

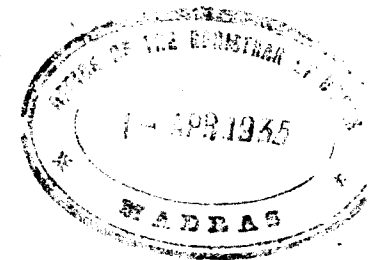
MISCELLANY *Ver. 1st*

OF

THE TRICHINOPOLY DISTRICT

MEDICAL ASSOCIATION

(REGISTERED)



JANUARY 1935



For free and private circulation only.



OURSELVES.

The Miscellany of the Trichinopoly District Medical Association is started with a view to supply members of the association with notes on current medical literature culled from the various medical Journals. It may not be possible for the busy practitioners to read the enormous mass of medical literature nor will it be possible to circulate a few journals among all members. So it is proposed to publish a Monthly Miscellany for free distribution to members of the Association.

The Miscellany is proposed to be divided into various sections as follows :

1. Original articles.
2. Extracts.
3. Case notes.
4. Association notes.
5. Correspondence.
6. Tit-Bits.

Members of the association are requested to send in articles for publication and case notes and Extracts from journals. Extracts and Case Notes should be as brief as possible.

Correspondence is to be addressed to the undersigned marked on the left hand corner "For the Miscellany."

P. A. S. RAGHAVAN,
Secretary.



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The Trichinopoly District Medical Association
(Registered)

At a General Body Meeting of the above Association held on 18-1-35, it was resolved that the following Journals be distributed among Members who are not in arrears of subscription for the Association, and who pay an advance of Re. 1. The Journal can be retained for 5 days and should be returned by the Member to the undersigned. The following Journals will be available:—

1. British Medical Journal, (London).
2. Lancet, "
3. Practitioner, "
4. Clinical Journal, "
5. Indian Medical Gazette.
6. The Antiseptic

A Member who fails to return the Journal will not be given fresh Journal until the old Journal is returned. For second default, Journals will not be issued for a month. For third default, Membership will cease. For non return of Journal the advance will be forfeited.

Members who wish to avail of Journals are requested to intimate the undersigned, and remit the advance of Re. 1 after paying up arrears (for the Association).

A monthly Miscellany containing review of Journals, original articles, case notes, etc., will be issued free to all Members.

TRICHINOPOLY, }
23rd Jan. 1935. }

P. A. S. RAGHAVAN,

Secretary.

Sterility, its causes and Treatment.

(Address delivered at the 5th annual Gathering of the Trichinopoly District Medical Association on 19-12-1934 by Dr. N. C. Appayya L.R.C.P., M.R.C.S., M.B. (Ed.), F.I.M. (Rot.) D.G.O.)

Man has been admitted to be the most perfect of all animals on this universe. Darwin has been able to prove that man has evolved from the lower animals as the result of evolution. Sir Arthur Keith, at one time the curator of the Royal College of Surgeons of London, has been able to tell us that most of the findings of Charles Darwin are not disputed to-day. In spite of these, man differs fundamentally from other animals in some striking way. He is the only animal that is able to talk—though most of the higher type of animals have their own language and are able to communicate with one another—smile, use his reasoning power and is able to discover the secrets of Nature in a remarkable way. Besides these, man differs from all the other animals in the methods of reproduction. All the animals except man begin to reproduce at a certain age and continue to reproduce until almost to the end of their lives, unless disabled otherwise. While man or rather woman begins to reproduce even in India at about the age of 12, 13 or 14 and end 33 years later. After this period of active reproduction has ended by the advent of menopause the woman continues to live until the age of 60 and is then expected to die. The reason for this extraordinary behaviour in human beings has been explained by the fact that the human infant is the only animal who is completely helpless at birth and continues to be dependent upon its mother until the child has reached puberty. So nature has devised that the human mother should stop reproducing at about 45 years of age and continue to live until her last infant has reached puberty and is able to take care of itself.

In order that we may better understand the causes of sterility I request you to study with me the anatomy, physiology, and histology of the reproductive organs of woman before we go to discuss the causes and treatment of sterility.

The Vagina, the Uterus, the Fallopian tubes and the Ovaries comprise the internal genitalia. The absence of any of these causes absolute sterility. I shall not bore you with the details of anatomy of these organs except to mention that all these are closely connected

to one another, the ovary being at one end of the chain while the vagina at the other end. When a girl reaches the stage of puberty of her each ovary contains about 30 to 40 thousand primordial follicles. Out of these large number of P. F. not more than a hundred and fifty come to the surface of each ovary and rupture, one or the other ovary yielding a mature graafian follicle every month. Ovulation or the rupture of the G. F. in the ovary was considered for a very long time to be concurrent with menstruation, but the work of Fraenkel of Vienna and the work of Halban, Meyer and others have conclusively proved that these two acts take place at two different times. Fraenkel says that ovulation takes place between the 9th and 16th day after menstruation. So it is certain that ovulation takes place about the middle of intra-menstrual period. After the rupture of G. F. mature ovum is deposited in the Peritoneal cavity and is thence carried into the F. T., and it, passing along the tube enters the uterus and then dies. The F. T. is a long hollow tube lined by means of a Cilia from its fimbriated end to the opening in the Uterus. The moment the G. F. ruptures and ova escape into the peritoneal cavity, the fimbriated end of the tube leads the ova into the opening in the tube and from there the cilia of the tube carry them on to the uterus.

The Uterus which is divided into a cervix and a body plays a very important part in the reproductive system. The interior of the uterus is covered with a lining membrane which undergoes several changes during the sexually active period of a woman. During this period of about 33 years, the lining membrane of the uterus i.e., the endometrium, undergoes constant changes in preparation for the nutrition of the possibly impregnated ovum. Failure of the impregnated ovum to become embedded results in the breaking down of the endometrium or menstruation. In other words menstruation is the expression of disappointment on the part of the uterus to conceive.

A menstrual cycle which usually lasts of about 28 days is divided into :—

1. The post menstrual period (5 days) or Regeneration.
2. The Interval (15 days)

3. The pre-menstrual period (5 days)

4. The menstrual period (3 days)

1. The post menstrual period follows as it is apparent, the menstrual period. This period which is of about 5 days is chiefly spent in regenerating the lining membrane of the uterus.

2. The interval stage lasts for 15 days and this is considered to be the resting stage. What exactly this means I have not been able to find out ; but perhaps it means that the interior of the uterus does not show any great changes.

3. The third period known as the pre-menstrual period is of the greatest importance as during this stage the lining membrane of the Uterus undergoes great changes and seems to prepare and keep ready the bed for the reception of the impregnated ovum. If this does not take place the uterus finding that all her labours are wasted, as there is no seed ready for the soil which she has so elaborately prepared, goes into the 4th stage known as the menstrual stage. Hitschmann and Adler were the two great people who were for the first time in 1908 able to classify the various stages of the Uterus during the menstrual cycle. The theories of older writers were replaced by these two and since 1908 many other workers have fully confirmed the theory of Hitschmann and Adler. Having briefly stated the Anatomy Physiology and histology of the female generative organs I shall state a few points regarding Coitus.

During Coitus the ejected semen which is said to contain millions of spermatozoa are deposited in the posterior fornix of the vagina. These make their way into the tubes apparently in search of the mature ova. In one of the tubes this spermatozoan meets the mature ova and one of them enters and fertilizes the ova. Immediately the ova is fertilized by one spermatozoa the remaining spermatozoa are prevented from entering the mature ova and they all die being disappointed. The fertilized ova now makes its way into the interior of the uterus where a perfect bed has been prepared for its reception. It is estimated that the ova having left the G. F. about the middle of the Intramenstrual period meets the spermatozoa in the tube and gets

itself fertilized. Then the fertilized ova moves towards the uterus and takes 8 to 10 days before it reaches it. So it will be seen that the impregnated ova gets itself embedded in the uterus during the premenstrual stage.

I shall now try and tell you the causes that either prevent the spermatazoa from getting into the tube or the matured ova not coming to meet the spermatazoa at the appointed time and place, or the fertilized ova not being able to grow in the uterian cavity.

Reproduction depends upon the normal sexual activity of the male as well as that of the female; and if for any reason one of the couple is unable to contribute his or her share, then the result will be a Sterile marriage. Sterility is usually described as of two kinds.

1. Absolute. 2. Relative.

1. In absolute sterility there is persistent failure to conceive, while in the other, failure to carry pregnancy to a successful termination. Absolute sterility is due to the absence or disease of the ovaries, tubes uterus or vagina in the female and absence or disease of the generative organs in the male. Apart from these causes where there are developmental errors and disease of the generative organs, there are a large number of cases where sterility exists, in apparently normal individuals. In such cases the causes are due to the following: --

(a) *Excessive Coitus*. Where there is excessive coitus as in prostitutes no conception can occur. In such cases the cause of sterility is said to be due to the formation of an antibody in the woman which is caused by absorption of the semen from the vagina. The continuous absorption of the semen from the vagina produces an antibody in the woman which either kills the spermatazoa or prevents the impregnated ovum from embedding in the uterus.

(b) In order that impregnation of the mature ova should take place the spermatozoon must be present in the tube at the time the mature ova enters. So in order that there should be successful impregnation the live spermatazoa must be present in the tube at the same time. Dead or absence of spermatazoa causes no impregnation.

(c) Immunization of one particular type of ova to the spermatazoan, as in the case of Europeans with African Natives. Those, I am told, who have thick skin, thick lips and coarse hair are always sterile when they marry the European nationalities (Please don't confuse East African Natives with Negroes). Here is an example of immunization of one type of ova to a particular type of spermatazoan, for it may be that the Vitelline membrane of the ova of these thick set people are too thick for the civilized spermatazoan to be able to penetrate without the help of any of the modern implements of War.

Before I proceed to the actual treatment of Sterility I would like to bring to your notice a statement made to me a few weeks ago by a Hindu Sanatanist Doctor wellknown in our district. He tells me that according to Hindu Sastras every married couple must co-habit immediately after the 3rd or 4th day of menses, and if they do not follow this Dharma it is a sin. If this were true, then it is certain our ancestors believe that the best time for conception was immediately after the woman had her first bath. I am not here to tell you which is the correct theory. Westerners also held the same view during the 18th and 19th century. But now it is changed. Let me tell you, however, that this doctor friend of mine has a large family.

Treatment

Every case of sterility must be carefully examined and whenever any operation is indicated every small abnormality should be corrected. When a woman consults you, make a through examination of her, beginning with the sexual organs and ending with the examination of all other systems. If you are not in a position to diagnose a disease with which you are not familiar, you will be helping the patient by sending her to a specialist and getting her treated.

In case you find that there is nothing wrong with her examine her husband and find out from him whether his sexual congress is complete and whether there is any impotency. Next examine the semen for the presence of spermatazoa and whether they are active, sluggish or dead. This examination must be done immediately the semen is discharged and if possible it is better to collect it from the

Vagina immediately after Coitus. I know this is an impossible method, and it cannot be carried out in India among Indians in general, and with Hindus in particular.

