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MEDICO - SURGICAL
SUGGESTIONS

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MEDICO-SURGICAL SUGGESTIONS

A MONTHLY JOURNAL OF PRACTICAL MEDICINE & SURGERY

VOL. V

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No. 1

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MEDICO-SURGICAL SUGGESTIONS

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Leading Articles

AFFECTIONS OF THE LUNGS AND PLEURA

BY DR. SANKARA RAMAN, M.B., B.S.

Cuddalore.

This is a subject with which we are familiar in our everyday practice. I do not propose to go into minute details of this vast subject, but will confine myself to the pathology and the important lines of treatment of the affections of the lungs and pleura.

PASSIVE HYPERAEMIA OF THE LUNG.

This results from—

- (1) conditions impairing the venous return from the lungs as (a) left-sided heart lesions; (b) obstruction of the pulmonary veins either internally by a thrombus or externally by an aneurysm or a tumour;
- (2) by increasing the resistance to the passage of blood through the pulmonary capillaries as in emphysema, chronic bronchitis, fibrosis of the lung and pulmonary tuberculosis;
- (3) by a failing right ventricle;
- (4) other factors as bed-ridden, old and enfeebled persons, toxæmias, due to diseases as enteric fever, and poisons as morphine, or as a terminal event in cerebral lesions causing increased intra-cranial pressure.

Morbid anatomy: The pulmonary veins and capillaries are engorged, the lung is darker and heavier, but floats in water. The alveolar walls are swollen. In long-standing cases, pigment derived from the haemoglobin of R.B.C.s escaping by diapedesis is deposited in the epithelium of the alveoli and in the fibroblast in the interalveolar septa, causing the condition of brown induration.

Treatment: Treat the cause. Change of decubitus in elderly patients, venesection in right side heart engorgement cases, about 10 ozs. of blood being drawn off from the antecubital vein, leeches and dry cuppings, purgatives and diuretics, are some of the lines of treatment.

ACUTE PULMONARY OEDEMA.

This condition is so acute that the patient dies within a few minutes or a few hours. It is generally met with in elderly people suffering from arterial disease and hypertension, or diabetes. The exciting cause may be on epileptic fit or the administration of an anaesthetic or even a heavy meal.

Morbid anatomy: The alveoli are flooded with thin serous exudate. The lungs are heavier than normal and on squeezing exude large quantities of greyish yellow fluid.

Symptoms: Cyanosis is present, frothy fluid stream from mouth and nose, chest movements are hurried, the accessory respiratory muscles are in action, vocal fremitus is diminished, percussion is dull; breath sounds first harsh become faint and finally obscured by rales. The heart beats after respirations have ceased.

Treatment: Morphia and Atropine injection immediately given prevents a fatal termination of the attack; otherwise, prognosis is very grave.

PULMONARY INFARCTION OR PULMONARY APOPLEXY.

This results when a branch of the pulmonary artery becomes occluded by embolism or thrombosis. Emboli may be from (1) thrombophlebitis of the extremities, (2) veins of the uterus after child-birth, (3) wasting diseases as Enteric, Tubercle, Cancer, Septicaemia or Pyaemia; (4) vegetations from heart valves; (5) fat or even air embolism.

Although the pulmonary arteries are not strictly end-arteries, since there is an anastomosis between them and the bronchial arterioles, yet obstruction produces infarcts similar to those in other organs. In severe cases, there is cyanosis, distension of the veins of the neck, cold clammy sweats, deep laboured breathing, feeble pulse and sudden death. In less severe cases, the cyanosis and distress are less urgent, vocal fremitus is increased, percussion is dull, and breath sounds absent.

Treatment: "Prevention is better than cure" should be the watch-word in this condition. Venesection and injections of strychnine are our only aids in the latter type of cases, namely, the less severe ones.

ATELECTASIS OR COLLAPSE OF THE LUNG.

I do not propose here to deal with congenital atelectasis, but only with the condition as met with in adults. Collapse of the lung may be massive (lobar) or lobular, may be active or passive.

Active Lobar Collapse. This occurs (1) when the diaphragm is paralysed, as in diphtheretic paralysis, (2) as a sequel of abdominal operations, (3) as a result of wounds and injuries of the chest wall and lungs.

Morbid anatomy: The lung is deflated and retracted towards the spine. The collapsed area is bluish red, firm, does not crepitate and

sinks in water. The heart and mediastinum are displaced towards the affected side and the sound lung is bulky and distended. It must be distinguished from lobar pneumonia, pneumo-thorax and pleural effusion. The position of the cardiac impulse is often the deciding factor; in collapse, it is displaced towards the lung involved, in pleural effusion it is pushed away from the affected side, whereas in lobar pneumonia there is no cardiac displacement.

Massive Lobar Collapse results from pleural effusion, pneumo-thorax empyaema, or obstruction to a main bronchus.

Massive Lobular Collapse results from any condition impeding the air entry to the smaller bronchi or bronchioles, as in bronchitis, broncho-pneumonia, pulmonary tuberculosis, whooping cough, diphtheria, or by obstruction of a main bronchial division externally as by new growths, aneurism, foreign body, ascites. Abdominal distension from tympanitis causes basal collapse, while obstruction by adenoids and tonsils causes partial collapse of upper lobes.

EMPHYSEMA OF THE LUNG.

A conjoint diagnosis of chronic bronchitis and emphysema is very frequently made in middle-aged and elderly patients suffering from chronic or recurrent cough, but this diagnosis must only be made after full investigation since emphysema tends to conceal other pulmonary lesions and bronchial signs are a feature of tuberculosis, fibrosis of the lung, bronchiectasis, asthma, nasal sinus infections, cardiac failure.

Morbid anatomy: The barrel shaped chest when opened shows the lungs bulging so that the pericardium is almost completely obscured. The lungs are pale, soft, pit on pressure giving the sensation of down pillow. The surface of the lung under the pleura shows a finely vesicular appearance and shows bullae formation. The bronchi are dilated and, in progressive cases, right sided heart failure signs are present.

Treatment: When emphysema develops to a severe degree all that can be done is only to arrest further progress and not cure the condition; hence, prophylaxis is an important factor in the treatment. Examination of the heart and urine, investigation of the nasal sinuses and pharynx, enquiry into the occupation and habits of the patient may reveal abnormalities conducing to cough. Work in dusty, damp or draughty conditions must be avoided. Smoking is forbidden, alcohol and overfeeding regulated. Vaccines, particularly, autogenous, are useful preventives, especially in those who are subject to recurrent bronchial attacks in the winter months. The vaccine must be repeated once a month during the winter months. Adrephine or ephregel is useful in cases where the recurrent infections commence in the nose or pharynx. Patients with chronic bronchitic tendency should avoid close, overheated and stuffy rooms, should avoid living on clay soil and marshy districts and

high altitudes. The rarefaction of air and reduced oxygen tension in high altitudes produce dyspnoea. Avoid exposure and dusty trades. The general ordering of the patient's mode of life, though of great importance, cannot be obtained for lack of finance. Wintering on the coast of the Riviera is ideal but few can afford it; hence, the practitioner has to content himself with advising the patient to keep indoors in foggy damp and windy weather, and to avoid unfavourable conditions as far as possible. Clothing the patient with coloured flannels and extra shirts in the hope of preventing a chill only induces one, by the sweating caused by wearing them. Wool and cotton mixture shirtings are the best to wear.

Medical treatment consists in promoting expectoration, preventing useless cough and treating special symptoms. For expectoration:

Pot. Iodide	gr. vi	Syr. Tolu	dr. ss
Pot. Bicarb	gr. x	Aqua Chlor.	ad oz. i. t. d. s.
Am. Carb.	gr. iv		

Tr. Lobelia aeth. and Adrenalin may be added in asthmatic cases.

In anæmic patients,

Pot. Iodide	gr. vi.	Ferri et. Am.
Pot. Bicarb	gr. x.	Citras.
		gr. x.
		Aqua Camphor
		ad. oz. i. t. d. s.

If profuse expectoration is present, Ol. Terebin. m. 5, Syr. Tolu dr. I, mucilage q. s. aqua chlor. ad. oz. i, t. d. s. Creosote may be given in 3 minim doses, or as Famel Syrup or Lacto Creosote Syrup.

For dry cough, Peps or Valda Pastilles are useful. Eucalyptus or Friar's Balsam, steam inhalations are useful. For sleep and rest at night, Syrup Cocillana Co. in mild cases or Medinal at bed-time in severe cases may be given.

Treat cardiac failure, if present,

Various attempts have been made to increase the respiratory ventilation of the lungs by breathing exercises or compressed air chambers. The patient enters a special iron chamber fitted with a window and the air pressure is raised to $1\frac{2}{3}$ atm. in half an hour. He remains at this pressure for an hour and is then de-compressed slowly in half an hour to the normal. These sittings are given every alternate day. Breathing into rarefied air and mechanical compression of the thorax during expiration is also useful. Contra-indications to this method are: plethoric individuals, high blood pressure, hæmoptysis, and rigid chest walls.

(To be continued)

CONVOCATION ADDRESS

AT THE ANDHRA UNIVERSITY ON NOVEMBER 28, 1935.

BY RAO BAHADUR T. S. TIRUMURTHI,

B.A., M.B. & C.M., D.T.M. & H. (LOND.)

Professor of Pathology, Medical College, Visagapatam.

