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The Medical Practitioner

A Monthly Medical Journal

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Original Articles.

JAUNDICE.

By

DR. S. S. RAU, M.D.,
(Bombay).



Jaundice is a symptom characterised by increase of bile pigments in the blood and the staining of the skin and conjunctiva by it. Normally the blood contains 1-250,000 of bile pigments.

To understand the subject it is necessary to understand fully the formation and function of bile pigments and bile salts.

The bile pigments are two in number, bilirubin and biliverdin. The latter is formed by the oxidation of the former in the bile passages. Bilirubin is formed from the dead R. B. C. by the reticulo-endothelial cells which are found chiefly in the liver (Kupffer's cells) spleen and bone-marrow. The average life of the R. B. C. is about three weeks; before death it throws out a process and is called a poikilocyte, the process separates, fragmentation takes place and fragments are taken up by the reticulo-endothelial cells which manufacture from it haemosiderin an iron containing substance which is used for the manufacture of fresh haemoglobin and bilirubin which is handed over to the hepatic cells where it undergoes certain changes and then passed on to the minute bile capillaries.

From the bile capillaries it goes through the hepatic duct to the gall bladder and from it *via* the common bile duct to the descending part of the duodenum. It mixes with the food and no change occurs in it until it reaches the colon where the bacteria transform it into stercobilin, a part of which is excreted through the faeces imparting it the yellow colour; the other part is absorbed and goes back to the liver from where some is excreted as urobilinogen in the urine and the rest used for the manufacture of haemoglobin of the R. B. C.

The bile salts are also two in number *viz.*, Sodium glycocholate and Sodium taurocholate. They are the sodium salts of Sodium glycocholic and taurocholic acids respectively. Both of them are derivatives of the amino acids, glycine and cystine. The bile salts are most probably manufactured by the hepatic cells and together with the pigments are poured into the duodenum. They increase the activities of the pancreatic enzymes *viz.*, trypsin, amylase and lipase and also increase the permeability of the intestinal mucosa to the products of fat digestion. The bile salts are not excreted but reabsorbed and stored in the liver.

The signs and symptoms vary according to the kind of jaundice and hence are described under the respective varieties.

VARIETIES.

Jaundice may be divided into Latent Jaundice and Dissociated Jaundice.

LATENT JAUNDICE: Here the urine is not coloured bright yellow though the blood contains a very large amount of bile pigment. This condition is found in Addisonian anaemia where on account of the dissemination of a large number of R. B. C. the liver cells are not able to cope with the large amount of bile pigments, brought to them by the reticulo-endothelial cells. The excess flows into the blood and stains the skin—faint lemon yellow. The urine does not contain the bile pigment because the kidney threshold for the variety of bilirubin which has not passed through the liver cells is much higher (1—12,000) than for that which passed through it (1—50,000).

DISSOCIATED JAUNDICE: In this condition as the name indicates, there is dissociation between the bile pigments and bile salts in the blood. It is found in Haemolytic Jaundice when though the concentration of the bile pigments in the blood increases the bile salts flow into the intestines as there is no obstruction to their passage. Hence their concentration in the blood does not increase.

Clinically Jaundice is divided into:

1. Obstructive Jaundice,
2. Haemolytic Jaundice,
3. Toxic and infective Jaundice.

OBSTRUCTIVE JAUNDICE.

As the name indicates there is obstruction to the flow of bile, the obstruction is generally found in the main bile passages though it may occur in the bile capillaries on account of their obstruction by the fibrous tissue as in cirrhosis or by the malignant growth in cancer, sarcoma or by the scar tissue of a gumma.

The obstruction to the main bile passages may occur either inside the passages as by a gall-stone or round-worm; in the wall as by inflammation cicatrice or malignant changes; or outside the wall as by the pressure of enlarged glands mostly malignant or Hodkin's, by malignant growths as in cancer of the head of the pancreas or fibrous changes as in chronic pancreatitis.

SIGNS AND SYMPTOMS: The sign usually noticed first is the change of colour in the urine which becomes bright yellow, on account of the bile pigments found in it. The stools are whitish or clay coloured and stinking. The change in colour of the stools is due to want of stercobilin and the bad smell on account of the large amount of fatty acids and soaps which have not been absorbed in the intestines due to the lack of bile salts. The conjunctiva is yellow. This change of colour can best be observed in natural light and in the early stages by asking the patient to look down without bending the head when the bulber conjunctiva covered by the upper eyelid shows the earliest manifestations.

The skin has a yellow tinge best seen in fair patients; this colour sometimes changes to a deep olive green when the obstruction is due to cancer of the liver pigmentary deposits of the nature of xanthoma are sometimes seen specially in the eyelids.

The pulse is slow, most probably on account of the action of the bile salts on the heart. There is pruritus also on account of the irritation due to the bile acids.

The coagulation time of the blood is increased due to the binding of the blood calcium on account of excess of bile pigments.

The cause of obstruction may be found only by the history and physical examination. In the case of gall-stones there is a history of biliary colic and the jaundice varies in intensity according to the amount of obstruction. X-ray examination after administration of tetra-

iodo-Phenolphthalin will confirm the diagnosis.

Examination of the stools will show the characteristic ova of the round-worms in rare cases when the obstruction is due to that parasite.

Catarrhal Jaundice is a very common disease. There is fever, vomiting, high coloured urine, clay coloured stools, yellow conjunctiva and enlargement of the liver which is tender also.

Malignant growths of the liver are mostly cancerous and generally secondary to cancerous growths of the digestive tract. The primary growth should always be looked for. The liver is enlarged; there is ascites and the colour of the skin and conjunctiva change soon to a deep olive green tint.

Jaundice occurs in cirrhosis of the liver in the early stages in Hanot's unilobular cirrhosis which is very rare, fairly early in syphilitic cirrhosis of the congenital type and gumma of the liver and in the last stages in the portal cirrhosis and in infantile biliary cirrhosis. Hanot's cirrhosis is familiar, the liver is enlarged and smooth and the jaundice very deep. Syphilitic cirrhosis occurs generally in congenital cases. The liver is enlarged and the other stigmata of syphilis like snuffles, the napkin rash, separation of epiphysis are present. In portal cirrhosis, the characteristic facies, the enlarged veins of the abdomen, the hobnailed liver and the ascites are diagnostic. The infantile biliary cirrhosis is a fairly common disease among the children in South India. It is familial and hereditary. Children above the age of four are not generally attacked, a low grade fever, obstinate constipation, lead shot like hard clayey stools, high coloured urine are characteristic in the early stages. The liver is definitely enlarged and painful, jaundice, ascites and cholaemia close the final scenes of this disease which carries a heavy toll.

In cancer of the head of the pancreas the gall-bladder is always enlarged and

secondary deposits are found elsewhere. In chronic pancreatitis though the gall-bladder is enlarged there is less pain and there are no secondary deposits. In both the diseases there is hyperglycemia, sugar in the urine and the stools contain undigested fibres and globules of neutral fat.

DIAGNOSIS: The urine should always be examined by Gmelin's test for bile pigments by Hay's test for the bile salts and by Benedict's test for presence of sugar. The naked eye examination of the stools have already been referred to. It should be examined for gall-stones. Microscopical examination may reveal a large number of crystals of fatty acids.

Blood examination for bile pigment by Van den Bergh test is useful not only for diagnosing jaundice, but for differentiating the three clinical varieties of it. The principle of the test depends upon the fact that the bile pigment becomes altered during its passage through the hepatic cells, and colour changes produced in the reaction depend upon this change which is produced during the passage through the liver cells.

Briefly described if 1 c. c. of Ehrlich's diazo reagent is added to 1 c.c. of blood serum the following changes may occur:

1. A change in colour to bluish violet within 10 to 30 seconds. This is called positive direct reaction, and is found in obstructive Jaundice when the bile pigment has passed through the liver cells.

2. No change in colour for 1 to 15 minutes and then a change to reddish violet. This is called a delayed reaction and is found in haemolytic Jaundice, when the blood pigment circulating in the blood has not passed through the hepatic cells. The change in colour may be hastened by the addition of absolute alcohol. This is called positive indirect and is also found in Haemolytic Jaundice.

3. An immediate change to red becoming violet after 10 minutes. This is called biphasic reaction and is due to a mixture of pigment some of which has

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passed through the liver cells and some not. This reaction is found in infective and toxic Jaundice where because the liver cells are diseased only a small amount of the pigments pass through them.

WASSERMANN'S TEST: should be done to differentiate cancer of liver in early stages from gumma of the liver.

PROGNOSIS: This depends upon the cause and whether it can be removed or not and also upon the stage at which the disease comes under treatment. The prognosis is very good in catarrhal Jaundice and in round-worm obstruction. In syphilitic cirrhosis and gumma the prognosis is also good provided suitable anti-syphilitic treatment is adopted. In gall-stones the prognosis is good provided surgical treatment is resorted to before extensive adhesions of the gall-bladder have taken place.

In malignant growths the prognosis is uniformly bad. Cirrhosis of the liver when it has attained the stage of Jaundice is mostly fatal.

TREATMENT: The diet and regimen in all cases whatever be the cause, are usually the same, the patient being restricted to bed and given food which does not contain fats. Liquid diet such as skimmed milk, butter milk, fruit juice etc., should be advised. Spices should be avoided. In catarrhal Jaundice, a saline diaphoretic mixture containing Soda-Bicarb, Ext. Kalmegh Liquidum will usually suffice. Bowels should be kept open by gentle aperients such as Magnesium Carb. Bile pills and small doses of Hexamine may be given in the later stages. In severe cases of epidemic catarrhal Jaundice, glucose and Soda-Bicarb in saline should be given intravenously. Obstructive Jaundice caused by roundworm is relieved by a dose of Santonine followed by a suitable purgative.

For Jaundice caused by gall-stones cholecystectomy is indicated. When cancer of liver or pancreas is the cause of Jaundice the treatment is only palliative.

The cases where Jaundice develops in Portal or Infantile Biliary Cirrhosis are always fatal.

If Jaundice is due to Syphilitic Cirrhosis of liver of congenital type, it may be successfully treated with iodides, mercurial injections and Bismuth injections. Later, Arsenical injections in small doses should be had recourse to. In adults if it is a gumma that caused Jaundice large doses of Iodide should be given along with injections of Bismuth. And later small doses of suitable Arsenical preparations should be resorted to.

HAEMOLYTIC JAUNDICE.

In this variety there is a large destruction of R. B. C. either due to the immaturity of the cells as in Addisonian anaemia, due to excessive fragility as in acholuric Jaundice, to the presence of toxins as in black water fever and to redundancy as in the Jaundice of the new born.

The large amount of bile pigment which is formed is not capable of being dealt with by the liver cells. Hence a large part of it circulates in the blood without passing through them and stains the skin and conjunctiva. A small part which passes through the liver cells undergoes the usual changes and is partly excreted in the stools which are yellow. The kidney threshold for this kind of bile pigment being high, the urine is not affected.

SIGNS AND SYMPTOMS: Generally there is no fever in this Jaundice; but high temperature is found in Black Water Fever and a low grade fever in Addisonian anaemia. The skin and conjunctiva are yellow, the colour varying according to the amount of blood deterioration. The stools are always yellow and the urine not coloured. The Van den Bergh reaction is delayed positive and positive indirect.

The chief varieties of Haemolytic Jaundice may be discussed under the following 4 Heads:

1. **ADDISONIAN ANAEMIA:** The patient though seemingly well nourished com-

plains of extreme weakness, the skin is slightly lemon yellow, conjunctivae and finger nails pale. There may be slight fever.

On examination the heart shows murmurs especially well marked in the pulmonary area; the liver and spleen are enlarged, the knee jerks lost and the plantar reflex is extensor. Blood examination shows diminution of R. B. C. poikilocytosis, anisocytosis, megalocytes, magaloblasts, polychromatophilia and sometimes punctate basophilia. There is leucopenia with diminution of polymorphonuclear leucocytes. The percentage of haemoglobin is diminished and the colour index more than unity. A fractional test meal reveals achlorhydria.

The treatment consists of administration of liver extract by injections. The disease being due to deficiency of the antianæmic principle, the injections should be continued even after the blood picture becomes normal.

2. **ACHOLURIC JAUNDICE:** There are two varieties in this; the hereditary and the acquired. In both, there are Jaundice and anaemia but the latter is more in the acquired type than in the congenital. The patient seems to be all right but for these two symptoms. The Jaundice becomes more on exposure, exertion or excitement. Attacks of biliary colic occur on account of the concretions of pigment.

The most characteristic feature in this Jaundice is the excessive fragility of the R. B. C. Normally the R. B. C. begin to haemolyse in 4 per cent saline and the haemolysis is complete in 3 per cent saline. In this disease the fragility commences at 6 per cent saline and is complete at 4 per cent saline.

The treatment is mostly surgical. Removal of the spleen ameliorates the symptoms.

3. **BLACK WATER FEVER:** In this fever as the name indicates the passage of urine which is black in colour due to excess of haemoglobin is the characteristic feature. It occurs in certain endemic areas where malaria is rampant. The

persons who are attacked had previously malarial fever and have resided in the endemic area only for a short time. The malarial parasite is not found in their blood during the attack of fever. Taking of quinine precipitates an attack; the patient gets suddenly a rigor followed by fever. Soon after there is haemoglobinuria which goes on even to suppression of urine. There is intense Jaundice and severe vomiting.

The treatment consists in giving large doses of glucose in saline intravenously. Soda bicarbonate both by mouth and intravenously is very useful. Quinine should not be given. After recovery iron by mouth should be given for the anaemia.

4. **JAUNDICE OF THE NEW BORN:** Soon after birth there is a large destruction of R. B. C. which are not necessary after the lungs begin to act. This produces slight Jaundice which disappears after a few days and for which no treatment is necessary. Sometimes this destruction exceeds normal limits and there is intense Jaundice with drowsiness and enlargement of liver and spleen. This is a serious disease and should be immediately treated by daily injections of 15 c. c. of parental blood for 3 or 4 days.

TOXIC AND INFECTIVE JAUNDICE.

In this condition a poison acts upon the liver cells which become diseased and hence are capable of dealing with only a part of the bile pigment brought to them. The same poison acts upon the bile passages also causing a swelling of their walls which produce a certain amount of obstruction. Hence the bile pigments circulating in the blood are partly those which have passed through the liver cells, but have been reabsorbed into the blood on account of obstruction and partly those which have not passed through the liver cells because they are diseased. The Van den Bergh reaction is therefore biphasic.

The toxin acting upon the liver may be:

1. Bacterial as in typhoid fever, pneumonia, portal infections and ascending cholangitis.

2. Spirochaetal as in spirochaetosis ictero-haemorrhagica.

3. A Virus as in Yellow fever.

4. Poisoning by inorganic substances such as phosphorus and arsenic.

5. Poisoning by organic compounds like chloroform.

6. Metabolic causes as in pregnancy.

A brief description containing a few diagnostic points of each of the causes is given below along with treatment:

Jaundice occurs as a complication of typhoid fever in the 2nd and 3rd week. The Widal's reaction and the characteristic physical signs of typhoid fever are present. In pneumonia one sometimes meets with jaundice on the 5th day onwards. The physical signs and the pulse respiration ratio are diagnostic. In addition to the usual treatment large doses of soda-bicarbonate and glucose should be given.

Spirochaetal jaundice is caused by infection taking place through the skin or the food by spirochaetæ which are found in the excreta and urine of infected rats. The disease is mostly found in temperate climates. There is high fever with shivering, hæmorrhages from various parts of the body, herpes about the lips may also be present.

The diagnostic test consists in finding the spirochaetæ in the blood which can be done by the injection of 3 c.c. of the blood intraperitoneally in the guinea pig in the first five days of the disease or a similar quantity of urine intraperitoneally in the later part of the disease.

Treatment consists in giving large doses of soda-bicarbonate, glucose by mouth in mild cases or intravenously in saline in severe cases; calcium gluconate 10 c.c. of 10 per cent solution intravenously is very useful.

Yellow fever is found in certain endemic areas in the Southern part of North America, Northern part of South America

and West Africa. It is due to a virus conveyed by a mosquito which becomes infective 12 days after feeding on the blood of a patient suffering from yellow fever during the first four days. The disease is characterised by rigor high fever, black vomit, albuminuria and by a peculiarity of the pulse and temperature ratio called Faget's sign. About the third day, the pulse which was high, begins to slow down to 60 or 70 per minute though the temperature remains high. Jaundice appears about the fifth day of the disease.

The patient should be protected by mosquito nets and should have complete rest in bed. Plenty of glucose, sodium bicarbonate and calcium lactate should be given. The diet should be liquid consisting of milk and fruit juice and should be increased slowly after the fourth day of convalescence.

In the poisoning by phosphorus the jaundice appears two or three days after the irritant effects of the phosphorus have subsided.

Arsenobenzol poisoning occurs after its intravenous administration. The jaundice may appear a few days after the injection or it may be weeks or months after it. Hence a careful history should always be taken whether an arsenical derivative has been given by injection.

Chloroform poisoning occurs after anaesthesia especially in children. The signs appear three or four days after the anaesthetic has been given. Before anaesthesia urine should be examined for acetone and if found, chloroform should not be given until it disappears. Plenty of sugar should always be given during the time that food is withheld before chloroform anaesthesia.

Injections of glucose and calcium form the best treatment for all the Liver poisons.

Acute Yellow Atrophy of the Liver occurs generally during pregnancy. There is fever, vomiting at first which are followed later on by drowsiness, headache,

restlessness, and delirium and twitching of the muscles. The urine contains albumin and on microscopical examination leucine and tyrosin.

The prognosis is very grave. The patient should be kept on fluid diet containing half pound of glucose per day dissolved in a pint of lemonade and fed at intervals of five to six hours. The bowels should be freely opened by

magnesium sulphate. If the patient cannot take anything by mouth, rectal route should be resorted to. Insulin injections 10 units twice a day should be given 15 minutes before the morning and evening feed to ensure better absorption of the glucose. If the patient cannot take food by mouth, saline should be given per rectum and 25 c.c. of 50 per cent solution of glucose given intravenously twice a day preceded by 10 units of insulin.

DYSENTERIES

By

DR. K. NARAYANAMURTI, M.D.

AMOEBIIC DYSENTERY,

(Continued from the last issue).

Treatment: The Medical Practitioner who is called upon to treat a case of acute or subacute case of Amoebic dysentery is at times in a most unfortunate position as the patient tries a number of supposed cures before he comes to him. Every day the literature is flooded with drugs such as Yatren, Dimal, Stovarsol, Rivanol and a host of others. If the claims made for some of these specifics could be substantiated it is not easy to understand why Amoebic dysentery should continue to afflict the human race to the extent it does now. After trying all drugs and after reading the reports of treatment of Amoebic dysentery with a host of proprietary drugs so far put into the market, I may say with a certain amount of confidence that nothing as yet has been found that can replace Emetine in the treatment of Amoebic dysentery. But it is desirable that the practitioner should know and study the mode of action and the cumulative toxic effects of this most useful preparation which if not administered with caution is likely to do permanent damage to the system, at times more harmful than Amoebic dysentery itself. The mode of action of Emetine on *E. histolytica* still remains a problem. Vedder in 1912 was the first person to discover that the action of Ipecacuanha in Amoebic dysentery was due to its alkaloid Emetine.

Rogers in 1913 was the first person to take up Vedder's suggestion and to introduce Emetine in the routine treatment of Amoebic dysentery. Vedder and Rogers believed that Emetine had a direct parasitocidal effect on the amoebæ. Wenyon in 1926 pointed out that *E. histolytica* either in faeces or in liver abscess pus could not be killed in strong solutions of Emetine, and that the amoebæ could remain as perfectly active as in the control preparation. Therefore he concluded that Emetine has no toxic action on the Amoebæ at least to the extent believed by Vedder and Rogers.

Dobell investigated the action of Emetine on experimentally infected cats and came to the conclusion that its action on the amoebæ was an indirect and not a direct one. Its primary action was apparently on the host in some way rendering the tissues unsuitable for the amoebæ to grow. Mayer came to a similar conclusion. The latest study of the whole problem is found in the memoir written by Dobell and Laidlaw in 1926. These workers tested the action of Emetine and other alkaloids on *E. histolytica* and other Entamoebæ. Their observations were more or less to the following effect:

1. There are four alkaloids of Ipecacuanha. Emetine, Emetamine, Cephaeline

and Psychotrine, whose exact composition is not yet known. Emetine and Cephaeline have been found to be specific poisons for *E. histolytica* under cultural conditions. Emetine is found to be 10 times as poisonous as Stovarsol and about 50 times as poisonous as Quinine under identical conditions.

2. *Entamoebae coli*, *Entamoebae gingivalis* and *Entamoebae nana* are not affected by Emetine in cultures. *E. coli* was found to withstand a constant ratio of the alkaloid 100 times that is found lethal to *E. histolytica*.

3. One per cent or more of Emetine is needed to kill this parasite instantaneously but in very weak solutions the amoebic can live for a very long time.

In view of these findings it may be concluded that Emetine has a direct lethal action on *E. histolytica*. One must also bear in mind that the patient's own powers of natural resistance can exterminate the disease without the drug. It is true that in all protozoal infections we have to attempt to exterminate the parasite in the tissues of the host by maintaining continuously for a long period the drug in sufficiently strong concentrations so that it might act as a parasiticide. But it should be also remembered that the bodily resistance and the natural powers of recuperation finally help to exterminate the residual infection. For instance it is common knowledge that a large number of patients of Kala-azar and Malaria are seen in perfect health after the conclusion of a course of treatment though a few parasites may be seen in their blood film or in the spleen punctures. Whether the action of Emetine is direct as a parasiticide or indirect acting through something in the host is still not settled. It is safe to keep an open mind remembering its double action. Chopra and Ghosh (1922) and others have shown that Emetine has a cumulative effect, it increases peristalsis, it is a depressant on the cardiac centre and also on the central nervous system, and the maximum quantity for a course that one is justified to give to an adult in relatively fair health should not exceed 10 to 12 grs. In the Calcutta School of

Tropical Medicine a case was seen which had received 23 grs. of Emetine during the course of 11 weeks, the drug having been administered thrice a week. Yet the dysentery was not cured. The frequent motions in this case were attributed to the overdose of Emetine which as referred to above has a tendency for increasing peristalsis and thereby cause diarrhoea. Acton and Knowles report in their book on the Dysenteries of India, about a military Medical Officer giving as many as 5 grs. of Emetine per day to his patients. "If the dysentery cleared up he presumed the case to have been of amoebic origin, if it did not or the patient died, diagnosis of *B. dysentery* was made. How many patients he killed we do not know, but one of the saddest of the numerous war cases which we know of personally, is that of a military medical officer whose cardiac mechanism has been permanently damaged by overdosage with Emetine, but who still suffers to-day from periodic relapses of amoebic dysentery and cannot take Emetine at all and has tried a large variety of the new treatments without success." In excessive doses more than 1 gr. a day to an adult Emetine produces toxic symptoms cardiac irregularity, mental depression, asthenia, emaciation and in rare cases myositis and even to neuritis which may affect a group of muscles producing paralysis. The paralysis might resemble chronic poliomyelitis. Desquamation of the skin and an atrophic condition of the nails are frequently found after Emetine administration.

Emetine given in the form of an enema (1:1000) does not give good results. It is extremely painful and may therefore be avoided.

Emetine injections have to be carefully given especially to debilitated persons. It may produce wide spread cellulitis leading to a localised abscess or the cellulitis might leave behind a patch of irritative eczema or an ulcer. It is to be borne in mind that this drug is extremely toxic to young children. On no account Emetine be given hypodermically to patients who are moving about and taking hard physical exercise as this leads to cardiac damage. The treat-

ment with a course of Emetine injections (Emetine hydrochloride 1 gr. in 1 cc. of distilled water) should be supplemented by the administration of Emetine Bismuth Iodide by mouth.

EMETINE-BISMUTH IODIDE generally known as E. B. I. was first introduced by Dale in 1916. It is an insoluble brick red powder containing 26 p.c. Emetine. When it comes in contact with the tissue juices Emetine is set free. Tablets made out of this substance pass through the intestinal tract unaffected. Therefore it is desirable to give it in Keratin or Stearin Capsules or the powder may be mixed up with gum or syrup before administering it. The maximum dose for an adult is 3 grs. per day which treatment is to be continued for not less than 10 to 12 consecutive days. For debilitated individuals and in women the dose is frequently started with 1 gr. till 3 grs. are reached. If treatment is commenced with smaller doses the patient gradually gets accustomed to the drug. Manson-Bahr is of opinion that the full dosage of 30 to 36 grains need not be given and that if a combined treatment with Emetine is carried on, 19 grs. of E.B.I. are quite enough for a complete course of treatment. There are certain difficulties and dangers which the practitioner should remember in administering this drug. The practitioner should give definite instructions to the patient while prescribing E. B. I. as there is always a tendency in the patients to abuse this drug. The patient should know the proper dose and the duration of the use of E. B. I. It should be given at bed time four hours after evening meal, and not even a glass of milk is allowed to be taken after. Patient should have absolute rest in bed and should endeavour to go to sleep. Any saliva coming from the mouth should be wiped off and should not be swallowed. Vomiting and diarrhoea are to be expected in the earlier part of the course roughly on or about the 6th or 7th day of treatment and this is to be taken as an indication that the drug is being absorbed. If there is no nausea it is justifiable to assume that the drug is not being dissolved and so not absorbed. Excessive vomiting and nausea may be prevented by giving tincture of opium 10 to 15 mms. or luminal 1 gr. half an hour

before the administration of the drug. The condition of the heart and pulse should be noted daily and the treatment need not be discontinued unless the depression is moderately severe. Alcohol should not be given in any form, the patient loses weight and there will be a drop in blood pressure, when the course is complete the patient may be permitted to move about in moderation; but care in diet is necessary. The combined treatment with Emetine injections and E. B. I. has much better results than either of the drugs given singly. Relapses are found to be few with this combined treatment. It is positively dangerous and also an unsound therapeutic procedure to give repeated courses of E. B. I. It is good to examine the faeces microscopically after six weeks of treatment. Possibly no cysts will be found if the treatment is carried out as outlined above.

A modification of E. B. I. is Emetine per Iodide which is found to be less toxic. Its dose is also three grains and it is given in capsules mixed with dried ox-bile 5 grs. The addition of ox-bile seems to facilitate the liberation of Emetine. Another drug known as Auremetine is a compound of Emetine and Auramin (a dye). It is given in 1 gr. doses in gellatine capsules four times daily on alternate days for seven days, and then daily till a total of 40 to 60 grs. are given. It is found that this drug has no advantage whatsoever over the E. B. I. or per iodide.

As referred to above there are a host of other preparations available in the market. Discussion on the treatment of Amoebic dysentery will not be complete unless the relative benefits of these preparations are dealt with.

YATREN. (Bayer.) The drug is sodium-idoxy-quinoline sulphonate is also known as Chiniofon (U. S. Pharmacopeia) Quinoxyl (B. W. & Co.). Other substances with similar chemical composition are known as Anayodin (U. S. A.) and Dysentulin (Germany).

