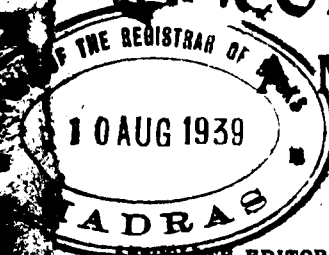


The Medical Practitioner

Monthly Medical Journal



EDITED BY
Dr. V. Rama Kamath,
Member, Madras Medical Council.
Capt. E. S. Gopalan, M.B., M.S.; A.I.R.O., (Madras)
Dr. S. S. Rau, M.D., (Bombay).

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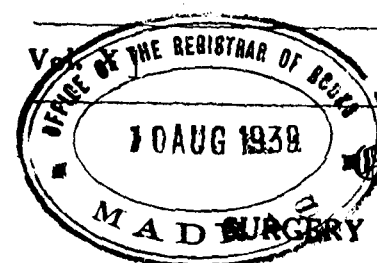
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[No. 10

Original Articles.

MAD SURGERY IN PARALYSIS OF CHILDREN*

By

DR. N. S. NARASIMHAN, F.R.C.S. (Eng. & I.),

Orthopaedic Surgeon, Government General Hospital, Madras.

Before discussing surgical treatment adopted in the various types of paralysis in children, it is desirable to give a brief outline of different types of paralysis found in them. Paralysis in children may be classified as follows:

I. Pseudo-paralysis in infants due to congenital syphilis.

II. Acute paralysis starting with fever.—

(a) Acute antero-poliomyelitis.

(b) Diphtheritic paralysis.

III. Paralysis with slow and insidious onset:

(1) Progressive muscular dystrophy—different types of myopathies.

(2) Hereditary ataxy.

(3) Syringomyelia.

(4) Compression paraplegia:

(a) Tuberculous caries of spine.

(b) Spinal cord tumour.

(c) Injuries.

(5) Cerebral spastic paralysis.

Acute Antero-Poliomyelitis has been published as a separate article in the March 1939 number of The Medical Practitioner.

In Diphtheritic paralysis majority of cases are between two and ten years of age. In the 5, 6, 7th week of the disease a diffuse paralysis, usually symmetrical occurs in limbs. Paraesthesia is sometimes present and a slight disturbance of tactile sensibility at the periphery of the limbs.

(1) Primary progressive muscular atrophy called muscular dystrophies—myopathies.

Myopathies are extremely common. Sixteen cases were seen during one year in the Madras Government General Hospital. The diagnosis is extremely difficult in the early stages. Two male children had extensive distribution involving all the four limbs. These again are subdivided according to the authors describing them as:

(a) Pseudo-hypertrophic type.

(b) Juvenile type (Erb).

* Lecture delivered under Dr. Elizabeth Mathai Endowment Fund, in the University of Madras, 1938—39.

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(a) FACIO-SCAPULO-HUMERAL type (Landouzy-Dejerine).

(d) Distal type (Gowers)

(a) PSEUDO-HYPERTROPHIC muscular paralysis :—

More than one child in the family may be affected; age of onset is 4th or 5th year—child has been weak in its legs since birth.

Girls are seldom affected. First signs are :—loss of power, tendency to fall, inability to rise again with ease, rapid rise in increase in some of the muscles as those of calf, extensions of the knee, glutei, infrapinatus and increase of weakness. Mode of progression is of a peculiar waddling nature and is similar to that seen in congenital dislocation of hip. There is wasting of the lower part of pectoralis major and latismus dorsi. Mode of raising from the recumbent position is characteristic of family history. Weakness of extensors of the hip causes lordosis.

As the spinal muscles become involved, lordosis is replaced by kyphosis and subsequently lateral curvature sets in.

Prognosis is grave. Majority do not attain adult life.

TREATMENT :—

1. Planned muscular exercises.
2. Spinal support.
3. Tenotomy for Tendo-achilis, if required, is good.

(b) ERB TYPE :

Atrophy commences in the Scapulo-humeral group: onset 7th year; both sexes equally affected; several generations may be affected. The muscles of the pelvic girdle may be affected. The progress of the disease is extremely slow and may become arrested.

(c) FACIO-SCAPULO-HUMERAL TYPE: (Landouzy-Dejenue).

This may be both hereditary and familial affecting both sexes. The

onset is in early childhood and atrophy commences in the facial muscles. The disease progresses very slowly, and may show a temporary or permanent arrest.

(d) DISTAL TYPE OF GOWERS :

Atrophy commences in the feet and hands, extends up the forearm and the leg. The onset is about the 12th year.

TREATMENT: No rest; no appliances; no tenotomies. The patient must be encouraged in the use of his limb.

HEREDITARY ATAXY.

The deformities present are lateral curvature of the spine and talipes equinovarus and occasionally contraction of the knees. The lateral curvature is due in the first place to muscular weakness, and then to the effects of posture, but as a rule despite recumbency and supports, it increases and becomes permanent. The condition of the foot is talipes plantaris. The heel is raised; the instep is excessively arched and in the sole of the foot bands of contracted plantar fascia may be felt. The heads of metatarsal bones are at a lower level than the heel, the toes are hyperextended at the phalanges and flexed at the second and third and the whole front part of the foot is adducted; the result is a partial or entire loss of equilibrium of the patient.

In the majority of cases it is advisable to interfere surgically.

SYRINGOMYELIA.

This is uncommon in children but cases have been reported with an onset before the 10th year.

The chief features of syringomyelia are :—

- (1) Loss of sensibility, chiefly to pain and temperature.
- (2) Muscular atrophy very similar to that of progressive muscular atrophy.
- (3) When the compression affects the pyramidal tracts—a form of spastic paralysis.

(4) Lateral curvature of the spine—due to atrophy of the muscles of the trunk.

(5) If the dorsal and lumbar regions of the cord are affected, the lower extremities are seen to be in a spastic condition but this is rather rare.

(6) Thickening of bones.

(7) Charcot joint.

Occurrence of spinal tumour in childhood is rare. Early childhood is almost exempt, if the teratoma complex congenital tumour of the sacro-coccygeal region is excluded.

COMPRESSION PARAPLEGIA.

Paraplegia due to spinal caries is a common disease in early childhood, the majority of cases occurring before the 10th year. The features to be noted are :

(1) This occurs 1 in 8 cases of spinal disease.

(2) With reference to pressure on the cord by pus, it is a very true observation that abscess and compression paraplegia are seldom associated, and further, that if an abscess makes its appearance the nerve symptoms subside.

(3) Its onset is, as a rule, gradual, occasionally sudden.

(4) Causes : (a) Granulation tissue in the spinal canal.

(b) Formation of intraspinal abscess.

(c) Tubercular pachymeningitis.

Causes of sudden onset : Displaced bone, rupture of blood vessel, acute myelitis or tubercular meningitis.

(5) Even the most hopeless cases recover under recumbency and extension; even cases who have had four attacks and many three attacks make good recovery.

(6) Laminectomy is a disappointing operation.

SPASTIC PARALYSIS.

During the course of a year I have seen thirty-two cases of this distressing

disease admitted in Madras Government General Hospital. There must be many more who die in the post-natal period. There is an almost equal incidence of sexes; the average at which the mothers bring the children has been from 3 to 5; 2 were forceps cases; 9 had convulsions off and on. A good deal of thought and attention has been devoted to these subjects in other countries as Australia, England and Germany. The prophylaxis of the condition properly belongs to the domain of the obstetrician. This may be briefly recapitulated here.

There is great frequency of intracranial trauma and hæmorrhage in extreme degrees of moulding and in unduly rapid moulding from the rupture of venous sinuses due to tears of tentorium cerebelli and cerebelli and falx cerebri. There is infratentorial hæmorrhage around the medulla oblongata or supratentorially upon the surface of the cortex cerebri or in both situations. In the severe cases the following symptoms may be noted :

Asphyxia, stupor, great restlessness, rigidity, extremities appear helpless.

Pupils of the eye dilate unequally.

Hæmorrhage from nose, bowels, bladder and convulsions may occur.

Baby may cry incessantly for many days.

Lumbar puncture may show the presence of altered blood in the cerebrospinal fluid; Ophthalmoscopic examination may reveal a high percentages of cases with retinal hæmorrhages.

Prematurity itself does not cause any symptoms as asphyxia, somnolence. The premature child despite great unripeness and very small size, often discloses quite extraordinary vigour and tenacity of life. Repeated withdrawal of cerebrospinal fluid may be of some use.

There is no doubt a high initial mortality in cases of subtentorial hæmorrhage but in the cases of supratentorial hæmorrhage it is difficult to diagnose. Medullary symptoms as

dysphagia, aphonia, persistent in-coordination of the respiratory muscles, palatal paresis with stridor are rarely found.

Unlike the medulla which is functionally active from the first, the infantile cerebral cortex is for long a silent area of the brain. Medullation of the pyramidal tract proceeds only slowly. That is why even when there had been extensive supratentorial haemorrhage it is usual to find that a long time has elapsed, a year or two before the parents bring the child for advice; the common symptoms are inability to grasp, rigid spastic legs with adductor spasm, stiff expressionless face with delay in speech or dribbling of saliva. An earlier recognition of this disease is urgently called for.

The following forms of spastic paralysis may be met with:

(1) *Cerebral diplegia*:—There is rigidity and paralysis, rigidity is the more striking feature leg more affected than the arm. Severest is often fatal; patient often lies in bed like a log.

