

MEDICO-SURGICAL SUGGESTIONS

Vol. VI.

JANUARY 1937

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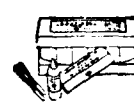
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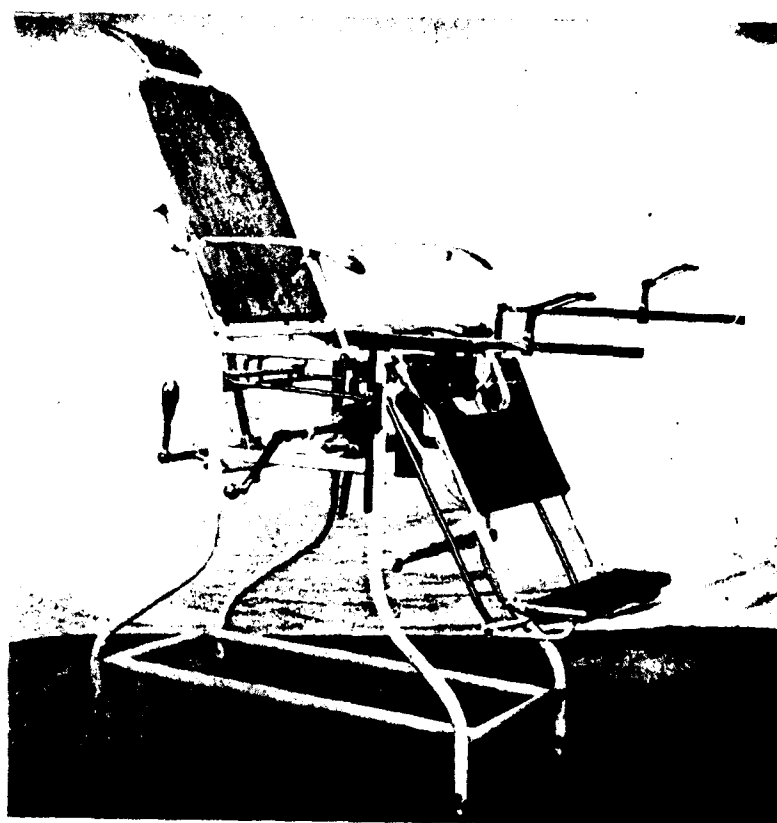
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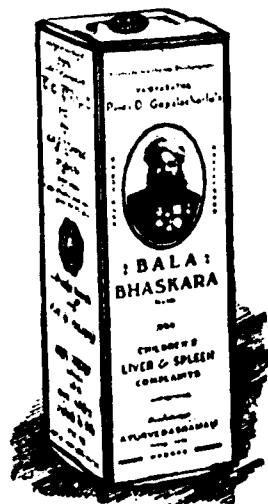
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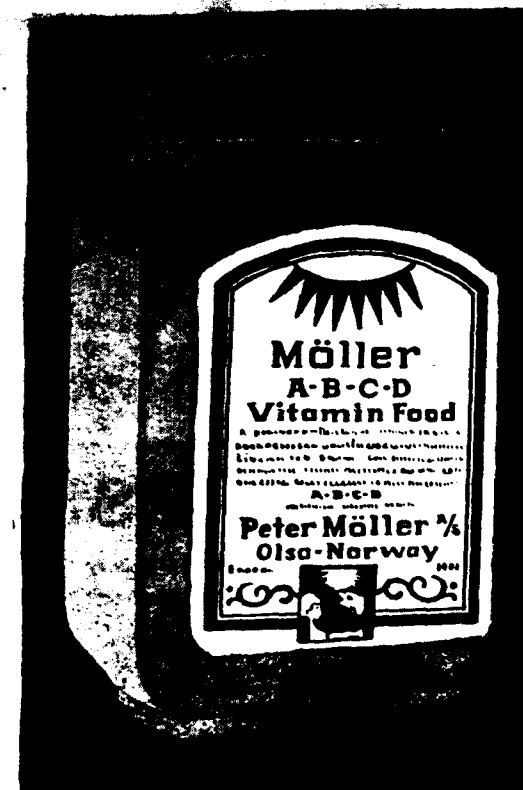
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MEDICO-SURGICAL SUGGESTIONS

A MONTHLY JOURNAL OF PRACTICAL MEDICINE & SURGERY

Editors: Dr. K. P. Rama Hebbar & Dr. P. R. Venkappaya.

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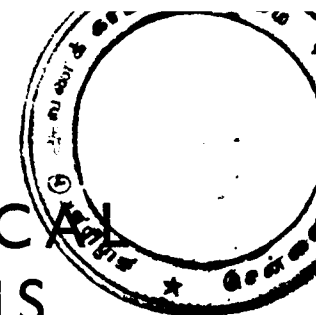
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XIII ALL-INDIA MEDICAL CONFERENCE 1936, KARACHI.

WELCOME ADDRESS

BY DR. A. SAID, I.M.D., (RETD.),
Chairman, Reception Committee.

MR. PRESIDENT, BROTHER DELEGATES, LADIES AND GENTLEMEN,

It is my proud privilege to-day to welcome you all to Karachi, the capital of Sind, on the happy occasion of holding the All-India Medical Conference in our midst. We value this honour and the privilege for more reasons than one. We are like Orissa, the youngest province in the Indian Federation; and so soon after the separation we are holding this Conference containing the cream of the Medical Profession of India which had done notable service in the direction of alleviation of human suffering and medical research. To you, more than any body of persons, the whole country looks forward in future to advance those causes that vitally affect its health and welfare, not merely by the cure of disease, but by the prevention thereof. You are the custodians of the health of the Nation and to you is given the duty of converting a C3 Nation into an A1 Nation in the years to come.

The medical profession of India has a rich record of service to its credit and the responsibilities that will devolve upon it in a politically free India are of enormous magnitude, and we have to prepare ourselves to meet them.

This occasion of extending to you our hearty welcome is to me of peculiar gratification, in as much as the whole of the medical profession of this province have whole-heartedly joined hands to hold this Conference—an indication of better days to come.

THE AERIAL CLAPHAM OF INDIA.

Brother Delegates, you have come to us over long distances after a tedious and insufferably dusty journey. As you know Nature has placed us in a desert and in the westernmost corner of India. Our gratitude to you is all the greater on that account. Let us hope that by the time the next Conference is held at Karachi, this City will have become the Aerial Clapham Junction of India and that you will come then to us by air and not by the dusty desert.

Although you have passed through a desolating scene with pyramids of sand dunes, marked by thorny dust-begrimed bushes and leafless stems of trees, before you reached Karachi, you have, I am sure, noticed an agreeable change as you stepped in our City. Here is a modern City, the Liverpool of the East, which rose to its present position from a fisherman's village of eighty years ago. Many hands have laboured to make it an attractive and, on the whole, a healthy city—the Government, the Municipality and private enterprise. It has the most equable climate of any city in the plains of India; and it has vast areas of land for building purposes obtainable at cheap prices. One day it bids fair, provided it has an assured water supply, to become an industrial city with a million people—the thronged home of titanic industry.

EFFICIENT MUNICIPAL ADMINISTRATION.

Within the resources of the Municipality, the city administration is efficiently run. We have a clean city with wide roads, everywhere asphalted, some gardens, and many parks, playgrounds for children, and many amenities for human welfare such as municipal dispensaries, maternity homes and clinics. Extensive building operations are going on everywhere to meet the demands of the future which indicate that in the opinion of investors and private builders Karachi will become big and famous as one of the great cities of India.

The constitution of Sind into a new province has added greater dignity to its people and their importance in the scheme of things. This young province is looking forward very hopefully, with the prosperity brought by the Sukkur Barrage, and commercial and industrial development, to be the Egypt of Asia.

But with perennial irrigation and cultivation of an area of nearly five or six million acres of land there will arise, if they have not already arisen, certain health problems which fall within the province of our profession. Malaria is already a most dreaded disease in this province, and it will commit heavier ravages unless it is dealt with, with the most determined will. Water-logging does not conduce to the promotion of the health of the village peasantry. Yellow fever is particularly to be guarded against and I am glad Government are aware of this and making preparations to segregate the sufferers and taking other precautionary measures at the Drigh Road Aerodrome.

There must be set up active Malarial and other research workers, as in other parts of India, to grapple with the problem of Malaria, sanitation and health; and, in the days to come, with better communications than at present exist, it will pay the members of our profession to move to villages to minister unto the needs of the village population growing economically better under the Barrage and other commercial and industrial developments.

MOST ANCIENT PROVINCE.

Brother Delegates, before I leave this subject and deal with other important subjects concerning our city and province let me not forget to mention that Karachi enjoys the enviable reputation of being the aerial gateway of India from which will go forth in increasing numbers air mails and passengers to the East and the West, and all parts of the country. Permit me to tell you, from what I have said above, that we are citizens of no mean city and province, Sind possessing a legendary history going back to the mists of ancient times as evidenced by the discoveries of Muhanjo-Daro-(Valley of the Dead). India derives its name from the river Indus-the Sindhu; and Sind was the cradle and nursery of Indian civilization.

WANTED A MEDICAL COLLEGE.