I am very thankful to His Excellency the Chancellor for the high academic honour he has bestowed on me in asking me to deliver the Convocation address of this University on the present occasion. On previous occasions, such honour fell fittingly on the broad shoulders of renowned scientists, famous philosophers, great engineers, devout divines, legal luminaries, learned judges and able administrators.

I am somewhat surprised that a medical man should have been chosen on the present occasion. I take it to be the desire of His Excellency to give an opportunity to a member of every learned profession, so that academicians, the general public and the students who take their degrees, may have some idea as to how the various problems connected with education and the welfare of the country are viewed from different angles by men of different professions. I consider that this gesture of his is of very happy augury, as it is an indication of how His Excellency will deal with the problems connected with this University, of which he is the Chancellor, and with the great and difficult problems of administration of this province, which he is called upon to solve taking into consideration different view points. I regard His Excellency's invitation to deliver this address as a compliment paid to the profession to which I have the privilege to belong. It is also a recognition of that important part of medical science—Pathology—which unravels the mysteries of disease processes and lays the foundation of the whole Science of Medicine, including Preventive Medicine.

There are only two professional colleges, affiliated to this University, one of which, the Medical College, is located at the headquarters of the University. The College is older than the University.

A resolution was tabled at the last Senate meeting that the University should take over the control and management of the Medical College and the King George Hospital. The idea of the University administering a Medical College and the Hospitals attached to it, though it is a natural growth in the progressive western countries, is not new even in India. There is the example of Lucknow University. But the University acted wisely by accepting the advice of our Surgeon-General, Sir Frank Connor, who, while sympathising with the aspirations of the University, cautioned us to defer the matter for the present and renew the application after the Government had spent the necessary funds to improve the College and the Hospital, in pursuance of the recommendations of the Inspectors of the Medical Council of India.

It is well known that the ruthless axe of retrenchment was levelled at the Vizagapatam Medical College a few years ago. But the catastrophe was prevented by the broad-based academic sympathy of the then Surgeon-General of Madras, Major-General C. A. Sprawson, who is now the Director-General of the Indian Medical Service, and the firm determination and vigilant care of our illustrious Pro-Chancellor, the Hon'ble the Rajah Saheb of Bobbili.

The stability of the Medical College was again threatened by the adverse report made by one of the Inspectors of the Medical Council of India, who recommended that the M. B., B. S. Degree of the Andhra University be not recognised for inclusion in Schedule I of the Indian Medical Council Act, as, in his opinion the defects pointed out by him were of such a nature as to make the institution "insufficient". In his opinion, neither the College nor the Hospital was sufficiently equipped or sufficiently staffed. He observed that he saw no reason to assume that the Government of Madras, who are responsible for the maintenance of this College, would sanction sufficient funds to carry out the recommendations, because the repeated attempts, which had been previously made by the successive Principals, the Surgeon-General and the Minister-in charge, had been without any success in the past. He felt certain that the Government would make no other answer than that previously given. Even if there be any change of heart, the proverbial delay of the Government in the carrying out of the recommendations would mean some years, and it was, therefore, unwise on the part of the Medical Council of India to recognise the M. B., B. S. Degree of this University.

Subsequent events have shown that prophecy is a risky game. At any rate, this prophecy has been falsified by the prompt action taken by our Chancellor, Lord Erskine, and his Government.

In consultation with the Principal, Major J. A. W. Ebdon, and Sir S. Radhakrishnan, the Vice-Chancellor of this University, Sir Frank Connor, the Surgeon-General of our province, drew up a programme of improvements for the College and the Hospital as regards staff, equipment and buildings. Through the kind assistance of His Excellency's Government, a sum of Rs. 16 lakhs (non-recurring) is likely to be sanctioned to give effect to the complete scheme for the expansion, equipment and the re-organisation of the College and the Hospital and an additional sum of Rs. 1½ lakhs per annum towards recurring expenditure. To all those who have been responsible for bringing about this happy consummation, the Andhras will ever remain deeply grateful. We hope and pray that no future financial earthquakes will shake the stability of this really most useful institution, which has a great future before it in the prevention and alleviation of human suffering, in the betterment of the health of the people of the Andhra Desa, and as a centre for higher medical education and medical research.

PUBLIC HEALTH—A STUDY IN CONTRAST.

It is very depressing but interesting to compare the progress made in Public Health during the last century of British administration in India and during the same period in England. It was only just one hundred years ago that the first steps were taken to organise public health measures in England. It is stated that the stimulus for this was an epidemic of cholera. Chadwick and Symon and the Victorian sanitarians, who planned the main lines for the progress of public health, will ever be remembered. Compare the State Medicine of England which has become the all powerful social service organisation of that country to-day with our present position.

More than 16,000 medical men are in insurance practice; over 60 per cent. of expectant mothers are attended to in ante-natal clinics; every year 40 per cent. of infants and children are looked after in child welfare centres; over 33 per cent of school children receive medical inspection; 140,000 suspected cases of tuberculosis and their contacts receive attention from tuberculosis specialists; 98,000 persons are treated at the venereal clinics. There are over 180,000 hospital beds, excluding those in mental hospitals and more than twice this number are provided by voluntary organisations. I leave you to compare these figures with those which can be gathered in a similar area of our country.

Again, to quote Dr. Jameson's figures for England and Wales, more than £26 millions are spent annually on medical services by local authorities and over £31 millions on environmental sanitation, including housing.

What is the reason for this difference between the Public Health progress in England and India? In the opinion of General Megaw, who was the Director of the Calcutta School of Tropical Medicine and later D. G., I. M. S., in England sanitation has achieved its victories not merely by the preventive measures taken against disease but also because the public co-operated, and an improvement in the economic standards of living was taking place at the same time as the work of disease prevention, but in India the progress has been poor and this is due to "the new wine of scientific sanitation having been poured into old bottles of antiquated customs."

But General Megaw's reason by implication condemns the Indian people as a non-co-operating lot. But it is, however, gratifying to see his statement flatly contradicted by no less an authority than Col. W. G. King, the best part of whose service has been spent in laying the sound foundations of Public Health in this Presidency, which brought him into intimate contact with the people, that "the average educated Indian is not only capable of grasping the benefit of but of receiving, with very much gratitude, health education by practical demonstration of sanitary works of the community."

It cannot be doubted that education is the most desirable ally of sanitation, though it might be contended, not without some reason, that the educational policy has not pursued profitable paths and has, of late, been ploughing barren sands. This is realised by the Government and the people and has awakened them to a consciousness that all is not well with education in this country and that it needs a re-orientation and reform in all its branches.

A SHORT HISTORY OF PUBLIC HEALTH POLICY IN INDIA.

Col. King had rightly remarked that Politics cannot disregard Political Economy, nor Political Economy, Sanitation—in its broadest sense—as applicable to man and beast and that, if sanitation be an integral part of politics, equally must laws be evolved for restraint of the selfish instincts of the individuals, which endanger the health of their neighbours, and their corollary, multiples of communities and nations.

From the early days of the East India Company its administrative officers were provided with sanitary advisers. In 1859 a Royal Commission was appointed to enquire into the heavy mortality among the officers and ranks of the British and Indian troops. The Commission issued the report in 1863. In 1864 Sanitary Commissions were appointed for Madras, Bengal and Bombay. The Sanitary Commissioners of Madras and Bengal recommended the organisation of the Public Health Service. This was pigeon-holed with the remark that the funds must be provided by the Provincial Governments. The plea that education should precede sanitation was advanced. The Government considered it inadvisable to force public health on a population, that was resisting the innovation. It wanted to create good-will by curing diseases and widening education to prepare, as it were, the ground on which the seeds of Public Health may be sown later.

In 1869 the appointment of the Sanitary Commissioner was transferred from the Military to the Civil Medical Department. A junior Army Medical Officer was considered enough and was subordinated to the Surgeon-General. Some time later plague broke out and the Plague Commission, which was constituted to enquire into this disease, recommended a status of equality to the Sanitary Commissioner with that of the Surgeon-General, the Head of Curative Medicine. Subsequently, within a few years the Sanitary Commissioner was again thrust to a subordinate rank to the Surgeon-General. Later, his name was changed from that of the Sanitary Commissioner to that of Director of Public Health.

In 1889 the Madras University undertook to institute the qualification of Licencié in Sanitary Science, which was later changed to Bachelor of Sanitary Science, a qualification equivalent to that of D. P. H. in Great Britain. Other Indian Universities followed the example of the Madras University. Civil Assistant Surgeons qualified

themselves for degrees in Sanitary Science. Sanitary Inspectors were trained. At an earlier date Col. King recommended the utilisation of qualified men for Public Health work in Municipalities and District Boards. In those days the District Medical Officer was also the Sanitary Officer of the District. I have had the honour of being the District Medical and Sanitary Officer of one of the then biggest districts in the Presidency which was sometime ago bifurcated into two districts.

I can testify from experience that the District Medical and Sanitary Officer could not have carried out satisfactorily either his medical or his sanitary duties from the modern public health point of view. He clamoured for separate assistance for the discharge of sanitary duties. Civil Assistant Surgeons were appointed as Sanitary Assistants. The Surgeon-General wanted that these men should be appointed by him and subject to his control and discipline. The District Board protested that he who paid the piper should have the right to call for the tune. The Sanitary Commissioner was a mere passive witness in this ugly squabble for power.

Later, the nucleus for a Public Health Service was laid; almost every Municipality and every District Board were compelled to have a medical officer with Public Health qualification to look after the Public Health of the local bodies concerned. These District Health Officers and Municipal Health Officers were placed under the Director of Public Health, who was also given a few assistants of the rank of Assistant Directors of Public Health. In this Presidency our thanks are due to Col. Russell for the inauguration of the present well-planned scheme of public health service. Even here Madras took the lead.

