JULY 1935

# The Medical Practitioner

A Monthly Medical Journal

EDITED BY
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## CONTENTS.


| | PAGE. |
|---|---|
| **Original Articles :** | |
| Some complications of fractures and their treatment, By K. Rama Menon, M.B., F.R.C.S. (E.) ... ... ... | 215 |
| Drug Adulteration, By E. A. Harlow, M.S.R., F.C.S., ... ... ... | 217 |
| **Abstracts :** | |
| The Medical Curriculam. ... ... ... ... | 218 |
| **Notes on Therapeutics, Diagnosis and other Medical Subjects :** | |
| Filariasis, By S. Sundar Rao ... ... ... ... | 223 |
| Bacteriological Investigation in the Diagnosis of Disease, By B. P. B. Naidu, M.D., (Edin.) M.H., D.T.M., D.P.H. (L'pool). ... | 225 |
| Madras Medical Council: Review of Work from October 1933 to March 1934 By V. Rama Kamath. ... ... ... ... | 226 |
| **Editorial :** | |
| Aimless Policy. ... ... ... ... ... | 231 |
| **News and Comments:** | |
| Reform of Medical Curriculam in Great Britain. ... ... | 233 |
| Government School of Indian Medicine. ... ... ... | 235 |
| Economy in Madras City Hospitals. ... ... ... | 235 |
| Admission to Medical Schools and Colleges. ... ... ... | 236 |
| Dental Profession. ... ... ... ... | 237 |
| Agency Duty ... ... ... ... ... | 237 |
| Anonymous information. ... ... ... ... | 238 |
| **Correspondence, Reports, etc.:** | |
| Chief Minister's Reply on Criticisms against Medical Administration. ... | 239 |
| The Tinnevelly District Medical Association, Palamcotta. ... ... | 240 |
| The East Godavari District Medical Association, Cocanada. ... ... | 241 |
| Bellary District Medical Association. ... ... ... | 241 |
| The Trichinopoly District Medical Association. ... ... | 241 |
| Statement of Pupils admitted into the Medical Schools and Colleges. ... | 242 |
| **List of Postings of Sub-Assistant Surgeons for the month of June, 1935.** ... | 242 |

# THE Medical Practitioner

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

VOL. VI.] JULY 1935. [NO. 10


## Original Articles

## *SOME COMPLICATIONS OF FRACTURES AND THEIR TREATMENT.


BY

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I propose to talk to-day about some complications of fractures and their treatment. A certain amount of injury to soft tissues around the fracture is usual and is to be considered normal. But when the injuries are extensive and injures an important structure in the neighbourhood, such as a main artery or a main nerve, it should be considered as a complication of the fracture. Similarly the fracture may extend into a joint, or in the young, injure the epyphysis. Then these require special attention on our part along with the treatment of the fracture. Otherwise, the after-effects are almost irreparable.

Infections from a concurrent surface wound whether communicating with the fracture and making it compound or whether it is superficial, lead to far-reaching after-effects unless properly attended to. These are mainly the complications one mainly meets with in a recent fracture. In cases that come to us late one usually meets with non-reduction of the fragments, malunion and deformity, wasting of the muscles, ankylosis of joints (complete or partial) fibrous or bony, tenosynovitis, delayed union or in some very late cases non-union. A few cases come with ischaemic contractures of various degrees, and a few with myositis ossificans.

Secondary or pathological fractures constitute a class by themselves, and in general very little treatment is possible for them.

*Treatment.*—In early cases, every case that comes must be properly examined and the extent of damages gauged. Skin wounds must be carefully looked for, and treated by thorough disinfection. In compound wounds, a thorough exploration of the wound and disinfection is absolutely essential. In this connection attention must be specially drawn to dangers of punctured wounds which have not been thoroughly explored and disinfected. More than once have I seen cases brought to the hospital within 24 hours of the injury with a punctured wound, which had been cleaned on the surface and dressed but in which gas gangrene had developed. One such case died within six hours of being brought into the hospital. In another case, an emergency amputation of the limb in a patient who was almost moribund saved life. In punctured wounds there should be no hesitation in excising the margins of the wound, and if necessary enlarge it for thoroughly exploring and disinfecting.

Some cases come grossly infected and with threatened gangrene. The threatened gangrene, in some cases is the result, not so much of the infection as of the faulty preliminary tight splinting or other treatment that had been followed. In threatened gangrene whether local surgical interference alone is required or whether the limb requires amputation, is entirely a matter to be

* Madras University extension lectures.

judged on individual cases. In the case of gas gangrene when present or suspected, there is no option but to follow the radical method.

Fractures involving a joint should be accurately set. Some of these will have extensive hæmorrhage into the joint cavity, which will prevent the limb being put into the position considered most favourable. In such cases a few hours after the injury when it could be safely presumed that actual bleeding process has stopped the joint should be aspirated under strict aseptic precautions, the limb put up into the desired position and a pressure bandage applied to the joint. If such a procedure is not done in most such cases a certain amount of ankylosis is sure to result. The blood that is effused organises and produces fibrous ankylosis. In other cases, from the injured articular surfaces of the wound callus may form and may result even in complete bony ankylosis.

Splinting of fractures have to be carefully done. Unduly prolonged splinting may lead to undue wasting of muscles, and this is often seen in many cases which come late to the hospital. Again splints applied too tight lead to interference with the blood supply and produce to various degrees that dread condition "ischæmic contractures".

Ischæmic contractures are seen far more commonly than they ought to be. The commonest cause I have seen here is a tight splint applied or a light pressure bandage put on in a case in which the fracture has not been reduced. Again and again, this condition has been seen in supra-condylar fractures, in which the limb has been put up forcibly in as much flexion as possible without reducing the displaced fragments.

If contractures are started, the affected muscles should be put in extension without any loss of time. In an early case with constant stretching movements and massage, very good improvement is to be expected. In late cases with confirmed contractures and marked deformity the results of treatment are unsatisfactory. With persistent manipulations, combined with such operative procedures of tendon lengthening etc., a few cases do show some improvement. With proper care, it is possible to avoid [illegible] ractures and in the cases that [illegible] is mos[illegible] either the result of inattention to details during treatment, or ignorance.

In mal-union, in early cases before callus has hardened, it is possible in some cases by manipulation and moulding (some-times with the aid of Thomas Wrench) to correct the deformity and set the fracture. In some others re-fracturing and setting is necessary.

In delayed union cases, the fracture does not unite in the normal period or within reasonable limits of time. They require careful investigation. Want of requisite amount of immobilisation (by too frequent attempts at adjustments) or insufficient splinting, (which ignores the effect of movements of the neighbouring joints on the fragments concerned, etc.,) or too wide a separation of fragments, especially with interposition of soft tissues, anæmias in general, or intercurrent diseases which call upon the patient's resources of recoupment or injury to the nutrient artery, or a mild auto-infection, or compound fracture and infection, last but not least injudicious and unnecessary surgical interference are the main causes. If the causes in a particular case are understood, treatment is, self-evident and need not be stressed on here.

In cases of compound wound, treatment in the open method and allowing to heal in immobilized position gives good results; the delay being due to delay in healing. But in these cases even after healing of surface wound a little mild infection lies latent in the wound and leads to osteomyelitis in a certain number of them – a condition not so very rare-either conservative treatment and waiting till the sequestrum separates is the best method of treatment in most of such cases. But whether early interference is necessary is a matter to be entirely decided by the conditions of individual cases.

Non-union is another complication which fortunately is rare. No case should be considered to be one of non-union till careful conservative treatments have been tried for at least a period of one year. In fact, they should be treated as cases of delayed union and all possible methods of stimulating callus formation should be tried (such as treating inter-current diseases and anæmias; causing mild local inflammation by autohæmic injections etc.) If unsuccessful then operative treatments should be considered. Exposing the ends and cutting away the fibrous tissue from both ends and freshening the surfaces, step-cutting if necessary or in other cases, auto-genous grafts from some other bone or sliding grafts from the same bones etc., may be tried and after the closing of the wound the limb immobilised with suitable splinting plaster casing or otherwise-and treated in the same as a new fracture. A certain amount of failure is to be expected in such cases, for the causes operating which produced the non-union primarily may still be present, the commonest cause for such failure being injury to the nutrient artery of the bone in the original injury. The role of mild infections in causing non-union must be kept in mind, and, in bone operations scrupulous asepsis in the operative procedure must be rigidly observed. If in spite of all these attempts, the bones failed to unite, then external corrective appliances may help to some extent. This is specially useful in the cases of fractures of lower extremity, especially below the knee. where walking callipers suitably modified may give the patient a great measure of relief. In the upper extremity especially in the fore-arm with both bones fractured even with the formation of a false joint, the limb is found useful for light work. How much one interferes in such cases is to be decided by the amount of utility of the limb.







## *DRUG ADULTERATION.

By

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The subject of Drug Adulteration is a very important one affecting the medical profession, but very little notice is taken of it by the profession. The medical man seems satisfied after giving a prescription to his patient and hardly takes trouble to see that the patient gets the purest medicines. Of course reputed Chemists and Druggists dispense the prescriptions very carefully and stock pure drugs and medicines. But most medicine vendors—and there are many such —hardly look to the purity of drugs they sell and they try to make as much profit out of the trade as they can. There is no proper control or legislation to check this indiscriminate selling of drugs in this country. Even virulent poisons such as arsenic, are sold in any bazaar.

This subject was brought up by the Government of India some 2 or 3 years ago and a committee was formed to thoroughly investigate the subject, but apart from a few desultory reports of their activities from different towns nothing has been heard of it since. It seems therefore that the Government were either unwilling or not ready to undertake definite legislation for the purpose of making certain that India should have drugs of a reliable and standard quality such as obtains in other countries. From my experience in India, I have found that the adulteration of drugs is increasing in these days to an alarming extent, and it will necessarily be the work of individuals to combat and if possible to remove this growing menace of unscrupulous profiteering in medicines. As we all know it is very necessary that we should have perfect faith in the quality and therapeutic value of the medicines prescribed to the patients; and only on that basis can we make any record of improvement or ascertain whether the treatment being given is suitable.

It is bad enough to know that certain foods can be adulterated and sold for large profits, but surely it is even a far more serious thing when we find the medicines also are being treated in this way. The foregoing statements are not mere talk, but in many cases I have verified by actual test the quality or rather the lack of quality in some of our common medicines, for instance, I purchased in Madras, a bottle of Quinine Sulphate with a label bearing a British name and a seal over the cork. To anyone who knows anything about Quinine, it was obvious at once that there was something wrong, as the contents of the bottle were coloured a beautiful rose colour and that colour is only produced in the Quinine sold by the Government of India. On analysis I found that about 50% of the so-called Quinine Sulphate was insoluble in dilute acid and on further investigation the impurity was found to be starch powder which costs about 3 or 4 as. per pound. It is true that the Quinine Sulphate was much cheaper than it should have been, but even then one was paying far more in proportion than by buying pure Quinine.

*Paper read at the Travancore Medical Association on 16th March, 1935, and specially contributed to The Medical Practitioner.

In another case, I purchased Ferri et Quinine Citrate, but could find no trace of Quinine at all. Similarly I have found Pot. Bromide labelled as Pot. Iodide, and needless to say the price of Bromide is only one fourth of the price of Iodide. These examples are all taken from firms who profess to be wholesale Chemists and Druggists, so if we cannot trust them, how can we expect the small shops who purchase from them and open the bottles and who wish to make a little more profit—to be any better, rather —I think we should expect to find more trouble than ever, and in this connection, I one day purchased Santonine from a small shop and found nothing but Boric acid crystals, also some Santonine lozenges which are nothing but sugar. You will surely agree that this is a serious state of affairs and one which should do all in his power to change. It is not an easy matter; for one thing, many of our patients take the prescription and obtain the medicine from their local places and in such a case, we do not know anything as to what they are taking.

I wonder if it would be possible for each district to have its own medical store where at least stock mixtures and various tablets of approved make could be dispensed, for out-stations one could draw small stocks from the main supply. The question of buying the main supply would have to be settled by arranging with some firm which has a reputation that they will not easily forego. I am thinking of someone like Spencer of Madras or Smith Stanistreet of Calcutta, and I am sorry that I do not know of any Indian firm that I could recommend at present. Of course in private practice it is very simple to prescribe some proprietary medicine which the patient may get anywhere, which is usually sealed. He cannot afford to buy these things; yet surely he should have reliable medicines just as much as the others. The above is the only means of insuring that they get pure drugs.

A few words only about legislation—Apart from using our influence to try for legislation in the matter of adulteration, it is even perhaps more important to push for some definite action to stop the practice of dangerous drugs being stored in any village kadai. Even in a Hospital like our own with many qualified men we are obliged to go through endless routine and trouble in order to obtain a few grains of Morphia or Cocaine, whereas, we may go up the road and buy such things as Arsenic or Strychnine and many other equally dangerous poisons with the greatest of ease.

I have seen only in Nagercoil one pound packets of these things stored anywhere with the papers broken and the powders leaking all over the other articles in the shop. Moreover, the public may go in and purchase whatever quantity they like without stating for what purpose it is to be used and without even being known to anyone in the place. Consequently if a case of poisoning comes along, no one is able to tell whether the case has been poisoned mischievously or whether it is an accident or even suicide, whereas in the western countries, the D.D.A. provides for all information being given for every grain of poison sold, and further it may be sold only by a qualified Chemist and Druggist.

