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MEDICAL, SURGICAL
SUGGESTIONS.

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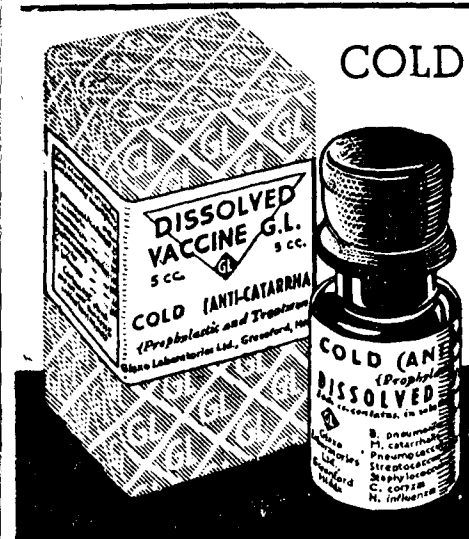
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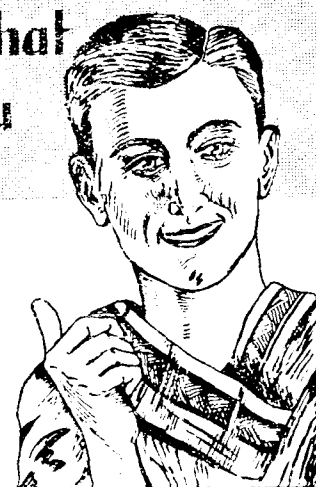
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A MONTHLY JOURNAL OF PRACTICAL MEDICINE & SURGERY

Editor: Dr. P. R. Venkappaya.

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MEDICO-SURGICAL SUGGESTIONS

VOL. VII

NOVEMBER 1938

NO. 11

***Original Article.**

INDICATIONS OF THE TONGUE.

By DR. S. K. GUPTA, B.D.Sc., B.O. (Pb.),

Surgeon Dentist, Pasrur, (Dist. Sialkote).

For hundreds of years physicians had to depend on their special senses, sight, hearing, touch, smell—to make diagnosis. As a consequence, they learned to pay special attention to the part of the body that could be easily observed. One of these was the tongue. The inspection of the tongue was considered of the greatest importance. The examination of the patient was not considered complete unless the tongue was carefully examined. Because of this the public was educated to attach value to the conditions of the tongue.

That was one part of the body that everyone could see for themselves. And even today hundreds of thousands of persons do not consider their morning toilet complete without a final glance at their tongue. It is important to do this; a great deal of valuable information can be obtained by doing it, but in order to obtain any real benefit, it is necessary to know what to look for, and to place a proper value on what is seen in the looking glass when the mouth is opened and the tongue protruded.

The healthy tongue should be moist, light pink in colour and uncoated. When protruded, the tip should be in the middle line and should be held there without any trembling movements (tremors). Any white deposits on the tongue after meals should be washed away easily when the teeth are brushed after meals. Such a tongue shows that the gastrointestinal tract (stomach and bowels) are in healthy condition. Any change in the healthy appearance of the tongue indicates some disease, either of the stomach, bowels, or large organs like the liver and pancreas, or some general disease affecting the entire body.

The moisture of the tongue is due to the presence of saliva in the mouth, a secretion which is constantly being produced by the

* Exclusively contributed to *Medico-Surgical Suggestions*.

three pairs of glands, the *parotid* the *sub maxillary* and the *sub-lingual*. In health, the flow of saliva is sufficient to keep the tongue moist at all times but when fever is present, the flow is checked and as a result the tongue becomes dry. In patients who are unable to breathe through the nose and because of this are "mouth breathers," the tongue is dry. In cases where the body is deprived of water, as in acute diarrhea or diabetes, there is not enough water in the body to form the proper amount of saliva and this is another cause of the dry tongue.

The effect of food is important as far as the tongue is concerned. When the proper amount of the right kind of food is taken and it is sufficiently chewed before swallowing, the act of eating automatically cleanses the tongue, so it should be cleaner and have a healthier appearance after eating than before. In persons who are sick and not eating regular meals, especially if they are on a liquid diet, this cleansing of the tongue does not take place, and because of this fact the tongue is usually coated or "furred."

In practically all diseases of the stomach and bowels, the appearance of the tongue is changed. In gastric hyperacidity, the tongue remains clean but changes from pink to red. If there is too little hydrochloric acid, it rapidly becomes coated. In chronic constipation the tongue is often coated, and this covering is difficult to remove by washing. Diarrhea causes dryness, coating, and even the formation of crusts, with an offensive odour.

Some diseases can be partly diagnosed simply by inspection of the tongue. In anemia, the tongue is pallid; and loses much of its pink colour because there is not enough iron and red corpuscles in the blood to color it. In heart disease, it may assume various shades of purple, due to the sluggish movement of the blood through the veins. This condition is called the cyanosis. In chronic disease of the kidneys and diabetes, the tongue is always dry. Scarlet fever produces the so-called "strawberry tongue" which is most marked on the second day of the disease. In typhoid fever, pneumonia and all diseases having high temperature, the tongue becomes dry, red, and later on coated and furry. Such fever tongues were seen more frequently in past years when all patients having prolonged fever were kept on a semi-starvation diet. If a fever case is properly fed, furnished sufficient liquids, and the toilet of the mouth properly cared for, the tongue can be kept free from the more serious coating and furrings.

According to Dickinson, there are at least eleven different varieties of tongue in disease. Such an extensive number is unnecessary for the average person to even try to remember. The important thing to know is simply the appearance of the healthy

tongue. If the tongue is not healthy, then the cause should be determined by a well qualified physician.

The relation of the tongue to the teeth is very important. In talking and eating, the edges of the tongue constantly rub against the gums and the teeth. If one of the teeth has a sharp point or a rough surface, it often causes an ulcer of the tongue which is slow in healing because it is being constantly irritated. Such injuries of the tongue frequently lead to *syphilitic chancre*, and this is one of the most common forms of contracting what is known as "innocent syphilis."

In spite of the great advance made in diagnosis by means of the Laboratory and X-Ray, the studying of the tongue to determine health or disease of the individual remains a very valuable aid in examination of the patient. It should rank with a taking of the temperature, and the determination of the blood pressure and the pulse rate. No matter how scientific the physician may be, he should always inspect the lips, mouth, teeth and the tongue of every patient. The average patient still expects this and very often, if the physician overlooks doing it, will call his attention to it.

At the same time, too much importance should not be attached to the inspection of the tongue. Some persons feel that it is so valuable a sign of health that they become nervous and even neurotic about it. They look at their open mouth and protruded tongue not once a day, but a dozen times. The slightest change in its appearance, makes them sure that they are seriously ill. Such patients are easy victims to the advertising quack, who in his literature pays great attention to this part of the body, and thus easily sells his patent medicines to the patient with what might be called "the tongue phobia." As a result the household medicine chest is filled with antacids, digestants, purgatives and blood purifiers, which the patient takes irrespective of whether he is in perfect health or not. Probably most of these patent medicines are harmless, but the statements and advertising them are, in most cases, false.

Look at your tongue once a day. Form some idea of what it should look like when you are well. If it becomes dry, red, coated, or furred, consult a well qualified physician. Let him place the proper value on the change and make a diagnosis and give the correct treatment. Don't try to make your own diagnosis or be your own physician.

NATIONAL HEALTH.

BY DR. A. LAKSHMI PATHI, B.A., M.B. & C.M.,
Bhishagratna, Madras, 12-9-38.

No one can say that National Health in India have now improved inspite of all the money that is spent by the Government. All the departments of Government and inspite of working directly or indirectly with the one and ultimate object of the improvement of the health and comfort of the citizen.

From a study of the past history, we know that the average Indian was a strong and stalwart person with long arms and broad chest. (Aajaanubaahu and Vishaala Vakshasthala). I always picture to myself the late Maharajah of Venkatagiri who died accidentally in a hunting excursion at about the age of sixty—his erect head, high and broad shoulders and his majestic gait as typical of Indian constitution. The Poligars, the Goundars, the Roddis and the Rajus of the South are also of similar structure. The seven brothers of Nuzivid Samsthanam, the famous Apparaos, are also remarkable for their valour, physical build, virile and prolific heritage as well as their charities. The ballad songs of the heroic deeds of the men and women of Bobbili and Palnad are a living testimony of robust India upto a hundred years ago. Therefore there is nothing in the South Indian climate that is responsible for the puny stature of the products of our modern Universities. The stunted growth of these boys and girls is not hereditary but is acquired.

