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A Monthly Medical Journal

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

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VOL. VII.]

OCTOBER 1935.

[NO. 1

Original Articles

*TOXAEMIAS OF PREGNANCY.

BY

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(Continued from last issue.)

ACUTE YELLOW ATROPHY OF THE LIVER.

It is also known as Icterus Gravis and is an acute necrosis of the liver cells accompanied by jaundice, disturbances of cerebation and reduction in the size of the liver. The disease usually proves fatal but fortunately it is very rare. I have seen only one case in a primipara in about the 24th week who I am glad to report recovered and gave birth to a live-child 8 years ago and had another two years ago with no recurrence of any kind of toxæmia.

ETIOLOGY: Nothing definite is known of the etiology of this disease. Poisons such as chloroform, arsenic, mercury and phosphorus as well as certain diseases such as syphilis, septicaemia and cirrhosis of the liver may perhaps be predisposing factors but I think the neurotic element plays a great part even here as in Hyperemesis and Eclampsia.

SYMPTOMS: The disease may develop very suddenly with sharp abdominal pain, headache, vomiting. Following these symptoms the patient may even become delirious. Jaundice is the outstanding feature. It may

develop quite rapidly. The patient becomes apathetic and finally comatose; convulsions sometimes occur. The pulse and respiration are rapid, the blood pressure is normal and the urine may contain a slight trace of albumin, leucin and tyrosin. The onset of the disease may be slower not unlike chloroform poisoning.

The condition may be differentiated from Eclampsia in that it is usually accompanied by marked icterus, a normal blood pressure, reduction in the size of the liver, leucine and tyrosin in the urine and a marked increase in the blood amino-acids. Apathy and coma develop in the later stages of the disease. A general septicaemia due to gas-bacillus may sometimes simulate acute yellow atrophy; and it is often very difficult to differentiate clinically between these two conditions.

TREATMENT: Due to the condition of the liver the best treatment is glucose. This may be given intravenously in 10% solution.

LOW RESERVE KIDNEY.

The term Low Reserve Kidney is perhaps inadequate nevertheless it describes a certain group of pregnancy toxæmia cases as well as any other term so far suggested. In this group are incorporated many cases of albuminuria of pregnancy. Albuminuria accompanies most of the toxæmias of the latter half of pregnancy and it therefore appears both illogical and confusing to attempt to designate any one type of toxæmia as ALBUMINURIA. It is analogous to calling it a hypertensive type of toxæmia, as the majority of women suffering from the various late toxæmias of pregnancy have an

elevated blood pressure. The term albuminuria should be reserved to denote a laboratory finding and no more.

There is justification for the use of the designation Recurrent Toxæmia. The only objection to it is that it does not tell us whether the process is benign or will become progressively worse with subsequent pregnancies. Either condition may be recurrent, but it is a matter of great importance for us to know whether the patient is suffering from a mild and benign toxæmia or from a kidney condition which, if treated inadequately may prove fatal in the near future. Furthermore even Eclampsia may be recurrent. For these reasons the use of the term Recurrent Toxæmia may be somewhat confusing.

Nephrosis as seen in the non-pregnant individuals is a fairly definite entity and usually signifies a degenerative change in the tubules of the kidney. Mussey and Keith divide the acute nephritis occurring during pregnancy into acute glomerulo nephritis and acute nephrosis, and state that while the former is associated with hypertension, oedema, oliguria and albuminuria, the latter differs from it in the absence of hypertension and of changes in the fundi, and usually in the absence of erythrocytes in the urine and in the presence of oedema.

It was only by studying repeated pregnancies in the same individual that Stander and Peckham were able to differentiate the Low Reserve Kidney from the other types of toxæmias. It is the mildest form of late toxæmia of pregnancy and usually manifests itself during the last two months of gravidity. The characteristic criteria are as follows:—

1. An elevated blood pressure which at the end of puerperium has dropped to a normal level. In most instances this elevation is not very marked, rarely exceeding 150 systolic and 90 diastolic.

2. The amount of albumin in the urine is never very great, varying before delivery between a fraction of a gram and two grams per litre although the lower figure are most usually observed. The albumin disappears during the puerperium and the patient leaves the hospital either with no albumin at all or with at most 0.1 gram per litre.

3. The outstanding characteristic is the fact that, in subsequent pregnancies the

patient's condition does not become aggravated and she is as well or better than she was in the preceding pregnancy.

Whether the number of pregnancies through which the individual may go plays any role in the development of this entity is very doubtful for the reason that it is observed in primiparae as well as in all degrees of multiparity. Moreover this type of kidney does not seem to be permanently injured by pregnancy. As the woman approaches term a certain amount of albumin may pass through the glomerular membrane, the blood pressure becomes elevated and some oedema develops. With regard to the last point it is interesting to note that in subsequent pregnancies there may be either no oedema or at the most a slighter degree than before. It is well known that in a healthy person, under normal conditions, all the glomeruli are not functioning at capacity at any one time, and it has been estimated that there is usually a margin of safety which approaches 50%. In other words there is a decided kidney reserve which may be called into play. It therefore seems reasonable to suppose that in certain individuals such kidney reserve may be greatly decreased, due either to congenital causes or to factors which may have lessened the number of functional glomeruli without producing chronic nephritis. The strain of pregnancy always aggravates a chronic nephritis so that later the kidneys are less well prepared to stand the strain of subsequent pregnancies. In the Low Reserve Kidney this is not the case. All we can say is the kidney reserve seems to be too low to meet the extra demand of pregnancy, as is manifested by a certain amount of albumin through the glomerular epithelium and by a moderate elevation of blood pressure, and that these manifestations usually disappear completely within two weeks after delivery. Such kidneys appear to be functioning adequately while the woman is not pregnant as well as for her and her foetus till about the 8th month of pregnancy, when manifestation of the low reserve kidney begin to make their appearance.

Stander found that Low Reserve Kidney constitutes about 35% of the total number of pregnancy toxæmias. A considerable proportion of patients with low reserve kidney are grouped under albuminurias of

Hypotensyl tablets for High Blood Pressure.

pregnancy or pre-eclampsia while only a small portion are grouped as nephritic. From a study of the past history, blood pressure, urine albumin, presence or absence of oedema, urine and blood chemistry, eye grounds, symptoms and duration of pregnancy, it is usually possible to make a correct differential diagnosis between Low Reserve Kidney, chronic nephritis complicating pregnancy and pre-eclampsia.

TREATMENT: Rest in bed and a low protein diet are usually ample for treating these patients. Occasionally oedema of the ankles and legs disappear more rapidly with restriction of salt in the diet. Interruption of pregnancy is not indicated, as improvement generally follows this type of treatment. If however the condition becomes worse, notwithstanding rest in bed and proper dietary measures, we are probably dealing with nephritis and not a Low Reserve Kidney in which case premature induction of labour is indicated.

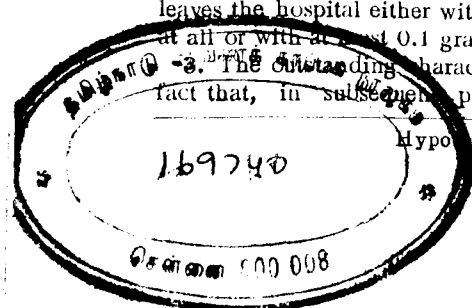
NEPHRITIS COMPLICATING PREGNANCY WITH OR WITHOUT ECLAMPSIS: The diagnosis is generally easy because of the outstanding characteristics in previous history, early onset even in the first trimester, high blood pressure, albumin in the urine casts and above all retinal changes—retinal arterio-sclerosis, thickening and tortuosity of the retinal vessels, and hæmorrhagic changes are often among the earliest indications that a chronic nephritis may be present. Routine ophthalmologic examination of the eye grounds is one of the essential routine examinations to which all toxæmia patients should be subjected. Study of the eye grounds often aids in differentiating nephritis from the other types of pregnancy toxæmia—Albuminuria retinitis is sometimes seen in nephritis complicating pregnancy while it is never present in true eclampsia or pre-eclampsia.

Pregnancy undoubtedly has a deleterious effect on chronically diseased kidneys, with the result that in each succeeding pregnancy the renal condition becomes more pronounced. The patient's past history is often of great help in establishing a correct diagnosis and the history of swelling of the feet and ankles appearing earlier in each successive pregnancy is most suspicious of renal disease. It is only in nephritis that oedema, visual disturbances and headache appear quite early in pregnancy. Symptoms and signs of Low Reserve Kidney and pre-

eclampsia present themselves during the last two or three months of pregnancy.

A careful study of the patients' blood pressure chart, proteinuria if present, oedema, symptoms of eye ground change, blood and urine chemistry and kidney function test will usually enable us to make a correct diagnosis. The behaviour of any of these abnormal findings, after the patient is put to rest in bed with appropriate dietary methods is of further help in the establishment of diagnosis. It must be admitted however that even with all these studies there is a small group of border line cases constituting approximately 10% in which a correct diagnosis cannot be made until late in the puerperial period. A careful following up study, however, conducted at six weeks, six months and one year post-partum will always ensure correct diagnosis and this, as I mentioned before, is necessary for prognosis, as in nephritis complicating pregnancy it is grave. The maternal mortality within a period of five years as found by Stander and Peckham is high, being 42.5% while that of toxæmias we find, is 25% of all maternal deaths in Madras.

I should like, however, to quote here a case reported by Goodall of a patient, Candian age 28, who consulted him in 1930. She gave a previous history of Scarlet fever at 2½ years of age, measles in later years. All her functions seemed normal, her weight was 104 lbs. skin a trifle dull and pimply, blood pressure 170/90, albumin in urine but no casts. Three days later she was re-examined—blood pressure, the same, albumin again, no casts. He gave a very bad prognosis as regards child bearing. She married in 1931, blood pressure 185/100, slight cardiac enlargement, a large amount of albumin and other clinical signs of nephritis, a few hyaline and granular casts. In 1932 she became pregnant and was in great fear. She had all the signs of nephritis and was sent to Goodall for therapeutic abortion. On examination he found the blood pressure 190/105, slight cardiac enlargement, no arterio-sclerosis, fundi normal, a very large amount of albumin, a few granular and hyaline casts, pregnant 2½ months. Her maternal instincts were so strong that she pleaded a trial, willing to undertake any risk for the fulfilment of her desire. He acceded unwillingly and put her on a very full



protein diet for two weeks, with a promise given that if she was worse at that period surgical intervention would be undertaken. On her return, however, the albumin was less, blood pressure had fallen from 160/90 and she felt reasonably well and determined to persevere. She gradually improved till June 1932, at 4½ months—blood pressure 110/70 and only faint trace of albumin in urine on boiling. There were no casts or blood elements in the urine and her general condition continued to improve. In July, she was free from albumin, her blood pressure was 110/75 and she had gained 15 lbs. at the end of pregnancy. She had gained 29 lbs and 'never felt better in her life,' and was on a full diet through out. The blood pressure never rose over 110 at any visit, and there was from time to time a trace of albumin, as the only indication that all was not normal. She had a normal labour with a live child nearly 7 lbs. in weight. This case was reported in May 1933 and up to that time mother and child were both well. Did the pregnancy in this case improve the condition of the kidneys? He reports 4 other cases of similar nature.

Goodall explains this as follows, on the one hand there are women who are normal in the non-pregnant state and toxic when in the last two trimesters of pregnancy and on the other hand he has quoted 5 cases of toxic non-pregnant and first trimester pregnant women who in the second and third trimester became quasi-normal. What internal condition will explain this paradox? Have we any other consideration which approaches this state of affairs?

He points out, how in certain cases of thyroid instability, some cases are decidedly aggravated by pregnancy while others who are decidedly better of their hyperthyroidism during the pregnant state. He explains that it is due to the interaction of a stimulus (pregnancy) which Mellroy calls a 'ductless gland'. This brings about a changing consumption and the reserve power of the gland or glands in question. In other words, an equation made up of stimulus, need and response. He states that elevated blood pressure, albuminuria and oedema may be signs of functional disturbance with minor reparable damage and

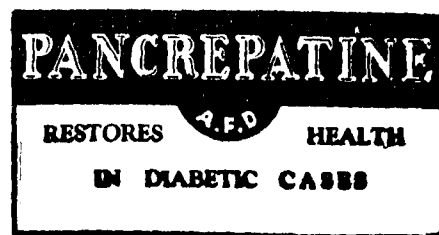
which eludes detection, while in the other, there may be irreparable discrete organic disease. In chronic poisoning the body cells have time to accommodate themselves more or less to this new environment. The result is usually a dysfunction, later, a vitiated function leading to slow cumulative toxæmia and slow organic changes.

On the other hand in acute fulminating conditions, the first stages of dysfunction and of vitiated function are too short to allow the body to meet the onslaught and in its unprepared state, widespread organic destruction follows rapidly. This explains why it is that chronic toxæmias rarely pass into eclampsia.

In other words functional albuminuria (or as Langdon Boaw calls it—Functional Proteinuria) has a better prognosis; parturition is safe and the proteinuria clears up after delivery. These cases may be compared to the glycosuria conditions without other symptoms seen, not infrequently in pregnancy and which have a similar fate.

Whereas chronic nephritis and true toxæmia (nephritic or hepatic) which may end in eclampsia, may show some retention of nitrogen in the blood. Values of 35 mgs. per 100 c. c. of blood for the total non-protein nitrogen and 28 mgs. for the urea may be associated with severe symptoms, whilst values ranging round 50 for the total non-protein nitrogen and 40 for the urea may be associated with slight symptoms. However, values of over 50 for the urea may usually be regarded as requiring drastic treatment.

To be continued.



Hypotensyl tablets contain a special hypopiesic principle of the spleen.

COMPLICATIONS DURING ANTI-SYPHILITIC TREATMENT.

BY

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(Continued from Last Issue).

NEPHRITIS AND ALBUMINURIA. Bismuth and mercury have a more toxic action on the kidney than the arsenobenzols. Mercury is more liable to give rise to Nephritis and subsequent albuminuria than Bismuth. In severe cases there may be casts and blood in the urine. It is not advisable to give both arsenic and bismuth simultaneously when there is any pre-existing disease of the kidney, as evidenced by the presence of albumen in urine. It is better to give arsenic in such cases in preference to bismuth or mercury. When albuminuria develops during treatment, stop the anti-syphilitic treatment and put the patient on Mist. Ferri Diurctica, (Tinct Ferri perchlor 5 ms, Acid Natro Hydro Dil 5 ms, Spt Chloroform 15 ms, Spt Juniper 10 ms, In Quassia 10 ms, Decoction Broom ad 1 oz.) Inject 5 to 10 c. c. of Sodium Thiosulphate (1 gm. in 10 c. c.) intravenously till urine is free from albumin and estimate albumin daily to note the effect of cessation of the specific therapy. When the urine is free from albumin, give small doses of arsenic, and avoid dual therapy subsequently.

