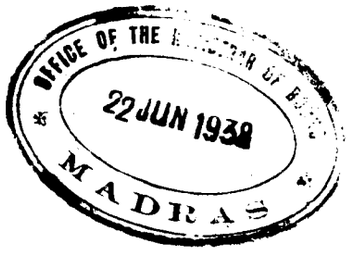
REGD. No. M. 3809

JOURNAL OF SOUTH INDIAN MEDICINE



APRIL & MAY, 1938

ISSUED BY THE SOUTH INDIAN MEDICAL UNION, MADRAS

VOLUME V

NUMBERS 1 & 2

JOURNAL OF SOUTH INDIAN MEDICINE

(*Incorporating the Bulletin of the South Indian Medical Union*).

VOL. V APRIL & MAY 1938 Nos. 1 & 2

ABDOMINAL PAIN.

BY

DR. T. SATAKOPAN, M.D.,

Physician, Government General Hospital, Madras.

Pain in the abdomen is one of the most frequent causes of patients seeking the help of the physician. In many cases it is easy to find out the cause of this complaint. But it is often difficult and in some cases it is almost impossible to be sure of the cause. For purposes of diagnosis, the abdomen is mapped out into irregular squares and it is generally believed that pain varies in etiology according as it is situated in one or more of these areas. This method of settling the diagnosis is often very successful. We are familiar with the terms epigastric pain, the upper quadrant and lower quadrant syndromes. When the pain and tenderness is limited to the right hypochondrium one thinks of the liver as the offending organ. The stomach or the duodenum is thought of in epigastric pain and the appendix when the pain is chiefly in the right iliac fossa. As an elaboration one talks of left epigastric pain in pancreatitis, and pain in the left iliac fossa in chronic dysentery.

But in the great majority of cases pain is not so clearly localised, nor is it definite. In such cases it would be helpful before attempting to localize the seat of pain to review briefly the neural anatomy of the abdomen. When patients complain of pain in the abdomen the physician desires to know which organ is the defaulter. It is well known that the viscera are not sensitive to stimuli. This has been proved conclusively in experiments and during operations under local anaesthesia. The exceptions to this are the *posterior parts of the mesentery of the small intestine or of the transverse or pelvic mesocolon.* These contain somatic nerves which are sensitive to stimuli.

But even in viscera certain stimuli do produce a sensation of pain. This is particularly noted in hollow organs during excessive or irregular peristalsis especially against obstruction. This pain is very distinctive.

Visceral Pain —The pain is deeply situated in the abdomen, it is not very much referred to the more superficial nerves of the abdominal wall, and it is only vaguely and imperfectly localized. Pain arising in the stomach is felt as localized in the epigastrium. When the small intestines are involved in any part of their length, the pain is felt in the umbilical region and in the hypogastrium when the trouble is in the colon. Visceral pain, whatever the organ, and wherever it is felt, is generally intermittent or spasmodic.

Unlike the visceral peritoneum, the parietal peritoneum, especially that lining the anterior abdominal wall and under surface of the diaphragm is richly supplied with somatic nerves. The parietal peritoneum is comparable to the cornea or conjunctiva. Light touch or contact of chemicals like gastric juice, blood clots or bacterial toxins is exquisitely painful.

Stimulation of the nerves of the perietal peritoneum is not felt in the peritoneum itself, but is projected to the more superficial nerves which are connected with the same spinal segments as those receiving the painful stimulus. The physiology of this remarkable phenomenon is still obscure. The best illustration of this phenomenon is the shoulder-tip pain in affections of the diaphragm—the phrenic nerve and supra acromial nerve arise from the same segment (3", 4" and 5" cervical). The diaphragm is a cervical structure in the fœtus. With the growth of the lungs and plural cavities, the diaphragm descends to its adult position. Thus an embryological accident gives an area of perietal peritoneum lining the diaphragm which is widely separated from its skin segment or dermatome, and yet retains its primitive nerve connections with the skin. Not only is all the pain of diaphragm stimulation felt in the supra-acromial area, but objective changes take palce in the skin, viz., tenderness or deep pressure and often hyperæsthesia on lightly pinching the skin. Inflammation of the gall-bladder, or appendix, and the contact of acid gastric juice in a case of perforated duodenal ulcer with the parietal peritoneum produce similar pain in the skin corresponding to these areas. Infiltration of these overlying areas of skin with novacain either abolishes or modifies such pain.

Acute appendicitis is characterised by two kinds of pain. The initial or visceral pain is a dull, heavy pain felt vaguely in the interior of the abdomen There is no tenderness or rigidity of the abdominal wall. This initial pain is due to the obstruction of the base of the inflamed appendix.

In cases where this obstruction is not present, *i.e.*, in acute non-obstructive appendicitis, this initial "central" pain is absent.

In obstructive appendicitis, when the obstruction is complete there is distension, but when it is incomplete, forcible peristalsis. The nature of the pain also varies according to the nature of the stimulus. The pain is colicky or griping when there is peristalsis and a gnawing ache in distension. This central pain is vaguely localized if it is not more or less generalized. This pain generally lasts a short period of two to four hours. In some cases the pain may last nearly two days. But while this pain lasts, no pain is felt on the surface, nor is there any local tenderness or rigidity. The second is the peritoneo-cutaneous pain due to stimulation of the parietal peritoneum nearest to the inflamed appendix by contact with the organ or the bacterial toxins. It is not viscero-cutaneous, nor muscular, because the site of the pain varies according to the site of the appendix. In some cases only one of these two types of pain recurs at every attack.

But the symptoms and signs of appendicitis are modified by the position of the appendix, particularly the retrocaecal and the pelvic positions. In the retrocaecal position pain is felt well above and to the inner side of Mc Burney's point, more or less directly to the right of the umbilicus about $1\frac{1}{2}$" from it (caecal point). It is a dragging pain sometimes relieved by lying down. Food may provoke or increase the pain. Caecal stasis also tends to worsen the pain. Diarrhoea is not common. Since the retrocaecal appendix is in relation to the posterior parietal peritoneum, pain may begin in the back in the right loin, and later as the caecum gets involved in the inflammation, may spread round to the front, and may be even referred down the leg. On account of its relation to the ureter and renal pelvis, there may be frequency of micturition and even haematuria. It is useful to remember that on account of its posterior position, retrocaecal appendicitis is likely to be associated with signs in the loin, viz., tenderness, and increased resistance on palpation in the loin.