I feel that if influential bodies such as medical associations, were to approach their local Governments and put this matter before them something could be done to make things more reasonable and this would result in a great service to humanity which is sadly needed to-day. I have not troubled to go into the details of either of these subjects, as my idea is at present simply to acquaint you with the bare facts, but if after consideration it is found that anything could be done, I should be only too glad to co-operate with you and give what help I could out of my considerable experience in drug matters in India and England.

# Abstracts

## THE MEDICAL CURRICULUM.

### LINES OF REFORM.

To-day appears the report of a conference which has met from time to time since December, 1932, to consider defects in the medical curriculum and ways in which they may be overcome. Its authors begin by pointing out that despite its imperfections the present curriculum is capable of producing well-trained and efficient practitioners of medicine. Their preponderance, however, depends on inherent qualities as much as on training. The more intelligent student is never likely to be handicapped by the faults





of a curriculum so much as his less gifted brother or sister. But the intention should be to give the student of average ability such knowledge and such education as will enable him to approach the problems of practice with some degree of confidence and put him in a position to learn from subsequent observation and experience. A scientific outlook, once acquired, will prove of more lasting value than a store of knowledge; at the same time it is impossible to inculcate general scientific principles without the introduction of many facts.

The conference has felt unable to recommend changes which would prolong the present minimum period of five years for a medical qualification. It has aimed instead at changes which will make it a continuous period of study, as little broken up by examination as possible, affording the student time and opportunity for self-education in spite of the efforts he is called upon to make in memorisation. It is hoped that under this regime his memory may prove equal to its burden, and that by developing at all points fields of association his mind may acquire that kind of culture which survives the forgetting of facts.

#### PRE-MEDICAL STUDIES.

The conference found that its dislike for early specialisation was shared by the scholastic profession. That a boy who has reached matriculation standard should spend his last two years at school almost wholly in the study of the natural sciences may not be undesirable, although it is important that the study of literature and languages should be continued up to the time of leaving. But it is a serious matter if intending medical students during their last two years are segregated in a small group, not only from the rest of the school, but even from other boys on the science side. The existence of "M.B. classes" at schools—small groups of boys who are engaged, not so much in the study of science, as in working through a prescribed syllabus in preparation for a series of small examinations—is a very unfortunate result of the present system. If all school boys and girls devoted a reasonable proportion of their time throughout the school period to the natural sciences there should be less need for a prolonged period of intensive preparation at the end of school life.

As a practical suggestion the conference would allow and encourage exemption from the 1st M. B. examination by means of the higher school certificate taken in the three principal scientific subjects and a subsidiary non-scientific one. In view of the variation of syllabuses for pre-medical examinations a common syllabus is recommended, whose chief modifications are a reduction in the amount of botany and of inorganic chemistry with the inclusion of some rudiments of organic chemistry.

It is agreed that medical studies proper (i. e., anatomy and physiology) should not be begun before the age of eighteen.

#### PRE-CLINICAL PERIOD.

No change is proposed in the present arrangement whereby the first two years of the medical curriculum are devoted to intermediate studies, leaving three years for the clinical period. It is believed, however, that rearrangements could be made so that the course would be more harmonious, consecutive, and interesting. To this end it is recommended that the work at this stage should be arranged by a board of teachers representing anatomy, physiology, chemistry bio-chemistry, pharmacology, and pathology. A suggested scheme of studies is the following:—

| FIRST YEAR. | SECOND YEAR. |
|---|---|
| *First Term* | *Fourth Term.* |
| Anatomy and Histology. | Physiology and Biochemistry. |
| Organic and Physical Chemistry. | Anatomy and Neurology. |
| *Second Term.* | *Fifth Term.* |
| Anatomy, Histology, and Embryology. | Physiology and Biochemistry. |
| Organic and Physical Chemistry. | Applied Anatomy and Physiology. |
| Physiology and Biochemistry. | Pharmacology. |
| *Third Term.* | General Pathology. |
| Physiology and Biochemistry. | *Sixth Term.* |
| Anatomy, Histology, and Embryology. | Applied Anatomy and Physiology. |
| | General Pathology and Bacteriology. |
| | Pre-clinical Examination (normally in June.) |

While it is essential that the student should become acquainted with laboratory methods of scientific research, should himself make experimental observations, and should be trained to carry out accurate

determinations as well as careful dissections, the relevancy of these requirements to his subsequent study of the living human body should not be allowed to escape his notice. The normal function of an organ can be described and observed in the course of physiological teaching, but it would form more permanent associations in the student's mind if variations from the normal could at the same time be demonstrated in the living human subject. Knowledge of the normal activities of the circulatory system observed in an animal or in normal man is amplified in a valuable way when compared with the results of a defect of the circulatory mechanism in man; the comparison not only reinforces memory and stimulates criticism but excites attention and interest. The demonstration of a hemiplegic patient will teach a student many facts about the physiology and anatomy of the pyramidal tract which cannot be learned in any other way. The conference holds that modifications in teaching anatomy and physiology along these lines would not only result in a better preparation for his later work but would make the curriculum appear less disjointed.

During the last two terms of the pre-clinicial period the gap between the intermediate and clinical studies should be bridged by examples of the applications of physiology and anatomy to clinical medicine and surgery and by an introductory course illustrating the principles of general pathology, immunology, and bacteriology. This proposal is made not with a view to initiating the student into the problems of clinical medicine but to enable him to appreciate the relevancy of his laboratory observations and experiments to the structure and functions of the living human body. At this stage the student should begin to practise the use of the stethoscope, ophthalmoscope, and otoscope and should gain experience of the relation of "physical signs" to the normal structure and function of the organs of the body.

*Anatomy.*—The conference has devoted earnest attention to the large proportion of the student's time which is spent in the dissecting room, and has considered a suggestion that it is unnecessary for every student to dissect the whole body. On this important question unanimity has not been reached. On the other hand, it takes the view that while dissection is valuable as a training in technique and a discipline, it can with advantage be supplemented by the use of models, by radiography, and by other methods. The teacher of anatomy could save the student's time if he had the opportunity of demonstrating the anatomy of the abdomen and thorax in the post-mortem room, and he should also be given access to hospital material for teaching applied anatomy, with or without the assistance of a clinician attached to his department.

In the past, it is felt, too much time has been spent and too great a stress has been laid on the memorisation of structural detail for examination purposes. It is therefore recommended that the student's acquaintance with the details of each part immediately after its dissection should be established orally by his teachers before he is allowed to proceed to the next, but the retention in his memory of all such minutiae should not be made the criterion of his fitness to pass on to hospital work.

*Histology.*—The idea prevalent in some medical schools that the object of histology is "to spot the organ" by a hasty glance down the microscope should be discouraged. The conference is of opinion that the student should have a practical knowledge of the more important methods by which material is prepared for microscopical examination, but thinks there is a tendency to spend too much time in the practice of technical details. The teaching of morbid histology would be made somewhat easier if during the teaching of normal histology the attention of the student were drawn from time to time to specimens illustrating the changes resulting from the reaction of tissues to chemical and physical influences.

*Organic and Physical Chemistry.*—The growing importance of a knowledge of chemistry in physiology, pathology, and medicine is universally recognised. Not only organic chemistry but physical and colloidal chemistry are essential for the medical student, and further instruction in chemistry is clearly necessary after passing 1st M.B. The conference holds that the teaching in this subject should be determined by conference in which the teachers of physiology, biochemistry, and chemistry meet together, due weight being given to





the opinions of the teacher of physiology on the special needs of the students of medicine. A special examination in organic chemistry is unnecessary, but questions in organic and physical chemistry should be included in the pre-clinical examination in physiology and biochemistry.

*Physiology.*—It is now an increasing and commendable practice in medical schools to lay stress on the physiology of man. The significance of these lessons, however, is often not realised and the medical student fails to recognise their importance when he is faced with their clinical applications. It is at this stage that co-operation with the clinical staff may prove essential. The object to be aimed at is that the head of the physiology department should have access to patients or command the services of some member of the clinical staff to give appropriate demonstrations. It should be made clear that the student at this stage is not in this way to receive instruction in medicine but in physiology. He should be shown patients, not as examples of disease, however typical, but as examples of deranged function, such as jaundice, oedema, cyanosis, breathlessness, or paralysis.

*Pharmacology.*—A knowledge of the physiological action of drugs is of primary importance to the student, and the conference believes that a short course of lectures and practical work on this subject is essential. While there should be no separate examination the candidate's knowledge should be tested either by the inclusion of pharmacological questions in the physiology paper and in the practical examination or by a viva-voce examination. A knowledge of doses should not be required from a student before he begins his clinical work, and in the pre-clinical teaching of pharmacology the therapeutic applications should be omitted except in so far as they are necessary to illustrate important principles.

*Pathology.*—As already indicated, the student should be introduced to the elements of general pathology, immunology, and bacteriology during the last two terms of the pre-clinical period. The object of this is to bring home to him the basic processes underlying the disorders of structure and function with which he is shortly to be faced at the bedside. The scope of this instruction should, of course, be a matter of agreement between the pathologist and physiologist, whose fields might otherwise overlap.

*Psychology.*—A course of about eight lectures introductory to the psychological aspects of medicine should be given during the last two terms of the second year. Attendance should be obligatory, but no examination should be held at this stage.

### THE PRE-CLINICAL EXAMINATION.

The pre-clinical examination at the end of the second year of the curriculum should test the student's general knowledge of the structures and functions of the human body and his acquaintance with the principles underlying simple reactions of its tissues to chemical and physical changes in their environment. The conference has been impressed by the high proportion of failures in examinations in anatomy and physiology, and believes that their number could and should be reduced, not by lowering the standard but by altering the methods of teaching and examination. Knowledge of detail should be tested orally by the teacher before passing on to a new part of the work, and success in the pre-clinical examination should depend not on a mere feat of memory but rather on such grasp of the structure and function of the body as is a necessary equipment for hospital work. Since instruction in elementary general pathology is to be included in the pre-clinical period the student's knowledge of this subject should be tested in the examination. The board of examiners should represent anatomy, physiology, pathology, and pharmacology, and they should meet and co-operate in setting their questions

### CLINICAL PERIOD.

The supreme value of periods of clerking and dressing in the general wards remains unchallenged. It must be recognised, however, that medicine is becoming, and should become more scientific and less empiric. The scientific standards and methods of thought inculcated in the pre-clinical years should be carried into the wards and applied at the bedside and in the laboratory. For this reason it is hoped that applied physiology and anatomy will be carried through the whole of the medical course, and also that pathology will be taught throughout the clinical period, in close association with all

the branches of medicine, and not be regarded as a special study.

There is in all large hospitals a mass of clinical material ready to hand for the study of minor ailments and much to this passes in and out of the casualty and out-patient departments unused. In special departments such as those dealing with the diseases of the eye, the ear, the nose, the throat, and the skin, the student may, under proper guidance, absorb a large amount of useful information and experience if he is encouraged to do so. But he knows that there is little likelihood of his being confronted with an "eye case" or a "throat case" in his final examination and is often content to run the risk of exposing his ignorance in these directions. The remedy appears to lie in having representatives of the special departments on the board of examiners and the fear of their expecting too much specialised knowledge from students need not be entertained if they examine in association with general physicians and surgeons. On the other hand, their co-operation would lead to the newly qualified practitioner being more familiar with the use of instruments, such as the ophthalmoscope and the laryngoscope and with common disorders of the sense organs which will form a big part of his work in general practice. Much of the time now spent in watching major operations might be more profitably used in attending the casualty department.

The teaching of *preventive medicine* will be adequate only if its importance is realised by teachers throughout the whole curriculum. The professor of physiology will demonstrate the scientific basis of personal hygiene; the teacher of pathology will emphasise the advances which have come from bacteriological and immunological research; the clinician will find innumerable opportunities for instruction in preventive medicine; while obstetricians and paediatricians must explain the practitioner's functions in relation to such matters as antenatal work, the conservative conduct of labour, the management of the puerperium, and the care of the child in its early years. In addition a short course in public health and State medicine, including forensic medicine, should be given mainly by a member of the public health service selected for his ability to teach. (The syllabus of such a course is outlined.) It is suggested that some of the lectures might be given by an experienced insurance practitioner, and some by a man skilled in medico-legal work.

*Medical psychology* has already been introduced to the student. Now, during the clinical years, he must become familiar with the psychological aspects of patients in the hospital, and with this object demonstrations should be held at least once a fortnight throughout the period of in-patient clerking and in-patient dressing. In every ward there are many patients suitable for teaching of this kind, and in some schools such demonstrations have long been in force with great success. The physician or surgeon in charge of the ward may undertake them himself or may hand over that duty to a colleague attached to the hospital for the purpose of teaching medical psychology. In this way the teacher of medical psychology may be able to draw upon the material in the hospital as a whole for teaching purposes, and by selecting patients whose condition is not primarily one of mental disorder he can bring the psychological features of illness to the student's notice. Besides such instruction attendance should be required at not less than six demonstrations at a mental hospital, where the student can observe the general aspects of advanced insanity, and the working of an institution for the care of the insane and mentally defective.