JAUNDICE occurs occasionally during and subsequent to treatment by arsenobenzol due to its toxic action on the liver tissue. Predisposing factors to its occurrence are constipation and gastro-intestinal toxæmia Icteric index and Vandenberg reaction qualitatively and quantitatively should be done to estimate the liver function, with a view to the possible prevention of jaundice and its early detection. Any increase of Bilirubin above 4 units is regarded as danger signal of a possible oncoming jaundice. Phenol tetrachlorophthalein test is done to study the liver function. If Vandenberg test is performed as a routine, it will safeguard against the development of post salvarsan jaundice. It is better to do Vandenberg reaction in cases which have developed jaundice, to estimate the liver function before starting the treatment with arsenic.

When jaundice develops during anti-syphilitic treatment, stop all therapy and

inject Soda. Thiosulphate intravenously and give Mist. Hepatica with lot of glucose by mouth till the patient is free from jaundice. (Mist. Hepatica: Ammon Chloride 10 grs, Acid Nitro-Hydro Dil 10 ms, Mag Sulph 10 grs, Tinct Nueis Vom 5 ms, Tinct Phirco 30 ms, Aquacinnamon ad 1 oz.) Examine the urine daily for Bile salts and Bile-pigments and the sclera for yellow tint. Inject 20 c. c. of 20% of glucose intravenously daily. Fasting before arsenic injection decreases the glycogenic content of the liver and that as a result, the liver is more vulnerable to arsenic. Give 50 c. c. of glucose by mouth half an hour before arsenic injection, as it increases the glycogenic content of the liver and fortifies the liver against the action of arsenic.

It is better to give only bismuth or mercury in cases who have developed jaundice during treatment. Never give arsenic to cases who have developed acute yellow atrophy of liver. It is characterised by the patient getting rapidly jaundice with associated intense abdominal pain, tenderness over the liver and great prostration. Death occurs from three days to a week in spite of the usual treatment by alkalies, soda thiosulphate, fluid glucose intravenously.

PURPURA HAEMORRHAGICA is a very serious complication but fortunately rare. Only one patient I have come across for the last five years in the Venereal Clinic, General Hospital, Madras, who has fortunately survived. In severe cases, besides the skin eruption, there is oozing of blood from all mucous surfaces. Practically all cases end fatally. Its onset is an absolute contra-indication for any further treatment of arsenobenzol. In mild cases, Cal. Lactate by mouth or Cal. Chloride or Soda Citrate intravenously or per rectum may be given. In severe cases, the blood transfusion is the only hope. Avoidance of alcohol is insisted throughout the whole course of treatment.

STOMATITIS is preventable to a great extent by the removal of septic stumps and decayed teeth prior to the anti-syphilitic treatment. Stomatitis begins with a slight redness and sponginess of gums. Later there is a slight metallic taste in the mouth and the odour of the mouth becomes foul. In advanced cases, ulceration of the mouth develops especially in the area behind the last molar teeth. When the ulceration has advanced, the whole mouth may become oedematous, sodden

and septic, with ulcerated areas around the base of several teeth. It is important to examine the patient's teeth and gums before giving each injection. When there is slight blue lining of the gums and excessive salivation, stop the drug and give Pot. Chloras gargle by mouth and inject 5 to 10 c. c. of Soda. Thiosulphate, till the mouth condition clears up. With bismuth a bluish black line along the margin of the gums may appear. When the acute symptoms have subsided, the patient should be sent to a dental surgeon for scaling and attending to all septic foci and decayed teeth. On resuming treatment small dose of bismuth, mercury or arsenic should be given, protected by Soda. Thiosulphate, if necessary paying great attention to the hygiene of the mouth.

Stomatitis due to bismuth or mercury is very rare in young children and edentulous subjects. Arsenic, bismuth, mercury and iodides give rise to stomatitis. Arsenic stomatitis differs from heavy metal stomatitis in the dry, red, glistening appearance of the mucous surfaces as distinguished from the lividity and exudative characteristics of heavy metal stomatitis. There is, moreover, no pigmentation unless the patient is taking bismuth conjointly. A grave sign in all stomatitis conditions is the appearance of necrosis and of submucous hæmorrhage. This warns not only of the severity of the stomatitis as such but of the development of agranulocytosis under Salvarsan or bismuth therapy, or the onset of aplastic anæmia. A complete blood count with a study of the blood smear for the hæmatological signs of damage to the hæmatopoietic mechanism is necessary. A bland diet rich in carbohydrate should be given in cases of heavy metal poisoning, fats and proteins if the hepatic complications are due to arsenic. 10 c. c. of Cal. Gluconate (10%) is given intramuscularly. Iodide stomatitis is very rare.

HAEMORRHAGIC ENCEPHALITIS is a fatal complication of arsenic, gives very little warning of preventive value. I have seen a case of Encephalitis due to bismuth, which is a rare complication not recorded in any book on Syphilology. Patient developed Encephalitis after the second injection of bismuth and brought to the Veneral Clinic, General Hospital, in a comatose

condition. Fortunately the patient got round after a prolonged and vigorous treatment having recourse to a lumbar puncture daily and Adrenalin and Soda Thiosulph injections. Only alcohol seems to be a predisposing cause. It is easily mistaken for simple apoplexy, uremia, or acute alcoholism with delirium tremens. Most of the cases begin rapidly within a few hours or even several days after arsenic injection. The patient becomes dull and apathetic, then rapidly disoriented, noisy, disturbed and inarticulate. If the onset of symptoms is gradual patient lapses from the inarticulateness into semicoma from which he is at first aroused, but later falls into a deep comatose condition with stertorous respirations; convulsions then occur and death supervenes within 24 to 48 hours. In some the onset may be abrupt with a convulsion and stupor or an apoplectiform attack. Treatment consists in the judicious draining of the spinal canal till the theca is dry, combined with sufficient doses of Adrenalin and Soda. Thiosulphate. Adrenalin restores the diminished elasticity of the arteries and thereby avoids hæmorrhage in the brain. If the patient is brought in the early stage, during the stage of stupor or depression, before delirium or convulsions set in, the prognosis is fairly good. Very few cases recover.

OCULAR DAMAGE: Mercury and bismuth have no effect on optic nerves. Tryparsamide, pentavalent preparation of arsenic gives rise to blindness, if it is injected when there is optic atrophy or neuritis. It seldom produces dermatitis.

INTOLERANCE TO IODIDES: The main signs and symptoms of intolerance to the use of iodides are headache, nasal catarrh, watering of the eyes, dyspepsia and occasional dermatosis. Withdrawal of the drug leads to the rapid disappearance of all the symptoms. In very intractable cases colloidal iodine may be injected intravenously, which seldom gives rise to intolerance. Iodide stomatitis is a very great rarity.

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Hypotensyl tablets contain a special hypopietic principle of the liver.

Abstracts

THE CONSERVATIVE ATTITUDE IN THE TREATMENT OF ACUTE PYOGENIC INFECTIONS

By

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The conservative attitude in the early treatment of acute surgical infections such as carbuncles, cellulitis, lymphangitis, and infections of the hand and face is not well enough understood or appreciated. Premature and unnecessary incisions are far too often made; adjuvant non-operative treatment is too often neglected. Conditions which frequently go on to suppuration and, in a small proportion of cases, to very grave complications, produce a perplexity in the practitioner's mind as to what early treatment should be instituted. For many years cases of acute surgical infection admitted to the London Hospital have, so far as possible, been segregated in two special wards comprising forty-four beds, and it is the purpose here to review the procedures which have been evolved in these wards with their large amount of material and to demonstrate the extent to which conservatism has been carried.

The virulence of the organism and the resistance of the patient are the two fundamental factors that determine the outcome of such infections. Little can be done to influence the former; the latter can easily be undermined by ill-timed operations. It is not proposed to discuss the question of serum or vaccine therapy, both of which, at the present time, can only be regarded as possible adjuvants to, and of much less importance than, clinical treatment. By the conservative attitude is meant the avoidance of incisions altogether, or their delay until a localised collection or collections of pus have formed. Most surgeons and practitioners have at one time or another made an incision in an inflamed area without revealing pus. A little disappointed, the operator nevertheless expresses the opinion that the incision will do good. It is not true. The local defensive processes have been impaired, the patient has been subjected to a needless and fruitless operation; a longer illness or convalescence has been entailed; and, most important of all, new channels for the

infection to follow have been opened up, this in grave cases and in certain dangerous situations turning the scale against recovery at all.

REASONS FOR INCISION

Premature and unnecessary incisions are made for several reasons. One is the perhaps not unnatural feeling that tissues made tense by inflammation, without necessarily pus-formation, ought to be incised in the hope of relieving pain and allowing an exit for the organisms and inflammatory exudates. But the pain is not relieved; the swelling is essentially a curative reaction, and far from the infection being allowed an exit it is only permitted a further spread afield. Another reason for over-early incision is that the patient or his friends, calling insistently for something to be done at the height of his malaise, which is usually before pus is present, persuade the doctor to it. Still another reason is the mistaken diagnosis of localized pus; while deeply seated pus is sometimes difficult to detect, there is not so much excuse for mistake in superficial collections. It is doubtful whether any physical sign of equal importance is so casually sought for as fluctuation. One observer's fluctuation indeed is often another observer's mystification.

Carbuncles, cellulitis, and infections of the hand and of the face provide a very great proportion of what one may call the septic infections. All, moreover, are liable to severe complications. A survey of these in regard to early conservative treatment and its outcome in fairly large series of hospital cases will now be made. A three-year period has been chosen, and the wards for the greater part of that time have been under the writer's supervision. It may be said now that in the treatment of all the infections to be dealt with much faith is placed in the copious administration of fluids and of potassium citrate, the latter being given as a routine procedure in doses depending on the severity of the toxæmia, up to as much as 60 grains two-hourly.

CARBUNCLES.

No carbuncle has been incised, excised, or scraped in these special wards during the past three years. The total number of carbuncles treated is seventy-eight. This abstention from operation is probably carrying conservatism further than usually

practised elsewhere. Except for carbuncles of the face and lips, so dangerous because of the possibility of intracranial extension, the most prevalent treatment elsewhere is excision or incisions, crucial or multiple. The non-operative treatment of carbuncles in other situations has with us evolved from the excellent results obtained in facial cases by means of hot hypertonic salt compresses. There are two distinct advantages. The first is the avoidance of an anaesthetic and operation; this, laudable in itself, is of additional importance since many carbuncular patients, whether diabetic or not, are in a debilitated state. The second advantage is a cosmetic one; incisions are the main cause of ugly scars.

These two advantages are stressed rather any attempt made to deduce a decrease in mortality rate, since in not a few patients the carbuncle is a complication to some other affection, and the mortality rate in any series must depend greatly upon the proportion of such complicated cases. In the series of seventy-eight presented (and it must be remembered that the cases were all deemed sufficiently severe for the patients to be admitted as in-patients) there were five deaths. Three of these five were complicated by acute leukaemia, uraemia, and severe diabetes respectively; a fourth patient died two hours after admission in a moribund state. In these cases the carbuncle was situated on the neck or back. The fifth death occurred in a patient with carbuncle of the upper lip, who developed cavernous sinus thrombosis and pyaemia. Such facial cases will be discussed separately later. Regarding the others, it will at least be conceded that the mortality rate is no higher than occurs with operative treatment. Series treated operatively in these wards in the past compare unfavourably, but it is not proposed to go into this in detail since it would be impossible to contrast even approximately similar series.

It may be asked,—do not incisions make the patient's complaint more tolerable? Rest in bed and the administration of such sedatives as aspirin and pyramidon will effect this state for the few days necessary before separation of the slough. It is erroneous to assume that much pus will be liberated by incision; there is little pus to liberate. At the same time, it may be conceded that incisions in carbuncles, because

of the great surrounding induration, are unlikely to be dangerous by causing spread of infection—that is, if the incisions do not extend beyond the carbuncle. Yet there are some who deny much value to incisions unless they are carried out into surrounding healthy tissue.

LOCAL TREATMENT ADOPTED

The actual local application employed is a fomentation or compress made of fluffed-up white gauze, which has been well wrung out of a hot solution of hypertonic salt—one ounce to the pint—overlaid by a flat piece of white lint similarly treated and further overlaid by jaconet or oiled silk. The fluffed up gauze collects the pus much better than a flat dressing. (Modifications for facial cases will be described subsequently). The salt fomentations are renewed two-hourly during the day and four-hourly at night. In a few days the slough comes away entirely, leaving a granulating area which in another few days presents a healthy colour. Dry, fluffed gauze dressings are now substituted, and the epithelium creeps in to cover entirely an area which in many cases would seem to need skin grafting. There has been no need to skin-graft any of the cases in the series, although in some the area covered almost the entire back of the neck.

The preference for strong salt solution over the magnesium sulphate and glycerine paste alternative is in virtue of the greater heat which can be applied with the former. While the carbuncle, with its large slough, gives the more striking results, the method is equally applicable to boils.

INFECTIONS OF THE FACE, NOSE, AND LIPS.

It should be unnecessary to have to indicate the dangers of infections of the face, nose, and lips, dangers which lead to some of the saddest tragedies in surgery, but the situation is still imperfectly realized. Often originating in an apparently trivial focus the infection spreads to the cavernous sinus by the angular vein of the pterygoid plexus with an almost invariably fatal result. While, doubtless, a virulent infection will find its way thereto whatever the treatment, it can be gainsaid that the process is frequently aided by incisions or squeezing of the focus. Infections of the upper lip

and the side of the nose are particularly liable to the complication. No incision should ever be made on the face for an inflammatory condition, whether it be boil, carbuncle, septic spot, or cellulitis. Should an abscess form it must be allowed to rupture spontaneously. Patients not under hospital supervision must be deliberately warned against attempts at expression of pus by squeezing.

During the three years 1932-34 there have been 112 cases of infections of the face admitted to these wards, among which there have occurred four deaths. One of the patients who died (mentioned above) had a carbuncle of the lower lip which spread to the upper lip and terminated in thrombosis of the cavernous sinus; a second, a diabetic was admitted with a furuncle of the nares, purulent frontal sinusitis, septicæmia, and cavernous sinus thrombosis and died the same day. The third and fourth both died of cavernous sinus thrombosis and septicæmia, having had incisions made elsewhere into a furuncle of the side of the nose (no pus obtained on two occasions), and a small furuncle of the upper lip respectively. Whether complications in the second case were aided by squeezing is not known, but it is evident that only one death occurred where scope could be given to conservative treatment, and of the 112 cases in the series the infection, apart from any concomitant cellulitis, was in rather more than a third of the total number situated in the nares, the side of the nose, or the upper lip, the most dangerous sites of all.