In the pelvic position, the appendix may extend over the brim into the true pelvis. The symptoms of disease will depend on the relation of the appendix to structures of the pelvic brim, as well as to the pelvic peritoneum and pelvic organs. The right leg may be flexed and the pain may be down the inner side of the thigh. By its relationship to the bladder and right ureter, the symptoms may be mistaken for cystitis. Physical signs may be absent. But pelvic examination is very essential and severe tenderness may be elicited by such examination, more towards the right side. A pelvic

appendix is more in the mid-line and peritonitis may involve the whole of the lower abdominal wall. Tenderness is therefore in the hypogastrium, often more marked on the right side.

Right ovarian or tubal inflammation may be misdiagnosed as appendicitis when the symptoms are limited to the right side only. Stone in the right ureter may also simulate appendicitis. An X-Ray picture should, always be taken. Symptoms of strangury may help in the diagnosis.

The Gall-Bladder and Bile-Ducts:— Biliary colic has a dual mechanism similar to acute appendicitis. But it is generally not so clearly manifested. There is the initial visceral central epigastric pain due to powerful contraction of the bile duct in an effort to push the stone into the duodenum. Then there is the right scapular pain due to stimulation of the somatic nerves in the posterior parietal peritoneum. Shoulder-tip pain is only met with in a few cases, since it is only in a small percentage of people (about 5% that the bile duct gets a supply from a branch of the right phrenic nerve. In the course of two or three hours a new pain in the right hypochondrium immediately overlying the fundus of the gall bladder is felt. This is due to some congestion and inflammation of the gall-bladder sufficient to irritate the overlying peritoneum.

In acute obstructive cholecystitis, pain lasts for days. Severe tenderness or rigidity of the abdominal wall over the gall bladder and absence of jaundice—differentiate this condition from an attack of biliary colic. The maximum tenderness is over the fundus of the gall bladder. And as this enlarges and descends, the site of pain, tenderness and rigidity also shifts until it might be easily mistaken for an attack of an acute appendicitis. The peritoreo-inteneous nature of the phenomenon is shown by the rigidity, and tenderness getting better as the inflammation subsides.

PITFALLS OF OPHTHALMOLOGY

By

E. V. SRINIVASAN, M.B., C.M.,

Honorary Ophthalmic Surgeon, Govt. Royapettah Hospital, Madras.

Case I. Dimness of vision.—Recently a young Mohammedan girl aged about 15 or 16 years came to me complaining that she could not see with one eye for about a fortnight. It was found on examination that her vision was restricted to finger counting at 1 foot and not completely blind. I was nearly making up my mind that she was hysterical. The unilateral affection of the eye and the absence of any sensory disturbance on that side made me examine her ocular condition in greater detail. Retinoscopy showed she had a unilateral compound myopic astigmatism of six dioptres in one meridian and ten in the other. The glass correction improved her sight a greal deal enabling her to count fingers at 25 feet and not more—evidently a case of amblyopia in one eye with no change in the fundus. It would easily have become a matter of ridicule if after a wrong diagnosis of hysteria by me she had improved her eye sight with an indifferent correction of refraction by a common optician. On the contrary a functional disorder wrongly diagnosed as an organic disease and treated ineffectually is equally a serious pitfall in ophthalmic practice.

Case II. Hysterical blindness.—A boy aged 18 years said to be blind for six months was brought to me having been previously treated in vain with iodides, setons, blisters and Salvarsan injections etc. The pointed gaze of the patient at fingers shown from a long distance though refusing to count them made me certain that it was a case of unconscious imagination. Finding no change in the fundus and pupillary reactions, I stamped hard on his feet which were probably low in sensibility. The palpebral fissures widened, the mouth gaped, and he started counting fingers straightaway and with stronger and stronger pressure of my foot the enfeebled sight was quickly restored in steady steps from 6/60 - 6/6 !

Case III. Malingering.—It is hard to say the difference between malingering and hysteria. A few days ago an unmarried girl aged 18 years came to me complaining of blindness in one eye as a result of the fall of a child on her face while playing with it. She was accompanied by very near and

sympathetic relatives who all joined with her in saying that she was blind in one eye. I soon found out by usual tests she was simulating blindness. On careful enquiry I found the need for the intentional deception was a proposed marriage which the patient did not like.

Oedema of the lid often causes more alarm to the patient than the lesions which lie behind it because he cannot open the swollen eye and hence cannot see with it. False diagnosis in œdema may cause the patient great anxiety for perhaps a very insignificant affection. A Desmarre's elevatoris all that is necessary to prevent a serious pitfall and to show a normal eye-ball freely moving and not proptosed beneath the lids. Inflammatory œdemas are caused by a hardeolum near the lid margin, acute dacrocystitis if the indurated and sensitive spot occupies the inner angle of the eye, commencing abscess of the lids, periostitis of the orbital margin, erysipelas, angioneurosis of the lids, eczema and trauma. Diphtheritic conjunctivitis, severe iridocyclitis, or panophthalmitis may be revealed on opening the œdematous or closed lids Non-inflammatory œdemas are caused by heart disease, hydraemia and nephritis etc , requiring a general examination.

A variety of œdema which can be called neither inflammatory nor non-inflammatory is the one associated with blepharospasm that has lasted a long time in cases of phlyctenular conjunctivitis in children. The œdema is confined mostly to the upper eyelid and is due to the compression of the palpebral veins by the contracting musculus orbicularis.

In the above mentioned conditions the vision is not impaired and the eyeball is normal.

Diphtheritic conjunctivitis, severe iridocyclitis, panophthalmitis may be revealed on opening the œdematous or closed lids—instances where an early diagnosis of the real state of affairs would help to avert serious consequences say for instance in cases of Keratomalacia.

Keratomalacia.—Is a condition where an early diagnosis of the real state of affairs would help to avert a serious irreparable damage to the eyes. People bringing these children are not alive to the seriousness of the general condition which they have neglected for days together. It is usual for these children to be brought for the treatment of a small pit in the cornea, while you perceive on close examination a xerosed conjunctiva, and perhaps a hypopion appearing as a small horizontal streak at the bottom of the anterior chamber showing the necrosis is independent of any superficial microbic invasion. A general examination which should never be omitted in such cases

reveals a marasmic child with swollen, shining tough abdomen with distended veins, the chest and limbs quite ricketty, face often monkey-like, the skin thrown into folds, a child aged two or three years looking like a baby of few months old. The liver may be enlarged, jaundice with diarrhoea and offensive micturition may be present ; the child is practically in a moribund state. The same evening, or the day following or within a few days the whole cornea is necrosed and a keratocele forms. Soon the keratocele bursts exposing the iris, the eye is lost and ultimately shrinks.