In the final qualifying examination adequate knowledge of the psychological aspects of ill-health should be expected from the candidates and should be thoroughly tested, not only in written papers but in the clinical and oral parts of the examination.

*Pathology* must be taught with two objects in mind. First, to give the student such a grasp of its importance that he will come to think at the bedside instinctively in terms of pathology, and, secondly, to give him such an interest in the science of pathology that he is alert to follow its progress and ready to avail himself throughout his career of the advances in pathological theory and their application. To ensure the latter the student must attend set courses





in pure pathology and spend enough time in laboratory work to learn something of its technique and experimental methods. To provide for the former he must throughout his clinical course renew his acquaintance with morbid processes as they are associated with physical signs. The conference is of opinion that the student will be helped to grasp the true importance of pathology and its bearing upon his practice if the examination in this subject—instead of being something separate, which can be passed and left behind is made part of the final examination.

### Final Examination.

There is much to be said for a final examination in pathology, medicine, surgery, and obstertrics, the whole to be passed at one time. But experience has shown that few students are able to do themselves justice in so stern a test; and while it is very desirable to preserve the unity of pathology, medicine, and surgery by combining them in one examination, it is felt that obstertrics, gyæcology, and disorders of infancy might well be taken separately. Modern conditions of practice make the recently qualified practitioner a consultant in obstetrics, and for this reason it would in fact be a real advantage if the test of knowledge in this subject were made the last step in the whole curriculum. And to a certain extent the same may be said of public health and State medicine.

The conference therefore recommends that the final examination should consist of two parts:—1. Medicine, Surgery, and Pathology.

II. Gyanæcology, Obstetrics, and Paediatrics; Public Health and State Medicine, including Forensic Medicine.

Both parts may be taken at the same time, or a candidate may enter for Part I alone; but no one will be held to have passed Part II until he has passed Part I. The examination will include a test of the student's knowledge of the physiological therapeutic aspects of pharmacology (including toxicology.)

The final examination, it is suggested, should be conducted by a board of examiners who are to meet and co-operate in setting questions so that the papers are reasonably balanced. The pass list should be prepared at a meeting of the board at which all are present. The examiners in Part I might include representatives of medicine, surgery, pathology, medical psychology, dermatology, ophthalmology, oto-rhino-laryngology, and orthopædic surgery (including manipulative surgery); and in Part II: obstetrics and gynæcology, pædiatrics and disorders of infancy, and public health and State Medicine (including forensic medicine). The conference is agreed that such a board would secure a better all-round education for the medical student, by a more thorough test of his knowledge of general medicine and surgery, without in any way adding to its difficulties. And incidentally it recommends that more time should be allowed for the clinical and viva-voce parts of the examination than is usually given at present.

### Post-graduate Clinical Experience

The conference holds that a medical student after passing the final examination should spend at least six months as a resident medical officer in an approved hospital before entering on private practice. It hopes that in the near future the number of such posts available to recently qualified men and women may be sufficient to make a statutory obligation of this kind practicable.

(*The Lancet, May, 18, 1935.*)

## Notes on Therapeutics, Diagnosis and other Medical Subjects.

### *Filariasis.

By S. Sundar Rao.

*Scholar, Filariasis Research Department, Calcutta School of Tropical Medicine.*

In India Wuchereria bancrofti infection is common chiefly along the sea-coast and along the banks of big rivers with the exception of the Indus. Elevated regions, as also those that are situated to the north of the line joining Karachi and Delhi are free from infection. The distribution of infection shows a marked variation which is determined only by the factors of endemicity viz. (1) Atmospheric conditions-a temperature of 90 °F and humidity of 90% (equivalent to conditions during monsoon months) being the optimum—the parasite

* Paper read at the 15th Andhra Medical Conference.

taking only 9 days to complete its development in the intermediary host. (2) Density of mosquito population—the number of breeding places in the locality of Culex fatigans which is the chief carrier of this infection in India, and (3) Density of human population—crowding as in towns. In general, towns show the heaviest infection; cities less heavy and villages are generally free.

The adult parasites live in the large lympatic vessels and glands. The male worm is 30—40 mm long and the female 70—80 mm long. Embryo which is about 200/u long lives in the blood and—exhibits nocturnal periodicity. The stage in the development of the embryo for which it has essentially to pass through the insect host—Culex fatigans—requires 9 days under the optimum climatic conditions. The period however is lengthened to 14 days in summer months and 22 days in the winter.

In the early stages of the filarial infection the presence of a mild toxin can be demonstrated by the complement—fixation test; yet no signs or symptoms are observed and in the majority of cases the infection is discovered accidentally. Eosinophiles show an increase on the average 10% and sometimes 60% or more. All the while, as a result of irritation of the inner lining of the lymphatic vessel by the toxin slow pathological changes take place which brings about partial block due to cellular infiltration and ultimately ends in the formation of lymphvarix and chyluria. Lymphangitis in the limbs or genitals and anaphylactic symptoms complained of by patients as recurring periodically are due to this toxin.

Secondary infection takes place at a later stage and the organisms commonly found are strepto or staphylococci. In the case of infection by the former the reaction is severe, whereas the latter gives rise to milder reaction and ends generally in abscess formation.

Lymph stasis in limbs and fibrosis ends in the formation of Elephantiasis which is aggravated by secondary infection from the skin.

Lymphangitis can therefore be classified according to whether the attack is due to the toxin (Toxic type) or the secondary infection (Septic type). In the toxic type the microfilariae are invariably present in the blood, there is Eosinophilia, the W. B. C. count is normal and Complement—fixation test is positive. In the latter type, there is no embryo in the circulation, no eosinophilia, there is leucocytosis chiefly of the polymorphonu clear type and the complement—fixation test is negative.

The treatment for the prevention of recurrence of the attacks consists of the use of compounds of Arsenic or Antimony in the former type and vaccines in the latter type.

In septic types of cases the focus of secondary infection has to be looked for and eradicated. Immunise the patient with auto-vaccine wherever possible or give stock vaccine of mixed streptococci and staphylo-cocci.

The treatment of acute attack of lymphangitis consists in rest and the application of sedative lotion to the inflamed area.

In Elephantiasis in addition to vaccines the application of pressure bandage is helpful. Operations for the drainage of lymphatics, have not been successful. Eradication of focus and immunisation of the patient with auto or stock vaccine, tonics, diathermy and pressure bandage are the measures which if persistently applied yield satisfactory results.

(*See page 225*).





# CLINICAL NOTES AND PRACTICAL SUGGESTIONS.

## Treatment of different kinds of Neurosis.

The treatment of neuropathic subjects sorely tries the patience of doctors who go on prescribing several remedies in order to fight against the various pathological manifestations of different forms of neurosis and other organic nervous affections. A single remedy, which is complete and which allows the patients complete relief from the afflictions caused by the disease, and at the same time builds up and revives the nervous system, is very essential and this aim is perfectly attained by Elixir Bromo-Valerianate, which avoids the annoyance and trouble of the patients having to use every day and at all hours different remedies under various forms. In this product the antispasmodic and the nervine tonic properties of Valerian are combined effectively with the sedative action of Strontium Bromide. Through the administration of Elixir Bromo-Valerianate it is possible to obtain very easily and effectively the calming and at the same time tonic treatment for patients suffering from functional as well as organic nervous affections.

The fundamental and chief action of Elixir Bromo-Valerianate depends on therapeutic efficacy of Strontium Bromide which acts almost as a specific when dealing with nervous diseases. The activity of this bromide is further increased by that of Valerianic acid and the extract of Valerian with which it is associated. The antispasmodic, sedative and tonic action of Valerianic acid and the extract in all kinds of neurosis is well known. This remarkable pharmacological action and therapeutic activity of the preparation is due to the fact that extracts of fresh juice of Valerian and pure Strontium are employed. This Elixir represents a well-proportioned combination of Bromides with Valerian and consequently it has an excellent tonic action on the nerve cells, added to which there is a suitable sedative action. The Valerianic acid and the extract of Valerian have a synergic action on the nerve cells. Again Strontium and other bromides and these Valerian products have pharmacological actions which make up an efficacious whole, as with the distinctly sedative effects of the halogen are associated in a satisfactory combination the tonic effects of Valerian, and thus the calming and balancing actions on the nerve function are brought about in a satisfactory manner. Any taste or flavour of the Valerian extracts has been fully disguised with Syrup of Orange which makes the preparation quite palatable This Elixir has indisputably certain curative properties in many organic and functional nervous affections, in which lack of equilibrium is usually associated with decline of organic cells. This Bromo-Valerianate Elixir, due to the excellent combination has become a classical remedy for the very frequent forms of neuropsychical disturbances, which are characterised by over-excitement accompanied by insomnia, nervous decline or mental confusion.

The ingredients in this preparation correspond very well to what is required in the group of the neurotic or nervous complaints described above, and hence it is very valuable in the most varied mental diseases such as epilepsy, hysteria, chorea and certain groups of affective psychosis forms.

The therapy of epilepsy is at present mainly symptomatic, the chief aim being to reduce the number and strength of the fits to keep the patient free from them, to render him capable for work and to prevent psychic alteration as far as possible. All these aim can be achieved by regular administration of Elixir Bromo Valerianate. The therapeutic effects of this Elixir in Epilepsy is far superior to Bromides, as it has an anti-epileptic action without any hypnotic properties. This Elixir in properly regulated doses can be taken for months or years without the patient being continuously in a condition of drowsiness and inability for work. This preparation controls epileptic seizures which soon become a few and far between until the patient is completely cured. It can therefore be considered a specific in this disease.

Another field of activity of this Elixir is Hysteria. Its favourable influence in this type of psychosis is really conspicuous. After its administration for some time the number of attacks of fits are considerably reduced until they are banished altogether. The psychic alterations become evident after a prolonged course of this treatment. In fact there is marked improvement in the psychic behaviour of the patients. Increased tendency to attacks due to

psychic excitement or emotions is obviated by this Bromo Valerianate medication.

Neurasthenia, Hypochondriasis and similar pathological states can be treated successfully by means of Elixir Bromo Valerianate. The numberless somatic disturbances and symptoms in patients suffering from the above complaints can be banished with this remedy, provided the causes of the morbid determinism are removed. The apt and rational composition of this remedy makes it possible to overcome all these complaints. Due to the calming and sedative action of this Elixir the patients get considerable relief from the disturbances. They improve to such an extent that after a month or two of this treatment the nervous system gets a renewed tone. This remedy has been found a rational therapeutic agent to meet the various manifestations of these forms of neurosis.

Further, this preparation has a decided curative value in various neurotic syndromes and states of neuro-psychic irritability characterised by lack of equilibrium of the nerve function and vital decline of all organic cells. Specially in patients with hereditary predisposition to insomnia and irritable weakness of the nervous system, to confusion of mind and lack of equilibrium in general, this Bromo-Valerianate has a notable curative importance.

In alcoholism and drug addiction this Elixir Bromo Valerianate serves as an excellent sedative. It has been found to overcome restlessness and induce sleep in these patients. In cases of drug addiction it effectively allays the excitement and discomfort which follow the withdrawal of habit-forming drugs.

In short, if after careful examination it has been found that we have to deal with functional disturbances of the nervous system with exaggerated nervous irritability or excitability, this Elixir should be exhibited as it has proved of valuable service.

Besides the double treatment of being a sedative and tonic to the nervous system, that this Elixir offers, it has various advantages which are really very important. The Strontium Bromide in it is absolutely well tolerated and unlike other bromides has no depressing action. It has, on the other hand, an excellent calming and moderating influence on the nervous system. This is due to the absolute purity of the Bromide salt employed in this Elixir. Due to the inclusion of Syrup of Orange this preparation has an excellent taste and is taken readily even by children. Skin eruptions, digestive disturbances etc. following the use of this remedy have never been observed, even when it is administered for years. It is entirely free from any troublesome secondary effects. In properly measured doses it can be prescribed continuously for months and years without giving rise to injurious by-effects. It has no marked hypnotic properties and therefore undisturbed continuous occupation is possible for patients undergoing this Bromo-Valerianate treatment. The patients are less depressed and are always fit for work.

Elixir Bromo Valerianate has become a classical remedy in the group of various psychic and neurotic affections, where the rapid building up and tonic action and the return of functional equilibrium of the nervous system is required. It is far superior to other similar preparations on account of its prompt and sure effects and the progressive and lasting character of the improvement.

Clinical experience has confirmed the above claims made of the product as is seen from the following case which is one amongst many :

The patient was a young woman of 32 with neuro-psychopathic hereditary conditions. She was subject to various disturbances mostly due to her impulsive and irritable nature. For sometime in the beginning she used to get some sort of attacks when her mind was completely obscured and she was in the habit of talking irrelevantly at this time. Later on she began getting fits with a tendency towards hysteria. These were accompanied by disturbances of the mind, disordered movements and general exaggeration of symptoms. During these fits, which used to last for long time, there was Opisthotonus, meteorism, vomiting, globus and erotic attitudes. Owing to the constant repetition of these attacks she had to seek medical advice. Being a little anæmic I started Hypercytol injections, which were given on alternate days. Along with this, Elixir Bromo Valerianate was prescribed and she was having one tablespoonful in a little water thrice daily before food. After finishing one bottle the fits, though they did not cease, used to come with very little intensity or severity. The intervals also began to be lengthened.