Examination of semen.

Put a couple of drops of semen on a glass slide and put a piece of filter paper on one end touching the semen and place a drop of distilled water at the other end. Place the slide under a microscope and examine it. If the spermatozoa are active they will move towards the distilled water. *i.e.*, against the current of water that is running towards the filter paper. If the spermatozoa is found to be dead or absent no treatment can be of any use. If the male is normal in every way and the sexual act is correctly performed, dilatation of the cervical canal followed by the introduction of a laminaria tent for a period of 48 hours often cures. Curettage is an unnecessary operation in these cases.

Amenorrhoea, dysmenorrhoea and metrorrhagia must be adequately treated. If ovaries are diseased they must be either removed or the cysts, if present, excised and treated.

Tubes. If the tubes are totally blocked open the abdomen and do a salpingotomy. The testing of the potency of the tubes is done by Rouban's apparatus or one of its modifications. In order to prevent the occlusion of the tube after salpingotomy, Tweedy of Dublin suggests the introduction of a thick cat-gut into the lumen and leave it there.

Dyspareunia must be treated by manual dilatation of the vagina. Recently a severe case of Dyspareunia was reported from Bengal where attempted sexual act resulted in severe spasms of the vagina and part of the body. Several specialists were consulted. What happened to this woman is not known. In such cases failing all treatment and suggestions, I think, that the so called test-tube twins method should be adopted so that if she has one child all her spasms should disappear. This test-tube method I believe consists in taking the semen of a man and injecting directly into the uterus of the woman. You know this method is well known to Veterinary surgeons and I believe America is copying it and putting it into practice with

human beings. Prof. Louis Faure, head of the Department of Gynaecology of the Paris Faculty of medicine, observes that test tube babies were known to frolic in the streets of Pompeii hundreds of years ago. The Romans knew a thing or two about "test tube" babies. Doctor Dight M. D. President of the Minnesota Eugenics Society states that in the near future we will be able to produce babies outside the uterus in an artificial media. In ancient Hindu India, thousand of years ago, test tube babies were manufactured outside the uterus. You all know that Kusa was brought into the world by the Will-power of Valmiki and, Drona the preceptor of the Kauravas and the Pandavas was born in a mud pot where the ovum of Menaka was fertilized by Bharadwaja.

Uterus. If sterility is associated with retroverted uterus it is essential to correct the position and retain it in the normal position.

In cases where nothing is wrong with the husband and wife, and where there is a history of excess of coitus, the wife must be ordered a change of air for a period of 6 weeks to 3 months. Of course it is essential that the husband should not accompany the wife. In these parts people don't easily understand the meaning of this change of air, therefore, it is better that the wife be told to go on a pilgrimage to Kasi or Gaya and worship at the various temples and take bath in the holy waters of the Ganges and observe abstinence.

Gentlemen, I shall not keep you long but before I sit down I shall briefly state the use of drugs in sterility. Many drugs have been suggested. But I shall not bother you with all of them except one or two.

Dr. Bethol Solamans, at one time master of the Rotunda Hospital, has been treating cases of sterility with Corpus Luteum and has had good results. C. L. desiccated is sold by P. D. & Co., in 5 gr. capsules. Two capsules should be given twice a day and it should be continued for about 3 months.

Howard Kelly states that much of our helplessness in this great problem is the outcome of too much attention to anatomical defects

and too little, to a possibly perverted Physiology i.e., loss of balance between the secretion of various ductless glands of our body. Among the Ductless glands the Pituitary, Thyroid Thymus and the Suprarenal play a great part in conception.

EXTRACTS

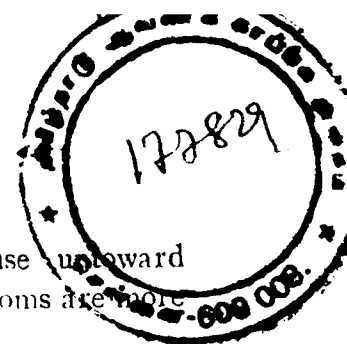
(From the Indian Medical Gazette January 1935)

Atebrin and Plasmochin.

Dr. C. D. Newman, M.B.B.S., D.T.M. & H, (Eng) Chief Medical Officer, Eastern Bengal Railway and Dr. B. S. Chalam, L.R.C.P. & S, (Edin) Malariologist, Eastern Bengal Railway, give their results of the use of the above drugs in 300 cases and summarise as:—

Summary and Conclusions.

1. Atebrin and plasmochin are effective in the treatment of malaria due to all strains of plasmodium in Bengal.
2. It is uncommon to find a temperature above 99 F, after 48 hours' treatment.
3. With the exception of subtertian gametocytes it is rare to find malarial parasites in the blood after the third day of treatment.
4. In subtertian malaria plasmochin also should be given owing to its specific action on the subtertian gametocytes.
5. In the absence of absolute certainty regarding the species of parasite, it is beneficial to use atebrin with plasmochin in all forms of malaria.
6. Atebrin produces a rapid reduction in the size of the spleen.
7. People exhibiting idiosyncrasy to quinine tolerate atebrin with plasmochin well.
8. Atebrin given alone occasionally produces certain untoward symptoms which are seldom serious.



9. Atebrin and plasmochin given together cause untoward symptoms in a larger percentage of cases and the symptoms are more severe.

10. It is safer to give atebrin for the first five days followed by plasmochin for the next five days.

11. The cost of treatment is on the whole less than treatment with quinine.

The treatment of malaria with atebrin and plasmochin is a distinct advance. The treatment is simple, short and economical. The consistent use of this drug should effect a considerable reduction in the number of malaria cases and the consequent loss of working days due to this disease on Indian Railways.

Dr. R. N. Chopra, C.I.E., M.A., M.D., (Cantab) Lieutenant-col, I.M.S., Professor of Pharmacology and Dr. R. N. Choudry conclude their observations on the Toxicity observed in 11 cases as:—

SUMMARY AND CONCLUSIONS

A number of instances of the toxic effects produced by the synthetic anti-malarial remedies have been given so as to impress on the profession that care should be exercised in the use of these drugs.

The main action of plasmochin is on the sexual forms and therefore it has neither very marked curative action in this disease nor does it prevent relapses.

The sexual parasites are destroyed by small doses after a few days' administration and therefore the main function of the drug is to prevent dissemination of the disease by mosquitoes.

Plasmochin is a toxic drug and does not bear repetition too often without producing serious toxic effects.

It has been shown that 0.02 gramme of plasmochin daily for a two or at most three days' course causes disappearance of the crescents in the peripheral blood in cases of Indian strains of malaria and prolonged use is unnecessary and dangerous.

Neither plasmochin nor atebrin should be used for prolonged periods for prophylactic purposes.

Patients should not be allowed to use these drugs except under direct medical supervision.

There is some evidence to show that combining atebrin with plasmochin increases the toxicity of the latter.

Dr. D. F. Williams, M.A., M.R.C.S., L.R.C.P., Chief Medical Officer, Assam Frontier Tea Company Limited, and Dr. RASAMAY BAATTA-CHARYA, L.M.P. (Assam), D.T.M. (Cal), Assistant Medical Officer, Bokpara Tea Estate, Doom Dooma, Assam, summarise as :—

1. The high incidence of malaria in a 'coolie line' in a tea garden in Assam gave an opportunity to carry out an experiment with atebrin and plasmochin as to the efficacy of these drugs as prophylactic and therapeutic agents.

2. Two hundred and thirty-four people—159 adults (children over 8 years were counted as adults) and 75 children were treated.

3. Prophylactic doses of atebrin and plasmochin were distributed among the line population in the dosage and by the method described.

Adults 3 grs; children between 8 and 4 years, 2 grs; between 4 years and 12 months one gr; and below one year $\frac{1}{2}$ gr; all once a day after the night diet for 5 days followed by plasmochin in daily single doses of $\frac{1}{3}$ gr., $\frac{1}{4}$ th, $\frac{1}{6}$ th and $\frac{1}{12}$ respectively for 5 days after night diet.

4. Those who developed fever were admitted into hospital and given a full course of treatment with atebrin and plasmochin in the dosage and manner shown below.

Atebrin for five days continuously in $1\frac{1}{2}$ gr. doses T. D. S., after food for adults; $1\frac{1}{2}$ gr. B. D. in children between 4 to 8 years, $1\frac{1}{2}$ gr. once a day in children between 1 to 4 years and $\frac{3}{4}$ gr. once in children below one year. This is followed by plasmochin for 5 days

in doses respectively of $\frac{1}{6}$ th gr. thrice, twice and once a day for the first 3 age groups, and $\frac{1}{2}$ gr. for the last one, after food once a day.

5. There were 50 relapses (21.36 per cent)—the vast majority of which were confined to the children population especially among those below two years of age, showing the absence of immunity in them. Of this age group, 11 cases had one relapse, 8 cases two, 3 cases three, and one case as many as four relapses.

6. The total infection and total incidence of malaria diminished to some extent; this diminution was due chiefly to the reduction of malignant tertian cases but there was no reduction either in infection or in incidence in benign tertian cases. But even this reduction of incidence in malignant tertian infections was not sufficiently satisfactory to compensate for the expense incurred.

7. The real value of an anti-malarial drug especially as a prophylactic agent can be gauged properly only when its efficacy is proved in terms of children and from this stand point atebrin and plasmochin have failed, in our claims made on their behalf. They have, however, decidedly better prophylactic value in adults.

8. We have not been able to determine the efficacy of atebrin relative to that of quinine but it is our impression that as a therapeutic agent atebrin is at least as efficacious as quinine in controlling the clinical symptoms and freeing the peripheral blood of malaria parasites.

9. On the point of toxicity atebrin is decidedly superior to quinine. It does not give rise to neurotrophic symptoms, is well tolerated by children and also those who have an idiosyncrasy to quinine, as well as by pregnant women.

10. Ill effects are attributed to the combination of atebrin and plasmochin. In the method and dosage we followed, ill effects were very few and not at all dangerous.

11. The cost of a course of atebrin treatment is much higher than that of Quinine but this higher cost is somewhat compensated for by the absence of neurotrophic symptoms. Therefore atebrin

is a more suitable drug for those who can afford, it but it cannot replace quinine in general use in a poor country like India.

12. Though it cannot be said with certainty that Atebrin is a more effective therapeutic drug than Quinine, it is undoubtedly a new anti-malarial weapon with some advantages over quinine and being, we hope, the precursor of more potent synthetic preparations has certainly opened up a new path for combating Malaria.

13. As a gametocyticide plasmochin should be used in mass treatment, only under proper medical supervision and under suitable conditions.

14. In these days of economic depression, quinine will, in a tea-garden, hold its present position till a cheaper and equally or more efficacious remedy is available.