TREATMENT ADOPTED

The treatment adopted is in the main similar to that described for carbuncle. It is however, not very practicable to adapt compresses to the lips or the interior of the nares. Patients with lesions situated there can have similar therapy by immersion of the area in hot salt solution, the patient bending forward over a wide-mouthed jug of solution placed in a basin of hot water to maintain temperature and to catch the overflow, or, in the case of the nares, by application to the part by the patient himself of a large piece of cotton-wool soaked repeatedly in the solution from a basin in front of him. This bathing is performed for a quarter of an hour at two or three-hourly intervals. During the intervals a

compress is applied as near as is practicable. Where the infection is on the lips, the salt solution is made weaker, about half an ounce to the pint. The cosmetic result after conservative treatment of carbuncles, however, large, on the face is always excellent.

CELLULITIS

Conservative treatment has certainly been more generally appreciated and adopted in cellulitis than in the other acute infections. None the less, mention of the practice of multiple incisions before suppuration has occurred has not altogether disappeared from the student's text-books. It seems extraordinary that the practice prevailed so long. Admittedly the patient usually recovered, in spite, rather than because, of the treatment, but even if he did get well without complication the incisions took time to heal, and the limb was disfigured with unnecessary scars. Present-day treatment takes the form of the application of large fomentations to the part, and abstention from incisions unless a localized abscess or abscesses arise or—and this is rare—diffuse unlocalised suppuration supervenes. In more than half of the cases no suppuration or other complication occurs. Such resolution is aided greatly in the case of the limbs by elevation. The number of cases which go on to grave complications is few, but recollection of such a case tends to precipitate ill-timed incisions where the general condition is disturbing.

Although cellulitis and lymphangitis fairly frequently coexist, what might be called cases of pure lymphangitis have been omitted from the series of 145 cases observed in these wards over a three-year period. The series comprises forty-eight cases of cellulitis in the upper and fifty-seven in the lower extremity, twenty-seven of the face and thirteen situated elsewhere. Cellulitis of the face has already been mentioned. Of cases occurring in the extremities, 105 in all, fifty five resolved without complications, forty-three had the minor complication of localised abscess or abscesses, while seven had the major complication of diffuse suppuration or and septicaemia. It is of interest that whereas the odds on resolution without complication, minor or major, is two to one in the lower limb, it is two to one against in the upper. This seems connected

with the fact that cellulitis originating in or reaching to the loose cellular tissue in the region of the elbow is almost invariably followed by suppuration. The only fatalities in the series of 105 limb cases thus treated conservatively were three associated with fulminating septicaemia; all three were cases of cellulitis of the upper limb. The number of patients who developed grave complications but recovered is four; one recovered from septicaemia, two from diffuse suppuration which entailed a series of incisions, and one from suppurative adenitis with much toxæmia.

The series refers to cellulitis in the more common use of the term—that is, a condition superficial or at least starting superficially—and not to forms of cellulitis occurring in deep fascial planes from original deep foci penetrating wounds, or operations. The chief situation of the cases occurring other than on the extremities or face in this series is in the neck, and this condition tends to present great difficulties because of the depth of spread and the effects of pressure. By reason of these two factors incision here has occasionally to be made without certainty of the presence of localized pus or of its accurate localization. If incision be deferred, however, as long as is reasonable, localized pus is usually encountered; such incision was needed in seven out of nine cases, and there were no deaths. Premature exploration incurs a grave risk of spread of the infection to the mediastinum.

INFECTIONS OF THE HAND

What of the conservative attitude in probably the most difficult of all surgical infections those of the hand? Here correct early treatment is imperative if the incidence of severe complications, local or even systemic, is to be kept at a minimum. The brilliant researches of Kanavel have revealed the potential spaces and compartments of the hand so that the tracks of spreading infections can be followed with accuracy and suitable incisions planned. Such anatomically complicated cases arise commonly from small original foci, and although the spread depends largely on the balance of virulence and resistance there is no doubt that local diffusion or systemic involvement can be aided by unsuitable early treatment.

THREE COMMON FAULTS IN EARLY TREATMENT

In the wards referred to there are annually some sixty patients with hand and finger infections, and the care of these is closely associated with an out patient clinic for less severe cases. There would appear, from our experience, to be three common and important faults in early treatment. The first is the use of incisions when pus is not present; the second is inadequacy in the size of the incision when pus is present; and the third the injudicious prolonged use of hot, moist dressings.

To dismiss the last first. A hand sodden and swollen by an endless succession of wet boric fomentations not only presents a baffling problem in diagnosis but has had its tissues so devitalized that diffuse spread of infection is inevitable. Such ultra-conservatism is not laudable, but let it be said that this condition is as frequently as not found in combination with incisions which have failed to reveal pus. Nor will anyone with experience, doubt the second contention that incisions to evacuate pus are often much too small.

What of the early treatment before pus is present? Although surgeons of experience in septic work are in the main agreed upon an early conservative attitude in most acute infections there is a distinct divergence on the part of some when infections of the hand are discussed. It seems to me that such have let the occasional tragic case weigh too heavily upon their minds. There will always be virulent infections, and too often the surgeon will not have the strength to stick to his principles, in order that it can be said that everything possible was done for the patient. Everything possible, but everything wise?

The immediate treatment of a prick is of peculiar interest to the surgeon. A not uncommon injunction is never to squeeze the digit; some advocate paring off the surface epithelium around so as to remove organisms left in the cuticle as the point passed through; immediate excision of the track has been advocated. The last may be ideal, yet how many surgeons would subject themselves to it? Organisms may get held up

in the cuticle of the horny-handed, but it is doubtful if this is so likely to occur in the hands of such as nurses and doctors. As regards the embargo on squeezing, it seems surely quite rational to hold the finger under the hot tap and compress its base in order to encourage bleeding and the possible immediate washing out of the organisms, not to speak of bringing to the area a greater supply of blood, with its normal bactericidal properties.

TREATMENT IN THE ABSENCE OF PUS.

But it is when the prick area or some similar lesion becomes inflamed and there is toxæmia, high temperature, may be a rigor, and streaks of lymphangitis or a spreading cellulitis that differences of opinion are most important. If there is localized pus at the focus an incision appeals to everyone. Some assert, however, that the focus should be incised even if the pus has not yet formed. Charts are produced to show how the temperature subsides after incision, with a caption that the lymphangitis did likewise. It is not an uncommon thing to see such charts, illustrating some particular therapy or other, with an arrow indicating an incision or an injection of some serum or medicament, and a consequent rapid fall in temperature. The weakness of these demonstrations is that a sudden drop in temperature and restoration of well-being is so very common a phenomenon in lymphangitis treated conservatively apart from special therapy. This occurs in approximately the first seventy-two hours, the period in which the special therapy will usually be found to have been given. What, however, seems the most striking argument against incision of the focus in the absence of pus, is that the incision of a similar focus unaccompanied by lymphangitis is often immediately succeeded by lymphangitis. If such can happen where lymphangitis was not present, what additional harm may not be done where it is already present? The rational treatment, however severe the case becomes, is surely the conservative one, the application of heat by large fomentations to the entire limb and deferment of incision until pus is present. Rest and copious fluids complete the treatment, although antiserum will probably be given by many. The more satisfactory treatment of virulent cases rests surely in the future progress of serum therapy.

The danger in conservative early treatment in hand infections lies in its overdoing. An account of the various entities is out of the place here, but from their well-known complexity it is obvious that a keen look out must be maintained so that suppurative processes are detected early, dealt with, and not allowed to spread insidiously. Recognition of these will be blinded by the use of prolonged wet dressings or too frequent salt baths. A well wrungout fomentation, whether salt or boric, will supply the necessary heat without the unnecessary soddenness.

In a three-year series comprising 176 cases of hand infections in these wards there were four deaths. One was in a man of 71 who developed a severe spreading cellulitis after an abrasion of the back of the hand, and died of septicaemia thirty hours after admission. A second patient, suffering from a thenar space abscess, developed a cellulitis of the limb and septicaemia. Both these are included in the cellulitis series above. A third died with lymphangitis and septicaemia secondary to a subcutaneous whitlow of the ring finger, while a fourth died of septicaemia unassociated with lymphangitis, following a hæmolytic streptococcal abscess in a lumbrical space. A mortality rate of 2.2 per cent. is certainly not unduly high for patients with hand infections severe enough to warrant admission to the hospital.

TWO OTHER SURGICAL INFECTIONS

Of the other surgical infections, two desire brief special mention, as they are so commonly explored far too early. One is puerperal breast infection. An over-early incision here very frequently entails further incisions, whereas a holding back until the various adjacent foci of suppuration have coalesced into one large abscess usually allows of one incision being sufficient. This is a waiting procedure beyond the knowledge that pus is present, but there is no danger and little discomfort by delay. When the abscess is deep and slow in moving superficially it may be difficult to know when to incise. A helpful sign is the palpation of a little break in the covering fascia of the breast into which the tip of a finger can be dipped. This, which is usually not far from the nipple, is the early stage of a collar-stud abscess, and exploration at this point will reveal a well-circumscribed solitary abscess.

The second instance is the external inflammatory swelling which precedes the formation of an alveolar abscess. Here external incision can sometimes be avoided altogether by internal drainage achieved by removal of the tooth. Over-early external incision frequently fails to reveal pus, and too vigorous exploration may set up a deep cellulitis with grave consequences.

It would be difficult to prove, as regards mortality rates, that such early conservative procedures as have been advocated are preferable to more active measures. The factors of virulence and resistance cannot be estimated so that parallel series can be compared. The object here has been rather to show how few complications occur in large series of cases deemed sufficiently severe to be admitted to hospital, and how frequently intervention has been unnecessary. Conservatism is, of course, no new fashion; rather is it a reversion to the old. Lessening of the risks of mixed infections after the introduction of antiseptics and asepsis possibly emboldened the free use of the knife. But reasoning on pathological ground and clinical impressions are both in favour of less interfering methods. There is certainly a danger in being ultra-conservative, and anyone who regards the attitude as merely surgical inactivity does injustice to surgery in regarding its only activity an operative one. A careful watch has to be maintained so that intervention, if needed, occurs at the optimum time. The old dictum, "where there is pus, let it out!" has become a commonplace. At the present time a more valuable injunction, despite its Irish flavour, might well be: Where there is n't pus, don't let it out!

B. M. J., 11th May 1935.

NOTICE.

Subscribers are requested to notify changes in their addresses in time and while doing so they should kindly quote the serial numbers against their names appearing in the postal wrapper of the journal.

V. RAMA KAMATH,
Managing Editor.

Hypotensyl tablets contain the blood pressure reducing principles of Mistletoe.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Prevention of Uræmic Coma

The prevention of uræmic coma in a patient threatened with it as suggested by the clinical phenomena described requires the following measures:

1. The patient should have absolute rest in bed.

2. The dietary regimen to be resorted to demands differentiation between at least four possible varieties of uræmia: (a) intestinal intoxication predominating (indican and phenol in serum); (b) acidosis prominent; (c) hypochloridosis; (d) hypohydration.

(a) Starvation for a day is a good beginning when intestinal intoxication predominates, provided the patient is well nourished. This is followed by high carbohydrate-low protein diet (see Nephritis).

(b) Acidosis does not permit starvation. It demands a sugar diet from the start, which may consist for example, of the juice of one lemon, one teaspoonful of cane sugar, and six tablespoonfuls of lactose in enough water for solution (1½ cupfuls). This quantity, given four times daily, yields 1,242 calories, which may suffice for possibly two days. It might be followed by the banana-cream diet; morning and evening 300 gm. of ripe bananas and 100 cc. of cream, and at noon 200 cc. of cream soup, 300 gm. of bananas and 200 cc. of milk, yielding 1,335 gm. calories, protein 29. gm and alkaline ash. This must not be continued for more than a few days and it should be followed by the lactovegetarian diet with an abundance of potatoes because of their alkaline ash. Protein must be but moderately restricted for continued sustenance.

Patients who are nearly always on the verge of uræmia may be kept in a fair degree of comfort for a long time by a more or less weekly repetition of this programme.

(c) Hypochloridosis requires the additional administration of sodium chloride given, if the stomach is nonretentive, in the form of retention enemas, hypodermoclysis or intravenous injection of physiologic solution of Sodium Chloride in accordance with the degree of the emergency. If this is extreme,

even hypertonic (10 per cent) salt solution may be used in phlebotomy, drop by drop. Great salt restriction is not advisable in any patient threatened with uræmia.

(d) Hypohydration is especially threatened when emesis predominates. Such vomiting indicates gastric lavage with 2 per cent sodium bicarbonate solution followed by duodenal tube administration of 1 or 2 liters of hot water (110° F) or of 2 per cent sodium bicarbonate solution (if acidosis is present) or of physiologic solution of Sodium Chloride if hypochloridemia prevails. Giving these solutions hot may succeed in establishing profuse and salutary sweating.

3. The necessity for intestinal evacuation is especially demonstrated by the presence of indican and of phenol in the serum.

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(a) If constipation prevails, a saline cathartic, such as Sodium Sulphate (15 gm), may be given every morning, with possibly initial Mild Mercurous Chloride administration in broken dosage for the first day or two. Magnesium salts are contraindicated in uræmia as, owing to retention of magnesium ions in the system, a condition of coma—easily mistaken for uræmic coma—may be induced in nephritic patients by magnesium sulphate purgation. It is not advisable to maintain a diarrhoeal condition by means of purgation, as this weakens the patient, because relatively more nutrient matters than nitrogenous waste products are lost in the watery stools.

(b) When there is diarrhoea and also in the presence of constipation, prolonged colon irrigation with hot 2 per cent sodium bicarbonate solution is desirable, with the use of 2 or 3 gallons of the fluid in the course of an hour or two.

4. Heat must be employed the more cautiously, the more critical the condition. Excepting for applications to the loin it is contraindicated by myocardial insufficiency. One may choose from among the following methods:

(a) The loin poultice or hot wet pack is desirable, moist heat being better than dry heat in those cases in which the skin is harsh and dry.

(b) The electric light "baker", either general or applied only to the loin, if the heart is weak, is the more convenient method. It is to be preferred therefore, provided the skin is tolerably active.