Brother Delegates, the constitution of Sind into a separate province has brought with it certain responsibilities for the sake of the health and prosperity of its people. For instance, there is a great need for a modern Medical College, and, in my opinion, the sooner it is started the better. Fortunately for us an amount of nearly a lakh of rupees has been collected to perpetuate the memory of King George the Fifth, and I think it cannot be put to a better use than this. We cannot send our students begging for medical education to other provinces; and I think it will be quite in the fitness of things to abolish the Medical School at Hyderabad and start a college in Karachi, the capital of Sind. This college will also serve the needs of Baluchistan if the local Government there is prepared to bear a portion of the financial responsibility. This institution is a concomitant of our provincial existence and I could conceive of no better purpose to which public funds and private charities could be diverted. We have already in Sind three Art Colleges and an Engineering and Law College. A Medical College, to which will be attached an up-to-date general hospital, should be the next step in the direction of educational self-sufficiency, which will bring to us, not before long a full-fledged Sind University. The Municipality of Karachi is contemplating to start a general hospital in this city; and the Civil Hospital itself is extremely congested and requires large improvements to entitle itself to be called a Provincial General Hospital. Hundreds of people from outside Karachi, too, come here for proper medical treatment. A city of this dimension, which is now a provincial headquarter, does require a big hospital and a Medical College. While on this subject, let me point out that the hospital itself should be located not in a congested area but on an open extensive plot commanding good transportation facilities; and the teaching in the Medical College itself should be of a very high order free from inherent defects and drawbacks which are to be found in similar institutions in other provinces.

TEACHING IN MEDICAL INSTITUTIONS.

The teaching in Medical Schools and Colleges, as it is done for nearly two generations, has brought out certain defects which ought to be strictly avoided by those entrusted with medical education in future. A successful physician and surgeon is not necessarily a very good teacher. There should therefore be a teaching corps created for our medical institutions. Vested interests should not monopolise the key-posts and service interests should not dominate the teaching profession. It is an unfortunate experience that several of these professors have no heart for the teaching line and have not even the time to teach, as they have an eye on their private practice. At times some of these lack up-to-date information of their subjects. Medicine and Surgery and allied arts are so rapidly developing that all teaching must be up-to-date. Defects of medical education could only be removed if a Medical corps is constituted which should consist of paid and honorary members. I doubt very much whether in this country we are making proper use of our research scholars for imparting the valuable knowledge that they have themselves garnered. I am afraid their talent is running waste for want of adequate encouragement. There is an old saying "creepers, scholars and women cannot grow without support". Research scholarship must find its way into medical colleges by proper support.

UNIFORM EDUCATION.

With regard to medical teaching, it should be of a uniform nature, without higher or lower grade, each student being allowed, after the course of general training, to take up the line he would like to pursue. By this method we would ensure a thorough grounding in medical knowledge with some sort of specialisation as a goal. Let every medical practitioner have the pleasure of writing the mystic letters M. D. after his name. By curtailing pre-medical education by one year, it can with great advantage be utilised for post-graduate hospital training. There is a widespread fear that, as the domain of medical knowledge is extending, and as the standard of teaching is raised, students get little time to gain practical knowledge; and the consequence is that they are more scientific and less practical. We must guard against the danger of modern medical science becoming more a scientific theory than a bedside art.

CAREERS FOR MEDICAL GRADUATES.

Friends, I have just stressed the need of having an up-to-date medical college for Sind. The question will be asked as to what should be done with the medical graduates that will come out of it. Already there is a complaint that the market is glutted with the various products of our universities with less and less chances of employment. It is true we have a large number of medical practitioners in our city some of whom are eking out precarious existence. But my view of the matter is that reasonable employment could be

found for these and the many students that will come out of the future medical college.

Let us bear in mind that India is a country of countless millions and the number of scientifically trained medical men is but a handful when the medical needs of three hundred and fifty millions of people are taken into consideration. Millions of men, women and children die in this country every year of preventible diseases only because skillful treatment does not and cannot reach them. The average expectation of life in our country is only 25 years whereas in England it is 47 years. Government by its own costly agencies can never hope directly to tackle this tremendous problem of human disease and suffering in this vast country, and ministers running Government under provincial autonomy will be faced with this—the fundamental problem of all problems.

Private agencies must perforce be employed to deal with questions of rural health and sanitation and therein lies the opportunity of the private practitioner. Within the next few years communications by roads will develop rapidly on account of the road fund and medical practitioners, who are crowding into the cities and towns, can move into large villages wherefrom they can minister unto the needs of the village population provided they get a reasonable subsidy from the Government. A practitioner with a motor cycle can cover a fairly large group of villages in a week. He can advise the village folks also in matters of sanitation and prevention of disease. And his close connection with the village people will bring him added private practice. Here is a vast field for exploitation by enterprising medical practitioners of this province and country.

Certain local governments have been sending out travelling dispensaries to treat the rural peasantry and, while I have my own doubts as to their utility, I must say that something is better than nothing. There should be no need for these travelling dispensaries if subsidised private practitioners are placed in charge of groups of villages. I am not against the indigenous Vaid or Hakim, if he has a thorough grounding in his art, and he too is one of the healers whose subsidised services must be requisitioned to treat village people.

Medical practitioners have crowded into cities because of the amenities offered by them. But with the Radio and Television and the projects of rural reconstruction now in full swing, the whole face and structure of village life will change for the better within a generation; and rural life will not be so dreadful as it is pictured to be at present for the educated man.

Sanitation and medical relief are allied through different subjects. Sanitation is, if I may say so, preventive medicine. I am of the opinion that for a group of two or three districts in Sind there should be a health officer with a D. P. H. engaged by the District Local

Boards concerned, whose duty should be to advise on and carry out projects of rural sanitation and propaganda.

MEDICAL RELIEF IN KARACHI.

Now coming to the question of medical relief within our city of Karachi, let me tell you that we are face to face with niggardliness on one side and pernicious prodigality on the other. Here is a provincial capital having only a District Civil Hospital without some of the most essential requirements and conveniences and the staff necessary and associated with presidency hospitals at the headquarters of the Governor of the Province. It is a reproach which ought to be immediately removed; and, if the eternal plea of want of funds is raised, it should be pointed out that a lot of expenditure could be saved by Honorary Medical Practitioners and Surgeons of the city being engaged to work in the general hospital and medical college, as is the case in Bombay. There the J. J. Hospital, K E.M. Hospital and some of the medical institutions are staffed in a large measure by the local physicians and surgeons.

Our Municipality spends prodigally on medical relief, on maternity homes and other agencies for the amelioration of human suffering. It is estimated that in no city in India of equal population is the proportion of expenditure on its medical side so high as in Karachi. Out of an income of about Rs. 38¼ lakhs our Municipality spends Rs. 6½ lakhs on public health, conservancy and medical relief, and I urge that this largest item of expenditure in the Budget on the medical relief side should be carefully gone into and put to the best possible use.

As every doctor knows it is impossible for a municipal doctor to devote attention to two or three hundred patients a day within office hours and this sort of medical relief is almost a wasted charity.

We have a right to ask whether the ratepayers' money is being spent in the best possible manner. I have my grave doubts about that. We are not jealous because we are private practitioners. But we have a better scheme, which, while providing Karachi with an excellent Municipal General Hospital, will extend medical relief to the citizens more widely.

My suggestions are that money, which is being diffused for the maintenance of so many dispensaries, maternity homes, and clinics, ought to be devoted to raising a big central medical institution called the Municipal General Hospital, where the best medical talent should be concentrated for medical and surgical relief and nursing. There is room enough in this city for two general hospitals—one run by the government and the other by the municipality. Their governing bodies can also co-ordinate their work and divide their labours.

THE PANEL SYSTEM.

In the localities where the municipal dispensaries and maternity homes are abolished, the system of panel doctors may be tried, which can also be introduced all over the city in the course of time. I need not go into the question of the working of the panel system as it is well known to you, and as it was the subject of thorough investigation by our local municipality and there is, I am sure, a large amount of support for the same. Of course, there are differences of opinion as to the practicability, or utility of the scheme under Indian conditions but further thought and attention devoted to the subject at a conference with municipal and governmental authorities on one side and local private practitioners on the other side will still find a solution of the difficulties; and the Karachi Municipality will enjoy the honour of being the first in India for having adopted an economical and efficient system of medical relief.

OUR OBJECTS.

Let no one go away with the impression that by advocating the Panel system we are actuated with the selfish motive of fishing for more practice.

Our object is to ensure for this city (1) a well equipped Municipal General Hospital serving a wider and better purpose (2) a corps of well trained medical practitioners enjoying Panel practice, whose services will be always at the disposal of the city in the general hospital, in the medical college, and in case of any emergency. (3) To spread the blessing of medical relief and succour into all the corners of the city, however humble or poor, which does not reach them at present. It is nothing but larger relief for the widest commonalty by putting to the best and most efficient use the funds of the Municipal Corporation allotted for medical relief. The Same Panel system can also be introduced in other towns and cities of Sind and with advantage copied by the rest of India. Let Karachi lead the way.

In the above paragraphs I have attempted to show how rural and urban medical relief could be organised. I emphasize once more that these problems of health, sanitation and medical relief are very pressing, and future provincial ministers and legislators will be judged by the way they attack and solve these problems. I assure the public that the panel system in the cities and towns, and the settling down and making use of private practitioners in rural areas is a very desirable system combining effective service with cheapness.

SICK ATTENDANCE.

I have another suggestion to offer to this distinguished gathering.

It is not possible for people in poor circumstances to be attended by Nurses who charge fees which they are unable to pay. And without proper nursing in a case such as Pneumonia, Typhoid,

Cholera etc., the chances of recovery are very remote. It is also impossible for all such patients to be removed to public hospitals where very often there is scarcely any room for them. Even with two more general hospitals, in the happy contingency of their coming into existence, there will still be scores of patients who cannot be removed or allow themselves to be removed to any hospital, private or public. Even the best skilled treatment is at times very ineffective when it is not attended by proper nursing. It is within our experience that many patients have died simply because the doctor's instructions were not carried out for want of proper nursing; and the people at home are in most cases completely ignorant as to how to nurse a patient. On the contrary they spoil many cases at home by disregarding the doctor's instructions.