An early diagnosis of this dire malady is easily made in all cases that come with a complaint of night blindness. In the early stages the conjunctiva has a characteristic lack-lustre appearance with a transparent white foamy patch on either side of the cornea. The fatty character of the epithelial surface gives the dry appearance to the conjunctiva and cornea though the eye wells with tears and may be closed. Bandaging of such eyes does not prevent the dryness as in the case of Neuroparalytic Keratitis or Keratitis with lag ophthalmos.

Treatment.—As soon as you see the early dryness of the eye put the child on raw unadulterated milk from cows fed preferably on green fodder undeterred by the bowel symptoms that may be present, and by the statement of parents that the child does not tolerate milk and by not venturing to use boiled milk considering the urgency of energetic and effective treatment during the first few days of the illness. A liberal amount of fruit juice, thyroid extract, administration of sufficient amount of salts like chlorides of sodium, calcium and ammonium, attention to personal hygiene, warmth and protection as essential for the local treatment of eyes go a good way in alleviating the keratomalacic babies. The improvement in good many cases after this regime of treatment gives the lie to the grave pessimistic prognosis given in text books on this disease. This has to be strongly deprecated considering the good that can be done to most of these cases by giving them at least moving sight in their later life provided the condition is diagnosed early and active measures instituted from the very beginning.

Trachoma.—Another common pitfall is the diagnosis of Trachoma which is becoming more and more difficult nowadays, even for the experienced trachomatologist. In this connection it is worth recapitulating the disposition of the vascular system at the limbus. The vessels at the margin of cornea or limbus are divided into three distinct zones. The most peripheral zone called the palisade zone is 1 mm. in width and consists of elongated vessels. Next, the zone of vascular loops about 0·3 mm. in width is a mesh

work of anastomosis. Finally, nearest the clear cornea with a distinct clear-cut margin is the very narrow zone of end capillary loops, from which the cornea is nourished by exudation of lymph.

The vascularisation of this clear corneal tissue as seen by a slit lamp is characteristic of trachoma even at its very inception. Anastomosing loops are found in clear cornea in many conditions, but the presence of non-anastomosing vessels alone differentiates trachomatous pannus from a severe case of advanced limbus.

There are besides, grey elevations or infiltrations characteristic of trachomatous pannus. Thus the so called pannus that is seen with the naked eye in some cases of granular ophthalmia as a complication is present in every case of trachoma from the very beginning if seen with a corneal microscope.

The vessels in interstitial keratitis cannot be traced from cornea to conjunctiva. They always stop short at the corneal margin. Again the presence of follicles of a non-specific nature are so common in the lower fornix that only a careful biomicroscopic examination of the follicles with the detection of pannus at the limbus can justify a diagnosis of trachoma.

Superficial Punctate Keratitis.—This is commonly mistaken for Trachoma and here again the slit lamp comes to our aid. The detection of curdlike deposits and absence of pannus in the cornea settles the diagnosis in favour of S. P. K.. This is necessary as treatment on mistaken lines ofte- leads to disastrous result.

Spring Catarrh.—This disease is getting more common nowadays, and should be easily diagnosed from the history of allergic tendencies in the patient, the typical naked eye appearances of the follicles, the presence of conjunctival cosinophilia and the absence of pannus. In my experience in almost every case of spring catarrh the cornea is studded with dots as in S. P. K.. Not infrequently trachoma and spring catarrh co-exist in the same case.

Case IV. Heart Disease and papillary hypertrophy.—Years ago I was treating the lids of a Mohammedan boy for Trachoma. The papillary hypertrophy continued unabated in spite of the various methods of treatment usually adopted for trachoma. To-day I would not be harassing the patient as a case of granular ophthalmia as the slit lamp would have revealed the absence of pannus. The peculiar lividity of conjunctiva like a cyanosed skin, drew my attention to the heart rather late. The boy had congenital heart

disease. In this case the passive congestion due to the presence of a patent foramen ovale was the cause of trachomatous-like papillary hypertrophy.

Parinand's conjunctivitis.—May be mistaken for trachoma with acute onset. The monocular nature, presence of pyrexia and enlargement of preauricular and submaxillary glands, freedom from corneal complications and absence of sequlae after lasting for a few weeks to few months characterise the disease.

Another follicular Catarrh that may be said to be a total property of the ophthalmologists is the toxic type caused by atropine, eserine, scopalamin having nothing to do with the purity of the drug, sterility of the solution nor the *pH* of the solvent and only to be accounted for by the idiosyncrasy of the patient. Irritation of the eye is heightened by Agno$_3$

Recurrent Pterygium.—Never remove a recurrent pterygium *ie.*, the one recurring after excision or transplantation.

In one of my cases of recurrent Pterygium, when I removed the apex of the Pterygium and the adjacent portion which had to be snipped with scissors the sclerotic showed a black slit with escape of vitreous evidently through the epithelial invagination which has taken place after the first operation.

The solution of continuity of the corneal epithelium which takes place after removing the apex of the pterygium from the cornea, probably gives rise to an in-dipping of the surface eqithelium which grows back through the sclerotic and subsequently lines the vitreous chamber. This is my own explanation analogous to anterior chamber cyst formation after cataract operation causing incurable glaucoma.

Acute Dacryocystitis.—Opening of the abscess cavity behind instead of in front is a rare complication causing orbital cellulitis and secondary optic atrophy. Orbital cellulitis from other causes like infection of the posterior ethmoidal cells as occurring in children never mars the integrity of the optic nerve, at any rate in my experience. I have seen two instances where optic atrophy supervened an attack of acute Dacryocystitis bursting behind into the orbital cavity. Both of these were in obese woman about 35 years old. It was only after the cure of the orbitual cellulitis that the orginal chronic dacryo-cystitis became evident. In one case the eye was already blind when I saw the patient with well established orbital cellulitis. In the other I opened the acute dacryocystitis, not with much success, and the cellulitis travelled

behind causing proptosis and immobility of the eye. In this case multiple incisions were made and the cavity was emptied by driving in a sinus forceps to the apex of the orbit. This procedure though it cured the cellulitis following the perforation of the posterior wall of the sac was of no avail to avert the gradual onset of atrophy of the optic nerve which was complete by the time the phlegmon was cured.