15. We hold a very strong view that the published reports of atebirin and plasmochin treatment as prophylactics lose most of their value unless the age groups of the people so treated are given as well as the average length of time such people have resided in that locality.

Antimony Preparations in the Treatment of Diseases.

Of the few specifics that are available for treatment of diseases, Antimony is an important one. It acts as a specific in some and improve the condition in some others. It is administered intravenously as Sodium Antimony tartrate, starting with half a grain and going up to 5 grains, but the more effective and easy way is to administer it in the form of Ureastibamine. Intense treatment with Ureastibamine by daily injections often relieves acute conditions. It acts as a specific in (1) Kala Azar, (2) Oriental Sore, (3) Infective Granuloma, (4) Pityriasis-Nigra, (5) Filariasis, (it acts like a miracle even with one injection in Chyluria) (6) Bilharziasis. It shows improvement in (1) Trypanosomiasis, (2) Syphilis, (3) Yaws, (4) Chancroid, (5) Keratitis and (6) Leprosy.

—From "Antiseptic" January 1935.

SAFE PERIODS.

Prof Herman Knaus of Prague states that a woman ovulates only once during the intermenstrual period and that spontaneously and regularly, 15 days before the commencement of menstruation. In a woman with 28 days cycle it takes place on the 14th day and in a woman with 25 days cycle on the 11th day and in a woman with 30 days cycle on the 16th day of the cycle. An ovum can live only for a few hours and less than a day. The Spermatazoa can live in the female genitalia for less than 48 hours. So conception can take place only if there is coitus two days before, on the day of ovulation or the next day.

—From Clinical Journal January 1935.

High Blood Pressure Not a Calamity.

High blood pressure should be regarded as a warning. Its cause should be sought and treated. It has frequently been reduced by diet, attention to focal infections or by glandular therapy and, therefore, it may be assumed that faulty eating, infections and glandular dyscrasias are causes of hypertension.

The above-mentioned measures benefit the kidneys. They may lower the blood urea nitrogen and cause albumin and casts to disappear from the urine in mild cases of Bright's disease. They also operate against the most frequent causes of death among adults—heart, arterial and kidney diseases. They constitute the best measures for rejuvenation and life extension.

—(M J & Rec., May 4, 1932.)

Synthetic action of Antimalarial Drugs on the Uterus.

1. The pregnant uterus is much more sensitive to the action of antimalarial drugs than the non-pregnant uterus.

2. Experiments on animals indicate that Plasmochin and Atebrin, in therapeutic doses, are not likely to produce Oxytocic action on the pregnant human uterus.

3. Large therapeutic doses, are not likely to increase the contraction of the pregnant uterus, and therefore in pregnancy small doses (i. e., 5 grs.) repeated every 4 or 5 hours should be prescribed.

(I. M. G., October 1933.)

Does Insulin Cure?

An interesting discussion of this point is given by Leyton (Lancet, II, 120, 1933), who believes that insulin will cure diabetes mellitus if given in adequate doses. An adequate dose of insulin rests the pancreas. The dose of insulin will depend on the diet prescribed. In the majority of adults the acceptable diet is found to contain more than 150 gm. of carbohydrate, and the amount of protein and fat differs greatly in different people. The lower the sugar content of the blood can be kept, the greater the chance of the patient making a recovery. The idiosyncrasy of the patient has to be taken into consideration. The ideal is to arrange doses of food and insulin to keep the sugar content of the blood between 0.08 and 0.15 per cent throughout the twenty-four hours. In severe cases on a diet fairly rich in carbohydrate this may necessitate three or even four injections of insulin in the twenty-four hours for a time; it is the exception for more than two to be needed for longer than six months. The interval between the injection of insulin and the meal must be determined by trial in each case. After a meal rich in carbohydrates the sugar contents of the blood will tend to rise, and if the dose of insulin is sufficient to prevent this exceeding 0.15 per cent, there is considerable probability that between three and four hours after the injection the sugar in the blood will fall low enough to cause symptoms. This is prevented by the patient taking a small amount of carbohydrate in a form that is easily assimilated, about two and a half hours after the injection of insulin. The quantity must be determined by trial. Insulin may be hampered in its action by the patient taking substances that stimulate the cells of the islands of Langerhans to secrete; the most important of these is alcohol. Toxins elaborated by viruses or micro-organisms may retard recovery.

The Journal of Clinical Research, April, 1934.

The Trichinopoly District Medical Association.

(REGISTERED.)

A monthly meeting of the above Association was held at 5 p.m., on Friday the 18th instant in the Railway Hospital, Golden Rock when Dr. R. A. Johnson D.M.O., S.I.Ry., was "At Home". About 40 doctors attended. Dr. C. E. R. Norman presided in the earlier part and Capt. Sanghamlal later.

Before the proceedings commenced the following resolution was moved from the chair and passed all standing :—

"This Association grieves the sudden and untimely demise of Dr. T. Krishna Menon, M.B.C.M., L.R.C.P., M.R.C.S., of Madras and places on record its appreciation of his interest in this Association."

Dr. S. T. Achar, M.D., of Tanjore delivered an interesting lecture on "Medical practice in the mofussal", and explained the need for keen and careful examination of the cases and how the average practitioner could get the aid from the Laboratory. Correct diagnosis was essential for treatment. He dilated upon anaemias and stressed the necessity of differentiating the various anaemias as on that depended correct treatment. He showed a number of X-Ray plates on various diseases. After the lecture there was discussion.

The report of the Journals' Sub-committee was then discussed and it was resolved that members who are not in arrears of subscription would be eligible for Journals by paying an advance of Re. 1.

The following Journals will be available for circulation :—

1. British Medical Journal, (Kindly supplied by Dr. C. E. R. Norman)
2. Lancet, (Kindly supplied by Capt. Sanghamlal.)
3. Practitioner, (London.)
4. Indian Medical Gazette, (Kindly supplied by Dr. M. Subbiah.)

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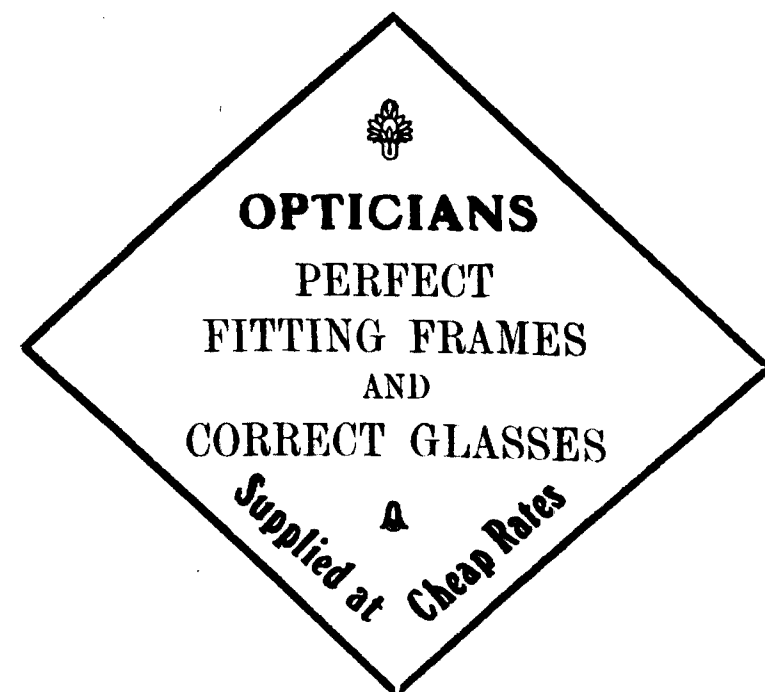


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MISCELLANY

OF

THE TRICHINOPOLY DISTRICT

MEDICAL ASSOCIATION

(REGISTERED)

FEBRUARY 1935



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MEDICAL ASSOCIATION

(REGISTERED)



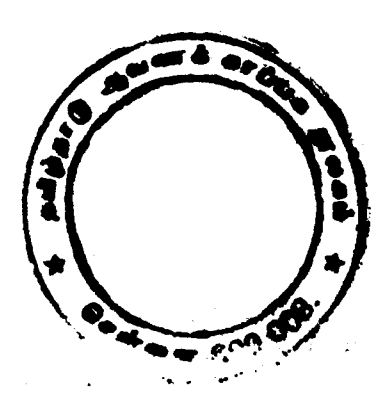
FEBRUARY 1935



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BURNS.

A burn is a lesion resulting from the contact of tissues with any heated medium. If the heated medium is a moist or a liquid one then the lesion is termed a scald. Under the same heading the following are also considered ;

1. Electric burns,
2. Ultra-violet ray burns,
3. X-ray burns,
4. Radium burns,
5. Burns by chemicals.

Various degrees of burns are mentioned in text books beginning with the simple erythema called the first degree and ending with the complete charring of the part called the 6th degree. In the first degree there is a simple congestion of the skin ; the second degree is the one where simple blebs form between the cuticle and the cutis ; in the third degree the sensory nerve endings are exposed thus resulting in the most painful variety of burns. In the circulatory system there is a marked loss of blood plasma with the consequent increase of R. B. C. per C.C , which is estimated by an increased haemoglobin percentage The sodium chloride value of blood is decreased.

During the first 24 hours there is found to be an increased flow of adrenalin into the system which decreases after the 24 hours. This fact is important when we think of adrenalin therapy in a case. It is contra-indicated in the first 24 hours. The general toxæmia is due to the toxins liberated at the burnt site by the tissues and is taken up by the blood stream. An essential condition for this is that the damaged tissues must be in contact with living tissues.

Clinical findings

Immediately after extensive burns there is the stage of profound shock probably due to peripheral nerve irritation. The second stage is one of secondary shock due to acute toxæmia which comes on as

stated after 24 hours. Then if sepsis supervenes as often happens as when the case either is not treated properly or comes under medical care rather late, there is the stage of septic toxæmia where sloughs form at the site. The last stage is the stage of healing with the separation of the sloughs and formation of granulation tissue if the patient has not already succumbed to the toxæmia.

Laboratory investigations show an increase in the haemoglobin percentage, and a decrease in the blood chloride value.

Treatment.

The primary thing in treating a case of burns is to treat shock with its addendant low blood pressure, cold clammy extremities. At the earliest possible moment the patient should receive a moderately large dose of morphia. Treat primary shock by warmth and fluids given in plenty either by mouth or parenterally. When treatment of the burnt area is begun a further dose of morphia will obviate the use of an anaesthetic.

The dosage of Morphia recommended by some, is as follows:—

Child of 1 month	2 to 3 mins of Tint Camph Co.
6 „	$\frac{3}{4}$ m of Tint opii.
1 year	2 m „ „
3 „	8 m „ „
12 „	$\frac{1}{8}$ gr Morphia
adults	$\frac{1}{3}$ or even $\frac{1}{2}$ gr morphia.