South Indian dietary consisting mainly of rice may be said to be responsible for the dwarfing of their stature, but rice by itself is not at all bad. The courser varieties of Sambalai, Pishini and Karu of the South, Yaradamu, Budama and Aatragada of the Circars which are even now used with advantage by the poor classes and which are more glutinous than the fine and polished Nellore rice are nearly as good as wheat. They are more easily digested than wheat and are probably more suitable to this climate.

Body building on a nation wide scale requires the restoration of the old Indian dietary, rich in milk and ghee, pulses, meat and fish. Ghee is very highly praised for its properties of improving the higher intellectual capacities, namely :—

Smruti Mati Medha
Kanti Svara Lavanya
Soukumaryah
Ojah Tejo Balakaram
Ayushyam Vrushyam Medhyam
Vayastapanam.

Ghee is said to improve Memory, Wisdom, Genius or retentive power, Lustre of skin, Clearness of voice, Grace, Delicacy, Biomotiv power or vitality. Brightness, Strength, Long life, Sexual power, Purity of mind and body, and Establishment of youthful feeling.

Those who do not know about our Ghee talk much of Cod-liver oil.

Gavyam Sarpah Gunottaram.

That is the ghee of the Cow is superior to any other ghee in improving all the above properties.

Books on modern Pharmacology may say that animal fats are more easily digestable than vegetable fats, but the knowledge possessed by the Indian. The Pharmacologists regarding articles of daily diet is remarkable. All food materials are classified, in addition to their botanical and chemical properties, into differentiation according to three classes, according to their action on the human mind as Satwika food promoting peace or equilibrium of the mind, Rajasika food promoting energy, and Tamasika food promoting dullness of mind or inertia.

Professors of nutrition research now say that ragi is a nutritious food suitable for general adoption. I wish to tell you that, though ragi may build a physical body in working man, it is believed to produce dullness of intellect. While ghee is so much extolled as a Saathvika food, improving the subtle faculties of the mind, ragi is classified under Kudhanyas meaning inferior grains.

It is not the knowledge of what one should eat that is needed for the Indian citizen, but it is the actual quantity and quality of food materials, the deficiency of which is responsible for his under nourished condition. This is again due to want of economic planning of agriculture and neglect of exploitation of the resources of this country for its own benefit. The increase of commercial crops like cotton, and jute in the place of ragi and cholum, large scale export of groundnut and the oil seeds useful both as food and manure serve as examples.

It is estimated that the population of India would increase to 400 millions by the time of the next censuses in 1941, but the productive capacity of the land is not only not increasing in the same proportion, but it has fallen very much below the level of the last decade. Round about Madras, in the Chengleput District, I see that many patta lands which were once cultivated with the valuable food crops and now left waste. Because it does not pay any one to cultivate these lands, the well to do people migrate into the city for the education of their children, the able bodied poor to earn their livelihood as rickshaw pullers or carriers of heavy loads in the harbour, and the disabled as beggars in the busy streets of Madras. The

slender resources of those that still stick on to the land are hardly enough to meet the cultivation expenses in these days of low prices.

The cities are thus overcrowded with the unwanted population and the villages have been deserted. The provision of part time work for the farmer and his family by the introduction of cottage industries and the encouragement of the sale of country made articles by imposing a suitable duty on imported ones and by every other possible means —these are the urgent reforms that are required for the improvement of National Health.

Let the autonomous Village be again restored with its own revenue, its own courts and its own schools and Talimkhanas and the rest will follow. Much valuable popular knowledge that has permeated into every village home is denied to the European scientists and administrators because they had no opportunities of associating themselves socially and culturally with the people of India.

The rapid transport facilities and the liberal education were sufficient to disorganise the autonomous and self contained village unit, but they were not enough to reconstruct the same on modern parliamentary lines of representative and responsible Government. The products of the modern University, in fact, any man or woman who received any education in English, became exotic and felt that he or she was a superior being. Many an English educated man developed certain uncleanly and un-Indian habits which lowered them in the estimation of the old and learned folk in the village. Habits of daily life such as neglect of cleaning teeth immediately after getting up from bed, proudly smoking cigar, cigarettes, sipping from a cup, which have no serious meaning to one who is accustomed to such things, greatly offend the delicate feelings of common decency of the unaccustomed villager. We have now a glossy civilization permeating into our society with its insidious influence upon every condition of our life creeping into the very vitals of our existence and eating into the very marrow of our bones.

The key to live a long life is for every individual to cultivate healthy habits. Aahara, Nidra, and Bramacharya, proper Food, Sleep and Control of sex life are considered to be the three supporting pillars of the tripod of long life. The Indian method is to insist on every man performing his dharma i.e., his duty to his own body and to the society. The necessity of keeping public sanitation on a very high level was long ago felt in India and it was very strictly and religiously administered.

Navegan graama nagara devataa yathana
Padhi jalaasaya sannu krishtaan
Visrujeth. Na nagnam jalam niviseth.
Na apsu muthram kuryaath.

Do not pollute the vicinity of villages, towns, temples, roads and water sources.

Roads and Water are as sacred to us as our temples. No one dare pollute them. Suchi or cleanliness is the essence of Indian civilisation. Epidemic diseases break out when people are permitted to live a life of unrighteous conduct.

Adharmena prajaam varthayanti

Thasmaath Udhvam samthe janapadaath

If there is any thing at all that can be done to prevent disease, it is the education by the State, and the enforcement of the practice of clean habits and the development of moral and physical strength so as to enable the population to withstand the inroads of diseases if they should still prevail. Otherwise any amount of money spent on the Mains and the Drains is wasted.

Asoka did much propaganda work in his time. When he did not have the radio to talk to his people at the farthest ends of his Empire, he sent out his officers to engrave the rules of health on the rocks, pillars, boulders and walls of caves and in the language of every locality. He made it the business of his life to educate the people to be charitable and sympathetic. At the same time the punishment inflicted on those who infringed the laws of cleanliness and good conduct was very severe.

"As is the king, so the people." The people used to emulate each other in public charities, the reminders of which you will see if you go beyond the city limits — the wells, the bathing ghats, the water troughs for cattle, the groves of Mango and Banyan trees and the comfortable rest houses called chatrams at a distance of half a koso, barely a mile and a quarter from each other.

It would be impossible in those days even for an ignorant mother to allow her child to soil the streets and bye lanes. It was her first duty every morning to see that her street front is perfectly cleaned and adorned with floral designs, lest she should be chastised by her neighbours, as a lazy and sinful woman. But to-day I am ashamed to tell you that I often see a decently dressed and educated woman in the city of Madras fetch her child from inside and make her soil the clean and cemented pavements in front of her house. Is this not a disgrace to you and to me?

To most of you, who are young, the past has left a great ancient legacy. It is for you to vindicate the greatness of this country in comity of nations. Feel proud of your ancient customs that are based on accurate and scientific observations and of the intellectual development of those that formulated them, and if you once feel proud, there is not the slightest doubt that you will improve your vision of a bright future for India. There is no reason for despondency. Therefore—rise up, young man to fight your battle against all Duraacharaas evil habits, both of the east and the west.

Thasmaath Utthishta Kaunteya
Yudhaaya Krutha Nischayah

Bhagavadgita,
Chap 2.

ACUTE INFECTIOUS CONJUNCTIVITIS.

DR. POLK RICHARDS, U. S. I. S.

Medical Director of Trachoma.

This form of conjunctivitis is often called acute catarrhal conjunctivitis or "pink-eye."

Conjunctival inflammations are usually divided into 2 groups: those due to purely chemico physical agents and those caused by infection. Of the first group, if we exclude irritations and inflammations due to pollens, we see few, and the history generally suggests the cause. But the acute infectious forms are common, especially in our schools. It is this type that we wish to discuss, particularly with reference to treatment and prophylaxis.

There are 2 pre-eminently common forms of epidemic conjunctivitis with which we in the service are most often called upon to deal. Pneumococcic conjunctivitis, produced by the Fraenkel-Weichselbaum diplococcus, and the Koch-Weeks bacillus form, produced by the Koch-Weeks bacillus. The spontaneous course of these conjunctival infections depends much upon the etiologic factor. And our therapeutic and prophylactic measures, to some extent, depend upon their differentiation.