I was helpless and it was heart-rending to see the pupil getting slowly dilated and inactive while the optic nerve was losing its pink colour giving place to china-like whiteness during the course of the treatment. I have included these two cases under the heading of my subject to-day just to show how impossible it is to avert the serious calamity to the optic nerve in these rare cases where the sac bursts posteriorly or the phlegmon travels behind according to the chronicity or the acuteness of the infection, though the history of one-sided epiphora and chronic discharge from the angle of the eye in these cases makes us feel certain about the aetiology of the condition.

Hypopion ulcers.—In this affection the patients usually give a history of a thorn prick, an injury with a leaf or the angle of a cloth, an insect bite or a scratch with finger nails. Dacryocystitis is very often the underlying cause and one must not be misguided by the history which in some cases is only the immediate cause and by omitting to remove the sac immediately.

Operation of or the Removal of Lachrymal Sac.—For detection of the sac the white shining apponeurosis anterior to the sac forms a good land mark, and this must always be looked for as otherwise a wrong incision and careless procedure would lead to the removal of orbital fat as the lachrymal sac.

Headache.—There is no symptom like headache which the physician is called upon to treat that may not be due to or influenced by symptoms of eye strain. Eye stress very often affects the vegetative nervous system in susceptible individuals. Hence when the autonomous nervous system is interfered with, the basic functions of circulation and cellular innervation are disturbed and a regular 'Pandora's box' of troubles may be opened.

Disturbances of vegetative nervous system are caused by many other factors affecting adversely the various parts of the body. Hence most of the symptoms ascribed to the eye strain are seen in the domain of every branch of medical specialists, thus for instance, the symptom of headache, dimness of vision, pain in the neck and shoulder often running down to finger tips with numbness, tingling nnd parasthesia are manifestations of eye strain. But this

can be claimed by sinuologists as Sluder's Syndrome, by urologists as due to kinks in the ureter, by internists as indications of focal infection, by cardiologists as effort Syndrome and probably by podologists as a sign of fallen arches. And as such headache is a symptom round which all medical men, general practitioners and specialists should rally, co-operate and relieve the patient of his suffering.

Headache may be classified as

(*i*) originating from the eye.

(*ii*) not originating from the eyes.

Even the most experienced medical men may sometimes make the mistake of treating headache as a symptom of minor significance when it really may be the first and the earliest symptom of some grave impending organic disease. About 10 per cent of all cases of headache are of ocular origin. The results of eye strain are obvious in many cases, but I am convinced that we will often be in error in concentrating all the attention on the eyes and the error of refraction, without paying due attention to the patient's general health. Big errors go without symptoms of eye strain while small errors cause great systemic disturbance. It so happens while correcting big errors of refraction, a residual astigmatism may be left uncorrected with the result that the patient is made alive to the headache and annoyance of eyestrain for the first time because his large error has been almost but not quite corrected leaving him with a small error.

The contrary that all small errors must be corrected is certainly wrong unless there is an incriminating symptom associated with a small error. No eye is perfect and I learnt recently that a—0.25 cyl. horizontal or + 0.25 cyl. vertical is necessary for many eyes though the ametropia is very often symptomless.

In bifocal glasses want of correspondence of optic centre of glass and optic axis of the eye is a common cause of headache even after a meticulously done correction by an ophthalmic surgeon.

A loose circular frame gives rise to the change of axis of the glass while cleaning and consequently the glass loses its effect if it is a simple or compound cylinder by a change of its axis and thus causes headache. This difficulty may be obviated by fitting the glass in an oval frame or prescribing a rimless glass.

Muscle imbalance.—This is another cause of headache. Very rarely any investigation is made to find out latent fault in muscle balance, latent,

in the same way as latent hypermetropia. Such latent errors cannot be easily detected as there is no myoplegic analagous to cyclopegic available to throw the extrinsic muscles out of gear and relax them. Resort must therefore be had to prolonged occlusion tests, *i.e.*, to occlude one eye making binocular vision impossible for a sufficiently long time so as to abolish all spasm of the extrinsic muscle of the eye. By these tests any deviating tendency of the eye is made evident. If it be admitted that a latent deviation involves an enormous expenditure of energy and therefore brings on a condition of muscle exhaustion or fatigue then it is easy to understand how an eye with muscle imbalance can produce a headache. Absence of such a condition must be shown conclusively by adequately carried out occlusion tests or other means before acquitting the eye as the cause of headache.

Cases with muscle imbalance go on without any relief whatsoever after several examinations and prescriptions from several eye surgeons and even after wearing accurately corrected lenses. The symptoms of imbalance are photophobia worse after reading, while reading brings about soreness of the lids and if persisted in acute pain. If reading is still further persisted in, pain in the eye-ball, blurring of vision and acute occipital headache ensue.

Treatment.—After a week's occlusion latent deviation may become manifest as exophoria, esophoria or hyperphoria of different degrees, which may be corrected by prescribing accurately calculated accepted prisms. The patient is finally relieved and finds to his disgust how useless were his different pilgrimages to various specialists.

Glaucoma.—Though the headache in this affection is associated with inflammation, weeping, photophobia, pain and tenderness, these signs may actually be absent at the moment of examination of a glaucomatous eye—a bigger pitfall in diagnosis there is yet to be for a general practitioner, or for that matter a specialist.

In prodromal Glaucoma pain is in the afternoon or evening with sleep. Patient never wakes up with headache. Excitement such as the death of a dear relation, business crises bring on the increased tension. The signs of glaucoma need not be enumerated here, but the mistakes which many practitioners of medicine commit is the wrong diagnosis of cataract for Glaucoma and asking the patient to wait till his vision reduces completely believing the condition to be an immature cataract that should take time to mature. Such a mistaken diagnosis and advice inevitably results in incurable blindness while an early and a correct diagnosis hold every prospect of retaining useful if not good vision.

Every physician has an opthalmoscope in his armamentarium, and when he can with ease diagnose the finer changes in the retina in certain constitutional conditions like hyperpiesia, or renal retinitis, would it be too much of an appeal to request him to examine the anterior segment of the eye to detect the presence of any lenticular change which is the easiest to accomplish and at least to refer patients to those working in this speciality when they find no lenticular change with the headache and failing sight ?