General diaphoresis by any one of these measures must not be attempted until improvement has commenced to set in for fear of weakening the heart or of aggravating the uræmia. When definite improvement has set in, a mild degree of sweating may be salutary; but exhausting and drenching sweats should be avoided, for the skin is but a poor vicarious emunctory for the kidney. Pilocarpine Nitrate (5. mg. hypodermically or 10 mg. by mouth) is admissible only if the patient, while in a general heating procedure, does not sweat, and has become extremely hot and uncomfortable. It is contraindicated by heart weakness and pulmonary oedema. Excessive or dangerous pilocarpine action may be promptly checked by Atropine Sulphate (0.5 mg.) given hypodermically.

5. Diuresis is contraindicated until considerable improvement has set in. Then it may be attempted cautiously, as discussed under "Therapy of Nephritis", with continued observation of the effect. The diuretic least likely to be harmful is water, which might be given as a deliberate "water thrust" of 2, 3 litres of water or of other fluid daily, a careful watch being made of the effect on the urine and the intake being promptly diminished if the quantity of urine is not increased or as soon as the initial diuresis commences to fall off.

(J. A. M. A. May 4, 1935, p. 1602).

Treatment of Lung Abscess

Dr. Chandler maintains that the cases of lung abscess should always be given a fair trial by a preliminary course of medical treatment as spontaneous cure is by no means uncommon. As far as possible the patient should be nursed in fresh air and should avoid any adverse weather. Postural drainage is of great importance and should be thorough and rational. To be so the exact site of the abscess and the bronchus draining the abscess is essential, and this can be ascertained by means of anterior and true lateral skiagrams with or without lipiodal injections. Cough which is paroxysmal, distressing and exhausting must be relieved

without in any way suppressing the cough reflex or inhibiting the action of the cilia and without making the expectoration too tenacious to be brought up. Inhalations of menthol, Friar's balsam, pine, etc., are helpful but sometimes the use of opium has to be resorted to in the shape of Morphine 1/6th to 1/4th grain or Omnopon 1/6th to 1/3rd grain. Relief of the cough is specially important as the patient may have sleepless nights besides wearing himself out, and it may spread the contents of the abscess into other parts of the lung. He goes even so far as to say that if the cough is uncontrollable it is one of the indications for early operation.

Various injections have been suggested as for example alcohol injections but are of no use. He believes that lipiodol injections orally or by nasal catheter or the cricothyroid route are helpful towards spontaneous recovery. If all these measures fail bronchoscopy under avertin or local anaesthesia should be tried to produce a freer drainage by relief of the edema of the bronchus, or some treatment of the granulation tissue, be it painting, with cocaine, dilatation, or cauterisation.

If after three or four weeks waiting to give nature a chance no improvement occurs he advises operation in two stages. The first stage is to produce adhesion of the pleural layers and the second stage is for the opening up of the abscess cavity preferably by the diathermic current, opening up of all affected bronchi, all bleeding points to be stopped by the diathermy button, adequate drainage to be established and abscess not allowed to heal too soon. The first is done under local anaesthesia and the second under gas and oxygen. In conclusion he maintains that if he had lung abscess he would wait a month before being operated unless the symptoms were intolerable. He prefers the

open operation and drainage rather than bronchoscopy although he admits many may differ from his views.

(B. M. J. March 20, 1935, p. 429.)

Psoriasis of Scalp

In reply to a query to the Editor of the *J. A. M. A.*, regarding psoriasis of the scalp the following has been recommended: An ointment consisting of ammoniated mercury 12 gm., wool fat 4 gm. and sufficient petrolatum to make 30 gm. is often efficacious. This should be rubbed into the individual patches every night, and may be left over for a day or two or it may be washed out every morning. The scalp should be washed twice a week at least and any soap will do for the purpose. If this treatment fails, an ointment consisting of oil of cade 4 c.c., salicylic acid 2 gm., and ammoniated mercury 4 gm. may be tried. A 3 per cent chrysarobin ointment is effective but is likely to discolour the hair.

(J. A. M. A. March 9, 1935 p. 1935.)

Treatment of Warts

Lurie treated 49 patients suffering from warts by intramuscular injections of bismuth salicylate. Thirtyfour of these patients were observed for varying periods following treatment and in all cases the warts completely disappeared. Injections were given at weekly intervals intramuscularly in the upper outer gluteal quadrant. Children from 6 to 10 years of age were given 1 grain of bismuth salicylate intramuscularly, children from ten to thirteen years of age 1½ grains and older patients 2 grains. Plantar warts, so-called papillomas, responded spectacularly to this treatment.

Arch. Dermatology and Syphilology, July, 1932

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CLINICAL NOTES

AND

PRACTICAL SUGGESTIONS.

Treatment of Dyspepsias.

Perhaps the most common disorders that are frequently encountered in every day life are the affections of the digestive tract. Dyspepsias, to use the term in its widest sense, is the commonest among these and is the bane of our modern civilization. This is due probably to the large percentage of carbohydrates in the modern diet which imposes a great strain on the stomach, specially when the food is hurried through without proper mastication to permit of complete digestive action by the ptylin of saliva. The result can more or less be imagined. There is a feeling of acute digestion characterised by fullness and pain two or three hours after eating. This is because the gastric secretions are unable to convert the large amount of starch ingested into a soluble form. If this condition is neglected or remains untreated, it becomes chronic or sometimes a serious state of affairs such as gastritis or peptic ulcer may follow.

In the treatment of these dyspepsias Papyta is the remedy of choice. It is a well blended preparation of recognised vegetable ferments, practically odourless and tasteless and possessing a remarkable property for converting starch. Unlike other ferments those contained in Papyta are not rendered inactive in the gastric juice. The papain found in Papyta is radically different from ordinary pepsin. It is a digestive vegetable ferment prepared from the juice of *Carica Papaya*. It is able to digest a hundred times its own weight of fibrin. Being a vegetable ferment no objections can be raised, and further, it acts in any medium whether acid or alkaline. It is stable and reliable in action and it does not cause any distaste. Pancreatin is another constituent which gives Papyta its value as a digestant. Being a mixture of trypsin, amylase and lipase it converts in the intestines proteins and albuminoids into absorbable peptones, starches into assimilable sugars and fats are rapidly emulsified. The most important role, however, is played by Bile Extract, which also forms a constituent of Papyta.

It prevents hyperacidity by alkalisation of the gastric juice. It promotes the normal digestive functions by stimulating the intestinal secretions and peristalsis of the intestines. It emulsifies and saponifies fats and disinfects the intestinal tract. Thus it prevents fermentation and auto-intoxication.

It will be evident from the above that Papyta is composed of ingredients which ensure adequate provision for expediting digestion and relieving gastric discomfort resulting from simple indigestion hyperacidity and other functional derangements. It must be admitted however that it cannot exert a curative influence in structural or organic affections of the stomach but in these cases it will help much to ease the patient's condition.

The best time to administer Papyta is after meals so that it is able to act upon amylaceous food before peptic digestion starts.

It ensures digestion of amylaceous substances before its action is inhibited by the rise in acid concentration. In ordinary cases of amylaceous dyspepsia 3 to 4 tablets after each meal are sufficient.

In all forms of dyspepsias Papyta can be administered with definite and rapid results. These effects are more marked when pyrosis is a conspicuous symptom and pain occurs an hour or two after food. Whether it is atonicity, subacidity or hyperacidity that is the cause of dyspepsia, Papyta invariably acts beneficially. Due to the excellent combination Papyta assists the digestion of carbohydrates, fats and proteins in a remarkable manner. While Papain assists the first stages of digestion in the stomach, Pancreatin completes the digestion of proteins and albuminoids in the intestines and the Bile Extract disinfects and cleans the intestinal tract. Papyta thus alleviates pain and over comes hyperacidity and flatulence in most cases of Dyspepsias. Coupled with care and discretion in diet Papyta will very often in these cases avert the onset of more serious symptoms and will cure the condition in the shortest possible time.

In gastralgia, nervous dyspepsia and vomiting the use of Papyta is of great advantage. It not only checks pain and alleviates vomiting but prevents the condition from giving rise to serious trouble. The cramps, the

heart-burn and epigastric pain, the usual symptoms complained of are soon relieved, digestion is regulated and the intestines are toned through this medication. Cure is thus effected if the treatment is continued sufficiently long.

Some cases of Dyspepsia are attributed to impaired function of the pancreas rather than to any gastric disorder. This condition is difficult to diagnose, but the presence of unsplit fats in the stools and decreased sugar tolerance may indicate the nature of the disturbances. Papyta is of much help in this affection, as the Pancreatin contained in it is not affected by the acid of the gastric juice. Hence it passes through the stomach unaltered and splits up in the intestines. Here it emulsifies fats, digests proteins and converts starches and carbohydrates into assimilable sugars. Thus Papyta renders valuable service in this kind of Dyspepsia.

Successful clinical results can also be obtained with Papyta in under-nutrition or indigestion of constitutionally thin persons, and in dyspepsia or want of appetite in tuberculous individuals.

Sometimes the affections of the gall-bladder or the biliary passages are associated with gastric symptoms. In these cases the symptoms very often point to impaired digestion and the condition is frequently associated with peptic ulcers, on account of which the biliary trouble is obscured. In such cases Papyta together with Boldine (A. F. D.) is a useful combination, as the former will relieve constipation and dyspeptic symptoms, while the latter will overcome bile stasis and the catarrhal inflammation of the bile ducts. Boldine is essentially a cholagogue and biliary antiseptic and exerts a softening effect on gall concretions and facilitates their disintegration and excretions.

The treatment of Dyspepsias would be incomplete unless measures were taken to deal with constipation which may be a concomitant affection and which may be due to digestive disturbance. This intestinal stasis may lead to intestinal toxæmia which must be treated vigorously to prevent the formation of any vicious circle. Mycol

is the remedy which can be usefully combined with Papyta in these affections. It exerts a tonic effect on the intestinal peristalsis. It acts as an antiseptic and disinfectant of the bowels and is thus an ideal preparation in these conditions. It may be prescribed with confidence wherever a tonic laxative and a bowel educator is indicated.

After extensive clinical trials for years Papyta has been found very useful in the management of all kinds of Dyspepsias. It is a preparation entirely different from ordinary pepsin products. Due to its permanency, agreeability, and enzymic and digestive properties Papyta excels other similar products. It not only cures the various dyspeptic conditions but affords symptomatic relief in structural or organic diseases of the stomach.

Some typical clinical results.

1. I was called one night to see a patient almost writhing with pain in the abdomen. The paroxysms of pain were frequent. The pain radiated from the left loin shooting down to the scrotum. There was vomiting, sweating and a certain amount of collapse. History of spontaneous passage of several small stones previously, was elicited, and attacks of this sort of pain he got at weekly intervals. Diagnosing this as an attack of renal colic I injected at once one ampoule of Pituitary (Endocrine 'A.F.D.'). After this the pains became severe and one and a half hours afterwards I injected another ampoule of the same preparation. The attacks became violent and after about 20 minutes a small stone of about the size of a pea was passed. Local measures such as fomentations, hot sitz baths etc., were adopted, but they did not prove of much benefit. I gave afterwards an alkaline mixture with Spt. Amom. Arom. etc., This case clearly shows that Pituitary Extract brings about contractions of the ureter just as it does in the case of other strong muscled hollow organs. It can thus expel renal calculi, if they are small, from the renal pelvis or the ureter. This case reveals how prompt treatment with an effective preparation of the pituitary

extract can in suitable cases lead to the desired end. After the acute attack I kept the patient on Urogenine with the usual dietetic restrictions. He is taking 4 teaspoonfuls of Urogenine every day. Attacks of colic in the meantime have not appeared again.

2. A Hindu married woman aged 35 came to me for the treatment of her Obesity. Her height was 5' 3" and her weight was 250 lbs. She was married at the age of 21 and her weight at that time was very much less, say about 120 lbs. She had never been pregnant and her menstruation had stopped about three years back. Iodobesin tablets were prescribed and the dosage adopted was this for the first week she took two tablets daily, the second week 3 per day and the third 4 daily. Then the treatment was stopped for a week and recommended in the same manner afterwards. As to diet she was allowed meat once a week and all green vegetables and raw fruits were permitted. Sugar, starches or fats were entirely forbidden. Simple physical exercises were recommended and scrupulous skin hygiene daily was encouraged. Too much of water drinking was not allowed. Under this treatment she lost about 30 lbs in 5 weeks. The same routine was continued for about five months and her weight was brought down to 150 lbs. Her heart condition remained excellent. Within six months of this treatment her weight was reduced to 140 lbs. and she was menstruating regularly. Previously she had vague rheumatic pains in the joints, neuritis etc., and all sort of symptoms resulting from a cycle of amino acid end products. All these entirely disappeared after six months of this treatment. After this reduction in weight she grew progressively stronger and more alert. She began to feel more active steadily, reduction in weight was gradual and sure without much loss of strength. The patient is at present following the treatment along the lines mentioned above and she weighs 130 lbs. This case clearly illustrates a defaulting endocrine system which was effectively brought to normal by means of Iodobesin.

3. A young boy aged about 12 was brought to me suffering from intense itching of the scalp. The examination of the scalp revealed several patches there, pink in colour, swollen and covered with minute brown scales. Typical broken hairs were present,

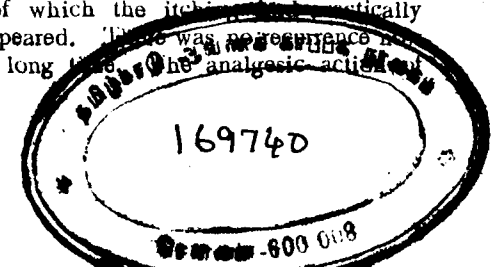
which when examined by the pathologist showed mycelium tubes under the microscope. The little patient was unable to sleep at night due to intense itching. He was prescribed Sarcotol lotion, the proportion being 1 of the solution to 2 of water. The scalp was thoroughly scrubbed with this lotion three or four times a day, particular attention being paid to the pink patches. The result after eight days of this treatment was simply gratifying. The itching was completely relieved and the child commenced to sleep well at night. The patient suffered absolutely no discomfort. The strength of the lotion was then increased, equal quantity of the solution and water being employed. The boy was completely free from this troublesome complaint after 10 days' application of this lotion. The fungus was thoroughly killed by the remarkable penetrative and antiseptic action of Sarcotol, a concentrated colloidal sulphur preparation with antiseptic and analgesic properties. It has a reinforced and energetic sulphur action. It is clean in application and it rapidly relieves itching. Due to all these properties it had given excellent results in the above case, which was nothing but typical ringworm of the scalp.