I, therefore, suggest that there should be opened simple sick attendant classes, for men and women, who know how to read and write, and who can carry out the doctor's instructions. It will take about six months to give them a course of general training and they will be available for poorer families on the payment of a rupee or two during day and a little more during night. Hundreds of lives can be saved in poorer families in our towns and cities by employing such men and women nurses. The latter can be trained in the general hospitals to which I referred in the previous paragraphs.

THE MENACE OF QUACKERY.

One of the greatest dangers besetting the system of scientific allopathic treatment in this country is the widespread system of Quackery. These quack doctors, often only mere compounders or midwives, pose themselves as qualified practitioners exhibiting diplomas, degrees, and designations which are ambiguous and misleading, and are colourable imitations of allopathic degrees.

A Vaid or Hakim follows the ancient system of healing and does not pose as a practitioner of western medical science. These quacks using allopathic drugs, methods of diagnosis and treatment, are utterly unqualified to practice this science, proficiency in which could only be obtained by years of study at medical schools and colleges and by practising as a qualified doctor for a number of years. The greatest possible harm is being done to human beings by these bogus doctors whose existence will never be tolerated in any other country.

They are a menace to the health and well-being of the community and the sooner they are prohibited from practising the allopathic system of treatment the better will be for all concerned. Let us hope that one of the first fruits of provincial autonomy in Sind will be the passing of a bill prohibiting Quackery, which I have no doubt will meet with universal support.

Brother Delegates, I have come to the end of my Address. I have confined myself mostly to matters of provincial interest as we are holding the Conference in the Province of Sind.

I have also refrained deliberately from touching matters of larger import and of All India importance concerning our profession for the very good reason that such matters can be left in the more capable hands of the worthy President of this Conference and the speakers on the various resolutions.

Brother Delegates, I beg of you to forgive us for the inadequacies of our reception of which we are only too conscious. I pray that you will ignore our defects regarding the arrangements for your stay in Karachi with the same generous heartedness as characterises the members of our noble Profession in their mutual dealings.

XIII ALL-INDIA MEDICAL CONFERENCE 1936 KARACHI.

PRESIDENTIAL ADDRESS

By R. B., Dr. B. N. VYAS., M.B.

President,

LADIES AND GENTLEMEN,

I thank you for the great honour you have done me in electing me President of your Association this year. The profession can boast of far worthier men than my humble self who could have filled the Chair with much greater distinction than I can ever hope to do. I believe in choosing me you desired to honour the Province from which I come. I take it in that light and thank you again not only on my behalf but also on behalf of medical profession of the United Provinces of Agra and Oudh. I feel a natural sense of diffidence when I compare myself with my distinguished predecessors in this Chair and crave full measure of your indulgence if I fail to come up to your expectations in the discharge of my duties.

The country in general and the Association in particular have to mourn the loss of some of our most eminent and distinguished members of our profession. The untimely death of the late Dr. M. A. Ansari, one of our past Presidents has caused an irreparable loss and has left a gap not only in our profession but also amongst the political leaders of India. Apart from his professional and political eminence, he was such a charming personality that those who had the privilege of knowing him and associating with him will miss him for a long time to come. He possessed the combination of qualities seldom met with in a single individual—modesty, culture, professional capacity of the highest order, selflessness, catholicity of views, social charm and intense patriotism. If the younger generation of our profession need an ideal to follow, it will be found in the life and work of the late Dr. M. A. Ansari.

The loss the Association and the profession have suffered in the sudden passing away of the late President Col. Bhola Nath is incalculable. After having served with great distinction in the

Indian Medical Service, he retired and devoted himself thereafter to the cause of the Indian Medical Profession and our Association. If this Body today occupies the position which it does it is due to a great extent to the zeal, sacrifice, and devoted labour which he brought to the cause of the Association. He twice toured the country at his own expense inspite of indifferent health and helped in the establishment of a large number of branches all over the country. His noble example, I hope, will be followed by other eminent men of his service. What better work could they desire than service to the country and help and guidance of the younger generation of our profession.

The Bengal has lost two foremost Gynaecologists of the Province in the death of the veteran, Sir Kedarnath Das and Dr. Narendranath Basu of the Carmical Medical College. While the Indian Medical profession was in its infancy, Sir Kedarnath Das was a leading figure in that branch of medicine in which we as a profession were thought to be deficient. He was perhaps the only Indian belonging to the private medical profession on whom the honour of Knighthood was conferred purely for professional eminence. In the untimely death of Dr. N. N. Basu, the profession has lost a valuable colleague and champion of its cause.

Our Association is 13 years old. The membership stands at present at 1806 as compared with that of last year 1533. It has 64 branches, 23 in the United Provinces, 13 in the Punjab, 8 in Bengal, 3 in Behar, 2 in the Central Provinces, 6 in Bombay, 2 in Madras, 1 in Hyderabad and 1 in Delhi. I am glad Madras from which hailed our last year's distinguished President is coming into line with us. I hope to see in the near future the cause of the Association flourishing in that important and advanced Province. It is a matter of great satisfaction to me that the largest number of branches are in the Province from which I come. It is due solely to the untiring zeal, energy, and selfless work of our distinguished colleague from Meerut, Dr. Bhopal Singh and his friends. Though the Association has made a fairly good advance during the present year, thanks to our indefatigable and energetic Secretary, Dr. K. S. Ray, it has yet to make a considerable headway before it occupies that strong and influential position in this country as the British Medical Association does in the United Kingdom. We should endeavour to strengthen our position which will enable us to give an unchallengeable verdict on any thing affecting the medical profession of India. I do realise that provinces in future will be autonomous and each Province will have its own problems; yet there will be a large number of important questions needing help and guidance which a strongly constituted and representative body can only give. The public, the Government and the provinces will have in future

to consult the Indian Medical Association when they wish to ascertain the opinion of the Indian Medical profession. It is only when we are in that position that the Government will have to have our representatives on bodies like Indian Medical Council and Medical Research Association and the like. To raise the Association to this position, it will need enthusiasm of a few and the good will of all, absence of personal bickerings and putting the cause of the profession before the individual or class interest. I would strongly advise the appointment of a Working Committee consisting of representatives of each Province to deal solely with the advancement of the cause of the Association in all legitimate and possible ways.

Closely associated with the cause of the Association is the matter of the mouth-piece of our Association namely its Journal. We are all glad to see the improvement it has made in the last few years both scientifically and financially, yet it has to be so improved in both these directions with the co-operation of our members that it may compare favourably with similar organs of similar Bodies in foreign countries, such as the British Medical Journal. Remember that the other countries will judge us by the standard of our official organ. Instead of frittering away our energies in the production and up-keep of various little journals of indifferent merit, we might concentrate on improving our Journal to such an extent so that it may prove worthy of the country and the Association. After 13 years of its existence, it is hardly necessary for me to enter into the matter of achievements of the Association. It has not only justified its existence but has become the essential factor in our professional life. I may mention what can be achieved by an organised Body by giving an instance from the United Provinces. The U. P. Government had promulgated certain amendments to Poisons Rules which were very obnoxious to the members of the medical profession in that Province. It was due to the efforts of your Provincial Branch of the Association and its worthy Secretary, Dr. Bhopal Singh and his friends that these obnoxious amendments were entirely done away with. I therefore appeal to our members and through them the Provinces to do all they can to further the cause of the Association to the best of their ability and make it a supreme body which it deserves to be, so that its voice may be heard with respect and attention throughout the length and breadth of India as well as in other countries. Governments of various Provinces have so far seen no objection to allowing their officers to join our Association as our main object is to improve the profession in all respects yet there are provinces which have chosen to put a ban on its membership. The outstanding example of this uncalled for arbitrary action is the Punjab. I would request you to lodge a strong protest against this wholly unnecessary and unjustifiable for action of the Government

of that province. I understand that the British Medical Association is sending a representative to India perhaps with a view to ascertain the possibility of amalgamation of our Association with theirs. Though we shall respond with cordiality to any friendly gesture, we must keep our mind, open on the question of merging. So far the British Medical Association has never looked with favour on the aspirations of the Indian medical profession.

The services open to the Profession are the Indian Medical Service, Provincial Medical Service, the Public Health Service, the Subordinate Medical Service, and now to some extent the Railway Service. It is right and proper that we should consider the position of Indian Medical profession with regard to these various services.

INDIAN MEDICAL SERVICES.