This treatment was continued for three months after which the fits were very few and far between and they hardly lasted for ten minutes. She had a feeling of decided improvement after four months of this treatment and her psychic condition had improved remarkably. She was no longer anæmic and the fits did not harass her any more after six months of this combined treatment of Bromo-Valerianate and Hypercytol.

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## Biomucine.

Its indication in gastric disturbances—such as Gastric Ulcer, Duodenal Ulcer and certain forms of Gastritis.

The above mentioned disorders arise from a disturbance of the normal mucous membrane lining the gastric region. This mucous membrane contains innumerable glands which secrete a mucus which is essential for maintaining the gastric region in a condition which will allow normal digestion to proceed. We also have mucus secreted in other regions of the gastro intestinal tract, but the properties and function of the mucus varies according to the region in which it is located.

The mucus which is secreted in the gastric region is viscid and strongly resists the action of the gastric juices. The function of this mucus is a protective one; this it accomplishes in a physiological and chemical way. Thus physiologically on account of its viscosity it mechanically protects the gastric mucosa against irritation from coarse particles of food material, further, it prevents the gastric juices from attacking the mucosa.

Chemically it exerts a protective action through its property of absorbing acids, particularly hydrochloric acid, converting the hydrochloric acid into a colloidal form which restricts its ionic activity. In many affections we find a disturbance of the normal secretion of mucus, the secretion being of a poor quality or reduced in quantity, both conditions resulting in reduced protection of the gastric mucosa.

Among the most commonly occurring and serious disorders which appear to originate through inadequate protection of the gastric mucosa, are gastric and duodenal ulcers, also post operative peptic ulcers. The aetiology of these primary and secondary ulcers are closely bound together and observations arising from many gastrojejunal operations afford substantial support to the theory that these ulcers are the result of the action of an excess of gastric acids upon the mucosa. Thus in cases of high gastrectomy there is a permanent reduction of acid secretion, following which the occurrence of ulcers is very rare. Again after operations for carcinoma the secretory function of the mucosa is greatly reduced or abolished, in these cases ulcers never make their appearance. Furthermore the ulcers are invariably situated in the region of the alimentary tract which is exposed to the action of Hydrochloric Acid. They never occur when the acid secretion is congenitally absent or lost through chronic gastritis, cancer or other causes.

In a number of cases the presence of hyperchlorhydria has not been established, but this may be due to the onset of gastritis following ulceration causing hypochlorhydria.

When the mucus secretion is below the normal standard the walls of the stomach have an inadequate covering of this protective mucus, consequently the pyloric region of the stomach becomes hypersensitive to food material and this promotes an increased secretion of Hydrochloric Acid and pepsin by the glands in the fundic region of the stomach. This condition of reduced protection facilitates the corrosive action of the gastric juices on the mucosa, and unless the condition receives early and appropriate treatment a gastric or duodenal ulcer may be formed, these developing into the chronic variety if neglected,

Defective mucus secretion may be associated with various infections or septic foci, such as the teeth and tonsillitis in which case toxins may enter the stomach and damage the mucosa. Gall bladder infections and stasis may also produce gastric inflammation or ulceration, due to bacteria working their way into the stomach and attacking the mucous membrane in the pyloric region which is the region where the mucous glands are situated. Irritants taken by the mouth and endogenous poisons of metabolic origin may attack the mucous membrane and induce inflammation.

Coarse particles of food material are sometimes responsible for the onset of inflammation or ulceration of the mucous membrane, due to their mechanically removing some of the protective mucus, thus exposing the membrane to further friction, also to the direct corrosive action of

Hydrochloric Acid and pepsin.

Despite the variety of causative factors, there is one feature of the treatment which is essential in all cases: that is, the ulcerating or inflamed area must be as free as possible from irritation. The absorbent alkaline powders such as bismuth and kaolin have largely been employed for this purpose, but the introduction of Biomucine represents a far more suitable and rational form of treatment.

Biomucine is an absolutely pure and sterile mucin obtained from the gastric mucosa and its introduction provides the gastric region with the pure natural mucin which is its normal protector, but which is lacking in these disorders. Taken in the prescribed manner with the dose graduated according to the severity of the disorder, Biomucine will effectively coat the gastric region and alleviate irritation which may arise from food ingested, while it also protects the lesions from the irritating and corrosive action of Hydrochloric Acid and pepsin. Biomucine will not hinder the secretion of Hydrochloric Acid and pepsin in the fundic region but permits its diffusion as found under normal conditions, at the same time neutralising, or, to be more correct absorbing and converting into a colloidal state with a restricted ionic activity, excess acid, which in the presence of an imperfectly protected membrane causes the development of ulcers or prevents their healing.

In cases where the stomach is hypersensitive to contact with food material and consequently produces excess of Hydrochloric Acid, Biomucine will provide an additional protective layer thus reducing the sensitivity of the pyloric region of the stomach and the excessive secretion of gastric of juice.

The treatment of these conditions of gastric hyperacidity, gastric and duodenal ulcers requires that medication should afford adequate protection without increasing gastric secretion and in this connection Biomucine is superior to the alkalies. General opinion appears to be in agreement that alkalies (notably the corbonates) cause an immediate reduction in acidity which is later followed by increased secretion of gastric juice, in the case of carbonates this is very pronounced due to the carbonic acid formed, increasing the sensitivity of the pyloric region, which reflexly stimulates secretion of gastric juices from the fundic region of the stomach. However Biomucine is entirely free from this drawback since it represents the natural protective secretion which emanates from the glands in the pyloric region, covers the mucosa and reduces its sensitivity.

Another disadvantage connected with the alkalies is that they may completely neutralise the Hydrochloric Acid and thus prevent the activation of pepsinogen which is followed by a disturbance of digestion while Biomucine is not a strong ant-acid and does not hinder digestive processes.

When we consider the absorbent powders such as Bismuth and Kaolin which are so freely prescribed in cases of hyperacidity and ulceration we have similar disadvantages associated with their administration. Thus, they tend to form an impermeable covering over the wall of the stomach and so considerably hamper secretion of gastric juice and digestive processes. Furthermore these powders accumulate in the intestine and promote constipation, a condition which should be avoided in these gastric disorders since constipation favours intestinal bacterial activity and where acidity has been neutralised it may permit bacteria to work their way up into the stomach and attack the mucosa in the pyloric region thus causing an exacerbation of symptoms which may be responsible in some cases for the disease assuming a chronic nature. Biomucine is entirely free from this detrimental action, in fact it assists in the promotion of regular bowel movement.

It is important that treatment is not delayed, employed half-heartedly or for an insufficient period and if these conditions are carefully observed the results obtained with Biomucine will be found highly satisfactory; but any infection or septic foci must receive the necessary attention early.

It is essential in all cases of gastric and duodenal ulcers that treatment should be continued over a lengthy period and this is possible with Biomucine without the occurrence of any disagreeable secondary symptoms. Biomucine will effectively cover the mucous membrane and quickly relieve pain by protecting the lesion from particles of food and from the action of the gastric juice; it produces no disturbance of digestion, but reduces hyperacidity and promotes normal bowel activity; factors which combine to render Biomucine one of the most suitable forms of treatment for these disorders.



*(Continued from page 224.)*

## *Bacteriological Investigation in the Diagnosis of Disease

BY

B. P. B. NAIDU, M.D., (EDIN.) M. H., D. T. M., D. P. H., (L'pool).

BOMBAY.

Although the importance of bacteriological investigation in the diagnosis of disease is universally recognized and such examinations form an essential feature of our modern hospitals, yet, in private practice, it is only the consultant who insists in cities like Bombay and Calcutta, on such an investigation to arrive at a definite diagnosis. To meet this demand there are a number of well-equipped and privately owned laboratories in these cities. As regards the general practitioner he looks upon such investigations as an unnecessary costly aid to his bedside clinical diagnosis and is content with an occasional examination of the urine or blood of his patient. To illustrate the importance and the necessity for bacteriological investigation in diagnosis three cases are here very briefly referred to among the many that have been observed because of their special interest.

No. 1. A CASE OF GOAT FEVER (UNDULANT FEVER):—

A well known Parsi Solicitor of this City who was on a short visit to the Punjab developed continued fever soon after his return. His family physician had the patient's blood examined for parasites with negative findings; he then suspected the case to be one of typhoid fever and called in a consultant. Bacteriological examination of the blood of the patient was ordered, blood cultures were sterile and Widal tests for the enteric group of organisms negative. No parasites were found in the smears of blood. A few days later another bacteriologist was called in to repeat the examination of blood. While this bacteriologist was taking blood for culture the attendant on the patient remarked that the patient, while at the Punjab, used to drink goat's milk. This suggested the possibility of the case being one of undulant fever. A blood culture and a culture of urine were made. The urine gave a pure growth of Micrococcus melitensis. The cultural examination of the urine was repeated two days later with identical findings. Thus a definite diagnosis of undulant fever was made by bacteriological investigation.

No. 2 A CASE OF PARROT FEVER (PSITTACOSIS):—

A Parsi lady, wife of a medical practitioner, developed continued fever. The family physician had her blood smears examined for parasites with negative results. The temperature chart of the patient suggested enteric and, therefore, he suspected her to be a case of typhoid. A consultant was called in who ordered a bacteriological investigation of the case. The blood proved sterile and no parasites were found in the blood smears. Widal tests also proved negative. On the seventh day of the fever the patient began to get drowsy and exhausted and showed signs of commencing pneumonia. A bacteriologist, a personal friend of the patient's husband, was called in to see the case. While the examination was in progress the husband casually remarked that some days prior to his wife's present illness she purchased a green parrot from a street hawker and that while she was feeding the bird it bit her finger and drew a little blood and that she immediately applied tincture of iodine over the bite. Subsequently the bird sickned and died, three days prior to his wife's illness. This suggested the possibility of her suffering from parrot fever. Therefore a healthy parrot was inoculated intramuscularly with 0.75 cc. of the patients blood and was kept under close observation. The bird fed well and remained bright and healthy during the first three days On the fourth day it was off its feed and dull, with a greenish diarrhoea which sometimes contained blood. On the fifth day it was off its perch, disinclined to move, with wings drooping and the feathers standing open and having lost their gloss. The eyes were closed and the bird hid its head under its wing. It showed signs of great weakness. On the sixth day the bird was lying flat, apparently paralysed, on the floor of the cage, in one corner. Convulsions set in and the bird died on the same day.

The lungs, liver and spleen of this parrot were ground to a fine emulsion and passed through a sterile L. 3 candle. The filtrate, in a dose of 1 cc., was injected intramuscularly into a second healthy green parrot.

*Paper read at the 5th Andhra Medical Conference.

Like the first it manifested all the signs and symptoms of parrot fever and died on the sixth day following the injection.

The lungs liver, and spleen of the second parrot were ground to a fine emulsion and passed through a sterile filter candle (L. 3) and the filtrate was injected into a third healthy bird in a dose of 2 cc. This bird also developed signs and symptoms similar to those of the first and second and died on the sixth day with convulsions.

The lungs, liver and spleen of the third bird were ground into a fine emulsion filtered through an L. 3 candle and 2 cc. of the filtrate was injected into another healthy bird. It began to pass bloody diarrhoea on the fifth day of injection. On the 6th day it was off its perch and on the seventh day it died in an apparently paralysed condition.

Signs and symptoms observed in these birds showed that they were all typical of parrot fever. Further passages were discontinued as the causative agent in this disease is a filterable virus contracted by man from his association with sick birds. Hence a definite diagnosis of psittacosis was thus made.

No. 3. A CASE OF BUBONIC PLAGUE WITH SECONDARY PNEUMONIA DIAGNOSED AS SEPTIC PNEUMONIA :—

A young man who was bound for Pakur from Calcutta received a needle prick from an unknown man on his right shoulder. A few minutes after the prick a drop of yellow fluid oozed out. Three days after he developed glandular swelling nearest to the region where he received the prick, attended with high fever. He immediately came to Calcutta for treatment. A consultant was called in, who ordered a blood culture. While the cultural examination was in progress the patient died. A death certificate was given on clinical appearances as septic pneumonia for purposes of cremation. Subsequent laboratory diagnosis proved that death was due to plague, isolated from the blood of the patient. This led to the prosecution of what is known as the Pakur Murder Case.

These three instances will convince the general practitioner how important it is that a thorough bacteriological examination should be called for in the diagnosis of disease.

# MADRAS MEDICAL COUNCIL.

## REVIEW OF WORK FROM OCTOBER 1933 TO MARCH 1934.

BY V. RAMA KAMATH,

*Member, Madras Medical Council.*

The readers of The Medical Practitioner might remember that last year I gave an account of the work transacted by the Madras Medical Council for two years including March 1933 session. Till now it was not possible for me to review the proceedings of the Council. Session after session as the affairs of the office of the Registrar were so unsatisfactory that at times it took a couple of years or even more for the council to complete a particular proceeding and the proceedings of a particular session being confidential till they were confirmed at a subsequent session, I could not get sufficient material to comment earlier than once in two years. I intend reviewing the work under the same heads as it was done in the previous years.