Severe form of cerebral diplegia. There is much general rigidity. Superficial lesions in cerebral hemisphere.

(2) *Haemilegic form* (infantile):—Paralysis predominates and rigidity is secondary to it; arm is more affected than the leg.

(3) *Bilateral Spastic Hemiplegia*:—Convulsions are more common. Disease is due to congenital affection. Lesions in the cerebral hemisphere are deeply situated.

(4) *Rare variety*:—Congenital chorea, bilateral athetosis and choreic diplegia.

Athetotic movements are seen in the face and tongue; and in severe cases the muscles of the trunk and limbs are involved also. Convulsions are not marked and the mental condition is good.

It is well-known that the crossed pyramidal tract at the 7th month of foetal

life has only reached the medulla, and an arrest of development of the pyramidal tract occurs in a child born prematurely at the 7th month then general rigidity should follow. At the 8th month the tract has pushed its way down the spinal cord as far as the dorsal region, and if an arrest of development occurs at that stage, then paraplegic rigidity of the lower extremities should ensue.

Infantile spastic paralysis more often affects the younger children of a larger family than the elder ones. The affection is rarely met with in the elder children.

Operation is contraindicated in:—

- (1) A hopeless idiot.
- (2) If there be general rigidity.
- (3) If the child suffers from persistent bed wetting.
- (4) If there be persistent dribbling at the mouth and loss of control.
- (5) If athetoid movements are present.

In the less severe cases there is always a distinct natural tendency to improvement, more especially in the paraplegic variety affecting the lower extremities.

The following points may be of interest to the Orthopaedic Surgeon:—

- (1) The upper limb is more severely affected than the lower.
- (2) The lesion of the upper limb is more permanent.
- (3) The power of dorsiflexion of the hand and the simultaneous extension of the fingers is lost.
- (4) The movements are performed without precision, spasmodically and slowly.
- (5) The power of abduction of thumb is often lost.

The disabilities of the lower limb are:—

- (a) Contraction of the knee.
- (b) Extension of the foot.

(c) Internal rotation of the femur with adduction.

(d) Rigidity.

Cerebral diplegic group can be divided into:—

- (a) Cases with and without severe mental complication.
- (b) Complete and partial disabilities of the hands.
- (c) Complete and partial disabilities of the limbs.
- (d) Cases Complicated with athetotic movements.

The term 'Little's disease' is applied when the spasm is limited to the leg.

Course of the Disease:—(1) If there be excessive general rigidity the disease is rapidly fatal.

(2) If there be only paraplegic rigidity or slight general rigidity, the condition is nonprogressive or it may tend to improve.

(3) The amount of unaided improvement is never great and normal function is never acquired.

(4) Complete improvement may occur in the upper limbs, with persistence of spastic rigidity in the lower extremities.

(5) No improvement is possible if athetosis is well marked.

(6) Cases afflicted with hemiplegia or paraplegia live longer than those in which three of the four extremities are affected cerebral diplegies rarely attain adult life.

TREATMENT:—Physicians are pessimistic, it is not wise to leave the improvement to nature alone, but to give every assistance in our power to the restoration of limbs to their proper position and function. It is surprising, to what an extent, these defects may be overcome in later childhood; unlike the child with primary amentia due to a numerical deficiency of cortical neurones, the spastic

child is often patient and persistent in the effort to learn.

Cases suitable for Treatment:—

(1) A child or young adult of fair intellectual development who has had no fits for the last three or four years.

(2) A child may be brought for contractures at the knee for adduction of the thighs or for talipes equinus or equinovarus. Such contractures are capable of removal.

Entirely Unsuitable for the Treatment:—

- (1) The idiotic.
- (2) The micro-cephalic.
- (3) Violently irritable type of diplegic subject to fits.

(4) Children with active athetotic movements and convulsions who have no control over their excretions.

(5) If the affection of the hands is so great that they will not be of any use to the limbs during walking, i.e., if the spasm of the hands is so great as to hinder movement.

(6) If the fingers of the affected hand are only moved in conjunction with the fingers of the opposite side, the results are discouraging.

(7) If it can be ascertained that the patient is able to do more with hands now than a little while ago, the success of the treatment is provable.

(8) If any degree of voluntary relaxation exists, treatment is urgently called for.

Period of Active Treatment:

Active treatment is required for two years; it is unwise to undertake a case in the hospital for two months.

We must secure the co-operation of intelligent parents anxious to do all they can for their child and will face all the trouble involved in careful training.

Principles of Treatment:

(1) An overstretched, parietic muscle must be placed in a state of rest—in a foot by tenotomy of the tendo-achillis.

(2) Excessive deep reflexes are characteristic of this disease, limit this excitement by division of a highly contracted muscle.

(3) The removal of this excessive reflex excitability of the spinal cord affords of that quiescence of nerve centres so essential to the welfare of these children.

Treatment falls into two divisions:—

(a) Operative.

(b) Post-operative: the post-operative being mechanical and persistent training of the patient to utilise to the best advantage his limbs, when the deformities have been rectified and the contractures removed. Sister Kenny's work in Australia as recently demonstrated in London is a further proof what patient work can do for the patients; this was referred to in detail in the paper on aterio-polio-myelitis published in the March 1939 number of The Medical Practitioners.

There is no indication whatever for electric treatment.

Treatment of Upper Extremities:—The most pronounced deformities of the hand and arm in these cases are pronation and flexion of the wrist; treatment should consist in rendering the forearm supine and hyperextending the wrist; gradual extension of the wrist may be brought about by the use of a malleable iron splint, in which the angle is increased from time to time, but very gradually. The most difficult part of the treatment is to secure supination.

Prolonged fixation of spastic muscles in a position opposed to their contraction gradually lessens the severity of the spasm.

In a mild case, the extension must be kept up over twelve months without intermission. The test for relaxation must be return of power of voluntary movement, however slow it may be. At this stage, the patient, in endeavouring to extend the wrist, will first of all close his

fingers and will only open them on completion of extension. The process is reversed when the wrist is flexed. To meet this difficulty, the splint employed to extend both wrist and fingers is modified so as to extend the wrist alone and to allow freedom to the fingers.

If the progress is unduly slow, operation on the forearm and hand is required.

The objects of the operation are:—

(1) The excessive action of the pronator radii teres into a supinating power.

(2) Reduction of carpal flexion and conversion of carpal flexors into carpal extensors.

It is the muscles which arise from the internal epicondyle which are involved and these muscles are both pronators and flexors. Any operation designed to lessen the pronator spasm will diminish the flexor spasm, both at elbow and wrist.

Tubby's technique of the operation of converting the pronator radii teres into a supinator:—

(1) Incise $2\frac{1}{2}$ to 3 inches in length over the position of the radial artery, and near the middle of the forearm.

(2) Identify the inner margin of supinator longus and separate it from flexor carpi radialis.

(3) Identify radial vessel and nerve and draw to the inner side.

(4) Identify the pronator radii teres insertion; this is not constant and is situated at a varying position in the length of the forearm. It can be recognized on attempting to forcibly supinate the forearm, when the muscular belly stands out quite clearly, just as it passes under the supinator longus. It is a broad muscle with a short flat tendon, which rapidly merges into the periosteum of the radius. Clear the upper and lower borders of the muscle well, and the tendon with a good piece of periosteum, is detached from the radius.

(5) Pass a stout silk suture through it.

(6) On the inner side of the radius pass an aneurysm needle quite close to the radius through the membrane and around the bone and work vigorously vertically for a space of an inch and a half.

(7) The tendon is brought to the outer side and back of the radius.

(8) Refix the tendon on the outer side of the radius by drilling a hole through the radius from front to back.

(9) When the tendon is re-inserted, the forearm is in a position of supination.

The insertion of pronator quadratus is also divided in addition to the above procedure in these cases.

An incision is made over the tendon of flexor carpi ulnaris just above the annular ligament and another is made over the flexor carpi radialis. Both tendons are divided low down, and the flexor carpi ulnaris is inserted into the extensor ulnaris and the radial flexor into the radial extensor.

The improvement effected by these operations is in my experience most marked. Voluntary movements were steadily performed.

After-Treatment: Wound heels 10 to 14 days. Educate and train the limb in its new position gradually, but after the sixth week movements are more vigorously practised.

In a hemiplegic child, the sound limb can be tied up so as to induce the child to use the affected one as much as possible.

No effort should be spared in urging and practising exercises from simple to complex.

The principles governing the exercises are:

(a) The movements should be practised slowly and without excitement.

(b) They should be interesting to the child.

(c) Those movements opposed to the direction of the deformity should predominate.

(d) Those presenting the greatest difficulty should be chiefly practised.

Treatment of The Lower Extremities:

Operative treatment may be grouped into four classes:

(1) Division of posterior spinal root (Forster)

(2) Operation on sympathetic nerves (Royle)

(3) Operations on efferent nerves (Stoffel)

(4) Operation on muscles.

All these methods have been extensively tried and as a result of the experience gained it may be stated that though division of the posterior nerve roots is performed with the object of diminishing uncontrolled reflex arc, it no doubt diminishes the spasm but does not lead to any increase in co-ordination of the affected muscles.

Royle's operation is based on the theory that the abnormal muscle spasm is caused by the presence of non-medullated nerve fibres in the voluntary muscles, and that division of the grey rami communicantes passing from the sympathetic nervous system to the motor nerves will result in the cure of the spasm; this has proved to be very unsatisfactory.