Yatren can be given by mouth or by enema. The maximum daily dose is 15 grs. in powder form, in capsules or in keratin coated pills which are given for 10 days; after an interval of one week the course should be repeated. Yatren in pill form

(4 grs. each) is given when the symptoms are controlled by Emetine. It may be also given in conjunction with Emetine. The maximum dose of these pills is 4 a day. To my knowledge the Yatren treatment has been rather disappointing. German and Dutch writers speak very highly of the value of this preparation but all the world over Emetine is the drug of choice and any other drug cannot act as a substitute for it. Manson-Bahr speaks of getting permanent results with Yatren when it is given by the rectum in the form of retention enema as well as by the mouth. The patient each morning gets an alkaline enema (2 percent Sodium Bicarbonate in a pint of water) and after this the patient has an enema of 8 ounces Yatren solution 2.5 per cent. The patient is encouraged to retain the solution for 8 to 10 hours. The solution is then excreted as a greenish liquid containing mucus and debris. The treatment is continued for 10 days and if necessary a second similar course of treatment may have to be given two or three weeks later. Strict dieting and rest in bed are absolutely necessary. In intractable cases 10 per cent solution of Yatren can be given as retention enema but it is liable to give rise to pain and discomfort. In the hands of Manson-Bahr the combined treatment of Yatren enema and E.B.I. given by mouth is found to be most successful. It is not necessary to give more than 19 grs. of E. B.I. in all and the maximum single dose need not exceed 2 grs. The treatment on the whole is very exhausting to the patient and in order to regain his strength the patient must be permitted 2 day's rest. A sense of weakness or stiffness is produced in the limbs after this treatment is complete. Yatren pills one or two at night are prescribed for the next 3 weeks. Larger doses of Yatren brings on diarrhoea.

STOVAR SOL. (MAY & BAKER). (ACE-TARSOL.—This arsenical preparation (3 acetylamin-4-hydroxy-phenyl-arsenic acid) has been advocated in France as an amoebicide. This drug is extensively used in combination with other drugs. Really this drug has feeble amoebicidal action but it possesses tonic or stimulating properties to counteract the depress-

ing effects of Emetine. Therefore it can be used specially after Amoebiasis is cured. It is sold in 4 grs. tablets. Stovarsol cannot be regarded as a substitute for Emetine but it is of special value as an after treatment. The dose usually required is 4 grs. tablet broken up in a half a tumbler full of water taken once or twice a day systematically for 10 days. Stovarsol has been found useful in some cases which resisted Emetine and E.B.I. The administration of the drug must be carefully watched as it may give rise to toxic symptoms such as erythema with fever closely resembling measles or it may even give rise to arsenical exfoliative dermatitis which may be fatal. A delayed papular toxic rash may appear three weeks after the administration of the drug. The arsenical poisoning may be combated with Sodium thiosulphate injections and the administration of glucose.

CARBARSONE (ELI, LILLY & CO.) (*P. Carbamino-phenyl arsonic acid contains 28.8 per cent of arsenic*).—It is used in India and in America in the same manner as Stovarsol. But it is more toxic than Stovarsol. Therefore it should not be given in cases with complications of liver.

KURCHI AND ITS DERIVATIVES. Kurchi bark contains an alkaloid known as conessine. Acton and Knowles tried this drug in acute cases of amoebic infection without any other subsidiary treatment. They administered 5 grs. of the bark made into a pill three times a day. The patient could easily tolerate a dose of 60 grains a day with no unpleasant symptoms. In experimental conditions the drug appears to be an active amoebicide. Kurchi is available in India on a large scale. It is used extensively by the Ayurvedic physicians. The alkaloid conessine could be manufactured at a price much below that of Emetine and this could be given in doses of $\frac{1}{2}$ -1 gr. by hypodermic injection on 3 successive days. After this, Kurchi bismuth iodide (Anabin) is given by mouth in 10 gr. doses twice daily for ten days without producing any deleterious effects. Acton and Chopra treated a number of cases and gave very encouraging reports. But unfortunately in the hands of several others the results are not satisfactory and even discouraging.

The liquid extract which is sold is not standardised and in effect the bark or its alkaloid is not as useful as Emetine.

RIVANOL. This is a derivative of acridine and is given as a retention enema 1: 200 dilution. It has an action somewhat similar to Yatren; 10 or more retention enemas may be necessary. Rivanol in addition to its effects as an antiseptic is also antispasmodic and it relieves pain and tenesmus. Some advocate its administration by mouth 3-5 grs. three times daily for nine days.

BISMUTH SUBNITRATE. Deeks and James strongly advocate its use in heroic doses of 180 grs. mechanically suspended in a tumblerful of milk or water every three hours night and day in severe cases. On account of impurities contained in Bismuth some toxic symptoms may at times be noticed, as cyanosis and forcible action of the heart. The patient is put on strict diet for 10 days and not allowed irritating food for 2 or 3 months.

After having said so much relating to the treatment of Amoebic dysentery it is necessary to know the criteria of cure. Dobell and Low say in their book:

"It is a general rule that patients undergoing treatment with Emetine become 'negative' i.e., no amoebae or cysts are discoverable in the stools—whether they are ultimately found to be rid of their infection or not. Negative examinations made during treatment are therefore of no value to prove that the disease is extinct. This 'negative phase' may continue for some time after the administration of this drug has ceased, though the effects of Emetine usually disappear within two or three weeks of the cessation of treatment. It is moreover frequently impossible to discover either free amoebae or cysts of *E. histolytica* in the stools of infected persons even when they have not been subjected to specific treatment, in other words the stools of untreated cases infected with the parasite are frequently negative. For such reasons, therefore it is necessary to make considerable number of examinations of the stools of any patient, and to make them at suitable times, if the negative findings are to have any decisive value as an index of non-infection."

"In dealing with a few cases only the stools may be examined microscopically every day after treatment, and if they remain consistently negative for three weeks the chances are that the patient is permanently free from infection. The parasites rarely reappear in the stools after such a period. The examinations have to be made daily and by a competent and careful protozoologist. In practice, examination of the stools every few days for a period of about a month after treatment is usually sufficient to establish

with considerable probability—if all examinations have been negative—that the patient has been cured. Six negative examinations made in three weeks should be regarded as the irreducible minimum required before one even ventures to speak of a cure having been effected."

In the course of treatment of Amoebic dysentery acute or chronic, hepatitis due to infection of the liver by the amoebae may be noticed attendant with rigors followed by high fever without the formation of pus. This condition yields to Emetine. Saline aperients, rest and low diet, fomentations or dry cupping and the injection of Emetine will avert the graver complication of a liver abscess. Manson-Bahr advocates aspiration of liver even at this stage with good results.

There may be peritonitis with or without perforation. The seat of perforation is usually the ileo-caecal region and the ascending colon.

Such a lesion in close proximity to the ileo-caecal area is many a time mistaken for appendicitis. Perforation is definitely more common in Amoebic dysentery than in Bacillary dysentery since the ulceration is deeper. It may occur at any stage of the infection acute or chronic and also during the relapse. In acute cases, the perforation frequently takes place at several sites simultaneously and nothing can be done for the patient. In chronic cases, where the perforation is single, immediate laparotomy may save life. Plastic peritonitis may at times set in and cure such a condition spontaneously. Sudden and severe intestinal haemorrhage may take place and it might be mistaken for one of duodenal ulcer.

Other symptoms are treated as they arise. Abdominal pain is relieved by the application of hot water bag and colic by a sedative mixture as the following which is the recipe of Manson-Bahr.

R/	Tr. Bellodonnae	mms. 8.
	Pot. Bromide	grs. 10.
	Tr. Chloroformi et.	
	Morphinae co.	mms. 10.
	Syr. Aurantii.	dr. 1.
	Aqua menth pip add	oz. $\frac{1}{2}$.
	oz. $\frac{1}{2}$ T. D. S.	

Diet is a very important element in the treatment of dysentery. Slight indiscre-

tion always brings on a relapse. In chronic cases diet is a most important factor to be taken notice of. The patient need not be starved but a judicious selection of diet should be borne in mind avoiding pungent things and spices. Milk is an ideal diet and also butter milk, lean meat and fish may be gradually added.

Prophylaxis is the same as mentioned in Bacillary dysentery. Raw vegetables, unboiled water and other foods likely to be contaminated by human faeces should be avoided and patients advised to live in good hygienic surroundings.

Treatment of mixed infection—Amoebic and Bacillary—will be dealt with while writing on other forms of dysentery. It is important to bear in mind that cases not properly treated have a tendency to relapse and pass on to the condition of a Sprue syndrome.

SUMMARY: Basing on the above discussion the following routine treatment may be adopted in cases of Amoebic dysentery.

1. The patient is kept in bed for 10 days and is advised to use a bed pan with the idea to give rest to the ulcerated gut.

2. Early morning a mild saline purgative is given to flush out the colon.

3. Two drachms of Bismuth Carbonate suspended in water or soda water is given every 4th hour during the day. Bismuth is very little absorbed into the system when given orally; and so there is no fear of poisoning. Bismuth converts the acidity of the contents of the colon to alkalinity which is desirable in the treatment of Amoebic dysentery. (Deek's method)

4. 2½ hours after the first dose of Bismuth Carbonate 1 gr. of Emetine hydrochloride is given intramuscularly. Intravenous method however severe the case might be, need not be tried as no better results are produced than the intramuscular method. Subcutaneous injection of Emetine gives rise to ecchymosis; and this may alarm the patient. Intramuscular injection is painful but the patient cannot see the local capillary haemorrhage which follows. The drug is

well absorbed by this method. Cawston (1922) recommends dissolving the tablet of Emetine in one per cent carbolic acid. This renders the injection painless without interfering with its efficacy.

5. The time of the injection according to Acton is very important. Quinine and Emetine exert their maximal activity when the environment in which it acts is on the alkaline side. 2½ hours after the administration of Bismuth Carbonate there is a slight rise in the alkalinity of the portal blood. What one wishes to attack are not the amoebae that come out into lumen of the bowel, but the tissue invading forms of the amoebae. Hence the need of throwing Emetine into the circulating blood.

The above treatment is carried out for nine consecutive days. For three days afterwards Bismuth and Emetine are suspended and only a milder saline aperient is given. Again the same treatment is repeated for a further period of 3—6 days. In the above order the treatment is carried out for 15 days. Doubts may arise at this stage if the patient is cured. If six to eight examinations of stools after complete suspension of treatment proves negative, it may be declared that the patient is free from the infection. Constipation must be carefully avoided for at least three weeks after the cessation of treatment and a dose of liquid paraffin or ispaghulae seeds may be useful. Abdominal massage may be necessary if there is faecal stasis.

In spite of the above treatment though some cases may look clinically cured of the disease, yet the infection might have not been eradicated. In these cases cysts of *E. histolytica* and Charcot Leyden crystals will be found in the formed stools of the convalescent. Haemolytic streptococci may be isolated from the stools. These cases may be either treated with autovaccine, Bismuth Emetine Iodide, or with Stovarsol.

Osmo-Kaolin is as useful in Amoebic dysentery as it is in Bacillary dysentery; and it may be substituted for the Bismuth Carbonate in the above line of treatment. It may be given 1—2 drachms doses suspended in water every 4 hours.

Abstracts.

ACUTE HEAD INJURIES.

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In the treatment of head trauma we have at our disposal certain principles whose fundamental objectives are of proven value. These objectives are the provision of competent nursing care to the unconscious patient, the prevention of infection in open wounds of the scalp and brain by adequate and timely operation, and the prompt recognition and removal of local space restricting lesions. There are other methods of questionable merit such as spinal drainage and dehydration which must be kept in mind for use occasionally. In this paper I will attempt to evaluate these principles of therapy with emphasis on the selection of cases for surgery.

When the patient is first seen, bleeding points should of course be immediately controlled; then while inquiring into the history, a careful systematic examination should be made with particular attention to the possibility of such associated injuries as a fractured spine, a crushed chest, or a ruptured viscus which in an unconscious patient might not be evident. Such associated injuries are of common occurrence and often require primary consideration. Shock as determined by the usual signs of that state is not common in head trauma except in the presence of such associated injuries, but, if it exists, it should receive first attention.

The value of x-ray examination of the skull in head trauma is not to be questioned. Such examinations immediately upon admission, however, are rarely necessary and it is usually wiser to wait until the patient's cooperation can be obtained or his general condition is satisfactory before subjecting him to the manipulations necessary in obtaining satisfactory films of the skull. In the great majority of cases, x-ray findings are of no immediate importance in outlining the treatment. It is of course necessary to know whether or not the

patient has a depressed fracture of the skull or pneumocephalus. But these do not as a rule require surgery during shock. The one instance in which an immediate x-ray examination may be useful, is the unconscious patient in whom we suspect an extradural hematoma. A fracture line crossing the groove of the middle meningeal artery is helpful evidence.

In the study of patients with brain injury, careful and frequent consideration of the state of consciousness, the temperature, pulse, B. P., respiration, the condition of the pupils, motor paralyses, the reflexes and convulsions all give information of value. But experience has shown that the state of consciousness takes precedent over all others in importance, and the interpretation of these other signs must be made in reference to the state of consciousness. We would not be greatly concerned about one who showed a paralysis of one side of his body or a dilated pupil, if he were conscious and alert. Nor would we be inclined to operate upon a stuporous patient who showed these signs if he seemed to be waking up. If, however, these signs were present and stupor was deepening or stationary, immediate operation would be advised. Repeated observations at intervals of 15 to 30 minutes for changes in these phenomena supplemented by diagnostic spinal puncture studies, enable us to select those cases that should be operated upon.

Nursing Care—Competent nursing includes familiarity with the signs of progressive brain involvement. Changes in the pupils, the nature of convulsions, the development of restlessness of involuntary urination may be the first sign of impending coma and should be promptly reported. The nurse should also be able to take systolic and diastolic blood pressure readings.

The orthodox position in bed for patients with cranio-cerebral trauma is with the head elevated. But as Coleman has pointed out, many stuporous or unconscious patients, whether the coma be from brain injury or other causes, develop large amounts of mucous secretion in the respiratory tract. This fluid so embarrasses respiratory exchange that cyanosis and anoxemia of the brain result. I have seen many patients arouse from deep coma immediately after the evacuation of large amounts of bronchial fluid by placing them in a position for postural drainage. The benefit obtained therefrom by evacuation of the fluid more than offsets that which may be derived by reduction of intracranial pressure from the head-up position. A suction apparatus greatly facilitates the removal of these secretions.

Food and fluids are best administered to the unconscious or semiconscious patient by a small rubber tube passed through the nose into the stomach which may be left in place for 24 to 48 hours without being removed. Certainly no attempt should be made to give food or fluid by mouth until the patient is able to take them without coughing or strangling.

Indications for Surgery in Head Trauma—The indications for operations in head trauma are: (1) Prevention of infection, (2) The removal of compressing local intracranial lesions, (3) The control of increased intracranial pressure from cerebral edema, and (4) The prevention of late Sequellæ, particularly epilepsy.

Prevention of Infection—Lacerations of the scalp are usually regarded as simple wounds and are not serious if promptly and adequately treated. But, when supuration develops, osteomyelitis of the skull, meningitis or brain abscess frequently follows. If the scalp is shaved widely, the wound cleansed mechanically, its margins debrided, and snugly approximated with non-absorbable sutures, infection will rarely occur.

Operations for open wounds of the skull and brain are carried out as soon as the patient's general condition will permit. The anesthetic of choice here, as in all

neuro-surgical procedures is novocaine, though avertine or rectal ether may be added if the patient is restless. The depressed fragments of bone are elevated and removed, unless they are extremely large and attached to the pericranium. In children, the defect created by removal of the fragments will usually close, and in adults they produce no harmful effects. When the dura and brain are lacerated, the devitalized brain tissue should be removed to prevent excess scarring which would predispose to epilepsy. The dura should be closed tightly in all cases using a temporal fascia or fascia lata graft if necessary. No packing or draining material is used within the dura. A septic cerebritis with a cerebral fungus, nearly always follow their use. If infection develops within the dura, it is much more apt to wall off and remain local if the dura is closed.

Simple depressed fractures are elevated as soon as the patient's general condition permits. These fragments are saved if possible.

Linear fractures of the vault when compounded occasionally show hair and debris in the fracture line. This should be looked for and of course removed. Other than this, they require no specific treatment.

Fractures of the base may be complicated by cerebrospinal fluid, leaks through the nose and ears or by air within the skull. Fortunately the leaks usually seal spontaneously. But if they continue, meningitis always follows. Fistulas through the frontal fossa with cerebrospinal fluid rhinorrhea can often be closed by surgical repair of the torn dura and this should be done if the drainage persists without evidence of abatement for more than four or five days. Attempts to close leaks through the ear are usually unsuccessful. Spinal punctures are contraindicated until at least 48 hours after the fistula closes.

The Diagnosis and Control of Increased Intracranial Pressure—The general signs of intracranial hypertension are headache, if the patient is awake, stupor, restlessness, alteration in the pulse or respiratory rate, focal paralyses, convulsive seizures,

a rise of temperature and often vomiting. Choked discs are seldom seen in acute head injuries. Any combination of these signs is suggestive but not pathognomonic of this state, as identical changes follow direct injury to the brain.

The general interpretation of these signs as an indication of pressure on the brain and the widespread belief that all patients with head trauma suffer with increased intracranial pressure, has led to the institution of measures directed at its control as a routine in many clinics. It is around this question that the greatest controversy is being waged today.

A well done spinal puncture with manometric record is the only accurate procedure for determining the degree of intracranial pressure. A reading of 100 to 200 mm. of spinal fluid is generally regarded as normal. Some consider a lower figure to be the upper limit of normal, but my experience indicates that variations within these limits are of no serious concern.

Once having proven by clinical study and spinal puncture that intracranial pressure of dangerous degree exists we must then proceed to determine its nature. In connection with this we must remember that local compressing lesions are our first consideration.

An extradural clot of dangerous size nearly always has its origin from the middle meningeal artery which is torn where a fracture line crosses it, though it may occur without a demonstrable fracture. Since the hemorrhage begins in the temporal region, its first signs and symptoms are referable to this area. It rapidly expands however, and may fill almost one-half the cranial cavity. The bleeding continues in somewhat of a vicious cycle, the dura being progressively stripped away from the skull, opening new bleeding points which add to the hematoma. Head trauma with a brief period of unconsciousness followed by a lucid interval and a return to coma is almost pathognomonic of this lesion. Dilatation of the pupil on the affected side, and a progressive hemiplegia, with perhaps Jacksonian

convulsions in the opposite side usually appear.

Subdural Hemorrhage—A subdural hematoma may attain sufficient size to produce symptoms within the first few hours but in the majority of cases this is not true. When it does occur, the bleeding is from a large vessel, either arterial or venous, and is seen only after severe head injuries. They resemble extradural clots clinically.

By chronic subdural hematoma, we mean an encysted collection of blood in the subdural space. Its origin is usually from the veins that bridge from the cerebral cortex to the sagittal sinus. The amount of bleeding is not sufficient to cause dangerous cerebral compression at first, but a mesothelial membrane which is thrown out by the dura and arachnoid envelopes the clot. This membrane is semipermeable and as the blood breaks down, the osmotic tension within is increased and fluid dialyses from the surrounding tissues, thereby increasing the size of the mass. This accounts for the late onset, (sometimes weeks or months), and the gradual progression of symptoms of local compression. These lesions are frequently confused with brain tumors.

Subdural Hydromas—The subdural space is only a potential cavity and normally contains very little or no fluid. Occasionally, however, after trauma, large amount of subdural fluid are found. The source of this fluid is not definitely known, but it is believed to result from a "ball-valve" rent in the arachnoid membrane. With each pulsation of the brain, fluid is forced through the opening into the subdural space. Since there is no absorptive mechanism in the subdural space, the mass increases. This lesion cannot be differentiated clinically from subdural hematoma.

The treatment of extradural hematomas is a conventional subtemporal decompression incision with removal of sufficient bone to evacuate the clot and seal the bleeding point. In this connection it is well to remember that adequate bony

exposure should be obtained before attaching the hematoma, as profuse bleeding often follows the dislocation of the clot, and fatal hemorrhage may ensue if one is not immediately able to occlude the bleeding vessel.

Subdural hematomas and subdural hydromas usually cover almost the entire superior surface of one or both cerebral hemispheres, and are thickest in the superior temporal region. Therefore this area is elected to make a single burr opening. It may be necessary to enlarge this opening slightly to evacuate a clot. Evacuation of the liquid content is usually sufficient, though if recovery is not rapid and complete, it may be necessary to reflect a bone flap to remove the membrane of the hematoma. The hydromas never require this, though they may refill and have to be aspirated once or twice. Some surgeons prefer to make openings in both the frontal and post-parietal areas. I am convinced that the lesion will be missed more frequently by this procedure than by one centrally placed opening. Occasionally at autopsy, subdural clots may be found in other locations, but they cannot be diagnosed clinically and attempts to remove them are usually unsuccessful.

Local space restricting lesion may attain tremendous size without producing localizing signs or may produce ipsilateral signs. Contusion and laceration of the brain may render a patient so profoundly unconscious that a local lesion would escape recognition clinically. Therefore it becomes necessary at times, to make exploratory openings in the skull. A single opening over each hemisphere is sufficient. If no clot or hydroma is found, but the brain is tense from edema, a subtemporal decompression may then be carried out.

A normal or diminished spinal fluid pressure does not preclude the possibility of a surgical lesion and it is wise to explore patients who show paralysis, Jacksonian convulsions, a rising temperature, or progressive stupor even though the spinal fluid pressure is not increased. This practice will of course result in many negative explorations, but the operation is justified since it incurs little risk.

Contusion, Laceration, and Edema—Statistics indicate that less than 10 per cent of head injuries suffer with dangerous intracranial hypertension from edema secondary to laceration and contusion of the brain. Recommended for control of this pressure are:

1. The subtemporal decompression operation.
2. Spinal drainage.
3. Dehydration by restriction of fluid intake and the intravenous administration of hypertonic solutions.

Of these methods I prefer the subtemporal decompression with the supplementary use of spinal drainage and hypertonic solutions. The effect of a decompression operation is not well understood for many times the mean spinal fluid pressure after operation is only slightly reduced. Excursion with cardiac pulse however, is much wider. Frequently we note that when the dura is first opened there is no visible pulsation, only to observe the quick development of wide pulsation. It appears therefore, that converting the rigid vault into an expansile chamber, permits better circulation to the cerebrum. This operation is required in less than 10 per cent of the cases.

Hypertonic Solutions—The use of hypertonic solutions is routine in many clinics. The use of these solutions in my hands has not indicated any appreciable effect on the mortality rate. Glucose (50 per cent) intravenously will reduce the intracranial pressure, but within a short while after its administration, it is followed by a secondary rise to a stage higher than the original level which is sufficient to contraindicate its use. Sucrose (50 per cent) in larger amounts will affect an equal lowering of pressure and is not followed by the secondary rise. It is a useful supplement to more permanent steps such as decompression.

Restriction of Fluid—Some men routinely limit a patient's fluid intake to from 500 to 1,000 cc. of fluid in 24 hours. It has been my experience that when fluid is withheld in sufficient degree to appreciably lower intracranial pressure, the patient grows worse rather than better. A rising temperature and deepening stupor are frequent results of such treatment. The fluid requirement of these cases is the same as that of any seriously ill patient.

Spinal Puncture—There is wide disagreement as to the use of therapeutic spinal punctures in head injuries. Withdrawal of fluid from the spinal canal will lower intracranial pressure but the relief is very transient for the fluid secreting mechanism rapidly replaces that removed by the spinal puncture. In severe injuries the period of relief grows progressively shorter with each successive puncture, and it is doubtful that the temporary benefit obtained, justifies the procedure. Dandy's dogmatic statement that spinal puncture in head trauma is always harmful, is not substantiated, but I have never been impressed with any notable beneficial results by its use in severely injured patients.

Lumbar punctures are useful for diagnostic purposes and to remove bloody fluid in those patients who, though not often in serious danger show retarded convalescence and complain of headache.

Subarachnoid hemorrhage, which is demonstrable in the spinal fluid, nearly always comes from either the basal cisternae or the ventricles; rarely if ever from over the cerebrum. If the bleeding is so profuse that life is threatened from pressure, little can be done about it. If

it is not so profuse the opposing pressure of the brain is probably helpful to control bleeding and spinal drainage at this stage seems contraindicated.

When the blood cells begin to break down and the fluid becomes xanthochromic the patient often shows signs of severe meningeal irritation. Daily spinal puncture at this time relieves symptoms and appears to speed recovery. It is unlikely, however, that it is ever a life-saving measure. Repeated spinal punctures early, do not remove sufficient blood to prevent this.

Summary—The great majority of patients with head injuries recover with general nursing care. The mortality rate in those patients with damage to basal structures and extensive lacerations and contusion of the brain is and probably will remain high.

Prompt and adequate treatment of open wounds of the scalp and brain and the prompt recognition and removal of local space restricting lesions is essential, but, harassing physical and x-ray examination, and extensive surgical procedures should be avoided during shock. Bilateral exploratory openings in the skull are justified in doubtful cases.

Subtemporal decompression is the most effective measure for controlling dangerous cerebral edema. Spinal drainage and hypertonic solutions cannot be advantageously substituted, but may be used as a supplement. Marked restriction of fluid is harmful.

Withdrawal of bloody or xanthochromic spinal fluid relieve symptoms in patients with meningeal irritation.

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SOME GENERAL CONSIDERATIONS ON THE PROBLEM OF LEPROSY.

By Dr. R. G. COCHRANE, M. D. (Glas),
M. R. C. P. (Lond.), D. T. M. & H (Eng.)

It is impossible in a short paper even to attempt to give an account of the disease and its control and therefore I shall confine my remarks to some general considerations. Leprosy in many parts of the Madras Presidency is an endemic disease of major importance and therefore it behoves medical men to take the time to become better acquainted with the disease. Training Courses for Post Graduates are held at the Lady Willingdon Leper Settlement twice a year. The course is for 14 days duration. While in that time it is impossible to attain an adequate knowledge of the disease, yet it is hoped that those who come will achieve two things, (1) a better appreciation of the disease, (2) a better knowledge of the main lines of treatment and prevention.

The study of leprosy is handicapped by the universal fear of the disease and until medical men lead the way in the approach towards this disease little can be accomplished, all words such as 'leper' and 'clean' should be expunged from our vocabulary, for such words indicate an outlook which is more akin to the middle ages than to modern medicine. The first essential then in the approach to this problem is to remember that those afflicted with leprosy are ordinary human beings with a soul and mind susceptible to friendship, and resentful and embittered by approaches which indicate fear or distrust on the part of the physician. If a medical man is to treat leprosy successfully he must make a friend of the patient, and not so much by word or action indicate that he is afraid of the disease. This does not mean reasonable precautions should not be taken, but there are those who try and give injections without touching the patient, or give dressings without handling

the ulcers; these things are mentioned for all. Too frequently the results of such actions are seen in the Lady Willingdon Leper Settlement when patients come for admission. It may be well to indicate a few points of importance.

1. Leprosy is not a highly contagious disease and not every type is contagious.
2. Leprosy is dangerous in childhood and there is evidence to show that the younger the child and the closer contact with an infective case the more likely is leprosy to develop.
3. All forms of leprosy are not equally serious, certain types are comparatively innocuous and tend to become spontaneously arrested.
4. The only known method of control is the prevention of contact of healthy persons especially children with cases in the infective stage of the disease.
5. The pauper leprous beggar, while objectionable, does not constitute the major danger to society; it is the infective case in the home unisolated and mixing freely with children which constitute the gravest danger.
6. Frequently the less obvious cases are more infectious many of the more obvious cases belong to the comparatively benign neural type of leprosy and are not contagious.

Investigations are being pursued which will we hope result in devising a system whereby the infectious cases will be isolated in the home, village or institution and thus be prevented from coming into close contact with healthy persons especially children. In so far as leprosy is not infrequently present in families of good social standing, it would contribute materially towards its control if the following elementary precautions were observed:

- (1) Separate room, bedding, eating, washing utensils, separate chair.
- (2) Avoidance of close contact with individuals in the household especially children.