The importance of knowing the active morbid agent in infectious conjunctivitis, or any other disease for that matter, is obvious. It is, as we all know, a fundamental principle of scientific medicine. But in the stress of our practice where we have many irons in the fire, as it were, and often improper or no laboratory equipment, we must necessarily depend upon the clinical picture and course of the disease to furnish a clue to the diagnosis. It is well to remember that an etiologic diagnosis cannot be made in these conjunctival infections, with certainty, without microscopic smear examinations. Even then it is not always easy to find the organisms unless specimens are taken in the early stages of the disease.

SYMPTOMS AND COURSE OF PNEUMOCOCCIC INFECTION.

The incubation period is not definitely known, but in a once established case of average severity, the inflammation develops rapidly, and if not at once, soon involves both eyes. The margins of the lids, especially the upper ones, become rosy and edematous, and the bulbar conjunctiva particularly becomes red. Indistinct little hemorrhages often appear, especially in the upper part of the ocular

conjunctiva and soon acquire a yellowish-red tint. The disease generally reaches to height quickly, usually in 1 or 2 days. The striking redness of the bulbar conjunctiva is a characteristic feature at this stage. At the same time there is much discharge of thin, watery secretion which contains bits of fibrin.

One finds mild and severe types of this disease. The variations in severity are often remarkable, and it is common to hear the expression, mild pink-eye and severe pink-eye. In the more virulent types the discharge is often purulent, and sometimes even small membranes may form on the transition folds. It is essential, therefore, that we should not assume, from clinical observations alone, that we are dealing with diphtheritic or streptococcic infection. Pneumococcic conjunctival infections are, however, generally mild or of medium severity and quite often clear up as quickly as they come on. Indeed it is often characteristic of this disease that it ends in a crisis, like that of pneumococcic infections in the lung. The discharge then lessens rapidly, the reddened mucous membrane fades and recovery is generally complete within from 6 to 8 days. From clinical observation alone we are sometimes able to make a diagnosis of this form of eye infection. The rapid attack, the extreme redness of the bulbar conjunctiva and the rapid subsidence are characteristic features.

Pneumococcic conjunctivitis frequently appears epidemically, especially in schools. Children are much more susceptible than adults, so much so that this type of conjunctivitis may almost be termed a child's disease. There are always individuals, however, who remain immune to the infection. Sporadic cases, too, often develop without further spread of the disease, even though there is excellent opportunity for its transmission. Infection, no doubt, takes place by contact, in the vast majority of instances, but many persons have pneumococci on their healthy conjunctivae and in their mouths, so it is quite probable that some cases originate by auto-infection, the microbes becoming more virulent or the resisting powers to the organism less strong.

COMPLICATIONS.

Although this conjunctivitis, and that due to the Koch-Weeks organism, is generally looked upon as being benign, complications can and do occur, especially in severe forms of the infection. Nasal involvement in the form of rhinitis is often observed in connection with the eye disease. On the eye itself marginal infiltrates and often small ulcers are seen, but generally we need not fear severe corneal complications. Iritis, generally mild, is met with now and then, even where the cornea is not involved, and may outlive the conjunctival disease. Its genesis is probably due to resorption of toxins.

SYMPTOMS AND COURSE OF KOCH-WEEKS CONJUNCTIVITIS

The symptoms and course of the Koch-Weeks conjunctival infection are not greatly different from that of the pneumococcic disease. After a short period of incubation the lid margins begin to swell, and the secretion from the Meibomian glands is increased. The discharge from the conjunctiva is apt to be copious and the membrane itself greatly swollen, though smooth and glistening. The fluid, a muco purulent secretion, glues the lids together in the morning, and gathers in large quantities at the canthi. The bulbar conjunctiva as in the pneumococcic infection, is often deeply reddened, and we sometimes find in its upper part the same small hemorrhages. In this infection, as in that due to pneumococci, there is a great variation in severity in different epidemics, but in general the symptoms are more violent. Photophobia is apt to be more pronounced and the patient generally complains of more pain about the orbit and in the superior maxilla. Also, the pre-auricular gland is generally swollen. The syndrome, in severe cases, may be such as to remind one of bionorrhoea. The disease lasts, on an average, from 2 to 4 weeks, much longer than the pneumococcic disease, and subsides much more slowly. Hypertrophy showing papillary bodies, especially in the upper folds, may and often do persist for some time after the acute symptoms have subsided.

COMPLICATIONS.

Complications in this disease, I think, are more likely to occur than in that due to pneumococci. Blebs at the corneal limbus are common. Marginal corneal infiltrates and even serious corneal ulcers, especially in adults, are apt to occur. The infection is spread through the secretion. In this disease it is well to bear in mind that long after the acute symptoms have subsided the secretion may contain living organisms that are infective. In afflicted persons the infectious secretion may pass from the conjunctiva through the lachrymal ducts into the nose and mouth and thus be spread by speaking or coughing.

Because these conjunctival infections vary so markedly in their virulence, very often presenting atypical syndromes, we cannot, depend upon clinical manifestations if we wish to make an etiologic diagnosis. So, for those who are interested, I shall give briefly a film technic for bacteriologic examination. Gram's stain gives all the information needed for conjunctivitis of bacteriological origin. A good method, suggested by Dr. Phillips Thygeson, is as follows:

Solution A—Crystal violet, 4 gm. dissolved in 20 c.c. of 95 per cent alcohol.

Solution B—Ammonium oxalate, 0.8 gm., dissolved in 80 c.c. distilled water

The technique is as follows:

Mix solutions A and B, and stain films for one minute. Wash in water and immerse in Gram's iodine solution for one minute. Wash in water and blot dry. Decolorize in 95 per cent alcohol for $\frac{1}{2}$ minute. Cover with counterstain (saturated solution of safranin in 95 per cent alcohol, 10 c.c. water, 100 c.c.) 10 seconds. Wash, dry, and examine. The pneumococci are Grampositive and Koch-Weeks Gram-negative.

TREATMENT.

Aside from diphtheritic conjunctivitis, which does not come within the scope of this paper, we have no specific remedy with which to combat conjunctival infections. I think we often do things for this type of eye patient, such as applying compresses and prescribing drug mixtures, that are of questionable value. Since we have no specific drugs or serums for these patients, the treatment that can most be depended upon to give relief and promote spontaneous healing, in my judgment, is frequent washing away of the conjunctival discharge by irrigating the eye with warm boric or saline solution. Irrigations should be done as often as necessary to keep the eyes free from accumulated secretion. After such irrigations, especially during the acute and subacute stage of the disease, a much used, and I think, very good treatment, is the instillation of a solution of the organic silver preparations. My own experience has been mostly limited to the use of protargol 2 per cent to 3 per cent and argyrol 15 per cent to 30 per cent. Some physicians prefer zinc sulphate $\frac{1}{4}$ per cent solution to the organic silver solutions. Personally, I like to use the zinc in cases that tend to or have become chronic. In the pneumococcic infection, optochin has been advocated by some as being more or less specific, but generally, I believe, it has been found disappointing. A good routine treatment that can be used in the home by unskilled persons is frequent bathing of the eyes in warm saline or boric solution, and the instillation of protargol or argyrol drops. Often in these cases the skin of the lids, especially about the canthi, becomes excoriated from the constant discharge. A good procedure in such cases is to dry the skin after irrigations or bathing and apply sterile or borated vaseline to the margin of the lids in the evening, so that they will not become glued together during the night. Where the lids are glued together at night, locking the secretion within the conjunctival sac, the danger of such complications as ulcer and iritis are augmented.

In the Koch-Weeks type of infection, especially, some cases do not respond to treatment as readily as we should like. Often these cases tend to persist and become chronic. The retrotarsal folds show thickening and sometimes follicle formation. In such cases we may be led to believe that our patient is the victim of trachoma rather than a simple bacterial infection. It is in this type of case that we shall do well to use the silver nitrate. A 2 per cent solution

applied to the fornix of the everted lid every second day, and neutralized with saline irrigation, has been found to produce results that could not be obtained with other medication. In the majority of such cases it is remarkable how the lingering disease in the folds responds to silver. Some physicians use silver during the acute stages of the disease; they claim good results. My own experience has been with its use only in the more chronic stages. Silver is a harsh remedy and when applied, as those of you who have used it in the treatment of trachoma know, the conjunctival secretion and hyperemia already present is much increased. There is induced photophobia and the patient is apt to complain of pain, especially if we have not been careful to avoid getting the solution on the cornea, or have failed to neutralize and wash away the excess silver by irrigation with saline or boric solution. When the burning pain has ceased, the patient sometimes complains of a foreign body sensation in the eyes. The conjunctival sac should then be irrigated. Within 12 to 20 hours the epithelium, coagulated by the silver application begins to slough away. By casting off this sloughing layer, many organisms imbedded in the epithelium are removed. To that, probably, along with the induced hyporemia and the bactericidal effect of silver, the good effect of such treatment is due.