With regard to the Indian Medical Service, I need add very little to what our late President, Col. Bhola Nath, said in his Presidential Address in 1934. I have no hesitation in acknowledging that this Service did a lot in initiating in India the scientific system of medicine. It has produced a number of distinguished and eminent medical men. I have no quarrel with the members of this Service, among whom I count a large number of personal friends. But on the other hand, I have equally no hesitation in saying that it has long outlived its use and the sooner it is scrapped the better—at any rate so far as the Civil Side of it is concerned. The excuse for keeping the Civil side of it was for the so-called war reserve. Later it was the necessity of maintaining European doctors for looking after the health of the European members of the various services, and now throwing aside all pretence they have established a Civil part of the Service to be imposed perpetually on the Provinces, filling up all the important administrative, educational and Civil appointments. It is difficult to speak with restraint on this uncalled for infliction of a Military Service on a civil population. With a large number of Indian Medical men with the highest qualifications available for any appointment, the best appointments in the Provinces are reserved for officers of this Service with, in good number of cases, very ordinary qualifications. The racial distinction has been carried so far that the Indian members of their own service have been relegated to smaller and unimportant stations in the Province. With the medical administration perpetually in their own hands, no wonder, their own interests every time come first. I could quote numerous instances of disregard of legitimate claims outside their service and also of the non-European elements of their own service. Recently in a province they needed a professor of gynaecology and obstetrics and a European officer of their service was selected when a large number of highly qualified and experienced Indians were available. Could there be any justification for such an appointment? While we are told the European members of the service insist on their being

attended to by men of their own race, they deliberately appoint an European member of the service when a large number of patients are Indians in such a branch of medicine as gynaecology and obstetrics. We are told that medicine is a transferred subject under an Indian minister in all the Provinces. They evidently are powerless against the Governor in Council on the one hand and the Inspector-General of Civil Hospitals on the other. When the matters are represented to the Hon'ble Ministers they tell us that they can do nothing owing to what are known as devolution rules, which means that the powers with regard to the interests of the service are vested in the Secretary of State for India. The position of Indian entrants to the service has been brought down to a level that it is only due to the increase in unemployment, that they are able to find candidates for the service. The better qualified Indian neither desires nor is encouraged to enter the I. M. S. The Indian entrants will in future have the Viceroy's Commission. Their pay has been proposed to be reduced, and they are distinctly told that they will have no prospects on the civil side. I do not think that I have drawn an overcoloured picture. The New Reforms may or may not bring autonomy to India, but it has certainly rendered the future prospect of the Indian Medical profession gloomy. It has tightened the grip of the Indian Medical Service on the Medical administration of the Provinces, particularly of the European element thereof for a long time to come. We should bring to bear all the resources at our command, in the presently to be established Autonomous Government. We should try to convince the public the Legislatures and the Government, that though we have no ill-will against our European colleagues, yet we as a people do not desire anybody but Doctors of our own race, to treat us just as European themselves like to be treated by no body except by doctors of their own race. Protesting and passing of resolutions have only resulted in tightening of their grip.

PROVINCIAL SERVICES.

Provincial services have been the back-bone of urban medical relief, just as much as the Subordinate Provincial Services have been the back-bone of the medical relief of rural areas. In spite of all the disadvantages in which these services have been placed, they have rendered splendid service in all the provinces; yet we must recognise that times are rapidly changing and we should have, as a profession, a larger outlook and consider the welfare of not this or that service, but the future of the profession as a whole. We must admit even these services have outlived their use in their present forms. Yet Government must have a service to look after their medical obligations. If therefore a Civil Medical Service on provincial basis is constituted, to replace the present Provincial Service, and recruited by open competition from the profession in general,

it should supply the need of the Government. It would have a limited cadre, each District having one District Officer who would be the medical superintendent of the principal district hospital, an inspecting officer for the rural dispensaries and the principal medico legal officer of the district. In large hospitals he would have a resident medical officer from amongst the freshly qualified young medical men from colleges and schools, as the case may be, on a temporary basis for a year or two. The main indoor and outdoor work should be distributed among the private medical practitioners with requisite qualifications on an honorary basis. Some similar arrangements would obtain in outlying rural dispensaries. Future administrative officers could be selected from amongst the most competent members of the new Provincial Medical Service. Of course, I am envisaging that the Indian Medical Service will gradually be eliminated. The proposed scheme will result in greater efficiency as each branch of medicine namely, medicine, surgery, ophthalmology, and, if necessary, gynaecology will be in charge of specially qualified men. There is no dearth of such specially qualified men amongst private practitioners. A scheme of the nature suggested would cost much less than the present medical administration, and spare sufficient money for equipment of hospital and dispensaries.

THE PUBLIC HEALTH SERVICES.

I hope that our new Legislatures would devote more time to medical relief and public health. The Public Health Services are starved for want of funds and their personnel is very inadequate. The public has paid very little attention to public health and its problems. They are so busy in the political turmoil that they have allowed this vital factor in the life of a nation to escape their attention. They are oblivious of the appalling infant mortality, lack of maternity care, continued prevalence of large number of endemic and epidemic diseases and the prevailing atmosphere of dirt, disease and death. No nation weak in bodily health can ever attain political power. It is futile to boast of our ancient civilisation and glorious past, while we continue to live surrounded by appalling unhygienic conditions. If we are to live amongst comity of nations on equal terms we must raise our public health standard upto that of modern civilised countries. This would need a considerable expansion of Public Health Services and sufficient funds to carry through schemes of improvement of public health. We as members of the medical profession should do all we can to focus public opinion on these matters and endeavour to bring public health questions to be given that importance which they deserve.

Closely connected with the matter of medical services is the question of unemployment among the ranks of the medical profession. If we succeed in persuading the Government through pressure of

public opinion, to adopt some of the measures suggested for the improvement of medical relief and public health, the question of unemployment to a certain extent will be automatically solved. If the work of the Government, municipal and district board hospitals and dispensaries is carried out through the honorary agency in place of highly salaried and therefore limited staff of district and other hospitals, it will absorb a large number of young medical men, living so far on a slender private practice. Having the advantage of a hospital to work in, they would get additional experience and better status, they would be in a position to develop the private practice better than they have been able to do so far. The same observations would apply more or less to the outlying dispensaries. The expansion of public health services and development of public health schemes would need a large number of products of our school and colleges. But all these suggestions, if you agree with me that they are improvements on the existing state of things depend on the understanding and good will of others outside the profession. The question therefore that we have seriously to consider is, whether we ourselves can do something in this direction. One thing is very clear. If all the medical men, qualifying, roughly about a thousand a year from colleges and perhaps double that number from schools, concentrate on practicing in the large towns as more or less they are doing at present, the overcrowding and congestion in the profession which is already existing will intensify, leading to deterioration, further unemployment and misery. The present number of qualified medical men in scientific system of medicine is estimated to be 25,000 throughout India. When we compare this number to the total population even after taking into consideration the number of practitioners of various other so-called systems, it is a mere drop in the ocean. What then is the reason for unemployment? The reason to my mind is apparent. The majority attempt to establish themselves in large cities producing congestion and consequent unemployment. The services can only absorb a fraction of the men qualified each year. It follows that the majority of the qualified men will have to depend upon private practice for their means of subsistence. The newly qualified young medical practitioner is disinclined to move away from the city and desires to follow in the footsteps of the doctors of the past generation. It is this tendency which has led to congestion and unemployment. They have to realise, whether they like it or not, that the future of the majority of coming generation of medical men lies not in the urban but in rural areas. The vast number of Indian population with hardly any or no medical aid is waiting for them. We as a profession have so far always thought in the urban sense, the future members of the profession will have to develop a rural sense from sheer necessity if not from a patriotic point of view. The plan suggested to help our young

medical practitioners to settle down in the rural areas is somewhat as follows :—

That a general survey of the district be made, and those areas which have no outlying dispensaries be divided into units of a certain number of villages with a small town in the centre where the practitioner is persuaded to settle and subsidised by the authorities concerned to the extent of a house, minimum equipment and a small allowance and left to develop his practice in the surrounding areas. It would necessarily mean a simpler life and perhaps an entirely new outlook in life. But he will, I am sure, in course of time be able to make a decent living, if he continues to observe the honourable traditions of the profession. He would more or less occupy the same position as a country doctor does in the United Kingdom. I am fully aware that the young practitioner, accustomed to the traditions of the town practitioners of the present day, jibs at the idea of rural life. Whether he likes it or not, the future of the majority of the practitioners lies in the rural rather than in urban areas, if ever-increasing products of our colleges and schools have to be provided for.

Another direction in which there is a considerable scope of employment for young members of the profession is, the development of industries for the manufacture of simple chemicals needed for medical purposes. These industries are developing at a more rapid rate than is generally realised. Simple Chemicals like Hydrogen Peroxide, Potassium Permanganate are now imported in enormous quantity from foreign countries, which could with a little enterprise be manufactured in this country, and our young medical men with business tendencies can find considerable scope with great benefit to themselves and the country. There is yet another field for the younger generation of medical men—to help to utilise the products of research in indigenous drugs. Researches in this direction have found, and will continue to find a number of preparations derived from indigenous drugs which have been in use in the country for centuries. This will not only give employment to a large number of young medical men with a tendency in that direction, but will cheapen the cost of treatment which is at present prohibitive for the poorer classes. These when ready in suitable number will form the basis of Indian Pharmacopæia. Col. Chopra's pioneer work in this direction has given great impetus for the future development of this important work. When we talk of unemployment in the profession we mean that a number of our younger generation of medical practitioners are sitting with folded hands in large towns, waiting for practice to come to them. This I am afraid is due to the utter lack of enterprise. Unless enterprise and determination are forthcoming, they will have to continue to wait without success for practice which is unlikely to come to them.

While there is so much talk about unemployment, ever-increasing numbers are seeking admission to the medical colleges and schools, so much so that all the colleges and schools have put a limit to the number of admissions and competition for seeking admission is increasing. I wish the system of admission to the medical colleges by open pre-medical competition, which obtains in the Lucknow University will find favour with other medical educational institutions in India. Through such a competitive examination, you not only get the best material available but save a lot of favouritism and heartburning.