Some interesting clinical reports.

1. This was a case of a man of 30 who complained of intense itching of the lower extremities upon undressing at night. There were no objective symptoms. The skin was extremely harsh and dry with a tendency to scalliness. This itching was so severe that it kept him awake for a very long time at night. Beyond rather a harsh dry skin no other dermatological characteristics could be detected. Except Oxaluria there was no other pathological condition that the patient was suffering from. I advised Sarcotol lotion, the strength recommended being, one part of the solution to two of water. This lotion was rubbed into the affected parts after they were washed with warm water and soap. One week of this treatment showed appreciable signs of improvement. He was now free from itching to a great extent, was much more comfortable and could sleep without much disturbance. The same treatment was continued for four weeks at the end of which the itching had practically disappeared. There was no recurrence for a long time. The analgesic action of

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LYMAN, N. S.
N 35



Sarcoptol coupled with its parasiticial effects brought about great amelioration in this refractory case of pruritus.

2. A young man came to me with a huge swelling of the right thumb. The swelling had extended right above the elbow and the glands in the right axilla had enlarged. The swelling of the thumb was soft, tender and fluctuating, while that of the forearm upto the elbow was diffuse and slightly hard. This was nothing but a case of whitlow of the thumb, which had led to severe lymphangitis of the forearm. I incised the swelling on the thumb and after cleaning the wound with warm water plugged it with plain gauze soaked in an ampoule of Bacte-Pyo-Phage and dressed it in the usual way. Nothing was done for lymphangitis of the forearm as I knew it would disappear automatically after the local condition is cured. The next day I found the wound discharging still and the patient complaining of pain. Hence in addition to dressing the wound as on the previous day I injected an ampoule of Pharmasol Manganese (1 c.c.) intramuscularly. The day following the injection the pain had completely vanished and the wound appeared quite healthy. The Bacte-Pyo-Phage dressing was continued for the following four days, at the end of which another injection of Pharmasol Manganese (1 c.c.) was given. The wound had completely healed by this time and lymphangitis as also the enlarged axillary glands had disappeared. The patient was completely free from the trouble within a short period of six days. The rapid healing in such a short time in this case of whitlow was possible because of the remarkable antiseptic properties of Bacte-Pyo-Phage supplemented by injections of Pharmasol Manganese, which has the power of increasing the resistance of the organism.

Case reports.

1. I was summoned one night to see a young lady of 24 who had a very high temperature of 103.8. The fever came with slight shivering. There was no headache but the patient was apathetic and listless. She had delivered about four days back and on examination I found that she had a slight perineal tear. There was nothing abnormal about the lungs or the heart. The perineal tear showed definite signs of suppura-

tion and the entire perineum was very much discoloured. Lochia was intensely foetid. Diagnosing this as puerperal fever I at once started Septicæmine injections besides the usual diaphoretic mixture in which Iodolose was included in 10 minim doses. I gave two injections of 4 c.c. intravenously morning and evening. Locally the wound was dressed twice a day with sterile vaseline only. Gradual improvement started from the very next day and on the fourth day the temperature was brought down to normal. The pulse and the general condition also improved after that. The injections were well-tolerated and she had no troublesome reactions or by-effects. After the temperature had gone down only two injections were given, one every day. Six days after there was no pus and hardly any discharge from the perineal tear, which had begun healing very nicely. Subsequently she made an uneventful recovery and the tear got itself united by second intention leaving a scar.

2. This was a case of a man of 40 who was in a state of terrible nervous exhaustion with characteristic neurasthenic symptoms. The history revealed that about a month back he suffered from enteric fever which lasted for 21 days. After recovery he immediately resumed his duties, but soon relapsed into the present state for which he was seeking advice. He felt pain in the nape of the neck, irritable weakness and insomnia. He was unable to do his work steadily. I started Hypercytol injections intramuscularly and Elixir Bromo-Valerianate by mouth. After completing 12 injections which were given every other day and finishing one bottle of the Elixir there was a decided improvement in his condition. I gave him a week's complete rest after which I again started the same treatment viz. the injections and the Elixir. He was taking a tablespoonful of the latter twice a day after meals. After this he always slept well at night and later on he resumed his duties on which he could concentrate well. Irritability, weakness and pains all yielded to this combined line of treatment. In fact complete recovery took place after two months of this regime which afterwards did not have to be repeated. The patient's condition has been perfectly normal since then, both as regards the physical and mental condition. This improvement and well-being has now been maintained for more than six months.

THE Medical Practitioner

VOL. VII.]

OCTOBER 1935.

[NO. 1

MADRAS NEEDS A STATE MEDICAL FACULTY.

Medical education is now imparted in Madras in three different standards, for three classes of practitioners,—the graduates, the military assistant surgeons and the licentiates. The first two are trained in the college and the licentiates in a school, the University controls the education of graduates and conducts examinations to grant them degrees. The curriculum of students for the military assistant surgeons is prescribed by the Director-General, Indian Medical Service under the authority of the Government of India. The Surgeon General with the Government of Madras controls the medical education of licentiates under the authority of the Madras Government. The examinations for the military assistant surgeons as well as the licentiates are conducted by the Medical Board of Examiners who are selected by the President, Board of Examiners. The President is appointed by the Government of Madras. Years ago the Madras Board of Examiners consisted of a President and two members chosen by the Government from the staff of the Madras Medical College, the President being invariably the Principal of the Madras Medical College. From the year 1918 to 1927 various changes took place in the method for the appointment of the Board of Examiners with the result that the Board of Examiners is now composed of as many members as may be found to be actually necessary to conduct the annual examinations at the Madras Medical College and Medical Schools. The certificates of qualifications are granted by the President of the Board of Examiners, who is the Superintendent of the Royapuram now Stanley Medical School.

There are at present three medical schools in the Madras Presidency, two in the city of Madras and the third at Vellore. The two schools in Madras are under the control of the Local Government, one for the male pupils called the Stanley Medical School and the other for the female pupils, the Lady Willingdon Medical School. The Vellore Medical School is run by American Missionaries. The Willingdon Medical School came into existence in the year 1924 and the Vellore Medical School in the year 1918. There was another Government Medical School in Tanjore which was abolished two years ago.

Ever since the Superintendent of the Royapuram, now Stanley Medical School, was made the President, Board of Examiners, there was dissatisfaction in the other Schools but as the results at the examinations in the schools compared favourably with those of Stanley Medical School and on many occasions the Vellore and the Willingdone Medical Schools fared better at the examinations than the Stanley Medical School, the prevailing discontent in the other schools did not take any serious turn till about a couple of years ago. The fact that the examiners who are the members of the Board of Examiners were selected by the Superintendent of the Stanley Medical School, himself being the President made matters worse. We refrain from commenting as to way and how the results of the Stanley Medical School showed better percentage than was the case in the year 1929 or earlier. We thought it is best to leave the judgment of the state of affairs of the examinations conducted by the President of the Board of Examiners to our readers them-

selves To help the readers to arrive at impartial conclusions we have published in the correspondence columns, the percentage of passes from the 1st to the final year in all the three schools from the year 1929 to 1935. It may be seen from the results published elsewhere that in the year 1929 the percentage of passes in individual subjects and complete passes from the first to the final year in the Stanley Medical School was much lower than that of the Women Medical Schools, and ever since the year 1930 there has been a gradual increase in the percentage of passes in the Stanley Medical School. Yet the Women Medical Schools did on the whole fare much better. The increased percentage of results at the Stanley Medical School from the year 1931 and upwards might be due to the more efficient training given to the students during that period. But this fact cannot be reconciled to the results achieved by the Stanley Medical School at the last October Examinations. There was yet another purpose in our publishing these tables. Our readers might remember that in the April issue we published a letter from one of our readers, the Honorary Secretary of the Local Branch of the All-India Medical Licentiate's Association, who complained amongst other things that the teaching imparted to pupils at the Willingdon Medical School was not satisfactory. Lt. Col. Hingstone, who was deputed by the Madras Medical Council as a visitor at the final L.M.P. Examinations reported that the teaching of medicine and surgery in both the Women Medical Schools were not up to the mark. The results published by us elsewhere prove without a shadow of doubt that the remark of the correspondent referred to above and also that of Lt. Col. Hingstone were not justifiable. There is yet another fact which we wish to place before our readers. Inter-school competitive examinations are held every year for awarding prizes in Pharmacology, Medicine and Surgery. From the year 1927 to 1934, the Stanley Medical School did not get the prize in Surgery even once, whereas the Vellore Medical School got once, the Tanjore Medical School twice, and the Willingdon Medical School 4 times. In Medicine the Stanley Medical School secured the prize only once, the Tanjore Medical School once, the Vellore Medical School twice, and the Willingdon Medical School for three years.

In Pharmacology, the Stanley Medical School secured 2 prizes, the Vellore Medical School one, the Tanjore Medical School one, and the Willingdon Medical School three prizes. The papers for these competitive examinations were set by examiners who are not the lecturers of any of the schools. We hold no brief for any particular school but we thought we should place before our readers the facts and figures gathered by us in fairness to all concerned especially as The Medical Practitioner published adverse remarks against the teaching of medicine and surgery in both the Women Medical Schools. It should also be borne in mind that the number of students at the Stanley Medical School are proportionately more than at either of the Women Medical Schools, and even if allowance is made towards this circumstance, the fact remains as proved by the results of the examinations, that the teaching at the Women Medical Schools compares very favourably with that imparted at the Stanley Medical School.

During the discussion of the Budget for the current official year on the floor of the Madras Legislative Council an alarm was raised by one of the Honourable members of the Council that all was not well at the Lady Willingdon Medical School for women as shown by the results of the examination in that school at the last April examination, and even a suggestion was made to close the school. The then Minister in charge of the Medical Portfolio promised that he would hold an enquiry about the poor results at the Lady Willingdon Medical School to find out the real causes at work, which produced such bad results. In the meanwhile the Head of the Medical Department, Major General Sir Frank Connor who we are told, has heard rumours that even the question papers were smuggled on some occasions, took a most sagacious step by changing the examination centre from Royapuram Hospital to General Hospital. All the examiners except three were appointed from outside the three schools. The Surgeon-General with the Government of Madras was not only judicious but also very fair in the choice of the examiners at the recent examinations. As it was reported that the teaching of medicine and surgery was bad at the Women Medical Schools and that female pupils fared comparatively well in midwifery, the Surgeon-General appointed

the lecturer in medicine of the Vellore Medical School, the lecturer in surgery of the Lady Willingdon School, and the lecturer in Midwifery of the Stanley Medical School as examiners to guard the interests of each school. We are told that the examiners who set the question papers sent them direct to the Surgeon-General and they were cyclostyled under the direct supervision of the Surgeon-General. The final results as published this month show that the Vellore Medical School stood first having secured 76.47 per cent of passes in Medicine, 86.66 per cent passes in Surgery, and cent per cent in Midwifery. The Lady Willingdon Medical School stood second having secured 64.7 per cent in Medicine, 72 per cent of passes in Surgery, and 90 per cent of passes in Midwifery. The Stanley Medical School stood third having secured 31.25 per cent of passes in Medicine, 22.09 of passes in Surgery, and 66.7 per cent of passes in Midwifery. These results prove to a great extent that the teaching of medicine and surgery at the Women Medical Schools is not bad as was indicated by the results at the last April examinations and that there were other causes at work which depicted the Women Medical Schools to be what they really were not. As the Surgeon-General with the Government of Madras has solved the problem regarding the mysteries of very poor results at the Women Medical Schools there will be little or no purpose in holding an enquiry by any outside agency, nor it will be possible for anybody to arrive at conclusions more accurately and decidedly than those that could be adduced by the results of October examinations. There would not have been any room for conjectures, fair or unfair if the examinations in the three medical schools were conducted all these years outside Royapuram Hospital by an agency who had nothing to do with the training of the students in these schools. The new procedure adopted by the Surgeon-General with the Government of Madras should convince the Government of the urgent necessity of bringing about drastic and radical reforms in the methods of conducting examinations and for granting the diplomas to the Medical Licentiatees. We have mentioned in these columns more than once that the control of the medical education and examinations for the licentiatees should not be one man's show.

Recent events have justified our remarks, and we trust the Government would not lose time in effecting radical reforms. We would suggest to the Government the desirability of bringing into existence a State Medical Faculty for the purpose of controlling non-University medical education and for conferring suitable medical qualifications. The Bengal Government was the first in this country to establish a State Medical Faculty, which they did in the year 1914. Example of Bengal was copied by the United Provinces, in the year 1926, with necessary modifications to suit local conditions. We shall in a future issue of The Medical Practitioner place our views before our readers regarding the constitution and working of a State Medical Faculty for the Madras Presidency.

News and Comments

Rumours and Whispers : It is rumoured that at the last session of the Indian Medical Council which met on 29th October, 1935, at Delhi, the curriculum of studies of the Medical Colleges under the Bombay University were approved by the Council, that the Patna Medical College got recognition and the question of recognition of the Rangoon Medical College was postponed to the next session. We also heard somebody whispering that the Andhra Medical College was refused recognition. The three medical colleges, whose degrees were not entered in the schedule of medical qualifications recognised by the Indian Medical Council Act were the M. B. B. S., degree conferred by the Universities of Andhra, Patna, and Rangoon. The visitors who were deputed to inspect the three medical colleges seem to have recommended to the Execution Committee of the Medical Council, the recognition of the Patna M. B. B. S. degrees and also that of the Rangoon. It is said that the visitors or visitor who inspected the Rangoon Medical College pointed out many defects in that college and yet recommended its recognition, whereas, the visitor who inspected the Andhra Medical College complained against the quantity but not the quality of the staff and had reported that the M. B. B. S. degree should not be recognised till the staff recommended by the visitor was supplied to the

college. It is also news to listen to the rumour that the member who strongly opposed the recognition of the Andhra M.B.B.S., is a strong nationalist in the Indian Politics, and the member who lost his battle in favouring the recognition was a white skinned official Bureaucrat.

The other subject that caused hated discussion is said to be a proposal that the Indian Medical Council should itinerate from one University centre to the other. The purpose why this conclave should move from place to place is not known. It is said in very low whispers that the proposition was lost after a tie, the President giving his casting vote against the proposal.

There was an unusual and rather unexpected happy coincidence worth reporting. Major General Sir Frank Connor, Surgeon-General with the Government of Madras, who was recently nominated by the Madras Government to the Indian Medical Council took charge from Major-General Sprawson as Director General Indian Medical Service and automatically occupied the Presidential chair of the Indian Medical Council on the 30th October. The Madras Medical Council feels proud that its President is also the President of the All India Medical Council, but we raise a doubt whether one person can preside over two councils at one and the same time. India is a place where impossibilities are made possible.