(3) Disinfection of all clothing before it is sent to the dhobie.

A word with regard to treatment. It must be remembered that all types of leprosy do not need treatment, the first duty of the patient is to consult a competent physician and ascertain whether he requires treatment for his disease and whether it is infectious or not. If treatment is required the following points should be remembered:

- (1) Avoid all medicines which are advertised to 'cure' leprosy.
- (2) Remember the latest vaunted remedy is seldom the best.
- (3) Hydnocarpus Oil (*Chaulmoogra*) or one its derivatives such as the esters still remain the basis of treatment.
- (4) Generally speaking the best methods of administration are the subcutaneous and intradermal routes.

Persons who are unfortunate enough to suffer from leprosy must not imagine that there is a royal or quick route to the healing of their malady: patience, perseverance and co-operation are the key notes to success. Specious promises of rapid relief and cure are unreliable, and only bring discredit to the treatment and disappointment to the patient. It may however be said that while the treatment of leprosy is still far from satisfactory, yet given intensive and intelligent treatment, there is a reasonable chance of healing, and it would be a bold man who said any case was hopeless.

TETANUS AND DIPHTHERIA.

(CASE-NOTES REPORT.)

(The following is a brief report of a lecture delivered by Dr. G. Dorairaj, M. B. B. S., of Koilpatti on 13-8-1938 at The Independent Medical Practitioners' Association, Tinnevely.)

An adult employed in the Koilpatti Mills who had sustained a machine accident in his thumb developed Tetanus 15 days after the injury. The wound was being attended to by Dr. G. Dorai Raj from the very day of the accident. Soon after Tetanus started, the patient had a

course of injections of Anti-Tetanus Serum and for ten days had 17,900 units intravenously. In addition he had Luminol tablets three times a day. At the end of this period the convulsion stopped and the patient became convalescent.

The second case of Tetanus was in a boy aged 12 years who got his toe injured as the result of the fall of a heavy stone. He developed Tetanus nearly 10 days after the accident and he came for treatment 5 days later. He was under treatment for 17 days and had during this period 442,000 units of A. T. Serum (Bayer) intravenously with Luminol and Morphia injections, Chloral and Bromide mixture and Chloroform inhalations occasionally. He was also given Mag. Sulph. Solution subcutaneously at a time when A. T. Serum was not available with no effect on the convulsions. During the course of the treatment his toe was also amputated. Both the cases were fed on liquid diet during the convulsive stage and solid diet was resumed afterwards.

Dr. Dorairaj then discussed the details of treatment to be followed in cases of Tetanus. He said every case of injury however trivial it may be, must be given a prophylactic injection of A. T. Serum irrespective of cost and that earlier the Serum treatment is started the better the prognosis. He discussed the different routes by which the Serum was best administered—subcutaneous, intramuscular, intravenous intrathecal and into the cisterna magna. In his opinion one route is as good as another though he prefers intravenous route since it is the least painful method considering the frequency and bulk of the Serum to be administered. Regarding the dosage of the Serum in his opinion age is no consideration but only the severity of the disease. 20,000 units both morning and evening till there was definite improvement was an adequate dose. The brand of the Serum he said he had been using was only Bayer's and he found it quite good. Regarding the question of amputation of the part he said amputation might be done with advantage if no physical disability or deformity was produced as a result of

operation. Relating to sedatives he mentioned Chloroform, Bromide, Chloral, Luminol, Chlorotone, Morphia and Avertin. In his experience he had found Luminol in 2 grs. doses both morning and evening very effective. In very severe cases injection of Morphia and Chloroform inhalation to check fits were necessary but one must be cautious regarding the use of Morphia so as not to produce the Morphia habit. Regarding injections of Mag. Sulph. Solution he had not found it effective in his practice and the intrathecal route is fraught with danger of respiratory paralysis and subcutaneous route was useless. Even the free use of sedatives sometimes led to Broncho-pneumonia.

Diet he said should be nutritious, fluid and not stimulating. Plenty of water should be given orally and if found difficult saline be given per rectum. Nasal feeding under anaesthesia was also advised but it was fraught with dangers. Solid food might be given after the fits had ceased.

Next he read detailed notes of a case of Diphtheria which he had treated in a child aged three years for which he gave anti-Diphtheritic Serum three injections each 5,000 units on alternate days and had recourse to tracheotomy. As a result of the operation a fistula between the oesophagus and the trachea developed and this closed itself in course of time. After reading the case notes he discussed about the frequency of the disease in the Tinnevely District and said that sore throat in a child of less than 5 years of age accompanied by moderate fever should be looked upon with suspicion and that a routine examination of swabs taken from the throat of such cases must be made.

Regarding the treatment he said the antitoxin must be given as early as possible and in suitably large doses, the dosage depending on the severity of the disease not on the age of the patient. Absolute rest should be enforced for the fear of heart failure. Salines with expectorants and Nucis Vomica might be administered orally. Diet should be

easily digestible and highly nutritious. If necessary Tracheotomy must be done sufficiently early before complete obstruction sets in. Then he gave details of Tracheotomy operation and the after treatment for the same.

1. ACUTE EPIDEMIC PHRENIC NEURALGIA

J. TORGENSEN (*Nord. med. Tidsskr.*, April 9, 1938, p. 572) gives an account of a small epidemic of phrenic neuralgia in a rural area of Norway with a population of about 4,000. Between August 9 and October 27, 1937 he observed eight cases with such a uniform clinical picture that they could be regarded as the units of one and the same epidemic, although the patients lived far apart and had had nothing to do with each other. Their ages ranged from 12 to 48, and the sexes were equally represented. The onset of the symptoms was sudden, with fever and pain in one or other of the shoulders. After a short interval violent pain set in, being referred to the lower part of the chest and the whole of the abdomen down to the iliac fossae. The symptoms were alarming and simulated those of cholecystitis, pneumonia, pleurisy, a perforated ulcer, or appendicitis. Indeed in one of the patients, a man aged 26, laparotomy was performed; it revealed nothing amiss in the peritoneal cavity. In several cases relapses were observed either on the same or on the opposite side. Discussing the aetiology, the author draws attention to the likeness of this epidemic to those of epidemic myalgia or Bornholm disease. What was remarkable was the invariable limitation of the symptoms to the areas supplied by the phrenic nerve.

2. ACTIVE DIPHTHERIA IMMUNIZATION

W. REINHARDT (*Dtsch. med. Wschr.*, April 8, 1938, p. 535) reports from a children's hospital in Lubeck certain observations indicative of the inability of active immunization to protect against diphtheria in many cases. In a convalescent home, housing on an average 110 children, as many as sixteen cases of

diphtheria occurred, although the children had been actively immunized at a time when there was no epidemic of diphtheria. All the children had been examined for diphtheria bacilli in the nose and throat before being admitted to this home, and the bacteriological reports had been consistently negative. The children had, in fact, been artificially immunized against diphtheria under the best conditions. The shortest interval between immunization and the outbreak of the disease was one of seventeen days, and in four cases this interval was longer than three months. The behaviour of the diphtheria in these sixteen cases was what might be expected in children not immunized; the disease ran a light course in four cases, a moderately severe course in ten cases, and a severe course in two. In a footnote to his article the author states that twelve further cases of diphtheria have recently broken out in the same convalescent home among children who had been artificially immunized; the interval between immunization and the outbreak of the disease had ranged from one to three months in most cases, but had twice been less than twenty days and had once been almost nine months. The author contrasts these observations with the claims made on behalf of active diphtheria immunization that the immunity it confers begins in four to five weeks and lasts several years. The principle of such immunization is not challenged by him, but he does insist that there is evidently room for improvement in the technique.

3. X-RAY THERAPY OF PROSTATIC HYPERTROPHY

J. KNEIP (*Dtsch. med. Wschr.*, March 11, 1938, p. 377) reports from a surgical hospital in Worms his experiences with the x-ray treatment of hypertrophy of the prostate. Since 1930 the candidates for x-ray treatment have been those patients who for some reason or other had been considered as unsuitable for operation. In spite of this selection the author can claim a high proportion of cures and improvements in his series of thirty-seven cases. In sixteen the results were so good that they could be classed as recoveries; in twelve other cases some improvement

could be claimed. Two patients had subsequently died of unknown causes, and four of sequelae to the hypertrophy of the prostate. In three cases prostatectomy was performed after x-ray treatment had failed. In no case did the treatment do harm, and the author concludes that, provided the new growth in the prostate is benign, vasectomy followed by x-ray therapy is to be recommended, particularly for those cases for which an operation is undesirable.

4. RADIUM THERAPY OF BENIGN SKIN CONDITIONS

A. MUSGER (*Wien. klin. Wschr.*, March 4, 1938, p. 274) points out that radium is of value in the treatment of certain benign skin conditions. The soft alpha rays may be used in the treatment of herpes zoster neurodermatitis, forms of dermatitis due to salvarsan, and in pruritus the rheumatoid dermatoses, and psoriasis. The hard beta and gamma rays should never be used when there is evidence of former damage by irradiation to the skin—for example, telangiectases, atrophy, and pigmentary changes. Treatment should be discontinued when evidence of increased sensitivity to irradiation is present. Radium therapy is the method of choice in the treatment of cavernous haemangioma, spontaneous keloids and hypertrophy of scar tissue, sycosis, and plastic induration of the penis. Certain conditions react better to radium than to other forms of treatment. They include plantar warts, anal eczema, chronic inflammations of the nail fold and behind the ear, circumscribed pruritus, and various forms of tuberculosis of the skin and mucous membrane.

5. NOVOCAIN INFILTRATION OF THE PELVIC SYMPATHETIC

J. HENRIET (*Rev. franc. Gynec.*, March, 1938, p. 139) alludes to recent modifications of current views concerning the anatomy and physiology of the pelvic autonomic nerves in the human subject; and to the evidence—from Leriche's lumbar sympathectomy in Little's disease, Cottés's pelvic sympathectomy for vaginismus, and Reeb's finding of relaxation of the levator ani during labour in a

woman in whom the presacral nerve had been resected—that striated as well as smooth muscles are susceptible to autonomic nerve control. He records eighty-five obstetrical cases in which he has anaesthetized the pelvic peritoneal plexus, lying laterally to the upper third of the vagina and to the cervix. In reaching the plexus access through the lateral fornices is rejected (as carrying, from practical difficulties in asepsis, the danger of infecting the broad ligament) in favour of insertion of the long needle of the syringe in front of the posterior commissure, external to the labium majus. The transit of the needle is controlled by two fingers in the vagina; the injection is made with 20 c.cm of 1 per cent. novocain, without adrenaline. The object of the technique has in fifty-six cases concerned the perineum, in twenty-nine the cervix. In the first group it was sought to diminish perineal resistance and prevent tears in four primiparae aged 38 to 43, thirty-one primiparae with vulval constriction, eleven multiparae who had previously had bad tears, and ten cases of abnormal presentation. It was found that pain was diminished, passage of the head over the perineum accelerated and facilitated by the muscular relaxation, and the number of obstetrical interventions greatly reduced. The second group comprised all cases of protracted first stage of labour from cervical rigidity, oedema, or scarring; full dilatation speedily followed. Antispasmodics were given at the same time, or small doses of pituitary extract, according to the state of the uterine contractions. Obstetrical interventions were unnecessary in the series of twenty-nine cases.

6. AGE AND FERTILITY

O. KOLB (*Munch. med. Wschr.*, April 8, 1938, p. 502) has reviewed 59,117 gynaecological and obstetrical cases from the point of view of fertility and age. The fertile period stretched between the ages of 12 and 49, with an optimum at 23. The fertility of the group between the ages of 12 and 15 was only slight, but it rapidly increased from the age of 16. The gradual decrease of fertility after the age

of 23, apart from natural causes, seemed to be due to diseases resulting from previous childbearing; acquired sterility as a result of criminal abortion; the increase of venereal diseases; the increased use of contraceptives; and the decrease in sexual intercourse with increasing age. Since the war the difference between the habits of the urban and rural population has been levelled out. The rural population, too, have become acquainted with contraceptives and criminal abortion. Conditions have probably changed in those countries where a premium is put on fertility. On the whole the survey showed that fertility in a civilized country is influenced by a variety of factors, not the least of which are economic. A true picture of the relationship between age and fertility could only be obtained in a primitive community, uninfluenced by modern civilization and free of material cares.

(Above 1, 2, 3, 4, 5 & 6 are extracts from *B. M. J.* June, 25, 1938.)

1. PREVENTION OF GONORRHEAL OPHTHALMIA IN THE NEW-BORN. A. J. SKEEL.

J. A. M. A. 111: 143 (July 9), 1938.

In the present communication Skeel presents the experience at St. Luke's Hospital (Cleveland), the technic of which was developed by him and his associates, and the results of this technic in over 10,000 successive deliveries. Their routine procedure is:

1. At the time of delivery of the head, the eyes are carefully cleansed with dry sterile sponges. No boric acid solution is used.

2. When the cord has been cut, 3 or 4 drops of 0.5 per cent solution of silver nitrate are instilled and the lids are gently manipulated to distribute the solution to every part of the conjunctival sac. After forty-five seconds the sac is freely flushed with a 20 per cent solution of mild silver protein. This irrigation is repeated on three successive days as a routine part of the nursery technic. The substance

must be completely dissolved. The solution is prepared twice weekly.

We think that the repeated conjunctival flushing with a bland silver preparation is vital to the success of the method. Our rationale of this technic is as follows:

1. Irrigation with a boric acid solution is not used; this solution is not a gonococicide, and its use serves merely to introduce the organisms into the conjunctival sac.

2. We believe that the occasional late infection which was observed before the use of repeated irrigations with bland silver solution occurred as the result of the presence of a few organisms of reduced virulence, which are destroyed by the successive treatments.

We realize our relative freedom from cases of virulent gonorrheal vaginitis. The technic is presented in the hope that more extensive trial may be made of the procedure and its value determined.

2. THE BASE OF THE SKULL, WITH PARTICULAR REFERENCE TO FRACTURES. WILLIAM J. MELLINGER.

Ann. Otol., Rhin. and Laryng. 47:291 (June), 1938.

1. The base of the skull with its many foramina, their direction and the structures which pass through them, as well as the tightly adherent dura, must be carefully considered in fractures.

2. Fractures involving bones containing air cells may bring serious complications, particularly when this pneumatization is extreme. It may extend to the limits of any bone in any or all directions and the process may extend into adjoining bones.

3. The floor of the anterior fossa may consist entirely of pneumatized bone, the floor of the middle fossa almost entirely and the floor of the posterior fossa always consists partially of bone containing air cells. A basal fracture then must usu-

ally be considered compound unless proven to be otherwise.

4. The sphenoid is the "key-stone" of the skull, situated in the middle of the base and is in line of practically all basal fractures.

5. The temporal bone occupies a wide area in the base of the skull, and is unique in its connection with other bones. The arrangement is usually such that a certain amount of movement from below upward is possible.

6. Transverse fractures of the petrous pyramid usually extend through the labyrinth and seldom heal by bony union because the endochondral layer is not endowed with regenerative power. Thus in such cases there is constant danger of intracranial involvement in the event of upper respiratory infection.

7. The abducens nerve is placed in a very vulnerable position on account of its intimate relation with venous spaces throughout most of its long course, also on account of its relations with the basisphenoid and the petrous apex. It is very frequently involved in fractures through the middle fossa.

3. X-RAY TREATMENT OF DEAFNESS

In the first place the term "deafness" is vague, since it does not specifically designate the type of hearing defect. No treatment can be discussed for a condition which is not clearly defined diagnostically.

The X-ray treatment of certain forms of hearing impairment has been seriously considered for a long time. Unfortunately, in some instances, the treatment has been employed unscientifically by inexperienced workers who were unfamiliar with the numerous problems of diagnosis and pathology. Under such circumstances the rationale of X-ray therapy was apparent. Results were imaginary and psychic rather than positive. In some selected situations, there is use for X-ray procedure, but such use must first be established on the basis of the existing pathology or associated pathology. The

problem is a large one and cannot be discussed here in detail. Numerous articles have been published dealing with the subject, the consensus of opinion being against the value of roentgenotherapy in the large majority of instances. Hayes (Laryngoscope 48:176 (March), 1938), in an attempt to give the facts concerning X-ray treatment of deafness, concludes:

"1. X-ray treatment of deafness should only be attempted in selected cases.

"2. In the majority of cases of deafness this type of treatment is useless.

"3. In those cases in which there is a definite pathology in the nasopharynx (as determined by a minute examination with the nasopharyngoscope) and in the eustachian tubes, proper X-ray irradiation may in itself improve the hearing or may clear up the pathology sufficiently to allow of suitable local treatment."

(Above 1, 2 & 3 are extracts from *The Eye, Ear, Nose, and Throat Monthly*, August '38.)

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PUBLIC SERVICE AND PRIVATE PRACTICE.

In the issue for August 1938 commenting on an ineffectual G. O. we referred to an item of news published by a local Daily stating that Government contemplate forbidding private practice to all medical officers of the Provincial Medical Service. We shall explain here how as stated in that comment this order, if it materialises, will bring the Department into line with the Congress spirit and Congress policy. It may even be said that the reform in question is in consonance with the original intention of Government in organising the Department.

For a proper appreciation of the situation we should visualise the state of things as it must have existed at the time of the inception of the department. The Allopathic system was then non-existent here and the Government looked upon the indigenous systems, Ayurveda and Unani, as little short of quackery. In the interests therefore of their own officers, civil and military especially the European element it was necessary to introduce a system which was looked upon as scientific and up-to-date. In course of time the department was developed so that the benefits of the system were extended to the general public but it was all along treated as a Service Department, one that existed for the service of the people and not a commercial Department which existed for bringing in revenue either for Government or for the service. In fact the Medical Department is an exception to the general rule which treats Government servants as whole-time officers and prohibits them

from accepting any remuneration for services rendered. This exception was conceived not in the interests of the medical officers but in the interests of the ailing public who, the Government evidently thought, must have sound scientific treatment which in their view was Allopathy and which was then restricted to the medical officers of the Department.

A perusal of paras 279 to 281 and 285 of the Civil Medical Code shows that Government were not unmindful of the necessity to maintain the integrity and independence of the profession while they extended to it the concession of private practice. It is also clear from the safeguard provided in section XII.B relating to private practice that service and not the accumulation of fees for the medical officers was the motive behind the grant of this concession. In other words the medical officer was meant for the people and not *vice versa*. For example, it is stated in para 282 (4) of the Civil Medical Code that a medical officer visiting a patient beyond the limits of his jurisdiction may be given by the Local Board or Municipal Council concerned his travelling allowance if he is unable to recover the fees due to him from the patient. This rule evidently visualises free service to a poor patient. The disciplinary action contemplated in para 285 (5) is also a sufficient indication of the intention of Government.

As we have already indicated, much water has passed under the bridge since the Medical Department was first organised; there has been a constant outflow of qualified medical men from the colleges and schools established by Government. A large number of Indians

have also qualified themselves in foreign Universities. As a result an independent medical profession has come into being which can hold its own against the Government officers. This is especially so if the artificial advantage secured for them by their official position is eliminated. The main reason that influenced Government to allow medical officers to engage in private practice *viz.*, absence of private practitioners who had scientific training does not now exist. Medical practitioners, dispensaries and private nursing homes and hospitals are on the increase in spite of the handicaps unintentionally imposed on them by Government. These consist among other things of the glamour that still attaches to Government office in the eyes of the common people, the artificial advantage that the charge of a Government hospital confers on the medical officer as against the private practitioner and the influence that the former can wield by virtue of his position to attract practice. We are aware that the rules and orders of Government seek in effect to put the two *viz.*, the medical officer and the medical practitioner on a level with each other. The medical officers is for instance, prohibited from treating his private patient in the hospital. (Vide para 284 C. M. C.). He has to pay for the use of hospital instruments for private practice. It is however evident that the medical officer is continually put in temptation's way and that the rules can only minimise the evil. Again by means of study leave and other privileges Government virtually gives its subordinates higher and better qualifications which many of them could not obtain but for those facilities. The knowledge and experience thus gathered at people's expense do not serve the people at large so much as the possessors thereof because the latter are thereby enabled to claim higher fees which is beyond the means of the common people. We wish to draw the pointed attention of Government to this phase of the question so that this grievance may be redressed early. It may be argued that a medical officer must be given a right to lay down his own terms no less than any other man. As

against this it must be stated that laws often work in pairs and that a principle which works against the public good must give way for such good. Besides this, it must not be forgotten that special qualifications were acquired at the expense of the people who have therefore a moral claim to contend that services of persons so qualified must not be placed beyond their reach.

In a word, circumstances have now changed so far that there is now no more justification for allowing private practice to Government medical officers—at least to the future entrants than there is for allowing private trade to Land Revenue or Excise officers; for, those now in service can contend that they joined the department when private practice was allowed and that their claims must be saved when conditions of service are altered to their prejudice. There is point in the argument though similar cases must have arisen ere now in other departments and Government should be able to meet the situation to the satisfaction of everybody concerned. This must however form a subject for discussion in a future issue.

The Medical Officer more than any other subordinate of Government should be imbued with a spirit of service, of service dedicated to the people. In this connection we are reminded of an observation made by the late Sir V. Bhashyam Ayyangar in the course of a convocation address. Referring to the graduates of the year he remarked that some of them would enter Government service. Those young men, he went on to say, should bear in mind that as the term indicated with sufficient clearness, they would be public servants, servants of the people whose salt they ate and whose interests they must serve. In fact we see that both in the East and in the West a missionary spirit, a spirit of selfless service untainted by consideration of remuneration, was the ideal of the medical men and women. Coming lower down in the ladder the nurses were graded into "mothers" and "sisters" working for the love of God. We have heard that medical men in India once believed that their

drugs would lose their virtue if they accepted remuneration. Instances are not rare of persons giving away their property to a missionary institution devoted to the care of the sick and themselves serving therein as medical men or in any other capacity for a bare living. It is appropriate to quote here the concluding words in the Hon'ble Dr. Rajan's address delivered at the annual prize distribution ceremony of the Madras Medical College held on the 3rd September 1938. Addressing the graduates of the year the minister said :

"They should not start and go through life counting rupees, annas and pies, though these were not unimportant at all in life. They should remember that if these alone should be their goal and motive force, they could not progress far. Let them therefore aspire for something more real and fundamental than material success. This result could be achieved only through real service disinterestedly and sincerely given. The medical man lived in the midst of death. It should not kill the humanity in him. Death was as certain as life and, in between, it was the duty of all to make their days on earth as full of service to fellowmen as they could. The condition of India to-day called for a spirit of optimism, idealism, service and courage, far more than was necessary in any other country and medical men, who had a sacred duty to perform by their fellowmen, would, Dr. Rajan hoped, rise up to the traditions of the profession, and ideals of service which the country expected of them."

One familiar argument advanced in favour of private practice seems to be that a man of means will be deprived of the services of competent medical officers if these were forbidden to engage in private practice. As for this we should remember that the whole is greater than the part and the interests of the nation as a whole should outweigh those of a portion however vocal it may be. The purity of service is also a paramount consideration for but for this consideration there is no reason why a distinguished lawyer should not be allowed consultation practice when he is raised to the bench even after proper limits are prescribed and proper safeguards are provided for such practice.

Besides, this state of things is bound to be only transitory if the department is

so reorganised that men who are moved by love of humanity to serve the people unfettered by rules as well as those who conscious of their ability want to make money by selling their services in the dearest market will stay out while the third class *viz.*, those who are content to serve for the salary they get without claim to private practice will join the service. As it is, the privileges and perquisites attached to the service are disproportionate to the return that Government gets and have given rise to a variety of abuses which it is not necessary to specify here. If these emoluments are severely pruned, the department will be purified, funds will be found for better purposes and a potent cause of mutual rivalries and jealousies among brother officers engendered by competition for private practice will be removed. On the other side a powerful profession will be organised which will mean an occasion of strength to the nation. For an analogy we may cite instances of lawyers and barristers who instead of entering Government service joined the bar and formed the core of the Congress organisation and backbone of the nation. Men like Messrs. Tilak, Gokale, Nehru and Bose if they had joined Government service would have added to the strength of the bureaucracy and weakened the popular movement, the net result being a double disadvantage.

There is another reason why the present Government should strengthen the profession. The Congress has accepted office with the avowed object of serving the people at large and will remain in office only so long as it is possible to do so. The relief of human suffering is *par excellence* a service of the people. Here as elsewhere the richer classes can take care of themselves. It is the poor whom the Congress Government should befriend if it is to justify its claim. The specialists and the general medical officers in Government employ can however reach but a microscopic fraction of the huge mass of humanity that makes the people. It should therefore be the concern of the Government to see how best to strengthen the profession. At present the best

men are lured to Government service by the pay, prospects, perquisites and privileges attached to the position. A reduction of these emoluments to the limits which the people can bear will achieve a double object. It will set free some revenue and will redress the balance now weighted against the profession. One instance we mentioned in our last issue of a Government officer subjecting a private practitioner to needless insult and injury. The latter gave a medical certificate to a patient of his which he, the patient, used in support of his application for leave. The Government officer who was to grant the leave instead of accepting the certificate sent the subordinate to a medical officer of the same qualifications as the private practitioner so that he might examine and grant a fresh medical certificate. This was plainly an insult to the practitioner who granted the certificate. It did an injury as well inasmuch as no Government servant would care to go to a private practitioner if the certificate he granted is to count for nothing and the patient is to be sent to a medical officer who, for aught one can know may be his rival and whose professional jealousy may be excited by the opportunity for its satisfaction.

The time is ripe for the reform. A popular Government imbued with the Congress spirit and with the portfolio in charge of one who was himself a successful medical man is a rare combination and provides a unique opportunity to introduce a measure of this kind. Those who have undergone suffering of every description and made all kinds of sacrifices for their country and are giving of their best for a living wage have proper credentials and an inherent right to call upon their subordinates to give up a luxury, for such is private practice to a medical officer in receipt of decent salary in the interests of the nation at large. We earnestly hope that all rightminded persons will strengthen the hands of the Minister and his regime will be made memorable by a reform which, as we have explained, is of far reaching importance.

News and Comments

Troubles and Difficulties: On 30—8—1938 the Hon'ble Mr. C. Rajagopalachariar, the Madras Prime Minister addressed the students of the Government School of Medicine, Madras. The occasion was the inaugural meeting of the "Students' Association". We have quoted major portion from his speech as reported in one of the Madras Dailies so as to enable our readers to know the cherished views of the Head of the Madras Government regarding the 'Eastern' and 'Western' systems of medicine.

"The Premier thanked the students and staff of the College for the warmth of their welcome and said that while he appreciated greatly the honour they had done him in asking him to address them, he felt handicapped in not having any knowledge of medicine.

It was also pleasant to have something to do which did not involve some administrative trouble. He realised, however, that even on occasions like the present, it was difficult to talk as one would wish to, because anything that might be said, even what was said in a light vein, was taken all too seriously and discussed at length in the columns of newspapers. For example, the Premier said, the other day he spoke at some lawyers' meeting and the jokes he made and the dreams he dreamt were discussed so seriously that he got quite frightened about it all. (Laughter.) So much so, he thought he had better give up accepting invitations to such gatherings. But when the representative of the pupils of the school came to him with a request to address them, he forgot all about his previous decision and agreed to address them. Perhaps he might be causing offence to some medical men and even medical students in what he might say on the occasion but he would venture it.

Most of them, the Premier said, were perhaps under the impression that they were learning a particular school of medicine.

A few voices: No.