It should, however, be acknowledged that public health appointments under Municipal and Local Boards were at the beginning not attractive. Even with additional encouragement, these appointments are not eagerly sought; but they are taken up because better openings for service are not available for qualified men. The report of the Ministry of Local Self-Government for 1921 contains the following statements:—"The reluctance of professional men to accept service under Municipal Councils is a menace to the future of sanitation of this Presidency.....Even men qualified as sanitary inspectors avoid service under local bodies, if they can get other employment." Things have improved since, but the improvement is due to unemployment and the overcrowding of the professions.

IMPORTANCE OF PREVENTIVE MEDICINE.

We must reckon with the fact that 'Preventive Medicine' has come to occupy a higher place than that of 'Bottle Medicine'. In the Dictionary, Medicine is defined as "the art of curing, preventing and alleviating disease." This is due to a general realisation

that the physician should be equally interested in both Curative and Preventive Medicine. The efforts of such eminent persons as Dr. Jameson, Col. King, General Megaw, Col. Russell and others should be augmented by the other members of the services, the profession and from among the public, interested in Public Health work, by the insistence on the fact that the most essential factor in the development of Public Health in India is the question of cost. To the question of Sir William Osler why malaria should not be stamped out of India as it was done in Panama, Sir Leonard Rogers is reported to have pointed out the impossibility of such an improvement, because in most Municipalities in India the whole of the work—teaching, hospitals, schools, roads, sanitation—had to be paid for out of an income of 2 or 3 shillings per head of the population.

A healthy nation is largely a question of money. Health has to be purchased with money. Like all other good things it cannot be had for the mere asking. A nation must be healthy to become wealthy and it is only wealthy nations that have attained to high standards of health. Judicious expenditure of wealth can create health. The absence of health inevitably leads to absence of wealth of the nation as of the individual. Every one should remember that the "first wealth is health," and that "within human limits health is purchasable by communities".

I earnestly hope that the truth of Col. Russell's statement, that in no sphere of human activity can richer dividends be earned than by judicious investment in the preservation and promotion of the health of the people, will be fully understood.

Cruel catastrophies, harrowing horrors of famines and highly sponsored appeals for the treatment of the sick have proved successful in arousing public sympathy and in the collection of the necessary funds. But the voice of the appeal of Preventive Medicine seems to be a cry in the wilderness. Philanthropists have come forward to endow beds or build wards or dispensaries but I am yet to hear of a single endowment by any one in this country for an Institute of Preventive Medicine, the services of which are non-spectacular. Preventive Medicine, though despised to-day in India, will be enthroned in its proper place to-morrow. Our philanthropists will, I hope, bear in their mind the saying of Sydenham that the effect, even the slightest reduction in the incidence of sickness, suffering and death, must always be a matter of greater felicity than the riches of a Tantalus or a Croesus.

Lt. Col. H. E. Shortt, Director of the King Institute, Guindy, in his address to the Rotarians in Madras last August, is reported to have suggested that the funds provided for higher education, i.e., the amount expended on Universities, may be diverted to the promotion of the physical well-being of the people, by which he means endowments for Medical Research. I do not consider that this suggestion

will find favour. There is no doubt about the need for the re-orientation of University Education with the object of introducing useful reforms in it. But the mere diversion of a part of the amount now allotted to the Universities to the Public Health Department will only starve both the Universities and the Health Department. I, however, agree with him that the University Education, which is mostly of an academic nature, is being poured in many cases into bodies physically ill-equipped. The poor physique of our University students has been repeatedly pointed out in the reports of the Medical Inspections of University students in different parts of India.

I have been myself an eye witness to the haggard look, bent back, sunken eyes, emaciated frame and other signs of poor physique of the graduates, who come up in the variegated colours of their academic robes in an impressive procession to bow before the Chancellor and take their degrees. The Convocation function, which ought to leave a happy buoyant feeling, has often given me a sense of depression, not only due to the doubts as to the capacity of the graduates to keep their heads above water in the sea of unemployment, into which they are driven from the portals of this University, but also to the melancholy prognosis, that the large majority of them are physically unfit to weather the cruel storms of many diseases which abound in their neighbourhood.

NUTRITION.

During recent years a remarkable advance has been made in the Science of Nutrition which has resulted in a re-orientation of Public Health problems. Public Health work is not merely the control of diseases from spreading and the defending of people against attacks of disease but it aims also to create a maximum physical well-being. Nutrition plays a very important part in increasing the stamina and vitality of the nation.

This science of nutrition is slowly changing the dietetic habits of the people. In the industrial wealthy countries the old bulky predominantly starchy diets are giving place to lighter but balanced diets, richer in animal proteins. We find an increased consumption of milk, butter, cheese and other dairy products, sugar, eggs, fruits, and green vegetables.

Increasing attention is being paid to food production and distribution. People are realising that the world's food production can be increased many times without increasing the area of cultivation, if only they make use of the available scientific knowledge to the fullest extent. Have not engineering and biological sciences ridden certain parts of the world of malaria and other deadly diseases, which prevented men from going there and cultivating the soil and turn dreary deserts and sickly swamps into fertile fields and green pastures and vegetable and fruit gardens?

There are those who deplore a Nation's adopting a policy of economic nationalism and aiming at the ideal of economic self-sufficiency by the barriers of customs and high tariffs against the import of food-stuffs. But the fact remains that this spirit of economic nationalism is rapidly spreading.

Poor nutrition lowers vitality and leads to disease; and disease in turn to the poverty of the people. Higher wages need not necessarily lead to better nutrition. Popular education in the science of nutrition, however elementary it may be, is very necessary for the well-being of the people. The attention paid to nutrition, even in the curriculum of medical studies, is inadequate at present. It is very satisfactory to note that the small book on the "Elements of Nutrition" by Col. McCarrison is being more widely read, by being translated into the vernaculars of this presidency. There is also a Department of Nutrition in the All-India Institute of Hygiene and Public Health, Calcutta. Post-graduate students who take a course in Public Health will in future study the science of nutrition. The Nutrition Laboratory at Coonoor is serving a very useful purpose in undertaking research in nutrition and is under the management of the Indian Research Fund Association.

It is hardly necessary for me to say that the first help to the Nutrition Laboratory, Coonoor, came from this part of the country, from the Rajahsaheb of Parlakimedi who, by a princely endowment of a lakh of rupees, has given a great impetus to research in nutrition, thereby drawing the attention of other Zamindars, Rajahs and Maharajahs to the importance of this new science of nutrition and giving a lead to them to help this Public Health cause.

In Japan and Soviet Russia, Nutrition Institutes are connected with the State Departments of Public Health and with the Universities. The American Dietetic Association has a large body of nearly 3,000 members. It is recommended that a chair for Dietetics should be created in each of the medical schools and colleges. It would be to the advantage of both research work in nutrition and the teaching of the subject to medical students and others interested in the science, by the specialists attached to the nutrition laboratories, if the laboratories are shifted from Coonoor to Madras or to Vizagapatam. A Nutrition Institute has been recommended to be erected and endowed and if this fructifies, I hope it will not be located in a place that is not a University centre with medical colleges and hospitals. In such a centre there is the additional advantage of an intellectual contact between the nutrition specialists and other scientists, whose collaboration would be of immense value and whose work may be correlated with the rest of the Science of Public Health.

The value of teaching elementary principles of nutrition and simple rules in regard to diet is recognised in other countries. In Boston and other parts of America there are Nutrition Classes.

There are five Nutrition Clinics in London. The Department of Agriculture in U. S. A. disseminates information on nutrition and rational diet among the people. The importance of publicity and propaganda is well recognised.

Dr. Aykroyd, the Director of the Nutrition Laboratories, Coonoor, has drawn our attention to the urgent need in this country for a detailed enquiry into the dietetic habits of the people in the different provinces, and into the prevalence of food deficiency diseases. I hope the necessary financial aid for this investigation will be forthcoming and the enquiry commenced very soon.

The League of Nations Health Organization has in view the constitution of a Permanent Commission to study the problems of nutrition in the proposed International Institute of Nutrition. The general problem of nutrition to-day is the need for the harmonising of economic and public health development. I believe the different aspects of the problem can be better tackled by shifting the Nutrition Laboratories from Coonoor to Madras.

The report of the Director of the I. L. O. at the 19th Session of the International Labour Conference in June last, has drawn attention to the relationship between adequate consumption and a proper standard of healthy living. The fact that large masses of people are at present underfed or malfed is not open to dispute. The foundation of a reasonable existence should be that amount of wages which enable the worker to obtain a minimum of healthy diet for himself and his family and a healthy shelter for them. The report also states: "No one can doubt that there is immense scope—nay urge, urgent need—for the increasing consumption of most kinds of fruits for almost every country in the world." Increase in consumption would go to solve the agricultural problem and also to improve health, so as to reduce the budget expenditure of Government on medical aid. The increased efficiency of the population would increase the production of wealth and stabilise political conditions and solve to a great extent the difficult problems of unemployment.

Especially in our country poverty is the most important factor which has to be considered in the solution of the food problems. We cannot raise the purchasing capacity of people without exploiting the internal market of the country more intensively and also the external market, if possible, thereby effecting a marked rise in the level of agricultural price. Countries which have no natural conditions for the production of all their food requirements cannot aim at the ideal of self-sufficiency in the matter of food-stuffs. But it is generally held and supported by authoritative opinion that India, which has an infinite variety of soil, climate and other natural resources, need hardly go beyond her boundaries to produce a sufficiency of food-stuffs, to give an adequate and well-balanced dietary to the whole nation.