Stoffel's operation consists in the division of part of the motor nerve fibres to each of the affected muscles with the object of reducing the spasm in that muscle. It is not possible to gauge the exact amount of nerve tissue to be divided and these may be too restricted or too free divisions.

Operations for muscle balance are common. The overacting groups are weakened by complete or partial division.

In slighter cases with little contraction at the hips, improvement may be effected

by placing the patient on a double abduction frame.

Operations on muscles can be done in stages beginning with the hips and subsequently attending to the knees and feet; open operations are to be preferred; subcutaneous division and stretching may take long time and there is a probability of recurrence of adductor spasm. Adductors are dealt with; longus, brevis, gracilis, horizontal portion of adductor, magnus and the pectineus are divided; in fact any and every tissue which limits free abduction. The sartorius, the ilio-tibial band and tensor vaginae femoris are dealt with by the open method. The knee is then dealt with. The hamstrings are seldom sufficiently tight to require lengthening. Only very occasionally, in the presence of a severe contraction, the tendons or semitendinosus and gracilis may be lengthened by Z shaped division performed through an incision in the popliteal space.

N.B.—*The semimembranosus tendon should under no circumstances be divided or elongated.*

The tendo-achilis is elongated by the Z method. The patient is stretched comfortably by the abduction frame with the lower extremities fully abducted, the knees straight, and the foot at right angles.

At the end of three months, the splint is taken off during the day and movements are sedulously practised. At first these are painful; but if both passive and active movements are carried out vigorously the pain disappears and the patient will make efforts to walk.

For the first two weeks, frequently during the day, adduction, flexion and extension of the hips must be carried out. This should be done with and without resistance.

At night the feet should be attached to the sides of the bed in order to maintain abduction.

After the first few days the splints should be removed twice daily the muscles well massaged, and both active and

passive movements of ankles, toes, knees and hips encouraged.

Walking may now be taught. Walking must be carried out under the direction of a nurse or an intelligent parent. Thomas's walking knee splints are to be ordered to prevent the knees from bending. A child can walk with two walking Thomas's new splints. The boots should be made of felt with substantial shoes. The patient must keep the boots and splints both day and night.

It is most necessary to teach the patients to walk properly.

The special points regarding walking are:

(1) Swinging of the lower limbs must be prohibited.

(2) Therefore crutches should not be allowed until the patient has been taught to stand unsupported.

(3) During the early stage of walking the limbs should not be approximated.

(4) Every step must be deliberately perfected, the feet being maintained in a proper distance apart and the toe and heel coming in contact alternately with the ground.

RESULTS: If properly treated and the after-treatment supervised, a child, aided by hands or sticks, will be able to walk distances in from 12 to 24 months, and this with perfectly straight limbs, and toes and heels on the ground. Later on many cases will manage with one stick only, and others will dispense with all kinds of artificial aids.

With the improvement in the physical condition, the mental outlook is widened.

The treatment of spastic paralysis should be rigorously systematic; the case must be under the surgeon's control for 12 months. The surgeon's work does not cease with the operation, he becomes the patient's physician for both body and mind. Specially trained nurses are required to manage these children and

educate them. Scholastic institutes for the care of paralytic children of all classes should be instituted. These cases should be treated on a surgical basis; the pessimism conveyed by Sir William Gowers and other distinguished neurologists still prevails. One can see how surgery can be silenced in the matter.

These cases should not be left to the care of the masseuse or native bone-setter in the hope that nature will eventually do something towards their care.

PREVENTION: Antenatal examination of mother to foretell an abnormal labour is essential; instrumental labour will have to be conducted with all care.

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VOMITING IN CHILDREN

By

DR. V. RAMA KAMATH.

Vomiting is a symptom, and not a disease. The causes that give rise to vomiting are numerous—some may be very trivial and others very serious. In case of children the physician has to depend upon his observation and indirect history gathered from the parents and therefore he may at times get confused while deciding the rationale and indications, for the treatment of vomiting in children. A clear knowledge of the gastric movements and of other factors that give rise to vomiting is essential for understanding the aetiology of vomiting as it is only a symptom. The mechanism of vomiting consists in the closure of the pyloric sphincter, the contraction of gastric muscles from the pyloric orifice to the cardiac orifice of the stomach. At the same time contraction of the abdominal and respiratory muscles compress the stomach to drive away its contents through the oesophagus. The stomach is not only a reservoir but also a churner of the food and the pyloric orifice is the controller to allow or not to allow the food to pass further down. The higher controlling nervous mechanism and centres not being developed in children, the sympathetic activity predominates and any slight violation of laws of nature relating to food brings on vomiting in children in addition to more serious causes resulting in regular pathological conditions.

MECHANICAL VOMITING: Slight overfilling of the stomach may bring on vomiting in children so also slight pressure over the stomach and any other movements of the body disturbing the contents of the stomach. Such vomiting comes on within a few minutes after nursing. The vomited matter is small and the milk is hardly altered. The stomach contents are brought out without retching and there is no uneasiness exhibited nor there is any pain. In fact a child may be seen smiling when a little food dribbles

down the mouth. A mother who gets a baby for the first time may at times get worried when such vomiting is frequent and the family physician will be forced to prescribe medicine. The prescription in such cases should not be drugs but advice to the mother to keep the child at breast for a shorter period than she used to do and not to disturb the child soon after nursing.

DYSPEPTIC VOMITING: The practitioner will do well to remember a few points relating to digestion in children. Alkaline and neutral fluids seem to leave the stomach without delay. Acidity or over acidity of stomach contents is brought about by foods and so different foods will have different reaction and they will be retained in the stomach not being allowed to pass through by the pylorus. It has been found out that carbohydrates without admixture of other food pass out quickly, fat and protein are retained longer, while fat mixed with starchy food, delays carbohydrate digestion and such a combined food is retained longest. These facts should be noted by the practitioner while treating children for vomiting.

Mental disturbance of any sort and fatigue causes the stomach to lose its tone as in these cases the sympathetic nervous system becomes more active which in its turn constricts the pyloric orifice. It must also be remembered that gastric function and movements are influenced by the condition of bowel, especially stasis. The food that enters the stomach its nature, its quality determines the efficiency of the remaining portion of the alimentary canal. So also reversely stasis or any other factor in the alimentary canal affects the function of the stomach.

It should also be not forgotten that the gastro-intestinal system is one of the

co-ordinating mechanisms in the human organism and it is therefore bound to be disturbed reflexly on account of any functional or constitutional changes in the other systems of the body. With the knowledge of the above facts vomiting as a symptom will be better understood and more rationally treated and controlled.

Next to the physiological or mechanical vomiting referred to above which is found only in breast fed children the next variety of vomiting which is very common in children, is due to bad artificial feeding. In addition to overfeeding the quality of the food is a most important factor to be considered. It is known that in children fed on cow's milk high percentage of fat is the chief cause of trouble. The vomit in these cases is highly acid due to the formation of fatty acids. There is a popular belief that the vomiting is due to formation of curds which are seen in the vomit. It is true that cow's milk contains proportionately large percentage of casein which gives rise to clots, yet the vomiting may not be due to these clots. The formation of milk into clots is a physiological process during the course of gastric digestion and these are expelled on account of the irritation due to fatty acids. Too much dilution of the milk may also cause vomiting.

TREATMENT: Tendency to rush to drugs is to be resisted and enquiries must first be made to find out the cause of vomiting. Artificially fed children are a source of anxiety both to the mothers and the medical practitioners and as a preventive measure mothers especially those educated on Western lines should be told that it is baby's birthright to be nursed by its own mother. This is usually forgotten by such mothers who are keen on fighting for their sex rights not minding their primary duties to their households. Unfortunately the problems of infant feeding by artificial methods are growing more and more in India to the extent of the spread of female education. I cannot be far wrong in saying that to the same extent the infant mortality is on the increase. So

the first responsibility of the practitioner when he is called to attend on a child suffering from vomiting is to find out if the mother has a supply of milk (especially if the patient is an infant) and is healthy and advise the mother that all her worries will come to an end if she permits her infant to enjoy its birthright. Then he should find out if his little patient is being given the artificial food in proper dilution remembering that the excess of fat in the food that is generally the cause of vomiting. Apart from the dilution of milk he should ascertain if the patient is having the adequate quantities of food and at proper intervals depending upon the age of the child and rectify this defect referring if necessary to the diet tables found in the standard books. In spite of the increase of specialists in the treatment of diseases of children (as in other specialities) it is indeed disappointing that the general practitioner in India has not as yet the benefit of the knowledge and experience of the pediatricians working in hospitals in regard to the artificial feeding of the infants suitable to Indian conditions.

If at the time of the first visit, the practitioner finds that the vomiting is acute he will do well immediately to wash the baby's stomach preferably with a solution of Soda bicarb (a dram to a pint of water) and for a few hours give the patient only water in small quantities at a time. If the baby is fed on milk, the milk should be diluted in the proportion to the age of the baby remembering that Indian babies cannot usually tolerate the proportion of cow's milk to water mentioned in diet tables and therefore the milk should be diluted a bit more than what is mentioned in books. It is always advisable to give the patent dried milk before resuming to fresh milk feeding during the course of treatment. Diluting the cow's milk with barley water instead of plain water is a very good device. It helps in emulsifying the milk which is consequently more easily digested. In older children thin barley gruel or gruel of any other cereal prepared with cow's milk is more easily tolerated. In delicate children Lactose is the best material for sweetening milk. If there be tendency for

constipation dextro-maltose is beneficial. Malt must be avoided if the child has diarrhoea. Acidified milk is a favourite recipe with some. The best way to do this is to mix the milk with lactic acid a drachm to a pint. The lactic acid is to be poured into the milk (a bit warm) drop by drop stirring the milk all the while. Home made butter-milk may be substituted if carefully prepared in clean vessels without making it too sour. Fat in the milk may be reduced to some extent by skimming it before diluting. The milk used for preparing butter-milk may also be skimmed. Peptonised milk may also be tried.