In these acute infectious eye disorders prophylaxis should accompany therapy. Precaution should be taken to destroy bacteria contained in the secretion that is washed from the eyes. The patient should be admonished to use only his own towel, wash cloth and handkerchief, and that he keeps his hands clean. Children in schools who develop acute eye infections should be excluded.

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THE PRESENT MANAGEMENT OF CANCER OF THE RECTUM

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This condition, affecting both sexes beyond the second decade, sparing no race, apparently more prevalent in the white, takes such a toll of life or causes such disability that it is an extremely important factor in the economic affairs of the world.

It is unfortunate that the symptoms of rectal cancer rarely become evident until the growth is of such size, that the greater portion of the wall is involved, and extension or metastasis, has taken

place. As a rule, the early growths are found only upon routine examination, when bleeding from a degenerating polyp, or an ulcerating tumor arouses interest of the patient or physician, or when the lesion is near the anus and causes pain. The history given by the patient, frequently includes treatment for colitis, amebiasis, dysentery, constipation, or piles. The essential symptoms are: changes in bowel function, frequency—more often than retardation, passage of blood and mucus, with a later loss of weight and secondary anemia.

Only about 5 per cent. of rectal cancers appear at the anus; they are almost always epidermoid in type, and may be mistaken for luetic, tuberculous or other inflammatory lesions. Diagnosis must often be made by laboratory examinations. About 70 per cent occur in the rectum proper and the remaining 25 per cent. in the recto-sigmoid. Diagnosis is made easily by finger examination and by the use of the proctoscope. The tumor is a nodular, or ulcerating mass, generally firm, except in the polypoid type; the mucosa is always involved. In extra-rectal lesions, as secondary carcinoma from prostate, cervix, pelvic, or upper abdominal organs, the bowel is constricted without change in the mucosa. The negative opaque enema may be misleading since many rectal lesions do not show a demonstrable defect.

Tissue examination should always be made, and the grade of the tumor estimated. A negative biopsy in a suspicious tumor should be repeated. It is now generally considered that a high grade cancer metastasizes rapidly, is highly infected, and is extremely radio-sensitive. Thus, the grade of the tumor is an important factor in deciding the treatment. Usually, the younger the patient, the more malignant are the lesions.

In our group of 350 cases, 95 per cent. were adenocarcinoma, and of those graded histologically, 55 per cent. were of high, 36 per cent. of moderate and 9 per cent. of low malignancy. About 75 per cent. of the epidermoids were of high grade.

According to age, 13 or 4 per cent. occurred between ages 20 and 25, 30, or 7 per cent. between 30 and 40, 48, or 14 per cent. between 40 and 50, 90, or 26 per cent. between 50 and 60, 105, or 31 per cent. between 60 and 70, 49, or 14 per cent. between 70 and 80, and 13, or 4 per cent. over 80. This shows that 11 per cent. occur in the unfavourable 2nd and 3rd decades, in which cancer spreads rapidly, only 40 per cent. in the more favorable 4th and 5th decades, and 49 per cent. in persons over 60 years of age, many of whom are physically unfit for curative surgery. Less than 50 per cent in this series were operable as far as chance of cure was concerned. Of this number, 201 were treated as follows: radical removal, 66; semi-radical, 15; local excision with cautery, 10; fulguration, 11; cauterization of malignant polyps, 11; and colostomy only, 88. There were 3 recurrences in the radical removals, and 5 in the other groups.

Each cancer patient must be considered individually and not just as another cancer case. Definite factors are essential in determining the procedure which offers the best chance of cure, or continuation of life with maximum comfort and minimum disability. The most important are: (1) age; (2) general condition as determined by study of the heart including electrocardiogram, blood count, kidney function with NPN estimation, and study of the lungs including x-ray; (3) presence of metastasis or extension to adjacent organs; (4) location, size, mobility and grade of the tumor; (5) mental attitude of the patient; and (6) experience of the operator.

As a general rule, the older the patients the less radical, and the younger the more radical, are the indicated procedures. Thorough pre-operative preparation for 1 to 2 weeks consists in establishing the water balance by fluid intake, decompression of the bowel by mild catharsis, building up the general condition by diet and blood transfusions, and convincing the patient that his case is not hopeless, and that even if a permanent colostomy is necessary, he will not be an object of pity to either himself or family.

It has been thoroughly established by Miles and other, but cancer of the rectum spreads by the lymphatics, the blood stream and by direct extension. To prevent recurrence, all lymphatic channels draining the tumor area must be removed, even in the absence of demonstrable lymph node involvement. Occasionally the cancer cells have migrated beyond the limits of even most radical procedures, with resulting remote metastases and continuation of the growth in nodes not removed.

With the main objective, complete eradication of the cancer in mind, and all the factors pertaining to the individual patient correlated, the procedure best suited for the particular case must be determined. The accepted methods of treatment to be considered are: abdomino-perineal resection in one or two stages; colostomy and posterior resection; posterior excision with cautery; local excision with cautery; fulguration with or without colostomy radium or deep x-ray or both; and colostomy.

Only the first 2, the abdomino-perineal and the colostomy and posterior resection, are considered sufficiently extensive in removal of lymphatic structures, to give a reasonable chance for cure. The other operative procedures are used only in poor risks or in early, small, or low grade lesions. Radium and deep x-ray are at times valuable as pre-operative measures in high grade tumors, especially in the epidermoid of the ano-rectal region. In the latter, combined radiation is considered by some to give better results than surgery. "The value of deep therapy in adenocarcinoma is controversial. Good palliative results are reported." Deep x-ray is used with good results during pre-operative preparation; most radiologists prefer a long period between the radiation and the operation.

The anesthetic should be chosen for the individual patient. Endotracheal gas or ether is probably the safest in the majority of cases. Spinal block is excellent in good risks for short operations.

With certain exceptions, the abdomen should be explored in all cases. The surgeon is assisted in his choice of operation by the amount of adjacent involvement, and the metastasis in the liver or nodes. A moderate liver involvement does not contraindicate removal of the tumor. Fixation of the tumor may be due to inflammatory changes, and in some cases, will decrease between stages. If obstruction is marked, the 2 stage procedure is probably the safer in the hands of the occasional operator.

Cecostomy is valuable in cases of acute obstruction and sometimes as a 1st-stage in the abdomino-perineal resection. It decompresses the bowel and does not hinder future procedures through the midline.

The abdomino-perineal resection removes more of the lymphatic structures than any other procedure and has the least recurrence rate, although higher mortality. The 1-stage procedure is the method of choice in good risks, and is advocated by some surgeons—as T. E. Jones of Cleveland. This operation consists in removing the lower sigmoid, recto-sigmoid and rectum at the 1 operation. The permanent colostomy is established either in the midline or in the left inguinal region.

The 2-stage operation is used when a 1-stage is deemed too hazardous, especially if there is marked obstruction or tumor fixation. The Lahey method is one of the most popular today. He severs the sigmoid, places the colostomy in the left wound and the distal stump over the pubes. The 2nd stage is carried out the same as the 1-stage resection after 3 to 4 weeks, during which time the patient's general condition improves and bowel function becomes more normal. Other 2-stage procedures, such as that of the modified Coffey, may be used to advantage.

The colostomy and posterior resection described by Lockhart-Mummery, is the method of choice in poor risks and in the aged. The upper border of the tumor should be easily reached in order to obtain the best results. A double-barralled colostomy is established and later the growth is removed from below. The peritoneal cavity is entered and several inches of bowel with accompanying lymphatics are removed. Recurrence is more frequent, but the mortality is lower than in the abdomino-perineal resection.

Colostomy and posterior excision are used in exceptional cases. Local excision or posterior excision with the cautery is used only as a palliative measure. Recurrence is frequent in the latter 3 methods because sufficient lymphatics are not removed.

Fulguration has been given an impetus by Strauss who reported good results in both operable and inoperable cases. I have used fulguration as a palliative procedure in the aged, and as an adjunct at the time of colostomy in the 2-stage procedures.