Though it may be difficult to diagnose glaucoma yet it is easy to see if the lens is clear and easier still to advise what to do, thereby lending the ophthalmologist a helping hand in reducing ocular mortality.

Headaches not orginating from the eyes :

Migraine, frontal sinusitis, supra-orbital neuralgia though causing headache have distinguishing characters. Very often a patient with chronic nephritis goes first to the ophthalmologist for his headache the severity of which depends upon the intensity of uraemic intoxication. In good many of these cases the sight may be normal although the changes in the retina and optic nerve are sometimes so characteristic as to draw one's attention to examine the urine to find it loaded with albumin.

Pregnancy.—Headache during pregnancy may mean rise of blood pressure. And with vomiting and nausea if retinal haemorrhage takes place threatening to damage the sight, the question of induction of abortion must be seriously considered.

Pituitary headache.—This form of headache with more frequent eye symptoms occasionally come for treament, Pituitary headache occurs usually in adoloscent women and is charactered by,

(*i*) Its location—Frontal and deep behind the eyes.

(*ii*) Its characteristic radiation.

(*iii*) Duration of persistence.

In the female it comes on with the periods which is usually profuse soon followed by nausea and vomiting. Marked fatigue characterise the pain in the head. Patient develops periodic craving for sweets, indulgence in which increases the headache, polyuria and signs of dyspituitrism.

Contraction of temporal fields, primary optic atrophy, enlarged sella-turcica, failure to respond to treatment, all mean a progressive neoplastic growth. ½ to 2 grains of whole pituitary gland may be of use.

Cinema strain.—Seen more among the poorer classes induced by prolonged observation of pictures and other objects at a level much above the observer who often sits in the front pit near the screen. Hence, the proximity of the seats to the screen and the height of the screen are matters of importance. Angle of elevation should not exceed 35°. There is no use of prescribing low correction in these cases without going into the history of the cause of headache.

Disappointments after operation.—In a woman aged 30 years after an attack of small pox, I had to do an iridectomy for optical purposes in both eyes. Preliminary examination showed a good prognosis for giving useful sight and no contraindication was apparent. An iridectomy was done, the coloboma was fine and black, but the optical result after the operation was nil. I was disappointed. But on careful examination of the coloboma with a powerful illumination, I found out that the retinal pigment layer of the iris was adherent to the anterior capsule of the lens, and it was impossible for the light to pass through. In this case there was nothing left but to extract the lens though the lens was perfectly transparent. Both the lenses were extracted, with good optical result more than compensating the first disappointment.

Accidents after operation.—Expulsive haemorrhage. This is very often due to the degeneration of the vessels of the eye. In the absence of a hard eye, increased ocular tension or other general disturbances of metabolism like, diabetes, albuminuria—the mere opening of the anterior chamber with consequent sudden reduction of intra-ocular tension is enough to cause an expulsive haemorrhage.

Such accidents are more prone to occur in big fatty women, and I invariably put such patients on anti-haemorrhagic remedies before I do an extraction of the lens for cataracts. It was mentioned by some experienced ophthalmologist in of one of the sessions of the All India Ophthalmological Society that if one eye is lost by expulsive haemorrhage one is quite justified in doing a Mohammedan operation in the other eye.

Enucleation of the Eye-ball.—Enucleation of the sound eye by mistake is the worst pitfall that an ophthalmic surgeon will ever meet with. This happens only in hospital practice.

Rare complication during enucleation.—Enucleation is capable of causing sudden collapse of the patient, just as you cut the optic nerve, general anaesthesia having no influence on the oculo-cardiac reflex. This happened to one of my cases years ago during the pre-local anaesthesia days.

NOTICE.

ASSOCIATION OF SURGEONS IN INDIA.

Organizing Secretaries :

K. G. PANDALAI, M.B., C.M., F.R.C.S., Lt.-Col., I.M.S.

C. P. VISWANATHA MENON, M.S., F.R.C.S.

"BINFIELD"
KILPAUK, MADRAS.

15—3—'38.

Dear Sir,

In continuation of our letter to you, dated 6-1-'38, we have to report that a very large number of Surgeons in India whom we had addressed on the above subject, have sent encouraging replies and have promised to support us whole-heartedly. It was hoped that the inaugural meeting could be held in Bombay in the middle of April 1938; but, it is now found that adequate arrangements for the holding of the meeting could not be completed before that date. The Surgeons of Bombay city have, therefore, proposed that a more convenient time would be in October 1938 and have suggested 22nd, 23rd and 24th October 1938, as suitable dates for the meeting. The suggestion may be approved, especially as one of the Organizing Secretaries (K. G. P.) is obliged to leave India immediately for reasons of health. He returns before September next and in his absence the work will be carried on by the other Secretary Dr. C. P. Viswanatha Menon.

The Secretary of the British Association of Surgeons (Mr. Mitchiner, F.R.C.S.), whom we addressed on the matter, has kindly sent us a copy of their rules and has promised to send us shortly a message of goodwill from his Association.

The Surgeons of Bombay have met and formed a Reception Committee for making local arrangements.

Dr. M. D. D. Gilder, M. D., (Lond., F. R. C. S., (Eng.), Minister for Public Health, Bombay, will preside and deliver the Inaugural Address.

At the forthcoming meeting, discussion on the following subjects will be initiated by Bombay Surgeons :—

(1) Ileo-Caecal Tuberculosis.

(2) Carcinoma of the Tongue

We hope sincerely that Surgeons from other parts of India would also contribute papers of interest and make the Session a success.

We hope that the change would not cause you inconvenience and that you will take advantage of the interval for preparing papers for discussion.

It is the general feeling that the Association should have its own Journal at an early date. If this ambition of ours is to materialise, we should have at our disposal, most of the Surgical literary effort now scattered in sundry medical papers, published in different parts of India. We hope,

therefore, that all those who now practise Surgery in the country, would join this Association and send to the Secretaries whatever material they may have, for publication in the archives of the Association of Surgeons.

A further communication will be sent to you when the programme of the meeting and other details are ready.

STRAITS SETTLEMENTS GOLD MEDAL.

The Edinburgh University have awarded the Straits Settlements Gold Medal to Dr. T. Bhaskara Menon M.D., D.Sc., M. R. C. P. for the excellence of his thesis on "Pathological Studies on Splenomegaly", Dr. Bhaskara Menon who is Lecturer in Pathology & Bacteriology, Stanley Medical School, Madras, is the author of a book on "Tropical Pathology" a monograph on Filariasis, besides several papers on tropical medicine. He was recently awarded the D. Sc. degree in Pathology by the Edinburgh University.