Clothes should be carefully cut off and under strict aseptic conditions blisters are opened and loose epithelium removed. The whole area is cleaned with Ether soap and finally dried with spirits. Then warm tannic acid solution to a strength of 2½% is sprayed on the whole area by means of an atomiser or the ordinary barber's spray that is found in every shaving saloon. A useful formula is tannic acid 17½ grs; $\frac{1}{4}$ gr. of Hydrag perchlor; and 1 gr. of acid boric to every 2 ozs. of the solution. The burnt area gets tanned. The patient is put to bed covered over with a thin mosquito net spread over some sort of improvised cage to prevent flies settling over the

burn. Some sort of dry heat in the shape of an ordinary charcoal oven under the bed is put up. No dressings are allowed and no bed clothes are allowed to come into contact with the burnt area. Spraying is done hourly or half hourly for the first 12 to 18 hours till a thick coagulum is formed. If fresh blisters appear they should be opened under the strictest aseptic technique and sprayed. If the burn affects the whole circumference of the body, gauze of about 6 to 8 layers thick is thoroughly soaked with the tannic acid solution and laid over the less affected areas and a thick cotton wool pad is put over this. Instructions are given to the patient to lie over this pad while the other parts are treated as stated above. In 14 to 21 days scales will have formed and epithelial growth will be found over a good area. The scales will separate themselves and on no account should they be manually removed. When sepsis arises these scales should be cut and the pus let out. With children with their buttock burnt a good plan in treating them will be to hang them by their legs on a gallows splint similar to the one used for treating fractures of the femur in them.

Tannic acid should not be sprayed on the fingers on both sides since it may cause gangrene resulting from the constriction of the finger due to the coagulum. While spraying the face care should be taken to see that no acid gets into the eyes. The limbs must be placed in such positions that there is no contracture resulting after a burn.

If the area is raw and extensive, skin grafting should be done and is easily carried out under novocaine infiltration anaesthesia. The raw area after taking the skin graft is treated with tannic acid compress and any further attention to this is not necessary if done aseptically.

If granulations are exuberant an ointment of the following formula is good for local application.

Alum gr 20
Zinci sulph gr 10
Glycerine dr 5
Water dr 5

Scarlet red ointment is found to be good for promoting epithelial growth over the raw area. It is used in strengths of 5% and can be had in collapsible tubes which are convenient to use. This is spread all round the edges of the raw area. In excessive applications there may be a red colouration of the urine which does not matter much since the dye gets excreted through the kidney.

Hydrogen Peroxide and HCl., in Achlorhydria.

Achlor hydria is a common sequel of chronic gastritis. First septic foci have to be removed and then lavage of the stomach when fasting in the morning with dilute H_2O_2 $\frac{1}{2}$ Oz to the pint is done. This acts as a mild anti-septic and dislodges the adhering mucus as well. It is repeated daily till washings are clear. Treatment may last from a fortnight to a few weeks. Unless Achlorhydria is an inborn error of secretion this method succeeds. In case HCl. is necessary the usual doses are inadequate. One to 2 drachms of HCl., dilute (B. P.) thrice a day diluted with 5 ozs, of water with the addition of the juice and pulp of an orange and sugar should be taken before breakfast, lunch, and dinner, for ever after.

Adrenalin in Asthma.

One or two minims would be sufficient at the start of an attack and has not the disadvantage of raising the blood pressure. The rare conditions of Status Asthmaticus can be arrested by continuous adrenalin injection. The needle is kept in position with a full syringe and after an initial injection of a dose which does not cause any untoward symptom one or more minims are injected every 15, 30, or 60 seconds according to the patient's reaction, the rate being varied until it is found how frequently it is used without untoward symptoms. The injection is continued if necessary for even half hour or more. Relief follows and generally manifests itself by the patient falling to sleep which may be the first he might have had for several days.

Caffeine and Iodide in Asthma.

Cafene 2 grs. tablets 3 or 4 of them taken half an hour before food would enable a round of golf to be enjoyed by the patient.

Iodide is also a most useful drug in Asthma. A useful dose is 5 grs at night and morning. It renders tenacious mucus more watery thus facilitating expectoration.

Hexamine as Biliary Antiseptic.

At first a mixture of Sodium bicarb and sodium-citras aa gr 60 in 2 ozs of water are given thrice daily after food and urine tested every time to see that the reaction is alkaline every time. After this 100 grs., of Hexamine thrice daily is given with the mixture. Such a treatment can be carried on in cases of Poliomyelitis, otitis and sinus disease.

Morphine and Codeine in Diarrhoea.

This combination works better than either given separately alone 1/10 gr of each thrice daily; and may be repeated once at night if sleeplessness is present. If colon spasm is present atropine 1/200 gr., may be added; Belladonna may be given while in some other cases stramonium works better.

Charcoal in Intestinal Flatulence.

The immediate relief of severe colic during an attack of bacillary dysentery is brought about by charcoal. It also renders the stools odorless. One tablespoonful of pure powdered charcoal mixed with water to which a small quantity of warm milk slowly added is taken thrice daily.

A. F. HURST,

Clinical Journal, 1934.

SOME MIDWIFERY PROBLEMS

BY

A. M. CLAYE M.D., F.R.C.S.,

Adapted from Clinical Journal Jan. 1935.

The commonest subject causing trouble during labour is the slow Primipara.

1. Uterine Inertia.

Cause is to be found in the weak muscular pains. Such a subject should be asked in her ante-natal period to take plenty of outdoor exercise without tiring herself overmuch. She must be prescribed abdominal exercises as well. Usually again the "Inertia patient" is one who is very much frightened over her pregnancy and steps must be taken by the medical attendant to see that nothing is said about any abnormality that is to be found in the patient's presence till the time comes for treating the same.

When patient goes into labour, mechanical obstructions, malpresentations, disproportions, and pelvic tumours are excluded before inertia is diagnosed by a process of pure exclusion.

Treatment is to give an adequate sleep since the patient is quite often sleep starved. Careful watch must be kept on the bladder and rectum which must be relieved. This is a very important step. For the production of sleep Morphine and hyoscine combination is the best. Chloral and other hypnotics are inferior to this combination. After good rest it is rational to stimulate the uterus, if delivery is not spontaneous; after this rest quinine in 10 to 15 grs. doses every 4 hrs. is sometimes effective. Pituitrin is ineffective unless cervix is $\frac{1}{2}$ dilated and then a safe dose is 2 Voegtlin units every hour.

So long as the membranes are intact nothing need be feared. In those rare cases where membranes rupture early with incomplete dilatation of the cervix, Caesarian section through the lower uterine segment is a good practice. The practice hitherto has been to dilate the cervix artificially or to inject Novocaine or to incise the cervix.

2. Retained Placenta.

If primary inertia is continued to the third stage expulsion of the placenta is difficult. Partial separation leads to postpartum haemorrhage. The method advocated is to inject 10 to 120 zs. of normal saline through the umbilical vein to make the placenta bigger in size. The uterus responds to this and ejects the placenta into the vagina. (Mojn's method).

3. Occipito Posterior Positions.

If in the 36th week the head is well flexed and fixed in the pelvic brim, the rotation that occurs on the pelvic floor is a long one that takes place invariably and delivery may be anticipated to be an easy one. If the head is still floating above the pelvic brim trouble is to be anticipated since it means that the head is not flexed well. But in the case of multipara delivery is almost always spontaneous even if flexion is deficient.

As regards ante-natal treatment, no treatment is necessary for the well flexed type. In the poorly flexed cases the position may be changed by one of two methods

1. Manipulation by hand over the abdomen with the mother supine and by giving a series of pushes over the child's anterior shoulder.

2. Buist's binder method. Patient is kept recumbent in bed; padding is arranged in the Iliac fossa where the occiput lies, a tight binder is applied to fix the padding for 24 hours patient remaining in bed till then. 75% of cases are corrected in this way.

If labour has set in with a poorly flexed head, try to keep the bag of membranes intact by keeping the patient in bed to preserve the same and ensure adequate sleep. Patient should lie on the side opposite the occiput. Sometimes flexion increases even in the second stage and delivery is effected.

If delivery is delayed in the second stage, interference is indicated when,

- a. There is foetal or maternal distress,
- b. Head ceases to advance,
- c. It becomes a case of persistent occipito posterior.

Two steps are now available:

a. Pulling the child out which has disastrous effects.

b. Extraction by forceps after rotation of the head.

Rotation is best done manually which is more safe than rotation by forceps. The patient is anaesthetised, the vagina is dilated gradually by the hand after which the hand grasps the head and rotates the head into the anterior position if necessary pushing up the head before starting the rotation. This hand continues to grasp the head till the other hand inserts one blade of the forceps and then the other after which extraction is done. Only very few cases require lower uterine caesarian section.

4. Hydramnios.

Tapping the fluid is done through the abdomen if x-rays show no monstrosity. If it is found to be a monster by x-rays labour is induced since there is no object in allowing pregnancy to proceed.

EXTRACTS

Rupturing the Membranes to Induce Labour.

DELBERT L. JACKSON.

(*American Journal of Obstetrics and Gynecology*, 1934, xxvii, 329.)

Rupture of the membranes is essential for a start of labour, and observations have led to the belief that pituitary extract is not essential or dependable and that response to its use depends greatly on the stage of labour, and more particularly on the condition of the cervix.

If the cervix is flat or thin when the membranes are ruptured, the start of labour is usually instituted so quickly and with such satisfaction that pituitary extract is not necessary. On the other hand, with the elongated, non-effaced cervix, it can be expected that satisfactory labour will be delayed until the cervix is "taken up" when labour will assume a satisfactory rhythm, obviating the need of pituitary injection. It is probable that if pituitary extract is given after rupture of the membranes when the cervix is long, the effacement will be somewhat hastened, but "whipping up" the uterus in this early stage of labour many times leads to distressing conditions such as contraction ring and tonic contractions of the

uterus. A little patience after rupturing the membranes, where the cervix is long, will allow the painless, constantly present, uterine contractions plus the pressure of the presenting part to efface the cervix, after which true labour will start.

All cases divide themselves roughly into two classes so far as indications for induction of labour are concerned:

1. Cases where some prenatal complication such as toxæmia, bleeding from partial or marginal placenta previa, hydramnios, slightly contracted pelvis, cardiac and renal diseases, diabetes, etc., make induction imperative.

2. Cases at term where elective induction of labour seems desirable and safe, either from the view point of the patient or the physician, but not for pathological conditions.

In the first class, where pathological conditions demand termination of pregnancy, rupture of the membranes offers the simplest method for labour induction. In the second class, the problem becomes a matter of the maturity of the ovum and of those physical findings in the pelvis which point to the readiness of the generative tract for the onset of labour. It is, of course, understood that under no condition should elective induction of labour be attempted through the vaginal passage until there is complete compatibility between the passenger and the passage.

