces were not represented, especially Bombay. None of the prominent ophthalmologists of India north of Madras was present.

After the welcome address by Dr. E V. Srinivasan, the Chairman of the Reception Committee, Sir Md. Usman opened the conference with a short speech. Lt. Col. R. E. Wright of the Government Ophthalmic Hospital presided over the scientific sessions. It is a pity none of these addresses were printed. The delegates had to read the newspaper reports to get a clear idea.

A visit to the King Institute was arranged in the noon and many went out to see the institution.

In the afternoon, the main subject of the conference, namely Nutritional Disorders of the Eye, was taken up. The opening paper was to have been read by Lt. Col. Sir Duggan of Bombay, but as he was absent, Dr. B.K. Narayana Rao of Bangalore started the subject. It was followed by many papers, the chief of which was on Keratomalacia

by Lt. Col. Wright. The discussions were keen and interesting.

Evening tea was provided by Dr. E. V. Srinivasan and immediately after, a group photo was taken. Trips round the city were arranged for non-Madras members.

The second day's session was held in the Elliot School after a visit round the Ophthalmic Hospital, where there were also cases for demonstration. Most of the papers read here were by the staff of the Hospital. That which excited a keen discussion was on sympathetic ophthalmia by Dr. Koman Nair. In the end, there was a demonstration of magic lantern slides on prevention of blindness, followed by a discussion as to what the Society could do to help in the campaign against blindness. One would have wished the conference dealt with this important subject a little more seriously than it did.

Mrs. & Col. Wright were 'at home' after the session was over on the Madras museum grounds. The function was attended by leading official doctors of the city and Sir Md. Usman. At night, the annual dinner was held when about thirty guests were present.

After a visit round the General Hospital, the third day's session began again in the Medical College Library Hall. The discussion on Dr. Mohan Lal's paper on "Routine of Cataract Extraction" was long and interesting. Dr. Doraisamy read a paper on Diptheria of the Conjunctiva and also demonstrated a case.

The business meeting of the Society was started after the scientific session was over. It was lively throughout. Dr. Zachariah was re-elected Secretary unanimously, but votes had to be taken for the next presidentship, the question being whether an official or a non-official should be selected. Lt. Col. Kirwan of Calcutta was selected as against Dr. Ratnakar of Bombay. The number of members of the Executive Committee was raised to 16, an unheard of number for such a small organisation. This number is being increased at every conference, just to include all who made new suggestions. It looked as if those present did not mind the sense of proportion or indulged in too much courtesy. One could never get courage to send out one and replace him with another. At this rate, we should soon see the whole conference for-

ming the executive of the Society! Madras seems to be the most fortunate of all the other Provinces. There are five members from this Province alone on the Executive Committee including the Secretary and the President.

The general trend of opinion was that the Madras session was not a success in comparison with the previous conferences. The arrangements made were poor. The programme was ready only on the morning of the conference! One cannot understand why the main meetings were held in the Medical College Library Hall, where there was no provision for exhibition of lantern slides and charts or other conveniences. Many of those who had given papers did'nt care to attend the conference to read them.

It is a pity the Secretaries did not realise how much more effective and real the discussions would have been if the programme was sent out in advance. The present practice is as follows. The members get to know the nature of the papers presented only after arriving at the hall. The papers so presented however long and important they may be must be read within ten minutes. One wonders what useful information one could impart in ten minutes. The discussion that follows is in many instances amusing. One simply gets up and airs his views sometimes without reference to the subject, statistics and perhaps facts. Whereas if one got the programme in advance it will greatly help every member to come thoroughly prepared in every subject he intends taking part in. Secondly, the ten minute rule must be done away with. If there are too many papers, one should have the courage to reject all worthless stuff so that all discussions could be concentrated on important subjects. The justification for the ten minute rule seems to be that one could read the papers leisurely when they appear in the proceedings. It might interest your readers to know that the proceedings of the conference held in December 1933 appeared only in March 1935:

It is said the Society is still in its infancy. It has to learn many things. But the sooner it does, it is better; for judging from the many notable abstensions of this year one is inclined to fear whether the Society will survive its too slow study.