CORRESPONDENCE.

Sir,

As a member of the Union, may I be allowed to point out to you the gross injustice done to the Independent Medical Practitioners of the Presidency by the recently introduced Madras Traffic Control Act of 1938. In Fort St. George Gazette Extraordinary dated 29th March 1938, on Page 13 under Section 95, it is stated as follows :—

"A medical certificate in Form D-1 shall not be accepted unless it is that of the Police Surgeon in the City of Madras or of a Government Medical Officer not below the rank of Assistant Surgeon in the Mofussil."

It is the policy of the present Government to give as much scope as possible to the Private Practitioners, and as such, is it not extremely unfair on the part of the Government to make a distinction between the Government Medical Officers and independent Medical Practitioners of the State. If the independent medical practitioners are prohibited by Law to issue ordinary certificates of Physical Fitness, the status, the prestige, and the honour we now command among the Public will be hampered a good deal. Hence, I request you to move the matter before a General Body Meeting of the Association, and then to appeal to the Authorities to alter that Act in such a way that all the Registered Medical Practitioners can issue such certificates to the applicants. Requesting you to do the needful in the matter,

I remain,
Yours Faithfully,
K. C. KOSHY, M.B. & B.S.

JOURNAL OF SOUTH INDIAN MEDICINE.
APRIL & MAY, 1938.

CO-ORDINATION OF THE MEDICAL SERVICES.

The desirability of amalgamating the Medical and the Public Health Departments is frequently discussed in the medical and the lay press. The subject requires careful examination in all its bearings.

Prior to the year 1923 or thereabouts, excepting in the city of Madras and a very few of the large municipalities, there were no Medical Officers of Health as such in most Urban areas. In the rural areas there were officers styled Deputy Inspectors of vaccination. The duties of these officials consisted even as their designation denoted, mainly of supervision of vaccination work. These officers were subject to the partial control of District Medical Officers or District Medical and Sanitary Officers as they were styled at the time. They were more especially under the control of the Sanitary Commissioner and his deputies.

There were Sanitary Inspectors in some of the Urban areas and a very few local boards also employed qualified Sanitary Inspectors. But the duties of these Sanitary Inspectors consisted of anything ranging from collection of the local rates to the siezure of bicycles for non-payment of taxes. Except perhaps during epidemics little public health work was attempted. They were not qualified doctors and were thus completely at the mercy of officers of the Medical Department who looked on them as agencies mostly responsible for the conservancy of the area and little else.

The Public Health Department as such owes its present form mainly to the genius of Col. A. J. H. Russell. A provincial cadre of Medical Officers of Health was created and every

district and practically every municipality of any size has now a medical officer with special training in Preventive Medicine and Public Health. The duties of these officers cover a very wide field and include the control of epidemics, the management of fairs and festivals, food inspection, the control of dangerous and offensive trades, vaccination, vital statistics etc.

We have found it necessary to mention at some length the evolution of the Public Health Department only to emphasize our view that it would be a retrograde step to revert to the old order of things. We envisage the time when there would be a Public Health Act and other aspects of preventive medicine like anti-tuberculosis work, will be tackled. A whole-time Medical Officer of Health would then be essential for the co-ordination of all the activities in a given area.

Besides, if we read the signs of the times correctly, with the association of more practitioners with State institutions for the treatment of disease, State-paid *medical* officers will largely come finally to be associated with the administration of jails, with the maintenance of the health of the fighting forces and perhaps with the administration of public infirmaries.

On the other hand we are not unaware, that, at the present time, in not a few instances there is a total absence of co-operation, if not an actual spirit of antagonism between the officers of the two departments. The causes for this are somewhat obscure but the need for a firm attempt to co-operate their efforts is imperative.

We would also sound the warning that there is a possibility of the enlarging activities of a Public Health Department encroaching on the particular field of the private medical practitioner. Such fears are already being voiced in the United States. The position would be even more full of the possibilities for disharmony nearer home, where the class-consciousness of the Government services, especially in the mofussil, is something to be seen to be believed.

ASSOCIATION NOTES.

SOUTH INDIAN MEDICAL UNION, MADRAS.

A meeting of the Council of the Union was held at 6 p.m. on Tuesday the 12th April 1938, at 32, Broadway, Madras.

Members present :

Dr. M. Subramania Iyer.
„ M. Sanjeeva Rao.
„ E. V. Srinivasan.
„ P. Govinda Rao.
„ T. Satakopan.
„ V. C. Sudarsanam.
„ M. Krishnamurthi.

Dr. M. Subramania Iyer was in the chair.

1. The minutes of the last meeting were read and comfirmed.

2. The financial statement for the month of March 1938 and for the year ending 1937—1938 were presented and approved.

3. The following practitioners were enrolled as members of the Union.

1. Dr. R. Kameswara Rao, M.B., B.S., Bobbili.

2. „ A. Chandramowli, L M. & S., B.S. Sc., L.O., Conjeevaram.

4. It was arranged that the accounts of the Union should be audited by a chartered accountant and circulated to the members with notice of meeting, which was decided to be held in May.

With a vote of thanks to the chair the meeting terminated.

Annual Report of the working of the Union with Financial Statement for the year ending 31st March 1938.

OFFICE-BEARERS.

President.

M. Subramania Iyer.

Vice-Presidents.

U. Rama Rao.
V. D. Nimbkar.

Members of the Council.

E. V. Srinivasan.
C. R. Krishnaswami.
B. M. Sundaravadanam.
M. R. Grandhi.
K. C. Paul.
G. Zachariah.
P. Rama Rau.
M. Krishnamurthi.
M. Sanjeeva Rao.
P. Govinda Rao.
J. M. Colaco.
S. Thambiah.

Secretaries.

T. Satakopan, (General).
V. C. Sudarsanam, (Scientific).

Editorial Board.

T. Satakopan, (Publicity Officer).
E. V. Srinivasan.
K. C. Paul.
P. S. Varadarajan.
K. Bhujanga Rao.
U. D. Gopal Rao.
C. R. Krishnaswami.
B. M. Sundaravadanam.
P. Rama Rao.
K. R. C. Hebbar.
M. Krishnamurthi, (Secretary).

Membership.