Routine and technic: Patient enters the hospital at 8 P.M. on the evening before induction, and is given nembutal, gr. iii, or luminal, gr. v., to insure a restful night. She is given castor oil, 1½ oz., at 4 A.M., quinine, gr. x at 5 A.M., and again at 6 A.M. The membranes are ruptured at regular visit between 8 A.M. and 9 A.M.

The technic of rupture of the membranes is as follows:

The patient is prepared and the vagina is filled with hexyl-resorcinol. A long hysterectomy clamp is easily slid along the examining fingers of the left hand and without force passed through the os uteri until its tip encounters the foetal head. The jaws of the clamp are opened slightly and then closed while held firmly, but not

forcibly, against the vertex. If the tips of the clamp close accurately they will pick up the membranes, which rupture as the clamp is drawn outward. The examining fingers are held in the vagina throughout this manouvre, acting as a guide to the forceps in regard to both its direction and its relation to the presenting part. All the fluid that can be readily released should be encouraged to escape. The patient is then put in the prone position and the foetal heart auscultated. In the majority of cases, where the indications for elective induction have been properly judged, the uterus will show signs of contractions almost immediately. Where delay occurs at this stage the judgment of the operator shall dictate whether he will use patience or pituitary extract. Labour will ensue in any event.

The above procedure is technically easy, safe, can be performed with complete cleanliness, and involves little more risk and liability to infection than the ordinary vaginal examination during labour. Infections and complications are no more to be expected after artificial rupture of the membranes than when labour is conducted after the orthodox manner, and the shortening of labour is an important factor gained. With care, the probability of the prolapsed cord is not more to be expected than is its average occurrence in obstetric practice, and this, together with the dry uterus and consequent dry labour, is not a cause for worry in relation to this procedure.

Pregnancy Polyneuritis.

T. S. SZE.

(*Chinese Medical Journal*, 1934, xlviii, 651.)

Manifestations of pregnancy "toxaemia" are protean and have all been summarily regarded as due to some unknown toxin, but in none of them has the hypothetical toxin been isolated and identified. The author favours the view that multiple peripheral neuritis of pregnancy is a food deficiency disease, in the same way as pregnancy anaemia is a deficiency disease. Peripheral neuritis occurring during pregnancy following "toxic" vomiting has been reported by many workers, and in all the cases persistent vomiting preceded the onset of paralysis, death usually ensuing in spite of therapeutic

abortion. Wilson and Garvey (1932) consider that polyneuritis gravidarum is a "presumable" toxaemia of pregnancy and that this symptom is to be expected in the early months of pregnancy in 50 per cent of normal pregnancies, the paralysis following later on after a period of relief. They divide cases of peripheral polyneuritis of pregnancy into three groups:

1. Cases with numbness and tingling in the hands and arms with possibly radiating pains in the arms or lower extremities.

2. Cases of a more severe type in which numbness and tingling are soon followed by pain, and later by weakness and paralysis, without any disturbance of general health. This may occur during the course of pregnancy or may originate during the puerperium, and the prognosis is usually good as far as life is concerned.

3. Severe cases with persistent vomiting, rapid and progressive loss of weight, profound general and mental disturbances, severe muscular paralysis, and a high mortality of about 25 per cent.

Others suggest that the polyneuritis of pregnancy is probably a dietary deficiency disorder similar to beri-beri, and that rational therapy should aim to supply the deficiency, which may be specially some portion of the vitamin B complex, administered orally or parenterally.

The author reports three cases under his observation at the Hongkong University Medical Clinic, in whom the symptoms of neuritis appeared either shortly before or after parturition and became aggravated after childbirth. All the patients refrained from taking vegetables after confinement on the advice of friends, and in none of them was "pernicious" vomiting present during pregnancy. The patients responded satisfactorily to a vitamin-rich diet, especially in vitamin B content. These cases do not appear to be cases of dry beri-beri.

The author concludes that pregnancy polyneuritis is probably a diet deficiency disorder and not a "toxaemic" manifestation. The deficiency is possibly rendered acute by two factors: firstly, just as the blood requirement of the foetus may be conducive to the causation of pregnancy anaemias, so the additional strain of the foetal

demand for vitamins during its intra-uterine life may be largely responsible for the deficiency in the mother; and animal experiments tend to show that the mother often sacrifices her own well being in order to satisfy the needs of the offspring; secondly, abstinence of certain foods after childbirth still more increases the deficiency. Prophylaxis should therefore consist in supplying abundantly the vitamin B complex and a high protein diet, and in avoiding restraint of eating vegetables during and after the puerperium.

TIT-BITS

A method of taking raw liver.

Practitioner, December, 1934

Although the liver treatment in pernicious anaemia (and indeed in other debilitating diseases) is established, the difficulty still remains in persuading the patient to eat enough raw or half cooked liver. In order to overcome this difficulty various liver extracts have been prepared and are upon the market, but some authorities maintain that liver itself is more potent than the extract. Louis Desclaux has put forward (*Journal des praticiens*) a simple method of taking raw liver that he has found effective, in pernicious anaemia and in tuberculosis. Raw calf's liver is minced finely and rolled into little balls, which are dipped in crated bread crust and swallowed without being masticated. This can be taken along with a vegetable soup or during the course of a meal, and none of the author's patients have made any objection to taking up to 300 grammes daily of calf's liver in this way.

Hormonal Factors in Menstruation and Pregnancy.

(1) Prolan A (Rho 1): follicle-maturing hormone of the Anterior Pituitary.

(2) Prolan B (Rho 2): Luteinizing hormone of the Anterior Pituitary.

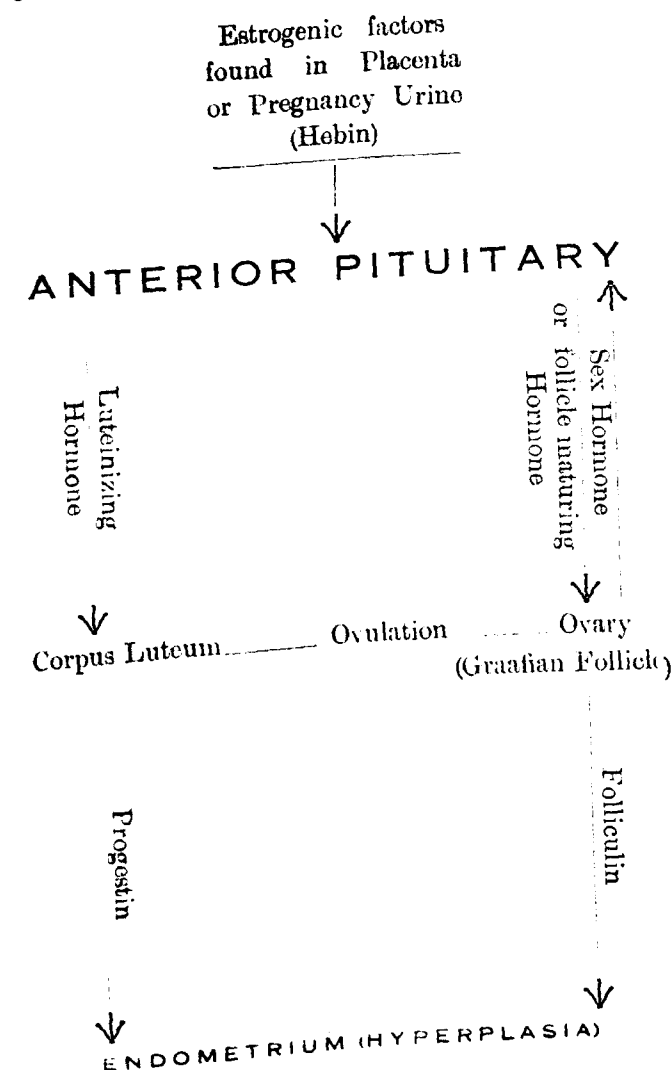
(3) Follicular Hormone of the Ovary (Allen-Doisy Hormone or Estrus-inducing Hormone or Estrin or Folliculin).

(4) Luteal Hormone of the Corpus Luteum. (Progestin).

No. (1) Acts on the ovary and produces Estrin or Folliculin. Folliculin in turn produces Hypertrophy of Endometrium.

No. (2) acts on Corpus Luteum and produces Progestin. Progestin in turn acts on the hyper-trophied Endometrium and produces a pro-gestational Endometrium.

N. B: If a fertilized ovum is not available at this stage, this pro-gestational endometrium degenerates and is thrown out resulting in bleeding called Menstruation.



A simple test for detection of albuminuria.

Practitioner, July, 1934.

5 ccs of the urine to be tested, preferably filtered, is placed in a test tube. $1\frac{1}{2}$ ccs of liq. carbolic acid B. P. is added slowly pouring it down the sides of the test tube by means of a pipette. The carbolic acid will collect at the bottom of the tube. If within 2 minutes a definite white ring forms where the two liquids come into contact the test is considered to be positive; namely the urine contains albumen. The sensitiveness of the test is just as equal to that of the boiling acetic acid test; but is not absolutely specific for albumen (seralbumen and globulin). It may be positive also when urine contains certain proteoses.

(Sir Aldo Castellani.)

PREGNANCY TEST (HORMONAL).

OR

ZODEK-ASCHEIM TEST

OR

RABBIT-OVULATION TEST.

This test consists in the injection of pregnancy urine into the skin of virgin rabbits (female); positive result being (1) Production of hemorrhages in enlarged ovarian follicles called Blood-Points; (2) Formation of Corpus Luteum (Luteinization)

This test is positive in 98% of cases, and that within 5 to 6 days after non-appearance of expected menstrual flow.

Limitations for this test:—(1) Toxicity of some specimens of Urine. (This is remedied by extraction with Ether and addition of 3% solution of dextrose. This remedy reduces the time also to 3 days).

(2) Test takes 4 days. (This is overcome by intra-venous injection which reduces time to 1 to 2 days.)

Uses for this test:—For normal pregnancy as well as its pathological conditions:—Viz. Hydatidiform mole and its sequelæ, chorion epithelioma, Tubal pregnancy, missed abortion.

Anterior Pituitary.

Hormones:—(1) Growth.
(2) Thyroid-activating (metabolic).
(3) Prolan A. (Follicle-maturing).
(4) Prolan B. (Luteinising).
(5) Uterine Hemorrhage. (?)

A Chaud.

Explanation:—Expression used to denote removal of the tonsil at the same time as a quinsy is opened, i.e. at the height of infection.

Notes:—The practice is dangerous and painful and not to be recommended generally (Canuyt and Daull, Strasbourg, *Lancet*, Feb. 24/34, p. 409.

Sputum Plate (for pertussis).

Explanation:—A specially prepared culture medium plate introduced by Chiewitz and Meyer for the diagnosis of whooping cough

Notes:—The patients are required to cough directly on to the plates of culture medium. It permits of diagnosis in the early stage before the whoop is marked.

Phleboclysis.

Explanation:—Intravenous administration of medicaments by perision.