Colostomy alone has no value as a cure, being only a means of relieving obstruction, thus possibly relieving rectal discomfort.

The post-operative care is extremely important, especially in the radical procedures. Blood transfusions should be routine. The blood pressure must be watched and kept up by ephedrine. Oxygen and carbogen must be available in emergencies—cardiac or respiratory failure. Sufficient 5 per cent glucose must be administered to keep up the water balance. The colostomy is opened within 48 hours or sooner if there is distension. The duodenal tube is passed at indication of nausea or upper abdominal distension. Water is given by mouth early and food as soon as the colostomy is opened. Intestinal peristalsis is stimulated early and pitressin or other drugs may be of value.

A combination of surgery, radium, deep x ray and fulguration may be used in the attempt to cure rectal cancer. In radical surgical procedures, a mortality of less than 10 per cent has not been generally attained. Recurrence is frequent in less dangerous methods. The life of cancer patients after operation is not the most pleasant, but with the modern colostomy hygiene of morning lavage, and the rubber bag relegated to the junk heap, it can be made useful to him and not obnoxious to his friends. Cures in rectal cancer will increase when the idea, that colostomy is worse than death, is divorced from the minds of physicians and laymen.

When it comes to deciding what to do for the cancer patient in the upper age brackets, the surgeon is confronted with the problem of whether after operation, the individual will be a burden to himself, family or state, and whether in hopelessly inoperable cases it is justifiable to use palliative treatment such as radiation or colostomy. In the more favorable ages, if there is a certainty that the individual will die of cancer unless something is done, and that an attempt at cure is fraught with danger, he should have the opportunity to be cured, even though the odds are against him. He may be returned to a useful existence by bold interference. The successes more than compensate for the losses.

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A NEW CONCEPTION OF BRONCHIECTASIS.

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It has been recognized for many years that sinusitis and bronchiectasis commonly co-exist; in fact bronchiectasis is seldom found without at least some evidence of sinusitis. No convincing explanation of this co-existence has been forthcoming. It seems absurd to try to explain this on the basis that the sinus secretion drops down into the bronchial tree causing infection there. We wish to offer another explanation.

It was noticed that many cases of bronchiectasis had some manifestation of allergy, such as hay fever, asthma, urticaria, eczema, or rhinitis. Investigating the cytology of the nasal secretions we were impressed with the frequency of high percentages of eosinophiles. We then began cytologic examinations of the sputum of all bronchiectatic cases, and were surprised to find an abundance of eosinophiles in a high percentage of these cases. Since this time we have not only examined all new cases of bronchiectasis but also old cases that were available. We have seldom failed to find an abnormal percentage of eosinophiles in the sputum if repeated examinations were performed.

The observation that the large majority of bronchiectasis cases have abnormal percentages of eosinophiles in their sputa gives the impression that bronchiectasis has an allergic background.

The question arises as to whether sinusitis and bronchiectasis in an individual have a common etiology, namely allergy. Skin tests and history taking have largely confirmed this. A number of cases have been found to be non-reactors as far as the skin is concerned, and true atopy could not be proved. However, this is not uncommon in allergic conditions.

Other evidence supporting our hypothesis is that many cases of bronchiectasis respond to elimination of allergens or to desensitization treatment with offending substances with marked reduction of cough and sputum, or with even entire elimination of symptoms if the case is not too far advanced. We realize that bronchiectatic dilation of any great degree is usually permanent especially if of long standing and accompanied by much peribronchial fibrosis, but the secondary infection and allergic irritation can be benefited with improvement of symptoms and the patients' comfort. We do not mean to give the impression that all bronchiectasis is due primarily to allergic sensitization. There are mechanical factors predisposing to this condition. Any factor reducing pulmonary elasticity, such as pulmonary fibrosis, or oblitative pleuritis with pulmonary fibrosis which transmits the expansion of the chest wall through the lung to the bronchial tubes, will favor dilation and pocketing. Bronchiectasis can develop also in cases where there is obstruction of a

bronchial tube from foreign body or tumor. It is interesting to have made the observation that in 2 cases believed to have bronchiectasis due to pulmonary fibrosis, abundant eosinophiles were found in the sputa. Perhaps in these cases the fibrosis was secondary to the infection resulting from bronchiectasis rather than the primary cause.

Pneumonia as a primary cause of bronchiectasis can reasonably be questioned unless empyema or severe pleuritis with fixation or reduced pulmonary elasticity results. It is well known that bronchiectasis cases commonly have obstruction of drainage by acute bronchial infections and, under these conditions, they closely simulate pneumonia. When one gives a history of having had frequent attacks of pneumonia, bronchiectasis or allergic pneumonia should be suspected, especially if the attacks are of short duration and there is chronic cough with sputum between the attacks. However, an attack of pneumonia may cause a breakdown of allergic resistance and initiate bronchial allergy. The onset of bronchiectasis following pneumonia, influenza, measles, or whooping cough is similar to the history given by asthmatic patients following these infections.

In reviewing the history of a series of cases of bronchiectasis one is impressed with the frequency of blood raising and attacks of pneumonia. We repeatedly have seen one of these attacks of pneumonia and found it to be due to an obstructed bronchiectasis which promptly subsided when a large quantity of purulent sputum was raised.

The question arises as to what percentage of eosinophilic polymorphonuclear leucocytes is necessary to prove that the secretion is allergic. There is considerable variation of opinion. According to Kahn and Stout:

"1. A positive eosinophilic nasal smear of from 10 to 90 per cent is almost invariably diagnostic of allergic rhinitis.

"2. A positive eosinophilic smear of 4 per cent or over is highly suggestive of allergic rhinitis.

"3. Conditions such as a pure, thin, watery discharge, allergic quiescence and, at times, intercurrent infections in previously definitely proved cases of allergic rhinitis are proof that the absence of eosinophilia at a single examination does not bar allergic rhinitis.

"4. The presence of abundant non-eosinophilic polymorphonuclear leukocytes in the smear is practically diagnostic of infection.

"5. Allergic and infectious rhinitis and sinusitis may exist coincidentally or at alternate periods in the same person.

"6. This simple nasal smear test, if done as a routine measure, will prove of decided diagnostic value to rhinologists and to workers on allergy."

We believe that 10 per cent of eosinophiles in nasal secretion or sputum is suggestive of allergy and 15 per cent or over is diagnostic. There is considerable variation in the number of eosinophiles from time to time. Three examinations at different times are decidedly more valuable than one examination, because eosinophiles may be absent in one examination and abundant at another time. Consequently, one examination for eosinophiles, if negative, is of no value.

It has been generally supposed that allergic sputum is mucoid in type but it has been our experience that the most typical purulent bronchiectatic sputum may contain a high percentage of eosinophilic cells, even without any clinical evidence of allergic symptoms. A nasal eosinophilia in bronchiectasis is presumptive evidence of bronchial eosinophilia.

It is becoming common knowledge among nose and throat physicians that about one-third of their patients consulting them for nasal complaints are allergic. We venture to say that almost 50 per cent of chronic sinusitis cases which we encounter in the west are allergic; usually we see only the ones who have obtained little benefit by treatment elsewhere, or have had the condition for a long time. This would naturally increase the percentage of allergy and sinusitis cases in the west as it is well known that the presence of allergy in the nose predisposes to sinusitis and prolongs this condition markedly. Nasal operations in the presence of allergy are not particularly beneficial, nor do they usually give lasting benefit.

Nose and throat specialists are remiss in not doing more cytologic examinations of nasal secretions and discovering what cases are allergic and recognizing the allergic background of many chronic sinusitis patients. The early recognition of nasal allergy and its proper management often prevents troublesome sinusitis, and also probably prevents bronchiectasis from developing later.

In performing lipiodol examinations of the bronchial tree in allergic individuals we have found all stages of bronchiectatic dilatation from a moderate amount of lack of tapering to decided cylindrical dilatation and large saccular pocketing. It probably requires many years to produce decided dilatation. We believe that these cases of bronchiectasis to which we refer always begin as allergic bronchitis with no previous organic bronchial change. Can we then benefit our patients more than we do by postural drainage, treatment of sinusitis, favorable climates, rest, etc. Our results so far lead us to this belief. We hope that considering many cases of bronchiectasis as primarily due to allergy we may not only relieve troublesome symptoms but actually prevent the progression of a slight bronchiectasis into a far advanced one necessitating lobectomy to accomplish a cure.