HEALTH AND HYGIENE.

"Neither Æsculapius nor his daughter, Hygeia, is represented as in tears, with the habiliments of mourning; but instead Æsculapius is armed with serpents, the symbol of wisdom and convalescence; and Hygeia is bestowing warmth and succour—beautiful symbols of Health and Preventive Medicine". (Dr. D. W. Cathell, M.D.).

"With health everything is source of pleasure; without it, nothing else, whatever it may be, is enjoyable. It follows that the greatest of follies is to sacrifice health for any other kind of happiness, whatever it may be, for gain, advancement, learning, or fame, let alone, then for fleeting sensual pleasures." (Schopenhauer.)

Lost stamina and lost health make for poverty. Political power, economic progress, educational advancement, scientific research, industrial expansion—in fact, even good habits and noble aspirations, cannot be got by mere chance. Hygiene plays an essential part in the rearing and maintaining of a healthy Nation.

What is the use of holding Health Exhibitions which have degenerated into an annual *tamasha*, whose effect is of ephemeral nature? The 'Gospel of health' has to be preached in a sustained manner every day in the year and a Health Museum should be opened, at least one in every district, to which a permanent staff should be attached for publicity and propaganda. This 'Temple of Hygeia' should be so built as to attract the people of the district to go on a pilgrimage for worship to be blessed with the knowledge of how to secure and keep health for themselves.

There is such a thing as Physical Morality. It is not only a duty to one's own self but also to the neighbours, the community, and the Nation and also to other Nations and future generations.

'Dynamics of Health' is the Science of Health. Health is never static. It is a constantly changing dynamic force. Good health gives vitality, vigour and vim. A realisation that health is a dynamic progressive force and that vitality is the inherent, latent doctor in us, which resists disease or makes us get well quick, should engender in us the desire to foster health and to study Hygiene, which teaches us how to get and keep health.

Man's transgressions of the Laws of Health are not forgiven. Diseases have been compared to thieves and murderers, and the Preventive Medicine of the present day recognises that it is far more sensible to employ Scotland Yard Detectives to track the Criminals of Disease than to employ an Army of Doctors for the cure of the same. "Prevention is better than cure" has become well-worn by repetition. But it is worth repeating, until such knowledge leads to action. There is only one inebriety, which, instead of being censured, can be commended and that is the intoxication with the 'Joys of Health'.

To the question which may reasonably be put to me, why I

should talk to you about 'Health' on the present occasion, which was not expected to be used for a health talk or for propagandist purposes of the Health League, my reply is that it is not realised how all this propaganda is wasted, so long as Hygiene does not form an essential part of the school curriculum in all its stages. Graded courses in Hygiene, which is after all the most important subject from the personal and community points of view of healthy living, should be prescribed in all the classes, right up at least to the Matriculation standard.

Mens sana in corpore sano. "A healthy mind in a healthy body" is a trite saying and a truism admitted by Psychologists and Psychiatrists. A healthy body is necessary if the mind should be healthy. Unless the mind is healthy, good habits and good character cannot be formed. Persons without good character and conduct in life are a drag on and a danger to Society. If we realise that the essential virtues can be fostered only by a healthy mind working in a healthy body, we will not lose any time to make Hygiene (including Mental Hygiene) a compulsory subject of the school and college curriculum. What availeth man, if he in the process of gaining wealth loses health of body, mind and soul?

I hope that Your Excellency's observation, during the recent Prize Distribution Function of the Government College at Mangalore, would have obtained sufficient publicity already. But it is worth repeating. "Education does not merely mean stuffing one's brain with facts; it means that, in order to be able to use those facts, one must keep healthy, so that he may be able to make use in future life all the knowledge and learning that he may get, when he was at school or college." In wish that the above observation of Your Excellency is put up in bold blazoned letters as the motto in every educational institution.

SANE OUTLOOK ON LIFE—MENTAL HYGIENE.

In comparison with other progressive countries, the position of India, from the public health point of view, is anything but satisfactory. Though the economic condition of the people has much to do with their state of health, the problem of tackling the deplorable state of health conditions cannot be solved by looking at it purely from the economic standpoint. It should be remembered that even in the western countries, where the economic position of common man is infinitely better than that which obtains in India, there is still plenty of misery of diverse kinds. But it should not, however, be lost sight of that a certain level of comfort is absolutely essential for healthful living.

It is not the multiplication of wordly goods, but human happiness depends to a considerable extent on a sane outlook of life which can be brought about by what Everett Dean Martin calls "a liberal education".

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The creation and growth of a sane outlook on life is attempted in other countries which have scientifically planned their educational progress through the medium of Mental Hygiene Clinics and by the inclusion of Mental Hygiene as an important subject of study for a liberal education.

The preaching of the 'Gospel of Mental Health' is more necessary than the propaganda for compulsory physical education. It is no doubt true that body and mind react on each other but there is no use of a giant frame if it is to harbour a weak mind; far better a frail frame, which enshrines a strong and well-developed healthy mind. Emotional self-control, the cultivation of normal relations with one's neighbours and a knowledge of the real wholesome 'Philosophy of Life' are a few of the many benefits, which can be derived by a comprehensive course in Mental Hygiene.

Prof. William Mc Dougall has described that the heart of the human personality, its "cylinders", are the primary emotions as fear, anger, etc. If these are removed, we should be, mentally, like springless clocks or fireless steam engines. Mental Hygiene will help the individual to self-discipline and create in him the desire to subordinate the self and merge it in the larger interests of the "bigger self" i.e., the Community. In that sense is it not true that a man has to lose himself in order that he may find himself?

THE IMPORTANCE OF BIOLOGY AS A COMPULSORY STUDY.

The importance of the study of Biology is well recognised in Europe and in America where the subject forms a compulsory course for school-going students. In our country only the students who choose Medicine or Agriculture as their vocation appreciate that a sound biological knowledge stands them in good stead. I hope the defect that the Natural Sciences have not been introduced so far in the Andhra University College of Science would be noted and remedied at an early date. The teaching of Biology should be of a more practical nature including sufficient laboratory work and ample observations in the field. It is regretted that in the examination for the Intermediate there is no practical test even in the Physical Sciences. No examination in a science subject can be considered to be complete, unless the knowledge of the candidate is tested by an oral and a practical examination. It is probably to this kind of examination in theoretical knowledge that we owe the reputation of theoretical intellectuals which other nationals have given us.

Biology teaches what life is and how life's environment is constantly changing and how the organism reacts to such changes. It teaches the physical basis of living things and that division of labour is associated with specialisation of structure in the increasing complexity of animal and plant life in the course of its evolution. The student of the subject obtains also clear ideas regarding animal instincts, reflex actions, memory, intelligence, methods of growth

and reproduction. On the basis of the above knowledge he obtains some idea of variation and heredity and a desire to study 'Eugenics', which considers the well-being of the race.

The study of plants and animals in relation to human affairs and human progress, a knowledge of disease germs and defensive powers of the body against them and an appreciation of the remedial measures adopted in Public Health measures cannot fail to be of incalculable benefit to the student and to the country indirectly. Biological knowledge has evidently played a great part in raising the standard of living by increasing the ability to earn higher wages and creating ideal citizens, who are a source of strength to themselves and to the State.

Biology tells us that human race can be improved by good environment and by good education and that the belief "that truck horses will breed only truck horses, the trotting horses only trotting horses" should be given up.

Though even the desirability of making Biology a compulsory subject of school education in India is being tardily admitted, there are not a few persons who even now doubt its value in the school curricula.

ADVICE TO STUDENTS.

It appears to be the practice to give some words of advice to the graduates of the year, when they assemble at the Convocation function to take their degrees. I do not propose to do anything of the kind. Youth is in revolt and resents advice. Such advice is construed to be gratuitous and may even be felt insulting. Advice not paid for is not valued. Respecting youth sentiment, I shall not bore you with what will be considered to be platitudes.

But, I shall be failing in my duty, if I fail to congratulate the graduates of the year on their success, as, otherwise, it may be considered to be ungentlemanly or bad manners on my part. I was hesitating at first whom I should congratulate—the successful graduates or the unsuccessful candidates. There is a pleasure in the enjoyment of the fruits of the chase. In the pursuit of knowledge those who had worked hard have secured success and possibly distinctions. I wish I do not mar their feelings of rejoicing in the slightest manner. In this world pleasures are so few and come so rare, but pain abounds and comes frequent.

But there is also pleasure in the mere chase, though it may have ended unfertile. If the unsuccessful students had been sincere in their attempts to obtain as much knowledge as they can absorb in the prescribed course of their studies, they need not consider that they had wasted their time. Let the failed candidate not get disheartened at his failure. Failures and obstacles exist only to be overcome. The failure should be an incentive to subsequent better planning and renewed and vigorous attack.

The best part of a man's life is the stage of his life as a student, as it is mostly pleasant and care-free in the corporate life of the residential students of a University. If you utilise fully the opportunities which are afforded to you to enlarge your mind, broaden your sympathies and increase your stock of ideas, you would not regret for having prolonged your stay in the University. You may congratulate yourself on the other hand on having postponed the evil day, when you have to solve your bread-winning problem.