During the year under review 103 new members were enrolled (Local—47, and Mofussil—56). Four members resigned from the Union.

Finance.

The Financial Statement upto the end of March 1938 as certified by the auditor is herewith appended. A table of the annual revenue of the Union for the last quinquennium is also given below.

Periods.	*Subscriptions.*			*Publicity Sec.*		
	Rs.	A.	P.	Rs.	A.	P.
1933—34	705	0	0	532	13	6
1934—35	542	0	0	2,016	10	4
1935—36	440	0	0	1,512	6	8
1936—37	465	0	0	1,563	0	8
1937—38	1,213	0	0	1,574	7	8

Meetings of the Council.

The Council of the Union met on 11 occasions during the year. Of these 9 meetings were for transacting the routine business of the Union. Two special meetings were held on the 3rd and 12th January 1938 to consider the Scheme of Re-organization of the Medical Department and the Honorary System.

Ordinary General Meetings.

1. 19th August 1937.—Dr. E. S. Gopalan lead a discussion on (1) Organization of the Medical Profession and Medical relief in the Presidency and (2) The Honorary Medical Scheme.

2. 3rd and 23rd September 1937.—The Union considered the points raised in the paper of Dr. E. S. Gopalan, *viz.*, The Future of the Medical Profession in the Madras Presidency.

3. 15th November 1937.—The Union considered the report of the *ad hoc* Committee on the points raised in Dr. E. S. Gopalan's paper read before the meeting of the Union held on 19th August 1937 and the proposed amendments to the Madras Medical Council Act.

Clinical Meetings.

The following papers were read before the Union:

1. 8th April 1937—"Peripheral Nerve Affections complicating Diabetes Mellitus"—By Dr. K. C. Paul.

2 27th May 1937—"Pain in the Right Iliac Fossa"—By Dr. B. M. Sundaravadanam.

3. 5th July 1937—"The Mechanism of the Heart in Health & Disease"—By Dr. P. Rama Rau, (with exhibition of a film).

4. 3rd November 1937—"Some Pitfalls in Ophthalmology"—By Dr. E. V. Srinivasan.

5. 20th January 1938—"Diagnosis and Treatment of Hydrocele"—By Dr. E. S. Gopalan.

6. 24th February 1938—"The Effect of Natural Conditions on Cavities in Pulmonary Tuberculosis"—By Dr. U. D. Gopal Rao.

Social.

The Union was "At Home" to the Hon'ble Dr. U. Rama Rao and the Hon'ble Dr. T. S. S. Rajan, the Minister for Public Health, on the 5th August at the Madras Medical College Grounds. It was very well attended by the Medical Practitioners, officials and non-officials, of the city. A few members from the mofussil were also present.

The Journal of South Indian Medicine.

The Journal, the official organ of the Union is enjoying a wide circulation and its usefulness to the profession and to the public has been steadily increasing during the year. The thanks of the Union are due to the members of the Publicity Section for their efforts in running the Journal with credit.

The advertisement revenue of the Journal during the year under review was nearly the same as that of the previous year.

Acknowledgments.

Dr. E. V. Srinivasan has once more placed the Union under a great debt of obligation to him by permitting the use of his premises at 32, Broadway, for the activities of the Union.

The Union is indebted to Messrs. Brahmayya & Co., Accountants and Auditors, for kindly auditing the accounts of the Union for the period ending March 1938 free of all charges.

THE SOUTH INDIAN MEDICAL UNION, MADRAS.

Receipts and Payments Account for the year ending 31st March, 1938.

RECEIPTS.	Rs.	A.	P.	PAYMENTS.	Rs.	A.	P.
To Cash as on 1-4-1937 ...	72	8	0	By Publicity Section ...	2,806	10	0
,, Indian Bank C/A ...	313	11	4	,, Repayment of the loan to Secretary ...	60	0	0
,, ,, ,, S/B ...	783	6	11	,, Establishment ...	300	0	0
,, Publicity Section ...	1,574	7	8	,, Stationery and Sundries ...	33	15	3
,, Loan from the Secretary ...	85	0	0	,, Postage ...	16	0	6
,, Subscriptions ...	1,213	0	0	,, Cash on hand ...	25	4	0
,, Bank interest ...	25	2	6	,, ,, Indian Bank C/A ...	143	11	3
				,, ,, ,, S/B ...	681	11	5
Total ...	4,067	4	5	Total ...	4,067	4	5

Examined and found correct,

M. SUBRAMANIA IYER,
President.

BRAHMAYYA & CO.,
Incorporated Accountants and Registered Accountants, Auditors.
7, Kondi Chetty Street, Madras. 23—4—38.

T. SATAKOPAN,
V. C. SUDARSANAM,
Secretaries.

The Annual Meeting of the South Indian Medical Union was held at 6 p.m. on Monday the 16th May 1938 at 32, Broadway, Madras.

The following members were present:—

Dr. M. Subramania Iyer.
,, E. V. Srinivasan.
,, T. Satakopan.
,, V. Govindarajalu.
,, G. Sriramulu.
,, T. Venkateswara Rao.
,, J. A. S. Masilamani.
,, S. Deivasikamani.
,, B. M. Sundaravadanam.
,, P. T. Raghavachari.
,, N. Gangadharan.
,, S. Thambiah.
,, S. Subbunarayanan.
,, S. Rajagopal.
,, N. Natesan.
Dr. V. C. Sudarsanam.
,, P. S. Kuppuswami.
,, U. D. Gopal Rao.
,, P. Balakrishnan.
,, U. Venkata Rao.
,, C. S. Guruswami.
,, P. S. Varadachari.
,, M. Radhakrishnan.
,, P. Govinda Rao.
,, G. S. Katre.
,, P. S. Varadarajan.
,, K. G. M. Bhandary.
,, L. V. Srinivasan.
,, M. Krishnamurthi.

There was Tea before the meeting. Dr. M. Subramania Iyer was in the chair.

1. After a few introductory remarks by the President, the Secretary presented the Annual Report for the year ending 1937—38.

2. Dr. U. Venkata Rao proposed and Dr. U. D. Gopal Rao seconded that the report be adopted. The resolution was carried unanimously.

3. Dr. T. Satakopan proposed and Dr. E. V. Srinivasan seconded that Dr. M. Subramania Iyer be the President of the Union. The resolution was carried unanimously.