### STAFF.

Major-General Sprawson continued to be the President of the Council till October 1933 session. He was succeeded by Major-General Sir F. P. Connor. The term of office of Major E. W. A. Coshan who succeeded Dr. Chatterjie on 22nd September 1932 was terminated by the Council on or about 9th April 1934, the Council having appointed Mr. J. P. Pinto, B.A., as part time Registrar. Mr. Pinto is the senior Superintendent at the office of the Surgeon-General and is paid Rs. 100 for the part time work. The full time Registrars were paid Rs. 200. The part-time Registrar had been conducting the business of the office so satisfactorily that there will be little or no room in future for complaints either by the members of the Council or the members of the profession who are in the Medical Register. As reported in the 'News and Comments' columns of The Medical Practitioner, last January the Medical Register for Madras was published for the first time on the due date, an achievement of which the new Registrar may justly be proud of, as his predecessors did not publish the Registers in time in spite of their being the full time officers of the Council. The Council has to be thankful to Major General Connor for permitting one of his capable subordinates to do part-time work for the Council. The conversion of a full-time Registrar to a part-time one has not only brought economy but efficiency too at the office of the Council.



### REGISTRATION.

The affairs of office of the Registrar did not much improve during the brief period of office of Major Coshan. He took charge on 22nd September 1932 and was not able to publish the Register for the year 1932. There were complaints from practitioners about the delay in registering their names in the Medical Register. Some of them also complained that the Registrar did not even acknowledge receipt of their communications. Though it has to be said that the cause of delay in registering the practitioners were not of such serious nature as was the case during in regime of the office of Dr. Chatterjei, when the Council did not like the idea of questioning Dr. Chatterjei for the cause of delay in registering the practitioners and which eventually cost the Council Rs. 5,000, I thought it was desirable to move the following resolutions which I did at the October 1933 session of the Council and all of them were passed unanimously.

**1. The Council is of opinion that the Registrar should be able to register a practitioner in the Medical Register within 8 days after receipt of his application in case all the necessary conditions for such registration are fulfilled by the practitioner.**

**2. The Council directs the Registrar to acknowledge in time the receipt of communications received by him.**

**3. That a Committee consisting of Drs. U. Rama Rao, S. Rangachari, M. R. Guruswami Mudaliar and the mover of this resolution be appointed to find out the cause of delay in publishing the Medical Register in time and to report to the Council at its next meeting as to what steps should be taken in future to enable the Council to publish the Register within the time fixed in the Medical Registration Act IV of 1914.**

The total number of registrations at the beginning of 1933 were 213 in Part I, 1159 in Part II and 3614 in Part III and at the end of 1933, 223 in Part I, 1214 in Part II, 3771 in Part III.

### RIGHTS AND PRIVILEGES.

While reviewing the work of the Council last year, I mentioned that I moved a resolution requesting the Government to treat all registered medical practitioners alike with regard to the certificates, and that this resolution was passed after prolonged discussion inspite of the then President, Major-General Sprawson leading the opposition. It is not known whether this resolution was communicated to the Government. Previous to the regime of the present Registrar the office had been in a much topsyturvy condition that it is impossible to find out what was done and was not done by the previous Registrars, with regard to the proceedings of the Council. After enquiries I hope to be able to get some definite information on this subject in the near future. At the last session of the Council in March last I moved the following resolution which was unanimously passed.

**The Council respectfully points out to the Government that countersigning of vaccination certificates issued by Registered Medical Practitioners to the passengers embarking out of India, by a particular class of Government Medical Officers, is against the spirit of the Medical Registration Act and requests the Government to withdraw the circular published by the Director of Public Health on this subject.**

As the subject of the resolution affected those in service also it was possible to get the support of the whole Council for this resolution.

### DISCIPLINARY CASES.

In 1933 at the March Session of the Council Drs. M. R. Guruswamy Mudaliar, T. Krishna Menon and V. Rama Kamath were appointed by the Council as members of the Preliminary Committee for Penal Cases with Dr. V. Rama Kamath as the Convener, the term of office of this Committee being 14 months. Dr. V. Rama Kamath ceased to be a member of the Committee due to efflux of time, his term of office having expired in July 1934 and was re-elected as a member and convener in 1934 at the October Session of the Council. The Council decided also to re-elect Drs. M. R. Guruswamy Mudaliar, T. Krishna Menon and V. Rama Kamath for another period of 14 months from first January 1935. In the vacancy caused in the Committee on account of the sad death of Dr. T. Krishna Menon, Dr. T. Satakopan was appointed as the member of the Preliminary Committee. In 1933 at the March Session 5 cases came for the final decision of the Council. The first was a complaint against two practitioners in the city of Madras for alleged criminal abortion. The person concerned being a nurse of one of the city hospitals; the information came through the then Surgeon-General. The matter was reported to the Inspector-General of Police by the Surgeon-General and a reply came

from the head of the Police Department that there was no *prima facie* case. The Preliminary Committte in 1932 consisted of Dr. F. J. Dyson, Lt. Col. K. G. Pandalai and Dr. V. Rama Kamath who after going through the merits of the case at great length reported to the Council that the medical practitioners concerned, could not be held guilty of infamous conduct. As there was difference of opinion between Dr. F. J. Dyson and the then President of the Council Major-General Sprawson regarding certain procedure adopted by the Committee the case was gone through again by the Preliminary Committee consisting of Lt. Col. Pandalai, Dr. M. R. Guruswami Mudaliar and Dr. V. Rama Kamath and was placed before the Council and the Council after careful consideration decided to drop the matter. Cases against registered medical practitioners which could be taken cognisance of by the criminal courts and about which the police after enquiry report to have 'no case' should not be taken up by Medical Councils. In such cases after the court decides that a particular medical practitioner is guilty of criminal act, the Medical Council should then intervene and consider if the guilt established, amounts to infamous act in a professional respect.

The second case decided by the Council was about a practitioner who was reported by the D.S.P. Cuddapah, who alleged that the practitioner issued false certificates to the police constables. The D.S.P. relied on the opinion of the D. M. O. Cuddapah for his allegations.

The third case was one reported by the D.M.O. Coimbatore who sent information to the Registrar about alleged indecent behaviour by a practitioner against a midwife.

The fourth case was a complaint by the District Munsiff, Payyoli, Malabar District, against a practitioner alleging that the practitioner issued a false certificate to a subordinate of his and the District Munsiff relied on the opinion given by the Civil Surgeon, Tellicherry.

The fifth complaint was by the District Magistrate, Madura, against a practitioner alleging that the practitioner issued false certificate to a person concerned in a criminal case. In all these cases the Council accepted the opinion of the Preliminary Committee that there was 'no case' against the practitioners complained against.

In 1934 at the October session the Council decided 5 cases. The first was an information from the D. M. O., Chingleput, alleging that a practitioner at Conjeevaram tried to hide real facts about a patient's condition, in a certificate issued by him. The Preliminary Committee came to the conclusion that a practitioner could not be charged for infamous conduct in a professional respect if he could not detect more than what he had stated in his certificate. The Council accepted the findings of the Committee.

The second case was against a practitioner in Chodavaram, Vizag Dt. for having advertised about himself by means of handbills. The practitioner admitted his guilt. He was let off with a severe warning.

The third case was against a practitioner at Kachanan, Tanjore Dt. reported by a Sub-Magistrate who alleged that the practitioner gave a false certificate. The Magistrate relied upon the opinion of a Civil Assistant Surgeon. The Preliminary Committee found that the certificate was not altogether false but was wanting in precision and recommended to the Council that the practitioner should be warned to be more circumspect in future. The Council while agreeing with the Committee decided to substitute the word 'advised' for 'warned'. The other two cases were with regard to violation of the rules of medical etiquette. In the first case the complainant was a private practitioner at Cochin and the practitioner complained against was a Sub-Assistant Surgeon in the same station. In the second case the complainant was a private practitioner in Madras and the practitioner complained against was a Civil Assistant-Surgeon. In the former, the Preliminary Committee found 'no case' and in the latter recorded that the Civil Assistant-Surgeon should be warned. The Council upheld the opinion of the Committee in the first case and decided that there was 'no case' against the Asst. Surgeon in the second case.

From the perusal of the available records at the office of the Medical Council prior to 1929, I could find that the Medical Council did not bestow much care and attention in going through the Penal cases against the practitioners reported against. In the matter of allegations of false certificates the Council usually relied on the opinions given by practitioners in Government service against the opinion of the private practitioners.

From the brief reports of the cases reported by me, the readers will notice that there is a distant change in the angle of the vision of the Council in these matters. The preliminary enquiries conducted by the Committee specially appointed by the Council year after year are more elaborate now than they were before 1929 when the Preliminary Committee's reports did not go above a dozen lines at the most. The Committee, and the Council concern themselves now on facts and circumstances of cases before them rather than the position of the persons supplying the information or making the complaints. The opinion of medical practitioners in Government service against the opinions given by the private pratcitioners are not given undue importance. The practitioners complained against are at present having more considerate and judicial trials. Registered practitioners cannot be punished for ignorance. If they are accused for deliberate infamous conduct in a professional respect, those who supply information or make regular complaints ought to prove criminal motive for the action or behaviour complained against. In all cases reported above the complainants or informants did not attribute any criminal motive for the alleged infamous conduct. The concerned sections in the Medical Registration Act for trying practitioners for infamous conduct nor the rules framed thereunder are quite precise and the Council has not the benefit of legal advice as is the case in Great Britain where the Medical Council has an official solicitor to help them in trying medical practitioners for infamous conduct in a professional respect. In spite of these defects, I should say that the Penal cases before the Council are at present having the best possible consideration and attention. I should also mention that during the regime of the present President of the Madras Medical Council there prevails an atmosphere of freedom which was rare in the past and one could see that Major-General Sir Connor forgets for the time being that he is the Head of the Medical Department. It is hoped that the same atmosphere of freedom will continue in the future. (*to be continued.*)

THE
# Medical Practitioner

VOL. VI.] JULY 1935. [NO. 10

## AIMLESS POLICY.

For various reasons chief amongst them being the protracted illness of the Editor, it was not possible for us till now to express our views on the speeches made by the Hon. members of the Madras Legislative Council and the reply of the Hon. Minister in charge of medical portfolio regarding the criticisms levelled against the Government with regard to Medical Administration. But we did not lose time to discuss in these columns about one of the most important topics—the running of private hospitals by Government Doctors—about which the Government took prompt action in accordance with the promise made by the Hon. Chief Minister on the floor of the Legislative Council during the discussion of the Medical Budget. Apart from this subject all the other items of criticisms did not obtain from the Hon. Minister any satisfactory answers. The Minister referred to almost all the points raised in the speeches of Hon. members but the replies did not indicate any aim or policy on the questions raised. Year after year Hon. members of the Legislative Council talk on some subject or other which comes upper most in their mind and the ministers pacify them by giving steriotype replies. Inadequate rural medical relief was explained away by the Hon. Minister with little or no concern for the lives in the rural areas though the Government have to depend for the largest amount of revenue on the rural population. The Hon. Minister brushed aside this question by saying that it was a 'Collossal task' to render medical relief in its entirety, to the teeming millions in this province with the funds available with the Government. A good Government exists for the welfare of the people and is it not the duty of the Government to find out ways and means by which the public in rural areas get atleast the first aids in medical relief. The public in the urban areas are at present getting more satisfactory medical relief than it was the case in the past and this is due to the existence of private practitioners who have been settling in large numbers in these localities and not due to the existence of the Government medical institutions. On the other hand the Government institutions are more a hindrance for the development of the independent medical profession who alone and not the Government will have eventually to solve the question of adequate medical relief to the masses not only in this province but also in this country as a whole. The Madras Government have been trying as an experiment the management of one of the city hospitals by honorary medical officers. This hospital which was staffed by a Civil Surgeon or a member of the I.M.S. assisted by two Civil Assistant-Surgeons and about half a dozen Sub-Asst. Surgeons has now a complement of two honorary Surgeons, two honorary Physicians, 2 honorary Asst. Physicians and two honorary Asst. Surgeons and two honorary Sub-Asst. Surgeons. The Superintendent and the Resident Medical Officer in the grade of Civil Assistant Surgeon, are the only two Government paid officers in this hospital. The Hon. Minister did acknowledge on the floor of the Madras Legislative Council that the honorary medical service had resulted in a substantial saving to the Government. The only Government institution in the province where the paid officers were replaced by honoraries is the Government Royapettah Hospital referred to above where the experiment did prove successful. The question naturally arises that if one hospital could be run almost entirely by honorary staff why

not introduce this experiment in other hospitals. It is not our intention that those now in service should be sent away to make room for honoraries. But the Government is not at all justified to recruit any more medical officers whether male or female on whatever plea such as leave-reserve etc. They can fill in the vacancies with honorary medical officers and gradually replace paid staff by honorary staff when the former retire. The amount thus saved could be utilised for developing rural medical relief scheme or for increasing the in-patient accommodation in the existing hospitals. It is not fair for the Government to afford medical relief to some villages and refuse the same to the rest, on the excuse of want of funds. The present system of paying subsidies to rural practitioners on a permanent basis should be given up in the interest of the expansion of the scheme and for maintaining the spirit of the scheme. The idea of subsidy is to encourage a practitioner to go and settle in a village. The period of payment of the subsidy should be fixed for a reasonable period so that the Government may be able to supply subsidised practitioners to all the villages in the province where private practitioners have not settled. We have been mentioning repeatedly in these columns that it is not possible for the Government to afford medical relief by paid medical officers to the entire public and that the independent medical profession alone should be depended upon for this service. That being the case it is the duty of the Government to encourage the growth of independent medical profession. The unequal and unwholesome competition that now exists between the Government doctors and private doctors should be put an end to. Radical changes in the policy of the medical administration to attain this end should be introduced immediately. Vested interests will not permit the Government as it is now constituted to put a stop to the privileges of private practice to State paid doctors and unless this is done there is no hope for the growth of independent medical profession which alone will be capable to answer the needs of the public. Any immediate change of policy on the part of the Government towards this end will not cost the Government anything on the other hand, will bring about a large saving. So it is desirable that the people's representatives in the Legislative council should be persistent in their demand and press the Government to do all in its power to foster and develop independent medical profession.