TRUTH

L. G. O. Diploma

The Government of Madras have recently instituted a Diploma in Gynaecology and Obstetics. This diploma will be styled L. G. O. (Licentiate in Gynaecology and Obstetrics) and will be awarded to candidates who undergo a special course of clinical training at the Government Hospital for Women and Children, Madras, attend the prescribed tutorial classes and pass the final qualifying examination at the end of the course. The course is open only to non-graduate medical men and women of not less than 5 years' standing. The number of candidates to be trained at one course will not exceed 6. The following fees will be levied from all candidates other than those in permanent Government service under the Madras Government: (a) The fees for the course is Rs. 100 for the first quarter; and (b) Rs. 50 for every subsequent quarter; (c) Examination fee Rs. 30. Full details of the scheme can be obtained from the Superintendent, Govt. Hospital for Women & Children, Madras. Applications for admission to the course should be made to the Superintendent of the above hospital.

A. LAKSHMANSAWAMI MUDALIAR,
M. D, F. C. O. G.,
Superintendent, Govt. Hospital for W. &. C. Madras.

Eye, Ear, Nose and Throat Hospital for Chettinad.

Before a crowded audience of Officials and non-Officials besides several influential and prominent Nagarathars of the District, Mr. M.P. Pai M.A., I.C.S., Sub-Collector, Devakottai, declared open on 14-6 35 the newly constructed extensions for the Eye, Ear, Nose & Throat Hospital of Dr. Shetty at Chettinad in Ramnad District.

Dr. Shetty who is specially qualified in Vienna for Eye, Ear, Nose & Throat Treatment welcomed the Collector and the audience and made a short speech tracing the successful working of the Hospital for the past two years. He said that the institution had been fully equipped with the most up-to-date Electric Therapeutic Apparatus, besides apparatus for special department of Eye, Ear, Nose and Throat and for general surgery. The Hospital, he added, had provision for about 20 beds with modern convenience. Dr. Shetty, the founder of the Hospital, was glad to announce that it had been always the principle of the institution not to refuse any case when he felt he could do some good, however poor the patient might be and assured that the Hospital would cater to the needs of the poor patients free of all charges in the special department if such deserving patients would bring a note from their Doctors.

In declaring open the new buildings amidst cheers, Mr. Pai congratulated Dr. Shetty on his private enterprise in successfully working the institution for the past two years, which he observed, was a real boon to the public in these parts. He was glad to note that 40 poor out-patients and 4 in-patients were daily treated free and that the people were realising the usefulness and importance of this private Hospital for special treatment. The institution, the speaker observed, was being conducted with high ideals catering free treatment to the poor and any institution with such ideals was bound to succeed. He wished the institution a bright future.

With a vote of thanks by Dr. Shetty, the function terminated. This was followed by a well attended dinner in the night arranged by Dr. Shetty at the "Chettinad Aero-Drome Grounds."

School of Indian Medicine.

ITS REAL PURPOSE.

(BY MR. K. VYASA RAO.)

Presiding at a meeting of the Madras Ayurveda Sabha on the 18th March, Mr. P. T. Rajan, Second Minister, admitted that he entirely sympathised with the demand of the Madras Ayurveda Sabha, that "there should be no distinction in status between the practitioners of the different systems of Indian Medicine". He further emphasised that he would do his best to see that no unfair treatment was meted out to the qualified practitioners of Ayurveda. Coming as this assurance does, as a welcome corrective to the hastily conceived G. O. to which I referred in The Hindu" of 16th January last, the subject calls for some comprehensive consideration.

It may be pointed out at the outset that the School of Indian Medicine was meant to give instruction in systems of Indian Medicine by persons of recognised competency in the practice of those systems and to confer a diploma on the successful alumni of the school. It was not meant for classifying and grading practitioners of Indian Medicine in general.

Medical registration is now conducted under an Act of the Legislature and the subject is comprised in the port-folio of the Home Member, not having been included among transferred subjects. To issue a number of G. O.'s classifying practitioners of Indian Medicine in comparison with the alumni of this school without the classification receiving the approval of the Legislature, either in the form of a legislative bill or otherwise is an ill-considered procedure.