We cannot comment on rumours and gossips and have refrained from doing so. But the fact that the Indian Medical Council holds its meetings in a conclave cannot be a rumour and we are justified in commenting upon the absurdity that the Council shuts its doors against the press. The Council was not brought into existence for discussing any secrets and there can be no secrets when the Council consists of more than one member. The Council was brought into existence for the specific purpose of improving the standard of medical education of the Indian Graduates of Medicine. Unlike other Medical Councils it does not try practitioners for any unethical and infamous conduct. Even such proceedings against the members of the legal profession are not held in camera. There is provision in the Indian Medical Council Act for members to move resolutions. May we suggest to the elected members of the Council to table a resolution at the next session of the

Council to throw open the doors of the Council to the public at least the medical graduate public, who are interested in the proceedings of the council. We hope the elected members will not lose an opportunity of moving the resolution suggested by us during the temporary regime of a President who is not biased and not likely to force his views on the Council, when controversial subjects are to be voted upon by the Council. This is our experience of Major General Sir Frank Connor as the President of the Madras Medical Council. A surgeon, by nature is likely to be less compromising than a physician when he knows what he does is for public good.

Is it a Temporary Farewell: On 22-10-35, Major-General Sir Frank Connor, the Surgeon General with the Government of Madras, was the chief guest at a dinner party arranged by the members of the medical profession, consisting chiefly of medical officers at the top, belonging to the various Government Institutions in the city, stipendiary as well as honorary. Dr. M. Kesava Pai, retired Civil-Surgeon, and Drs. P. Rama Rau, U. Krishna Rau, V. Rama Kamath represented the independent medical profession. Hon'ble Mr. Kumarasami Reddiar, the Minister, who recently took charge of the medical portfolio and Rao Bahadur Subbiah Naidu, Joint-Secretary, Local Self-Government were the other two guests. There were after dinner speeches. The toast of the chief guest was proposed by Rao Bahadur Dr. A. L. Mudaliar, who said that the Madras Medical Department was proud of the fact that three successive Surgeons-General, belonging to the Madras Service, were promoted as Directors-General of the Indian Medical Service, consecutively and that the chief guest of the evening was the fourth one, who was chosen by the Government to act temporarily as the Director-General of the Indian Medical Service, in the place of Major-General Sprawson proceeding on four month's leave. He said that Major-General Sir Frank Connor was very courteous to his subordinates and he could not easily forget the pleasant occasions, when he had to meet the Surgeon-General on official duties. The Chief guest was lustily cheered when he got up to answer the toast. Major-General Sir Frank Connor thanked his hosts and expressed that it was his frank opinion, that the medical profes-

sion in the province of Madras was fast progressing and compared favourably with the medical profession in his own country and the work turned out in the hospitals was of a very high order. He said the equipment of state hospitals in the city of Madras was up to date, but regreted that the condition of Government Hospitals in the moffusil, was far from satisfactory. He added that the public, especially the poor section of it in the rural areas depended entirely on state hospitals in the Taluk and the District Head Quarters and that no time should be lost in improving the moffusil hospitals. The indigenous system of medicine, said Sir Frank Connor, was a tough problem confronting the scientific medical profession in this country. The relationship between the graduates and the licentiates was in the opinion of Sir Frank Connor another complicated problem, which required a satisfactory solution, in the interest of the medical profession.

The toast of the other two guests was proposed by Dr. Satagopan, honorary physician, Government General Hospital, Madras. The gist of his speech was to the effect that during the regime of Sir Frank Connor as the Surgeon-General with the Government of Madras, nothing tangible was done to improve the lot of honoraries, and that Sir Frank Connor was usually partial to service men. Mr. Kumaraswami Reddiar, who answered the toast agreed with the chief guest that the moffusil hospitals had been much neglected, and as an instance mentioned that the Headquarters Hospital of his native district, Tinnevely, was still in an old building, which was once the godown of the East India Company. The Minister congratulated Sir Frank Connor, on his elevation as Director-General, which office he said Sir Frank Connor would occupy permanently after the retirement of Major-General Sprawson. Regarding the remark of Dr. Satakopan that the Surgeon-General was partial to men in service, the Minister said that it was not dignifying to the prestige of the independent medical profession to depend upon the Surgeon-General for favour.

The function was very pleasant and the hosts must be thankful to the organisers, Lt. Col. Newcomb, Dr. Satakopan and S. K. Pillai, for making the function a grand success. The junior members of service amongst the

hosts would have enjoyed this social function more than they did if they had an opportunity of mixing freely with the seniors at the dining table. This would have been possible if the principle of seniority was not strictly observed, in the arrangement of seats. It is said that the function was a Farewell. To us it looks as if it is a temporary Farewell. We hope it be so in the interest of the medical administration of this province though not in the interest of the chief guest. Major-General Sir Frank Connor was one of the few administrators, the Madras Government had, at the head of the medical department, who tried his best to know things as they were and not as they were reported to him. It may be to a certain extent true that he devoted himself more to the paid department than the honorary. But knowing as we do, his record of work as the President of the Madras Medical Council, it will be most uncharitable to say that he did not mind the interests of the independent medical profession. It was not even full 2 years since he assumed office as the Surgeon-General with the Government of Madras. He would not have had time even to grasp the complicated situation in service. If he continued in office for the full period of 4 years, the honoraries would not have had any reason to blame him for want of sympathy towards their legitimate grievances.

Honorary Appointment Questioned: Soon after the death of Dr. T. Krishna Menon about a year ago the Government advertised the vacancy of an honorary physician in the Government General Hospital Madras and five candidates applied for the same. As this is an appointment in a teaching institution the rules required that the honorary physician should possess either the M. D. or M. R. C. P. qualification. Of the five candidates only three had the required qualifications. One was a Medical Graduate of the Madras University and an M. R. C. P. (London) the other was M.R.C.S. L.R.C.P. (London) and also M.R.C.P. (London) in addition to his being an L. M. P. of Madras, and the third was an M.D. Madras and an honorary physician in another Government teaching institution. The claims of the other two need not be taken into account as both of them did not possess either the M. D. or M. R. C. P.

qualification required by the rules. All the same, we do not deprecate their claims as medical practitioners, as we do not agree with the Government formula of qualifications for honorary appointments. Of the three candidates that had the necessary qualifications the first and the last were not British-born subjects. With regard to their merit and experience the 1st entered the profession in 1920, and was for some time in the service of the Madras Government as a temporary Assistant-Surgeon and later discharged and joined the temporary I.M.S. Still later he was discharged from this service. He got the M.R.C.P. (London) diploma in 1934. The second candidate qualified himself as an L.M.P. Madras in 1920 and practised as an independent practitioner till about 1930 and went to England and qualified as M.R.C.P. (London) in the earlier part of 1932 and has since been practising in Madras. The third passed the L.M.S. in 1932 and later the M. B. B. S. degree of the Madras University and qualified for the M.D. degree about four years ago; he had been serving as an honorary for about six years.

For all stipendiary appointments, the Government is insisting that the candidates should be British-born subjects, the same principle ought to have been adopted by the Government in the appointments of honoraries especially as the Indian States are adhering to this principle very strictly. Regarding the capacity of the candidates, we refrain from making any comments as we have no information about the contents of the applications made by them to the Government. We depended upon the news paper reports of the interpellations on this subject on the floor of the Legislative council for our comments and would not have considered the desirability of commenting upon the subject, but for the publicity given to it in the newspapers. But this much has to be said that in British Isles when candidate for honorary appointments are chosen by the appointing authorities, they are very keen on seniority, qualifications being equal. The Minister while answering the interpellations made mention about the L.M.P. qualification of a candidate who possessed the M. R. C. P. (London) qualification without mentioning yet another qualification possessed by this candidate, the M. R. C. S., L. R. C. P.

The latter English Diploma has higher value in the Government market than the M.B.B.S. degree of Madras. The Minister was not fair in suppressing one of the qualifications possessed by a candidate while answering the interpellations. Instead of making an attempt to undervalue the L.M.P. Diploma, the Minister ought to have encouraged the holder of this qualification and selected him for the honorary post, and felt proud that a person possessing a Diploma granted by the Madras Government had the courage and necessary ability to go to a foreign country and qualify himself to one of the highest and the most coveted Diplomas granted in London. The candidate possessing the M. D. qualification though not a British-born subject, has been in honorary service for six years and qualified for the M.D. degree earlier than the candidate whom the Government selected, got the M. R. C. P. (London) qualification. The Government would have been very wise in selecting this candidate, as by so doing they would have encouraged the honorary system.

Irresponsibility: There seems to be little or no responsibility in the matter of transferring and appointing Surgeons-General. We have mentioned in these columns more than once, the causes that led to the necessity of importing heads of the medical department of a province from outside. As this practice has now been uniformly adopted in all the provinces, the Government of India, who are the final authority to make these appointments ought to have with them a ready made list of officers for the appointment of the heads of the medical department in all provinces in India, making provision for exigencies of sudden transfers as has now happened in Madras, Major-General Sir Frank Connor, Surgeon-General with the Government of Madras, being suddenly transferred to act as Director-General, Indian Medical Service. The Government of India ought to have immediately posted to this province an officer who is likely to be the next permanent Surgeon-General of this province. The Local Government ought to have temporarily put the Personal-Assistant of the Surgeon-General in charge of office, as such a step would have been not only more economical but also conducive to the sense of responsibility of action in the office of the Surgeon-

General. It can never be possible in a short time for any officer of whatever capacity to know the details of administration connected with the duties of the Surgeon-General. There was no necessity to disturb the work of a teaching institution, the Madras Medical College by asking its Principal to be in charge of the office of Surgeon-General till the Government of India secures a suitable officer to act as Surgeon-General. It looks as if the authorities concerned mind the prestige of their officers more than the interests of a province. There was an occasion in Madras, when within a course of one year as many as four officers were put in charge of the office of the Surgeon-General. We wonder whether on the present occasion many more officers will be put in charge of the office of the Surgeon-General, than was the case on the last occasion.

Profession to laugh and cry: We learn that as apprehended by us, the Government have passed orders, changing the designations of the honoraries, who are the licentiates in medicine and surgery. Those holding the L. M. & S. diploma of the universities are also included in this category. They will be called Honorary Licentiate Medical Officer, First Grade; Honorary Licentiate Medical Officer, Second Grade; Honorary Licentiate Medical Officer, Third Grade, after ten or five years service in the second and third grade respectively. It is not clear from the order, whether this designation is to begin after the licentiates have finished the service as honoraries under the designation of Clinical Assistant or soon after they enter honorary service. It is most unfortunate that the Government undid what the Government Committee on Honorary Medical Relief Scheme did, in abolishing caste distinction in the medical profession at least in the honorary service. The Committee recommended to the Government to abolish the designation of Honorary Sub-Assistant-Surgeon, which existed at the time they made fresh recommendations, doing away with the latter designation. On the principle adopted by the Government every honorary medical officer must be styled adding the prefix of his qualification before the word Medical Officer, and after the word Honorary. Thus bachelor of medicine and surgery may have to be styled Honorary Bachelor of Medicine and Surgery Medical Officer and doctor of medicine

Honorary Doctor of Medicine, Medical Officer, and so on and so forth, if the Government is to be consistent with the principle they have adopted in styling only one class of practitioners in the way they have decided to do. It is a surprise to us that the Surgeon-General with the Government of Madras, who is certainly expected to be more competent than the Government Officers at the Secretariat, should have consented to adopt this designation for a particular class of practitioners and thus violated the spirit enunciated by the Medical Registration Act, which is strictly adhered to in Great Britain, and other civilised countries, where honorary and stipendiary medical officers are designated indicating the nature of duties they perform and not by the qualifications they possess. As suggested by us in the last two issues, in these columns, the Surgeon-General and the Government would have been wise, if instead of changing the designations of honoraries to satisfy the imaginary sentiments of a few in service, they changed the designations of the Government Medical Officers in service indicating the nature of duties performed by them and not on any other consideration. It is very unfortunate in this country, that there is no organised medical profession, nor is there a chance, at least in the near future, of having such a one under the present state of medical administration. The profession will have therefore only to laugh at the folly of the authorities who are devoid of any sense of imagination and at the same time cry because they are helpless to protest against the injustice done to a section of the medical profession. All the same, the existing Medical Associations, all-India, Provincial, and the District, wherever they exist should not lose time in showing their indignation against the order of the Government. It cannot be disputed that the action of the Government is morally wrong. The practitioners who joined Honorary Service before the passing of the new Government Order may even question the legality of the order as the later order cannot affect them. The fact that the Government did promote at least a few Licentiates from the rank of Clinical Assistants as Honorary Assistant Surgeons as per their previous order regarding the designation in the Honorary system, is a strong point, not to be lost sight of by those affected by the new order.

The South Kanara District Medical Association: The General annual meeting of the Association was held on 21-9-35 at 5 P.M. at the Government Wenlock Hospital, Mangalore. There was a fairly good audience of medical men, both members and non-members. Dr. M. Shiva Rao, the President of the Association, occupied the chair. The annual report and the Budget of expenditure were approved and the By-law No. 9 in the articles of the Association was changed as follows:—
 "The Association shall be managed by an Executive Committee of eleven members of whom eight shall be resident members and three non-resident, including Honorary Secretary and the Treasurer".....
 Dr. L.P. Fernandes was unanimously elected as the President of the Association for the coming year and Dr. K. R. Kini as Honorary Secretary and Treasurer. Two separate resolutions were passed, one, placing on record the services of Dr. M. Shiva Rao, the retiring President, and the other appreciating the services of Dr. K. G. T. Menon, the retiring District Medical Officer, South Kanara who during the tenure of his office in Mangalore, was an active member of the Association. Dr. H. C. D'Souza proposed the toast of the Association. The Honorary Secretary thanked the retiring President and the members of the Association for the co-operation shown by them during the previous year, and for the confidence they reposed in the Honorary Secretary as indicated by his re-election as Honorary Secretary of the Association by its unanimous vote. The South Kanara District Medical Association closed the fifth year of its existence, and has been showing steady progress. It is the first District Medical Association which realised the desirability of having a President from amongst the members of the independent medical profession, in spite of the fact that the District Medical Officer was one of its members. It is very gratifying to note that the District Medical Officer, who is the Superintendent of the District Head Quarters Hospital, and his staff co-operated whole-heartedly with the office bearers of the Association and permitted the Association all possible facilities to hold its meetings in the Hospital premises. We are glad that another senior most practitioner of the locality Dr. L. P. Fernandes, the Chief Medical Officer of Father Muller's

Hospital was chosen by the Association as its second non-official President, and we trust that the affairs of the Association will appreciably progress during the regime of the new President. We are also glad that Dr. K. R. Kini, who has been the life and soul of the South Kanara District Medical Association, ever since its inspection was elected as its Secretary for the sixth time. Doctor Kini deserves the confidence reposed in him by his comrades.