Whereas, I have to sympathise with the winners, because the spectre of unemployment would have already begun to stare at them. They have to face and solve the problem courageously, honestly and in the best manner possible. They should not prostitute for base purposes or obtain employment by any pretext or false pretence to positions, to which they have not fitted themselves by the required training or take to a vocation, for which they have no aptitude.

SCOPE FOR HONORARY SERVICE.

But whether you get paid employment or not, the field for honorary service is extensive and rich in possibilities of achieving not only success in life, but also, a name and a fame. Ignorance and illiteracy, poverty and sickness, disunion and discord, discontent and disaffection, famine and floods and many more allied miseries clamantly call the youths of the country to render honorary service—youths who are bold and enthusiastic, intelligent and interested, skilled and trained, active and alert, disciplined and disinterested. These miseries and misfortunes challenge you to fight them. Will you take up the challenge?

THE CALL OF THE VILLAGE.

The villages are in mourning. The crying need of the villages is that you should go back to them. Their deserted and orphaned appearance and gradual decay are due to the depletion of the best energies and brains from their midst.

The professions are over-crowded in the urban areas. Independent practice in the learned professions has nearly reached the saturation point. The future of the graduates in the city looks gloomy. There is still some hope for them in the villages.

Medical graduates are settling down in rural areas. Lawyers too can settle down in villages. They will be able to considerably lessen the expenses of the villagers by helping them in conveyancing, drawing up plaints, complaints and legal documents, for which the villagers have to travel long distances now to cities, where living and legal advice are costly.

There are many villages without schools. A small band of educated young men may combine to start a school and their work will not go unrewarded. We have known many instances in which foreign Missionaries started primary schools, worked them

single-handed for many years and built up gradually big institutions with an efficient staff of enthusiastic teachers.

There is also scope for agricultural graduates and engineers in the rural reconstruction scheme. The vital needs of the villages are elementary education, good drinking water, good roads and medical aid. Development of rural industries requires the services of skilled technicians. It is to the proper working of the Rural Reconstruction Scheme that we should look to a partial solution of unemployment.

As for social service, in the working of the Village Panchayats, Co-operative Societies, Scout Movement, Red Cross Work, Harijan Uplift, Rural Reconstruction, etc., there is enough scope for the exercise of your intelligence and energy.

The foundations on which you can firmly build the New House of the Nation should be made up of Village Panchayats, Co-operative Movement, Rural Reconstruction, Harijan Uplift, Economic Nationalism and a Common Language. It is for each one of you to choose in which of the above works you can profitably help the construction of this great edifice and act accordingly in a deliberate and determined manner.

DIGNITY AND SIGNIFICANCE OF LIFE.

The stress of life and the reign of defeatist creeds are making for a mood of rebellion in the more active and of passive indifference in the quieter sections of the race. The old values are crumbling: the new ones are yet to be born. "We have neither immediate nor remote aims and in our soul there is a great empty space." These words of Anton Tchekov are not entirely inapplicable to the state of mind of several young men all the world over. Into empty spaces anything might enter and spurious philosophy enters quicker. I want you, young friends, to resist the inflow of such ideas as would undermine the essential loyalties of life. Never listen to doctrines that would lessen in your eyes the dignity and significance of life. "Nothing lasts, so nothing matters" is a dangerous and pernicious idea, which would lead us back to the jungle. There are many things in life that matter; and they matter tremendously. May you all have the imagination and the understanding to think of life as "an elevated and lofty destiny", and whatever be the material success that you might be able to achieve, let it be said of all of you that you never let down the great traditions of civilization and learning.

Extracts

THE DIAGNOSIS OF HEART DISEASE IN CHILDREN

(REGINALD MILLER: *Practitioner*. 1935. cxxxiv. 462.)

It is generally easier to be sure of the presence or absence of heart disease in children than in older people, mainly due to the fact that in the young we are not concerned with the possibility of chronic and insidious myocardial degeneration. In children the presence of the acute and transient form of toxic or infective heart disease, such as may occur in rheumatic, diphtheretic, and influenzal infections, may readily be suspected. The obvious illness of the child, the languor and exhaustion, with the rapid feeble pulse, quickly call attention to the possibility of cardiac involvement. In the chronic forms, consisting for practical purposes of congenital malformations and acquired rheumatic carditis, the physical signs of disease are more distinctive in the young than in the old: the size of the heart is more easily appreciated and the murmurs are more distinctly heard.

A sound routine examination of a child's heart should discover any abnormality with facility, but it is essential that such an examination should be conducted with the child in at least two positions, erect and lying on its back. A careful note should be made of the area of the maximum intensity of any thrill or murmur, the direction of the conduction of the murmur, and its variation with alterations in the position of the child, the respiratory movements and the pressure of the stethoscope. More difficulty arises in estimating the significance of abnormal heart signs in a child than in detecting them, especially in connection with the systolic murmur which is regarded as of exocardial origin. Such a murmur is common in children and young people, and, when the left ventricle is neither dilated nor hypertrophied, is usually louder along the edge of the lung at a higher level than the actual apex of the heart and not conducted to the axilla; the exocardial murmur differs from that of mitral regurgitation by fading or disappearing with increased pressure of the stethoscope, and its variations with position and respiratory movements are excessive.

In children showing as their chief abnormality a persistent tachycardia, the pulse rate ranging between 90 and 120 per minute, the question arises whether this rate is occurring in the nervous and perhaps atonic heart of the excitable child, or in one which is poisoned or infected from tonsillar or rheumatic infection. If the readings of the pulse rate during sleep (uninfluenced by extraneous nervous factors) are within normal range, and the general health of the child is satisfactory, it is unlikely that the heart is the seat of

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active trouble, and the child's nervous system demands more attention. But when the child is obviously out of sorts, thin, languid, tired and anaemic, extra rest should be ordered and the case watched until the diagnosis is clear. It is true that persistent tachycardia may be associated with rheumatic infection, yet the majority of the children showing this tachycardia as the sole abnormality are nervous rather than cardiac problems.

Congenital and acquired heart disease: If symptoms are present in congenital cases they consist of degrees of shortness of breath and cyanosis quite unlike those seen in rheumatic heart disease except in a very ill child. Clubbing of the fingers, if of cardiac origin, is much in favour of a congenital as opposed to an acquired condition of the heart, especially if malignant endocarditis, a rarity in children under 12 years of age, can be excluded. Too much stress should not be laid on the history of the case in attempting to distinguish between congenital and acquired heart disease.

In pulmonary stenosis and patent foramen ovale, the cyanosis is quite out of proportion to the other cardiac symptoms. In cases of patent interventricular septum and patent ductus arteriosus there are no symptoms but the thrills and murmurs are, as a rule, easily distinguished from those found in acquired heart disease.

The possibility of confusing a "functional" pulmonary systolic murmur for that of congenital pulmonary stenosis has to be considered, but the latter has its maximum intensity in the pulmonary area and conducted down to the apical area and not into the axilla. It is not always easy to distinguish between the murmur of congenital patent interventricular septum (*maladie de Roger*) and that of rheumatic mitral regurgitation. In the former the bruit has its area of maximum intensity centrally placed in the third or fourth spaces next the left border of the sternum, and is conducted towards the periphery of the heart, getting fainter as it reaches the apex or borders of the heart; in about a third of the cases the bruit is accompanied by a thrill with the same area of maximum intensity; there are no symptoms of cardiac insufficiency when this is the sole congenital lesion present.

Rheumatic heart disease:—Acute or chronic carditis: In children with severe rheumatic heart disease already established, it is well, in the presence of any unknown febrile illness, to consider carefully the possibility of fresh carditis. In later attacks of rheumatism, particularly in the "cardiac cripple," fresh and even fatal pericarditis may develop with no evidence of friction at its onset, or throughout its course.

Active and quiescent carditis: A child suffers from some acute rheumatic attack with obvious active involvement of the heart; when can it be said that the activity of the infection in the heart has died down? Only if the child looks and feels well, has gained colour

and weight, and shows a normal evening temperature and sleeping pulse-rate. The sedimentation rate is of value. But it is well to face the fact that persistent infection of the tonsils will produce much the same picture of subnormal health.

Valvular disease : In a child's heart the diagnostic signs are for the most part quite straight forward. The diastolic bruit of aortic regurgitation is almost always more audible in the third left space next the sternum than at the aortic area ; from this it is conducted down the left side of the sternum or down to the outer part of the apex. In cases of great enlargement of the heart, which often show precordial bulging, pericardial adhesions should be borne in mind. The signs of these are entirely those established by inspection : systolic retraction of the interspaces near the apex of the heart which persists when the child is rolled over on its right side ; fixation of the apex beat ; and cardiac pulsation visible posteriorly in the region of the tenth and eleventh left ribs, along the attachment of the diaphragm.

SIGNIFICANCE OF PYREXIA IN CHRONIC PULMONARY TUBERCULOSIS.

(M. MYERS : *British Medical Journal*. 1935. ii. 250).

In the absence of any other more reliable guides, the temperature was considered an index of the activity of the disease changes in body weight and other objective and subjective symptoms were secondary. But the advent of x-ray, and especially the serial x-ray, has fundamentally altered our ideas of the relation between the activity and the temperature of the patient. It has become apparent that not only can the disease be active and spread without any disturbance of the temperature curve, but also, conversely, that the patient can be febrile over comparatively long periods without showing any extension of the disease. Now-a-days the serial x-ray is undoubtedly the most accurate means of determining the progress or retrogression of the disease. But still, observations on temperature are of the utmost importance and give us valuable and definite information, especially when combined with x-ray.