He was glad of that negative answer, but he would like to tell them that it was not right to imagine that medicine could be divided into Western or Eastern or even as Hindu, Unani and so on. While art, fashions, dress, customs and manners might differ from country to country, truth could not differ and therefore science could not differ. There could be no nationalism in science as there could be in art. What he said of science was true also of medicine. Drugs acted on the human body irrespec-

tive of the person's political views or religion. These opinions, the Premier said, he was gathering courage to speak out just then, though he had held them for a fairly long period. It was impossible to divide medicine into Eastern and Western.

The Ayurvedic system was really the father of what was now known as the Allopathic system (cheers). The statement was certainly pleasant and was equally true. The two were essentially the same and there could be no opposition between them. There was, in his opinion, no difference between the modern development of medicine known as Allopathy and the ancient Indian system known as Ayurveda. Pharmacopoeia should not be confused for the system of medicine.

It was the duty of students to discover the unity of these systems and seek the truth in the practice of their professions. That should be the aim of the medical student in India.

Let them all pursue truth and let there be no "caste" among medical men. The one common goal of all of them should be to get at the best, the most advanced and the most effective methods of treating disease and to this end they should take in all the material available.

The Government School of Indian Medicine, the Premier continued, had a great future. It had "a proper mixed curriculum" and in that way was superior to other institutions. Their confidence in their ancestors should give them strength to pursue truth.

But do not quarrel with me for not giving you this or that much. Do not create troubles and difficulties. We are trying to serve a very poor country which has long been waiting for relief and for happiness and prosperity. Let all of us contribute each his or her bit to this end and achieve the goal that is before our country." (cheers.)

What all the Premier said has the effect of a brilliant speech from the mouth of the leader opposing the Government for their policy in wasting public funds in running two sets of medical institutions the 'Eastern' and the 'Western' when 'the two systems were essentially the same' to quote the Premier's opinion.

The Premier said by way of intro-

duction that at the gatherings of the type he addressed that day he at times talked in 'a light vein'. We wish it were so even at the Government Indian Medical School which the Premier declared as 'superior to the other institutions' for in his opinion it 'had a proper mixed curriculum'. As anticipated by him this statement of his 'must be causing offence' not to 'some medical men and even medical students' but to a considerably large section of medical men and students belonging to the Eastern system as well. For the Premier must know that Ayurvedic Physicians not belonging to the Government School of Indian Medicine have been protesting that the methods of teaching Ayurveda at the Government School far from regenerating the Eastern system is definitely detrimental to the very system. When the Premier referred to the 'proper mixed curriculum' in the Government School of Medicine he must have meant that both the Eastern and Western Systems of medicine were taught in the School. The course of studies in the Government School of Indian Medicine extends only for four years which period is now universally considered to be inadequate to teach the Western System of Medicine in Schools pertaining to this system. We wonder if the Premier during his extensive tours in the Province had seen that as a matter of fact the students that passed out from the Government School of Indian Medicine actually practised the Western System at least a large majority of them. We might say that we gathered this information not only in the very Government School of Indian Medicine in Madras but also from a large number of students that passed out from the School. The state of affairs do not seem to be different in other provinces. The Hon'ble Health Minister of Bombay endorsed the view expressed by us after his personal inspections of many of the institutions of Eastern medicine in that Province. The 'mixed curriculum' has been distinctly harmful to both the systems and enable the votaries of the 'mixed curriculum' to create a feeling of false safety in their patients.

Though the Premier has a predilection for the Eastern system, he seems to have no bias for the Western. It is too much for the Premier to expect students to be synthesists especially so when the Government are running two Medical Departments under a Diarchical System. Synthesis can only be brought about by the Government. The opposition is likely to ask the Premier if the Government were justified to spend nearly a crore of rupees on Western System of Medicine and not even a lakh and a half for the Eastern System when it was the considered opinion of the Premier that the latter system is superior to the former. The Premier has really '*created troubles and difficulties*' which he wished to avoid from the students of the Government School of Indian Medicine. He had put forcible arguments into the mouths of others '*to create troubles and difficulties*' which his trusted colleague, the Health Minister will have to meet.

Toll of Diseases in India:—The Public Health Commissioner with the Government of India in his report for the year 1936 mentions that there were nearly 6,400,000 deaths in India of which approximately 160,000 were due to Cholera; 13,000 to Plague; 3,600,000 from Fevers of all description; 280,000 from Dysentery and Diarrhoea; 490,000 from respiratory diseases, 1,730,000 from all other causes. It is not known how far the special Health Staff in charge of Public Health has been responsible for decreasing the death rate in individual Provinces where independent Public Health Departments have come into existence in recent years. We do not for a moment underrate the work turned out by the Public Health Department in the Provinces but we cannot resist the temptation of expressing the general impression even amongst medical circles that the bulk of work turned out by the Preventive Department is not felt. This may be due to many causes including the one put forward by the Public Health Commissioner that the Preventive Staff is inadequate to meet the demand. While referring to the heavy figures of death, the Public Health Commissioner pointedly mentions about the urgent need for the

extension of rural medical relief on a large scale. The Public Health Officers will be able to do substantial good work in rural areas with the help of the Subsidized Rural Practitioners. Amongst the eleven provinces in India Rural Medical Relief Scheme seems to be more extensive in the Madras Presidency than anywhere else. Bombay has just begun the experiment. In the Punjab the scheme is reported to be not popular, in Bihar it has not made a mark so far. In the rest of the provinces nothing is heard. Excepting in the Punjab which is a non-Congress Province, in the rest of the Provinces where the scheme exists on a meagre scale, it is likely to be extended on a larger scale but the tendency seems to subsidize practitioners of all the existing four systems, the Allopathic, the Ayurvedic, the Unani and the Siddha. Homoeopathy may also have a share in all other Provinces excepting in the Madras Presidency where the Public Health Minister openly disfavoured the idea of encouraging this system which he did on the floor of the Legislative Assembly during the last budget session. The question naturally arises if Public Health work could be entrusted to the practitioners of indigenous systems. The Madras Health Minister usually does not mince matters and there was a recent announcement in the newspapers that the Madras Government intended to give a special course in Public Health Work to the Subsidized Practitioners belonging to the Scientific System of Medicine. As the pendulum of Public Health measures have to depend upon political winding we are afraid even with the extension of Rural Medical Relief Scheme whether, it will ever be possible to decrease the toll of preventable diseases in this country which has the notoriety of being a reservoir of epidemic diseases especially Cholera. The fate of India depends upon the Working Committee of the Congress and unless there are persons in that Committee having requisite knowledge of Public Health Work to the extent the Public Health Commissioner is expected to possess it is likely India will continue to live up to the evil reputation of being a hot bed of diseases known and unknown.

Rural Practitioners to Wake Up: There cannot be any doubt that the Rural Medical Practitioners will have to play very important part in the reconstruction work in the villages though in the village uplift schemes so far formulated either by the Government or other public bodies in this province or elsewhere very little is mentioned about them. The Public Health Commissioner expects that with the extension of Rural Medical Relief Scheme the toll of death is likely to decrease in India and it augurs well in the Madras Presidency that the Public Minister who has introduced the Public Health Bill in the Assembly is preparing the Subsidized Practitioners to meet the responsibilities expected of them to be the Rural Sanitary Officers, in addition to their being the Rural Medical Officers. We hope that Madras Health Minister who is likely to lead his comrades in other provinces in the way he did in regard to the introduction of uniform standard of medical education, will soon realise the necessity of bringing the Subsidized Rural Medical Relief directly under the Government control and confer on the Subsidized Practitioners freedom of action in matters concerning their profession so that they might feel their independence and co-operate with the Government heart and soul keeping in view the ideals of service consistent with those of the National Congress. Servitude under which the Subsidized Practitioners are at present groaning has been a great hindrance for the evolution of Rural Medical Relief which has a great future not only to evolve the growth of independent medical profession but also to solve the question of Medical Relief in Rural areas. We would advise the Subsidized Practitioners of the Madras Presidency to wake up and shake off the inferiority complex now surrounding them. It is true that this complex is not of their own making. The more so it is easier for them to get rid of it. They should make their Association as their mouth piece to assert their rights and privileges and steer clear of the party factions minding only their noble and legitimate work of making the villages a healthy place to live in.

Government proposes; District Board disposes: We refer the readers especially the Subsidized Rural Medical Practitioners of the Madras Presidency to an order of the Government of Madras on the question of termination of the services of a Subsidized Practitioner in one dispensary with a view to appoint him in another dispensary published in the Correspondence Columns. The question arose on account of indiscriminate transfers made in one or two districts by the presidents, District Board. When a reference was made to one such President of the District Board by the President, Madras Provincial Subsidized Rural Medical Practitioners' Association that Subsidized practitioners could not be transferred as per terms of the agreement executed by them, the Vice-President of the District Board informed the President of P. S. R. M. Ps' Association that he did transfer the practitioners with the previous sanction of the Surgeon-General. Then the Surgeon-General was addressed on the subject and as his reply was not satisfactory the matter was placed before the Government. The G. O. referred to above is a reply on this subject.

Clause 10 of the form of agreement referred to in the G. O. runs thus:

"The practitioner shall not be liable to transfer from one dispensary to another. If after obtaining the opinion of the District Medical Officer or the Principal, Government School of Indian Medicine as the case may be the Board considers that the dispensary is not working satisfactorily it may close the dispensary after giving three months notice in writing to the practitioner."

The provision that the Subsidized Practitioner should not be transferred is mandatory. Yet the District Board Presidents did transfer the practitioners and the practitioners meekly submitted fearing that in case they disobeyed the orders of the District Board Presidents there services might be terminated making disobedience of orders a plea. Appealing to the Government tantamounts to the practitioners not having any work till the date of disposal of the appeal which means actual starvation in a village. So the practitioners preferred submitting to unjust

orders rather than starve. To avoid repetition of such hardships the Government was requested to issue instructions to the Presidents of District Boards not to transfer rural medical practitioners. The Government would not have lost anything at all but the suffering Subsidized Practitioners would have gained much if the Government were pleased to inform the concerned District Boards that what they did was against the conditions of the Agreement to which the District Board is one of the parties.

A few months ago Subsidized Rural Practitioner in Tinnevely District was served with a notice terminating his services assigning no cause at all but merely mentioning that the period of one year mentioned in the Agreement was over. On 25th January the representatives of the Provincial Subsidized Rural Medical Practitioners' Association waited on the Hon'ble Dr. T. S. S. Rajan, the Minister for Public Health to discuss some of the clauses in the Agreement form with a view to modify them consistent with the spirit and the principles of the scheme and the very first request from the deputationist was that the period of service should not be mentioned in the agreement and if mentioned it should be a period not less than five years. It was even pointed to the Minister that some of the subsidized practitioners were harassed by the Presidents of the District Boards on this score. The Minister informed the deputationists that it was not necessary to mention the above condition in the Agreement but the Government would issue instructions to the District Boards to keep up to the principles of the Scheme and not to terminate the services after the period of one year though mentioned

in the agreement. When the Presidents, District Board do not respect the principles of subsidized rural medical service, the Subsidized Practitioners naturally despair.

When the Government is drafting a new agreement embodying the decisions arrived at by the Public Health Minister, when the representatives of P. S. R. M. Ps. Association waited on him on 25.1.38, some of the District Boards are agitating to nullify even the existing conditions such as the transference of practitioners. The East Godavari and the Malabar District Boards have passed resolutions to this effect. We advise the Subsidized Practitioners not to lose heart on account of passing events. They should organise themselves and keep on the agitation for progressive reforms in Rural Medical Relief Scheme. Their agitation should be in the direction of getting for the villages the maximum benefit on account of their work and of establishing freedom of action in welfare work without being affected by political currents or party factions.

An Announcement :—We are requested to announce that the next Post Graduate Course in Leprosy at the Lady Willingdon Leper Settlement, Tirumani, Chingleput District will commence on 22nd November and end on 6th December 1938. Applications for the course must reach the office of the Medical Officer by the first week in November.

A Correction :—The President of the Saidapet Health Association whose work was commented upon in these columns last month is Mrs. Buck and not Mr. Buck.

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THE MADRAS PROVINCIAL SUBSIDIZED RURAL MEDICAL PRACTITIONERS' ASSOCIATION.

Memorandum submitted to the Government of Madras by the President, The Madras Provincial Subsidized Rural Medical Practitioners' Association relating to some of the Resolutions passed at the Annual gathering of the Association which met at Manachanalloor, Trichinopoly District on 26-6-1938.

The Government may be aware that the Subsidized Practitioners belonging to the Allopathic System of Medicine met in Conference at Manachanalloor on 26-6-1938 and the Hon'ble Dr. T. S. S. Rajan, the Minister for Public Health was pleased to honour and encourage the Association by his presence at the Conference which he was kind enough to open. At the annual meeting of the Association 21 Resolutions were passed which were published in the June issue of The Medical Practitioner, a copy of which was sent as usual to the Secretary to the Government, Education and Public Health.

Resolution No. 6 conveyed to the Hon'ble Dr. T. S. S. Rajan the heart-felt gratitude of the Association for his having announced at the Conference that the tentative conclusions arrived at during the interview which the representatives of the Association had with him on 25-1-1938 would be incorporated in the form of Agreement to be executed by the Rural Medical practitioners and that a Government Order containing these conclusions and a consolidated form of Agreement would issue early.

The Association realises that the publication of the G. O. relating to the above subject may take some more time as the new Agreement form may have to undergo legal scrutiny and other formalities. As some of the District Board presidents are pressing the Subsidized Practitioners to execute the Agreement as

per the old form, the Association prays that the Government may be pleased to advise the District Boards to postpone the execution of the Agreements till the new form of Agreement is approved.

Resolution No. 7 which is self explanatory runs as follows:—

"The Conference views with satisfaction the recent G. O. relating to the transfer of control of Subsidized Midwives entirely to the District Medical Officers and for the same reasons mentioned by the Government in the G. O. relating to the subject, suggests respectfully to the Government that the entire control of the Subsidized Rural Medical Relief Scheme be vested in the Surgeon-General with the Government of Madras as the Government is aware of the persecutions and victimisations of Subsidized Practitioners by the Local Bodies, and such a transfer of control will, in the opinion of the Conference, enable the Subsidized Rural Medical practitioners to evolve into a self-reliant Scheme of Medical Service as envisaged by the Hon'ble Dr. T. S. S. Rajan this day in his address to the Conference."

The association wishes to inform the Government that in the Bombay Presidency where the Government and District Board share the expenditure of running Subsidized Medical Service in certain proportion as is the case in this province, the appointment of the Subsidized Practitioner is made jointly by the Civil Surgeon and the President, District Board, subject to the final approval of the Surgeon-General. The Bond executed by the practitioner is in the custody of Civil Surgeon. The Bill for the subsidy or for any allowance is to be submitted to the Civil Surgeon who countersigns the same and payment is made directly from the District Head Quarter Treasury or the nearest Taluk Treasury. It is most appropriate that a Subsidized Practitioner should be directly under the control of the Head of the Medical Department. The District Board Presidents in the Bombay Presidency have only the right of inspecting the Dispensaries. The Association therefore prays that the above resolution may be given effect to as it makes for efficiency and prevents a great deal of discontent that now prevails among the practitioners.

Regarding Resolution No. 8, which is a prayerful suggestion to the Government that the Rural areas should be the first concern of the Government regarding the expenditure for Medical Relief, the Association does not feel it necessary to say anything more than what this resolution conveys.

The 9th Resolution is a reiteration of the Resolutions No. 9 and 10 passed by the Association at Bezwada where it met on 24-4-1935. They run as follows:

Resolution No. 9 (1935): "This Conference brings to the notice of the Government that some Subsidized Practitioners have not yet been equipped with the most necessary Surgical, Dental and Midwifery instruments in spite of G. O. No. 761 P. H. dated 7th April 1925, reiterates resolution VII of the II Conference and requests the Government to direct the District Boards to make such supply as one of the conditions of the Agreement, the allotment for such supply and equipment to be separate from that of drugs.

(b) This Conference requests also that every Subsidized Practitioner shall be allowed every year a sum not exceeding Rs. 40 in addition to the cost of drugs for the repair or renewal of old and worn out instruments or for the purchase of new ones.

(c) Also in view of the heavy discount excise, packing and transit charges, this Conference requests that every practitioner should be supplied with drugs to the actual value of Rs. 360 a year and that the other such incidental charges should be borne separately by the District Boards.

Resolution No. 10 (1935): As it is the experience of many practitioner that the drugs supplied to them at District Boards' cost are not even sufficient to meet the requirements of the ordinary poor that seek relief at the practitioners' residence and as those practitioners with midwives attached find it a great handicap to be obliged to supply from such stock the midwives' requirements for their use outside the dispensary, this Conference earnestly requests the Government to direct that all the requirements of the midwives shall be separately budgeted for and supplied on separate indents by the District Boards."

In the best interests of efficient medical relief in the villages where the practitioner cannot even get a loan of instruments in any emergency, the Subsidized Dispensary should be made self-sufficient as far as possible. The fact that some of the District Boards have been negligent in spite

of a specific G.O. on the subject dated 7th April 1925 should convince the Government of the necessity to make specific mention in the agreement about the supply of such instruments that are considered indispensable. If, for any reasons the Government find that there is no need to mention this in the Agreement a definite order may be passed by the Government that such of the Dispensaries as have not been supplied with the specific instruments should be so supplied without further delay.

The request that a reasonable allowance should be given to the practitioner for the repairs of instruments or for buying new ones on old one being condemned by the D. M. O. is modest and reasonable having special regard to the financial condition of the Rural Practitioners. The Government may be pleased to consider this request favourably.

Equally reasonable is the request that the Practitioner should be supplied drugs free of packing and conveyance charges etc. The freight will depend upon the distance and other incidental causes. So there will not be any uniformity. The dispensary which is most distant from the Government Medical Stores will necessarily suffer most regarding the drug supply as a large amount will be adjusted towards freight. Moreover it is clear from the wording of the Agreement that the practitioner should be supplied drugs actually worth Rs. 360. It is natural that the same should be the intention of the framers of the Agreement originally. It need hardly be submitted that a practitioner would feel crippled by the want of drugs and instruments and full use cannot be made of the money spent on the Scheme.

Regarding Resolution 10 of 1935 it may be said that when the Subsidized Rural Relief Scheme was first started, midwifery practice was not so much in demand as it is now. A special allowance may be given for drugs relating to Midwifery work proportionate to the work turned out at the dispensaries.

Resolution No. 10 (1938) runs as follows:—

"The Conference brings to the notice of the Government the inordinate delay at times even for a period of two months regarding the passing of the Subsidy Bills consequent to the delay of the District Boards not communicating the sanction of leave availed of by the Subsidized Practitioners which delay prevents the District Medical Officers from passing the Subsidy Bills with the result that the Practitioners are put to great hardship in not realising the Subsidy earned by them in time. The Conference therefore requests the Government to vest the power in the District Medical Officer of granting permission to Subsidized Practitioners to avail of holidays whenever required by them."

In the Bombay Presidency the Civil Surgeon is the sole authority to grant leave. If the same rule is followed in Madras it will not in any way be detrimental to the interests of the Rural Medical Relief Scheme. The District Board cannot possibly object if the D. M. O. is made the authority to grant leave. As the natural and proper head of the medical staff it is inevitable that he must be entrusted with the duty of granting leave and making arrangements for the work during the period of leave.

The 11th Resolution is as follows:—

"The Conference points out to the Government that District Boards have generally failed to give effect to the G. O. No. 9156 P. H. dated 7-8-1937 and amendments thereon which now form clause No. 12 of the Agreement executed by the Subsidized Practitioners in either not appointed Subsidized Practitioners to the vacancies in preference to others or not appointing the Subsidized Practitioners in charge of a Subsidized Dispensary which dispensary the Government sanctioned to be converted into a L.F. Dispensary consequent on the increasing demand of medical relief in localities where the Subsidized Dispensary existed; the Conference therefore respectfully requests the Government to keep in view the G. O. referred to in the resolution when Local Bodies approach the Government to accord sanction to the appointment of medical Officers in L. F. Dispensary or for the purpose of converting Subsidized Dispensary into L.F. Dispensary. The Conference further requests the Government that the District Boards should be advised to the effect that whenever the temporary or permanent vacancies in the cadre of Medical officers in L. F. Dispensaries in a District arise the seniormost Subsidized Practitioner of approved merit should be selected to fill in the vacancy."

The Association as a whole does not favour the idea of the conversion of Subsidized Dispensaries into full fledged L.F. Dispensaries nor does a large section of the Subsidized Practitioners wish to enter regular L. F. Service. As far as I could judge a majority of the practitioners desire that they should not be disturbed from the field of their work. On 25th January 1938 the representatives of the Association told the Hon'ble Minister that if the demands of medical relief in a locality called for the establishment of a dispensary with the staff and equipment of a regular L. F. Dispensary, the practitioners are willing to work as honorary medical officers in charge of such dispensaries and forgo the subsidy. It is also against the spirit of Subsidized Rural Medical Relief Scheme to convert Subsidized Dispensaries into L. F. institutions. The Association passed this resolution having in mind the pressure brought to bear on the Government by some of the District Boards to convert Subsidized Dispensaries into L. F. Dispensaries. In case it becomes the settled policy of the Government to convert Subsidized Dispensaries into L. F. Dispensaries which the Association very much doubts, the Association respectfully presses the claim of Subsidized practitioners to regular L. F. Service seniority and merit be taken into consideration for selection. It is submitted that the hard work of the Rural Practitioners raises the status of the Subsidized Dispensaries and makes it popular. It is only just therefore that they should reap the benefit of this work.

Resolution No. 13:—

"The Conference views with great concern a tendency in some of the District Boards for converting Subsidized Dispensaries of Allopathic Medicine into Subsidized Dispensary of Ayurvedic medicine on some excuse or other even against the advice of the District Medical Officers who certify to the popularity and usefulness of Subsidized Dispensary of Allopathic System of Medicine and therefore requests the Government not to accord sanction to such conversion (especially against the advice of the District Medical Officers) as such conversions violate the principles and the spirit of Subsidized Rural Medical Relief Scheme and make the Scheme very unpopular. The Conference further wishes to bring to the kind notice of the

Government that termination of the services of a Subsidized Practitioner for the purpose of converting an Allopathic Dispensary into an Ayurvedic Dispensary is not contemplated in the Agreement and therefore is *ultra vires* if not illegal."

The Association respectfully wishes to point out to the Government what happened in the case of the Subsidized Dispensary, Kilayur. The District Board, East Tanjore District first served a notice on the practitioner who had been in charge of the dispensary ever since the Subsidized Rural Medical Relief Scheme came into operation to the effect that this dispensary would be converted into an Ayurvedic Dispensary in response to the wishes of the Panchayat Board of the village. The District Medical Officer, it is stated, did not agree with the Board to terminate the services of the practitioner on this ground and the practitioner also protested. Later the District Board brought forward another excuse to terminate the services of the practitioner and said that the dispensary at Kilayur was superfluous. This suggestion also was disapproved by the District Medical Officer. The records of the Kilayur Dispensary show that this is one of the most popular subsidized dispensaries and that *'the practitioner is conscientious and hard working and is popular with the local population.'* The Association also learns that the Panchayat Board of Kilayur and one or two Panchayat Boards in the neighbouring villages and also the villagers residing in Kilayur and adjacent villages have memorialised to the Government to retain the Subsidized Dispensary at Kilayur. Under the circumstances the Association views with grave concern the recent G. O. on this subject which while not approving the action of the District Board, East Tanjore instructs the Board to terminate the services of the unfortunate Subsidized Practitioner giving him six months' notice. Though the Association notes with relief that the G. O. instructing the District Board to terminate the services of the existing Subsidized Practitioner contains a condition that an Ayurvedic Dispensary should not be opened at Kilayur in case the practitioner continues to practise in the same village, the Association

feels very much humiliated that the affairs connected with this episode were such as not to justify the termination of the services of the practitioner as per the conditions of the Agreement. It will be little short of a tragedy if a medical institution were to be made the sport of local politics and the voice of the D. M. O. should be drowned by the noise of the factions.

Resolution No. 14 :—

"As it is the experience of some of the Subsidized Practitioners that the District Boards delay in sending their indents to the Government Medical Stores the Conference requests the Government to advise the District Boards not to commit such delays and as it is not possible for the Government to know which District Boards commit these delays, the Subsidized Practitioners are requested to bring these delays to the notice of the General Secretary through the Joint-Secretary of the respective territory."

The delay in getting supply of medicine will not arise if the District Medical Officer is entrusted with this work as in Bombay, the District Board being asked to remit the amount to the Government Treasury in advance. It is likely that the people will lose faith and attendance fall off if the medical practitioner is present in the Dispensary and not the drugs he is to dispense.

Resolution No. 15 :—

"The Conference requests the Government to advance loans to the Subsidized Practitioners for the construction of suitable buildings for their residence, the amount of loan to be returned in easy instalments to be deducted from the subsidy."

As in Bombay Scheme of Subsidized Rural Medical Practice it is desirable that the Local Bodies provide the building for the location of Subsidized Dispensaries. If this is not possible the next best thing would be to advance loans on proper security. It is desirable that a Rural Practitioner should have a permanent habitation of his own for himself and his dispensary and not be at the mercy of local landholders and leaders of factions.

Resolution No. 16 :—

"The Conference requests the Government that till the Subsidized Rural Medical Relief Scheme is made self-reliant so as to secure free medical relief to the necessitous poor in the Rural areas the existing Subsidized Dispensaries should not be closed even if there were to be qualified practitioners in a village where a Subsidized Dispensary exists."

The Association are not in favour of opening Subsidized Dispensaries in villages where qualified practitioners have settled but does not approve the idea of transferring or closing an existing Subsidized Dispensary in villages where Subsidized Dispensaries already existed as the indigent villagers who get free medical service will be deprived of the same.

In conclusion the Association begs to be excused if it reiterates its prayer to the Government which it does most respectfully that the Subsidized Rural Medical Relief Scheme will work more satisfactorily if the Government are pleased to transfer the control to the Surgeon-General, the District Board having the power of supervision. This has been possible in a sister province.

The Rural Practitioner has to contend against a good deal of ignorance, apathy and prejudice in the villages where even now quacks of all descriptions hold the field. The Association only prays through these resolutions that the hands of the practitioners may be strengthened by a sympathetic Government so that the rural dispensary may be helped to reach a widening circle of patients and that rural medical relief be made effective in the villages which make India.

V. RAMA KAMATH,
MADRAS, } President,
P. S. R. M. P. S.
Association.
30th August, 1938.

Education and Public Health Department.
G. O. No. MS. 1810 P. H., dated 17th May 1938.

ABSTRACT.

Medical Institutions—Rural (subsidized) Termination of services of a medical practitioner in one dispensary with a view to appoint him in another dispensary—provision in the form of agreement—considered unnecessary.

Read the following :—

From Dr. V. Rama Kamath, No. R. M. P. S. 7/177, dated 23rd February 1938.

From the Surgeon-General, In. R. No. 3486 Hospls., dated 24th March 1938.

ORDER :—

The Government consider that there is no need to provide for the termination of services of a rural medical practitioner in one dispensary with a view to appoint him in another rural dispensary even in exceptional cases. They do not consider it necessary to issue any instructions to the Presidents of District Boards not to transfer rural medical practitioners, as the provision in clause 10 of the form of agreement to be executed by medical practitioners in charge of rural dispensaries is clear on the point.

(By Order of His Excellency the Governor.)

C. H. MASTERMAN,
Secretary to Govt.

To the Surgeon-General,
To Dr. V. Rama Kamath, Vepery, Madras.