Breast milk in some mothers contains fat and sugar more than could be digested by delicate infants. So, in breast fed infants who suffer from vomiting mothers should be advised to drink a cup of water before nursing or better still the baby may be given a few spoons of water before it is put to breast.

Drugs should be prescribed only after the effect of correction of food is noticed and not till then. Addition of time-honoured lime water to milk (half to one teaspoon to two ounces of milk depending upon the dilution) may be the first prescription or addition of Soda citras to milk (1 gr. to 3 grs. to an ounce depending upon dilution). The next prescription to be thought of is a Bismuth and Soda bicarb mixture. Recourse to opium should be the last resource. There are some intractable cases where vomiting persists in spite of attention to feeding. They may be due either to hyperexcitability of the stomach or depression and debility of the stomach. For the former the following prescription may be tried for a baby three months old.

R/
Bismuth Carb. grs. 5 to 8
Gum Acacia. Q. S.
Soda Bicarb. grs. 5
Tint. Aconite. m. 2 to 4
Spt. Chloroform. m. 5
Aqua add. oz. $\frac{1}{2}$

1/8 part every two to four hours depending upon severity of vomiting preferably 15 minutes before food.

Aconite should not be added to this mixture in asthenic cases when Acid Hydrocynic dil will be a valuable substitute. If the baby vomits even the mixture the best thing to do is inject through rectum a solution containing

R/
Chloral Hydras. gr. $\frac{1}{2}$
Potas or Soda Bromide. grs. 2
Aqua. drs. 2

The following prescription has at times given very good results.

R/
Tinct. Iodine. drop 1
Acid Corbolic. drop 1
Aqua add. oz. $\frac{1}{2}$

1/8 part every 2 to 4 hours.

When it is surmised that the vomiting may be due to want of tone in the stomach Vin. Ipecac or Tinct. Nucis Vom is worth trial both in small fractional doses one or two drops in half an ounce of water for 8 doses, a dose to be given every two to four hours.

OBSTRUCTION VOMITING: Vomiting due to pyloric stenosis or pyloric spasm is at times met with in infants within a few days of their existence. There is still a controversy if pyloric stenosis is congenital or brought about after birth as a result of spasm. It is conceivable that both may exist and there may be spasm without stenosis due to hypertrophy of pyloric muscle fibres. Text books mention that vomiting due to pyloric obstruction are always in breast fed infants and usually male. In my practice of 32 years I came across only two cases one in the early days another recently which I treated in consultation with Dr. M. B. Prabhu, M.D., M.R.C.P. of the Government Hospital for Women and Children. The former lived for eight months, that is six months after I diagnosed the trouble to be due to pyloric spasm. The latter baby died in the third month. Both were males and breast fed. In the former case I was called in 15 days after the vomiting was persisting when the baby was a month

and a half old. The second baby came exclusively under my care about 21 days after its birth and Dr. Prabhu was consulted when the baby was about a month old. Both the cases had the characteristic vomiting which as described in books was *forcible and projectile*. In the second case, a ball-like movement (peristalsis of hypertrophied pylorus) could be distinctly seen moving from below the ribs on the left side to the right soon after the baby was fed. This sign was not visible in my first patient. The characteristic features of vomiting as well as peristaltic movement of pylorus were not observed in the second patient at the commencement of the illness in the second week of its birth. These became marked when the baby was about a month old though vomiting started in the third week of birth. Very likely the first case was pyloric spasm and the second pyloric stenosis. This is why the former managed to live for 8 months. Evidently at each feeding larger quantity of the feed passed through the pyloric orifice in this case more than in the other, as the obstruction was due to hypertrophy of the muscles of the pylorus and not spasm. The vomit rarely contained anything else than the food given and was always several times more in quantity than that given immediately before vomiting due to the retention of previous feeds. Books say that in majority of these cases vomiting starts between the second or sixth week. Naturally the infants were constipated. Hunger was capricious, at times voracious and at times the babies had no inclination to be fed. The infants looked like living skeletons.

TREATMENT: In the books it may be seen there is still divergence of opinion regarding treatment evidently due to the doubt whether the obstruction is due to only spasm or hypertrophy of the muscle fibres of pylorus. I should say that it is possible that a baby is born with congenital pyloric stenosis and it is also possible that the trouble may begin primarily with spasm and later on lead to hypertrophy of the muscle fibres of pylorus resulting in stenosis. If the obstruction is due to only spasm and the

hypertrophy of the muscle fibres does not set in, there may perhaps be a chance of relieving the spasm eventually, by judicious feeding and administration of antispasmodics. Small frequent feeds and daily washing of the stomach is the usual ideal to be followed. Breast milk is not contraindicated. It may be drawn and given in small quantities by spoon or bottle, skimmed milk or patent dried milk with less fat may be tried. Administration of a thick sweet gruel prepared out of barley or corn flour does control vomiting for a few hours or perhaps a day or two. Regarding drugs Belladonna or its alkaloid Atropine Sulphate in suitable doses seems to be the only one to be relied upon to be given a few minutes before feeding. Gentle massage over the epigastrium may also help to relieve the spasm. In a recent issue of the Lancet very good reports were published on the treatment of pyloric spasm by the use of a patent drug called Eumydrin. By the administration of this preparation combined with careful and judicious feeding many babies are said to have been saved.

From my experience even of only two cases (it is just possible I would not have been able to diagnose more) I am of opinion that the moment one sees a regular pyloric tumour starting prominent in the epigastrium moving from left to the right immediately the infant is fed, the best thing to do is to have recourse to operation the risks of operation being far less these days than expectant treatment. Moreover the risk of operation will be more if the child is wasted far too much. In fact, in the second case under my care we were thinking of operation almost every day but as the infant had jaundice to begin with, it was considered that operation at that stage was contraindicated. In the interval the variety of feedings that we had recourse to, each of them giving temporary relief put us off to determine the need of operation till at last the operation was ventured and the infant stood it very well. A few feeds were given after operation without vomiting. But all at once about 10 hours after operation the infant suddenly sank down and succumbed.

CYCLIC VOMITING: Till about ten years ago no mention was made of this type of vomiting in any standard book except in journals. In 1932 a paper on this subject was contributed by me under the heading 'Cyclic Vomiting.' In the recently published books both in Great Britain and America this variety of vomiting has been described under one of the three headings, *Cyclic Vomiting*, *Periodic Vomiting* or *Recurrent Vomiting*. It is characterised by the attacks, appearing in intervals of weeks, months or years. The duration of attack is said in books as two to three days but in all cases which I had treated, the attacks continued for over a week before I tried insulin treatment and after this treatment was adopted by me the attack did not last for more than a day. Holt and Howland say in their book on the 'Diseases of Infancy and Childhood' that the vomiting 'may date from infancy'. The few cases I saw were between the ages three and four. They also say that 'the cases are seen chiefly in private practice' and I can endorse this statement, for, at the time I wrote the article on the subject in 1932, I enquired at both the Children's Hospital in Madras and if I could depend on my memory, it was then said that no such cases were ever treated in both these hospitals. The exciting cause is not a definite one but may be usually traced to the child's having taken large quantities of seasoned food. Fatigue and excitement may start an attack any febrile illness such as influenza, attack of tonsillitis may be the beginning of the trouble. English and Scotch authors say that children who are given cream or fatty food are prone to this type of vomiting. Children suffering from this sort of vomiting are of nervous temperament. I came across not more than half a dozen cases all about two years of age and all the children belonged to rich or above middle class and all were males. Out of these cases one continued to have attacks till the 15th year and the other till the 18th.

The vomiting would start quite suddenly attended with severe retching and unbearable suffering. Even a drop of water cannot be retained. Vomited matters consist of frothy mucus, at times

streaks of blood and plenty of bile. Fever starts on the second day if it is itself was not the exciting cause and ranges from 100° to 102° F. The intensity of vomiting is so severe that even on the first day of the attack there are fears of death due to exhaustion. Child is actually in stupor, eyes half open, tongue dry, throws away clothing and prefers to remain naked. Abdomen flat and flaccid, urine scanty and invariably contains acetone bodies. All my patients were subject to constipation. Though the condition looks almost always alarming, deaths seem to be very few none of my patients died. The practitioner who sees the patient for the first time is likely to be frightened at the sight of the patient and very much baffled to diagnose the case. The first idea that may get into him would be any organic disease of the brain such as tuberculous meningitis. Appendicitis or intussusception may also be suspected. In all cases of vomiting of children patient observation and as patient an enquiry about the present and past history of the case would be of immense help in deciding the line of treatment. Usually in these cases there will be a history of previous attacks and usually the parents would say that the vomiting started without any cause. There will be no history of the child having been given any indigestible food as in acute indigestion. Doubts of appendicitis may be brushed aside by the absence of pain, tenderness and muscular rigidity. Intussusception may be ruled out by the severity of vomiting and the absence blood or mucus in the stools also by the fact that intussusception is a disease of infancy. Above all the practitioner should not fail to examine the urine at the very first visit. Presence of acetone bodies will be a clear evidence for coming to a conclusion.