Post Graduate Lectures: Two months ago we discussed in the Editorial columns the need of Post Graduate training for the medical practitioners in this province and suggested to the Centenary Committee of the Madras Medical College, the desirability of including in the items of commemoration of the centenary this subject also. We also pointed out that the Madras University should be entrusted with this work and that all the registered medical practitioners should be included in the scope of the Post Graduate training. We have no idea whether our suggestion has appealed to the members of the Madras Medical College Centenary Committee. In the meanwhile we are glad to learn that Doctor T. Kanaka Raju of Ramachandrapuram, who was recently elected as a member of the Andhra University Senate has tabled a resolution, which he will move at the next meeting of the Senate of the Andhra University, calling upon the University to arrange to hold in the summer season, every year a course of post-graduate lectures "purely from the General Practitioners' point of view" in the Medical College, Vizagapatam, for the benefit of all the registered medical practitioners and appoint a committee with powers to co-opt, with Doctor T. S. Tirumurti as convener and the Principal Medical College, Vizagapatam, Sir S. Radhakrishnan, the Vice-Chancellor, Surgeon General with the Government of Madras, Doctors Tirumala Rao, T. Kanaka Raju, M. V. Krishna Rao, as members of the committee. We congratulate Doctor Kanaka Raju on his having conceived a very laudible idea for the benefit of the medical profession. The medical profession in any country exists for the benefit of the public, and it is the legitimate duty of a university to equip the members of the medical profession with up-to-date knowledge with the help of which they will be able to alleviate human suffer-

ings more quickly than they would do without the help of up-to-date scientific methods of treatment. We have great pleasure in commending the resolution to the Senate and trust that this non-controversial resolution of public importance, will be passed unanimously by the Senate. By doing so the Senate bring credit to the Andhra University that it was the first progressive University in India to introduce Post Graduate training to the members of the medical profession.

Touting and Canvassing: We have received a communication from a Registered Medical Practitioner in the mofussil that the compounders employed in the State Hospitals of the locality have been canvassing practice for the medical officers under whom they serve, and that such canvassing is materially affecting the practice of the members of the independent medical profession. We have refrained from publishing this communication as the allegations made in it are defamatory unless they are proved and the burden of proof is on the person who complains. There are several remedies open to this practitioner and also the rest of them in the locality for the redress of their alleged grievances. They may complain to the Head of the Medical Department of the District or the Province or to the Registrar, Madras Medical Council or to all three. All the registered medical practitioners including those under Government Service are by a Statute under the disciplinary control of the Madras Medical Council and if the allegations made by this practitioner regarding touting and canvassing are proved, the highest punishment may be awarded by the Madras Medical Council by erasing the names of the practitioners in Government Service who have recourse to touting and canvassing. If as alleged by this practitioner, the touting and canvassing are done so extensively and openly, it will not be difficult for him to bring the offenders to book. There is yet another remedy less drastic and more practical. There are at present district medical associations in almost all the districts and quite recently we have been noticing a great revival of activities in the Medical Association of the District from where we get this complaint. Nothing prevents this practitioner if he is a member of the District Medical Association,

to bring this subject to the notice of the President of the District Medical Association, who fortunately happens to be District Medical Officer himself. If the practitioner is not a member, he would do well to enlist himself as a member, and then do the needful. Medical Associations primarily exist for the welfare of its members and the consideration of a subject of the nature under reference, is certainly a legitimate matter for discussion at the meeting of the Association.

An Old Boys' Association: The medical licentiates at Poona, who passed out from the National Medical College, Bombay, have taken into their heads, of having a brother-hood of their own, which it is said was started not with a spirit of aloofness or rivalry. There are at present on the roll of this Association 13 members. The activities of the Association consists in the holding of clinical meetings, yearly pleasure trips, and its members are individually helping many social activities devoted to the welfare of the citizens of Poona. The Association has brought into existence a clinical laboratory to help not only its members, but also other practitioners in the city, who will require the services of the laboratory. We have no idea of the scope or the necessity of running sectarian Associations of the nature under reference. However laudible the objects of such Association may be, it will be rather hard for its members to suppress feelings of individuality and sectarianism. All the same, we congratulate the office bearers of the Association on the disinterested work they seem to be doing at Poona.

An Apology: Ever since the sudden death of our revered Chief Editor last year, the Managing Editor has not been able to cope up with the work of the journal, due to his continued indifferent health. It has not been possible so far to get a person of the capacity of our departed Editor. We therefore request our readers to bear with us and excuse us for publishing the journal late every month. We, however, hope to be soon able to have an Editorial Board to be in charge of the Scientific section of the journal, by the end of this year and trust we shall be able to publish the journal in time from the beginning of New Year.

Correspondence Reports Etc.

Recognition of Indian Medical Qualifications outside India and the duty of the Indian Medical Council in connection therewith.

DR. K. S. RAY,

Secretary, Indian Medical Association.

The Indian Medical Council has now been in existence over two years and it may be of interest to recall that it was formed for two main purposes. The first was to establish a uniform minimum standard of medical education among the various universities in India and secondly to secure reciprocal recognition of medical degrees between India and foreign countries. The first was a *sine qua non* to the second and that part of the ground has now been largely prepared by the laying down of a uniform minimum standard of qualifications for observance by all Indian universities. We understand that, excepting two, Andhra and Rangoon, all the rest have been recognised as coming well up to the minimum standard, and so the next question that arises is what action does the Council intend to take in regard to the recognition of Indian medical degrees in other countries and the recognition of their degrees in this. As a matter of fact the issue is mainly between India and Great Britain and a little recapitulation is necessary in order to appreciate the position as it now stands.

Since 1892 the Indian universities had enjoyed the right of having their medical degrees registered by the British General Medical Council. The rights conferred by registration were that, the holders of Indian medical degrees could practise medicine, surgery and midwifery in Great Britain and Ireland, in certain parts of the British Empire and in certain foreign countries where British degrees so registered are recognised. Conditions after the war, however, when the number of Indians in the medical profession and teaching institutions increased enormously, Indians making their way even into the ranks of the Indian Medical Service, and when the direct control hitherto exercised by Government was relaxed as a result of the constitutional reforms, led to apprehension (engendered mainly, it is believed by British members of the I. M. S.) on the part

of the General Medical Council as to the efficiency of the standard of teaching in Indian universities and in 1922 there developed a protracted controversy. An investigation resulted in the G. M. C. intimating that because of insufficient practical experience in Midwifery they would be obliged to discontinue their recognition of the medical degrees of all Indian universities, except Madras at the time, unless the defects were remedied and some guarantee were forthcoming that their minimum requirements would, in future, be fulfilled.

The G. M. C. stated they would continue recognition pending the formation of an Indian Medical Council, if a Commissioner of Medical Qualifications and Standards in whom they had confidence were appointed. Col. Needham was occupied in this work from 1922 to 1927 during which period the recognition was not withdrawn, the universities being found fully up to standard, and there is no reason why the arrangement should not have continued. But, subsequently the G. M. C. considered that it could no longer negotiate with the universities in India individually and insisted on the appointment of a Commissioner as suggested above to be appointed by the Government of India to deal with the universities as a whole. The chief objection to this suggestion was that the medical institutions in this country would not tolerate the idea of a dictator, especially as the G. M. C. insisted upon the appointment of their own nominee, Col. Needham. It was also felt that no one person could be expected to combine in himself all the qualifications required for the post. The proposal was consequently thrown out by the Legislative Assembly, though a suitable counter-proposal was put up at the same time but not accepted by the G. M. C.

In 1930, therefore, the G. M. C. withdrew their recognition of Indian medical degrees. It served only to exacerbate feeling in this country as it was looked upon as a measure of retaliation, since there was nothing to suggest that the standard of medical teaching in the Indian universities had deteriorated to warrant such action. So greatly was the insult felt that, though some recalled that redress might be had upon appeal to the Privy Council, the privilege was never exercised.

The proposal to form an Indian Medical Council then took shape with a view to putting our own house in order and hopes ran high for a time, but these hopes were soon damped. The house was proposed to be put in order by excluding the largest number of medical practitioners viz., the Licentiates; and the scope of the Council was restricted to the two purposes mentioned above and its composition was such as to do an injustice to the preponderating element of non service Indian medical men, which raised the suspicion that the strength of the I. M. S. element in the Council constituted the hidden hand of the G. M. C. Moreover, despite the existence of the ban, the Indian Medical Council Act continued to accord recognition to British medical qualifications for at least four years and in the fact the first appointee to the Secretaryship, and the Inspectorship as well, was what might be called a nominee of the British G. M. C. His successor, the present Secretary—a member of the I.M.S.—against whom we advance nothing in person but we regret the fact that both in his case and his predecessor the methods of making the appointment left much to be desired and hurt Indian susceptibilities by passing over the claims of Indians to fill this post. The combination of the posts of Secretary and Inspector also aroused severe criticism.

In the meantime, the destinies of India were being hammered out on the Round Table Conference and Parliamentary anvil and so far as medical matters are concerned it spells little change in conditions from those ruling before. In particular, the I. M. S., R. A. M. C. and medical officers of the Royal Air Force are entitled to practise in India by virtue of their commissions, although Indian qualifications are still under the ban of the G. M. C., which means that holders of Indian qualifications are denied the privilege of practice in the United Kingdom and colonies. Even if it be conceded that they (the I.M.S., R. A. M. C. and Air Force officers) should be allowed to practise by virtue of their commissions within the army sphere, to allow them unrestricted practice throughout the civil population in the country is hardly equitable while reciprocal treatment is denied to holders of Indian degrees.

In one respect we thought we had secured an advance. The Indian Medical Act pro-

vided that in the event of the Council refusing to recognise any foreign qualification an appeal would lie to the Governor-General-in-Council, whose decision would be final; but under the new India Act this right of appeal and decision is to be removed from the Governor-General-in-Council and given to the Privy Council in England, to that extent transgressing the principle of India's responsibility and self-Government. We do not see, while granting an unbiassed attitude in the Privy Council, that Council would be in a better position to decide such an appeal than the Governor-General-in-Council in India. The reasons adduced in the Joint Parliamentary Committee's Report are entirely unconvincing.

One may judge from these circumstances that the Indian Medical Council as at present established does not evoke much enthusiasm in Indian hearts. We are never greatly impressed with Sir Fazli Hussain's rhetorical outburst of "efficiency at home and honour abroad". The actual position is quite different and so far as the British G.M.C. are concerned we are under statute to grant recognition to British qualifications in India at least for the remaining period of four years specified in the Act, although they do not reciprocate in the same way. Nevertheless, Vol. I of the Report of the Joint Committee on Indian Constitutional Reform contains the remark "We hope that before the four years have expired, as a result of joint action between the two councils, the General Medical Council will have seen its way to restore its recognition of Indian diplomas, and that discussions may proceed between them free from political influence or bias and with the sole object of promoting the interests of medical education in both countries."

There is in this remark a broad hint and we wonder whether the General Medical Council of Great Britain has taken it. It is not necessary for them to wait until the four years specified in the Act have elapsed and we believe that in the course of its existence for nearly two years, the Indian Medical Council has found the standard of Indian medical education to be on a satisfactory level. For our part, we cannot easily forget the circumstances of the past. The attitude of the G.M.C. and their action in withdrawing the recognition continued for so many years before, can only be

regarded as humiliating and we do not wish to take any step or institute any measures, direct or indirect, that will humiliate us further. We have not heard that the British Council has given any sign of encouragement. In actual fact, its ban does not appear to have affected the position very much, as the outflow of Indians with M. R. C.P., F.R.C.S. and other higher qualifications is larger than before and, again, Indian qualifications are now admitted to the I.M.S. which was not the case before. Therefore, the ban has not proved a serious handicap and so it requires very careful consideration before we make an approach unless we are assured of a change of heart on the other side. Naturally one hesitates to add insult to injury by courting a refusal. At least, we being the aggrieved party, it is for the G.M.C. to make a gesture of goodwill, which might take the form of removing the ban without further delay or discussion.

Having regard to all these considerations, it is for the Indian Medical Council to take account of the feelings of the Indian medical profession as a whole and of the Indian universities before committing themselves to any action and we sincerely hope they will not take any steps that will tend to lower the prestige not only of the Council itself but also that of the medical profession in India and the various Indian universities

The Kistna District Subsidised Rural Medical Practitioners Association.

Resolutions passed at a meeting held in the Government Hospital, Bezwada on Sunday 22—9—35 at 3-30 P. M.

1. This Association requests the Dist. Medical Officer and the President District Board, Kistna to kindly permit the Rural Medical Practitioners to address the President, District Board, Kistna, through the District Medical Officer, whenever they apply for, and report after, casual leave, and thus obviate the necessity and expenditure incurred, for addressing both on the two occasions.

2. This Association respectfully requests the Government to condemn the action of some District Boards which are trying to replace the existing Rural Medical Practi-

tioners by new candidates either stipended by the Boards or otherwise.

3. This Association resolves to request the Government to define the status of the Rural Medical Practitioners in connection with their claims for the travelling and daily allowances when called for to give evidence in the courts of law, and requests to classify them as IInd Class Private Witnesses.

4. Resolved to request the District Board, Kistna to kindly sanction the remuneration due to the Rural Medical Practitioner, Thotavallu on account of his festival duty during the recent Kistna Pushkaram, under orders of the then President Taluk Board, Bezwada.

5. This Association resolves to urge upon and request the Government to kindly amend the G. O., No. 1626 P. H., dated 29-6-1929 as follows, in as much as the words "requested to consider invariably the claims of the Medical Practitioners already in charge of the Rural Dispensaries" are likely to be detrimental to such considerations of their claims by the Boards.

AMENDMENT :—Whenever the Local Boards propose to convert the Allopathic Rural Dispensaries maintained by them into regular ones, they should invariably appoint the existing Rural Medical Practitioners as L. F. Sub Assistant Surgeons in the proposed regular Dispensaries which action automatically cancels the existing agreements under which the Medical Practitioners are working.

This Association resolves to suggest that the Government should pass orders that the Rural Medical Practitioners while submitting their agreements, should do so in triplicate duly signed, the stamped one being kept with the President, District Board, and of the other two, one to be kept with the District Medical Officer, and the other to be returned to the Practitioner.