A suggestion to introduce Homeopathy in the system of medical relief was made by one of the Hon. members during the discussion of the Budget; this is the second or third time when such a proposal was put before the Government. The Hon. minister made a faltering reply indirectly giving hopes that at a future date there may be a possibility for the Government to patronise the Homeopathic system. Whatever might be the claims of a particular system of medicine with regard to medical relief by the Government, it is quite legitimate on the part of the people's representatives to demand the introduction of a particular system of medicine in which the public or a section of the public have faith. During these days of democratic system of Government the popular ministers have to yield to the wishes of the people whatever their personal views may be regarding a subject. India is a country notorious for the confusion of faiths due to the existence of heterogeneous elements whether it be in religion social customs; much more in medicine. So it is likely, when the Legislative Council has an influential section of those who are the votaries of a particular system of medicine, the Government will be forced to introduce that particular system as an additional measure of medical relief as they have been now doing with regard to indigenous systems of medicine. At this rate there will not be an end for the demand on the Government to patronise and maintain medical institutions of all existing systems of medicine in India. Under the circumstances the safest and the most reasonable policy for the Government to aim at or to adopt, will be to entrust the votarires of a particular system of medicine to maintain and develop such systems themselves, the Government taking care that only qualified practitioners of whatever system are permitted to practice medicine. The utmost the Government might be expected to do in the state of affairs of confusion of faiths now prevailing in this country, is to give grants for the maintenance of charitable institutions by private bodies. The Hon. minister did





admit the inability of the Government to finance the existing medical institutions adequately and said that in other countries the medical institutions mainly depend upon private resources. His predecessors in office had been repeating what the Hon. Raja of Bobbili said on the floor of the Legislative Council last March. The Governor of this and other provinces did express the same views whenever there was an occasion for them to speak about medical relief. But when actual opportunities arise as in the case of the Perundurai Sanatorium for the Coimbatore District undue anxiety is shown as to the capacity of the non-officials to manage medical institutions and the Government officers are thrust even for the management of non-official medical institutions with the result that there is little or no zeal in non-officials to come forward for shouldering the responsibilities of running charitable medical institutions. It is highly desirable in the interest of the development of medical relief that the Government should endeavour to educate the public to take upon themselves the responsibility of running the charitable medical institutions.

The other item of discussion during the Budget Session of the Council was with regard to Lady Willingdon Medical School for women. Mr. V. T. Arasu a nominated member of the Council who has been taking keen interest to improve the medical administration in this province, expressed his view that the maintenance of a separate medical school for women was not justifiable, considering the results produced at the last final year examinations of the school. He also suggested that the Government might as well pay a reasonable subsidy and transfer all women medical students to the Vellore Missionary Medical School. Dr. Natesa Mudaliar strongly pleaded in favour of the Lady Willingdon Medical School for women and said that the cause of poor results was due to unhealthy rivalry that existed between the Stanley Medical School for men and the Lady Willingdon Medical School for women. The Hon. minister did not like the idea of abolishing the school and promised that he would look into the matter of the poor results in the Lady Willingdon Medical School. We intend taking up this subject for discussion in a future issue. The system of conducting examinations in the medical schools requires a thorough and drastic change. We are at present collecting information as to the best methods of conducting examinations in the medical schools and shall revert to this subject again.

Before closing we wish to bring to the notice of the Government that the statement made by Mr. C. Basudev a nominated member of the Madras Legislative Council that, "in the General Hospital, the Royapuram Hospital and in several other hospitals there were touts to secure custom for the medical men," is highly derogatory if not defaming and it is the duty of the Government to find out if there be any truth in the statement made by the Hon. member. If not, it is desirable in the interest of the Government medical officers and also the medical profession that the concerned member should be asked to withdraw the statement with a suitable apology.

## News and Comments

**Reform of Medical Curriculum in Great Britain:** What a contrast our readers will find between the affairs of Medical Education in our country compared with that obtaining in Great Britain if they read the extracts of a report of a conference appointed by the representatives of all the teaching institutions in Great Britain, which report has been published in the Abstract Columns of the current issue? Though there are different institutions independent of each other for imparting medical education in Great Britain, all of them have recource to concerted action whenever such action is called for, as is seen from the proceedings of the conference under reference. In India though the medical colleges and schools are under the direct control of the Government in each province, it has not been possible to have a common standard of medical education both in schools and colleges and the recent action of the Government of India in bringing into existence a separate body to look after the education of medical graduates only, leaving out of consideration the medical licentiates who form the largest section of the members of the medical profession numbering twice and in some provinces even thrice the total strength of the graduates. Any amount of agitation both from the profes-

sion and the public could not create the sense of responsibility in the India Government who valued the prestige of the General Medical Council in Great Britain more than the welfare either of the medical profession or of the general public; as a well organised and equipped medical profession under the common guidance of one authoritative body was a guarantee for the safety of the public who have to entrust their lives to the members of the medical profession. Though the mentality in this country has been one of aping with regard to medical education, at times, the heads of medical departments feel the necessity of a change in the medical curriculum as happened in this province nearly six years ago when Major General Sir Megaw was the Surgeon-General with the Government of Madras. This committee concerned itself more about the status and prosperity of the products of the new scheme drafted by them than the cultural aspect of medical education. The committee recommended a five years' course in the medical schools without discussing the details of the curriculum. They fixed two standards of minimum preliminary educational qualification S.S.L.C. and the Intermediate for the entrants recommending to the Government that the latter after qualifying themselves might be made eligible for competition for the posts of Assistant-Surgeons. The Government in this country even ignore the existence of statutory bodies of their own creation—the Provincial Medical Councils—which are not at all consulted with regard to any reform in the medical curriculum though the statute contemplates distinctly that the Medical Councils are the sole guardians for the members of the medical profession whether it be to impart medical education or to exercise discipline over them after they are privileged to practise. The recommendations of the committee on medical education in Madras were not placed before the Madras Medical Council nor were the recommendations given effect to by the Government. The only recommendation which had the approval of the Government is the increase in the period of training in the schools by one year. The work of drafting the curriculum was entrusted to one individual, the Superintendent, Royapuram, now Stanley Medical School, who it is said has embodied the curriculum followed by the conjoined board for the M.R.C.S. and L.R.C.P. Diploma. So, if there have been any reform in the medical curriculum in this country it was mimicry and one man's show. It is true that the medical profession has not developed to the extent it is, in Great Britain nor is there any hope of its development to the standard obtaining in that country if the Government continues to be keen in guarding vested interests and will not entrust the affairs of the medical profession to the members of the profession. If Great Britain was under the yoke of a Government foreign to that country, the state of the medical profession would not have been better than it is at present in India.

In spite of these limitations which bind the medical profession in India, the members of the profession will do well to go through the valuable report of the conference on reform of medical curriculum in Great Britain. The central idea recommended by the conference is that, *'the intention should be to give the student of average ability such knowledge and such education as will enable him to approach the problems of practice with some degree of confidence and put him in a position to learn from subsequent observation and experience.'* Intelligent students whether it be in medical or any other technical institution are not handicapped in spite of the defects in the curriculum or the methods of teaching. It is the average students who form the bulk in the profession that have to be taken care of. This purpose has not only been kept in view by the Conference but the members—all of whom eminent authorities—seem to have worked most industriously for over two years and drafted a scheme which is less laborious yet more cultural than the existing curriculum of medical studies in Great Britain. If Great Britain is in need of urgent reform in medical curriculum, India must be so doubly. The task in India is confronted with many formidable difficulties. Large amounts of public funds are now wasted in half-hearted schemes for reviving the indigenous systems of medicine. The principle underlying the indigenous systems cannot be thrown out as quackery. It is desirable that these systems should be incorporated in the scientific system of medical education in this country. It is risky to entrust the work of the development of medical education to the



Government who are likely to be swayed away from the right path on account of political considerations. The profession cannot afford to be indifferent to the medical needs of the country whether it be medical education or medical relief. A report like the one under reference is worth the consideration of the members of the profession.

**Govt. School of Indian Medicine:** We have received four letters from the practitioners who have passed out of the Government School of Indian Medicine as replies to the Editorial on the above subject in the last issue. We regret our inability to publish them as each communication covers over 6 pages foolscap and it is beyond the scope of the journal to publish such voluminous correspondence. All the correspondents are unanimous in their justification for the teaching of Ayurveda in vernacular. They say that they are taught, medicine surgery and midwifery, by qualified practitioners of the Allopathic system as efficiently as it is done in the recognised medical schools of Allopathic system. One of them even claims superiority over the practitioners of Allopathic system on this account. We are strongly in favour of revival of the indigenous systems of medicine and reiterate our view that the methods employed for this purpose at the Govt. School of Indian Medicine are most unsuited not only for the revival of indigenous systems but also the harmonious development of medical profession in the country. The plea that Allopathic system of medicine is taught to the students in the school with an idea of enabling them to make a comparative study of other systems cannot be sustained as it is too much to expect from a young student who has not imbibed the principles of indigenous systems of medicine to make comparative study of another system nor is the period of 4 years sufficient for such a study. Comparative study of other systems of medicine can be done only by a few intelligent practitioners and that after they have successfully practised in a particular system of medicine. A course of four years for the students of recognized Allopathic Schools was considered to be not sufficient and the Government of Madras have recently increased the period of training in Allopathic Medical Schools to five years. Nobody can complain if the products of the Indian Medical School practise only the indigenous system of medicine, but it is dangerous to permit them to practise Allopathic system of medicine, especially surgery and midwifery with a smattering knowledge they receive on this subject during the course of a comparative study of the Allopathic system. So we conclude by repeating what we have said before that the only justifiable way to revise indigenous system of medicine, is to create special chairs for the teaching of indigenous systems of medicine in the existing recognized medical schools and colleges.

**Economy in Madras City Hospitals:** The Government of Madras have appointed Col. H. G. Dyer for a period of one year to effect economy and retrenchment in Government Medical Institutions in the city of Madras including the King Institute. It is also reported that freehand is given to him to suggest measures of economy and retrenchment in diet, medicine, contingencies etc. Though in effect the words, economy and retrenchment mean the same, they convey quite different ideas. Economy means frugality while retrenchment is cutting down and conveys the idea of a necessary cut in the expenditure. The reference is likely to cause anxiety to the hospital going population who are likely to harbour an idea that the comforts and necessities of the in-patients are likely to be affected. Economy is one of the best features of good administration. The need for retrenchment comes in when the administration cannot afford to spend even for necessities. The last Civil Budget for this province did not show any deficit. We were therefore rather inquisitive to know the necessity for the appointment of a retrenchment officer at a time when the cut in salaries has been restored. On enquiry at the proper quarters we are given to understand that Col. Dyer will concern himself in finding out the most economic ways of supplying diet, medicines and other necessities in medical institutions without in any way lessening the comforts and necessities of the patients in the hospitals. The Government will be certainly justified in incurring an additional expenditure towards the pay of Col. Dyer if this officer is immediately put in charge of the General Hospital, the bigest hospital in the city so as to enable him to demonstrate tangible economy in the administration of

this hospital. If after the period of one year the economy effected is appreciable covering the entire expenditure incurred towards the salary of the officer who worked out the ways and methods towards economy, the Government should lose no time to have the services of special officers to look after the non-professional administration in all the state-hospitals in the province. If, on the other hand, Col. Dyer is asked to go through the records and files of all the medical institutions in the city and write a theoritical report about economy, the time and money spent on this task will be a huge waste. The Government General Hospital spends over two lakhs a year for diet, medicines and surgical dressings etc. The Superintendent of the hospital who has to attend to professional work every day for the major period of his stay in the hospital cannot bestow the required attention for supervising about the details of diet, medicines, etc. So there is bound to be some leakage here and there which could be efficiently checked if the non-professional administration of the hospital is entrusted to a separate officer. We are told that the Col. Dyer's pay is Rs. 750 per month and will also be given an allowance of Rs. 100 as house rent Rs. 75 for conveyance, in case he maintains a car. All told the Government will be spending Rs. 11,100 a year on account of this special appointment. In 1930 the Government of Bombay appointed Col. Dyer as lay secretary as an experimental measure for the J. J. Group hospitals and it is said he effected economy of one lakh in the expenditure for diets, medicines, contingencies etc. The Government of Bombay have since appointed a permanent lay secretary for the non-professional administration of the J. J. Group Hospital in Bombay. We are told that the Madras Government have not as yet drafted a plan of work for this special officer. We hope the sanctioned plan will be a practical one justifying an expenditure of Rs. 11,100. We shall in a future issue suggest where and how economy could be effected in state hospitals.