It would seem reasonable, therefore, to consider the hypothesis that the common finding of sinusitis associated with bronchiectasis

can be explained by the fact that both conditions have a common etiology, namely allergy.

We venture a new etiologic classification of bronchiectasis into the following types:

1. Congenital—similar to congenital cystic disease of the lung.
2. Mechanical—due to pulmonary fibrosis, particularly associated with fibrous pleuritis.
3. Allergic—the result of hypersensitivity.

Of these 3 types the allergic is by far the most important, probably comprising about 90 per cent of the cases coming to the physicians' attention. Incidentally, about 75 per cent of our cases of allergic bronchiectasis were sensitive to orris root, wool, feathers, dust, or pollens.

The explanation as to just why allergic bronchitis predisposes to bronchiectasis is that swelling of bronchial mucosa and exudation of tenacious secretion interferes with efficient pulmonary drainage and, favoured by coughing, the chronic infection which results gradually weakens the wall of the bronchial tree. Bronchiectasis usually occurs in the most dependent portion of the lung, namely in the posterior half, actually in a straight line downward from the bifurcation of the trachea. This location is the most unfavorable point of drainage.

Far advanced bronchiectasis is a loathsome, objectionable disease. Victims of this condition are so discouraged and depressed that they are willing to undergo almost any suffering or take any risk to obtain relief. Failing to get relief frequently ends in suicide. Lobectomy is the only real hope of obtaining a cure, and it is a serious major operation. If anything at all can be accomplished to prevent far advanced bronchiectasis it will be a godsend to these patients.

One object in presenting this subject now with only a small series of cases is that we hope to arouse sufficient interest in this phase of bronchiectasis either to prove or disprove our impressions of the relationship of allergy and bronchiectasis. Personally, we are convinced that our hypothesis is correct because of the decided improvement in many cases which had been stationary, or progressive before allergic treatment had been instituted.

CONCLUSIONS.

1. One of the fundamental causes of bronchiectasis is the allergic state.
2. The explanation of the common association of sinusitis and bronchiectasis is that they are frequently due to a common cause, namely allergic sensitization.
3. Treatment along allergic lines offers another important method of treating bronchiectasis.

Southwestern Medicine, December 1937.

BLOOD TRANSFUSION.

GEORGE TURNER, M.D., and DELPHIN VON BRIESEN, M.D.
El Paso.

Something more than 200 years ago, Richard Lower, of Cornwall, England, performed the first recorded blood transfusion—from one lamb to another. After some success with animal to animal transfusions he gave lamb's blood to a man; with what result one can guess. In the 17th century reactions resulting from transfusions were so frequent and so severe that Parliament forbade by law the giving of blood from either animal to man or from man to man. So, transfusion was almost forgotten for 200 years.

Improvements in technique since 1900 have made transfusion a most valuable and often life-saving procedure, safe in the hands of any physician with ordinary skill even with a minimum of equipment. Modern blood grouping is largely due to the research of Dr. Landsteiner, of New York City, a recent Noble prize winner, who discovered that sera of diseased as well as that of normal persons will hemolyze some blood cells. From his work has come the knowledge of accurate blood grouping and cross matching. For technical refinement we are indebted, in no small degree to Dr. George Crile of Cleveland.

PURPOSE.

Broadly speaking, transfusion serves three purposes: Firstly, it substitutes for lost blood, secondly, it stimulates the blood forming organs, and thirdly, it serves to combat infectious processes by supplying antibodies, agglutinins, hemolysins, and other defense measures.

INDICATIONS.

The indications for transfusion are multiple. It is our purpose to present only those that are most frequently met, with little discussion as to their merits.

Hemorrhage from any cause is probably the most frequent. This may be due to trauma, hemoptysis, placenta previa, ruptured spleen, bleeding peptic ulcers, etc. It may be well to state here that when shock is present it deserves primary attention after the massive bleeding is stopped.

Secondary anemias are frequently such that transfusion is a most rallying procedure. Most often they are secondary to infections. Fulminating pyelitis, especially in children, is peculiarly responsive to small transfusion, repeated if necessary. Long standing osteomyelitis with multiple bone involvement sometimes responds gratifyingly to added blood. Ulcerative colitis, typhoid ulceration, tuberculosis, peritonitis, septicemia from any cause, and malignancy

or other indications. It must be said, however, that in malignancy only palliation is hoped for. In infections especially, small transfusion provides a stimulus that often changes a picture of impending death into one of frank optimism. In the poisoning from snake venom transfusion is said to have some value. It sometimes is useful in pre-operative preparation of patients, many times making a poor surgical risk a fair one. Such prophylactic transfusion is definitely indicated for any patient upon whom major surgery is planned and whose hemoglobin is lower than 60 per cent. Particularly is this true when heavy chest or abdominal procedures, shocking in themselves, or contemplated. Of course in the post-operative patient a transfusion may provide the means for an already overstrained hemopoietic system to catch up with the demands being made upon it.

In the primary blood dyscrasias transfusion is only a temporary aid. It does not allay the cause or prolong the life of the individual. The leukemias and agranulocytosis may be aided temporarily by small amounts of blood given at judicious intervals.

CONTRAINDICATIONS.

In some situations transfusion is contraindicated. For instance, in a rapidly bleeding peptic ulcer, ruptured varices, sometimes typhoid ulcers and tubercular hemorrhages; these, in many cases, and it is always up to the judgment of the attending physician, can better receive fluids under the skin for a few days while at complete bed rest and transfusion given later. The exception, of course, is when the hemorrhage has been exsanguinating—then blood must be provided at once. The rationale for this delay is this—that a new volume of blood, added to the circulation at the time of a large hemorrhage increases the blood volume and therefore the tension of the bleeding part rises with continuation of the bleeding.

REACTIONS AND THEIR MANAGEMENT.

First of all let it be emphasized that an ounce of prevention is worth pounds and pounds of cure.

The most dangerous reactions are those that occur within a few minutes of the start of a transfusion. These symptoms should cause increased vigil upon the part of the operator: 1. Lumbar pain. 2. Dyspnea. 3. Cyanosis. 4. Headache. 5. Rigor or chill. 6. Marked increase in pulse rate. 7. Sudden rise in temperature. Because of the importance of the first named symptom it is wise to refrain from opiates preceding transfusions since they will mask this and other leading symptoms. Dangerous reactions rarely occur when less than 100 c.c. of blood have been given. Therefore, it is well to proceed very slowly with the first 100 c.c.

Reactions that manifest themselves by oliguria and anuria are often fatal. They seldom occur before 6 hours or after 24 hours following transfusion. Hematuria or failure to void should excite

caution. The urine, if a few c.c. can be catheterized, will show hemoglobin, casts, and albumin. The pulse is normal and *there is no pain*. Rarely does this last more than ten days without a decisive indication as to the outcome. Sometimes this reaction is characterized by a marked increase in urinary output (1800 c.c.). A decrease in urine urea is the best indicator of what is taking place because the detoxification is often far behind the elimination. Sometimes a nephritis occurs as long as 10-14 days following a transfusion that otherwise gave no indication of mishap. Prognosis is hazardous. But if recovery ensues permanent sequelae are rare. Such reactions as these are nearly always due to incompatible blood and are always accompanied by digestive upsets such as vomiting diarrhea, and perhaps by coma, convulsions and death.

Hives sometimes occur but this reaction is more inconvenient than dangerous.

A small point that is worth remembering is that when possible a very ill patient's urine should be alkalized before transfusion is given. The reason is this: that in the cases of observed transfusion anuria nearly all have been in patients with acid urine, and, efforts to produce anuria in dogs was accomplished only in those having acid urines. Those having alkaline urine did not exhibit this in a single case.

Treatment of the immediate reaction is usually with adrenalin, of course removing the cause as much as possible by stopping the transfusion, about 0.25 c.c. subcutaneously is usually sufficient but sometimes it may be given even intravenously, depending on the severity of the reaction. It is well therefore to have at every transfusion an ampoule of 1 to 1000 adrenalin. It may not be needed for 9,999 transfusions but when it is needed there is no time to wait for someone to go and get it. For the remainder of the reactions the treatment is largely symptomatic. In the cases having hematuria following transfusion some writers recommend a second transfusion with absolutely compatible blood. There are only rare discussions of this in the literature, however, and it is not recommended without warning.

The best course is to prevent reactions. They can be minimized by careful attention to the small details. A smooth transfusion is the perfection of these small, but sometimes important details. Good precaution entails the following points.