This Association resolves to entertain as members all the subsidised Medical Practitioners in the district both L. M. Ps., and L. I. Ms., whether subsidised by the Government or by the Board.

N. RAMA RAO, L. M. P.
Secretary, 24—9—'35.

RATIONAL CALCIUM-THERAPY

CALCINOL

TABLETS POWDER GRANULES IRRADIATED DRAGEES WHIPPLE PLAIN DRAGEES WHIPPLE IRRAD. DRAGEES R.B. PLAIN DRAGEES R. B. IRRADIATED AMPOULES	The enthusiastic appreciation by a great number of physicians of the favourable therapeutic results from CALCINOL seems to have fully justified their confidence in it. If you happened not yet to have experienced the favourable action of CALCINOL — not yet to have enjoyed the satisfaction of using a calcium preparation ready to be applied to all the requirements of your cases — not yet to have realised that it costs no more to use this reliable and handy calcium preparation, then please ask us to satisfy with our samples and particulars your intention to try it.	ACIDOSIS PREGNANCY LACTATION DENTAL CARIES RICKETS BONE & GLAND TUBERCULOSIS PULMONARY T.B.
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The East Godavari District Medical Association, Cocanada.

MINUTES OF THE MEETING HELD AT
RAJAHMUNDRY.

The monthly meeting of the Association took place at Rajahmundry on 21st September 1935. Captain J. S. Mcmillan I.M.S. presided. The Rajahmundry group of members were at home to the Association. 48 members from all over the District attended. Dr. M. Ranganadham of Ryali exhibited three interesting cases of "Endocrine Deficiency". Dr. Miss T. E. Stephens of Rajahmundry exhibited a case of "Ovarian Cyst" operated recently in the Government Hospital, Rajahmundry. Three cases of poisoning due to the administration of the Indian durg called "Katukarohini" brought in a condition of collapse were mentioned by the staff of the Government Hospital, Rajahmundry.

Captain J. S. Mcmillan I.M.S. delivered an instructive lecture on "Parasitology" in relation to East Godavari District. After an enjoyable dinner followed by music, the guests dispersed.

Leprosy clinic in the East Godavari Agency.

A leprosy clinic was opened at Kunavaram on 19-10-35 by Mrs. Mc Millan, wife of Captain J. S. Mc Millan, I.M.S., District Medical Officer, East Godavari. There was a large gathering of people including teachers, clerks and school children. Dr. E. I. Deva Priam read a report of the leprosy work at Kunavaram. He said: 'Hitherto no active treatment was given to lepers in this dispensary. While treating cases of yaws in the dispensary, I noticed a few cases of leprosy among the Koyas. I advised them about the contagious nature of the disease, assured them of its curative nature and requested the affected people to bring their friends and relatives to the dispensary for free treatment. One brought another, another brought a third and so on. Not satisfied with this number, I made a house to house survey and detected a number of cases, so that there are now on the roll 38 cases of leprosy undergoing active treatment in this dispensary today. The disease is more common among the Koyas, less common among the Malas and Mathigas and least, among the caste-Hindus in this agency. No

case was detected among the school children when a survey was made among the schools in the locality.'

After the report, there was a Telugu song composed for the occasion by Mr. P. Devadas Headmaster of the Turakalagudem school. Mr. Kamayya the local Head Master read the printed pamphlet on leprosy, written by the local doctor in Telugu and English.

Mrs. Mc Millan after making a short speech about the usefulness of the clinic, declared it open. Captain Mc Millan then addressed the public.

Seventeen cases of different types of leprosy were brought and exhibited to the public.

The Medical Officer thanked the public for their co-operation in his work. The meeting terminated with a vote of thanks and distribution of sweets to children.

Review

Medical Case-Taking

By Bidu Bhushan Pal, I.M.S., Teacher of Medicine, Decca Medical School, Physician Mitford Hospital, Decca, with a Foreword by Captain R. Linton, M.B., Ch. B., B. Sc., 1935, 191 pages. Price Rs. 2-3-0 Cloth bound. (Published by Indu Bhushan Pal, M.B., 1/1, Ananda Ch. Roy St., Decca.

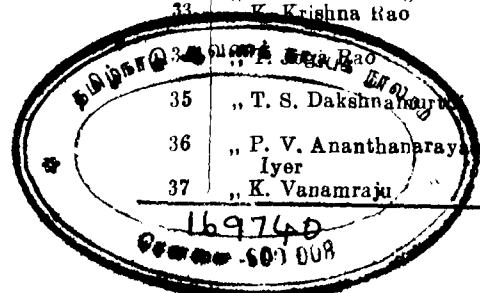
The successful treatment of patients depends on past history, for which a practitioner has to rely on the patient or his relations, and a careful physical examination of the patient for which a practitioner should depend upon his own powers of observation. Knowledge of subjective symptoms is as important as the study of the objective ones and for satisfactory Case-taking a practitioner has to depend upon both. Doctor Bhushan Pal's book deals with the physical examination of patients in detail. The book might have been more attractive if the author dealt with the subject of history-taking as elaborately. Doctor Pal is a teacher of medicine and also a practising physician, consequently has considerable experience to his credit to present the book to the medical students in a form most useful to them. A reference to the Bibliography acknowledged by the author indicates that the author has endeavoured to make the book up-to-date embodying in it not only his own knowledge but also knowledge gathered from various authors. The book is handy and will be highly useful to the medical students.

The Results of the Examinations of the three Medical Schools in the Madras Presidency, from the year 1929 to 1935

PERCENTAGE OF PASSES FOR THE FIRST YEAR.				PERCENTAGE OF PASSES FOR THE THIRD YEAR.			
Date of Examination.	Subjects.	Vellore Medical School.	Lady Willingdon Medical School.	Stanley Medical School.	April 1929. Complete		
					passes	100	53.33
					Hygiene	100	85
					Pathology	100	53
					Medical jurisprudence	100	85
April 1929. Complete					passes	100	85
Anatomy	73.91	65	43.31		Hygiene	100	89
Chemistry	80.00	85	67		Pathology	100	97
April 1931. Complete					Medical jurisprudence	100	89
passes	81	65	57		passes	100	100
Anatomy	70	67	66		Hygiene	100	87
Chemistry	89	100	89		Pathology	100	100
April 1932. Complete					Medical jurisprudence	100	95
passes	70	67	69		passes	100	100
Anatomy	77	76	66		Hygiene	100	87
Chemistry	95	95	77		Pathology	100	95
April 1933. Complete					Medical jurisprudence	100	100
passes	77	95	97		passes	100	87
Anatomy	80	68	68		Hygiene	100	100
Chemistry	96	77	76		Pathology	100	95
April 1934. Complete					Medical jurisprudence	100	100
passes	84	86	87		passes	100	83
Physics	40	21	65		Hygiene	100	100
Chemistry	53	21	90		Pathology	100	83
Biology	60	29	75		Medical jurisprudence	100	100
April 1935. Physics	100	71	85		passes	100	87
Chemistry	50	75	72.2		Hygiene	85	76
Biology	50	67.1	61.5		Pathology	100	94
	cent	60	86.9		Medical jurisprudence	94.4	80.0
					Hygiene	93.8	92.4
					Pathology	100	85.7
					Medical jurisprudence	87.4	100
					Hygiene	85	76
					Pathology	100	94
					Medical jurisprudence	94.4	80.0
					Hygiene	93.8	92.4
					Pathology	100	85.7
					Medical jurisprudence	87.4	100
					Hygiene	85	76
					Pathology	100	94
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					Medical jurisprudence	94.4	80.0
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					Medical jurisprudence	87.4	100
					Hygiene	85	76
					Pathology	100	94
					Medical jurisprudence	94.4	

N.B.—1930 Results were not available and October results not published.

No.	Names of Sub-Asst. Surgeons.	From.	To
1	Dr. K. Avudainayagam	L. F. Dy., Cheyyur	Jail Duty.
2	„ N. Srinivasachari	Leave	L. F. Dy., Addanki, Guntur Dt.
3	„ N. Venkatasubba Rao	L. F. Dy., Addanki, Guntur Dt.	Jail Duty.
4	„ T. S. Sivasubramaniam Pillai	Govt. Hd. Qrs. Hl., Madura	Training in Antirabic treatment at the Pastr. Institute, Coonoor.
5	„ Md. Chirag Ali Sahib	L. F. Dy., Allur, Nellore Dt.	L. F. Hl., Atmakur.
6	„ L. V. Jagannadha Rao	L. F. Dy., Maddiker, Kurnool Dt.	East Godavari Dt., for Agency Duty.
7	„ K. Ramachandran	Leave	L. F. Dy., Dhanushkodi, Ramnad Dt.
8	„ P. Kesavan Nair	L. F. Dy., Dhanushkodi	Govt. Dy., Paramagudi, Ramnad Dt.
9	„ K. Pichu Ayyar	L. F. Dy., Enangudi Tanjore Dt.	L. F. Dy., Tirukoyilur, N. Arcot Dt.
10	„ N. Sundara Rao	Police Hl., Vizianagaram	L. F. Hl., Gajapatinagaram.
11	„ A. Gurumurthi	L. F. Dy., Gajapatinagaram	Police Hl., Vizianagaram.
12	„ S. N. Sankaralingam Pillai	Leave	L. F. Dy., Sermadevi.
13	„ T. K. Nilakanta Ayyar	L. F. Dy., Sermadevi	Govt. Hd. Qrs. Hl., Palamcottah.
14	„ N. Saktharam Rao	Dt. Hd. Qrs. Hl., Tanjore	Koraput Agency duty.
15	„ B. Subba Rao	E. Godavary Agency	L. F. Dy., Chipurapalli.
16	„ K. Venkataramaswami	L. F. Dy., Chipurapalli	L. F. Dy., Allur, Nellore Dt.
17	„ M. Venkatachalam	L. F. Dy., Mylavaram, Kistna Dt.	L. F. Dy., Hadagalli, Bellary Dt.
18	„ K. Kamaraju	L. F. Dy., Hadagalli, Bellary Dt.	Govt. Hl., Rayadrug, Bellary Dt.
19	„ V. Subbaramayya	Govt. Hl., Rayadrug.	Govt. Hd. Qrs. Hl., Masulipatam.
20	„ A. R. Shunmuganathan	Leave	Govt. Hd. Qrs. Hl., Trichinopoly.
21	„ S. Krishnamurthi	Leave	Madras Forest College, Coimbatore, for camp duty.
22	„ Mrs. R. A. Kurian	Leave	Govt. Hl., Nandigama, Kistna Dt.
23	„ G. Lakshmana Rao	L. F. Dy., Tanakal, Anantapur Dt.	Govt. Dy., Markapur, Kurnool Dt.
24	„ N. Venkatacharlu	Govt. Dy., Markapur	L. F. Hl., Jaggayapet, Kistna Dt.
25	„ C. Krishnamurthi	L. F. Hl., Jaggayapet	Koraput Agency duty,
26	„ V. Natesan	Leave	L. F. Dy., Valangiman, Tanjore Dt.
27	„ N. G. Subramania Iyer	L. F. Dy., Valangiman	Koraput Agency duty,
28	„ M. Venkatratnam	Leave	Govt. Dy., Dhona, Kurnool Dt.
29	„ K. Chinnappa Reddi	L. F. Dy., Chintalapudi	Govt. Hd. Qrs. Hl., Ellore, W. Godavari Dt.
30	„ S. V. Raghavalu Naidu	L. F. Dy., Senduri	Govt. Hl., Ariyalur, Trichy Dt.
31	„ N. Gopalan	Govt. Hl., Ariyalur	Madras Forest College for Camp Duty.
32	„ A. R. Shunmuganathan	Leave	Govt. Hl., Ariyalur, Trichy Dt.
33	„ K. Krishna Rao	Leave	Tq. Hd. Qrs. Dy., Purushottampur, Ganjam Dt.
34	„ T. S. Dakshinamurti	L. F. Dy., Purushottampur, Vizagapatam Agency	Ganjam for Agency Duty.
35	„ P. V. Ananthanarayana Iyer	L. F. Dy., Edappadi, Salem Dt.	L. F. Dy., Edappadi, Salem Dt.
36	„ K. Vanamraju	Leave	Dt. Hd. Qrs. Hl., Tanjore.
37			Govt. Hd. Qrs. Hl., Nellore.



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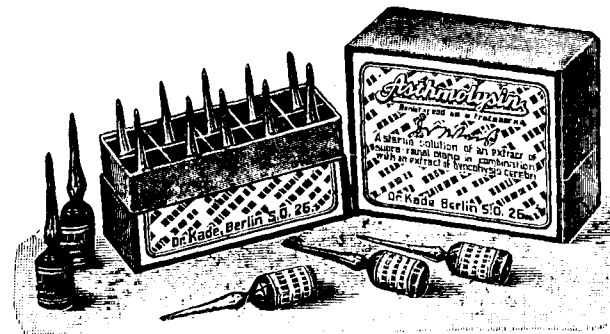
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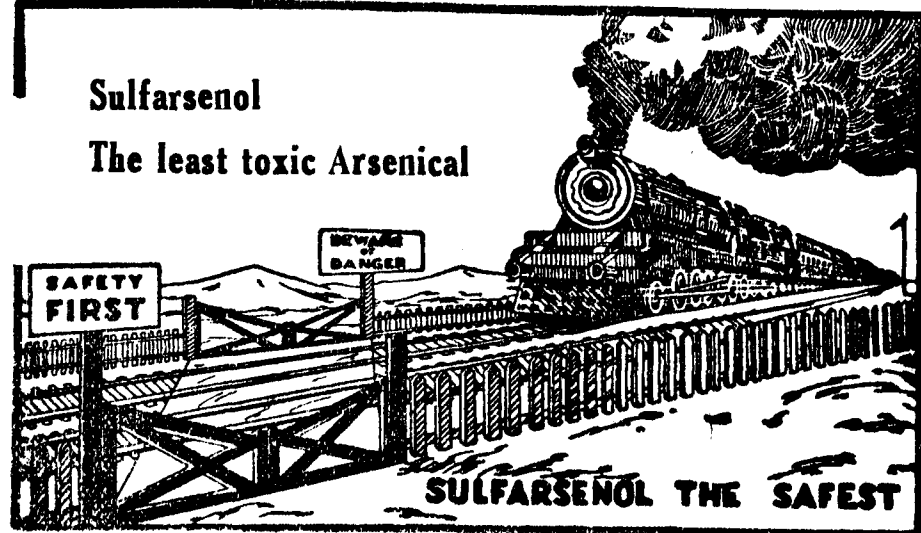
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