Notes:— Reg. A. Cutting (*New Orleans Med. Surg. Journ.*, 1933 p. 238) takes exception to "venoclysis" since the word is of mixed derivation, half Latin, half Greek. He suggests as substitute "phleboclysis", the roots of which are Greek. *Exer vein Knvois clyster.*

Treatment:— This method of treatment is used especially for the administration of dextrose (purified glucose) in septicaemias, hyperemesis gravidarum etc., when it is very frequently combined with insulin to promote metabolism.

Nyctalopia.

Explanation:— Inability to see in a dim light, night blindness. Disturbance in the metabolism of visual purple of the retinal visual rod cells under faint illumination.

(Also, day blindness, hemeralopia,—inability to see in a bright light.)

Notes:— This condition may result from intraocular disease or from nutritional deficiency. In the latter case vitamin A is the factor lacking and the condition may be the first sign of the avitaminosis. (Wight, Wilbur, Eustermann, *J. A. M. A.*, Feb. 3, 1934.)

Treatment:— Underlying disease, e.g. hepatic deficiency, intestinal disturbance, infectious disease. Supply vitamin A ('Detavit', 'Vogan').

Nucleoside.

Explanation:— A glucosidic compound derived from nucleic acid (polynucleotide) by the action of nuclease producing nucleotide which is then split up by nucleotidase into nucleosides and phosphatic acid.

Notes:— These substances which are derived from heart and skeletal muscle are of particular importance as vasodilators. They have a selective action upon the coronary arteries.

Use:— A preparation of these substances ('Lacarnol') relieves arteriospasm, particularly angina pectoris.

Gynecomazia.

Enlargement of breast before the age of puberty in males an abnormality occurring occasionally.

NEWS AND NOTES

The Trichinopoly District Medical Association.

(Registered)

A monthly meeting of the above association was held at 4 p. m., Saturday the 16th February 1935, in the Government Head Quarter Hospital, Trichinopoly, when about 35 members were present. Dr. R. Gopalan Hon. House Surgeon of the Government Hospital, Trichy, was "At Home". In the absence of Dr. Norman the President of the Association, the Secretary proposed Dr. James, Retired Civil Surgeon, General Hospital, Madras to the chair and requested him to give his views on the newly started Journal of the Association. Dr. James thanked the Association for honouring him and said that he read the small Journal with pleasure and was much impressed with the neat get up and the very useful information it contained. There were some information in the Journal which were of latest developments in medicines and news to him. He also said that the Journal is unique in South-India and wished it all success. He also congratulated the Association for its activities for the past six years which he had been watching with pleasure. He then called upon Capt. Sanghamlal, I. M. S. M. B., F. R. C. S., to deliver his Lecture on "Infections of the Hand".

Capt. Sanghamlal delivered an interesting lecture for one hour after which there was a discussion. He then showed a brain with huge abscess in the brain which was diagnosed during life and operated upon. Dr. R. Sambasivan who presided at the later part of the meeting made a few concluding remarks and the meeting terminated with a vote of thanks to the Chairman, Lecturer, and the Host of evening, proposed by Dr. R. Kalamegham, B. A. M. B. S., the meeting terminated.

The Chettinad Medical Association.

The monthly meeting of the Chettinad Medical Association held at the Dayapuram Hospital and Home at Manamadurai. 16-2-35. Rev. Wolsted Superintendent of the Leper Hospital kindly invited the Association. Over 40 Medical men and women were present from all over the District.

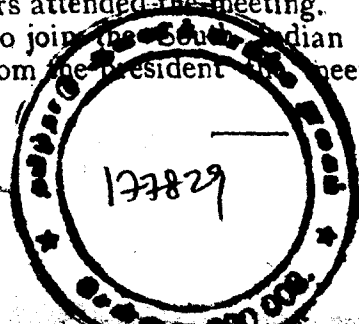
The Superintendent and the Medical Officer took the members round the extensive grounds of the colony and demonstrated all types of cases both in men and in women. Laboratory tests and Microscopic slides were shown and later a very instructive lecture was delivered by Dr. Devasirvatham L. M. & S. the medical officer of the Hospital.

In view of the newly formed District Leprosy Relief Committee, Rev. Wolsted has promised to take in doctors in batches and give them the necessary instructions for 4 days in order that the doctors in charge of the Leprosy clinics in the District may be able to help the patients.

The meeting came to a close at 5-30 p.m. after thanking Rev. Wolsted and the medical officer for the enjoyable evening.

Coimbatore Medical Association.

The monthly meeting of the above association was held in Radiology Block of the Government Headquarters Hospital 9-2-35 at 5-30 p.m. with Dr. Anantharanga Rao in the Chair. Dr. T. V. Ragothma Rao was at 'home' to the members. After the meeting Dr. P. Rama Rao D. M. R., (Wien) of Madras delivered an interesting lecture on 'X-ray in diagnosis of diseases of the Gastro intestinal tract'. The lecture lasted for an hour and a half. He also exhibited about 405 beautiful skiagrams of very interesting and instructive cases. About 35 members attended the meeting. The lecturer also requested the members to join the South Indian Medical Union. With a vote of thanks from the President the meeting came to a close at about 7-30 p.m.



— ♦ GANESH ♦ —

COFFEE

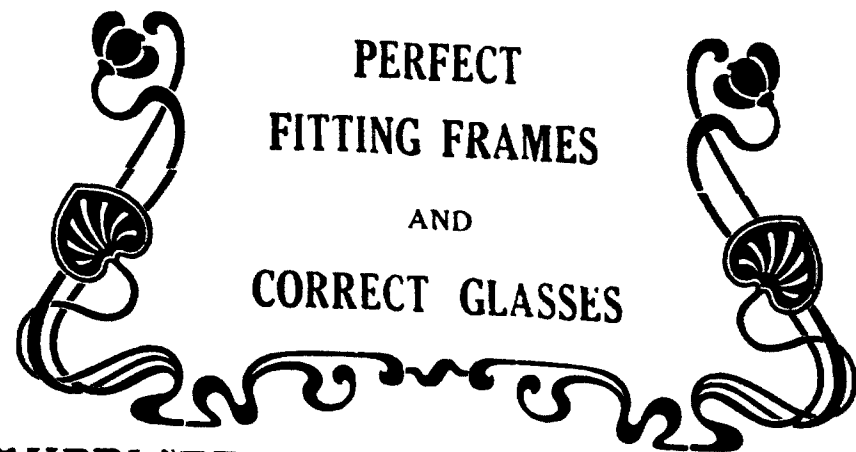
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MARCH 1935



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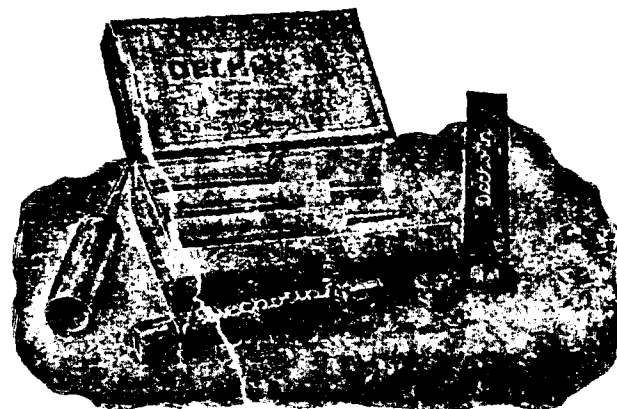
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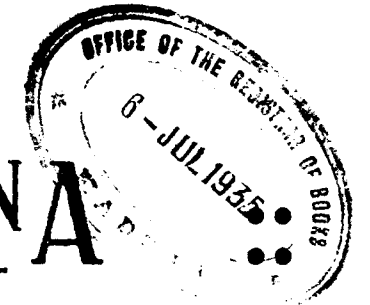
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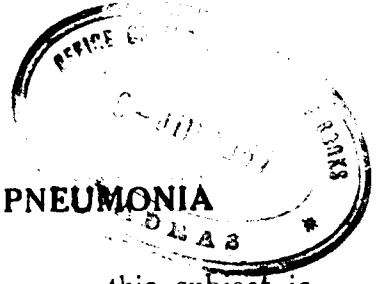
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TREATMENT IN ACUTE LOBAR PNEUMONIA

A Review of some of the current literature on this subject is attempted here. Most of the material is drawn from a very enlightening article on this subject, that appeared in the January Issue of the 'Practitioner'. Here the author criticises certain aspects of our routine treatment of Pneumonia with such remarkable courage and good sense, that I find it impossible to resist the temptation of quoting largely from it.

So far, the treatment of Pneumonia has advanced but little more than being expectant and symptomatic, with the mortality still remaining high:—about 25 to 30% in Types I and II, as high as 50% in Type III and 12 in the heterogenous Type IV. Yet, in the light of certain recent observations, it is becoming increasingly clear, that some of our ideas have to be radically altered and much of the usual treatment discarded as either useless or even positively harmful.

Quite aptly, at the beginning of the article above mentioned, the author quotes the maxim—"Before we consider the treatment of this disease, let us consider how its victims die". Most of us have the general impression that in several of the fatal cases of Pneumonia death is due to a failure of the heart, the myocardium gradually losing its strength under the influence of the toxin, till it is finally unable to maintain the circulation. Or perhaps in some cases, it is the result of the failure of the Vasomotor centre in the Medulla. Naturally therefore our aim so far in the treatment, has been to try and prevent such catastrophes. But, both these views have now been proved to be incorrect. The conclusion of several famous pathologists is, that the heart, at necropsy, shows very little change, beyond that of cloudy swelling, just like any other muscle tissue in a toxic state.

Also it has been shown experimentally that "the efficiency of the myocardium in Pneumonia, is as a rule, practically undiminished," except in cases where auricular fibrillation or flutter supervenes. Besides, clinically, it must be the experience of most of us that in the course of this disease it is really rare to observe the typical signs of cardiac failure—enlargement of the heart and the liver, oedema of the back or feet etc. Similarly it has been proved by experiment, "that the

efficiency of the vasomotor centre is certainly not impaired in Pneumonia", and the cause of death in Pneumonia is now shown to be "principally due to a circulatory failure" as a result of the septicaemia. This failure takes place at the periphery, the minute blood-vessels losing their contractibility because of the "Toxaemic shock" (Ritchie) much as in Histamine Shock.

In view of this evidence, it becomes necessary that we must modify our measures of treatment. The general principles that aim at conserving the patients strength and energy, and giving the best chance for his natural defensive forces, have their foremost place at all times. But as regards the numerous drugs, that are daily being used, it is imperative that our ideas have to be somewhat revised.

Young and Beaumontin, Price's Text-book of Medicine, preface their treatment of Pneumonia by saying that, "Medicinal treatment has probably but little influence on the course of this disease". I shall now quote in full, the paragraph from the "Practitioner" dealing with the use of drugs in the treatment of Pneumonia.