The advent of the Medical Council of India and the inspection of the colleges, have revealed the fact that the different universities had more or less different standards, which have now through strict inspections been brought more or less to uniformity. Some of them are lacking in equipment and personnel which when brought to the notice of the government and authorities were quickly attended to. So far as I know the medical schools have not only varying standards, but lack in sufficient equipment and efficient teaching personnel. They need considerable improvement both as regards equipment and teaching staff. Each Provincial Government treats these medical institutions according to their sweet will. The desire of the All-India Licentiates Association to bring all the medical schools, within the purview of the Medical Council of India is legitimate and justifiable. There is no other way of bringing uniformity of standard. But as these schools are under governing bodies called the State Medical Faculties in each province, outside interference is likely to be resented. I could suggest a number of ways to improve these institutions. But I do not want them mended but I want to see them ended, I want to bring all the schools and where there are too many to be combined in one and raise them to the standard laid down by the All India Medical Council as the minimum standard for recognition. I hope you will agree with me that there should be one standard for all the medical education in India. The system of turning out medical men with a lower standard of medical education is pernicious and obsolete. Why the diseases and ailments of poor classes need a doctor with lesser qualifications passes understanding. It is a remnant of the times when "the Saheb needed a Doctor Babu to look after the natives". Reforms have come and gone but this obsolete system has been left untouched. It is difficult to understand the persistence with which the proposals to raise the standard of the school to that of the college has been turned down by some of the provincial governments. The usual plea is that there is still a demand for cheaper medical aid. In a poor country like India if the masses are to be afforded medical relief, the cost of treatment has to be necessarily cheap, but that does not imply a less qualified doctor. I wonder what would happen if a worker or

a peasant in England was told, that he cannot be treated by a fully qualified doctor on account of the cost it would involve. Another reason given for not raising the standard of the medical schools is lack of funds. When the proposals are distasteful to powers that be, they turn them down for this unanswerable reason. The truth is that the agitation against this unjustifiable state of things has not been strong enough. We ourselves have not made efforts in this direction. I suggest that we tell the Government that the profession in India no longer wants a different standard of medical education in this country, and that the various schools be either brought up to the standard recognisable by the Indian Medical Council or abolished. I believe that strong and influential body of the All India Licentiate's Association agrees with us in this view. The education imparted in our medical colleges is second to none in any country. Among other things, it is shown by the fact, that our students are able to acquire the highest post-graduate qualifications of the United Kingdom and other countries without the least difficulty. They can hold their own in any open competition. This is perhaps one of the reasons that the open competitive examination for the Indian Medical Services has been abolished.

If sufficient number of medical graduates do not engage in research, it is not want of capacity but lack of facilities.

The Indian Research Fund Association in spite of inclusion of three representatives from the Indian Universities is still predominantly controlled by the hierarchy of the Indian Medical Services. Indian Medical men with a flare for research do not get the encouragement which they deserve. Our graduates flock to Europe in large numbers to get post-graduate qualification at great expense and trouble. I believe time has arrived for the expansion of advanced postgraduate training in various branches of medicine in our own universities. We might formulate a scheme for such a training, and submit it for consideration by the various universities. I have one strong grievance against the recruitment of teaching staff for our medical colleges. Some important clinical teaching appointments in majority of the universities, are still reserved for members of the Indian Medical Services. With a large number of highly qualified Indian Medical men to draw upon, such a reservation has no longer any justification. Our protest against this unjust and uncalled for reservation should be strong and emphatic.

For maintaining the uniformity of standards in medical education in our universities, a central agency with sufficient authority to enforce it is essential. This now exists in the shape of Medical Council of India. The tremendous agitation which preceded its establishment is now more or less at rest. The Indian Medical Act is by no means perfect and needs to be considerably amended before it will satisfy the Indian medical profession. Unless it satisfies the

aspirations of our licentiate colleagues it will continue to give cause for dissatisfaction. How this can be brought about. I have already suggested. The unity of action and solidarity of view and patience, shown by the medical profession against the high-handedness of the General Medical Council six years ago have triumphed at last. They have given recognition to our universities with retrospective effect. Most of us feel satisfied with the restoration of friendly relations on an equal basis with that body. Control of ethical standards and disciplinary powers are vested in our provincial medical councils. These are functioning more or less satisfactorily. The provincial medical council acts need considerable modification, before they can be called satisfactory. The U. P. medical council have lately submitted a proposal to Government for modification of the act. I suggest that the different provincial medical councils may take similar action, if not already taken.

I have referred above to the necessity of research in indigenous drugs with a view to find out as many drugs as possible of equal potency as that of British pharmacopæ with a view to establish an Indian pharmacopæ, suggested by Chopra Committee. While we are attempting to bring this about, the country is flooded with drugs and preparations of doubtful and even harmful properties. A large number of agencies of foreign countries like England, America, Germany, France and Italy have been established throughout India. They flood the practitioner with volumes of high sounding but worthless literature. Their agents tour the country distributing free samples and beguiling the practitioners in persuasive language to use their very doubtful wares. The practitioner is led to confuse genuine products with spurious preparations and drugs, and thus acquires a tendency of empirical ways of treatment. No law exists to prevent the flooding of the country with spurious and dangerous preparations. Such a thing would not be tolerated in any other country. We must influence the public opinion against allowing this country to be made a dumping ground for useless and harmful products from all over the world. Immediate legislation prohibiting the importation of doubtful and harmful products is called for. A clearly worded resolution expressing our views on the subject should be framed and sent to the government of India and various provincial governments.

You are doubtless aware that a large number of Insurance companies are daily springing up all over India. I am not competent to give an opinion on the economic soundness of this development but, safeguarded with proper and well considered legislation, I believe, it is a development in the right direction. I am only concerned with the position of the Medical profession *vis à vis* the development of Insurance business Examination for Insurance is a great responsibility on the medical man. He has to be adequately

remunerated for undertaking this responsibility. The young practitioner with scanty practice is persuaded to do this work without adequate remuneration. This must be prevented. If the profession is united, the companies must conform to a uniform standard in this matter. I suggest that we should appoint a sub-committee of men of experience in this line to formulate proposals and advise the members of the profession to confine to them.

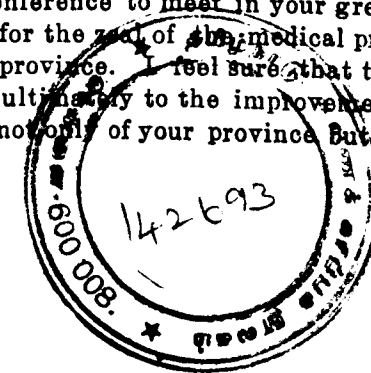
Our young practitioners have a legitimate grievance against tardy action for the suppression of bogus medical degree. Laws do exist at any rate in some provinces to make it penal to adopt bogus medical degrees. But these are apparently so feeble in operation that the pernicious system continues to flourish. The quack escapes punishment by adding a word to a bogus degree which makes it pass for a degree of some other system of medicine. The laws against adoption and displaying bogus degrees on sign-boards need to be considerably stiffened to put an end to this unlawful practice. We must draw the attention of the provincial governments to the necessity of early enactment against adoption of bogus degrees.

This brings me to mention of the ancient and indigenous system of medicine which have been flourishing in the country for centuries. A man belonging to our profession has to treat the subject with caution in dealing with it as we are accused of prejudice when expressing any view in this respect. However, I have not the slightest hesitation in saying that I have the highest respect for the systems and their genuine followers. My reverence for the systems is more or less of the same nature as that for Indian archaeology. Both Ayurvedic and Unani systems and their ethical code are suited to the temperament the spiritual leaning and simple life of the people of the country. But so are many other customs and traditions. Due to our contact with the material civilisation of the west, our customs and traditions are changing rapidly. How can then the ancient systems which have no doubt done splendid services to humanity in the past can continue to exist as they are? Acute observation, and correct deduction, urbanity of manner, sympathy, touch of spirituality and freedom from greed for which Vaidas and Hakims were famous are now things of the past. Still the system so suited to the popular temperament must exist. It can only do so if an attempt is made to bring it into modern shape. I suggest the continuance of the ancient system on a modern basis in the following form. The preliminary educational qualification i. e. Intermediate in Science with organic chemistry and biology, should be made the minimum requisite for any and all systems which the candidate desires to adopt finally. He should also be made to undergo a training in what are known as basic subjects, anatomy, physiology, hygiene, pharmacology and pathology. The final two years should be reserved for clinical

training in whatever system he wishes to qualify. The whole period of training should be five years as with us. This rule should not apply to Ayurvedic and Unani systems only but also to those who wish to qualify in Homeopathy. Some such similar regulations obtain in the United States of America. Training on these lines to a certain extent already exists in the Ayurvedic Faculty of Benares—Hindu University and Delhi and Lucknow Tibbya Colleges. But the training in the preliminary science and basic subjects—is inadequate and perfunctory. Until some such plan is adopted there is little likelihood of all recognised systems of medicine flourishing side by side with the scientific—medicine and poor and rich alike are not likely to receive the best medical relief. We as a profession have neglected to study the subject of Ayurvedic therapeutics. It may not be rational but is full of valuable suggestions. There is much in it which we can learn with profit. Therapeutic value of gold and copper used by them for centuries has now been scientifically recognised by us. I have already referred to the necessity of research in indigenous drugs which have been used for hundreds of years. Such research will not be only profitable to the profession and the country but is likely to enrich the medical science.

Gentlemen, I thank you for the patience with which you have heard me. I have endeavoured to deal with some of the subjects which affect the profession as a whole, avoiding the temptation to enter into details. Longer speeches are neither in my line nor do I wish to tire your patience. You may or may not agree with all I have said but I wish you to believe that future welfare of the profession has been my sole aim. Ours is an unfortunate country for colour, creed, castes, schisms, let the medical profession set the example of unity of aim and action. Given this all the difficulties and disadvantages you are labouring under will be things of the past, and the glorious heritage of this noble profession will be yours.

On my own behalf and on behalf of the delegates from distant provinces of India who have assembled here at your kind invitation, I thank you heartily for the most cordial reception and the very kind words of your worthy spokesman, Dr. Said, the Chairman of the Reception Committee. The very fact that your association have had the enterprise to invite this conference to meet in your great and charming city, speaks volumes for the zeal of the medical profession of your newly constituted province. I feel sure that the public spirit shown by you will lead ultimately to the improvement of the lot of the medical profession, not only of your province but of the rest of India.



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Selected Articles

THE DIAGNOSIS AND TREATMENT OF TERTIARY SKIN SYPHILIS

BY B. BARKER BEESON, M. D.