Following Wingfield's classification, the lesion in the lung may be classified as follows :—

1. The "secondary lesion" which is a local allergic tissue reaction due to a deposit of bacilli, probably haematogenous. This reaction may rapidly disappear or progress to
2. The "intermediate lesion", which corresponds roughly to what is known as the active fibro-caseous disease, and
3. The tertiary lesion, which is the "intermediate lesion" healed as far as possible and non-progressive. Both the intermediate and tertiary lesions may become secondarily infected by bacteria from the respiratory tract.

The disturbance of the temperature chart due to the appearance

of a secondary lesion is typical, but varies in degree according to the size of the lesion. The small one, of a size no bigger than a two shilling piece, may produce no rise of temperature and no symptoms whatever. The medium-sized one, involving a larger area, results in a typical disturbance of the temperature which is very like that of a mild attack of influenza. There may or may not be a slight rise of temperature for a day or two before hand, and then the chart shows a temperature of 100 to 101 degrees F. for a day or two. This gradually settles to normal in a few days and may remain so for some weeks and even months. The large secondary lesion involving perhaps the whole of the lung has an onset similar to the above, but more marked. The temperature rises higher and for a few days the chart may resemble that of an attack of lobar pneumonia. But the temperature does not settle by crisis, and comes to normal gradually by lysis, generally within fourteen days from the onset. The absence of crisis and the presence of tubercle bacilli settle the diagnosis.

As a general rule, an intermediate lesion which is spreading, as disclosed by x-ray examination, and therefore active, gives no indication of this activity on the temperature chart, for, at any rate, the first few weeks. Very frequently there is no pyrexia during the whole of this period, and what is more, the patient appears to be subjectively and objectively in good health. It is only when this type of lesion erodes a patent bronchus and infects itself with the bacteria of the respiratory tract that fever and symptoms commonly associated with pulmonary tuberculosis appear. Then the temperature rises every day, being a little higher each morning and evening than the day before, with, eventually, a fairly constant daily swing. The temperature is of an intermittent type, generally below 98.4 degrees in the morning and round about 100 degrees at night in cases of moderate severity. The height of the temperature and the daily swing are some indication of the activity of the disease. Provided there is no interference the temperature of these lesions gradually settles down with lysis in favourable cases. If during this pyrexial period there be added a fresh secondary lesion then the temperature of the new lesion will be super-imposed and there will be a definite and characteristic alteration in the chart. There is a sudden increase in the height and swing of the temperature which gradually subsides until after a week or so the temperature is again back at the original level. Though the "tertiary lesion" is static and the patient may be in good health, yet, a number of them run a mild pyrexia which is probably due to (1) secondary infection by bacteria of the respiratory tract of the various small cavities that remain in the interstices of the masses of fibrous tissue and (2) to the alteration of the temperature control which has taken place as a result of prolonged pyrexia and toxæmia.

When the cavities are secondarily infected the patient feels a little out of sorts for a day with some increase of cough and sputum and his temperature may be slightly raised the same evening. The following day the temperature rises to between 101 and 103 degrees and then settles rapidly to normal within 5 days. These attacks generally recur with some regularity, an interval of 2 weeks to 3 months elapsing between A streptococcus, not necessarily haemolytic, can be cultured from the sputum collected at the height of the attack. An autogenous vaccine prepared from this is frequently efficacious in controlling the frequency and severity of these bouts of fever.

Late cavitation is also responsible for a rise of temperature. This occurs in a patient who has had fairly gross disease followed by massive fibrosis. One day after a long period of good health he contracts a head cold, and there is a rise of temperature. After a few days of mild pyrexia the chart shows a steep rise associated with a marked swing, and the patient proceeds to expectorate a large quantity of purulent material, perhaps containing some caseous lumps or calcified nodules. The temperature then falls rapidly, in some cases to normal; in others a constant mild pyrexia remains. The x-ray film shows that there has been no spread of the disease, but only cavitation of an old fibrosed lesion; this cavitation results from secondary infection of the old caseous material.

LIMITATIONS AND DANGERS OF FASTING CURES.

(W. EISENBERG: *Munch. med. Wochenschr.* 1935. lxxxii. 1441.)

Fasting is a valuable therapeutic method or at least a therapeutic adjuvant. Fasting is of great help in some acute infectious diseases, high blood-pressure, bronchial asthma, eczemas, gout, rheumatic disturbances, gastro-intestinal disturbances, and obesity.

However, the fasting cure has limitations and may involve danger. Its indiscriminate use by lay persons is inadvisable, and physicians should not use this method carelessly.

Fasting should never be instituted unless a definite diagnosis has been made. Patients with cancer should not fast because of the tendency to cachexia. In pulmonary tuberculosis fasting is inadvisable since it may lead to reactivation; however, in tuberculosis of other organs, fasting has been known to be helpful. In patients with diabetes, fasting counteracts the glycosuria, but this improvement is only temporary, for the sugar elimination usually returns when food is taken again. Occasionally a fasting cure is followed by an increase in the tolerance, and furunculosis, gangrene, and increased blood pressure, which frequently appear as sequelae of diabetes, are favourably influenced by fasting. Hysterical patients should never be subjected to a fasting cure, and most mental disturbances, particularly manic psychoses and paranoia, contra-indicate fasting cures.

In exophthalmic goitre, fasting may be tried only if the patient is obese. In severe myocardial disturbances fasting is inadvisable, but it may be tried in the milder forms and it must be interrupted at the first unfavourable signs. In uterine myomas fasting has been advised by some, but the author saw no favourable effects from fasting in this condition, neither did his observations corroborate the suggestion that a fasting cure is helpful in stimulating a poor appetite; in fact, he warns against subjecting emaciated neurasthenic patients who lack appetite, to fasting cures even if they are subject to constipation, which ordinarily is considered an indication for a fasting cure. Chronic gonorrhoeal arthritides react to this treatment quite favourably.

The management of a fasting cure requires conscientious supervision. Especial attention must be given to the heart. Although patients with valvular lesions and with coronary sclerosis tolerate the fasting cure quite well, it is important to give proper attention to the cardiac function of patients with rheumatism, tonsillitis, inflammation of the renal pelvis, or syphilis. If myocardial disturbances appear in such patients, the proper medication and bed rest should be instituted at once, and if the pulse rate remains 120 or higher for several days, the fasting cure must be interrupted. The author is unable to make definite statements regarding the duration of a fasting cure, but he thinks that they should last longer than four weeks only in rare instances. The diet at the end of the fasting cure should be adapted to the individual case, for, although fruits may be advisable in the obese patients with a tendency to constipation, patients with gastro-intestinal or biliary disorders would require a blander diet.

GIANT-CELL TUMOUR OF BONE.

(H. PLATT: *Surgery, Gynecology & Obstetrics*. 1935. lx. 318).

Though giant-cell tumour of bone presents histological features which are identical with those of cysts of the osteitis fibrosa type, it still maintains its position as an independent clinical entity. Three types are recognised:

(1) The indolent, slowly growing tumour whose relatively feeble invasive and destructive qualities are evidenced roentgenographically by a thick bony wall and coarse trabeculation, and histologically by the presence of considerable areas of fibrous tissue;

(2) The active, rapidly growing tumour showing roentgenographically an attenuated bony shell perforated at one or more points and characterised microscopically by a profusion of giant cells embedded in a background of actively growing cells of both the round and spindle type;

(3) The rare malignant giant-cell tumour, for which the following histological and roentgenographic criteria have been laid down

by King (1932): *i.* a predominating spindle-cell stroma with mitoses and tumour giant cells, in addition to the typical benign giant-cell areas in other parts of the tumour; *ii.* loss of outline of the bony shell, irregular trabeculation, and the shadow of tumour material in the soft parts.

In the treatment of giant-cell tumour, the author believes that in certain selected cases curettage is the procedure of choice, though in regions where a local resection can be performed without undue mutilation this is to be preferred. In certain tumours of the lower end of the femur and upper end of the tibia (the classical sites), where there would be no difficulty in eliminating all traces of tumour tissue, the thickness of the barrier which separates the tumour from the cavity of the knee joint is the deciding factor, for there is a risk that in the course of curettage a fragile shell may be cracked or perforated on its articular aspect. The author reports a ten-year cure in a large haemorrhagic giant-cell tumour of the ilium after curettage and chemical cauterization followed by radium implantation.

In tumours in certain less accessible situations, curettage followed by repeated courses of x-ray therapy is an admirable substitute for the more mutilating alternative of excision. If local recurrence follows a primary curettage, the second operation should be either resection or amputation, according to the anatomical indications.

Excision is chiefly applicable to tumours of the upper extremity, where excellent function may be preserved after resection of the ends of any of the major long bones except the lower end of the radius.

Amputation becomes necessary in neglected tumours in the region of the knee which have progressed to the stage of advanced destruction with impending invasion of the knee joint, and in certain tumours which have recurred after curettage, or have defied irradiation. In tumours of the lower end of the femur or upper end of the tibia, which can be cured only by curettage and cauterisation at the expense of the integrity of the knee joint, the operation may be desirable at an early stage.

Except for the uncommon tumours of the flat bones, where curettage may be of doubtful efficacy and complete excision impracticable, the author does not favour irradiation as a substitute to surgery. He reports a case of giant-cell tumour of the lower end of the femur which increased in size in spite of irradiation and eventually required amputation, though it was undoubtedly curable by curettage when first seen.

THE INDUCTION OF ABORTION AND PREMATURE LABOUR—INDICATIONS.

(R. THERON: *South African Medical Journal*. 1935. ix. 220).