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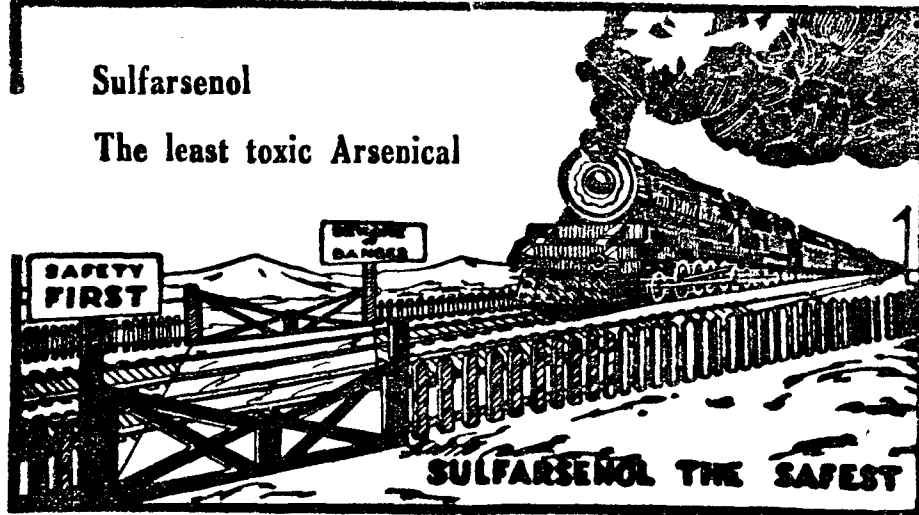
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Vol. X]

OCTOBER, 1938

[No. 1

Original Articles.

SIMPLE MANAGEMENT OF HYPERPIESIA.

BY

DR. P. S. VARADARAJAN, M.D., M.R.C.P. (LOND.)

Hon. Physician and Cardiologist, Government General Hospital, Madras.

I have dealt with this subject in as practical a way as possible for educating the lay sufferer on the subject and to serve as an advice to a lay patient. That knowledge is wealth but little knowledge is dangerous is best illustrated by the self imposed misery of certain over inquisitive hypertensive subjects through reading bright and attractive advertisements on the subject and the so called "educational" columns of certain lay papers. On the other hand, the same persons may derive considerable benefit by simple instructions from their medical attendants if only the latter take the patients into confidence without in any way creating panic.

Frequent readings of the manometer are to be deprecated as the procedure is liable to induce an "Anxiety complex" either prior to the procedure, during or even after. Even if the pressure is raised above average normal limits (due allowance should be made for the personality, environment, mode of life, occupation etc. It should be clearly understood that the rise is a compensatory mechanism to ensure an adequate supply of blood to all

parts of the body against some resistance whose exact nature is still a matter of conjecture. No great hurry should therefore be exercised in reducing the blood pressure merely because the manometer registers a higher figure, in spite of the fact that the person is fit and well and is free from any other sign of cardiovascular disease. The commonly employed methods of reducing the degree of pressure by drastic purgatives, cutting down the scale of diet even below the basal requirements, depleting the blood volume by venesection, administering of toxic drugs either orally or through parenteral routes and inducing sweating to a weakening extent, cannot but upset the harmonious imbalance between the physiological working of the body and this moderate rise in blood pressure. Every medical man is aware of the grave consequences of such an interference. Anything from a simple cerebral attack such as a mild grade of unconsciousness twitching of a group of muscles, transient loss of memory etc. to a morbid catastrophe such as an attack of major epilepsy, (the word epilepsy is here used in the broadest sense in accordance with the

heart further. Rest before food and more of it after should be enjoined.

The following diet may be advised.

7 to 9 P.M.—coffee or tea (half the usual strength) with one or two small biscuits or just one idli—the latter should not contain too much of black gram.

About 11 A.M.—some drink such as Marmite (2 teaspoonful) tea or orange juice made into a sherbet or watery butter-milk.

Between 1 and 2 P.M.—small quantity of rice, sambar, rasam, butter-milk, boiled vegetables, with occasional salads.

About 4-30 to 5 P.M.—some dilute coffee or tea or fruits.

Night.—an early feed of conjee.

(If hungry at nights, some light drink such as watery Horlicks)

The following scale is advised for those who have adopted an occidental type of dietary.

Chota.—A small cup of coffee or tea in bed if used to it.

Breakfast 8 to 9 A.M.—(1) a small or moderate quantity of oat meal porridge, Force etc., with a little milk and sugar.

Or bread, a couple of thin slices ($\frac{1}{2}$ " thick) toasted with $\frac{1}{2}$ to $\frac{3}{4}$ an ounce of butter and orange marmalade or some fruit juice. One or two eggs—poached, half-boiled or buttered may be added.

(2) A small cup of coffee or tea.

11 A.M.—A small cup of Marmite or half an ounce of orange juice made into a sherbet.

1 P.M.—Soup (European type) curry, semisolid well-boiled rice 4 ounces.

There is no hard and fast rule in the choice of the curry.

Dholl curry (4 ounces) or "Rasam" or watery Sambar.

Rice and butter milk often restores the appetite. Water or any other drink may be taken an hour after the meal. Two slices of bread may replace the rice.

4 P.M.—Tea or Coffee, If one so desires one or two biscuits may be taken along with the tea lest the appetite be lost for supper.

6 P.M.—An early supper, conjee made of sago, rice, arrowroot or tapioca etc. One or two biscuits.

A few people who have hitherto lived to eat may be utterly disappointed with this menu; but, without a *bonafide* gesture of diet restriction, no relief from the miseries of hypertension is possible. Now and again slight relaxations have to be made, for example, after a poor supper, sleep may be denied to a gourmet. Then he may be permitted an extra feed.

Other facts that should be borne in mind are:—

1. Attention to dentures.
2. Proper mastication.

Fried articles are not well borne. Alcohol is best given up but if it is inevitable an ounce or two of whisky (brandy appears to quicken the heart hardly necessary a procedure in hyperpiesia) well diluted with soda water in which the gas has been expelled by a fizzer. Beer is bad. Sherry rather than Port may be permitted. Tobacco is said to be even worse than alcohol. But a reasonably minded patient may be advised upon cutting the quantity smoked limiting the act to certain hours.

DRUG TREATMENT OF HYPERPIESIA.

Any suggestion of drug is likely to create a false sense of hope in the mind of the sufferer and even worse, he may fail to realise the importance of following some regimen as detailed in previous pages. However, a prescription written mostly in illegible writing and a few latin suffixes and prefixes tailed on to the prescription have their own psychological effect upon the mind of the patient and

why then deny this small service to the person. Further most of the drugs do little harm if no good at all.

Iodine, once again takes the place of pride. A pinch of Sodium Iodide in about an ounce of cold water at bed time has at times acted very well. Organic Iodine has its adherents. Lipo Iodine 5 grs. 1st day; 10 grs. 2nd day; 5 grs. the 3rd day; 10 grs. the 4th day and so on for 10 days. Then give rest for 10 days and begin again a second time. In this way not more than 3 courses are desirable.

Nitrites are certainly very efficacious especially when anginal pain demands quick and if possible lasting vaso-dilatation. One of the best of the series is the chocolate coated Trinitrin Tablets (dose 1/100 gr.) which is kept under the tongue till it dissolved. According to that great worker—Sir Thomas Lewis an anginal patient can rely on this drug to the extent that he can undertake to get through a busy day's work without dreading any catastrophe. B. W. & Co's compound nitrite tablets may be taken daily—about 2 or 3 a day for about 2 weeks at a time. The result of such a course is not conclusive. Amylnitrite capsules—5 minim dose crushed in a handkerchief and inhaled during the fit may avert serious consequences.

Empirical remedies are as numerous as the number of sufferers themselves. Bismuth Subnitrate capsules of ten grains can be taken thrice a day an hour or two after food. Liver extract for reasons not known, has done well in improving the morale of the patient.

Gipsim ($\frac{3}{4}$ grain) pills can be taken one T. D. S. either before or after food and definite reduction in the pressure readings has been noted by some authentic workers.

Excessive headache with vomiting is at times controlled by auto-haemotherapy. 5 to 10 c.c. of patient's own blood injected into the gluteal muscles—once a week for 6 weeks is all that is necessary.

Morning injection of 8 ozs. Magsulph (25%) into the colon after a plain water

enema over night has been of service in the immediate reduction of pressure. It can be repeated once in four days. Glucose 25%, 25 c.c. given intravenously acts very well and can be given daily for about 5 days. Venesection up to 15 ounces is another emergency measure. Likewise Sodium Chloride 40 c.c. of 30 per cent solution intravenously administered is of great help. Lumbar puncture with the foot of the bed raised and the procedure stopped when the individual drops do not run into each other or when the total quantity of C. S. F. does not exceed 20 c.c. may offer relief to a person with hypertension encephalopathy.

If Wassermann reaction is found positive, anti-syphilitic treatment should be immediately begun with mercury. Later any of the safer preparations of Neocars-phenomine group should be cautiously administered.

Colonic wash is said to reduce auto-intoxication and can be done as follows:

The patient is put in left lateral position. Saline (102° F) one or two pints is run in slowly with the water head at 18" above the cot. The patient is then helped on to the knee and elbow position and then on to the right lateral position. He should retain the water as long as possible.

Radiant heat and other measures to stimulate the skin to act (Turkish Bath—pucca one or with an improvised one as stated in the early part of the paper) is useful. But these measures should not flag the patient's strength.

Whatever the drug be, it is wise to lay emphasis upon the desirability of strictly adhering to a regimen and to remember that the drugs have even less value than a glass of hot water drunk before retiring to bed and directly on rising from bed.

Reference: Lewis—Diseases of the Heart.

East and Bain—Recent advances on Cardiology.

Price—Text-book of Medicine.

DYSENTERIES

By

DR. K. NARAYANAMURTI, M.D.

AMOEBIASIS.

(Continued from the last issue).

In an earlier article Amœbiasis was defined as an infection occurring with a protozoon—*Entamoeba histolytica* at any part of the body and when the infection is solely confined to the intestinal canal, it is termed Amœbic dysentery or primary Amœbiasis. When metastatic lesions develop in the Liver or elsewhere the term secondary Amœbiasis is used. The most common form of secondary Amœbiasis is hepatic Amœbiasis or Liver Abscess, Tropical Abscess of the Liver.

HEPATIC ABSCESS.

GEOGRAPHICAL DISTRIBUTION: Liver abscess occurs in warm climates where Amœbic dysentery is common. But in Central Africa, a tropical country, Amœbiasis is unknown. The Indians though they suffer from Amœbic dysentery for a long time do not so easily develop abscess in the liver; while the Europeans who catch the infection are very much susceptible to Amœbic infection of the liver. The cause for such a variation is not known definitely. Perhaps alcohol may be a predisposing factor. Probably also the indigenous population resist against all tropical diseases in general than the new comers from Europe as could be evidenced from the fact that infection from small-pox, cholera etc., usually take a more severe form in the European than in an Indian. Mention was made in the previous papers as to who are liable to get the Hepatic Abscess.

ÆTIOLOGY: There is a close and intimate relationship between Amœbic dysentery and Liver Abscess. Well authenticated statistics as well as every day experience attest to this statement. Out of 3,680 autopsies made in Amœbic dysentery in various tropical countries,

Woodward found 779 cases having Amœbic abscess of the liver. This works out to 21 per cent of the total number of cases. It is worthwhile to remember that extensive Amœbic infection of the gut may exist without any subjective symptoms. There are cases where abscess of the liver is discovered without the patient mentioning that he ever suffered from dysentery. On close examination and questioning one might elicit the history of an attack of mild 'diarrhoea' occurring long time ago. Low cited a case of an Amœbic abscess of the liver occurring 20 years after an attack of Amœbic dysentery. Therefore one is to be cautious in diagnosing hepatic involvement.

RACE, SEX AND CLIMATE: Liver Abscess is proportionately rare among natives as compared with Europeans. According to statistics of 1894 the mortality rate in the Indian army from Liver abscess was only 0.6 per cent, whereas in the European army it was 7.4 per cent. Man for man the relative liability of the European soldier and the native soldier was 95.2 to 4.8. This proportion holds in spite of the fact that a larger proportion of natives are infected with *E. histolytica*.

European women though they may suffer from Amœbic dysentery as European men, seldom develop abscess in the liver; and their children hardly ever. There are records to show that an Egyptian child of 3 months suffered from Amœbic abscess of the liver while in India, boys of 10 years were reported to have suffered from Liver Abscess. Manson-Bahr reported a case of liver abscess in an English girl of sixteen. Hepatic Abscess is usually common between 20—45 years of age.

PATHOLOGY: There will be general congestion and enlargement of the liver during the course of an attack of dysentery the lobular structure of the gland cannot be made out as there are greyish ill-defined anæmic circular patches which on expression exude out a drop or two of a reddish gummy pus. Still later the centre of the patches liquify and ragged abscess cicatrices are formed. An abscess thus formed extends partly by molecular breaking down, partly by the formation of additional foci of necrosis in the neighbourhood, and the subsequent breaking down of the intervening septa. The wall of such an abscess has a ragged appearance. The character of the pus contained therein also changes during the evolution of the abscess as it frequently becomes infected with streptococci and other organisms when the pus might assume a brownish or grey colour.

Liver Abscess may be either single or multiple: when single it attains a large size; if multiple they are much smaller. There may be an abscess as big as a cocoanut. When multiple, the individual abscesses may range from the size of pea to that of an orange. The seat of election of the single abscess is the upper part of the right lobe of the liver. Adhesions form with the surrounding tissue when the abscess approaches the surface of the liver. Such adhesions prevent the danger of intra-peritoneal bursting. Intestinal ulceration may be found extensively occurring in the neighbourhood of the caecum or there may be no visible lesions on the mucous surface.

The naked eye appearance of the liver pus is peculiar and almost characteristic. It is thick, usually of a chocolate colour and streaked or mixed with blood. Here and there we may find clear mucoid or yellowish material; the pus is so thick that it can hardly soak into the dressings and it is found to adhere to the gauze like treacle on bread, spreading out between the skin and the dressing. When the pus is quite fresh, brown masses may be made out as little islands. Sometimes on account of admixture of bile the pus is green tinged. The pus is rarely offensive.

When the abscess is near the colon it may have a faecal odour. Under the microscope the pus reveals red blood cells, much broken down liver tissue large granular pigment cells, leucocytes, oil globules, haematoidin crystals and occasionally Charcot leydin crystals and less occasionally *Entamoebae*. When the pus is secondarily infected streptococci and staphylococci and *B. coli* are found. The experience of tropical workers in India and Egypt is that *Amoebae* may be detected in only half the number of cases. Usually the *Amoeba* is not found in aspirated pus or in the pus that escapes during operation. They appear generally in large numbers in the matter that comes out from the drainage tube 4 or 5 days after the operation. These are found on the walls of the abscess cavity. The patient though treated with Emetine, the *Amoebae* may persist in the discharge until the abscess is healed. The longer the abscess persists the larger is its size and more difficult it will be for the pus to find a way out. In a large proportion of cases the pus is sterile, but occasionally it may become secondarily infected by *B. coli* or haemolytic streptococci. Cysts of *E. Histolytica* are never found in the pus.

The abscess in the liver may at times get encysted, but this is rare. The cyst wall is thick and fibrous. The contents of the abscess become ultimately cretified and the cyst shrinks up and contracts to a small size. Rogers is inclined to believe that in India, Cirrhosis of the liver is a frequent sequela to Liver Abscess. But there is no general agreement on this point.

THE GENESIS OF LIVER ABSCESS: The amœbæ are let out from the ulcer in the intestines, into the portal circulation. Though there is said to be heavy infection in the right sector of the abdomen *viz.*, in the caecum or the ascending colon it is believed that the liver gets infected through portal circulation and not due to the contiguity of the infected area. In fact what happens in the body is a portal "pyaemia" the infected blood infecting a congested and enlarged liver.

It is possible that a great majority of amoebæ are destroyed by the tissue; those surviving multiply and cause necrosis of the liver cells. It is at times found that the amoebæ themselves are destroyed by the products of their activity. The sterile Amoebic abscess at this stage becomes secondarily infected. The cells in the vicinity of the portal vessels are the least affected by the necrotic process while those at the periphery are undergoing vacuolation.

SYMPTOMS: Symptoms vary a good deal. The patient always gives a history of having resided in the tropics but the history of suffering from dysentery may be absent. A sense of weight and fulness on the right side of the chest is felt. Later stabbing pains are felt over the liver area and sometimes a dry cough may be present. In a considerable proportion of cases a sensation of pain is felt over the right shoulder—rheumatic in character—especially at night time. Usually the pain and tenderness are in the skin around the acromial end of the clavicle. It is reflex in character due to irritation of the phrenic nerve which arises from the fourth cervical route from which the supra-acromial and supra-clavicular cutaneous nerves arise from the cervical plexus. The same sort of pain is felt over the shoulder when condensation of the lung and pleura over the diaphragm are inflamed as a result of diphtheritic pleurisy. If there is an abscess in the left lobe, the pain is referred to the left shoulder joint. Fever starts with sharp rigours, morning temperature being either subnormal and the evening temperature reaching up 102° or 103°. The patient begins to lose flesh and he has a muddy tinge over his body. The high temperature is accompanied by profuse sweats, the tongue becomes furred, extremities become cold and the breathing is mainly thoracic. Sometimes we notice actual fulness on the right side of the chest and on palpation and heavy percussion tenderness can be elicited. In a majority of cases the liver is enlarged and can be felt below the costal margin. It may be further observed that the dulness is arched over the upper border

of the liver. Deep inspiration gives rise to acute pain. The skin outside the liver area may become red and oedematous. On auscultation a pleuritic rub may be detected. Or sometimes inspiratory crepitations, decreased breath sounds may be noted. Pain is relieved by lying on the affected side. It is peculiar to note that the spleen is not enlarged. An abscess on the left lobe of the liver may be palpated in the epigastric or hypogastric region. The left lung may sometimes be involved. Sometimes the enlargement of the left lobe of the liver may be due to a compensatory hypertrophy without any abscess forming therein.

The patient becomes thin each day; hectic fever with drenching nocturnal sweats continue. The pain increases and if the pus is not drained by operation, the patient may die after months of illness by exhaustion or the abscess attaining enormous dimensions may burst into the right lung or pleura and the pus may be discharged from the mouth as a result of which recovery or death from intercurrent complications may take place. The blood shows increase in the polymorpho nuclears, leucocytosis of 15,000 to 40,000. In some rare cases, no such rise is found which is always indicative of bad prognosis. The differential count in a series of cases is found to be as follows: 70 per cent polymorphs, 22 per cent lymphocytes, 6 per cent large mono-nuclears and 1 per cent Eosinophiles. With a large Liver Abscess of long duration secondary anæmia may result. Occasionally we find a blood picture of pernicious anæmia.

There are many instances where the initial symptoms are more urgent and the disease progresses more rapidly. In other instances the subjective symptoms may be almost not being felt and it is not strange in those cases an abscess bursting through the lung or bowel or a fluctuating tumour appearing on the side of the chest. It is also common feature to discover abscess of liver in unsuspected cases on the post-mortem table.

Sometimes the initial fever is very high, distinctly quotidian and of an

intermittent type. Large collection of pus has been detected in cases where no fever of any description is noted. Marked rigours are rare, but when they are present, they are indicative of threatened rupture of the abscess into some viscus. The sweating associated with temperature is found about the head and neck. Enlargement of cervical and axillary glands on the affected side may be present. Pain of some description is the commonest symptoms of the liver abscess. Stabbing and stitch-like pains are felt on pressure or these pains are aggravated by deep inspiration and coughing. Localised area of pain if felt over the costal margin is indicative of the abscess pointing in that direction. If there be pain on swallowing particularly at the moment when the bolus traverses the lower end of the oesophagus it is possible to localise the abscess with the finger tips pressing on the area of pain. Shoulder pain is present in about 1/6 of the cases and may be the only symptom complained of. This will be the earliest symptom which we can note before the onset of fever.

Cough of a painful character due to the irritation of the diaphragm may be a prominent symptom. The respiration may be rapid and shallow. The patient lies on his back slightly inclining to the affected side. The digestion is disturbed. Flatulence and diarrhoea are generally noted. There may be sometimes concurrent dysentery.

The area of liver dulness is extended upwards or downwards and very rarely horizontal. The upper line of dulness is not horizontal as is found in hydro-thorax; usually on approaching the spine it turns downwards. When the abscess is of a large size the heart may be displaced but laterally. Rapidity of the heart and sometimes irregularities of the heart may result from toxic absorption or from pressure.

The liver abscess may simulate closely intra-abdominal tumours and in cases where there is no temperature, their nature may not be suspected until they are aspirated. Sometimes one can

observe varicosity of the epigastric veins; local œdema over the intercostal spaces may at times be noted and if there is any local bulging, it is usually indicative that the abscess is pointing in that direction. The abscess may burst into any neighbouring organ and thereby produce a spontaneous cure. Most commonly it ruptures into the lung or the pleura. When it bursts into the lung the pus is coughed up in mouthfuls. Sometimes this process is more gradual, a few drams being brought up at a time. In favourable cases the expectoration becomes less and the patient is cured. The abscess of the liver when it bursts into the lung is liable to be mistaken for pulmonary T. B. Amoebæ are not found in the expectorated pus but a few striated muscular fibres from the diaphragm were noted by Manson-Bahr.

Arrest of the discharge may not mean recovery. Cessation of cough may once again be followed by temperature and night sweats. This is due to the alternate emptying and refilling of the abscess cavity and such a phenomenon usually occurs many times before recovery finally takes place. In some cases expectoration never comes and is accompanied by other signs of absorption of the toxins such as respiratory distress and clubbed fingers. Sometimes the expectorated liver pus without being chocolate brown in colour may be haemorrhagic. In such cases it may be mistaken for tuberculous haemoptysis.

Rupture into the pleura may give rise to the symptoms of Empyema. Aspiration above the line of pus may yield a clear yellow fluid highly albuminous in character.

A liver abscess may burst into the stomach and the pus may be vomited out, or pass into the bowel causing diarrhoea and discharge of pus in the stool, or it may burst into the pericardium or peritoneum with fatal results, almost immediately. Finally a spontaneous rupture may take place through the skin of the abdominal wall and the patient may recover and this is the most favourable and natural cure of a Liver Abscess. It is strange to find that

the skin is infected with Amoebæ though the pus from the liver may not contain them.

MORTALITY RATE: The mortality rate was as high as 50 to 80 per cent. formerly. But now, the use of Emetine combined with early recognition of the intimate connection of Liver Abscess with Amoebic dysentery and the adoption of improved methods for evacuation of pus, has brought down the mortality rate practically to nothing. Death when it ensues may be due to rupture into the neighbouring viscera, due to the gangrene of the abscess-wall, pneumo-thorax, pneumonia or to other intercurrent diseases. Recovery may follow encystment and subsequent absorption of the abscess.

From the study of 50 cases the following table is set out by Manson—Bair relating to Liver Abscess:

	Per cent.		Per cent.
History of previous dysentery ...	60	Shoulder pain, right ...	44
Entamoeba histolytic or cysts present ...	45	do. left ...	4.4
		Pyrexia, intermittent ...	77
		do. remittent typhoid like... 8	
		do. with sudden onset of rigors ...	4
		Pyrexia absent ...	13
		Night sweats ...	82
		Dysenteric infiltration of bowel sigmoid flexure ...	24
		Dysenteric infiltration of caecum and sigmoid flexure ...	8
		Enlargement of liver upwards ...	24
		do. downwards... 75	
		Pain and tenderness in liver ...	57
		Displacement of heart ...	8
		Associated signs at base of right lung ...	75
		Pleuritic rub ...	12
		Rupture of abscess into lung ...	11

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Abstracts.

GONORRHEA IN THE MALE.

HARRY O. LEPSKY, M.D., CINCINNATI, OHIO.

In February, 1931, a paper was read before this Academy on the treatment of gonorrhea in the male. In the years which have elapsed between that time and the present, there has been no word mentioned concerning this infection and its treatment; not even a case report. What can be the explanation for the lack of discussion concerning this important phase of medicine? It certainly cannot be due to the fact that we are not called upon to treat gonorrheal infections in the male! Nor can it be due to the fact that we know everything which is to be known concerning this disease and its treatment. The only answer which can be given for this paucity of discussion concerning gonorrhea seems to be the fact that we are neglecting the discussion of this very important topic. I hope sincerely that we are not, in like manner, showing a similar amount of neglect in the treatment of patients whom we see with gonorrhea.

and syphilis are, for the greater part unreliable, it is known very definitely that the incidence of gonorrhea is from two to four times that of syphilis. The average patient who receives a gonorrheal infection is in the second or third decade of life, when he is most active and most productive financially, and has dependent for whom he is responsible. I can see only two instances which may be brought forth in favor of syphilis as against gonorrhea, so far as their relative importance from a public health point of view is concerned. These two conditions are: first, syphilitic infections of the new-born, and second, the late sequelae of syphilis. In all other respects gonorrhea and its attendant problems is at least as important as syphilis and should receive our attention in at least an equally forceful manner.

The medical profession has been guilty so far as gonorrheal infections are concerned, of improper treatment, maltreatment and a general disregard for the patients who harbor a gonorrheal infection. Even to day we have practitioners who will inform a patient that his infection is no worse than a "cold in the head," and who will give him treatment which is in accordance with the above expressed view. Can we blame the laity therefore when many of them are convinced that their gonorrheal infection cannot be completely eradicated, or when they accept chronic recurrent infections as a matter of course and thus become carriers in the long and endless chain of gonorrheics?

There is one type of pseudo practitioner, however, who is not without guilt because of his attitude towards gonorrheal infections. I am referring to the corner druggist who in his little back room, will dispense treatment whether in the form of medication by mouth or locally, and Whereas statistics concerning gonorrhea

who, undoubtedly, does far more harm, promotes many more complications, and makes the burden of the honest practitioner more difficult than it would be otherwise. His guilt, however, usually consists of an error of commission and it is very difficult to determine whether his error is greater than the medical practitioner's error of omission.

I wish this evening to discuss merely the treatment of gonorrhea in the male. This is the only province in the treatment of gonorrhea which has been reserved to the urologist in this city. The gynecologists have taken unto themselves the treatment of gonorrhea in the female. In male gonorrhea we have an acute inflammation. One of the cardinal principles of therapy in acute inflammations in any portion of the body, is gentleness and diligence during treatment. Any method of therapy which disregards gentleness is an improper method of therapy. The practitioner who assumes the obligation of treating a gonorrheal infection in the male, has responsibility to give his patients the best available treatment known at that time in a gentle manner without jeopardy to the patient's life or limb and a method of treatment by which the patient can be assured a complete cure.

Every patient with a gonorrheal infection can be promised a complete cure. In a simple acute anterior gonorrheal urethritis we divide our therapy into two portions, first; that which we do for the patient; second; that which the patient does for himself. I wish to mention first what the patient can do for himself. It is incumbent upon us to instill forcibly in the mind of the patient the necessity for his complete abstinence from alcoholic beverages and sexual excitement. Here is a pitfall which is not appreciated by the medical profession as it should be. Pelouze, who has probably made more contributions towards the treatment of gonorrhea in the male than any other single individual both past and present, has proven time and again the futility of the very best methods of treatment in the face of alcoholic and sexual transgressions by the patient. It is the art of medicine

which is necessary to convince the patient that alcoholic and sexual abstinence are absolute necessities. The patient must be constantly reminded of the importance of these prohibitions and it is only too easy for him to prove to himself how much greater is the incidence of complications when abstinence is forgotten.