**Admission to Medical Schools and Colleges:** There is a widespread dissatisfaction in the minds of the public that in spite of the existence of the selection-committees for the admission of pupils into medical schools and colleges partiality and favouritism still play a part with regard to selections. The Government had laid down formulae to guide the members of the selection-committees basing not only on communal representation but also on special territorial distribution for which purpose the Presidency is outlined in three groups, Tamil Districts, Telugu Districts and West Coast. In addition to the communal and triple land area farmulae the Government insist with regard to individual qualifications of the pupils for admission, especially in colleges that candidates whose optional subject is science group consisting of Physics, Chemistry and Biology must be preferred to those whose group is Physics, Chemistry and Mathematics, the graduates having the first choice. The minimum qualification for the medical schools being S. S. L. C. much difficulty is not felt with regard to selection, on the merits of qualifications as there are limited number of intermediates seeking admission. So there is naturally less talk about the selection in medical schools. It is said that the selection committee for colleges did set at naught the formulae laid down by the Government and have selected a few candidates with Physics, Chemistry and Mathematics leaving out of consideration as many whose optional was Physics, Chemistry and Biology. Our representative interviewed a few students who were lucky in getting admission in the Madras Medical College and found that the allegation made against the selection committee (Medical Colleges) had some foundation. Last year the Ag. Principal of the Medical College did dispose the matter of selection not as proposed by the the Government when the option came to him to choose students from the waiting list. What the Ag. Principal did last year seems to have been done by the selection-committee this year.

The selection-committees for Colleges and Schools were brought into existence by the Government to appease the dissatisfaction then prevailing in the minds of the public who complained that partiality and favouritism more than merit weighed with regard to the selections then made especially in the Madras Medical College. It may be that the Principals and the Superintendents of the medical schools assisted by the concerned selection-committee might be doing their duties to the best of their judgment. But the Government would do well to publish the list of candidates selected in schools and colleges mentioning against the name of each pupil his caste, district and the qualifications. Then there will be less room for criticisms which at times are likely to be irresponsible and against facts. The nervousness now shown especially at the medical college in treating the subject matter of selection confidential has given room to an atmosphere of suspicion.



With some difficulty we were able to procure a statement of pupils admitted into the medical schools and colleges last June. The statement is incomplete and has been published in the correspondence columns. From a perusal of the statement it will be found that the general educational qualification of the majority of boys admitted in the Stanley Medical School is decidedly higher than those of the girls admitted in the Lady Willingdon Medical School and justifies to a certain extent the criticisms from one of our correspondents published in the May issue of the journal. Now that the standard of education in medical schools has been brought to a level of the standard for the M.R.C.S. and L.R.C.P., it will certainly be a hard task for the students who have only passed S.S.L.C. to cope up with the course of studies prescribed in the medical schools and we trust that the Madras Medical Council will take up this matter which is their legitimate duty and press the Government to fix Intermediate standard as the general educational qualification for admission in the medical schools.

**Dental Profession:** "Dental profession as it is practised in India" was a theme for discussion at the meeting of the Madras Branch of All India Medical Licentiates' Association on 10-7-35. The lecturer was Dr. S. R. Bhat, one of the leading dentists practising in the city Dr. Bhat said that there are about 5,000 dentists in India and 90% amongst these were quacks and consequently the suffering of the public on account of these quacks was 'unimaginable." Our imagination is pricked the more when we find that some of the qualified medical men who have taken to dentistry, have been actively manufacturing a large number of quack dentists and adding to the percentage of unqualified dentists complained against by Dr. Bhat. Dr. Bhat and other medically qualified dentists in the city of Madras can solve this problem to an appreciable extent if they realise that example is better than precept. If the medical profession in India though not well organised, makes up its mind to love the high ideals of medical ethics more than money, quackery in Dental science and many other evils to the profession and the public might be averted. The medical profession in India have to bend down their heads to the organisations of labourers, skilful and even the menial who are making themselves felt not only on the public but the Government by persistent agitation. The profession will do well to remember that unlike in other civilized countries the qualified medical profession in India came into existence to satisfy the administrative needs of an alien Government and matters medical whether it be dentistry or any other branch of medical science is recognised by the Government from the administrative view point and not for the purpose of supplying the needs of medical relief of the public. This is why the Government do not countenance the existence of well organised dental colleges under the control of private individuals or group of individuals such as that of one that exists in Calcutta or a similar one recently started in Bombay under the auspice of Dr. Nair Hospital. Want of funds may be the usual excuse for the Governments in the provinces for not having started Dental Colleges of their own but why should not the Goverment recognise and patronise institutions run by qualified dentists. Remedy for such indifference lies with the members of the profession themselves as was aptly said by Major McRobert in his concluding remarks, as the Chairman of the meeting organised by the Madras Branch of the All India Medical Licentiates' Association. We will go a step further and say that the medical profession should soon realise their responsibilities to bring about political emancipation in this country and then only the medical profession can hope to exist for the benefit of the public and not as an adjunct of Government administration.

**Agency Duty:** The Sub-Assistant Surgeons in the Madras Provincial Medical Service have to serve a fixed period of their

service in jails and in unhealthy malarial stations in the districts of Vizagapatam and Ganjam called the Agency Tracts. In good old days this duty was for three years, later it was reduced to two years as more hands were available. On account of retrenchment and the withdrawal of Government Sub-Assistant Surgeons from the service of local bodies recruitment of Sub-Assistant Surgeons has been temporarily stopped and consequently there is a paucity of Sub-Assistant Surgeons in Provincial Service and a need is felt to increase the period of Agency service for three years. Warning notices have been sent to those who did only 2 years Agency duty informing them to be ready to serve a year more. Some of those who received this warning happen to be in the selection grade nearer fifty or above fifty years of age. It is really a hardship for them to go back to the Agency tracts at the fag end of their service and at a time when at least a few of them must be subject to bodily infirmity of some sort or other. The Head of the Medical Department is a medical man so also his personal assistant and we trust they will be sympathetic to consider the hardship of such of those who have passed 40 years of their age and excuse them from this duty. We would suggest the few unlucky Sub-Assistant Surgeons to report their case to the Surgeon-General. In this connection it will not be out of place for us to bring to the notice of the authorities that there are a few in service who had been lucky to escape either the jail or the Agency duty for some reason or other. These few must have been the members of a happy official family with the D. M. O. at the head and there must have been instances here and there where a D. M. O. recommended to the Surgeon-General that without a particular Sub-Assistant Surgeon the station where he is, will suffer seriously. The head of the happy family in a district forgets that there are over 400 Sub-Assistant Surgeons in service and it is possible for the Surgeon-General to find a suitable substitute. They say that if the D. M. O. happens to be an European there may be some difficulty even to the Surgeon-General to get a substitute for an old member of the happy family. It might have been so before but not now when the Surgeon-General is Surgeon of great reputation and he will not hesitate to probe when probing is necessary. The best ideal to follow is fair-play to everybody in service and to regard the whole service as a happy family with Surgeon-General as the head. Then only there will be contentment in service and nobody will grumble to adjust himself for all service exigencies. In the meanwhile may we appeal to the authorities concerned to make a thorough search of the Civil Medical List and those who have escaped so far either the jail or Agency duty are made to have their turn. The period of service may be made less depending upon the age of the individuals but none even the senior most being exempted for any cause excepting bodily infirmity.

**Anonymous Information**: We have received a complaint from a practitioner making allegations against another amounting to infamous conduct in a professional respect and another practitioner had sent us information that two practitioners are advertising themselves through the agency of their friends who it is alleged have published hand-bills requesting the public to go to these two doctors for medical relief. There may or may not be any truth in the former but with regard to the information a printed a copy of the hand-bill is enclosed with a letter addressed to 'the Editor, The Medical Practitioner,' requesting him to send the concerned hand-bill to the Madras Medical Council. The informant has subscribed the letter as 'Members of the Medical profession.' With regard to the complaint the correspondent has endorsed the complaint thus, 'For favour of taking suitable action by Dr. Kamath.' We very much regret that both these practitioners belonging to a noble profession have chosen to be anonymous and wish us to take action against their professional brethren, themselves being guilty of breach of faith, friendship and goodwill. If their intention is to correct their erring brethren they could easily do so by pointing out to them that what they (accused) do was against the code of medical ethics. We know instances where registered medical practitioners erring against the code of ethics quite ignorantly and at times innocently also. Though in courts ignorance of law is not considered as a plea to escape punishment the ordinary laws of society should not be ignored by those who complain. Even for criminals the present tendency is for reformation more than punishment. The Medical Council should be the last resource for correcting an erring practitioner. We can be sure that both the complainants are members of the medical profession. We request them to warn the concerned practitioners that what they have been doing amounts to infamous conduct in a professional respect and that they should refrain from such conduct. In case they persist, then bring their offence to the notice of the Council who will punish them with a deterrent attitude. Well organised medical associations or members of such associations can certainly reform erring members of the profession more effectively than a Medical Council if the motive concerned is not malice or jealousy. Even otherwise we do not wish to encourage anonymity, by doing so, we will be doing harm to the profession by increasing the number of cowards.



## Correspondence Reports Etc.,

### CHIEF MINISTER'S REPLY

ON CRITICISMS AGAINST MEDICAL ADMINISTRATION.

The Hon. the RAJA OF BOBBILI said it was no doubt true that all the medical needs of rural areas were not fully met and it was also true that a large amount of money was being spent on city hospitals. But it should be remembered that the provision of adequate medical relief to the teeming millions of this province was a colossal task and it might not be possible, with the funds available to the Government, to meet the needs in their entirety. It should also be remembered that the hospitals in the City should, as far as possible, be maintained as model institutions for preparing students for the medical profession and for enabling medical officers to gain experience. It was therefore necessary that these hopitals should be maintained on up-to-date lines. Medical aid in other countries was mainly provided by private charity, but here every activity of the Medical Department had to be financed by the State. However much they might all wish to expand this very necessary public amenity, the real difficulty lay in the matter of finding adequate funds for the purpose. In regard to provision of medical relief for industrial workers, he believed that railway companies and certain industrial factories had provided some facilities. He was not aware of the exact position with regard to factories in rural areas. As for making it a legal obligation for employers to provide medical relief to employees, the speaker said he could not give a definite answer without examining the question. As regards opening an infirmary for the aged and those unable to work, it was a big problem which, in the present state of their finances, it would be impossible for Government to tackle.

#### LEAVE RESERVES

Referring next to the system of having honorary medical practitioners for hospitals, he said, the system had been in vogue for some years, and had resulted in a substantial saving to the Government; for it had made it possible for Government to run hospitals without increasing the paid staff. The exigencies of the medical service, he said, necessitated the maintenance of a sufficient leave reserve. As unexpected calls were likely to be made on medical officers, it was necessary and essential to maintain such a reserve. The importance of the service was such that it would not be in the public interests to do away with Leave Reserves. He would also mention that the percentage of Leave Reserve to the total sanctioned strength was ten and this was much lower than the percentage in other provinces.

There seemed to be a good deal of misapprehension in the minds of some members, the Raja of Bobbili continued, that simply by amalgamating the Stanley Medical School and the Lady Willingdon Medical School, a great saving could be effected. If the main object of the suggestion was economy, that object would not be achieved by the step. The Stanley Medical School even now was handicapped for want of accommodation, If such amalgamation was effected, it would necessitate the construction of suitable buildings at a cost of some eight or ten lakhs of rupees. Further additional staff would also have to be appointed. If, on the other hand, the object was to encourage co-education, he would state that although lady students were studying in Medical and other colleges, it did not follow that they had advanced sufficiently to dispense with separate institutions for ladies. The greatest need of the country was to provide better

medical relief for men, women and children and it was of the utmost importance that they should increase the number of women medical practitioners available in the province. The present supply of lady doctors had not met the demand.

The suggestion for transferring the students to the Vellore School, the Minister was afraid would not be advantageous. It might mean the payment of large subsidies to the missionary authorities. The facilities available in the City, both by way of clinical material and the teaching staff, were great and it would not be possible to give the same standard of medical education in Vellore. He was aware of the poor results in the last examination and the matter would be looked into. Captain Bernard of the Radiological Institute was engaged on a certain contract and the question could not be opened now. Recently the Government had passed orders abolishing the system of paying commissions to officers other than Captain Bernard and had now granted a fixed amount as compensation allowance every month. With regard to the suggestion of Mr. Langley, the Minister assured the Hon. Member that necessary steps would be taken to meet the requirements.

RURAL MEDICAL RELIEF

Proceeding, the Hon. Minister pointed out that at the present stage it would not be possible for the Government to adopt homeopathy, as suggested by Mr. Rameswara Rao. Regarding the appeals made for increasing the contribution to local bodies for expansion of rural medical relief, the Minister said that in the present state of the finances of the Government, it would not be possible to increase the allotment. But the local bodies were not prohibited from opening new dispensaries, and if possible, the Government might grant some contribution. He was in full sympathy with Mr. C. R. Parthasarathi Iyengar when he said that the Ayurvedic system should be devoloped and, funds permitting, he would do everything possible.