Chicago.

Tertiary skin syphilis appears most often during the third year after the chancre. According to Fournier's statistics 70 per cent of such lesions occur during the first ten years of the disease. It is not inevitable since early and adequate treatment may prevent it and it may be missing in some of the so-called benign cases. Its appearance may be greatly delayed as in Petit's patient quoted by Burnier in Jeanselene's recent treatise on syphilis, in whom a nodular syphilide at the age of 87 years was the result of an infection acquired when the man was 20 years old. Fournier has stated that 90 to 91 per cent of those presenting tertiary skin syphilis have had benign secondary skin manifestations. In his opinion and no clinician speaks with equal authority the chief cause of tertiary cutaneous syphilis is insufficient treatment.

The skin lesions of this period are the nodule or tubercle and the gumma. In contradistinction to the secondary lesions they are usually fewer in number, not so generalized, more monomorphous and more deeply seated, healing with scarring. The nodule is the more frequent. It is non-ulcerated or ulcerated in which case it is a miniature gumma beginning in the derma instead of in the subcutis. When purely nodular it is slightly convex, orbicular, the color of smoked ham, lentil-sized most often, firm and set into the skin much as a watch-crystal is held in its case. It is dry and scales slightly. In reality it is a large deeply-seated papule. Such nodules are most often found over the face, the alae nasi and the forehead but they may appear anywhere on the body. These nodules often present an orbicular formation like a circle studded with nodules, as a collar of pearls, in which case such a circle of lesions surrounds an area of healthy skin, as an arciform affair simulating a crescent, a half-moon, a kidney or a horse-shoe or as a series of excentric circles. This latter formation is especially characteristic of syphilis. Less frequently plaque formation results from the union of a number of nodules. In such cases the individual lesions are not apparent but a thick, firm, elevated, smoked-ham colored, well-defined, slightly scaling patch is present. This is most frequent on the palms and soles where it is definitely psoriasiform.

The nodulo-ulcerative lesions begin as nodules which soon break down and ulcerate. They are usually multiple and frequently spread

slowly scarring as they advance. Such an affair is termed serpiginous and is pathognomonic of syphilis. When fully developed a nodulo-ulcerative lesion consists of an ulcer covered by a crust, the whole being seated on an indurated base. The crust is firm, compact, set into the skin, circular or polycyclic where several lesions have coalesced, dark in color, often greenish, with a close resemblance to an oyster-shell. Such a lesion is often spoken of as rupial. The ulcer is round, punched-out, with firm adherent borders and a dark reddish peripheral zone. Its floor is uneven and covered by a core resembling cooked codfish or by a creamy coating. Such a lesion heals with scarring of a particular type which when present is strongly suggestive of syphilis. Such a scar is circinate and red at first; later it becomes brown or even blackish and may remain so for years. As it fades centrally a brown ring surrounds the atrophic scar which is somewhat depressed and in texture resembles an onion-skin. It is of course indelible and is of prime importance from the retrospective standpoint especially when grouped closely, en bouquet as Fournier has said.

As to diagnosis the four chief points relative to the nodular syphilides are their firmness, the smoked ham color, their orbicularity and circinate grouping. At times one hesitates when confronted with a non-ulcerated lupus vulgaris which however has its apple-jelly nodules, its very soft tissue, and extremely slow course as compared to syphilis. Lupus erythematosus is less infiltrated, has more abundant and adherent scaling, tack-like processes which go down into the follicles, and stippled scarring. Acne necrotica, which may lead to confusion, appears in crops especially over the temples and along the hair line. Its lesions are frankly inflammatory and lack the color and firmness of the syphilitic nodules.

The nodulo-ulcerative syphilide may be confused with a number of conditions among which may be mentioned leg ulcer, sporotrichosis, cancer, ecthyma, tuberculosis, the bromide and iodide eruptions. Fournier may be most appropriately quoted as follows in regard to leg ulcer. "Given any sort of an ulcer of the skin, one should always in making its diagnosis reserve a place for syphilis, no matter who the patient may be, whether he gives a history of syphilis or not, and all of this because of the frequent surprises by reason of the numerous cases of ignored syphilis." A simple leg ulcer is usually described as being situated in the lower third of the leg, often close to the internal malleolus and it is most often unique. It has no special configuration and is not punched-out, but has sloping edges. Its floor is not creamy nor does it possess a core which resembles cooked codfish. It is not crusted as a rule. Varicosities may be demonstrable. Cases in which syphilis affects a varicose limb are indeed difficult of diagnosis. Not a few so-called leg ulcers are accompanied by a positive Wassermann reaction and they may

respond quickly to appropriate treatment. A careful search should be made for other evidence of syphilis. The therapeutic test may be the court of last resort. Favre of Lyon, France, has described cases which he termed "Dermite pigmentée et purpurique" some even showing gangrene. All of them were due to syphilis and they presented phlebitis and periphlebitis which as to pathology resembled the changes seen in syphilitic arteritis.

An ulcerative lupus vulgaris does not possess the configuration of syphilis. It is irregular with a soft base and undermined edges. It is a torpid affair. Characteristic nodules may exist about the ulcer.

Sporotrichosis present lesions which when broken down are more fistulous than ulcerative. They are soft and do not possess a core. A culture readily makes the diagnosis.

A squamous-cell cancer is unique usually. It is often everted with a board-like hardness and bleeds easily. The neighboring lymph-glands are soon involved. A biopsy would settle the question if one were in doubt.

Ecthyma is more inflammatory than syphilis. It begins as a vesicopustule which ulcerates superficially. Its base is soft and it is auto-inoculable.

Iodide and bromide eruptions may be confused with the nodulo-ulcerative syphilides. A history of ingestion is usually obtained. An iodide eruption runs an acute course, is more inflammatory and lacks the firmness of the syphilitic nodule. It is more acneiform than ulcerative. A bromoderma is frequently vegetating, is soft and superficial and lacks the characters which the nodulo-ulcerative syphilide presents.

A scrofuloderma affects by choice the neck; its ulcer is soft, undermined, has a bluish halo; it is really more of a fistulla and does not have a core but suppurates freely.

The four stages of the gumma are too well known to require mention here. The gumma occurs most often from the third to the sixth year after the onset of syphilis. Fournier has noted its appearance fifty-five years after the chancre. Its favorite site is the leg especially just below the knee. A gumma usually lasts two to three months. It is unique in 60 per cent. of cases. At times such lesions are multiple and form plaques. When ulcerated it presents the same attributes as the nodulo-ulcerative syphilide except that it may be much larger. Its differentiation is discussed under that same heading, so repetition is not necessary.

A clinical diagnosis of tertiary skin syphilis is often possible. Some cases will tax the most skillful and in them laboratory measures may be of extreme value. Animal inoculation and a dark-field search for the *Spirocheta pallida* would be of slight value in tertiary lesions. A biopsy would distinguish them from cancer but

might be confusing in tuberculosis. Serological procedures should be neglected even though the Wassermann is frequently negative in late lues. A careful examination, especially of the mouth, throat and tongue, may disclose valuable corroboratory evidence in the form of a tertiary glossitis or a perforation of the hard or soft palate. The presence of lingual leukoplakia may constitute important evidence. The knee-jerks, Achilles and pupillary reflexes should be explored. The heart and aorta must not be over-looked. The therapeutic test may be of real value when done with arsenic, bismuth or mercury. Potassium iodide should not be employed for this purpose since it acts also in certain of the mycoses.

Treatment.—One can very appropriately quote from Schamberg and Wright:

"The treatment of late syphilis differs essentially from that of early syphilis, for the aim and object are not the same. In early syphilis the therapeutic goal is the extermination of all of the invading parasites in the body, with as vigorous an effort as is consistent with safety to the patient. In late syphilis, the purpose of treatment is to effect a removal of the presenting symptoms, to prevent their return and to keep the patient in good health for as many years as possible. The question of effecting a radical cure in late syphilis is not one that demands immediate attention. The patient, having had for a number of years a leptic infection with inadequate or no treatment at all, in all probability has lesions which interfere with the structural integrity of his organs. Such patients are prone to have aortic lesions or atheromatous changes in some of the blood vessels, or lesions elsewhere. The chances of eradicating the disease after long years of residence of the spirochete in the tissues are not at all favourable. Vigorous treatment with the idea of bringing about a radical cure is ill-advised and prone to do harm. Many patients have had their lives abbreviated by too zealous an effort on the part of the physician to overcome the disease."

When seeing a patient with tertiary skin syphilis even though he or she appears in excellent health one should make a thorough examination as has been mentioned when referring to the diagnosis of these skin lesions. The results of such an examination are all-important since they largely decide what can be safely done for that particular patient and thus influence his future to a marked degree. It must be remembered that one is not merely treating the existing skin lesions but the body as a whole and any abnormal finding should add to one's conservatism since in this instance we are dealing with those who are apt to be damaged goods.