TREATMENT: Regarding diet the same indications to be followed as in other varieties of vomiting withholding milk totally till the vomiting is controlled. Fruit juice accelerated the vomiting in my cases when given at the commencement of the attack but was well borne later. Gastric sedatives have little or no effect so also large doses of Bismuth or even alkalis like Soda bicarb. Yet the indication is

to administer large doses of Soda bicarb. along with glucose feeding. It is mentioned by Holt and Howland that due to some unknown metabolic changes at the beginning of the attack the blood sugar falls down and acetone bodies appear in the urine in large quantity and after a few days spontaneously the blood sugar rises again even without any treatment.

The presence of acetone bodies in the urine and the peculiar hurried respiration characteristic of acidosis prompted me to have recourse to Insulin therapy early in 1931. The effect was marvellous. I first gave 5 units for a boy nine years old and fed him on glucose powder as this was retained more than any other fluid even water. The dose was repeated every six hours. Later I felt bold to give bigger doses not exceeding 10 units. Instead of giving one big dose I thought it was safer to use medium doses at intervals depending upon severity of vomiting. After I had recourse to Insulin there was no need for me to think of anything else excepting divided doses of calomel to relieve constipation which is rather stubborn in these cases. My faith in Insulin therapy is so well established that I may confidently recommend its use in all cases of vomiting attendant with acidosis. I might mention in this connection that it is a routine with me now to examine urine in all diseases attendant with vomiting even

in adults. I had a few cases of Influenza and Malaria where vomiting was a most persistent symptom and Insulin glucose therapy relieved them instantaneously.

The other types of vomiting such as appearing in *acute intestinal obstruction*, *acute peritonitis* in *febrile diseases especially in small-pox*, in *uraemia* or other diseases where toxic materials are absorbed in the system or in nervous diseases such as *meningitis*, *tumour of brain* etc., are not peculiar to children only.

It should be noted that the vomiting due to brain complications resembles very much in its character to that of pyloric stenosis or spasm being *forcible and projectile*. The fact that such vomiting has no relation to feeding should clear all doubts in these cases. Treatment of vomiting being always symptomatic, the rationale and indications in the latter types of vomiting are just the same as for ordinary vomiting, gastric sedatives being called for more than anything else. In all varieties of vomiting the strength of the patient has to be maintained by the administration of stimulants not contraindicated for the original disease, administration of glucose by mouth, rectum or skin being the sheet anchor and also administration of saline solution by the skin, rectum or vein to maintain the needs of the body as these two ingredients are constantly drained with each fit of vomiting.

- References:** (1) The Diseases of Infancy and Childhood (Holt and Howland).
(2) Practical Therapeutics (H. A. Hare).

NOTICE.

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Abstracts.

THE VALUE OF RADIATION THERAPY IN SKIN CARCINOMA

ARCHIE FINE, M. D., AND SAMUEL BROWN, M. D., CINCINNATI, OHIO

From the Tumor Clinic and Department of Radiology Jewish Hospital, Cincinnati, Ohio.

With the improvement in methods of physical measurement of roentgen rays, radiologists have progressed a long way from the hit and miss methods of former years and are now able to deliver a predetermined dose to a tumor with much the same precision as physicians prescribe a dose of medicine.

The x-ray unit of measurement is known as the roentgen, the definition of which need not concern us here. Suffice to say that depending on the current, voltage, filter and distance, an erythema dose varies from 350 to 600 roentgens. An erythema is that quantity of x-radiation which when applied to the skin at one sitting will produce a definite blushing followed by brownish pigmentation in ten days to three weeks. Other factors entering into the production of x-rays may be briefly discussed. The voltages used in treatment of skin carcinoma ordinarily range from 100,000 to 200,000 volts or 100 to 200 KV. The higher the voltage the shorter the wavelength and the more penetrating the x-rays. Superficial therapy is the term applied to x-rays generated at from 100 to 140 KV; medium therapy 140 to 170 KV; deep therapy 170 to 250 KV; and super voltage 250 KV and higher. The use of filters requires some definition. The beam of x-rays proceeding from the tube is not a homogenous one, i. e., it consists of quantities of various wavelengths each of which have varying degrees of penetration. If one is treating a lesion which is quite superficial and thin, it is not necessary to use highly penetrating rays. If the lesion is deeply infiltrating, then it is highly important to use wavelengths of considerable penetration as otherwise the deeper layers of tissue will not receive a therapeutic dose, for most of the rays will have been absorbed in the top layers of tissue. The function of filters is to absorb

the longer wavelengths and to permit only the more penetrating or shorter wavelengths to pass through so that the beam becomes more homogenous. In practice with voltages up to 140 KV the filtration is usually 1 to 6 mm. of aluminum, from 140 to 165 KV, 0.25 to 0.5 mm. of copper and 1 mm. of aluminum; and from 170 KV and up copper and tin are used 0.5 mm. or more in thickness.

Radium and roentgen rays have approximately the same therapeutic effects and can be used interchangeably. In our Clinic we use x-rays more frequently, not that it is any more effective but we have found it time-saving and more convenient.

Radium is a metal which is used in the form of a salt, usually radium sulphate, and is contained in a metal needle, capsule or plaque. Radium is in a constant state of activity and it is because of this activity that energy is emitted in the form of alpha, beta and gamma rays. The alpha, beta particles are relatively poorly penetrating and in practice are usually absorbed by metal containers. The filters most commonly used are brass; lead, gold or platinum expressed in terms of thickness of platinum. The usual thickness of platinum used is about 1 m.m., though of course this varies with different workers. It might be added that the order of filter ability is monel metal, brass, lead, gold and platinum, the latter being the least penetrated by the gamma rays.

Types of Skin Carcinoma—There is as yet no universally accepted classification for skin carcinoma. For the sake of simplicity they may be divided into basal cell, basal-squamous cell, and squamous cell carcinomata. Carcinomata arising in old draining sinuses, burns, lupus, and following x-ray or radium burns present special

problems of treatment but time and space do not permit extended discussion.

Basal Cell Carcinoma—Basal cell carcinomata grow very slowly, rarely, if ever metastasize but if neglected may invade deep, important structures and cause extensive destruction of tissue with death from infection, exhaustion or hemorrhage. They are found on the face usually above the oral margin, ear and scalp and they rarely involve the mucous membrane primarily.

The clinical diagnosis is not a difficult one, though at times it may be quite difficult. Regardless of the certainty of diagnosis a biopsy should be done if possible. Although there are several forms of basal cell carcinoma the early forms present themselves as a nodule or group of nodules which are discrete or conglomerate, firm, waxy or translucent having a mother of pearl appearance. Occasionally telangiectatic vessels may be seen on the surface of the mass. The lesions may be stationary or undergo active growth. Some time later there occurs ulceration with formation of a crust which is picked or falls off, leaving a raw surface on which another crust soon develops. If the peripheral involvement progresses more rapidly than that in the deeper cutis there may occur areas of ulceration several mms. to cms. in diameter with characteristic rolled edges. Depending upon such factors as the stage of the growth and the location, the lesion may assume many clinical forms, there being nodular, ulcerating, flat, deep and cicatrizing types. Treatment of these lesions will be discussed under the same heading.

Basal Squamous Cell Carcinomata—This tumor is composed mainly of basal cells with groups or nests of squamous cells with pearls scattered here and there. They comprise about 10 to 15 per cent of basal cell carcinomata and are clinically indistinguishable. They are considered more resistant to radiation therapy than pure basal cell tumors and have a tendency to metastasize.

Squamous Cell Carcinomata—Squamous cell carcinomata, Broders, Luns-

ford and Taussig comprise about 15 per cent of the skin carcinomata. The common locations for lesions primary in the skin are the scalp, ear, face and dorsal surfaces of the hand. It commences as a small nodular or flattened area of infiltration which sooner or later undergoes ulceration. It may be papillary, covered with crusts and assume a considerable elevation, varying from several mms. to cms. in diameter. Although usually single, when developing secondarily to lupus vulgaris, or erythematosis, senile keratosis or chronic radiodermatitis, it may have multiple foci of origin.

The lesion metastasizes frequently, though, in our experience such an occurrence is often long delayed. Differentiation from the basal type is made by rapidity of growth, development in a precancerous lesion, lymph node involvement, absence of rolled edges and mother of pearl nodules. Microscopically the diagnosis cannot be mistaken. However, there are types of keratosis, and old ulcers which show marked and irregular epithelial proliferation with numerous pearls which may at times be indistinguishable from cancer. We feel that such cases should be treated as cancer.

Treatment of Cancer: The results of treatment of cutaneous cancer are generally speaking, quite satisfactory when adequately carried out. There are only two satisfactory methods, namely surgery and irradiation. The use of caustics and carbon dioxides now have their place in the treatment of very superficial precancerous lesions, but should only be used by an expert who knows their limitations. As to surgery and irradiation, there should be no quarrel among their proponents. Certain lesions properly belong to the surgeon, especially do we refer to those cancers developing in previous inflammatory processes, such as lupus vulgaris, old ulcers and scars which on account of the marked fibrosis of the tissue cannot stand heavy doses of radiation. Metastatic carcinoma in lymph nodes should be preferably excised rather than irradiated if at all possible. Of course, when the lymph nodes are matted to-

gether or fixed to the skin, they are beyond the realm of surgery and should be irradiated. Where the lesion is small and localized, instead of taking a biopsy from a portion of the cancer it is safer to remove the entire lesion, a procedure which has been called excision biopsy.