As regards private practice by Government servants, he stated that the present scales of remuneration were fixed taking into consideration the right of their having private practice. At the same time, he realised that permission to practise privately was subject to the rule that the normal duties were not to be affected. If they were to completely prohibit private practice, especially in the districts, they would be depriving the public of the services, of experienced doctors. As regards Government servants having private nursing homes, he considered it most objectionable and the Minister said that he would take necessary action to prevent such abuses in the future.

## The Tinnevelly District Medical Association, Palamcottah.

The Tinnevelly District Medical Association held its monthly meeting on 30-6-35 at Papanasam (Ananda Vilas) one of the most sacred places of the District, noted for sceneries. Members numbering 48 including some lady doctors gathered from all parts of the District. Some of the local officials and non-officials were also present. Mr. B. E. Hussey, I.C.S., Sub-Collector, Sermadevi was also present. All the members had an early bath in the River and had light refreshments.

The meeting began at 10 A.M. under the Presidentship of Lieut Col. T. S. Shastry, I.M.S. The first item was a sincere and unanimous expression of deep sympathy with those stricken in the recent Quetta Earthquake havoc. Advantage was taken to collect liberally for the Viceroy's Earthquake Relief Fund from all assembled. In the night a special benefit Talkie of Nallathangal was arranged at Ambasamudram at Kunhappa's Talkies.

The meeting proper was highly impressive and instructive. Case notes on Nephrectomy for Tuberculosis, on a case of habitual abortion treated with Corpus Luteurm, a case of Epithelioma Rectum, Benign Tertian Malaria with an obstinate temperature in a pregnant lady and a case of Tuberculosis of the lung successfully treated with Solognol B Oleosum, were read, discussed and various aspects of individual observer's view-point and experience given. The major cases of Laporotomy mentioned above were operated on at the Head Qrs. Hospital, Palamcottah, by Lieut. Col. T. S Shastry, I M.S., the District Medical Officer, and his observations on them were very instructive and interesting.

Then a discussion on Dyspepsia of all types was started by Dr. A. L. Ananthanarayana Iyer, M.B B.S, of the Tinnevelly Town Municipal Hospital. After discussion the president summed up the salient and important features in the correct and proper diagnosis of Dyspepsia, reviewing the most successful methods adopted in treatment. After a vote of thanks to the President, the meeting dispersed, after a hearty palatable lunch. At 5 P.M. the party reached Ambasamudram where a Health Exhibition was arranged at the Thirthapathy High School. After tea, the Health Exhibition was opened by Mr. B. E. Hussey. The exhibits consisted of posters relating to Cholera, Tuberculosis, Malaria, Smallpox etc., and a lecture on Tuberculosis was delivered by Dr. N. Lakshmanan.

Lieut. Col. T. S. Shastry, I.M.S., offered cordial thanks to Dr. P. Janardhana Rao, L.M. & S., and his co-workers for their kind and generous hospitality and for organising the meeting in such a grand scale.



## The East Godavari District Medical Association, Cocanada.

The monthly meeting of the Association took place at Pithapuram on 22nd June '35. A large number of doctors from all over the District attended. Pithapuram members were at home to the Association. After Tea, the members were taken round the wards of the Mission Hospitals in batches by Dr. Allyn and Dr. Eaton, and interesting cases shown. Noteworthy of mention is a silver pessary improvised by Dr. Allyn, of great value in cases of Antiflexion of the Uterus.

The proceedings commenced at 6 P.M. with Captain J.S. Mc. Millan, I.M.S., in the chair. Some interesting cases from Pithapuram were exhibited by Dr. Eaton. One was a case of typical Pseudo-Hypertrophic Muscular Paralysis and two cases of skin grafting where gauze soaked in melted bees wax was used in the place of guttapercha tissue as a dressing and one case of a fibroma of the lobe of the ear wherein a silver wire was inserted under the skin to keep up the cantour of the ear. Dr. Eaton discussed the operation for the removal of tonsils and expressed that in his experience the method of their removal with a blunt guillotine without preliminary dissection is very good. Dr. Murthy of the Headquarter Hospital, Cocanada, gave a discourse on "Pre and Post Operative treatment in Surgery".

A resolution was passed congratulating Dr. Allyn on the award of the Silver Jubilee Medal to her which she so richly deserved. After an enjoyable dinner on the lovely terrace of the Mission Hospital, the guests dispersed.

## Bellary District Medical Association.

The monthly meeting of the Bellary District Medical Association was held at the Headquarters Hospital on 22-6-35 at 5-30 P.M under the presidentship of Major M.S. Gupta I.M.S. (President of the Association). Dr. U. Ananthayya the Assistant District Medical Officer and Joint Secretary of the Association read a paper on 'Some common mistakes in diagnosis'. The lecturer at the outset congratulated Lieut. Col. A. S. Leslie, I M.S. (District Medical Officer), Major M. S. Gupta I.M.S. (President), and Dr. V.Swaminathan on their being the recipients of the Silver Jubilee Medals. Lieut. Col. A.S. Leslie also spoke about some of his experiences. The President in his concluding remarks also gave his views on mistaken diagnosis.

## The Trichinopoly District Medical Association.

A monthly meeting of the above association was held on Saturday the 18th May '35, at 5 P.M., in the E. R. High School, Trichinopoly, when about 30 members were present. Dr. C. Somasundaram of Puvaloor, was 'At Home' and Dr. R. Kalamegham, M.B.B.S., presided.

Dr. T. S. S. Rajan showed a small boy aged 10 on whom he had operated upon for Hydronephrosis. The removed matter resembled a big bag with the kidney substance embeded in its wall. He showed the old case of stricture of Oesaphagus demonstrated at the previous meeting and which showed some improvement. He also demonstrated a case of multiple arthritis in a girl of ten. Dr. V. Iravatham of Thirukkattupally demonstrated a few cases of interest.A case of Electric Burns treated with Cod-Liver-Oil-ointment in the Government Hd. Quarters Hospital, Trichy, was also demonstrated. After demonstrations there were discussions. Dr. K. S. Narayanan of Madura then delivered an interesting lecture on 'Peroral Endoscopy' explaining the technique, indications, and its usefulness for diagnosis and treatment.

## STATEMENT OF PUPILS ADMITTED INTO THE MEDICAL SCHOOLS AND COLLEGES.

### Stanley Medical School, Madras.

Total number of applications received ... 237 — 170 qualified and 67 unqualified.

Number of pupils selected (excluding 4 pupils from Indian States) ... 62 — Tamil area 29; Telugu „ 23; West coast 10

Educational qualifications of pupils selected. — Passed Intermediates 9; Passed in Parts Intermediate exmn. 22; Complete Junior and Senior Intermediate courses and S.S.L.Cs. 31

### Lady Willingdon Medical School

Total number of applications received ... 73 ... 28 qualified and 45 unqualified.

Number of pupils selected (excluding 2 pupils from Indian States) ... 22

Educational qualifications of pupils selected — Completed Junior Intermediate course and S. S. L. Cs. 22.

### Medical Colleges

Total number of applications received 262.

Total number of pupils selected *154 — Tamil area 69; Telugu „ 69; West coast 16

* The above list excludes candidates from Indian States and the L. M. Ps.

*List of Postings of Sub-Asst. Surgeons for the month of June, 1935.*

| No. | Names of Sub-Asst. Surgeons. | From. | To |
|---|---|---|---|
| 1 | Dr. P. Ananta Nayanar | Govt. Hl., Tuticorin | Jail duty. |
| 2 | „ R. Padmanabhan | Borstal School, Palamcottah | Govt. Hl., Tuticorin. |
| 3 | „ Mrs. C. M. Alexander | Govt. Hd. Qrs. Hl., Coimbatore | Govt. Hl., Kollegal. |
| 4 | „ C. Chintan Nair | Koraput Agency | Police Hl., Vellore. |
| 5 | „ K. Krishnamurthi | Govt. Hl., Chicacole | Govt. Dy., Sompeta. |
| 6 | „ M. Lakshminarayana | Leave | Govt. Dy., Sompeta. |
| 7 | „ P. Raman Nayar | L. F. Dy., Orattanad | Agency duty. |
| 8 | „ V. G. Parthasarathy Naidu | Govt. Hd. Qrs. Hl., Anantapur | Famine duty in Anantapur Dt. |
| 9 | „ T. K. Nagarajan | Leave | L. F. Dy., Nattam, Madura Dt. |
| 10 | „ Miss. K. Janakiammal | Govt. Hl., Madanapalle | Govt Hd. Qrs. Hl., Chittoor. |
| 11 | „ M. Jagga Rao | Govt. Hl., Ongole | L. F. Dy., Macharla. |
| 12 | „ M. Gopalan | Leave | L. F. Dy., Sriperumbudur. |
| 13 | „ A. M. Krishna Nambiar | L. F. Dy., Payyanur | Koraput Agency. |
| 14 | „ Mrs. L. Gnaniah | Leave | Govt. Hl., Sivaganga. |
| 15 | „ Miss. A. Lazarus | Govt. Hl., Sivaganga | Govt. W. & C. Hl., Vannarpet. |
| 16 | „ V. Muthuswami Iyer | L.F. Dy., Manamelgudi | Agency duty. |
| 17 | „ M. V. Ramamurthi | Govt. Hd. Qrs. Hl., Guntur | Govt. Hl., Narasaraopet. |
| 18 | „ Y. V. Basaviah Naidu | L. F. Dy., Kovur | Govt. Hl., Kavali. |
| 19 | „ K. A. Subramaniam | Leave | L. F. Dy., Kadayam. |
| 20 | „ T. K. Nilakanta Iyer | L. F. Dy., Kadayam | L. F. Dy., Shermadevi. |
| 21 | „ M. V. Srinivasan | L. F. Dy., Markanam | L. F. Hl., Vridhachalam. |
| 22 | „ Mrs. R. K. Behra | Leave | Govt. Hd. Qrs. Hl., Guntur. |
| 23 | „ Miss. K. Annapurna Devi | Govt. Hl., Guntur | R. S. Hospital, Tuni. |
| 24 | „ P. Somasundaram Pillai | Govt. Dy., Paramagudi | Koraput Agency duty. |
| 25 | „ B. Jagga Raju | On leave | Govt. Hd. Qrs. Hl., Cuddapah. |
| 26 | „ M. Venkatachari | Govt. Hd. Qrs. Hl., Cuddapah | L. F. Dy., Rayachoti. |
| 27 | „ V. Bhavanarayana | L. F. Dy., Rayachoti | Govt. Hd. Qrs. Hl., Nellore. |

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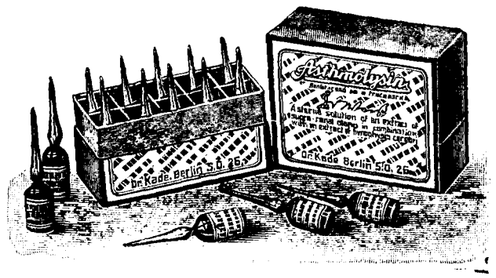


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# Reminders and Suggestions

| DISEASES. | INDICATED MEDICINES. |
|---|---|
| ARTHRITISM: | Panbiline, Iodalose. |
| AZOTEMIA: | Hepatrol. |
| BILIARY INSUFFICIENCY: | Panbiline. |
| BONE DISEASES: | Pulmo Calcium, Fer-Ma-Pho. |
| CARCINOMA: (Pains of) | Cryogenine. |
| CANCER (Anaemia of) | Hepatrol, Cryogenine. |
| DENTAL CARIES: | Pulmo Calcium, Fer-Ma-Pho. |
| DYSMENORRHOEA: (Pains of) | Cryogenine. |
| ECZEMA: (Irritation of) | Cryogenine. |
| FLATULENCE: | Sedogastrine, Papyta. |
| GLAUCOMA: (Pains of) | Cryogenine. |
| GOUT: | Iodalose, Urogenine. |
| HYPEREMESIS GRAVIDARUM: | Opocrin Ovary, Oestryl. |
| HAEMORRHOIDS: | Mycol, Mictasol. |
| HYPERSECRETIONS: | Sedogastrine, Genoscopolamine, Genatropine. |
| IRITIS: | Cryogenine. |
| INFLUENZA: | Orargol. |
| LYMPHATISM | Pulmo Calcium. |
| MALARIA: | Cryogenine (for temperature.) |
| METRITIS: | Cryogenine. |
| OSTEO MALACIA: | Calcium, Cryogenine, Opocrin Pituitary. |
| OBESITY: | Iodalose. |
| PAINS: | Cryogenine. |
| POST OPERATIVE PAINS: | Cryogenine. |
| PRURITIS: | Cryogenine. |
| PREPARATORY TREATMENTS BEFORE OPERATION: | Cryogenine, Agocholine. |
| PYREXIA: | Cryogenine. |
| REGURGITATIONS: | Sedogastrine. |
| SMALL-POX: | Cryogenine. |
| URTICARIA: | Mycol. |
| WHOOPING COUGH: | Iodaseptine, Felsol. |
| WORMS: | Rectopanbiline. |

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