If one's patient is found to be in good condition then he may be treated by the combined method using nearsphenamine and bismuth. Such a course would consist of 8-10 injections of the former with a

total dosage of four-five grams plus ten to fifteen injections of iodo-bismuthate of quinine with a total dosage of two to three grams. The initial dose of neo should not exceed 0.15 gm. The bismuth may be given twice weekly and the neo every seven days. To save time one injection of each may be given at the same visit. For the first year such a course should be followed by a rest of at least one month, after which it may be repeated as required. Tertiary skin lesions respond quickly to either neo or bismuth but heal more rapidly under this combined treatment. It may be well at times to reduce the number of injections of neoarsphenamine to six in a course. As Jadasohn has said it is rarely necessary to give more than 0.60 gm. of neo to a man or 0.45 gm. of that same drug to a woman. Such conservatism in dosage is particularly applicable to late syphilis. If our examination reveals an aortitis, a nephritis, or a liver involvement, then the rules for treatment will require revision. Sezary, a well-known French clinician, favors bismuth or mercury rather than the arsenicals in aortitis. Schamberg and Wright believe that Ehrlich arsenicals may be used in selected cases of cardiovascular syphilis. They prefer beginning treatment with bismuth or mercury. In chronic nephritis complicating tertiary syphilis Sezary suggests intravenous injections of mercury cyanide. Later a soluble bismuth salt may be given if necessary. When the liver is damaged in tertiary syphilis a mercury salt or bismuth preparation is preferable to an arsenical. It is often difficult to determine whether these visceral changes are due to syphilis or not. At times tertiary lues may be best treated with bismuth alone. Besides I. B. Q. already referred to iodo-bismutol is an excellent salt as is also bismogenol which is a bismuth salicylate. In old cases of syphilis which show little activity mercurial injections are in order. They constitute a slow but valuable method. Potassium iodide has lost much of its popularity in the treatment of tertiary skin syphilis with the advent of the newer agents. It is still employed in cardiovascular syphilis, in joint involvement, in eye lesions and in central nervous affairs. Potassium iodide may be given alone or combined with the other remedies. It is best given by mouth, intravenous injection being unnecessary. Fournier recommended 3 to 4 grams per day believing that there was no advantage in larger doses. Mercury salicylate is an excellent insoluble preparation which may be advantageously combined with neoarsphenamine. Of the soluble mercury salts the bichloride is deservedly popular.

CONCLUSIONS.

1. A careful physical examination should precede the treatment of any patient with tertiary skin syphilis.
2. Because such persons are frequently "damaged goods," treatment should be conservative both as to the drugs employed and their dosage.

3. It is better in such patients to carry on with a mild but long-continued treatment than to take chances with more radical measures which could be not only dangerous but fatal.

4. Neoarsphenamine plus bismuth is an excellent combination which should be used whenever possible. Bismuth even alone is often of distinct value and it appears to be preferable to mercury, in most instances at least.

5. Any ulcer of the skin may be due to syphilis. If this fact is kept in mind it may result in not a few surprises.

6. Clinical means of diagnosis should not be neglected in the skin lesions of syphilis. If the characteristics of such lesions are kept in the foreground they will do yeoman service.

7. The Wassermann and Kahn tests are extremely valuable but they should not be regarded with that simple and child-like trust which passeth all understanding.

8. Emphasis should be placed on a thorough examination of the central nervous system not omitting a study of the spinal fluid.—

(*Illinois Medical Journal*, Vol. 69, No. 2, Feb. 1936.)

THE TREATMENT OF HAEMOPHILIA.

Haemophilia is defined by H. W. Jones and L. M. Tocantins in "Journal of A.M.A.," 1934, ciii., as an inherited or non-inherited tendency of males to bleed, characterised by the presence of a prolongation of the coagulation and prothrombin time of the venous blood. Instances of so-called sporadic haemophilia are about as frequent as those in which a clear-cut history of inheritance can be obtained, which may indicate that the defect is sometimes atavistic.

The treatment of haemophilia may be preventive, or treatment of the condition itself.

Preventive Treatment consists in the prevention of the transmission of the disease and prevention of the accidents that usually precipitate the onset of a phase of haemorrhage. Since many of the cases exhibit a clear-cut history of inheritance, the sisters of patients with haemophilia and the patients themselves should be made acquainted with the mechanism of inheritance and told of the great likelihood of their having "bleeders" in the family. Both the individuals with haemophilia and the transmitters seem to have families a little above the average in number. The transmitters of haemophilia have more sons than daughters, while persons with haemophilia have more daughters than sons. All daughters of haemophilia males are carriers and should not reproduce.

With the knowledge that the haemophilic individual is more easily affected by trauma than the normal, he should be cautioned against engaging in strenuous occupations or undergoing operative procedures without the proper preparation. If operative intervention is indicated, there are two methods to which one may resort to

prevent undue haemorrhage, namely, preliminary blood transfusion (which reduces the clotting time for a period of from 2 to 6 days), and protein sensitisation (which increases the coagulability of the blood). It is important that the blood group of every haemophilic patient should be known, and a suitable donor kept available during and after any operative procedure. Operations in general should be avoided but, when performed, haemostasis should be painstakingly cared for. It is helpful to ligate each piece or section of tissue before incising it and to use fresh serum to dress the wound. The usual accidents to which children are exposed should be avoided. Some advise the use of a high protein diet but it does not affect the haemorrhagic phase appreciably. The use of drastic purges is undesirable. The removal of foci of infection is desirable. Dental extractions and circumcision operations should not be undertaken without the proper preparation described above. Some patients have stated that immobilisation in bed for long periods of time has increased the haemorrhagic tendency.

Treatment of the condition itself implies any attempt to change the fundamental defect (the prolonged coagulation and prothrombin time of the blood) or to diminish the incidence and severity of the manifestations associated with the condition. So far, the authors have remained unconvinced of the value of many advocated measures. Ovarian extract orally and intramuscularly was used in 4 patients, and no changes were noted in any aspect of the disease. So far we must content ourselves to explain the almost absolute limitation of the disease to males on the basis of the laws of heredity, rather than on the hypothetical disproved assumption that the defect is present in the female, but kept in check by ovarian hormones. Splenic and thyroid extracts were likewise of no immediate or remote value. The disease seldom makes its appearance until several weeks after birth, and from then on until maturity the attacks of bleeding occur at intervals. The preference of the haemorrhages for the joints and muscles during the developmental period leads to deformities and retardation in growth. After the third decade of life the incidence of attacks of bleeding decreases considerably. The venous coagulation time, however, remains unaltered. There is no method known at present that is of undisputable permanent value in altering the general course of the disease.

In the treatment of an acute phase of bleeding the therapeutic measure *par excellence* is the transfusion of blood, unmodified or citrated, which confers benefit by haemostasis and not by the changing of the coagulation time. Great care should be taken in having the blood cross-matched. The improvement resulting from a blood transfusion in the usual dosage lasts between 2 and 6 days. In children intraperitoneal transfusions of blood are of equal benefit, though slow. The intravenous or intramuscular administration of

various sera (sheep serum, horse serum, haemostatic serum), autologous blood given intramuscularly, or the use of calcium, ergot, peptone, parathyroid extract, thromboplastic substance or tissue fibrinogen have proved of little value. Oestrogenic substance was likewise useless. The administration of these drugs in haemophilia should be discontinued, since their use involves delaying the employment of measures of proved value. If the patient is or has been made sensitive to a certain serum, a small desensitising dose given intradermally is said to check the bleeding. The problem of stopping the bleeding is simplified if the area is accessible. In other places, the application of icebags and compression are of very little use. In the accessible portions of the body such as the skin and subcutaneous tissue, and oral, rectal or nasal mucous membranes, the following measures may be employed: Pressure; application of astringents and clot-promoters such as fresh serum (not over 3 hours old), and tannic acid powder (after removing useless clots carefully and without rubbing); superficial cauterisation by the electro-coagulation method in small areas; injection directly into the bleeding area of fresh serum with a needle of very small bore and long bevel. The local application of horse serum, Coagulose, tissue fibrinogen, and Ceanothyn was of no use.

The intravenous injection of defibrinated blood, whereby large amounts of thrombin are made available to the patient, was followed by some improvement, as also the intramuscular injection of 20 cc., of whole blood. Intradermal injections of antiplatelet serum seems rational, from the known pathology of the condition, and the disintegration of blood platelets leads to the liberation of prothrombin and thromboplastic substance; a shortening of the venous coagulation time is sometimes detected, but no prompt and permanent cessation of the bleeding follows.

Treatment of the complications of the disease: A severe anaemia develops, which yields readily to diet and iron when the bleeding ceases, as haemophilic patients appear to have an accelerated rate of blood production, sometimes even exceeding the normal levels of erythrocytes and haemoglobin. Any haematoma and any swollen joint, no matter how large, should not be opened. The part should be placed at rest by a splint until the swelling and pain disappear. Aspiration of a joint has its dangers, and is best practised only after proper preparation and then with a needle with a small bore. After the acute symptoms have subsided, heat, gentle massage, and passive motion are indicated.

The General Practitioner, Jan. 15, 1936.

Extract

VACCINE TREATMENT OF ASTHMA.

H. M. Rozendal, M. D., Division of Medicine and C. K. Maytum, M. D., Division of Medicine: In the past year we have treated a small number of patients suffering from bronchial asthma with a vaccine prepared from cultures obtained from nasopharyngeal swabs. No attempt was made to recover a specific organism, but the majority of the cultures contained a preponderance of streptococci. Both autogenous and pooled stock vaccines were used, the autogenous vaccine being used only in those cases in which skin reactions to the patients' own organisms were positive. The vaccines were prepared in Dr. Rosenow's laboratory according to his standard technic.

Twenty-seven patients were treated. In the majority of these cases the cause of the asthma was felt to be the result of infection rather than sensitiveness to a specific substance. Males and females were about equally distributed and the ages ranged from five to sixty-one years. The injections were given subcutaneously, starting with 0.1 c. c., and dosage was gradually increased. The intervals between the first injections usually varied from two to four days until the maximal dose (0.5 to 1.0 c. c.) had been reached; then the interval was one week. If considerable local reaction was noted, the dose was decreased. Constitutional reactions did not occur in any case in this series.

None of the patients obtained complete relief from treatment with vaccine. Ten patients reported no benefit; two stated that their condition was worse. Four patients experienced benefit estimated at 25 per cent or less while six reported 50 per cent improvement and seven reported 75 per cent improvement. We have assumed, therefore, that thirteen patients of the twenty-seven (48.1 per cent) obtained worth while relief, while treatment of fourteen (51.8 per cent) must be considered to have failed.