1. Careful choosing of donor—Wassermann negative, healthy, preferably fasting. Donors having eaten a large meal always show foreign proteins in their sera.
2. Meticulous matching and typing.
3. Slow administration of the blood.
4. First quality and cleanliness of all materials.
5. Condition of patient.

CONCLUSION.

Transfusion is a very valuable procedure without grave danger and practically without mortality when carefully and properly performed. It can be done by any physician, and even in homes, with a minimum of equipment, but is better done in a hospital, where better facilities are available.

Southwestern Medicine, January, 1937.

Extract.

VITAMIN C AS A SUPPLEMENT IN THE THERAPY OF PEPTIC ULCER.

A. B. Rivers, M. D., Division of Medicine, and L. A. Carlson, M. D., Fellow in medicine, The Mayo Foundation: No consideration of the cause and treatment of peptic ulcer can fail to reckon with the importance of hydrochloric acid. It is a *sine qua non* in the etiology of peptic ulcer. Most methods of treatment are directed toward the control of this factor, and the more successful they are in reducing the concentration of hydrochloric acid in the gastric chyme, the more efficient they are as a rule in controlling the symptoms of ulcer and in bringing about healing. The chemical factor, however, is only one of the interrelated causes in the production and recurrence of ulceration.

In a recent paper we considered lowered resistance of tissue as a possible cause of peptic ulceration. It is unnecessary to point out that, when a definite diminution in cellular resistance has occurred, ulceration could be accomplished in the presence of acid-pepsin of normal erosive potentiality. Some ulcers seem definitely to be related to nutritional disturbances which at times are probably on the basis of a vitamin deficiency.

We have been much interested in the work done in the last year on the importance of vitamin C in the diet. It has been demonstrated that deficiency of this vitamin produces a disturbance in tissues characterized by failure to maintain normal cellular respiration, normal cellular integrity and normal capillary structure and growth. In an attempt to maintain normal structure of tissue the requirements of the individual cells, their intercellular structure, as well as the state of the capillaries supplying nutrition to these cells must be considered. Furthermore, unhealthy mucous membrane cannot absorb all of the essential nutrient materials from the food and this cannot help but disturb the nutrition and hence the resistance of these tissues to erosion.

During the last year we have been investigating patients who have been taking approved ulcer diets for evidence of a deficiency in intake of vitamin C. We have been interested to find that in most instances the intake of this vitamin has been very low. This has been particularly noticeable of patients who have had repeated gastrointestinal hemorrhages, who before and after this complication have often been on grossly inadequate and unbalanced diets.

In order to gather data on the possible relationship of vitamin C deficiency to the ulcer problem certain information was desired: 1. Does the patient give a history of a decreased intake of foods containing vitamin C? 2. Is there an increase in capillary fragility as determined by capillary fragility tests? 3. Is the vitamin C content of blood plasma and urine below normal levels? 4. After adequate therapy with cevitic acid do the results of the capillary fragility test and the values of vitamin C in blood and urine become normal and is there an improvement in the patient's condition?

In the group of patients that we have studied in the last year we have found that the diets usually prescribed for peptic ulcer are likely to be deficient in vitamin C. As yet we do not know how important a part a slight deficiency of vitamin C may play in the causation of simple uncomplicated peptic ulcer, but we do feel that in treatment of peptic ulcer the physician should insure that each patient get an adequate intake of this as well as other vitamins.

In the group of cases under our care in which repeated gastrointestinal hemorrhages have occurred with or without demonstrable peptic ulceration we feel that a deficiency of antihemorrhagic vitamins, among which is vitamin C, may be important etiologically. At least the hemorrhage factor may be influenced by such vitamin inadequacy. In all of these cases there was a history of a decreased intake of vitamin C and in only one case did the capillary fragility test give normal results. In some cases as many as 200 petechiae appeared in a 5 sq. cm. area on the forearm after cuff pressure of 50 mm. of mercury for fifteen minutes. In all cases values of vitamin C were subnormal in blood and urine. We considered the normal value of vitamin C in blood to be more than 0.9 mg. per 100 c.c., and in urine to be more than 15 mg. in a twenty-four hour specimen. In all of the cases results of the capillary fragility test, and the values of vitamin C in blood and urine returned to normal after administration of cevitic acid. We usually gave 500 mg. a day in divided doses for three days and 200 mg. a day thereafter for six weeks. In all cases improvement in the general condition has been marked. In addition to vitamin C these patients also received a high calorie bland diet. Sedation in the form of barbiturates was used and, if they were complaining of distress, this was controlled by doses of 60 to 80 grains (4 to 5.3 gm.) of alkali daily.

CONCLUSIONS.

The usual diets given patients with peptic ulcer are likely to be deficient in vitamin C. Vitamin C deficiency may play an important role in the etiology of hemorrhagic gastroduodenal lesions. It seems reasonable to add supplementary vitamins especially vitamin C, to the usually approved ulcer regimens, particularly in cases in which the ulcers are complicated by hemorrhagic tendencies.

X-RAY THERAPY IN MALIGNANT DISEASE OF THE THROAT.

J. STRUTHERS FULTON, GLASGOW.

The Journal of Laryngology and Otology, July, 1937.

The three possible methods of treatment of malignant disease of the throat to be considered are complete surgical removal, implantation of radium and external radiation.

Surgically there is to be considered the risk as well as the probable partial permanent physical disability. The implantation of radium in throat cases is usually technically difficult. If the implantation is correctly done on the primary lesion, this does not take care of the usual accompanying or following gland problem. The external radiation takes care of both the initial lesion as well as the glands and does not interfere permanently with the function of the part treated.

The relative merits of the use of x-ray and radium are discussed. "Holtheusen has shown that if x-rays and radium be used at the same intensity an exactly similar biological response is produced." The best results with either is when the treatment is protracted and carried out at a low intensity.

Lower intensities of x-ray do much less skin damage - this fact makes it possible to give the throat lesion an adequate dose, which was not possible with the older methods.

Continuous application of radiation at low intensity would be ideal treatment. This is manifestly difficult but as much as six hours per day have been given nicely per patient.

There is the possibility of damage which could be done to the blood if sufficient dosage is given with the radium collar. There is a discussion on the disadvantages of this method.

The lead-lined cone in the use of the x-ray eliminates the possibility of damage to the blood. With x ray when two diametrically opposite fields of adequate area to take care of the primary and lymph drainage area are used, an ideal through and through homogeneity is obtained.

The author is of the opinion that the physical distribution of the therapy is of more importance than the continuous radiation.

Except Saturdays and Sundays, the patient receives daily treatment for a period of six weeks. Both areas are treated each time, two hours in the morning and two hours in the afternoon. The skin reaction begins about the third week and reaches its maximum about the fifth week. Lanoline is used as a dressing. Difficulty in swallowing is experienced after the fifth week for about two weeks. Unless the patient is debilitated he is treated as an outdoor case.

The two sequelae mentioned are: Dryness of the mouth (due to radiation of the salivary glands), which may persist up to one year; submental oedema, which subsides after months.

ACUTE APPENDICITIS. A COMPARATIVE SURVEY WITH REMARKS ON ITS MANAGEMENT.

BY H. JACKSON KING, M.D., *Binghamton, N. Y.*

The American Journal of Surgery, July, 1937.

"Certain conclusions may be drawn from this mass of information:

"1. The operative mortality for acute appendicitis at this hospital, under a regime of radical treatment as practiced by a sizeable group of surgeons employing varied techniques, was 4.2 per cent during the year 1934-35. This represents a marked reduction in the mortality of five years previously. While this mortality in no sense is comparable to that reported by certain clinics, better hospitals, and in various individual series, it nevertheless represents a rather respectable effort to cope with a problem of increasing difficulty.

"2. Inadequate hospital records prevented an evaluation of the importance which the factors of time and cathartics may have played in effecting this lowered mortality, but it is certain that better surgical judgment and improved surgery were largely instrumental in producing the marked drop in mortality which occurred in the group of cases complicated by peritonitis.

"3. The mortality in acute uncomplicated appendicitis at this institution is creditable and probably almost irreducible, but the treatment of appendicitis with abscess still shows a mortality which is much too high.

"4. A short experience with bacteriophage as an adjuvant in the treatment of ruptured appendicitis is reported. No apology is

made for the brevity of the series since the cases are considered to be representative. However, it is appreciated that only through trial in a reasonably long series of cases can a true estimate of its value be reached.