"With the exception of morphine, these can be practically always safely discarded in toto, and with benefit to the patient, who, too often has to contend not only against the infection, but also against drug poisoning. If the functional efficiency of the myocardium is generally so little impaired in pneumonia, to pour so called "heart tonics" into him as a routine measure and without any special indications, would seem to be illogical, and especially so, since most of them have no action on the heart. Neither strychnine nor camphor in therapeutic doses has any action, as far as is known, on either heart or circulation though by their temporary stimulation of the entire nervous system, they induce excitement and irritability—the very things, we are striving to prevent by rest and morphine. If circulatory failure, in pneumonia be due to impaired contractility of the minute blood-vessels in the periphery, the administration of adrenalin and pituitrin would, theoretically, seem to be specially indicated. Unfortunately, it has been proved by experiment, that in the presence of acute toxaemia, they have little or no action on them. If it however be contended that, at any rate camphor and strychnine stimulate the vasomotor centre, not only has this been shown to be

unimpaired in pneumonia, but it has yet to be proved that these have a special action on it, in any circumstance".

As regards digitalis, the question seems to be yet unsettled. Some maintain that digitalis ought to be given as a routine and may prove a lifesaving measure, while others doubt its efficacy and state that such routine administration may even prove dangerous. The teaching of one of my professors was, to prescribe a small dose of Tr. Digitalis along with the usual mixtures right from the start; &c the argument for this is quite sound. For when an emergency is felt to administer digitalis this cannot be done with any immediate effect. The action of digitalis is delayed and cumulative; and rapid digitalisation is too difficult to achieve. Hence, if a small dose is added daily from the start—just a little more than the quantity eliminated from the body in a day (about 20m)—then there may be left in the system a little extra digitalis, which will always be available and when necessary, an increase in the dose will have an immediate and desired effect. But once it is conceded that the myocardium suffers little damage, this routine digitalis medication appears obviously unnecessary; and it seems safe to follow Mackenzie's teaching, who maintained "that digitalis was useless in acute infection like Lobar Pneumonia except in the presence of auricular fibrillation or flutter, when there should be no delay in administering it in adequate doses".

"The routine use of expectorants in pneumonia should be deplored. It is not sufficiently appreciated that the exudate in pneumonia is entirely or for the most part, absorbed during recovery and not expectorated.

Just as in the case of vaccine therapy, the high hopes raised at the time when Felton's serum was first introduced, are yet to be realised in any considerable measure. The reports on the employment of this serum in large series of cases show much variation in results. Our main handicap here, is to get the infecting organism typed. Only for the types I & II do we have the respective sera. The indiscriminate use of the serum in all cases of severe infection as a routine, on the off chance that it may do good is to my mind to say the least, "unscientific". Further it must be remembered that, for the serum to do any good, it should be given very early in the disease.

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The author of the article already referred to, writes in detail about the general measures taken in the treatment; I shall refer below, to a few of them that are significant.

As regards diet, he deprecates the probably well-meant intention of the attendant in inducing the patients to take in large quantities of the so called 'nourishing foods', they are all poorly digested in the acute stage of the disease and only cause distension of the stomach and consequent respiratory embarrassment.

Since it is only a fever of short duration, plenty of glucose and water is enough. Sodium chloride is found to be largely diminished, and it is desirable to add about 10 gms of common salt every day.

Another important point he lays particular emphasis on, is that morphine should be more generally employed in the early stages with much benefit, when the pleuritic pains and sleeplessness are such prominent and exhausting features.

About Oxygen, his complaint is that it is not given early enough. For most of us, unfortunately it has not yet become an easy business proposition. About local application, he writes, "very light poultices of linseed meal or antiphlogistine give comfort, in the presence of pleuritic pain, but otherwise of course they have no virtue. Heavy poultices I regard as definitely harmful; the number of foot pounds of work, they are responsible for, in twenty four hours, is incredible till one begins to make a calculation—and this in a patient whose energy, we are trying to conserve in every possible way." Heavy, over heated poultices tightly surrounding the chest must be condemned. They must be applied preferably only to the back, at a temperature easily borne by the patient and kept in position by a loose many tailed bandage. "As a rule one should not interfere with the temperature with antipyretic drugs unless, it rises above 104 or 105 degrees F, when sponging, either tepid or cold, should first be tried."

So far it will be seen that no new remedy has been suggested and only a very blunt criticism is offered, of the little that one could do in such an acute illness, before which we are mostly helpless. It still remains a fond hope that further research may put in the hands of the profession, a more specific remedy.

N. C. SUBRAMANIAM, B.A., M.B.B.S.

EXTRACTS

Ascites Its Diagnostic Significance and Treatment

(Adopted from the Clinical Journal, February 1935.)

The causes of general abdominal distension have been alliteratively stated as "fat, fluid, flatus, foetus and formation." "Fluid" or ascites is distinguished from the others by eliciting "shifting dullness." It is essential that the stroke should be light. At no time, indeed, is it more necessary to remember the warning of Oliver Wendell Holmes:

"If the poor victim needs must be percuss't,
Don't make an anvil of his shrinking bust!"

Fluid containing tumours, if of large size, may also be difficult to distinguish from ascites especially *Ovarian cysts*. The distinguishing points between an ovarian cyst and ascites are these:

1. In a case of cyst the antero-posterior diameter of the abdomen is greatest, in ascites the lateral diameter.
2. The circumference of the abdomen in a case of cyst is greater *below* the umbilicus, in ascites *at* the umbilicus.
3. A cyst gives dullness round the umbilicus and resonance in the flanks; ascites gives the reverse (in very large cysts and in extreme degrees of ascites, however, this distinction no longer holds good.)
4. In cases of ovarian cyst the uterus is drawn up, in ascites it is not.
5. In cysts, the umbilicus is nearer the xiphisternum than normal, in ascites, lower.

These points of distinction sound very well on paper, but in practice a large cyst may simulate a high degree of ascites so closely that in a doubtful case in a woman it may be wiser to incise the abdomen rather than to tap, and to be ready to go on to the removal of the cyst if such it proves to be.

A greatly distended bladder may, on hasty examination, be mistaken for ascites. It is always a wise precaution to pass a catheter.

What are its causes?

1. It may be part of a general dropsy, *cardiac or renal*.
2. It may be the result of *portal obstruction*. The commonest cause of this is *cirrhosis* of the liver.

A slight degree of jaundice is in favour of a diagnosis of cirrhosis and the dilated venules on the cheeks and nose which with slight jaundice, make up the "cirrhotic facies." When all is said and done, however, it is not by any means always easy to be sure that cirrhosis is present.

A rarer cause of portal obstruction is the pressure of enlarged glands in the hilum of the liver. In such a case obstructive jaundice should be present as well.

3. *Obstruction of the inferior vena cava high up*—from adherent pericardium or from mediastinitis.

4. *Inflammatory effusion*.

(a) abdominal tuberculosis,

(b) chronic peritonitis and perihepatitis.

(a) *Abdominal Tuberculosis* as a cause of ascites is chiefly met with in children, and indeed should always be suspected when ascites occurs in a young subject. In such a case, feel a thickened and rolled up omentum crossing the abdomen as a sausage-shaped tumour at or above the level of the umbilicus. It may also be possible to make out tumours due to matted coils of intestine or enlarged glands. On the other hand, absence of fever by no means rules out tuberculosis.

(b) *Chronic (non-tuberculosis) peritonitis*. It occurs with chronic perihepatitis, and is often associated with renal cirrhosis.

5. *Peritoneal irritation*. There are three main sources of such irritation:—

- (a) malignant diseases, usually secondary (the primary growth being most commonly in the rectum, the stomach or one of the pelvic organs).
- (b) Proliferating ovarian cyst.
- (c) a solid ovarian tumour.
- (d) an enlarged spleen.

Treatment.

As ascites is a sign and not a disease it is not worth while trying to get rid of it unless it is causing great inconvenience. Drugs are not of much help. Purgatives have to be used cautiously, as they may set up an intractable diarrhoea. Ordinary diuretics are useless, but Salyrgan, given intravenously or intramuscularly ($\frac{1}{2}$ to 1 C. C.) is some times of great value, especially if used with ammonium chloride (120 grains daily.) (Salyrgan should not be repeated within one week.)

As regards diet, it seems reasonable to restrict fluids as much as the patient can bear, and to make the diet as far as possible salt free.

In the majority of cases, however, one has to get rid of the fluid by mechanical means. In abdominal tuberculosis, evacuation by laparotomy is best and is certainly more efficacious than tapping. In women, also, for reasons already given, incision is sometimes to be preferred even in non-tubercular cases. In most cases of ascites, however, if it is decided that the fluid should be evacuated, tapping is the method of choice.

If one is dealing with cirrhosis of the liver it is not worth while withdrawing the fluid unless it is causing great discomfort, as the ascites in such cases is a terminal event and the patient is not likely to survive long.

Operations designed to promote absorption of the fluid, have practically been given up.

R. K.

Diagnosis of Anaemias.

Anaemia connotes a diminution of Haemoglobin or in the number of R. B. C., in the peripheral blood and accompanied by other blood changes. Normal blood contains cent percent Haemoglobin, 5 million R. B. C. per cmm., 7500 white cells per cmm and a colour index of one. Anaemias are classified as primary, where the cause is not known and secondary where there is a definite cause. Secondary anaemia may be acute as when following severe haemorrhage, or chronic when following mild bleeding or other diseases.

Acute Secondary Anaemia.

This is characterised by faintness, thirst, sweating, sub-normal temperature, frequency of pulse, rapid shallow and sighing respiration and chalky pallor. Acute haemorrhage occurs in trauma, peptic ulcer, hepatic portal cirrhosis or splenic anaemia. History of previous dyspepsia is obtained in case of peptic ulcer. Haemorrhage of portal cirrhosis, is rare before 40 except in infantile biliary hypertrophic cirrhosis as an end picture. Portal cirrhosis is also diagnosed by a history of Anorexia, morning vomiting, alternative diarrhoea and constipation, haemorrhoids and a furred tongue. The liver is enlarged, firm and insensitive, the lower border rounded and irregular. There may be ascites and facies hippocratica. In splenic anaemia the spleen is enlarged before the haemorrhage and may not be palpable for a few days after the haemorrhage. Haemorrhage may also be due to rupture of ectopic gestation or bursting of an aneurysm. Bleeding into the peritoneal cavity leads to abdominal rigidity and other signs of acute abdomen.

Chronic Secondary Anaemia

Chronic secondary anaemia is characterised by dyspnoea and palpitation on effort, weakness and undue fatigue, sweating, nausea, anorexia, vertigo, tinnitus, head-ache, lack of power of concentration irritability, puffiness of the ankles at night and generally run down condition. The cause of it such as due to Ankylostomes, Myxoedema, Septic conditions etc., are discernable. Muddy pallor is characteristic of chronic secondary anaemia, while chalky pallor is due to acute secondary anaemia.

Pernicious Anaemia.