As to the form of surgery whether the cold scalpel or electrosurgical method, there again is no quarrel. Some feel, that the electrosurgical method has the advantage that it seals the lymphatics and the blood vessels which may possibly prevent metastases. We wish to draw attention to the danger of using electrodesiccation which is applied to the lesion by sparking. Usually the physician uses no anaesthetic. He does not remove the top layer which is merely desiccated, while the tumor remains viable underneath and oftentimes, in the case of moles, stimulated to grow. Lesions which are of large size, especially those which occur on the face cannot be handled conveniently by surgery, as the resultant scar may be, cosmetically speaking, quite disfiguring.

Radiation of Skin Cancer.—The factors determining the choice of method have already been outlined. Considerations of radiosensitivity have been overemphasized. An adequate dose of radiation delivered by a competent, well trained radiologist with adequate treatment facilities will cure the majority of skin cancers. All our failures, except two, have occurred in those cases which have been treated with inadequate doses of radiation applied haphazardly or by injudicious, lackadaisical surgery. A heavy responsibility devolves on the first man treating a case of skin carcinoma as the success or failure of therapy will depend on him.

Our method of roentgen treatment varies depending on the size of the lesion, location and thickness. Many radiologists apply a smaller dose to the basal cell carcinoma than to the squamous cell carcinoma because of the former's greater sensitivity to x-ray. We prefer to give the same dose to each, disregarding the histological diagnosis as we have seen occasional radioresistant basal cell carci-

noma. Moreover, a biopsy only represents a small part of the lesion and may miss the squamous cells in a mixed carcinoma. Where the lesions are small, we prefer to use low voltage unfiltered x-rays, applying three erythema doses at each of three sittings. Where the lesion is thicker, we usually use filtered radiation (1 mm. aluminum) for the second and third treatments. We formerly gave all the treatments in a week but we found the cosmetic results to be improved if the period of treatment is spaced over two weeks. When the lesion has been treated before, or has involved cartilage or deep structures we have preferred to use the method of Coutard which in essence, consists of small doses of x-ray given over a period of 20 to 41 days, heavily filtered (2 mm. of copper or zinc), the voltage being approximately 200 KV and the total dose 6,000 to 8,000 r. Although the total dose is tremendous, having been delivered over a long period of time the end results are cosmetically very good.

What has been said about roentgen rays applies with equal force to radium. However, it is an agent which can be very destructive when applied inexpertly. At the present time it can be rented very cheaply by any physician, and there is a distinct danger that it will be used by those who are inexperienced in its use and who may do considerable harm to both the patient and themselves.

It is often stated that a lesion which has once been treated by irradiation and which recurs cannot be cured by a second dose of x-rays. We have not found this to be the rule * * *. We believe that each case must be judged on its merits. Where there is considerable fibrosis of the tissue, evidences of over-dosage, then the tissues cannot safely receive a lethal dose and the tumor should be excised. Where the skin shows little or no changes or where the previous dose is clearly inadequate, then irradiation may be applied.

* * *
Results of Therapy.—Since the Tumor Clinic has been in existence only about three and a half year and, since in only a few of these cases have more than three

years elapsed, it would be hazardous to draw any statistical conclusions. Suffice to say that of seventy-eight cases treated, seventy-one have secured primary healing. Of the remaining seven cases, five failed to clear up or cancer recurred and had to be treated by other methods. Two other cases have been treated too recently to judge the effect of the treatment. It might be stated that of these five cases, four had been treated elsewhere with

x-ray, radium or surgery. Of interest are other statistics. Hazen and Whitmore reported in 1925 two hundred forty-four cases treated with x-ray with 88.8 per cent cured, and McKee in 1927 reported 90 per cent of six hundred forty-four cases cured. Others report figures ranging from 60 to 93 per cent cured.

* * *
(The Journal of Medicine, April 1939).

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EVALUATION OF THE INJECTION TREATMENT OF HERNIA.

F. I. HARRIS, AND A. S. WHITE, J.A.M.A.
Nov. 26, 1938, P: 2009.

The treatment of hernia by injection has been a controversial subject for over a hundred years. There was scepticism in the early stages. In the last five years this has been replaced by much enthusiasm. A planned and systematic investigation of the treatment of hernia by the introduction of irritant chemicals into fascial planes was begun. Experimental animals were used for study of the reactions of the proliferative tissue to various solutions, and the biochemical properties of such solutions were critically analysed.

From 1933-1938, 573 patients with hernia of all types have presented themselves for treatment. Of this number 236 (41%) were treated by the injection method, 91 (16%) by operation and 246 (43%) by the application of trusses. Injection should not be attempted in irreducible hernias.

In the injection method, there has not been a single death. There have been no atrophy or sloughing of the testicles and no peritonitis or formation of abscesses. No impotence has resulted. In the hands of experienced surgeons familiar with the principles of technic, the injection method is absolutely safe and devoid of serious complications. There is a place for this method in the treatment of hernia. But the end results are not comparable to those obtained with surgical procedures.

Of the cases treated 134 (57%) were cured. These patients were examined from six months to three years after the removal of the truss. 66 patients (28%) were considered as possibly cured. 36 cases (15%) were complete failures.

The length of the inguinal ligament was an important factor in estimating the prognosis. The length is measured from

the anterior superior iliac spine to the spine of the pubis. When the length was less than 13 cm. the hernia was always of the pure indirect type. When it was near 15 cms. the hernia was often found to be a combination of the indirect and direct type. When the inguinal ligament was over 15 cm. the hernia was always of the pure direct.

With pure indirect inguinal hernia there is an 80% chance of cure; with combined (indirect and direct inguinal hernia there is only a 37% chance of cure, while with pure direct inguinal hernia there is only a 30% possibility of cure. Recurrent post-operative inguinal hernias show 22% cures. Reducible umbilical hernias have shown a 100% chance of cure. Femoral and most incisional hernias are totally unsatisfactory.

It must be conceded that the treatment is of a very prolonged nature. There is considerable annoyance and inconvenience to patient and physician. In some cases the number of injections even exceeded 50 while the average was 11.

CONTROL OF URINARY SECRETION BY THE ANTERIOR PITUITARY.

B. G. SHAPIRO.

L: Dec 24, 1938. P: 1457.

The author's conclusions are as follows:— (1) The effect of oestrin in diabetes insipidus supports the pathological findings of Von Hann that the presence of functional anterior lobe tissue is necessary for the production of diabetes insipidus.

(2) The effect of large doses of oestrin and of anterior lobe preparations on urinary excretion provides evidence for a diuretic function of the anterior pituitary in man.

(3) It is suggested that the polyuria of Cushing's syndrome may be a manifestation of anterior pituitary hyperactivity.

(4) The response of urinary excretion to oestrin is considered to provide evidence in man of the "pituitary release phenomenon" described by Clauberg and Breipohl.

RENAL CHANGES IN MALIGNANT HYPERTENSION.

C. WILSON AND F. B. BYRON.

Experimental Evidence:—L: Jan 21,
1939 P: 136

The authors conducted their experiments on rats. In young adult rats of both sexes the kidney was exposed by a lumbar incision and the renal artery was compressed. In 65 per cent. of the rats the blood pressure rose from the normal 106 mm. Hg. to a level of 106—180 mm. The authors' conclusions are:—Sustained hypertension has been produced in rats by occlusion of one renal artery. Histological changes are often found in the opposite kidney and these appear to be identical with the lesions of malignant hypertension in man. It is concluded that these changes are due to the vascular strain imposed by a rapidly developing hypertension; renal failure apparently plays no part in their origin. These findings strengthen the conception of malignant hypertension as a form of essential hypertension in which the renal lesions are a secondary manifestation.

In hypertensive rats the occurrence of these lesions is frequently associated with a clinical syndrome consisting of weakness, wasting, convulsions, and coma, which is not accompanied by nitrogen retention and which is relieved by excision of the ischaemic kidney. The similarity, both clinical and histological, which frequently characterises the terminal stages of various forms of chronic Bright's disease is attributed to a vicious circle in which hypertension produces renal vascular lesions and thereby further reducing the bloodflow through the kidneys, aggravate the hypertension and lead to rapidly progressive renal destruction and functional insufficiency.

CHRONIC SYNOVITIS OF KNEE JOINT TREATED BY SYNOVECTOMY.

G. A. L. INGE,

J. A. M. A., Dec. 31, 1938, P. 2451.

The author bases his report on 86 cases treated by him. The operation is contra-indicated in tuberculosis, in which prompt recurrence was the sequel in the six cases attempted by mistake.

The technique was uniform. It consisted in two vertical parapatellar incisions. The synovial membrane was

excised from the anterior compartment and suprapatellar pouch only, except in one case, in which there was a herniation into the popliteal space and a separate operation was required. The infrapatellar fat pad was removed as a routine. Post-operative care was consistent in that gentle passive and then active motion was begun within 48 hours after operation in almost all cases. Bacteriologically the joints yielded nothing of particular interest. Pathologically typical monoarticular chronic villous synovitis, which constituted the disease in most of the cases, probably cannot be classified under either of the great commonly accepted divisions of rheumatoid arthritis or osteoarthritis. The change consisted of first hypertrophy and hyperplasia of the synovial layer of cells, so that this membrane is thrown into large villi and redundant folds, and secondly of thickening of the sub-synovial layers by oedema, fibrosis, engorgement of blood vessels, and scattered foci of cell infiltration. The round cell infiltration is usually perivascular and characterized by the presence of large numbers of plasma cells, thus simulating the histologic appearance of certain syphilitic lesions.