Among the indications to terminate pregnancy purely in the interests of the mother without regard to the foetus are intractable cases of hyperemesis gravidarum, vesicular mole, missed abortion—conditions which admit of very little discussion. Hyperemesis gravidarum should always be treated in an institution, and sometimes even the most alarming cases can be cured by suggestion alone. Indications which are more conditional are previous conceptional insanity, heart disease, pulmonary tuberculosis, and chronic nephritis. With heart disease, if there has once been decompensation, each succeeding pregnancy makes matters worse. In cases with renal disease, especially where the blood pressure is definitely raised, artificial abortion is the safest course; nature often safeguards these women by terminating the pregnancy in an abortion or miscarriage sooner, or later. In all these cases, a previous spontaneous abortion or miscarriage should be a serious warning. Besides these, there are a large number of less definite indications about which there will be sharp differences of opinion between practitioners.

There is the case of the unmarried girl who, in a moment of weakness, has overstepped the bounds of propriety and circumstances may make marriage undesirable. The question is, are we going to consider only the physical dangers to a woman in allowing pregnancy to continue, or are we going to think also of the mental and psychological side of the picture? With the present attitude of society towards these girls, some of them have their whole lives ruined and embittered by being forced to go through with it; and what about the illegitimate child? Unfortunately, as the law now stands, none of us dare take the risk of performing abortion in such cases. In married women with undesirable pregnancies the case is different, and even here, the nervous woman with rapidly succeeding pregnancies is an instance where the decision is difficult to make.

Induction of premature labour is the artificial termination of pregnancy *per vias naturales*, after the child has become viable. The indications for induction are, with one rare exception, *viz.*, habitual intra-uterine death of foetus, all with a view to the benefit of the mother and not in the interest of the child, but the interests of the child should be studied in post-poning induction as much as is compatible with the safety of the mother. Eclampsia is not an indication for induction but albuminuria is. If after adequate treatment the albumin content of urine remains above 0.1 per cent for more than a week and the diastolic pressure is not less than 100 mm., the author recommends induction of labour. Severe pyelitis and pernicious anaemia of pregnancy are other indications where the condition of the patient and her response to other forms of treatment should be carefully considered before embarking on induction.

The commonest indication for the induction of labour is a lesser degree of pelvic contraction. Munro Kerr has laid down that a true conjugate of less than $3\frac{1}{4}$ inches is an indication for elective Caesarean section at term; between $3\frac{1}{4}$ and $4\frac{1}{4}$ inches lies the field for the induction labour. One should not consider induction before the 36th week as the prematurity would be too great. The moment to induce is when the head just begins to over-ride the pubis, as examined by Munro Kerr's method. The previous obstetric history is of the greatest importance in guiding us in these cases the rigidity of the soft parts plays as large a part in preventing descent of the head as bony pelvic contraction, especially in elderly primiparae. In the vast majority of cases with slight disproportion the author would leave things to nature and confine induction, when employed, to the castor oil-quinine-pituition method, putting it off to as near term as possible; the rest will nearly all deliver themselves or need at most mid-forceps; a very few will need Caesarean section.

Medical News and Notes

TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION. The sixth annual gathering and conference of the above association was held on the 20th and 21st December 1935 at the National College, Trichinopoly. Dr. P. A. S. Raghavan, secretary, presented the annual report. C. E. R. Norman, F.R.F.P.S., D.P.H., Chief Medical Officer, South Indian Railway, and president of the Association delivered the welcome address, and said that medicine was a great leveller of men of all denominations, races, and academical qualifications, mingling without any prejudice and snobbery. Col. Bhola Nath, I.M.S., (Retd.) President of the Indian Medical Association declared the Conference open in a speech describing the problems confronting the medical profession in India. Dr. T. S. S. Rajan, L.R.C.P., M.R.C.S., M.L.A., also spoke a few words. Among the papers subsequently read at the Conference were those on "Some aspects of Radio-therapy" by Dr. P. Rama Rau, D.M.R. (Vienna), "Pseudo-cardiac pain" by Dr. P. S. Varadarajan, M.D., M.R.C.P. (Lond.), "the laboratory as an aid to the clinician, with special reference to diabetes" by Dr. S. Rajan, M.B., B.S., "bronchial asthma" by Dr. T. Muthuswamy Chettiar, L.M.P., "treatment of diabetes" by Dr. K. C. Paul, M.D., "eye symptoms in general practice" by Dr. T. S. Doraiswami, L.M.S., "ocular diseases leading to impairment of vision" by Dr. L. R. Fernandez, L.M.P., "accidents and complications in senile cataract operation, "private practice" by Dr. T. V. S. Sastri, L.M.S., and "touting in the profession" by Dr. N. C. Appayya, M.R.C.P., M.R.C.S., D.G.O. There was also a medical exhibition held under the auspices of the conference. The conference terminated with tea.

The seventh inaugural meeting of the same association was held on the 15th January at the Golden Rock Railway Hospital with Dr. C. E. R. Norman in the chair. Dr. Norman was "at home" to the members, and welcomed Lt. Col. C. Newcomb, I.M.S., Surgeon-General with the Government of Madras, who was present on the occasion. The Surgeon-General made a few remarks commending the activities of the association and appreciating the cordiality that prevailed among the members. Dr. P. A. S. Raghavan moved a resolution that the association be affiliated to the Indian Medical Association, which was passed. Dr. V. Iravatham demonstrated a case of septicaemia in a boy of 10. Dr. Norman demonstrated a case of empyema. Dr. P. A. S. Raghavan delivered a lecture on "ultra-violet ray treatment."

TRAVANCORE MEDICAL ASSOCIATION. A meeting of the above association was held at the General Hospital, Trivandrum on the 9th January. Dr. V. J. Lopez, I.M.D. read a paper on "toxæmias of pregnancy." Dr. Miss E. Samuel was "at home" to the members. The association decided to offer a prize of Rs. 1,000 to any one discovering a cure for malaria; the remedy must be other than what is already known to allopathic medicine and must stand bacteriological tests usually applied on the patients, and the ingredients of the specific must be other than what were known to allopathic medicine for malaria.

MALABAR DISTRICT MEDICAL ASSOCIATION. This association met on the 14th January at the Paran Hall, Calicut, under the chairmanship of Major A. I. Cox, I.M.S., District Medical Officer. Mrs. Margaret Sanger delivered a lecture on "birth control and contraception."

TINNEVELLY DISTRICT MEDICAL ASSOCIATION. The seventh anniversary of this association was held on the 18th January at the Centenary Hall, Palamcottah. Lt. Col. C. Newcomb, I.M.S., Surgeon-General with the Government of Madras, presided. After tea, group photo, and music, Lt. Col. T. S. Shastri, I.M.S., District Medical Officer and President of the association, welcomed the gathering. Dr. N. Isaac, Secretary, read the annual report, which showed a membership of 127. Lt. Col. Shastri read a report of a case of cancer and described the theories regarding cancer and its treatment, referring to the need for x-ray equipment for the Headquarters Hospital of the district. Dr. Narayana Menon of Kollengode delivered a lecture on "my experiences of heliotherapy in Switzerland" and the methods of treatment in Dr. Ollier's Sanatorium. Mrs. Edith How-Martyn delivered a lecture on "birth control," and said that medical men should be able to give the necessary advice in suitable cases to their patients. Dr. T. N. Govinda Aiyer, Vice-President, proposed the vote of thanks. The function terminated with dinner at night. A Public Health Exhibition was

also opened on the same day by Dr. Mrs. Poonen Lukhose of Trivandrum.

EAST GODAVARI DISTRICT MEDICAL ASSOCIATION. The annual meeting of the above association was held on the 18th January at the Cocanada Town Hall with Capt. J. S. McMillan, I.M.S., District Medical Officer, in the chair. After tea, Dr. V. C. Kamaraju, the joint secretary read the annual report of the preceding year, which showed a membership of 160, besides other activities. Some discussion ensued regarding the affiliation of the Association with the Indian Medical Association and final decision was deferred to a subsequent meeting. A resolution congratulating Dr. T. Kanakaraju on his election to the senate of the Andhra University was passed. Capt. McMillan was re-elected president, and Drs. P. Audinarayanaswami and V. C. Kamaraju were re-elected secretaries for the ensuing year. The function terminated after dinner at night.

MADRAS MEDICAL COLLEGE. The annual report of the Madras Medical College for the hundredth session (2nd July 1934 to 31st March 1935) shows an increase in the number of students to 890, as compared to 774 in the previous year. Of the 890, the newly admitted students were 226. There were 89 lady students and 74 military students. The percentage of passes in Part II of the Final M.B., B.S. examination of the University was 38.4, as against 25.8 in the previous year and 25 in the year 1932-33. During the year nine L.M.P.'s. passed out with the M.B., B.S. degree. The nett cost to the Government on account of the maintenance of the college was Rs. 3,43,697-5-4. Special coaching classes for the Primary F.R.C.S. (Eng.) examination were held for the first time during the year, and out of the 21 Madras candidates who appeared, 13 came out successful. This College recently celebrated its centenary on a scale be fitting the premier and pioneer medical institution in the Madras Presidency.