Very often patients with a marked degree of anaemia go about their work without feeling weakness and it is characteristic of this disease. It usually starts in a well nourished patient past middle age, with a complaint of gradual weakness and pallor. The skin is sometimes of lemon tint, there is sore throat, sometimes gastrointestinal disturbance, dyspnoea, sometimes palpitation and sometimes ataxia, careful examination reveals pearl white sclera, a small smooth clean, red, tongue. There is also rapidity of pulse, systolic haemic murmurs best heard at the base, especially when the patient is

lying. Sometimes the spleen is slightly enlarged. Paraesthesiae is an early and important symptom and weakness of tendo achilles is seen before other signs.

Paleness is present in all kinds of Anaemias but a lemon tint of the skin more marked in the abdomen and absent in the sclera, and dark pigmentation of the mucous membrane of the mouth is characteristic of pernicious anaemia when there is also lowered blood pressure, weakness and vomiting. Blood examination is essential for diagnosis of Pernicious anaemia.

(FROM THE PRACTITIONER March 1935)
P. A. S. R.

Treatment of Suppurative Otitis Media.

(Adapted from the Antiseptic of December 1934.)

Discharge from the ear should be looked upon as fire near a store of combustibles, which might be ignited at any moment by a chance spark; the patient is never safe, no matter, at what age, on account of intracranial complications which may come on at any time.

The various means for combating this disease are:—

1. Dry method, The ear is carefully cleaned up with loose pencil of gauze or sterile cotton, as often as the discharge fills up the meatus. It is an advantage to use glycerine containing 2% carbolic after each mopping. The glycerine is to be used as hot as comfortable. It should be cleaned at each subsequent mopping and fresh drops put in.

2. Mag. Sulph. treatment. It is used on account of its hygroscopic properties. First the meatus is thoroughly cleaned with pencils of sterile cottonwool; then half fill the meatus with a powdered mag. sulphas (crystals, not exicated) and cover it with a large of piece of wool in the bowl of the concha; when discharge is free, four-hourly treatment is needed; but in a day or two, twice a day will suffice. It is very valuable in acute and sub-acute cases. In chronic cases iodine boric powder is used in the same way. (Iodine: one part, mixed with one hundred parts of acid boric,

rubbed together into a fine powder. It should be kept in well-stoppered bottles as it is volatile.) The Iodine boric powder is used only twice a week.

In chronic cases with a perforation in the Shurpnell's membrane situated high up, powders-insufflation is to be condemned as it may close the opening with the attendant dangers. When however the perforation is large and low down it can be used with advantage.

3. Drops are other means of treatment. These drops can be used in combination with irrigation or insufflation treatment.

These are specially useful under the following conditions *i.e.*, Alcoholic drops are useful if the discharge is watery and extremely rebellious to treatment, where the mucous membrane is fleshy or there is a tendency to the formation of Polypus. Antiseptics like acid boric, acid salicylic, hydrarg perchlor may be incorporated in spirit of varying strengths, according to the sensitiveness of the ear.

Aqueous medical drops are sometimes used, such as mercurochrome in 1% solution. This stains the membrane scarlet, and during the acute stage impedes observation of the progress of the disease. It is a powerful disinfectant. In the subacute stage mercurochrome acts like a charm. It should not be used more than a fortnight.

In cases of children with discharging ears, the adenoids and tonsils when present, should be removed. More than fifty percent of cases heal up without further interference.

The chief danger signals in these cases are, pain, headache, vertigo, swelling and bulging of the postero-superior wall of the bony meatus, oedema of soft tissues over the mastoid, bleeding from the ear, increase in discharge, and sudden stoppage with the onset of pain, presence of granulations and polypus, facial paralysis and temperature above 99 degrees F. All these call for some surgical interference like Shwartz's operation or modified operation.

P. A. S. R

Atropine.

Arrests or lessens secretions, as the secretion of milk, perspiration, gastric juice, and that in the bronchiles.

1. Hence useful in gastric ulcer where it can be combined with alkaline medication. Note that the action on the secretion of the stomach is to reduce the amount of HCl, but not the amount of pepsin or the total volume of the fluid. Also as a preanaesthetic medication to prevent the excessive bronchorrhoea that results from inhalation of Ether.

2. To prevent cardiac inhibition in anaesthesia by making use of its inhibitory action of the vagal nerve endings in cardiac muscle.

3. To dilate the pupil and to secure loss of accommodation. Note that it increases intraocular tension by distorting the spaces of Fauntana and hence caution is necessary in its use and its indiscriminate use avoided.

4. To relax the involuntary muscles of organs. It is useful to relieve pain in renal and biliary colic and in asthma to promote good ventilation of the lung.

5. To relieve spasm of stomach and intestinal musculature. Hence its usefulness with cathartics and also in cases of STRANGULATED HERNIA etc.

6. To lessen pain, externally applied in the shape of ointment belladonna or emplastrum - belladonna.

7. To stimulate the brain in cases of depression.

R. K.

Chlorotone in Treatment of Vomiting.

O. Gartner considers that Chlorotone has a sedative effect on the vomiting centre just as Codine has the same effect on the cough centre, and employs chlorotone for the relief of vomiting without any reference to the particular cause. It may be given rectally if oral administration is impossible. It is better to add some caffeine to combat the narcotic action of the drug, and such a combination is useful even in children.

Dose :-

5-20 grs in a cachet. or 5 grs in a Suppository.

(PRACTITIONER, October 1934)

R. K.

Belladonna - in Migraine.

Migraine is supposed to be due to spasmodic constriction of the blood-vessels of the occipital lobe. Bellodana in doses of .25 to .5 cgm with a maximum of 2 cgm per day with a little luminal taken in pill form acts like a specific. It is enough to continue this treatment for a month. If cure is not affected by then another course for five weeks after an interval of 2 or 3 weeks and a third course for the same period but with a longer interval, almost relieves the trouble.

CLINICAL JOURNAL, March, 1935.
P. A. S. R.

The Pain of Herpes Zoster Treated with Pituitrin.

Dramatic results with the injection of pituitrin for the treatment of herpes zoster have been reported in the American and Continental medical press during the last few years.

It has been found that the injection of pituitrin is an uncertain and by no means an infallible treatment. It appears to act most dramatically when the pain is most intense, no explanation can at present be offered as to why it should be so, but the treatment is a valuable asset to the practitioner in his attempt to relieve a patient from the pain accompanying herpes zoster.

P. A. S. R.

Toxicity of Atebrin.

A few cases amongst thousands, show Toxicity on administering Atebrin and has manifested itself after a minimum of 6 Tablets (3 grams daily) and a maximum of 21 Tablets. The minimum period after administration has been $1\frac{1}{2}$ days and maximum 12 days. The duration has been from $\frac{1}{2}$ to 7 days. Of these a few had mental histories. The toxicity may be due to the action of the drug on the central nervous system or the liberation of toxins when the Malarial parasites are destroyed by the drug.

The symptoms usually are, head-ache, epigastric pain of a colicky nature, yellow colouring of the skin and sclerae unrelated to jaundice and cerebral excitation, mental depression and delusional insanity.

The symptoms pass off when the drug is withheld.

P. A. S. R.

The Trichinopoly District Medical Association.

(REGISTERED.)

A monthly meeting of the above association was held at 5 P.M., on Saturday the 23rd March 1935 at the Eye Hospital Cantonment, Trichinopoly when about 30 members were present. The staff of the Eye Hospital were "At Home". Dr. T. V. Swaminatha Shastri, L. M. & S. presided, and the following resolution was moved from the chair and passed all standing;—

1. "This Association regrets the sudden and untimely demise of Dr. T. S. Ramachandran, M. B. B. S., a prominent member of the profession and an Ex-Member of the Association."

2. The other resolution which was moved from the chair and carried unanimously is;—

"This Association conveys its greetings for the success of the Chettinad Medical Association annual to be held on the 30th of March 1935."

Then Dr. O. V. Muthukrishnan delivered an interesting lecture on "A Few Dont's in General Eye-Treatment".

He said that Silver Nitrate (2% solution) an excellent and efficacious drug, should not be misused by dropping into the eye but should be brushed on the conjunctiva of the everted lids as the former method, will irritate the cornea and cause ulcers. It should not be applied more than once a day nor for more than three days successively. The solution must be fresh and never older than a month. It is best applied in the mornings. Trachoma must be treated properly with caustics such as copper sulphate and goggles should not be worn. Foreign bodies in the eye can be removed easily if a little care is exercised. Gonorrhoeal ophthalmia and corneal ulcers are best sent to a specialist for treatment. A little hygienic attention to the eye in case of small-pox may save many an eye. Eye testing and detailed examination of the eye are better referred to the specialist.

After the lecture there was an interesting discussion in which many members took part and the meeting then terminated at a late hour with a vote of thanks proposed by the Secretary to the Lecturer, the Hosts and the Chairman of the evening.

TRICHINOPOLY, }
30th March, 1935, }

P. A. S. Raghavan,
Secretary.

The Trichinopoly District Medical Association.

(REGISTERED.)

IN MEMORIAM

It is our painful duty to record the sudden and untimely demise of one of our former members, a promising and a prominent member of our profession, Dr. T. S. Ramachandran, M.B.B.S. He was an unostentatious worker and suffered imprisonment for a year for political causes in the year 1930 and did, not a little, for the amelioration of the depressed classes by visiting cherries and digging wells for them. His was a life of service and sacrifice.

TRICHINOPOLY, }
8th April, 1935. }

P. A. S. Raghavan,

Secretary.

The Trichinopoly District Medical Association.

(REGISTERED.)

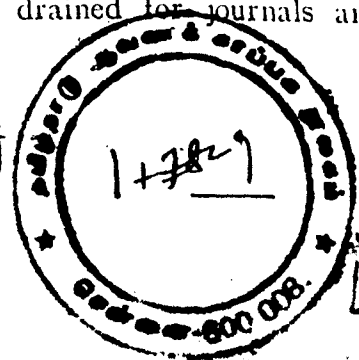
As the opinion of most of the members of the association was in favour of continuing the publication of 'The Miscellany' which was started as a trial, it has been decided to continue the publication for the year. The Chettinad Medical Association have requested that 100 copies be supplied to them for the use of their members. It is expected that other neighbouring districts may also require issues of 'The Miscellany' for their use. This can be easily complied with, if 'The Miscellany' will pay for itself by securing advertisements. Readers of "Miscellany" can help to secure advertisements by enquiring Medical Agents who visit them if their preparations are advertised in the Miscellany.

Journal members who are about 30 in number have agreed to pay a journal subscription of annas eight a month so that the Association funds may not be drained for journals and also to subscribe for more journals.

TRICHINOPOLY, }
31-3-1935. }

P. A. S. Raghavan

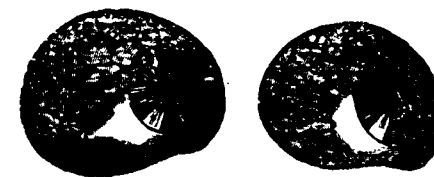
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