The author's conclusions are that, in this method of treatment there was 95% chance of improvement and 60% chance of restoring a practically normal joint. Cases of osteoarthritis with secondary synovial hypertrophy gives gratifying results from this operation. For rheumatoid arthritis synovectomy cannot be depended on to give symptomatic relief in more than about half the cases and many knees are made worse by the operation.

Tuberculosis of the synovial membrane is a strict contraindication for synovectomy, however early the diagnosis is made.

PULMONARY OEDEMA AND EMBOLISM

As complications of insulin shock in the treatment of Schizophrenia.

J. M. NIELSEN; S. D. INGHAM;
K. O. VON HAGEN,

J. A. M. A., Dec. 31, 1938, P. 2455.

Pulmonary oedema developed in three cases and pulmonary embolism in one

during insulin shock treatment for Schizophrenia. There are serious dangers, which might occur in one out of seven cases.

Before a patient is given insulin treatment one must be prepared not only to restore consciousness lost through insulin shock but to treat acute and possibly fatal pulmonary oedema with every means known for resuscitation. In treating pulmonary oedema one first attempts to restore consciousness by intravenous injection of dextrose; the patient then takes oxygen or oxygen carbon-dioxide mixture by inhalation, the physician simultaneously administering atropine, epinephrine, coramine, caffeine and morphine intramuscularly.

HYPERTENSION A CENTURY AFTER BRIGHT.

R. W. SCOTT,

Dec. 31, 1938, J. A. M. A., P. 2460.

Bright ascribed cardiac hypertrophy to increased peripheral resistance, which he believed was due to renal disease. He was the first to consider the renal origin of hypertension in 1836. In 1872 Gull and Sutton concluded that diffuse vascular disease is a primary pathologic entity responsible for increased arterial pressure and founded a school which stressed the non-renal origin of hypertension, a teaching which has influenced accepted conceptions even to the present day.

In 1882 Basch introduced the sphygmomanometer into clinical medicine and attempts were made to correlate hypertension with sclerotic changes in the blood vessels. In 1893 Von Basch after observing many cases of hypertension without demonstrable changes in the arteries, concluded that the elevation in blood pressure was but a precursor of arteriosclerosis. In 1915 Albutt expressed the belief that hypertension was primarily due to generalized vaso-constriction which finally led to organic changes in the smaller vessels. There remained the question of what caused the vasoconstriction, but the kidney was not considered

seriously as playing a major role in the production of this type of hypertension.

In 1934 Fishberg's view was:—"Essential hypertension is merely a collective concept for a number of conditions having in common the positive characteristics of arterial hypertension and the negative one of absence of primary renal disease. Hypertension, like fever, is merely a symptom, and not a disease, sometimes hypertension is produced by renal disease, but more often it is not".

Goldblatt from 1928 onwards began his animal experiments designed to impair gradually the blood supply to the kidneys. He constricted the main renal artery by a special clamp so designed that any degree of narrowing up to complete occlusion of the vessel could be produced. He has shown that constriction of the renal artery of one kidney in both the dog and the monkey causes an elevation in the systolic and diastolic pressures which lasts for weeks or months, whereas narrowing of both renal arteries at once or after an interval results in persistent hypertension, which has continued in some animals for six years. The elevated blood pressure following the constriction of one renal artery promptly returns to normal on either removal of the ischemic kidney or release of the clamp on the artery,—a crucial experiment illustrating the role of the kidney in raising blood pressure. Chronic hypertension is observed in animals that show no evidence of excretory insufficiency—the experimental counterpart of so-called benign essential hypertension in man. Also the picture of malignant hypertension with uraemia, including widespread arteriolar necrosis, can be produced almost at will by further narrowing of the renal arteries. In other words, a dog with benign hypertension lasting for several years may be thrown into the malignant phase with uremic death in a few days, or the acute malignant phase can be produced in the beginning by severe constriction of both main renal arteries. Arterial and arteriolar sclerosis of the renal vessels leads to renal ischaemia, which by humoral mechanism produces an increased muscular tone in the peripheral arterioles and thus causes elevation in the systemic blood pressure.

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THE PUBLIC HEALTH ACT AND THE GOVERNMENT'S RESPONSIBILITY.

The presence of a medical man in the cabinet has made it possible for the Madras Government to revolutionise the Medical and Public Health administration for the good of the public and time will be the best judge to give the final verdict. There cannot be any difference of opinion about the usefulness and utility of the Public Health Act. The Minister of Public Health who was the sponsor of the Bill took considerable pains to make the Bill as useful as possible, by incorporating in this measure almost all the provisions of the English Public Health Act of 1936 and other enactments existing in Great Britain before 1936. It is also a consolidating enactment containing the existing Local Board and Municipal Acts to which are added certain clauses such as regulation of fairs and festivals and control of venereal diseases etc. In fact the enactment is a "Death Relief Act" to use an expression of its author when he introduced the Bill in the Legislative Assembly. It is said that the rules and regulations for the practical working of the Act are now ready. So far so good. But we wonder if the Government have any apprehension of the obstacles to the working of the Public Health Act that are likely to come from the very Local Authorities which are entrusted with its working. We have been painfully observing all these years a tendency in those who

represent the people in the Local Bodies and Municipalities to set at naught the opinion of the experts in the Health Departments under those bodies. There are certain trades which are a source of nuisance to the public, others which require constant supervision of the Health Staff so that the foodstuffs prepared by those practising these trades are not contaminated or otherwise made unfit for human consumption. Mills, smithies, condiment factories, rice-mills, oil-mills, cattle yards, bakeries, sweetmeats shops, meat stalls, etc., come under this category. The owners of all these trades should obtain licenses from the executive authority of the Municipalities before they begin the trade. In case of a refusal order from the executive authority appeal has been provided for in the existing City Municipal Act and District Municipalities Acts. In the major municipalities the appeal is to the Standing Committees and in the minor to the Municipal Councils themselves. The purpose for getting the license to run these trades is to have a check on them so that, high sounding machine vibrations, noxious effluvia, smoke, etc., may not cause nuisance to the public residing near by. In the Public Health Act provisions and penalties provided for to take cognizance of acts of omission and commission on the part of the public offending health laws at least those relating to dangerous trades are just the same as in the City Municipal Act and District Municipalities Act. But what do we find in practice? The health con-

science of the Local Authorities does not depend upon the ideals of health and well-being of the people but on other considerations. Noises coming from high sounding vibrating machinery or the offensive irritating odour produced by any trade in the midst of residential quarters have at times a soothing effect of music and scent on the peoples representatives constituting the Local Authority. In all civilized countries efforts are made to lessen noise in busy congested places; even blowing of motor horns are prohibited but the prevailing ideal seems to be in Madras that citizens living in crowded localities cannot suffer more by additional noises in such localities. In India the sense and conception of nuisance even in the judiciary do not seem to be of the same degree as in Great Britain. High sounding electric machinery whose vibrations were so severe as to damage buildings was not considered to be a public nuisance in Madras whereas in England a citizen could get an injunction to stop the knolling of a church bell. Under such circumstances the Madras Government would do well to make the Madras City Corporation as a model training centre for the successful working of the Public Health Act by the Local Authorities. The Government cannot have a better opportunity than now when they have a solid majority party in the City Council and in the largest number of other Municipal Councils and Local Bodies. A healthy convention has been established by the Congress Ministers attending the meetings of the Local Bodies and the Health Minister who is so much interested in the welfare of the people will do well to attend a few meetings of the Health Standing Committee of the Madras Corporation on occasions when the expert opinion of the Health Officer is in conflict with the view of the majority

of the members of this committee. The Minister is a medical man and his presence at the meetings of the Standing Committee will certainly have a far reaching salutary effect.

The next step worth the consideration of the Government is to find a suitable agency to co-operate with the Public Health Department in its propaganda to create a sanitary conscience in the public. Processions, exhibitions arranged for the purpose of propaganda relating to Public Health Act by official, political or social parties will have only fleeting spectacular impressions on the public mind. Coercive action through Courts is sure to excite the masses and make them doubt the purpose of the Health Act as is the case with the introduction of Hindi in schools. The only profession that can afford to be free from political bias at least in regard to health laws, is the medical. We are glad to observe that the Public Health Minister whenever he has occasion to address public meeting makes it a point to do propaganda for popularising his pet Act. While doing so he reminds his audience about the ancient ideals of *Suddacharum* (personal hygiene) and he tells them that because the vast majority of people have forgotten the ancient ideals, he was forced to introduce a special Health Act. We dare say such propaganda conducted by a Minister who is a medical man himself will have a lasting effect on his audience. We trust it will be possible for the Public Health Minister to realise that next to him the members of the medical profession in active practice are the best agents to popularise the health laws. Ways and methods to create a co-ordinating contact between private practitioners and the health staff may be devised by the Government, the Health Minister taking the lead. The success

of the Congress depends mainly on mass contact and the success of the working of the Public Health Act, has to depend entirely on the contact of those working it with the medical practitioners. Practical demonstrations of cleanliness, disinfection, preventive inoculation by a popular medical practitioner who has the co-operation of the preventive staff in affording all facilities by the bed side will make preventive medicine as popular as the curative. The Government have started training centres for introducing the Wardha Scheme of education, for teaching village industries and for other purposes. Each one of these activities must cost the Government some money. But it will cost the Public Health Minister only some time to inaugurate centres to popularise health laws. Such an activity will serve him as a pleasant hobby and relaxation as the minister will have opportunities of coming in contact with the members of the medical fraternity in the midst of his more taxing political activities. It is true his political activities and sacrifices more than those relating to his profession that raised him to the position as a member of the Government. But the ultimate success of the Government both in preventing as well as in curing of diseases and in the more important work of creating a sanitary conscience in the people has to depend upon the co-operation of the private medical practitioners who should be treated as a limb of the Public Health Ministry. The more the Public Health Minister associates himself with his professional comrades the greater will be the welfare of the people and with it their prosperity.