The sheet anchor of our treatment in acute anterior gonorrheal urethritis in the male consists of mild low pressure anterior irrigations with potassium permanganate. We are still old-fashioned enough to retain those methods which have proven of value in the therapy of gonorrhea during the past four or five decades. It would be wise for us to heed the advice which Polonius imparted to his son Laertes: "Those friends thou hast, and their adoption tried, grapple them to thy soul with hoops of steel"; potassium permanganate irrigations given by the physician with care and gentleness will in the vast majority of cases eradicate all anterior urethritides and obviate any complications. I am saying nothing of the various types of azo dyes which are taken by mouth, nor am I saying anything of the various preparations which will render the urine any color in spectrum. The only rationale for the use of these preparations is the psychological effect upon the patient or the particular type of color with which we wish to stain the patient's underwear. This opinion is not merely a personal one, but receives whole-hearted approval from those who wish to use some scientific basis in their therapy of gonorrhea.

In speaking of therapy we are at the mercy of the various detail men and of the drug houses they represent. At fairly regular intervals we are assured that a new remedy is at hand which is specific for the cure of gonorrhea. These so-called specific medications may be vaccines, filtrates or phages. At other times these specific therapeutic measures may be various dyes, coloring materials, so-called germicides or any therapeutic agent which may have shown some success in the treatment of infections caused by organisms similar to the gonococcus.

Most of the agents which have been recommended, and their names are as familiar to you as they are to me, have been tried, tested, used under carefully controlled conditions, and have been found to be useless. A few words are in order here concerning the newest "panacea for all evils," i.e., sulphanilimide. Here again we are offered a "specific cure for gonorrhea." At least some drug manufacturers say so. However, we have here a very potent drug whose said actions are not thoroughly understood, a drug which has been used for practically every known organism which afflicts the human system and a drug which has already caused such severe secondary complications that its use must be guarded very carefully. I need only mention the occurrence of sulph-haemoglobinemia, aplastic anemia, violent gastrointestinal upsets, diffuse muscular aches and pains and erratic pyrexia in order to acquaint you with a few of the side actions whose causes remain to be determined as being due to the use of sulphanilimide. The use of sulphanilimide has become so widespread that where formerly a travelling salesman would enter the office and request a prostatic massage followed by a No. 24 sound, he now comes in asking for a haemoglobin determination and a red cell count so that he may juggle the number of tablets per day accordingly.

It would be folly to absolutely discourage the use of this drug in the treatment of gonorrheal infections because we have all obtained some brilliant results with it, however, at the present writing, its use is merely empirical and we are still ignorant of its modus operandi. We are neither prepared to condemn it nor to discard it, but we are anxious to know more of its therapeutic mechanism so that if we wish to use it we may do so intelligently. In speaking of the use of any methods of therapy for the treatment of gonorrhea, Pelouze has stated the following: "Above all things, we should demand of its originator more than high sounding words and poor clinical investigation. Nor should we subject the traditional one hundred patients to a plan of treatment that cannot show results on the first five patients

far beyond those obtainable with the plans of treatment upon which we have learned to rely."

Thus the majority of patients who are seen with an acute anterior gonorrheal urethritis can be completely cured without the development of complications. We have found that these permanganate irrigations given carefully, gently and under low pressure, together with cooperative behaviour on the part of the patient will bring a happy and successful result to both the patient as well as to his physician. It is unfortunate but true that even with the best therapy on the part of the physician and good behaviour on the part of the patient, complications will nevertheless occur. The most common of these is the development of a posterior urethritis.

With the development of a posterior urethritis all local treatment is immediately stopped. The patient is instructed to take hot sitz baths and is given bladder sedatives by mouth, the purpose of which is to counterbalance the frequency and urgency on urination and the spasm at the vesical neck. With the subsidence of the posterior urethritis potassium permanganate irrigations are again instituted under very careful technique. A few words are in order at this point concerning the "two-glass test." This consists of voiding approximately one-half ounce of urine in the first glass and voiding all of the remainder of the urine in the second glass. In a simple acute anterior urethritis the first glass is cloudy and the second glass is clear. With the development of a posterior urethritis both glasses will show cloudy urine. There can be no intelligent treatment of gonorrheal urethritis without the routine use of the two glass test together with an understanding of what its variations imply. This simple test is an accurate barometer of the progress in treatment as well as a means of prognosis.

The next most common complication is the development of an acute prostatitis, with or without an accompanying seminal vesiculitis. Fortunately the vast majority of prostatic and vesicular complications can be handled very easily in a manner

similar to the handling of a posterior urethritis. As a matter of fact, the majority of posterior urethritides are accompanied by a certain amount of prostatitis. The very acute fulminating types of prostatitis are rare, and each case must be handled individually. When all of the acute phases of prostatitis with or without seminal vesiculitis have subsided, gentle massage of the prostate gland and seminal vesicals is in order. This is continued until the physical and microscopic examinations indicate eradication of the prostatic and vesicular infections.

This brings us to a very distressing complication which is accompanied by much pain caused by edema and infection of the affected epididymis, elevation of temperature, generalized symptoms consisting of malaise, fatigue and mild toxemia. I am referring to the development of acute epididymitis. It is safe to say that the development of an epididymitis as a gonorrheal complication is practically always due to vigorous treatment on the part of the physician or the patient or to an alcoholic or sexual spree on the part of the patient. Study of our records, together with similar studies by others, shows conclusively that gonorrheal complications such as epididymitis, posterior urethritis, prostatitis and seminal vesiculitis occur due to transgressions by patients or violent therapeutic methods by the physician or the patient. With the occurrence of an epididymitis, again all local therapy must stop. About fifty per cent of patients with epididymitis must be put to bed for two, three or four days. The scrotum is elevated, an icebag is applied over the affected area and the use of various calcium salts intravenously in the form of calcium gluconate, levulinate or chloride have been found to be the most effective measures. Oral medication is given symptomatically. No local therapy is instituted until all of the acute phases of the epididymitis have subsided. Occasionally it is necessary to institute surgical procedures in the treatment of epididymitis.

The next most frequent complication of gonorrhea is arthritis. The diagnosis of

acute gonorrheal urethritis is a rather obvious one and I shall not bore you with its signs and symptoms. However, once the diagnosis has been made, the most effective therapeutic measures which we have found for this condition has been the use of hyperpyrexia, or fever therapy, as induced by the Kettering Hypertherm. This again raises the question of newer methods of therapy. In the case of fever therapy, however, statistics have proven conclusively, and these statistics are uniformly obtained throughout the United States, that we have here the most effective method thus far proposed not only for the complete cure of gonorrheal arthritis but for a cure without ankylosis or joint deformities. It is true that fever therapy does not yield one hundred per cent cures in gonorrheal arthritis. But the percentage of cures without ankylosis is so much greater than with any other method at our disposal that this medium of therapy is definitely indicated.

A few words are in order at this point concerning fever therapy. This therapeutic medium is still in the experimental stage. Nevertheless, a striking uniformity of good and excellent results with the use of this procedure warrants its definite acceptance for certain conditions. Among these latter conditions gonorrheal arthritis may be included. When a patient is subjected to fever therapy, he receives a treatment which usually lasts for approximately six hours, during which time the body temperature is raised to approximately 106.5 degrees Fahrenheit, and maintained at this temperature for approximately four or five hours. The selection of patients for fever therapy must include thorough physical and laboratory examinations to assure us that all of the vital organs are in perfect functional and organic condition. Fever therapy is unquestionably a procedure which should be carried out only in hospitals and under the constant supervision of an adequately trained personnel. This calls for the constant attention of the patient by a nurse and resident physician who can detect danger signals and discontinue a treatment at any moment. It is fairly obvious that fever therapy is not an innocuous

procedure. Deaths have been reported both during and shortly after fever therapy. While the number of these fatalities has been very few, nevertheless the precautions which should be taken must be most elaborate.

I will mention in passing only a few of the very rare gonorrheal complications such as ophthalmia, endocarditis and skin lesions. These latter complications must be handled in individual fashion and no specific therapeutic course can be outlined for them.

There remains to be discussed the patient who harbors the so-called chronic gonorrheal infection. In each and every one of these patients there must be some focus of infection which is responsible for the chronicity of the infection. This focus may be found in infected Littre's glands, a stricture in either the anterior or posterior urethra, a seminal vesiculitis, Cowperitis or an unrecognized prostatitis. Regardless of where this infective focus may be, with diligence on the part of the physician and patient on the part of the patient, each one of foci can be detected, treated and eradicated. I wish to stress here the fact that chronic gonorrhea is an admission of defeat on the part of either the patient or the physician or both. It is only through the complete elimination of the so-called chronic gonorrheal infection that any success may be had from a public health point of view in treating gonorrhea.

The limitations in time and the fact that these meetings are attended primarily by general medical practitioners have prevented me from entering into elaborate discussions concerning either diagnosis or treatment. I have tried to state a few simple facts in a few simple words. There is much knowledge to be learned in the handling of gonorrheal infections and considerable research is being carried on at the present time, so that our methods of treatment can be more effective within a shorter period of time. Until the results of these researches can offer us conclusive experimental and clinical proof that they are an improvement over these methods which are in use at the present time, we must not be ready to accept them to use

them routinely in the treatment of gonorrheal infections. We must remain openminded and be ever alert to accept new methods of therapy which have proved their reasons for existence, but until they have done so it is folly to discard those methods which are yielding gratifying results at the present time.

DISCUSSION.

DR. ARTHUR W. WENDEL: The essayist has given us a concise and very instructive resume of the present status of gonorrheal therapy. Such a subject is a timely one in view of the present day venereal disease propaganda spreading throughout the nation. Our statistical data concerning the incidence of gonorrheal infections is wholly inadequate; however, if there are two to four times as many Neisserian infections as there are those due to the treponema pallida, we must conclude that approximately thirty per cent of our people suffer from this infection in the course of their lifetime. Certainly something of a national scope should be undertaken to educate the public against this precursor of mental and physical torture.

We believe that more than sixty per cent of gonorrheal infections in the male are cared for by the general practitioner of medicine. This is, as it should be; however, if this is the case, it behooves these practitioners to thoroughly acquaint themselves with the fundamental principles of therapy and cure. Only too often do we see the catastrophic results of poor therapy directly or indirectly referable to the many sins of omission and commission within our ranks.

Among the many phases of the subject brought before you this evening, there are a few which cannot be over-emphasized.

We consider acute gonorrheal urethritis a self-limited, highly infectious disease from which the patient can recover. This recovery depends upon four cardinal factors:

1. A local tissue immunity response brought about by the patient's ability to develop certain anti-body formation. We do not know the exact mechanism of this response, but it is an observable fact that

certain individuals develop immunity less rapidly than others. For example, blondes respond less satisfactorily to infection and are more susceptible to complications than brunettes.

2. Good dependent drainage is a prerequisite toward minimizing complications. At the very onset, an abnormally small meatus should be enlarged surgically; likewise a phimosis requires a dorsal slit or circumcision. Only too often do we see a misinformed patient plugging up an oedematous discharging urethra with a ward of cotton.

3. The patient's full cooperation during his illness. We cannot over emphasize the importance of abstinence from alcoholic beverages, sexual excitement and strenuous exercise.

4. Local and systemic therapy given and directed by the physician. The old axiom that it is wise to undertreat rather than overtreat still holds good. We cannot hope to sterilize an infected urethra without destroying the histological structure. Gentle irrigations under low hydrostatic pressure should be used, except when contraindicated. Irrigating solutions should consist of weak solutions of potassium permanganate, acriflavine, chlorazene, etc. At times in sub acute and chronic infections, mild silver nitrate solutions are beneficial. Irrigating solutions, in addition to their cleansing effect, should merely stimulate a wholesome local response on an infected mucous membrane. Retained injections of Neosilvol, Protargal and various other silver salts are beneficial specially in combating secondary invading organisms.

Sulfanilamide given by mouth in adequate doses is offering us, in some cases, favorable and in others discouraging results. It is by no means a panacea. We have seen purulent specific anterior urethritis clinically cured in seven days under

adequate dosages of this drug. More often, however, the results are less satisfactory. If a patient does not exert a favorable response to the drug in one week, the drug is discontinued. Under sulfanilamide therapy remissions frequently occur. Gonococci have been isolated several weeks later in shreds from patients who have reacted favorably to this form of treatment. In the future, we may see more cases of chronic gonorrhea in patients who have been supposedly cured by sulfanilamide therapy.

In closing may I read a paragraph from a recent publication by Dr. Charles P. Mathe of San Francisco. In order to secure first hand information about the clinical results of this new drug, Dr. Mathe addressed one hundred and fifty questionnaires to the leading urologists throughout the United States and Europe, asking for a report of their results in order to contrast them with those obtained in his own private practice and in the out-patient dispensary of the University of California and St. Mary's Hospital. Quote: "An analysis of the replies to our questionnaire and our experience in private practice and in the out-patient department of the University of California and St. Mary's Hospital leads us to conclude that the use of sulfanilamide in the treatment of acute gonorrheal urethritis is a beneficial adjunct to the former methods of treatment. The period of cure is definitely lessened, the side reactions are few and with intelligent management they can be easily controlled. The drug should always be administered under close observation over a short period of time and one can usually repeat its use without danger to the patient. It is not specific for the cure of Neisserian infection but, up to the present time, it is beyond doubt one of the best adjuncts to the treatment of this disease."

—The Journal of Medicine, May, 1938.

NOTICE.

Subscribers of The Medical Practitioner are requested to note their registered numbers appearing on the postal wrapper of the Journal while corresponding with the Managing Editor.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

THE USE AND ABUSE OF ERGOT AND PITUITARY.

Because of the disastrous results due to the indiscriminate use of ergot and solution of posterior pituitary, M. Edward Davis, Chicago (*Journal A. M. A.*, November 13, 1937), reviews the indications for the use of oxytocics in obstetrics. Although solution of posterior pituitary will cause some contractions and tonicity of the uterus of the nonpregnant person, it is rarely indicated. The pathologic cause for the bleeding should be determined and treated. It is never justifiable to give ergot or pituitary extract as a temporary expedient unless one is absolutely certain that the underlying pathologic process causing the abnormal bleeding can await treatment. Oxytocic drugs will not terminate a normal gestation in the first trimester of pregnancy. Although oxytocic drugs fail to initiate an abortion in a normal pregnancy, ergot and pituitary may be used to hasten or to complete the process once it has begun. In inevitable and incomplete abortions, solution of posterior pituitary can be used in 0.5 to 1 cc. doses intramuscularly with benefit to the patient. This will cause increased uterine motility which may result in a complete and rapid termination of the process or the evacuation of portions of the products of conception still in the uterus. Following the completion of an abortion, ergot can be given orally for several days to limit the bleeding and favor normal involution. The medicinal induction of labour is rarely successful until term is approached. If, therefore, it is necessary to induce labour for some complication prior to term, one usually has to resort to mechanical means. The method of medicinal induction of labor at or near term at the Chicago Lying-in-Hospital consists of the following procedure: Castor oil, 1½ ounces (42 cc.), is given early in the morning, followed two hours later by quinine in 3 grain (0.2 gm. doses at) hourly or half hourly intervals for four or five

doses, followed by graduated doses of solution of posterior pituitary, beginning with half a minim (0.03 cc.) and increasing half a minim at each dose fifteen minutes apart until 3 minims (0.02 cc.) is given. The latter dose can be repeated until a total of 1 cc. is used. The uterus should be carefully observed, and if it exhibits tetanic contractions so that the fetal heart tones are interfered with, solution of posterior pituitary is discontinued. The oxytocic drugs are almost never indicated during the first and second stages of labor. It is dangerous to interfere with the normal uterine motility. Oxytocic drugs are rarely indicated in stimulating uterine contractions. The underlying condition that is responsible for the inertia should receive proper treatment. Thus, physical exhaustion on the part of the patient from a long, arduous labor may be best treated by sedatives. A period of complete rest will often result in a recurrence of normal uterine activity and a rapid completion of the labor. Solution of posterior pituitary and ergot find their greatest usefulness in the third stage of labor. Used judiciously and with the proper indications, the oxytocic drugs may often prevent the occurrence of Postpartum hemorrhage and the serious results that may be caused by it. In the normal conduct of the third stage of labor it is usually advisable to await the complete separation of the placenta, after which its expulsion can be aided. Immediately after the birth of the placenta, 1 cc. of solution of posterior pituitary can be given intramuscularly. In the event that the patient has had no anesthetic, fluid extract of ergot can be given by mouth or ergonovine can be given parenterally. These oxytocics should help to maintain the uterus in a contracted state, avoiding any unnecessary bleeding. If excessive bleeding occurs after the delivery of the baby and prior to the placental separation, one should administer 1 cc. of solution of posterior pituitary intramuscularly. The placenta can then be expressed by Crede's method. If this procedure fails to separate and expel the placenta, one should consider its manual removal in the face of continued hemorrhage. Should

excessive bleeding occur after the expulsion of the placenta, one must determine the cause for the bleeding. When the hemorrhage is the result of uterine atony, solution of posterior pituitary in 1 cc. doses should be given subcutaneously or intramuscularly. Small doses, from 2 to 3 minims, can be administered intravenously in an emergency regardless of the possible reaction. Ergonovine is the ideal drug because of the rapidity of its action and the sustaining character of the effect. It can be given in 0.2 mg. doses intravenously. If the patient is awake, fluid extract of ergot can be given by mouth. The use of oxytocic drugs in the puerperium has enjoyed almost universal popularity. Ergot has been the therapeutic bulwark for this period. It has been credited with hastening normal involution, decreasing the likelihood of the late postpartum bleeding, limiting the probable spread of intra-uterine infection if present, and helping to maintain the genital organs in the best state possible. Normal uterine involution is the physiologic process by which the puerperal uterus is rapidly reduced to about one-twentieth its size and returned to the normal nonpregnant state. It has been the accepted practice at the Chicago Lying-in-Hospital to prescribe ergot in the puerperium for delayed involution. Fluid extract of ergot, from 30 to 60 minims three times daily, or ergonovine maleate, from 0.2 to 0.4 mg. three times daily, can be given to patients who have had a postpartum hemorrhage, a difficult forceps delivery, intra-uterine manipulation, abnormal lochia, fever regardless of the cause or delayed involution without cause. This therapy is kept up for at least three days or as long as is necessary; this medication should be rarely continued beyond a week or ten days, however, because of the danger of ergotism. If uterine contractions become too painful, the dose of the drug is reduced or entirely omitted. The prophylactic use of ergot to assure a normal involution is probably of some value, although further studies will be necessary to confirm this impression. The physician who wishes to serve womankind conscientiously and honestly must allow labor to take its normal

course, rarely resorting to expedients which might hasten the process but which inevitably carry in their wake injury, mild or serious, and even death to mother and baby.

(*The Journal of Medicine*, July 1938.)

1. MODE OF ACTION OF SULFANILAMIDE.

Since sulfanilamide was first introduced in therapy, investigators have attempted to explain its mode of action. Numerous theories have been advanced, only a few of them being tenable in the light of more recent reports based on actual chemical data. The studies of Osgood seem especially interesting and valuable because they approach the problem in a rational manner. Osgood investigated the destructive action of sulfanilamide on the toxin of streptococci. "The toxins of hemolytic streptococcus are highly destructive both to erythrocytes and to leukocytes, and recovery from massive invasion of the blood stream by this organism is very rare. It seemed possible that, if the action of sulfanilamide were the neutralization, destruction or prevention of formation of these toxins, the organism would resemble a harmless saprophyte and be readily vulnerable to the ordinary defense mechanism."

Osgood found that the formation of toxin was prevented or that toxin was destroyed. His observations showed further, that a major action of sulfanilamide is the neutralization of the toxins of the streptococcus organism. The drug does not, however, permanently alter the toxin-producing ability of a strain of streptococci exposed to it over long periods of time.

Does sulfanilamide affect phagocytosis? Although this possibility was previously suggested by certain workers, experiments seemed to prove an absence of "direct action which favors phagocytosis either on the beta hemolytic streptococcus or on the cells of the marrow." Quantitative strides led Osgood to conclude that sulfanilamide itself does not kill bacteria but that it does, after a period of four hours, slow their rate of multiplication

and render them vulnerable to attack by human serum and cells.

It is probably superfluous to state that further studies of this character will greatly enhance our knowledge of the mode of action of sulfanilamide. "The possible effectiveness of and the mode of action of sulfanilamide on all other organisms known to produce human disease should be determined by the methods described as soon as possible. Cultures of human marrow should aid materially in the study of the mode of action of both noxious and therapeutic agents."

2. VITAMIN D AND MYOPIA.

Progressive myopia remains one of the unsolved problems in ophthalmology. The encouragement given by some eye specialists that vitamin D is helpful in retarding the condition has led to studies to prove or disprove this claim. Laval found from an investigation covering a period of six years that all the dietetic and hygienic measures instituted were of no avail in arresting the progress of the myopia. He gave his patients vitamin D and milk continuously and made observations periodically.

One should be conservative in promising results with any therapy which has not been proved conclusively to be beneficial. Medical articles with positive claims are taken up promptly by the lay press. Individuals seek the treatment advised and generally find someone willing to administer it. While it is true that much of our therapy is empiric, even empiric measures must possess some rationale. The fallacy of anticipating the impossible from vitamins which are now advocated for nearly every human ailment requires correction in no uncertain terms. Vitamins, no doubt, have a place in our therapeutic armamentarium. Specific indications exist, but let us demonstrate them scientifically and with proper evidence.

Kœpcke has recently pointed out that the past few years have witnessed a worth while change in vitamin therapy.

Development of accurate tests to mine vitamin content of body aided this change. "Contributions by workers versed in sound clinic and physiology are rapidly clarifying the problem of vitamin needs and the relationship between vitamin deficiency and disease."

In ophthalmology vitamins have been found useful in corneal ulcers, to light, herpes zoster ophthalmicus and certain other affections. The field has been widened as time goes on. No desire to deprecate the work done with vitamins in ophthalmic diseases, but we are opposed to publishing trials which cannot be supported by trials.

3. TRACHOMA.

One of the best ways to cure trachoma in this disease is to use electrolysis. The technic is to employ a positive electrode of pure copper metal, with the positive pole of the current at the neck, and to apply the negative electrode to the everted lids with a current of 3 or 4 ma. for three to five

4. ATROPHIC RHINITIS.

For the relief of this distressing condition try a 3% aqueous solution of zinc sulfate. The mixture is not really a solution but rather a suspension, and is best sprayed. It must be swabbed on the nasal membranes. The effect is usually satisfactory. The membrane will recover a considerable degree of vascularity.

5. BLEPHAROSPASM.

For some reason or other, blepharospasm is often relieved by the instillation of atropine into the conjunctival sac. Atropine is usually sufficient, and the effect of the treatment is lasting.

(Above 1, 2, 3, 4 and 5 are extracts from *The Eye, Ear, Nose and Throat*, September, 1938.)

ALOPECIA: ITS CAUSES AND TREATMENT.

Alopecia may be of congenital origin or due to senility, premature or normal secondary reactions of poisons, fevers, tuberculosis, diabetes or local causes such as fevers, ulcerating syphilides, lupus, or burns. One of the most common causes, however, is dandruff or seborrhoe. The endocrines play an important part in the ætiology of the condition and for this reason treatment on these lines frequently produces good results. L. F. Herz advocates glandular treatment combined with vitamins, iron, arsenic, liver extracts, and local applications. Pituitary extracts have produced the most satisfactory results, especially if the condition is treated in the early stages (2 c. cm of anterior pituitary extract thrice daily). In cases of hypothyroidism administration of thyroid hormone frequently causes an improvement in the condition. As regards local treatment the following method is suggested: The patient's hair is shampooed twice weekly with tincture of green soap, the hair thoroughly dried and vigorously massaged. This is followed by treatment with an air-cooled mercury arc lamp to the point of erythema. A lotion is used morning and evening, the formula of which is as follows:—

R
Sulphur precipitate 30 grs.
Spirit camphor 60 mins.
Glycerine 30 mins.
Aqua destil ad 1 ounce.

M. Sig: shake the bottle and sprinkle over the scalp before brushing.

A useful ointment to rub in at night is the following:—

R
Sulphur precipitate 15 grs.
Acid salicylic 10 grs.
Paraffin moll ad 1 ounce.

M. Sig: To be rubbed in at night (Ormsby).

The hair should not be shampooed too frequently as this tends to make it dry and brittle. When the condition of the scalp is oily and seborrhoeic a dusting powder for the scalp is useful, and the following formula is recommended by the author:—

R
Sulphur precipitate
Amyli aa 10·0

M. Sig: Dust on scalp every two to three days (Kro nayar)

In a young person, if alopecia is treated in the early stages, the prognosis is good, but in the advanced stage it is poor, as also in elderly people in all stages.

(The Practitioner, June 1938.)

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THE Medical Practitioner

Vol. X]

OCTOBER, 1938

[No. 1

OURSELVES.

The Medical Practitioner ushers in the tenth year of its birth this month and it is gratifying that the month of its birth brings the good news that its aims and policy are being recognised by Government and are given effect to. Last year this month the Government of Madras announced the abolition of the L. M. P. course with the object of having one uniform standard of University Medical Education and we have no more Medical Schools in this province and an additional Government Medical College, has been brought into existence in Madras. This reform will ultimately put an end to the caste system in the medical profession, which has been a great obstruction for the growth of a homogeneous and contended medical fraternity. It cannot be denied that this reform is likely to affect the existing Medical Licentiates and it is highly creditable that the Medical Licentiates instead of grumbling, have reconciled themselves to their lot in the larger interests of the profession. The Public Health Minister who has the gift of courage in his convictions and who is himself a medical licentiate, did anticipate the feelings of the Licentiates and has assured them that he would favourably consider any scheme which is likely to bring them equality of status with the Medical Graduates. As mentioned in these columns a few months ago, we hope to publish a scheme in the near future with the help and co-operation of our readers especially the Licentiates' section of it, which while giving the Licentiates the status and prestige that are due to them, will not in any way bring down the Medical Graduates.

This year the month of the birth of The Medical Practitioner brings the news

that the Government of Madras have decided to restrict the privilege of private practice to the full time Government Medical Officers. Our readers must be aware of the persistent agitation conducted in the columns of The Medical Practitioner on this subject ever since it came into existence. This reform was long overdue and the readers of The Medical Practitioner with whose patronage and co-operation it was possible for the journal to command influence, may feel proud of the achievement of The Medical Practitioner in this direction. The small minority of the members of the medical profession in service will surely suffer so long as they are in service but we trust they too would take into consideration the larger interests of the entire profession and would not take into account the temporary loss of private income bearing in mind that the moment they leave service or retire they will have no room for complaint. On the other hand their past experience in service under Government would bring them proportionately more income under the changed conditions than it would have been possible for them to earn during the period of their retirement. That we have been advocating this reform not in partisan spirit, will we hope be realised by our readers in Government service if they peruse the second Editorial on this subject appearing elsewhere. The most important aim of The Medical Practitioner is the uplift of the medical profession in India and all the reforms it has been advocating in the past and will be advocating in the future are entirely for the purpose of achieving this end. We have been doing our best to make the profession realise that "Self Help" is the best help and that the profession should try to get itself

out of the control of the Government, in other words be independent. In no other civilized country the medical profession is under the thumb of the Government as it is the case in India. The profession as well as the Government should realise that for the healthy evolution of the profession, it should depend upon itself and not on the politically minded members of the Government however progressive they may be.