"5. It is likely that no one operative procedure will effect a very material drop in mortality among the severe cases of appendicitis. Improved mortality in all probability will result largely from the exercise of better judgment as to when to operate and how much to do. However, three points in operative procedure do stand out as worthy of particular consideration in any plan for reducing operative mortality in appendicitis.

"1. The weight of evidence seems to indicate that in the very small percentage of cases where a severe spreading peritonitis complicates the picture, a regime of conservative treatment and temporary delay in operation offers the patient the best chance of recovery.

"2. Controlled series seem to show that the use of the McBurney incision or its modifications favours a lowered mortality by confining operative manipulations to a very limited area of the abdomen, thus helping to keep the peritoneal infection localized.

"3. In an admittedly short series of cases, bacteriophage has shown that it is worthy of further investigation in the treatment of cases complicated by peritonitis.

"The experience has been that improvement in the hospital management of acute appendicitis is capable of producing a marked lowering in the mortality rate of this disease. It appears probable, however, that any considerable mortality drop will occur only when the public is thoroughly enlightened regarding the dangers of catharsis and of procrastination in the treatment of abdominal pain, and when routine early hospitalization of these cases will make possible removal of the appendix at a time when the operation carries with it, in experienced hands, a mortality which is almost negligible."

Medical News & Notes.

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION, PALAMCOTTAH.

(Tinnevelly Branch of the Indian Medical Association).

The monthly meeting of the Tinnevelly District Medical Association was held at S. A. V. High School, Tuticorin, on Saturday the 29th of October 1938. Members numbering 27, including two women

doctors were present at the meeting. Fifteen members of the Tuticorin Medical Union were also present.

After Tea and Sweet music the meeting began under the Presidentship of Dr. P. Janardhana Rao, L. M. & S.

The Secretary and Treasurer read out the Minutes of the monthly meeting of the Association held on the 24th of September 1938, which were passed.

Dr. D. Kirubaimani, read out the following cases which were operated and treated at the Government Hospital, Tuticorin:—

1. Two cases of Diphtheria in extremis treated and cured by Tracheotomy and serum injections.
2. A case of Adenomatous Goitre operated in the Hospital.
3. A case of Meningitis due to Chronic Otorrhoea.

Dr. G. Manuel, L.M.P., of Tuticorin delivered an interesting lecture on "Excerpts from General Practitioner's Memoranda."

Thereafter Dr. P. Janardhana Rao, L.M. & S., summed up the salient and important features of all the cases and their differential diagnosis in detail. He thanked Dr. G. Manuel, L.M.P., for his interesting address and also thanked the School authorities for lending the school premises at the disposal of the Association for holding the meeting.

Thereafter an excellent Dinner brought the happy gathering to a close at 10-30 P.M.

HEALTH EXHIBITION.

Under the auspices of the Tinnevelly District Medical Association in connection with the monthly meeting, a Health Exhibition was arranged at the S. A. V. High School, Tuticorin, on the 29th of October 1938 at 10 A.M.

Dr. P. Janardhana Rao, L. M. & S., welcomed the guests and requested Sri Duraiswami Nadar, M.L.A., to open the Exhibition.

Sri Venkateswara Ayyar, Chief Sanitary Inspector, Tuticorin delivered an interesting lecture in Tamil, regarding sanitation, cholera, tuberculosis etc., for the benefit of about 300 boys and girls.

The Exhibition was kept open till 12 Noon. The exhibits consisted of Posters on Tuberculosis, Small-pox, Flies, Mosquitoes and Cholera etc. The exhibits of the Tuticorin Municipality were also exhibited.

THE KISTNA DISTRICT SUBSIDISED RURAL MEDICAL PRACTITIONERS ASSOCIATION.

A special meeting of the above Association was held at Bezvada in the Government Hospital at 3 P.M. on Sunday 6-11-'38 when Dr. H. C. Halge of the local Hospital Presided. Dr. N. Rama Rao, the Secretary read the minutes of the previous meeting which were passed and the address by Dr. V. Rama Kamath, President, P. R. M. A. was read over to the members who was invited for this

meeting but who could not go over there on account of unavoidable domestic inconveniences.

The meeting then passed unanimously the following resolutions.

(1) This association expresses its deep sorrow on the death of Dr. K. Venkaiah, R. M. P. Cheavurs and resolves to convey its sympathy to his family in bereavement and authorises the Secretary to communicate the same to the deceased's family.

(2) This association resolves that the Kistna Dt. S. R. M. P. Association be converted into the Kistna Branch of the Provincial subsidised R. M. P. Association; and that Dr. S. S. Ramarao of Kanuwole be elected as the representative to the Provincial Committee of the P. S. R. M. P. Association.

(3) This Association views with great concern, the Government's move as per their Memorandum 34730—1—D2 P. H. dated 30th September '38 to curtail or abolish the subsidy and medicines now given to the R. M. P. and requests the Government to drop it forthwith as such a step would be ruinous both to the R. M. P. as well as to the poor village patient whom he is expected to serve.

(4) This Association is of opinion that the Honorarium fixed for the R. M. P. doing Public Health Work in G. O. No. 2639, dated 21—7—'38 is too low when compared to the loss of private practice and the amount of work to be done and requests the Government to so alter the G. O. as to fix the Honorarium not lower than Rs. 30 per mensem with a vaccinator to assist him. It further requests the Government to give the usual subsidy while on Health training in addition to the proposed Honorarium of Rs. 25 for the period.

(5) Resolved to request the D. M. O. Kistna to afford facilities to the R. M. Ps. in the District to attend operations and study cases in the Head Quarters Hospital during Sundays and Public Holidays not exceeding four days in the month and also to arrange for bedside clinics and post graduate lectures on the penultimate Saturdays.

(6) Resolved to request the District Board Kistna to uniformly sanction a fixed contingency of Rs. 5 per month for each dispensary and do away with the present practice of granting of the actual expenses incurred and that too upto Rs. 3 and qualified by vouchers and certificates as such a procedure is most cumbersome and time-consuming.

(7) This association bring to the notice of the Government the delay and irregularity in the supply of medicines and the resultant dislocation of work and request the Government to so arrange the supply as to reach the R. M. P. not later than a date fixed and also see that all medicines indented for one supplied in one time without instalments as is at present done.

(8) The association thanks the Government for having done justice in reinstating the R. M. P., Pakevada who was unduly

thrown out of service for no fault of his; and resolves to request them to sanction his subsidy for the intervening period.

(9) Resolved to request the Government to give effect to the resolution No. 18 of the P. S. R. M. Ps. conference passed on 10-7-'37 as such a course would create an atmosphere in which the R. M. P. would be able to do more useful work.

CUDDAPAH MEDICAL ASSOCIATION.—At the invitation of Dr. G. Timma Reddi, M.B., B.S., Civil Assistant Surgeon of the local Government Hospital, the periodical meeting of the Cuddapah District Medical Association was, for the first time, held at Proddatur on 19th November in the premises of Mr. Sambasiva Rao Chaudary, District Munsif. Dr. T. R. Harinarayana Rao Pantulu, L.M. & S., D.M.O. Cuddapah, presided.

Dr. Timma Reddi read his paper on "Gastric Analysis." Questions were invited and answered.

The President, in his concluding remarks, conveyed to those present the appeal of the Surgeon-General to become members of the St. John's Ambulance Association and train up young people in first-aid. He then thanked Dr. Reddi for his paper and the excellent arrangements and the meeting terminated.

Immediately after the rural medical practitioners of the district met together in a conference and passed resolutions protesting against the recent proposals of Government to reduce subsidies to rural medical practitioners and requesting the Government to give a sum of Rs. 25 as honorarium to rural medical practitioners when on deputation to Madras for undergoing training in Public Health, in addition to their usual subsidies.

After an interesting programme of vocal and instrumental music by Misses Ramani and Madhani and violin by Mr. Jamal, the members were entertained at dinner by Dr. Reddi.

Review.

M. & B. 693 IN PNEUMOCOCCAL INFECTIONS.

We have received from Pharmaceutical Specialities (May and Baker) Limited a copy of a booklet entitled "M. & B. 693 in the Treatment of Pneumococcal Infections". This publication deals with the method of administration of M. & B. 693, the dosage scheme to be adopted in cases of lobar pneumonia in children and adults, and broncho-pneumonia in children. A further section gives general notes on the treatment of other forms of pneumococcal infections.

We are advised that copies of this booklet and the new price list are available to members of the medical profession on request.



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