VIZAGAPATAM MEDICAL COLLEGE. The report of the Vizagapatam Medical College for the year ending June 1935 shows the total strength to be 230. All the fifty seats available in the Pre-Registration class were filled up, and 49 of the candidates admitted belonged to the Telugu districts. The percentage of passes in Part II of the Final M.B., B.S. Examination was 40.32 against 22.73 in the previous year. The nett cost to Government on account of the maintenance of the College was Rs. 2,03,205-9-0. All the examinations except those relating to clinical and practical midwifery and gynaecology in the Final M.B., B.S. were held at Vizagapatam. The products of this College are at a disadvantage in that the Medical Council of India has refused recognition to their degrees, as the Council's inspecting officers have pointed out certain defects and deficiencies (mostly in the number of the staff, and not in their quality) which should be remedied before gaining such recognition.

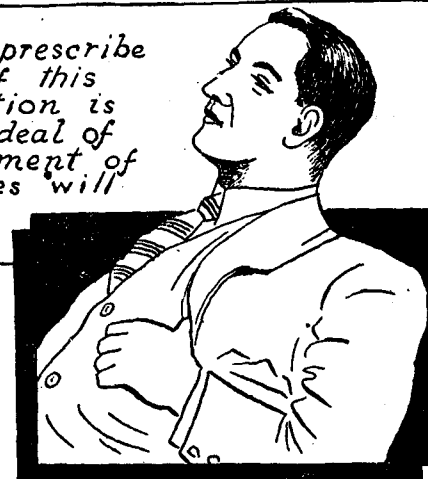
THE FIRST ALL-INDIA OBSTETRIC AND GYNAECOLOGICAL CONGRESS. This was held at the Museum Theatre, Madras, from the 2nd to 6th January. Dr. A. Lakshmanaswami Mudaliar, M.D., F.C.O.G., Chairman of the Reception Committee welcomed the delegates and visitors. He said that Madras claimed the honour of having the oldest maternity institution in the East—the Government Hospital for Women and Children, which was founded in 1844 - and of having the first post-graduate school in obstetrics and gynaecology. He felt that the Congress would acquaint the authorities of the land regarding the measures needed for the care of the mothers and infants of this country. He hoped that "the tender seedling planted to-day will grow to be a mighty tree spreading its sheltering branches throughout the length and breadth of India, such that under its shady bowers may gather together time and again the cream of the medical profession practising the twin specialities of Obstetrics and Gynaecology, such that its mighty breeze may waft to the remotest corners of our land and bring comfort and solace to rich and poor alike among the mothers of India." The Governor declared the Congress and the Exhibition open, and said that to save the mothers of India from suffering, disease, and death, and to rear up healthier and happier children, is a task than which none could be dearer to the heart of any nation. Dr. Miss Ida S. Scudder, M.D., D.Sc., Principal of the Missionary Medical School for Women, Vellore, delivered the presidential address. She said that as an outcome of the Congress, research should be stimulated and with that end in view on Obstetrical and Gynaecological Journal should be started. Another object should be, she said, to attack the obstetrical problem of the villages, which were wellnigh insurmountable. Lt. Col. C. M. Plumptre, I.M.S., Professor of Midwifery at the Madras Medical College proposed the vote of thanks. Several papers were read before the Congress, as detailed in our previous issue. The Exhibition was very instructive and contained medical and surgical goods as well as milk foods and infants' requirements manufactured in India and in foreign countries. The delegates were very much impressed with the instruments manufactured by Hebbar Brothers (of Madras), particularly the operation tables, screens, lockers, sterilizers and other surgical appliances which compared very favourably with foreign makes. It was decided that the Congress should be a biennial one, and that the next session be held at Bombay in December 1937. It was also resolved that provincial obstetric and gynaecological societies should be formed and that the question of a Journal be deferred till the provincial societies were completely formed. The Congress recommended to the Indian Medical Council to lay down a standard of training in Midwifery for medical students, consisting of not less than 6 months of hospital training and the personal conduct of 20 cases of labour. At the next Congress,

symposia and discussions on toxæmias of pregnancy and on carcinoma of the cervix uteri would be held.

DR. TIRUMURTHI ON PUBLIC HEALTH. It is not always that a medical man is called upon to deliver the convocation address at an Indian University, and it is a great honour to the medical profession that Dr. Tirumurthi was chosen to do so at the Andhra University. He drew marked attention to the woeful neglect of public health in this country and the consequent deterioration of the physical and economic condition of the people. Public health is almost always starved of funds, and education in public health is not strictly enforced in our schools and colleges. The food that the people eat is barely sufficient to ensure adequate nutrition of body and mind, and this poor nutrition is another factor in the low vitality and stamina of the general population. Dr. Tirumurthi advocates more widespread study of biology by students. His address is a welcome departure from the stereotyped platitudes that have been usually associated with university convocations, and his advice should be valuable both for the products of the University, and for those responsible for administering public health measures in this country. The Committees and Commissions that roam all over the country may be good in their own way, and high-sounding offices like the contemplated Central Ministry of Health may be necessary to tickle individual vanity, but all these cannot kill a single mosquito or nourish a frail human framework of skin and bone.

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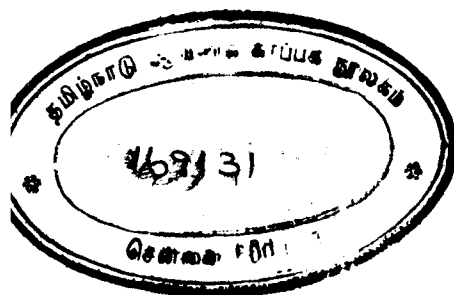
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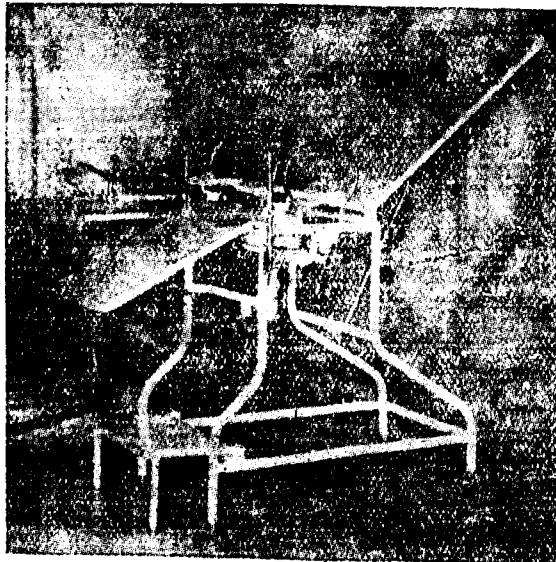
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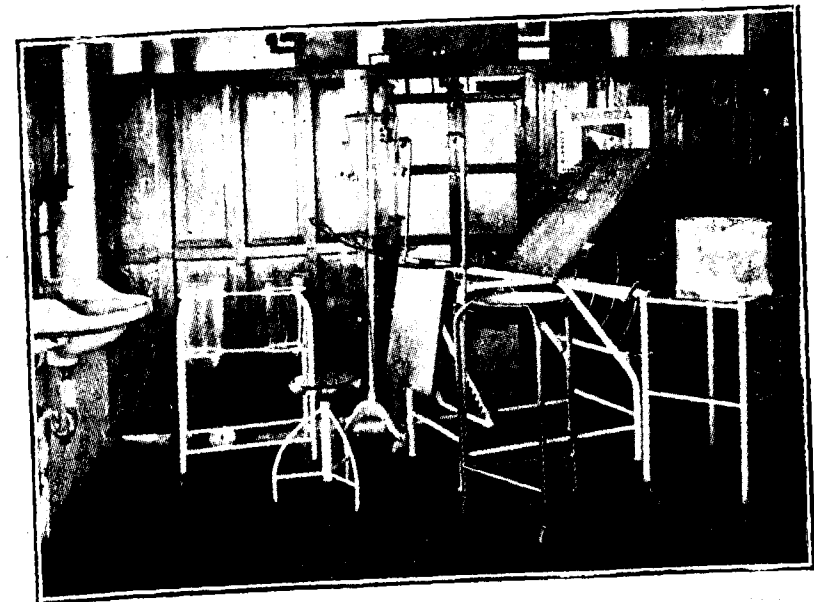
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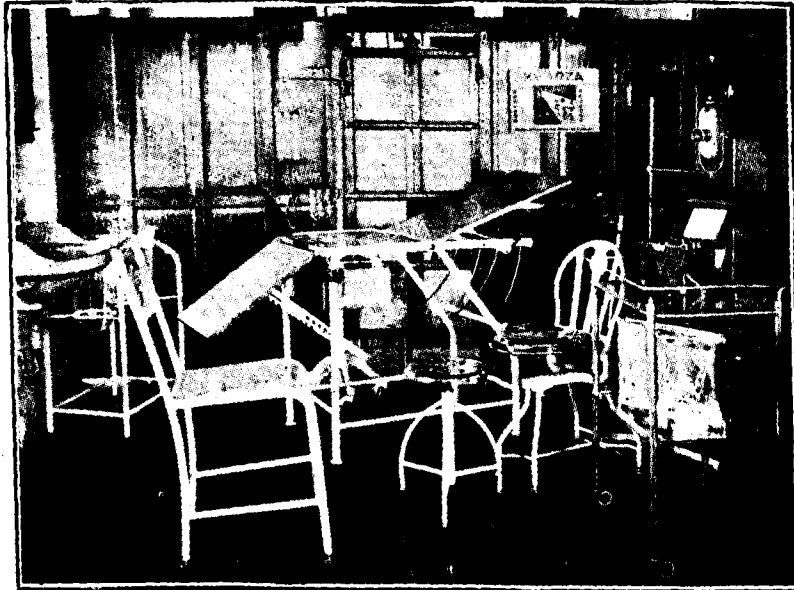
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