Now that the equality of status and equality of opportunities of service are assured to the profession in Madras Presidency there cannot be any hindrance for all sections of the profession to sit together and evolve schemes for public good. It is futile to depend upon the Government to find out fields for service. The profession should depend upon the public and disabuse from its mind that efficient medical relief can be procured only in State Hospitals. The largest section of the medical profession now depends upon dispensary practice and the general practitioners have not been able to conceive the idea of institutional treatment for their patients. There is a real danger to the general practitioner these days on account of Specialists and Honorary Service in State Hospitals with the result that even for minor surgical ailments and obstetrical relief people are admitted in State Hospitals. The general practitioners must have realised that for dispensing practice the tedious scientific course extending for over six years is not necessary at all and that they have very little scope in the dispensing practice to exercise their professional skill to the extent they can. It is therefore necessary that members of the profession should educate the public regarding the benefits of scientific medical relief and impress on them by good work that it is possible for the general practitioners to look after their patients with as much skill and responsibility as obtaining in State Hospitals.

There is therefore a great need for publicity and propaganda and this work could be done only through the Press. The Medical Practitioner is the only journal in the Madras Presidency

if not in India which has been devoting its columns for the discussion of problems concerning the life and prosperity of the members of the medical profession and has been able to achieve something substantial in this direction. With the additional help from the profession it hopes to achieve more in future years. The journal reaches all the Governments in India including the Central and the reforms inaugurated by the Madras Government are sure to serve as an eye opener to other provinces. We take this opportunity for thanking our readers for their help and encouragement in the past and trust they will move with the times and supply the necessary sinews to The Medical Practitioner so that it may continue to serve the profession with still more vigour and zeal worthy of the causes it has been espousing fearlessly.

PUBLIC SERVICE AND PRIVATE PRACTICE.

In the last issue we showed how the private practice allowed to the Government Medical Officers is an anachronism that is out of tune with the changed times. Nay, more, the concession—for it is nothing more than a concession—even interferes with the healthy growth of an independent profession. That this is not a partisan view is clear from the fact that two leading papers of Madras like 'The Madras Mail' and 'The Hindu' whose policies cannot be said to be identical, agree in this point viz., that this privilege should be restricted. Certain observations of 'The Mail' with which we are not in agreement will be dealt with later on in the proper place. Suffice it to quote here from rule 13 (d) of the Madras Medical Service rules (Vide G. O. No. 2232 Public (Services) dated 22.11.37) which says that *members of the service shall not as a matter of right, be entitled to engage themselves in private practice* and provides that the "Provincial Government may in the case of any particular officer or class of officers restrict such private practice to such extent as they think fit." How far the private practice should be restricted will depend upon the considerations which should guide the Government

in ordering such restriction. So far as we can see they are given below and will be taken up seriatim.

First, Government which employs the medical officers must have full value for the money spent on them. Then we must mention that Government officers are whole-time servants. Private practice is therefore a concession allowed in the interests of the public, for as G. O. No. 275 F. D. dated 8.8.1938 puts it, "a Government servant can be called upon to do Government work at any time according to the exigencies of public service". The G. O. proceeds to observe that "the main objection to private work is that it must always be more or less to the detriment of Government work as every man's capacity for work in a way is limited and the more time and energy he gives to private work for remuneration the less he has for Government work. If holidays and leisure hours which are intended for recuperation are given to earning remuneration by other work there is less recuperation and so ultimate detriment to the public service". Human nature being what it is, we need hardly remark that when it comes to the point the detriment will be to the public service and not to the private patient for there is competition in private practice and it will not do to stint service in that field. The medical profession is of an exacting nature. Further, science takes such strides almost from day to day that unless a person keeps a constant touch with the current literature he is bound to be soon out of date. A conscientious discharge of a medical officer's duties and the study of the progress made in the science will just leave him sufficient time if it does that, for recuperation and for attention to his private affairs.

Secondly, a competition has grown between the medical officers and the independent profession on account of this private practice. The advantages that the former derive by virtue of their official position has given them a leverage which is unfair to the private practitioner—a result that could not have been intended at the time and in the circumstances when private practice was allowed by Government. Dealing with this point

says, 'The Hindu' (dated 14.9.1938), "It (i.e. private practice) had its origin in the days when doctors were few and were absorbed in the Government Service as a matter of course for that has changed now". Again the same paper observes "It is only natural that in tackling it (i.e., the problem of private practice) radical changes have to be made in the arrangements made under different circumstances." With reference to the state of things brought about by the artificial advantage conferred by Government service, we have the following remarks from 'The Hindu' "Side by side with the large and growing number of private practitioners burdened with too much leisure we have a small body of Government doctors overworking themselves to meet calls on their time and professional skill. We need not here go into the reasons for this public preference, except possibly to refer to the increased contacts and opportunities for handling cases afforded to Government Medical men by virtue of their official position. This lopsided development of a profession so vital to the welfare of community could not but be taken notice of by the Government with a view to its rectification".

It should therefore be the aim of Government to organise and strengthen the profession which is so vital to the welfare of the community. One of the ways of achieving this end would be to extend to the profession the advantage of the Government Hospital. In other words to develop and expand the honorary service. The addition of honorary medical officers to the stipendiary incumbents employed in Government Hospitals to be shortly made seems to be in furtherance of this idea. It may not be out of place to state here that the honoraries should not themselves become a caste. In this connection we are reminded of a caustic remark of a social reformer that the caste system is so ingrained in the Indians that any one who forms a society to abolish it only succeeds in adding one more to the existing number of castes. In the case before us this tendency has been overcome by the Government who have limited the period of honorary service to five years so that all young men of whatever qualifications may have a chance of gathering the requisite

experience. The point we wish to make is that by the proper encouragement of medical profession and suitable changes in the system, the weightage that the paid service gets must be counterbalanced, and an honorary service organised in view to the gradual extinction of the former.

The fourth consideration that should weigh with the Government in this matter is that the patient must have the benefit of expert's services. As 'The Hindu' puts it "while the withdrawal of the provision to engage in private practice may be expected to make for a more even distribution of work among all available medical men, care must be taken to see that the patient's right to get the best medical attention be not taken away." In a sense the patient in the capacity of a citizen pays the salary of the Medical Officer. It is therefore proper that he should get services of that officer in the hour of need consistently with the public interests. We say "consistently with public interest" because otherwise if the patient were made the sole determining factor it is possible to thwart the reform altogether. Individual considerations must give way to the larger interests. In their order dated 8th August 1938 already referred to, Government permit their servants to undertake private work "in those rare cases where the 'rare qualification possessed by any one and the public importance of the work demand the utilisation of such service'". It is to be noted that public importance and not private advantage is an essential condition precedent to the granting of the permission. Even in such cases permission of Government should be obtained for doing the work and accepting the remuneration.

The fifth and the last point that we would suggest, should be considered in the determination of this question of private practice, is that the officers now in service should as far as possible not be subjected to undue hardship. Every reform generally hits hard some class or other, but this consideration should not stand in the way so long as the reform is a step in the right direction. And what can be done is to see as far as possible that it does not press hard on the persons concerned.

In our opinion the requirements of the situation and consideration mentioned above would be met if the private work of the Government Medical Officers is restricted to consulting practice in the hospitals. Consulting practice as defined by Government in their notification, G. O. No. 2232 Public (Services) dated 22.11.37, seems to be too wide for the present purpose. In this order the explanation given relating to Consulting Practice is such that the intention of the Government to restrict practice is likely to be frustrated. In addition, the spirit of G. O. No. 275 dated 8.8.1938 will be vitiated as it is not possible to restrict even "Consulting Practice" to reasonable limits with the result that the over-working Government specialist will be lacking in energy for his legitimate official work. We therefore suggest that the Consulting Practice should be allowed only in the very institutions where the officers are on duty, special hours being set apart for consultation by the well-to-do class of patients. A separate register must be maintained in the institution for this purpose. The consulting practice should be allowed to all the members of the Madras Medical Department from the existing Sub-Asst. Surgeon upwards. As a consequence if this change is introduced the working hours of the officers will have to be increased and adjusted in such a way that the consulting practice does not interfere with the usual routine. The fees charged for their practice may be treated as overtime fees, with this difference that a fraction of the fees to be fixed by Government should be credited to Government for the use the officers make of the instruments and other hospital equipment. This scheme is suggested as an interim arrangement applicable to the present incumbents. The honorary officers must of course have every facility enjoyed by the stipendiary officers. If facilities could be offered to a private practitioner of a certain status to use on special terms the Government operation theatre and instruments it would be a distinct encouragement to talented persons who are not fortunate enough to get into service, Government or Honorary. Provision

will also have to be made for cases in which patients are not able or willing to go to the hospitals and want the services of the medical officers in their houses. Each such case has of course to be dealt with on its merits and the officer concerned may be allowed to attend on the patient if it appears to be a fit case to the superior officer whose previous permission should be sought. If in any case it is not possible to obtain previous permission the fact of the case should be reported and permission sought for accepting remuneration.

'The Madras Mail' in its issue of 23.9.1938 suggests "consulting practice" though while doing so it has a fling at some members of the Madras Branch of the Indian Medical Association who appear to have suggested at a meeting of the Association on 22.9.1938 that "State medical officers should be inspired by the ideal of service and not require the privilege of private practice." Our contemporary suggests that the plea was disingenuous and that the members were not actuated by altruistic motives. It proceeds to remark that "there is no apparent reason why an ideal of service should be incompatible with payment for the service". Without meaning to controvert the statement we may remark that State Medical Officers do get their pay and can afford to be contented with it and if they render free service for the pay they get our hospitals would be models of their kind. The whole question is whether a person places service first or payment first. If he does the former thing and regards payment as a by-product being content with what he gets we may safely say that he is moved by the spirit of service. Such a man may be expected easily to forego private practice adjusting himself to the chang-

ed conditions and finding full scope for service in the restricted sphere. To take a concrete example, in pre-Congress days the ministers drew a pay of over Rs. 5,000 each per month and stood out against any suggestion for a reduction in the pay. The Congress ministers voluntarily reduced the sum to Rs. 500 each which is barely a living wage. Nobody denies that these gentlemen are moved by the spirit of service and sacrifice simply because they accept a pittance for their services. Is it contended that the pay of medical officers is less than a living wage? And what can be said for the other side is that when a person gets a certain income he orders his expenses in proportion and when there is a fall in the income it is fair to make it as gentle as possible.

It seems to be generally agreed that reform projected by Government is desirable. We would even say it is overdue. It would enable the State medical officers to devote more attention to their legitimate work and at the same time strengthen the independent medical profession, confining private practice to private practitioners. The present ministry is preeminently fitted to introduce the change. By their own example they have showed the way to sacrifice private interests to public good. They have shown vision and courage in enacting legislature and executive measures intended for public good undeterred by the out-cry raised by vested interests and the unpopularity resulting therefrom. Opposition there is bound to be for a scheme which destroys an age-long practice. There is all the more reason therefore that the advocates of the reform should mobilise their forces and support the Government.

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News and Comments

A Thunderbolt: The Rural Medical Practitioners subsidized by the Government of Madras are shocked and dumb-founded not being able to answer one way or the other, the three questions which they have been asked to do through the respective District Board Presidents under whom they serve. The sum and substance of the three questions seems to be to substitute Honorary Service in the place of Subsidized Service. The questions are:

1. Whether they are willing to receive only half of the amount of subsidy which at present is Rs. 500/- for the medical Licentiates and Rs. 600/- for the medical graduates.

2. If they agree to give medical relief in the villages without receiving any subsidy, the District Board supplying only medicines to the total value of Rs. 360/- a year.

3. Whether they are willing to serve in the villages without subsidy or supply of medicine in which case they will have the services of a midwife to be paid for by District Board or Government.

The Government more than anybody else must be aware of the conditions prevailing in villages regarding medical relief. Quacks and charlatans are still holding a sway over the credulous villagers. The few that have recourse to scientific medicine at the last stage of any illness after all the known quackery has been tried, are not in a position to pay. The rich and well-to-do class of villagers who are usually members of Local Bodies or partisans of one or the other local political faction do not pay and the Subsidized Practitioners feel nervous to demand from such people as experience had taught them that their position is not secure after such demands. There may be a village here and there in some Districts where a few subsidized practitioners are above want. The Government know that in such a village attempts are made by some District Boards to convert the existing Subsidized Dispensaries into pucca L. F. institutions with the ostensible intention of providing better facilities of medical relief, the real underlying object being to drive away the popular Subsidized Practitioner from out of the village. Such a practitioner is usually competent and

efficient and it is not possible to oust him from the village by any cock and bull story.

It is too early to think of introducing honorary system of medical relief in the villages. The proper time will be when qualified practitioners belonging to the Scientific System of medicine settle in villages where there are at present Subsidized Dispensaries. The helplessness now prevailing in the scientific medical profession is such that there is a large number of practitioners having little or no private practice and it is just possible that at least some amongst these are likely to take up subsidized village medical service on the 1st two conditions mentioned in the memorandum under reference. But it will be most unfair for the Government to displace those already in Subsidized Service on the principle of demand and supply. The Government should realise that the existing Subsidized Practitioners were the pioneers to do rural medical service and but for them the villagers would not have been educated to understand the benefits of scientific medicine. Unwholesome rivalry in the medical profession especially amongst starving, semi-starving practitioners will lead to disastrous results and the intention of the Government to supply efficient medical relief to the village folk will be frustrated. We do not wish to say anything more on this aspect of the subject for obvious reasons. The Hon'ble the Public Health Minister was till recently a very successful practising doctor and knows the relationship of a doctor and a patient especially in villages. There are a little over 450 Subsidized Practitioners at present. They are accustomed to village life. They have an organised Association. A large majority of them are congress minded. If the Government take them into their confidence, allow them all possible facilities to exercise their profession and devise ways and means to infuse in them the true spirit of missionary medical service there is every hope for enlarging the extent of rural medical service, the Government spending proportionately very much less on this account. We appeal to the Government not to hesitate any further to give

effect to the tentative proposals decided upon during the interview which the Health Minister was pleased to grant to the representatives of the Provincial Subsidized Rural Medical Practitioners' Association on 25-1-1938 and which the Minister said at the Manachanalloor Conference he would do early. The undue delay of nearly ten months and the recent circular foreshadowing drastic changes in the Subsidized Rural Medical Service have upset the practitioners to such an extent that many of them are confused not being able to understand the *bona fides* of the Government in issuing the memorandum instead of issuing the new agreement form.

Subsidized Public Health Work: A Government order relating to the training to be given to the Subsidized Practitioners, and the remuneration to be paid to the practitioner for doing Public Health Work has been published in the Correspondence Columns. The course is to last for one month both in the theory and practice of Public Health. It is said that the Subsidized Practitioner is to get Rs. 25/- as an honorarium during the period of one month when he is deputed to undergo the training and will be paid Rs. 15/- per month for doing Public Health Work in the villages within a radius of five miles from the Subsidized Dispensary and lesser area in case of more thickly populated villages.

Subsidized Practitioners have been doing Public Health Work in some selected villages and are paid Rs. 15/- a month. This amount was considered by them not adequate for the work they did at present and the representatives of the Subsidized Practitioners who met the Hon'ble Minister of Public Health at the Secretariat on 25.1.1938 discussed this subject with the Public Health Minister. It was agreed that the practitioners should not be asked to do actual vaccination operations. The Minister told them that till the Public Health Act was passed they might receive the remuneration at the current rate and that soon after the Public Health Act came into operation, he (the Minister) would reconsider the question of higher remuneration. There cannot be any doubt that

the Rural Medical Practitioner will have to play an important and responsible part regarding Public Health after the Public Health Bill becomes law. This will necessarily interfere with his private practice. It will be therefore just and reasonable if the subsidy for doing Public Health Work is fixed at Rs. 30/- a month a very modest amount taking into consideration the responsibilities of the work and the loss the subsidized practitioner is likely to incur due to loss of private practice at the time he is engaged in Public Health Work. It is expected that the vaccination will be done by vaccinators under the control of the Subsidized Practitioners as already agreed to. The G. O. is silent regarding the payment of the usual subsidy to the practitioner deputed for Public Health training. Majority of Subsidized Practitioners are married persons many of whom have children also. During the period of one month they are in Madras for training they have to maintain their house-hold in the villages and it is expected that in addition to the honorarium of Rs. 25/- referred to in G. O. the Government would pay them the proportionate monthly subsidy.

Time-Honoured Corruption: The Ministry of Public Information, Madras had published a Communique (extract published elsewhere) relating to deck passengers' grievances at Negapatam, a port on the east coast from where a very large number of emigrants ranging from nearly 14,000 to 50,000 embark seeking employment in the rubber estates in the Federated Malay States. The Communique deals with three methods of victimisation of deck passengers. The first relates to their accommodation at Negapatam before they embark; the second is in regard to the disinfection of the belongings of the emigrants by the Port Health staff and the third describes the hardships of the emigrants to procure vaccination certificates. We are not concerned with the first method of victimisation and we agree with the Government that the Health Department of Negapatam Municipality were guilty of culpable negligence in not making suitable arrangement for the hygienic accom-

modation of a large number of emigrants, numbering as many as 49,383 last year but mercilessly relegated them to the exploitation of unscrupulous and greedy touts or agents and persons of such and similar denomination. In the second category of victimisation the staff of the Port Health Department was entirely responsible so also in the third of the series relating to vaccination which till 1932 was supposed to be done by the Civil Surgeon, Nagapatam but actually done by a Sub-Assistant Surgeon directly under the Civil Surgeon, the latter not even signing the certificates but permitting his subordinate to affix the facsimile. The Communique is silent regarding the state of affairs of vaccination of deck passengers for 17 years before 1st January 1932 when this process was transferred to the control of the Director of Public Health from the Surgeon-General with the Government of Madras. The process of procuring vaccination certificates for passengers embarking for Strait Settlements, in the shipping department of M/s Benny & Co., in Madras, who have till this day the sole monopoly of issuing these certificates was first observed by us in 1928 a year before The Medical Practitioner came into existence and soon after we did observe in these columns that the exercise of such a monopoly by a shipping firm through only one practitioner under their employ was not fair to the medical profession. In 1930 when we had to embark at Negapatam to go to Penang we discussed with the then Manager of M/s Madura Company, Shipping Agents at Negapatam that the privilege of issuing vaccination certificates should be enjoyed equally by all the registered medical practitioners and not only by one who was for the time being the Civil Surgeon of Negapatam. We suggested that safety and responsibility of vaccination could be assured if the vaccination operations were done in the premises of M/s Madura Company by a panel of private registered medical practitioners in whom the Company had faith. We presume that the appointment of a private medical practitioner in the place of Civil Surgeon for the purpose of issuing vac-

nation certificates, after the Port Health work was transferred to the Public Health Department must have something to do with our suggestion. The fact that the Civil Surgeons of Nagapatam had been enjoying the privilege of making money on account of vaccination certificates without themselves doing the vaccination operations, must have encouraged the first Port Health Officer of Negapatam (from Public Health Department) who took charge of the port, to press the Madura Company to allow him a share in the fees collected by the company for vaccinating the emigrants. How and why this procedure which is now condemned as a victimisation and a corrupt practice escaped the notice of the then bureaucratic Government and later that of the Diarchic Government from the year 1915 to 1937 and which the present Government considered to be grave offences punishable with the highest administrative action of dismissal is beyond our comprehension. It is even said that the then Director of Public Health intervened in the dispute between the Health Officer and the Madura Company and suggested that the Port Health Officer should receive more than 1/3 fees collected for vaccination performed by the private practitioner engaged by the Madura Company. The Director of Public Health a responsible officer of the Government evidently considered that the fees earned this way was not illegitimate as he must have known that this procedure was in vogue for full 17 years when the port was under the administrative control of Civil Surgeons who were earning the vaccination fees without actually performing vaccination operations the only difference being that the certificates bore the facsimile of the Civil Surgeon till 1932 whereas later certificates bore the signature of the private practitioner with the countersignature of Port Health Officer till 1936. The Assistant Director of Public Health who was directly in charge of vaccination must have also thought likewise. The successor of the first Health Officer from the Public Health Department walked into the groove of his predecessor quite innocently.

The communique contains also grave charges against the private practitioners. It is said that some had been issuing ante-dated vaccination certificates and that some even employed touts who were furnished with signed vaccination certificates on which they got the names of the passengers entered. The Government action against the time-honoured corruption resulting in the dismissal of two Health Officers who had the approval of their immediate superior officers to do what the Civil Surgeons did for 17 years was at first considered to be rather harsh. For reasons explained in the communique the Government compromised justice with mercy and have been pleased to reinstate the two Health Officers to their old positions reducing the pay they were now getting and stopping their increment for a period of three years. The Assistant Director of Public Health who was in direct charge of vaccination has been also punished and we should say that the Government have been merciful to this officer to a large extent. But the action of the Government in punishing the entire medical profession by refusing its members their rightful privilege of granting vaccination certificates at Negapatam will be very much resented. We learn that after the Government instituted an enquiry about this affair at Negapatam some of the practitioners who are alleged to have granted ante-dated vaccination certificates have been reported to the Madras Medical Council. We are sure the Council will deal with them suitably. May we ask the Government why they did not condemn the entire Public Health Department for the sins committed by three or four officers belonging to this department applying the principle adopted in the case of other registered practitioners? There is a statutory body to enforce discipline over the entire medical profession including the Government Medical Officers in the Medical and Public Health Departments. The administrative disciplinary action usually taken by the Government in suspending, reducing and even dismissing their officers will not be as much salutary as the action of the Medical Council which

can erase the name of any registered practitioner if found guilty in professional respect. The Government cannot do this. There is nothing to prevent the Council to try all concerned in the Negapatam episode. We trust the Government will be pleased to reconsider their decision regarding the ban on the medical profession.

We take this opportunity and inform the Government that the affairs of Port Health work in Madras may also require scrutiny.

D. G. O. Diploma:—A diploma in Obstetrics and Gynaecology to be known as D. G. O. is instituted by the College of Physicians and Surgeons of Bombay. Full details of the course of studies etc., were published in the Correspondence Columns last month. The first examination will be held in August 1939 and will be open to all registered practitioners in Bombay. As the Bombay Medical Act permits the registration in the Bombay Register of all practitioners registered in other provincial Registers on the basis of reciprocity, practically all the registered practitioners in India will be entitled to appear for the D. G. O. examination. But in case of Medical Licentiates in addition to the special training in Obstetrics and Gynaecology they are required to undergo 12 months post-graduate training in Medicine and Surgery or should hold house appointments in recognised hospitals for a period of six months. Nobody can object to the additional course in general Medicine and Surgery demanded by the College of Physicians and Surgeons from the Medical Licentiates. But a fairer test would have been to fix a period of 5 years practice for Medical Licentiates and a lesser one in the case of those possessing the M. C. P. S. Diploma or M. B. B. S. degree after they qualified themselves. Dubbing specialist qualifications on medical men before they had opportunities to practise as general practitioners has been doing more harm than good. There are instances where general practitioners made a mark in a special branch of medical science without holding special qualifications in a particular branch. It is so particularly relating to Obstetrics and Gynaecology. A

practitioner who specialised himself taking advantage of special practice either in hospitals or outside must be far cleverer than a young graduate or licentiate who is artificially made a specialist by appearing for special examinations. So all the institutions who wish to grant diplomas or degrees in the special branches of medical science, will do well to insist that those who wish to qualify in specialities should be in actual practice for a minimum period of 5 years. The Medical Licentiates will have better opportunities for qualifying themselves for D. G. O. diploma if the College of Physicians and Surgeons demand from them a period of private practice as General Practitioners in lieu of extra post-graduate training in medicine or surgery or house appointment of six months in hospitals. Such a concession would be reasonable in the interest of the speciality as well.

Registration of Dentists: It is reported that the Punjab Government who are running a Dental College will soon enact legislation to register Dental Surgeons. In Bombay there was a proposal to start a Dental College and it is said that from the contributions given by a private donor a building was actually built for the purpose but the Government would not start the College for want of funds. A few qualified dentists are now running a private Dental School giving four years training both in theory and practice. The Dental Surgeons in the Bombay Presidency have organised themselves into an association. This association has drafted two Bills one for the recognition of the Dentists and the other for their Registration and submitted them to the Bombay Medical Council for approval. The object of the Punjab Government and the activities of the Bombay Dental Association are in the right direction. We have no idea of the scope of the proposed Bills in both the Provinces. We hope the effect of these Bills will be to prohibit quacks to practise the art of Dentistry. If this purpose is not served there will be little or no use of adding a few more pages to the Medical Registers of the Punjab and Bombay and make these Registers

a bigger volume. As it is, the Provincial Medical Registers do not actually serve the purpose for which they were meant and in Bombay there will be two rival Registers for identical purposes one for the qualified practitioners belonging to the scientific system and another for practitioners of all other systems. The practitioners in both the registers will be entitled also to enjoy identical rights and privileges. The possibility of having a separate Register for Dentists of indigenous systems of medicine will, we hope, not arise especially in Bombay.

A Happy Combination: Ever since the Congress took the reins of the Madras Government we have been wondering why the Public Health Minister, a medical man is saddled with the responsibility of management of Hindu temples. We had a long-looked-for opportunity of going on pilgrimage to Tirupathi quite recently. Our companion was another invalid. The infirmity being in different parts of the body each of us could keep the other in enjoyable company. It was natural the main topics of our conversation were about holy places of worship one such being the place of our destination. From the foot of the hills up till the top of the last hill where the sacred temple is situated we were noticing a stream of beggars a large number of whom were lepers in different stages of the diseases blind men or maimed persons who lost one or other of their limbs. There was also a good number of able-bodied men, women and children. Some amongst the latter kept by their side clay models and pictures of gods of all description. They belonged to the usual variety with the name of God on their lips and bitterness in their heart. They beg, they praise, they importune and finally abuse if disappointed. We reserved our charity for our return journey down the hills, as we wished to make a study of this problem, the time and patience for which we could only find on our way back. We walked a good distance of our way with this object. We saw a few amongst the beggars pointing to their maimed limbs which appeared to be gangrenous. We naturally doubted if it was possible for a beggar to sit up and

move his gangrenous limb in all directions as these did. We boldly approached two such beggars and stripped their clothing and were astonished to see that both of them had their limbs sound. The limb looking gangrenous was a piece of wood moulded and charred and fixed at the knee or the shoulder joint to resemble a gangrenous limb. Treacherous and most deceptive methods are being employed both by the beggars as well as those who are the servants of the temple especially the priestly class to decoy the pilgrims many of whom fall an easy prey due to blind devotion to God. We had very good accommodation in the temple Choultry down the hills and we asked one of the brahmin clerks wearing three marks on his forehead why the pilgrims were looted by all concerned in a holy place of worship. He replied, "Venkateswaran is fond of us and in His fondness He has settled in Tirupathi. We have His sanction to loot everybody so that all of us, His favourite children may live well." The nearer the church, the farther from God. The Thirumalai Hill where the sacred temple is situated is considered to be 'Vaikuntam' that is Heaven. In fact we saw the Heaven made into a hell. It is generally said by those not educated in the English language that persons educated in this language have no faith in the Hindu temples. This may be true to a certain extent. But if an English educated Commissioner was not at the head of the executive administration at the Tirumalai Hills, we are afraid things would have been much worse than what we saw them. We began to feel on the Hills that the Public Health Minister in the person of the Hon'ble Dr. T. S. S. Rajan is the fittest person amongst the Ministers to be in charge of Hindu Temples being a medical man and a Hindu at the same time. We were very happy to read the head lines about the Health Minister's recent visits to two famous temples in Tinnevely District in the Madras Mail on 25-7-38: 'Everything Else But God in Them', 'Temples Have Lost Magnetic Power', 'Government Preparing Legislation to prevent Crime'. Tirupathi temple is one of the richest if not the

richest temple in India. Population is flowing to Tirumalai Hills from all parts of India full of devotion otherwise known as 'Bhakthi'. It can be made a model place for the demonstration of both physical and mental cleanliness. The surroundings of the temple are in a most insanitary condition and any amount spent to make the surroundings clean and sanitary will not be too much. A large number of tidy dwelling places for the pilgrims have been recently constructed but, for want of water supply and a sanitary staff to look after them they are likely to deteriorate. There are a large number of infective lepers in fact almost all of whom we saw were of this type. They are found mixed with the pilgrims even inside the temple. The temple funds will be laudibly spent if a home for lepers is established immediately. These unfortunate people should be segregated and kept in an asylum. They can be easily maintained by public charity which must necessarily be diverted to these institutions in the absence of stray beggars such straying being absolutely prohibited and made penal if necessary. The Tirupathi Temples may thus become a model to attract the attention of other temples throughout India. Dr. Rajan has proved by example that medical men can be the best of devotees of Hindu temples. Spiritual devotion combined with scientific knowledge of the ailments of human body is the highest ideal for a medical man. We trust Dr. Rajan will make it possible for the members of the medical profession to serve God and man by working for Hindu temples. A man of thought, devotion and action in the position of a Minister as Dr. Rajan makes a happy combination of a Karmayogi guided by Jnana and Bhakti. Cleanliness is truly next to Godliness. Let Tirupathi temple which has at present a devoted Commissioner and large funds begin the work of purifying body and soul of the pilgrims with the help of the members of the medical profession. There cannot be a greater opportunity for the Madras Government than the present one when they have the Hon'ble Dr. Rajan in charge of Medical and Temple Portfolios.