REORGANISATION NECESSARY.

One would like to know whether the purpose of the School of Indian Medicine is to provide instruction in Indian systems according to the method laid down in them or to provide a cheaper class of medical practitioners mainly of the Western type for employment under local bodies. If it is the latter, it need not be called "School of Indian Medicine" and a course of appropriate training may be provided in the existing Medical Schools, for a certificate of proficiency for employment under local bodies. If, on the other hand, the object of the school is to furnish complete instruction in the mastery of the Indian systems and to confer a mark of distinction on those who have come up to a high standard of proven merit in the knowledge of those systems, the institution must be thoroughly orientalised, apart from any consideration of "registration" comparatively or otherwise, or eligibility for employment by municipal and local boards. It is simply amusing to train a body of practitioners with a view to cheap employment, who would be fit to use the stethoscope and thermometer and give an injection or vaccinate a child unlike an Ayurvedic practitioner and also prescribe Thirupala Churanam for constipation unlike an L.M.P. and call them Licentiates in "Indian Medicine". A practitioner of Ayurveda must diagnose according to his system, testing the pulse, the urine, the sputum, and the blood according to Ayurveda, and studying the other symptoms and stages of the pro-

gress of a disease according to Ayurveda, treat the patient as required therein, according to the Materia Medica of Ayurveda. Unless it is the object of a school of Indian Medicine to train students in this manner, the waste of money under the presence of reviving Ayurveda may be stopped and a cheaper class of certified allopathic practitioners may be trained for service under local boards. It is one thing for one out of many to be a trained qualified and competent practitioner in more than one system of medicine having studied in an appropriate institution for acquiring the necessary proficiency in each. *But no institution* can be designed to give instruction to a large number of pupils to enable them to diagnose according to one system, to prescribe according to another and to await the reaction to the treatment according to a third and vary the treatment from a diaphoretic mixture to a *kashayam* or *basmam*. At the top of producing this type of medical practitioners, to call them "registered medical practitioners" thereby setting on them the seal of approval of the Government and place them above fully qualified practitioners of Ayurveda is to indulge in a process of jugglery in making a compound of Ayurveda and Allopathy.

(*The Hindu.*)

Review

The Report of the Nowrosjee Wadia Maternity Hospital, Bombay, for the year 1934.

It is really a pleasure to go through the report which has been edited so methodically to afford intelligent reading not only to statisticians but also to those interested in obstetrics practice. The work turned out in the Hospital is, as usual, of very high order and brings credit not only to the Honorary Chief in charge of the Hospital but also to his several colleagues, all of whom have formed themselves into a happy team co-operating with each other to maintain a very high reputation for the Hospital. The credit is all the more when it is known that the professional work in the Hospital is entirely of voluntary nature.

The total number of admissions in the Hospital durink the year under report was 6,133 as against 6,184 in the previous year and the number of confinements conducted was 4,653 as compared to 4,734, conducted in 1933. The average number of beds occupied was 118.3 against 119.8 in 1933.

The institution continues to be a training ground to two Medical Colleges existing in Bombay, Seth Gordhandas Sunderdas Medical College and the Grant Medical College, and in addition has been training students from the Medical School, Hyderabad, Sind. Post-graduate training is also given for a period of six-months and facilities are afforded for the Medical graduates who wish to qualify for M. D. taking Obstetrics and Gynaecology as special subjects. It is a training centre for maternity nurses.

Interesting tables are printed in the report giving details of the cases treated under several heads and in addition, short notes are published on maternal deaths giving description of every case. The same arrangement is followed regarding the infant mortality. Emergent cases requiring surgical interference find a place in these tables explaining in a brief yet intelligent way the indications for interference and the resulting effects of the same.

We wish there were similar institutions in the capital cities of other provinces to serve as a model to demonstrate to the Government in each province that the members of the independent medical profession in India are capable of running public institutions for medical relief efficiently and creditably and with much less expense than that incurred by the Government for running similar institutions by their paid staff.

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