Although it is extremely difficult to evaluate the results of treatment of asthma, the results obtained in this small group correspond in general with the findings of other authors. Thomas, who treated a similar group of patients, reported material relief of 60 per cent following administration of autogenous vaccine. Wilmer and Cobe reported that following use of stock vaccines results were about the same as when autogenous vaccines were employed and that they obtained cure in 30 per cent and improvement in about 50 per cent of their cases regardless of the kind of vaccine used. Rackemann and Graham noted very little difference in end results between the effects of stock and autogenous vaccine. We are of the opinion that, when benefit does ensue, it probably is attributable to a nonspecific rather than to a specific reaction.

This form of treatment should be used only in certain instances; namely, those in which the asthma seems to be of a bacterial or infectious nature and in which skin tests fail to reveal sensitivity to external substances, or those in which patients are hypersensitive and give histories of frequent colds or recurring attacks of bronchitis not relieved by treatment directed toward the specific cause of attacks. Of 200 cases of bronchial asthma encountered at the Clinic in 1934, in forty-seven the condition was considered clinically to be of infectious origin and in thirty-six of these forty-seven cases all skin tests for external substances, including foods, were negative. It is in this small group that a trial with vaccine seems to be justified in spite of the fact that results with this treatment are not very encouraging at present.

The Mayo Clinic. Feb. 5, 1936.

Medical News and Notes

THE KISTNA DISTRICT RURAL MEDICAL PRACTITIONERS' ASSOCIATION. An ordinary meeting of the above Association was held at Masulipatam in the D.M.O's Office, premises on Sunday the 24th Jan. 1937 at 4-30 p. m. when Lt. Col. K.V. Rama Rao, I.M.S., District Medical Officer presided. Mr. N. Rama Rao, L.M.P., Secretary, after reading of the minutes of the previous meeting which were duly adopted. Put forth the following resolutions which were unanimously passed by the members.

This Association requests the Government to continue the usual subsidies for the Rural Medical Practitioners when they are sent for refresher courses.

This Association thankfully receives the proposal of Dr. V. Rama Kamath of Madras in suggesting. Dr. Vittal Pai of Pallavaram to succeed late Dr. S. Rama Subbu to officiate as Honorary Secretary of the Madras Provincial Rural Medical Practitioners' Association and request them both to arrange to call for a provincial meeting as early as possible to formally elect Dr. Pai as Secretary. Then there was a discussion between the members and the President about the disabilities of Rural Practitioners and the meeting came to a close by 5 p. m. after which the Kistna District Medical Association had their proceedings in the same place.

MADURA MEDICAL ASSOCIATION. The Ninth Annual meeting of the Madura Medical Council was held on 9th January under the presidency of Lt. Col. P. Verdon, I.M.S., District Medical Officer, when the following office bearers for the current year were elected. Lt. Col. P. Verdon, President, Dr. E. W. Wilder, Vice-President, Dr. T. S. Ranga Ayyangar, Treasurer, Dr. M. V. Natesan, Secretary, and Messrs. M. N. Rajan, A. Narayana Menon, T. S. Venkataraman, R. Devadoss and Dr. (Miss) Roberts, Executive Committee Members.

Addresses were delivered by leading members of the profession on important medical subject and the members were entertained at a pleasant social. An Exhibition of Medical products was held by the Bengal Chemical and Pharmaceutical Works the Calcutta Research Association and the Upjon Company.

THE MEDICAL PRACTITIONERS' ASSOCIATION, NUZVID. A monthly meeting of the above association was held at Nuzvid in the local Government Hospital on Sunday 29-11-36 with Dr. P. Anjaiah Naidu, L.M.P. in the chair. After light refreshments offered by Dr. T. Satyanarayana, L.I.M. who was at home to the members, the meeting commenced at 3 p. m. when Dr. N. Rama Rao, L.M.P. Secretary read the minutes of the previous meeting which were duly adopted. The members then began to discuss on several professional topics. Mr. P. Anjaiah Naidu mentioned about a new born child of only 2 days old that was born with moderately well developed upper and lower incisor teeth and as such caused much inconvenience to the mother while suckling and so he said he had to extract the teeth.

MADRAS MEDICAL COUNCIL WARNING NOTICE

We have been asked by the registrar, Madras Medical Council, to publish this notice in his letter dated 16-1-37.

The attention of medical practitioners registered under the Madras Medical Registration Act (IV of 1914) is hereby invited to the Warning Notice and the Code of Medical Ethics published by the Madras Medical Council. They are informed that ignorance of Medical Ethics will not be taken as an excuse in future for any infringement of the provisions of the same.

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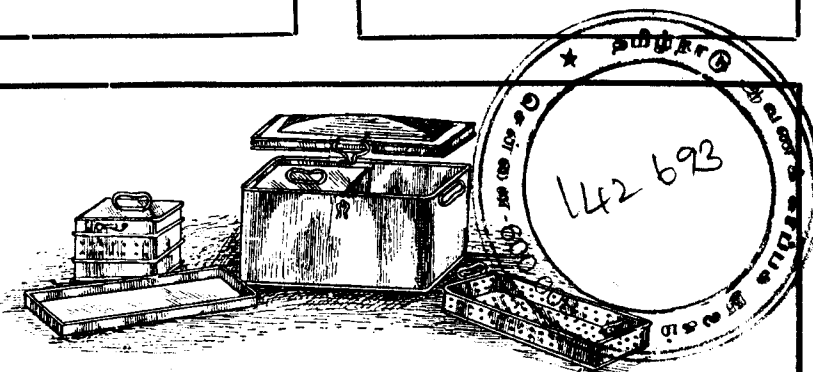
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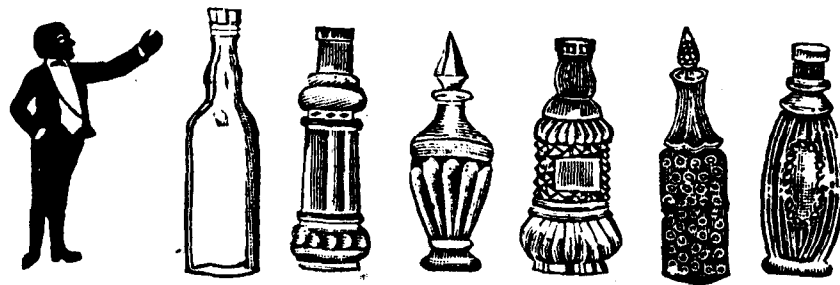
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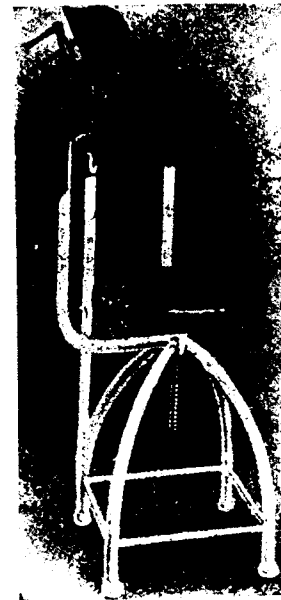
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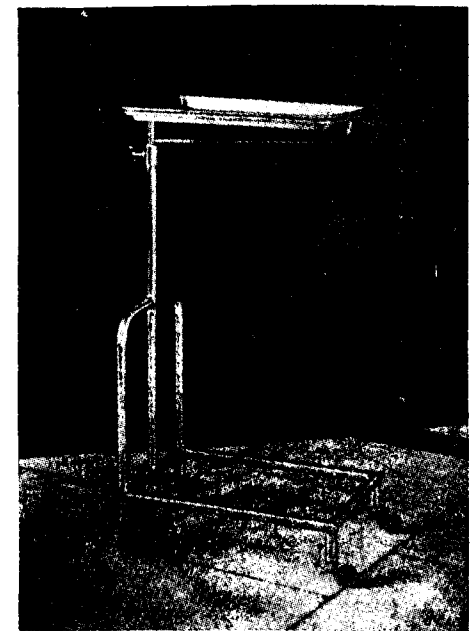
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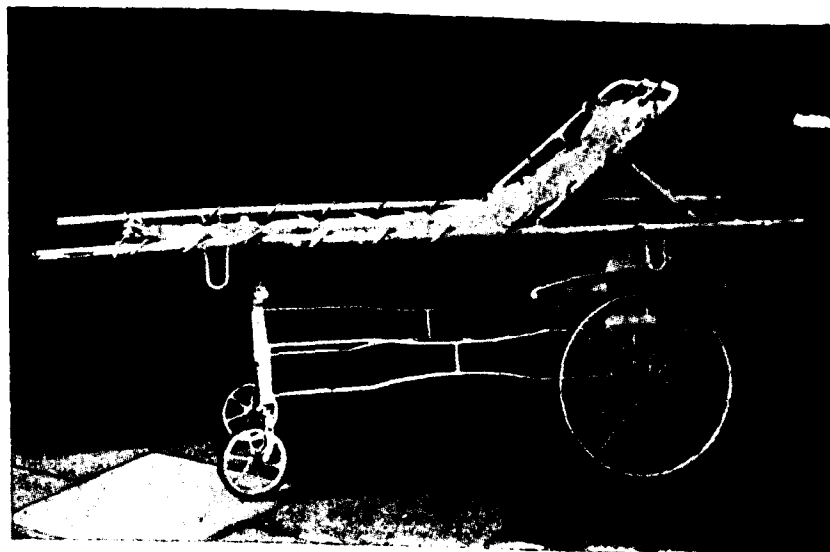


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