4. The names of Dr. B. M. Sundaravadanan, Dr. P. S. Varadarajan, Dr. P. Rama Rau, Dr. V. D. Nimbkar and Dr. E. V. Srinivasan were proposed for the Vice-Presidentship. After the ballot Dr. B. M. Sundaravadanam and Dr. P. S. Varadarajan were declared elected.

5. Dr. P. Govinda Rao proposed and Dr. J. A. S. Masilamani seconded that Dr. T. Satakopan and Dr. V. C. Sundarsanam be elected Secretaries. The resolution was carried unanimously.

6. The following names were proposed for the election of members of the Council.

Dr. C. L. Charles.	Dr. P. S. Kuppuswami.
„ E. V. Srinivasan.	„ P. Natesan.
„ V. D. Nimbkar.	„ V. Govindarajalu.
„ J. A. S. Masilamani.	„ M. Krishnamurthi.
„ S. Thambiah.	„ K. C. Paul.
„ U. Venkata Rao.	„ G. Zachariah.
„ P. Rama Rao.	„ G. Sriramulu.
„ P. Govinda Rao.	„ U. D. Gopal Rao.
„ S. Rajagopalan.	„ C. R. Krishnaswami.

and after the ballot the following 12 persons were declared elected.

Dr. C. L. Charles.
„ E. V. Srinivasan.
„ V. D. Nimbkar.
„ J. A. S. Masilamani.
„ S. Thambiah.
„ U. Venkata Rao.
„ P. Rama Rao.
„ S. Rajagopala n.
„ P. Natesan.
„ M. Krishnamurthi.
„ P. Govinda Rao.
„ C. R. Krishnaswami.

7. Dr. T. Satakopan proposed that Dr. G. Zachariah be the Publicity officer, Dr. P. S. Kuppuswami seconded the resolution which was carried unanimously.

8. The Publicity officer was authorised to select the Editorial Board.

With a vote of thanks to the retiring Office-bearers and to the President the meeting terminated.

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION. PALAMCOTTAH

The monthly meeting of the Tinnevelly District Medical Association was held on 26th March 1938 at the Public Library, Palamcottah.

Dr. P. S. Srinivasan, L M.P. read the Notes of a few cases treated at the Palamcottah Hospital.

* * * *

A joint meeting of the Tinnevelly District Medical Association and the Travancore Medical Association has held at Cape Comorin on 23rd April 1938.

The Secretaries of the two Associations read the minutes of the previous monthly meetings. The Minutes were approved.

Dr. P. S. Srinivasan, L M.P. read Clinical Notes of four cases of Acute Abdomen which were treated at the Head-quarters Hospital, Palamcottah.

Rao Bahadur Dr. K. Raman Tampi, the President of the Travancore Medical Association delivered an interesting lecture on 'Guinea worm infection'.

Dr. M. E. Naidu of Nagercoil read a short paper on the uses of Shark Liver Oil prepared at Nagercoil as a likely substitute for Cod Liver Oil.

* * * *

The Monthly meeting of the Tinnevelly District Medical Association was held at Mangalagiri, (Rural Reconstruction Centre near Tuticorin), on the evening of Saturday the 14th of May 1938. Forty-one members of the Association including five women doctors were present on the occasion. Some Private Practitioners of Tuticorin, also attended the function.

After light refreshments the Anniversary of the Summer School was held under the Presidentship of Lieut.-Col. T. S. Shastry, I.M.S., who distributed the certificates to the students.

The Secretary read the minutes of the Joint Meeting of the Travancore Medical Association & The Tinnevelly District Medical Association held at Cape Comorin, on 23rd of April 1938 which were passed. He read a letter received from Dr. Mrs. Poonen Lukose, B.A., M.B.B S., (London)., L.M. (Rot)., M.C.O.G., Surgeon-General, Trivandrum, offering thanks to the members of

the Tinnevelly District Medical Association for their passing a resolution congratulating her on her appointment as Surgeon-General, Travancore State.

Dr. D. Kribaimani, L.M.P., Sub-Assistant Surgeon of the Government Hospital, Tuticorin, read out case-notes on Epileptoid state which was successfully treated at the Government Hospital, Tuticorin.

Dr. P. S. Srinivasan, L.M.P., Sub-Assistant Surgeon, Government Headquarters Hospital, Palamcottah, read out the notes of the interesting cases which were treated and operated at the Palamcottah Hospital :—

1. A case of Sarcoma left hand.
2. A case of Tumour fore-head—secondary growth of Thyroid Cancer.
3. A case of Epithelioma—back of knee.

The following Specimens in connection with the above were also shown to the members :—

1. Sarcoma left hand.
2. Epithelioma—back of knee.

All the cases were fully discussed by the members.

Lt. Col. T. S. Shastry suggested to the members the opening of an Institute of Deep X-Ray Therapy on co-operative basis by the members. He also suggested to Mr. Roche Victoria, to work for donation for the installation of a Radium Institute. He thanked Mr. Roche Victoria for his kindness in organising the function at Mangalagiri and playing the host.

Thereafter an excellent Dinner brought the happy gathering to a close late at night.

Ramnad District Medical Association.

A meeting of the Ramnad District Medical Association was held on the 19th March 1938 with Captain B. Dayananda Rao in the chair.

The meeting discussed the merits of the scheme of Rural Medical Relief as obtains in this Presidency with that of the proposed scheme in the Bombay Presidency.

JOURNAL OF SOUTH INDIAN MEDICINE

NOTICE

CONTRIBUTIONS of medical interest—original articles, case notes, clinical memoranda—are invited. They should be addressed to the EDITOR, JOURNAL OF SOUTH INDIAN MEDICINE, No. 7, RITHERDON ROAD, VEPERY, MADRAS, and should be accompanied by a stamped addressed envelope if their return is desired in case of non-publication.

Articles are accepted for publication on condition that they are contributed solely to this JOURNAL.

MANUSCRIPTS must be written clearly or preferably type-written, with double spacing, on one side of the paper only.

Books and pamphlets for review should be sent to the Editor, who will be pleased to receive also reprints of which abstracts will be of interest to the profession. Journals for exchange or review should be addressed to the Publicity Officer.

CONTENTS

APRIL & MAY, 1938.

Printed at SOLDEN & Co. (Ampthill Press), Triplicane, Madras, S. E., by Manager M. S. Ekambaram.
Published by Dr. T. Satakopan, Publicity Officer, South Indian Medical Union, Vepery, Madras.