Correspondence, Reports, Etc.

DECK PASSENGERS' GRIEVANCES.

NEGAPATAM ENQUIRY

Extracts from Government's Communique

The attention of the Government was recently drawn to the grave irregularities corrupt practices and victimisation of deck passengers which were alleged to have been prevailing at the Negapatam Port for a number of years in connection with the embarkation of passengers to Malaya. On receipt of information the Government immediately ordered an enquiry by a Special Officer and the enquiry confirmed most of the allegations which had been made.

Unlike the assisted emigrant the unassisted emigrant has no responsible persons at Negapatam to protect and aid him on his arrival. He has to shift for himself, and a large number of persons, consisting of rest-house keepers, brokers touts and medical men have many opportunities to prey on him.

Passengers who have to embark at Negapatam have usually to stay from 1 to 4 days awaiting for the steamer. There are no convenient rest houses to accommodate them. Instead there are certain houses called, "vidudies" most of which lack sanitary arrangements. Excepting a few owned by the shipping company the rest are maintained for profit and it was found that the owners of these "vidudies" employed agents to bring the passengers from distant stations to their "vidudies" where men, women and children were huddled together like cargo. These unscrupulous owners of "vidudies" were found to be making lucrative business trading upon the ignorance of illiterate passengers. The Government regretted to observe that the Negapatam Municipal Council who had it in their power to prevent overcrowding in the rest houses took no steps to do so.

A second form of victimisation disclosed by the Special Officer is in connection with the Quarantine Rules. Under these rules

disinfection is compulsory when the Port is infected with plague but it is left to the discretion of the Port Health Officer when the Port is infected with diseases other than plague. As the process of disinfection involved the changing of clothes in open sheds where there was no privacy, the procedure was naturally unpopular and those who could afford to do so were naturally not unwilling to pay for exemption.

The vaccination rules gave opportunities for a third and even worse form of victimisation. A Straits Settlement Ordinance of 1915 required that no emigrant from any part of India who had not suffered from small-pox or had not been successfully vaccinated or revaccinated within five years immediately preceding should be permitted to land in the Colony until he had been vaccinated or revaccinated. For some time after this enactment came into force, the passengers were vaccinated before embarkation by the Assistant Port Health Officer, Negapatam, the facsimile of the Civil Surgeon, Negapatam, who was then the Port Health Officer, being affixed to the vaccination certificate issued by him. This arrangement was in force till 1st January 1932 when the Port Health work was transferred to the Public Health Department, the Municipal Health Officer taking the place of Civil Surgeon as Port Health Officer, Negapatam. The Madura Company then appointed their own medical officer to vaccinate deck passengers. The Port Health Officer and his assistant resented this arrangement and the Assistant Port Health Officer continued to vaccinate and issue certificates holding that it was the privilege of the Port Health Officer to vaccinate deck passengers. The Madura Company refused to accept certificates issued by any one other than their own medical officer with the result that several persons vaccinated by the Assistant Port Health Officer had to get themselves revaccinated by the Company's doctor on the payment of a further fee before they could get passage tickets. Misunderstanding and

confusion followed till in March 1932 the Medical Officer of the Madura Company and the Port Health Officer came to an 'agreement' in the matter. Under this 'agreement' which was signed by both on 12th March 1932, the passengers were to be vaccinated by the Company's doctor assisted by the Assistant Port Health Officer but the Municipal Health Officer was to receive one-third of the income derived by him from vaccination fees.

Following a decision arrived at the Regional Conference of League of Nations held at Cape Town in 1932 a rule was framed in 1934 under the Indian Ports Act to the effect that "a passenger may, before sailing, be required by the Port Health Officer to satisfy him that he has been vaccinated or revaccinated against small-pox not less than 12 days or not more than three years before the date of sailing or that he has scars of small-pox." This rule came into actual operation from August 1935. Any registered medical practitioner might issue a vaccination certificate and it had to be countersigned by the Port Health Officer free of charge. This counter-signature was, however, dispensed with in 1936.

With the enforcement of the above rule the practice of issuing ante-dated vaccination certificates appears to have been started. Most of the emigrants arrive at Negapatam only two days before the departure of the steamer and many of them are not in possession of vaccination certificates. In order therefore to avoid a long stay at Negapatam the passengers are anxious to get certificates dated at least 12 days before. The medical practitioners appear to have taken full advantage of this and to have issued ante-dated certificates charging as large a fee as they could extort from the unfortunate passengers. Some in their anxiety to get more clients seem to have employed touts supplied with signed vaccination certificates in which they got the names of passengers entered!

The special officer who was deputed to investigate into the Negapatam Port disclosed in his enquiry that the conduct of the officers of Public Health Department

are most reprehensible; under the rules a port health officer is not permitted to accept vaccination fee unless he himself does the vaccination and issues a vaccination certificate. In spite of these rules the Municipal Health Officer entered into agreement with a company's doctor and received a share of vaccination fee from 1932, a third of the vaccination fee collected from the emigrants. The income derived from them may be judged from the number of Deck passengers who sailed from Negapatam during 1932—37.

One of the Municipal Health Officers has admitted that he made Rs. 14,490 from his share of the fees and the other Rs. 7,260.

It was highly improper for officers of the Public Health Department to make such incomes under an illegal and irregular agreement for work actually done by private medical practitioners in the Companies' employ. In accepting this "remuneration", these health officers were clearly guilty of receiving illegal gratification. Moreover, they could hardly have been unaware of the exaction of large fees for ante-dated vaccination certificates by the private medical practitioners and of other abuses and scandals shown to have been existing at Negapatam Port. Certain superior officers of the Public Health Department also were shown by the Special Officer to have been aware of the illegal agreement and of the fact that the Port Health Officers were continuing to receive a share of the vaccination fees, but to have taken no steps either to cancel the agreement or to put a stop to the practice.

The Government, after considering all the facts which the enquiry had brought to light, came to the conclusion, in which conclusion the Madras Public Service Commission concurred, that the offences committed by the Health Officers were serious and accordingly ordered the dismissal of the two Health Officers from service and reduced an Assistant Director of Public Health to a Health Officer's grade. Subsequently, however, the Health Officers admitted their guilt and expressed regret. They also made amends by pay-

ing into the Government Treasury the amounts of their illegal earnings. The Government, in view of this and in consideration of the fact that the acceptance of these irregular fees was done openly, have decided to show them clemency and have accordingly reinstated them in service on a lower scale of pay with a bar on increments for three years although the Madras Public Service Commission was still of the opinion that the order of dismissal should not be modified. Extenuating circumstances in the case of the Assistant Director of Public Health have also been taken into consideration and the rules have been relaxed in his favour and on reduction to a Health Officer's grade he has been permitted to draw a personal pay of Rs. 400 per mensem so as to bring his emoluments upto Rs. 1,000 which is Rs. 200 below his present salary.

With a view to remove the defects in the existing system and improve the general efficiency of the Port Health Administration the Special Officer has made suggestions which are under the active consideration of the Government. In regard to vaccination which afforded the greatest scope for corruption the Government have under consideration a proposal to amend the rules to the effect that in the case of deck passengers no vaccination or revaccination before embarkation shall be insisted upon, except when, on account of the prevalence of smallpox, it is considered necessary to adopt special precautions, in which case all deck passengers except those who have scars proving that they have suffered from a previous attack of smallpox, shall be vaccinated or revaccinated before embarkation by the Port Health Officer or his Assistant and by no other whether he be a Government or a local board servant or a private registered medical practitioner. The fee for vaccination will be charged when such vaccinations are performed, and it will be credited to Government. The Government have also decided to stop the disinfection of clothing and have asked the Director of Public Health to examine the rules and suggest suitable amendments.

**GOVERNMENT OF MADRAS:—
EDUCATION AND PUBLIC HEALTH
DEPARTMENT.**

(Public Health)

G. O. No. 2639. 21st July, 1938.

Medical Institutions Rural (subsidised) deputation of Medical Practitioners for training and performance of Public Health Work. Orders Passed:

Read the following papers:—

From the Surgeon-General Dated 17th December, 1937 No. 1591, Mis.

From the Director of Public Health Dated 24th March, '38 No. 3445 I. P. H.

From the Director of Public Health Dated 9th May, '38 No. 12488 I. P. H.

From the Surgeon-General Dated 30th May, '38 No. 2548 H.

Order No. 2639 P. H. Dated 21st July, 38.

The Conference of Public Health Ministers held at Fort St. George, Madras on 29th December 1937 passed a resolution to the effect that Rural Medical Practitioners should have special course of training in the theory and practice of 'Public Health' to enable them to discharge efficiently their duties as Sanitary Officers. The Government have considered the resolution in consultation with the Director of Public Health and the Surgeon-General and have decided that it should be given effect to.

2. The training which will be in Madras will last for a month exclusive of Sundays and will be confined to medical practitioners in charge of Rural Dispensaries of allopathic medicine subsidised by Government. A detailed syllabus for the course of training is printed as an appendix to this order. The Director of Public Health is requested to arrange for the training of the subsidised practitioners in batches in consultation with the Presidents of Local Boards concerned. During the absence of the Practitioners while undergoing training the rural

dispensaries may be placed in charge of substitutes on Government subsidy. The practitioners deputed for training should be paid from the funds of the Local Boards concerned.

(a) Travelling allowances as on tour for their journey to Madras for undergoing training and for their return journey and

(b) an honorarium of Rs. 25/- a month during the period of training.

After the completion of training a remuneration of Rs. 15/- a month should be paid from the funds of the Local Boards concerned to each rural medical practitioner for doing Public Health Work. No separate travelling allowance or additional honorarium for inoculation or festival duty need be paid. The Rural Medical Practitioners will when doing Public Health Work be under the control of the District Health Officers. The area for purpose of Public Health Work should not as a rule extend to villages beyond a radius of 5 miles from the dispensary. Where this area is too heavy a charge as in delta tracts it may be reduced in consultation with the District Health Officer.

3. The Presidents of Local Boards are informed that in future those medical officers who have undergone training in Public Health should be given preference for appointments as Rural Medical Practitioners.

(By Order of His Excellency the Governor.)

(Sd.) C. H. MASTERMAN,
Secretary to Government.

**THE MADRAS PROVINCIAL
SUBSIDIZED RURAL MEDICAL
PRACTITIONERS' ASSOCIATION.**

1. TRICHINOPOLY DISTRICT BRANCH.

Proceedings.

At a meeting held at the Head Quarters Hospital, Trichinopoly on 17-9-1938 presided over by Dr. S. Sethurama Rau, Vice-President of the Madras Provincial Subsidized Rural Medical Practitioners'

Association the following resolutions were passed.

1. That the Trichy District Rural Medical Practitioners' Association be converted into the Trichy Branch of the P. S. R. M. Ps'. Association.

2. That Dr. N. Sundararajulu be elected as the representative to the Provincial Committee of the P. S. R. M. Ps'. Association and also as the Secretary of the District Branch.

3. That the Resolution No. 2 be communicated to the General Secretary of the P. S. R. M. Ps'. Association.

4. That the District Secretary be requested to enlist all the Subsidized Rural Medical Practitioners of the District as the members of the P. S. R. M. Ps'. Association.

5. That the District Secretary be requested to prepare a memorandum consistent with the rules and objects of the Association and to place the same before the next meeting of the District Branch.

6. That the District Medical Officer, Trichinopoly be requested to give to the members of the Association facilities to attend the operations and study such clinical material as available at bed side in the Head Quarters Hospital and arrange for post-graduate lectures on every penultimate Saturdays.

7. That the Secretary communicate the resolution No. 6 to the District Medical Officer, Trichinopoly and take such steps to give effect to the objects of the said resolution.

8. That the Secretary arrange periodical clinical meetings at the Head Quarters Hospital and visits to X-ray institutes, nursing homes and other existing medical institutions in the town with the help of directors or managers of such institutions as the case may be.

[We are informed that the D. M. O. Trichinopoly has been kind enough to give effect to resolution No. 6 and the practitioners had the first clinical meeting on 15-10-'38. Ed.]

2. THE BELLARY DISTRICT BRANCH.

Proceedings.

The members of the Madras Provincial Subsidized Rural Medical Practitioners' Association of Bellary District organised a Conference to inaugurate the District Branch, which was opened by Dr. R. Nagana Goud, M.Sc., Ph.D., President, District Board, Bellary on 20-10-1938 at Hospet. Sri. M. Raghavendra Rau, B.A., B.L., President, District Congress Committee presided. Sri. B. Ananthachar, B.A., B.L., M.L.A., was one amongst the distinguished visitors.

Dr. M. Krishna Rau, of Thambrahalli village introduced his comrades to the distinguished visitors and expressed his pleasure that almost all the subsidized practitioners were present not minding the inconveniences they were put to. He welcomed the guests and expressed his gratitude to Sri. M. Raghavendra Rau, for having taken up the responsibility of presiding over the function at very short notice. As previously arranged Dr. V. Rama Kamath, President of the Provincial Subsidized Rural Medical Practitioners' Association could not preside due to some unforeseen domestic inconvenience. Dr. Rau, eulogised the services of Dr. Kamath to the Subsidized Practitioners as the President of their Association and also in his capacity as the Editor, The Medical Practitioner. Dr. Rau said that but for his untiring efforts the Association would not have been as active as it was now. He then expressed his gratitude to Dr. R. Nagana Goud for having taken the trouble of going over to Hospet to do the inauguration ceremony of the District Branch of the Provincial Subsidized Rural Medical Practitioners' Association. Addressing Sri. B. Ananthachari Dr. Rau said that he and his comrades were very much encouraged by his presence being the popular representative in the Legislative Assembly.

Regarding the necessity of organising the District Branch of the Provincial Subsidized Rural Medical Practitioners' Association Dr. Krishna Rau said it was not so much for redressing their grievances that they wished to have a branch Association as fortunately they had none but they felt the need of having a branch for exchanging views and experiences in different villages so as to be able to do good service to the village folk.

Dr. Rau then traced the origin and growth of the Subsidized Rural Medical Scheme and said that the purpose of the scheme was to attract qualified practitioners to the villages and make them settle there permanently. Success of the scheme said Dr. Rau was to a great measure due to the self sacrificing attitude of the practitioners who with the hope of being able to stick to one place did not

mind material gain and lived the life of the villagers. The masses in the villages were miserably poor; the few rich were not paying and the practitioners did not demand from them as the very existence of practitioners in the villages depended upon their grace. Thus the practitioners were forced to be philanthropic both to the poor as well as the rich. He added that the Hon'ble Dr. Rajan's advice to the newly passed graduates not to count their services in rupees, annas and pies could be translated only by the Subsidized Practitioners in the villages.

Relating to the memorandum recently circulated by the Government asking the opinion of the Subsidized Practitioner if he was willing to serve on 50 per cent less subsidy or no subsidy he would say that time was not ripe yet to conceive the idea of practitioners giving medical aid to the villages depending upon private income. The Government should not be guided by the example of a very few practitioners who might be able to maintain themselves independently of Government subsidy. Dr. Rau opined that it was not fair on the part of the Government to oust the existing Subsidized Practitioners in case they expressed their inability to serve on the new conditions. They were promised fixity of tenure of service when they settled in the villages and after spending nearly 13 years in the villages it would be very hard for them to leave them. He concluded by saying that the Government would be digging the grave of Rural Medical Relief Scheme and would inflict a serious blow on the existing practitioners if they contemplated to give effect to the conditions mentioned in the memorandum under circulation. He then requested Dr. R. Nagana Goud to declare the Conference 'open'.

Dr. N. Nagana Goud thanked the organisers of the conference in requesting him to open the conference which he was glad to do and which afforded him an opportunity to know almost all the practitioners of the District. He was of opinion that the rural medical relief scheme has not worked according to the intentions of the framers of the scheme and a situation analogous to what could be termed

as putting the cart before the horse had been created. The people who could afford to pay and were expected to pay the practitioners were not doing so and hence the practitioners were unable to stand on their own legs. From his experience he was of opinion that voters, and members of the District Board and rich people who had some influence with the District Boards unduly exerted pressure on the practitioners to their advantage. In his capacity as President, District Board he was receiving many applications from various villages for the establishment of a rural dispensaries and his answer to them all was that the villages should maintain a private practitioner in their village for one or two years and then he would consider the payment of subsidy or supplying medicine for the benefit of the poor. Similarly if any medical man approached him for a job he would ask him to go to a particular place and begin private practice and then he would think of addressing the Government for the sanction of a rural dispensary. He was in agreement with the views expressed by Dr. M. Krishna Rau in his welcome speech that the practitioners were not getting any private practice worth the name and were subjected to all sorts of caprices of local factions. Regarding the circular he said that the Government was finding ways and means of spending as little as possible and benefitting as many people as possible. He then declared the conference open.

Sri M. Raghavendra Rao, B.A., B.L., President of the District Congress Committee in his presidential address said that in the unavoidable absence of Dr. V. Rama Kamath of Madras the honour of presiding over the deliberations fell on him and he was thankful to the organisers. He congratulated the Subsidized Practitioners of the District for organising themselves into an association and felt glad that he was to inaugurate the association on the eve of its first conference. He had heard the speeches of Dr. N. Nagana Goud and Dr. M. Krishna Rao and he had also travelled a great deal in the villages of the District as a Congress worker for the last six or seven years and he was convinced that the rural medical practi-

tioners have their own difficulties to cope with. But he might be excused for suggesting certain things in his own way as a Congressman. He wondered at the fact that everybody asked the Government not to cut short the emoluments received, to reduce the taxes and to introduce prohibition, compulsory primary education etc., and nobody came forward with any suggestion regarding the raising of any fresh taxes and indicating the sources of money required for the undertaking of the ameliorative measures. His advice to the doctors assembled would be that they should simplify their ways of living eschew all ideas of imitating the westerners in the matter of dress, food, habits etc., and thus they would be able to economise in their personal budget and would thus be able to meet the new situation created by the Government circular. He advised the practitioners to help the Government in rural reconstruction work being educated persons and by taking more interest in the welfare of the villages.

Then Sri. B. Ananthachari, B.A., B.L., M.L.A., addressed the gathering. He said that the enthusiasm displayed at the time of inauguration of associations as evidenced by group photos, refreshments and speeches by eminent persons gradually diminished and many associations died a premature death as the Indian children do. He wished that such a thing did not happen to this association. He was under the impression that doctors as a rule were well off and had no necessity to form an association to fight for the redress of the grievances and only the lawyers to which category the speaker belonged were subjected to the grievances such as overcrowding of the profession, no income etc., etc., but now he had to revise his impression and admit that doctors had also certain grievances. He wished the conference success and felt glad to be among their midst that day.

The following resolutions were then passed unanimously:—

1. Resolved that an association of the Subsidized Rural Medical Practitioners for Bellary District be formed.
2. Resolved to request the Madras Provincial Subsidized Rural Medical Practitioners' Association to affiliate this association to it.

3. The following office-bearers of the Bellary District Subsidized Rural Medical Practitioners' Association are unanimously elected:—

1. **President** :—Dr. M. Krishna Rau (Thambraballi).
2. **Secretary** :—Dr. C. T. Krishnamurthi Rao (Narayanadevarakeri).
3. **Member of the Executive Committee** : Dr. K. V. Govindarajulu (Moka).
4. **Representative to the Provincial Committee of the P. S. R. M. Ps' Association** :—Dr. M. Krishna Rau.

After interesting discussion the following two resolutions were also passed unanimously:—

5. This conference expresses its inability to accept any of the alternative proposals made by the Government in the memorandum circulated to individual Subsidized Practitioners.

6. This conference requests the President, District Board, Bellary to represent the grievances of the Rural Medical Practitioners of this District and make suitable recommendations to the Government to redress the same.

After a vote of thanks moved by Dr. C. T. Krishnamoorthi Rao, the gathering had an enjoyable lunch party and then the conference was dissolved.

(The Subsidized Practitioners of the Bellary District are to be congratulated on their

achievement in organising the District Branch and availing themselves of the advice and guidance of popular leaders of the District one of whom being a person having direct control over the practitioners as the President, District Board. We trust the proceedings of the Conference will not escape the notice of the Government especially the address of Dr. R. Nagana Goud. It is hoped that the Subsidized Practitioners belonging to other districts will follow the lead of their comrades in Bellary District. Ed.)

3. SPECIAL CONFERENCE OF THE SUBSIDIZED PRACTITIONERS, GUNTUR DISTRICT, HELD ON 22-10-1938 UNDER THE PRESIDENSHIP OF SRI. KONDA VENKATAPIAH GARU, M.L.A.

Resolutions.

(a) This conference resolves that in reply to R. C. No. 270 Sup. of '38 dated 17-10-'38 of Guntur District Board, that a memorial by every one of the subsidized rural medical practitioners of the District be submitted to the President, District Board, Guntur, and to the Government through the District Medical Officer, Guntur, or the Principal, Government School of Indian Medicine, Madras, as the case may be.

(b) This conference resolves that in response to the suggestion made by the President of the Provincial Rural Medical Practitioners Association, Madras, Mr. C. V. Subba Rao be elected to

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be a member of the body of the representatives chosen to appear before the authorities to discuss on matters relating to the grievances of the subsidized rural medical practitioners of the Province.

4. SPECIAL MEETING OF TINNEVELLY DISTRICT SUBSIDIZED RURAL MEDICAL PRACTITIONERS' ASSOCIATION UNDER THE PRESIDENSHIP OF DR. P. R. VENKATARAMA AIYER, RETD. CIVIL SURGEON.

The following reply from the subsidised practitioners to the District Board

regarding the Circular No. 2-87/37 dated 7th October, was unanimously approved.

"In giving a negative reply to the items 1, 2 and 3 mentioned in the Circular dated 7th October, 1938, we beg to submit that the existing difficulties under which the R.M.Ps' are labouring are not unknown and to be forced to work under the new scheme contemplated in the Circular under communication, will only augment our financial and social difficulties and entail serious hardship and jeopardise our position and interest in every respect. It is therefore our humble and fervent request that we may be allowed to work under the G. O. governing us at present."

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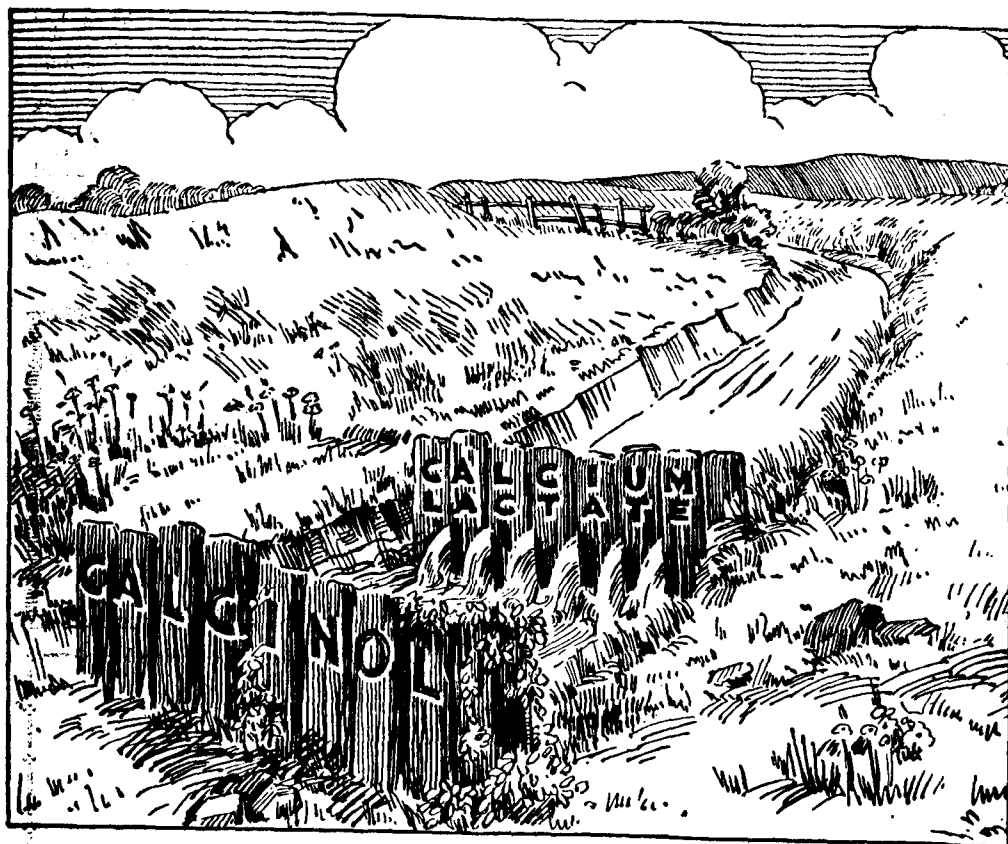
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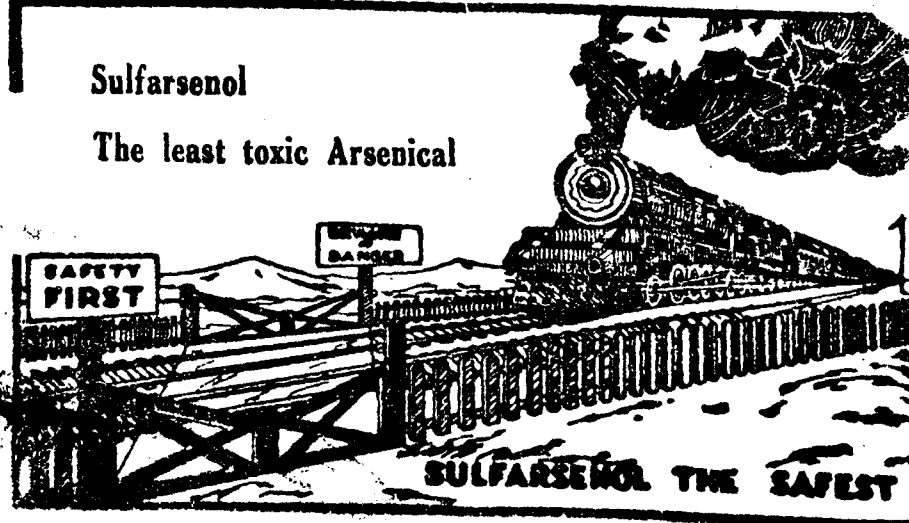
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