BRAHMARISHI TESTS FOR MEDICAL LICENTIATES.

In the history of this world, people who have secured privileged positions,

by reason of birth, hard work, or by fluke, cannot even dream of admitting others into their sanctum sanctorum, without inflicting on the aspirers, a very rigid test which might well-nigh break the backs and spirits of the majority. That in spite of these rigid tests a Visvamithra was admitted as a "Brahmarishi" by Vasishta, and a low born Nanda could find realization and consummation with Lord Nataraja, speak of the unexampled heroism of these great aspirers. But these stray exceptions cannot solve the problem as a whole. This problem is all prevalent, in every department of life, and the position of the medical licentiates is no exception. It is common knowledge that a few licentiates especially those in Government service who were denied the privilege of qualifying themselves for higher medical qualifications in their land of birth went to British Isles and obtained the membership and licentiate diplomas of different educational institutions in England, Scotland and Ireland. One amongst them was able to be a fellow of Royal College of Surgeons, England. The private practitioners amongst the licentiates who naturally minded to learn more of practical medicine and surgery preferred to go to Vienna and obtained various special qualifications. One such practitioner recently returned from Switzerland passing the M. D. degree of the Laussane University in the first class and topping the list of successful candidates representing many nationalities including the English and the American.

It was indeed bad to have conceived water-tight compartments and castes in a science which deals with the ailments and infirmities of the human beings. Medical science is one and fundamentally there should be only one standard and one system. An age-long error has been rectified by an

enlightened and bold iconoclast in the person of the Public Health Minister at Madras. All credit to his fore-sight and courage. Provinces, other than Madras, are still groping in the dark and surprisingly enough the majority opinion seems to be in favour of retaining the different standards. The average human mentality is always to cling with tenacity to anything which is handed over to them, and brooking no changes. It is this conservatism that has been a dead weight to progress. The average bureaucrat might be clever, efficient, honest, but by temperament and training he is unfit to conceive and hold visions for the future. These bureaucrats in administration can only be compared to the ultra-conservative pandits or priests. In spite of the prevailing bureaucratic and conservative tendencies, a few years ago the Madras University permitted the medical licentiates of five years standing and who had the general education of Senior Cambridge standard, to appear for the M. B. B. S. Degree with an additional course of only two years. It was perhaps considered at the time that the Senior Cambridge standard of general education which was required in Great Britain for entrants to any kind of medical education was enough and would not be objected to by the General Medical Council, Great Britain. Some men and women licentiates from the Madras Presidency and very few from other provinces took advantage of this concession. Almost all of them belonged to service evidently their idea must have been not so much

to improve their knowledge but to improve their prospects in service. But unfortunately the Medical Council of India objected to the concession permitted to the medical licentiates and directed the Madras University to demand the Intermediate Standard of general education and pre-registration course and compulsory attendance for three years. This practically means debarring medical licentiates from appearing for the M. B. B. S. Degree. The object of prescribing a standard of general education for medical course is to get candidates who would be able to understand what is to be taught to them. A medical licentiate who goes through nearly 20 scientific treatises on various subjects on medical science all written in standard English language is far higher in his general attainments than a student who has just passed the Intermediate. To force medical licentiates of five years standing to go through Intermediate course for two years and in addition three years course in the Medical College is nothing short of the high standard demanded by Vasishta against Viswamithra before the latter was admitted as "Brahmarishi." Rishis can afford to have such inhuman standards but we mundane men must act like human beings in a rational and practical manner. Will the slow moving conservative members of the Medical Council of India try to lift up the Medical Licentiates? And will the other provinces in India follow the lead of the Madras Government and abolish the Medical Licentiate diploma?

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.

News and Comments

Health Insurance Scheme: The Vizagapatam Independent Medical Practitioners' Guild deserve the congratulations of the medical profession on their formulating a Health Insurance Scheme for Municipalities. The scheme is intended for the poor and middle class people and it is proposed it should be compulsory in the case of those whose monthly income is below Rs. 100. Those whose income is between Rs. 101 to Rs. 200 are given the option to join or not to join the scheme. Persons whose income is above Rs. 200 are not to have the benefit of the Scheme. The abstracts of the Scheme are published in the Correspondence Columns. The scheme can be made compulsory only to the wage earner special legislation may help only such cases. It cannot be made compulsory to such of those who have no means of livelihood. It is perhaps due to such and similar difficulties the Health Insurance Act is made applicable in Great Britain only to persons employed in industrial concerns and not made universal. It is the responsibility of the State to look after the Health of the poor and the unemployed who have nobody to depend upon. We may also say that a person earning Rs. 30 a month or below must be reckoned as poor for the purpose of the Scheme and the Local Bodies or Government may be made to pay the subscription on their behalf. The subscription for the lowest class of subscribers fixed at As. 2 a month is indeed very modest if not very low so also the visiting fee to the panel doctors. But the panel should not be restricted to a fixed number of practitioners. All registered practitioners who are willing to serve in the panel must be included in the panel and the remuneration fixed at a certain rate per month for each family, for the subscribers having the full liberty to choose their own doctors. A fixed monthly pay of Rs. 125 mentioned in the scheme each practitioner in the panel cannot be workable if the panel is kept open to all registered practitioners willing to join the panel. The framers of the scheme seem to have lost sight of maternity

surgical, ophthalmic and similar special services to the insured. We do not think it will be possible for the practitioners in the panel to serve the insured persons at the rate of Rs. 1.8.0 per head per year including the special services. Perhaps they expect that such services will be made available at the State hospitals. Evidently the scheme has been adjusted to suit the existing conditions in Vizagapatam where there is a well equipped Government Hospital affording all kinds of specialist services. In fact, basing on its own facts and figures the Guild has worked out the details of the scheme for the Vizagapatam Municipality and have shown a saving of Rs. 15,000 a month which the Municipality is said to be spending at present for medical relief.

A committee consisting of the District Collector (President) Municipal Health Officer (Secretary) the Chairman, Municipal Council, the Commissioner, the Superintendent, the King George Hospital and two private practitioners to be nominated by the framers of the Scheme, has also been provided for in the scheme, to look after its management. We are informed that the draft scheme has been submitted to the Government with a request to amend the District Municipalities Act so as to enable the local bodies to levy a special tax for meeting the expenditure of the Health Insurance Scheme. It is also suggested, we are told, that the employers of the subscribers to the scheme and the subscribers should be made responsible to share the yearly subscription equally to be paid to the Municipality in the form of a special tax. We trust the Government will give their support to the principles underlying the scheme and show a gesture that the Government are prepared to consider favourably any good schemes started by the medical profession to ensure the health of the public. In the meanwhile the scheme under reference may be taken up by the independent medical profession as a skeleton to work out General Medical Service to the public on the lines suggested by us in the Editorial on the subject last month leaving the question of medical relief to the necessitous poor

entirely to the Government. If a beginning is made by groups of medical men or recognised association throughout the province, the Government will be automatically forced to take up this question which is a most important problem that should be solved by the Government sooner or later. At the same time Municipalities, District Boards and even the Government should be demonstrated by the members of the profession that cheaper and more efficient medical relief could be given to the people in places where there are more than a couple of private practitioners if the out-patient departments were closed and that this work may be entrusted to the private practitioners, a panel of such practitioners being formed who should be paid at some reasonable rate within the financial competence of local bodies or of the Government. If this is done, real good service may be claimed by the poor and the medical man undertaking such work having to depend upon the good will of those whom he treats and not of those indirect agencies who pay him irrespective of good, bad or indifferent work.

Honoraries Pull Up Stipendiaries.—There was an old Government order No. 3600 P. H. dated 23rd December 1937 relating to Honorary Medical Officers, which prohibited them from admitting into their wards patients who consulted them outside. They were also debarred from receiving any remuneration from patients in the wards under their treatment for services rendered. In 1925 the then Surgeon-General found it necessary to pass the following proceedings:

"Medical officers who are entitled to take private practice should not treat private cases, for which they have received fees, in the Hospitals or dispensaries to which they are attached....."

There must have arisen some necessity in 1925 which compelled the Surgeon-General to pass the above proceedings. How far this order was obeyed is a matter of common knowledge and it may be safely said that the order was honoured more in breach. It must also be said that even the most loyal medical

officers must have at times found it very difficult to respect the order. The Government have since passed a new order No. M. S. 1029 P. H. dated 17-3-1939 removing the ban on the Honorary Medical Officers and permitting them to admit in their wards patients seen by them outside the hospital. The order is silent regarding the agency who approached the Government with a prayer to rescind the old order of prohibition. In the course of their new order the Government incidentally mention that so long the Government Medical Officers can have private practice they can also admit their private patients in the wards under their charge. Whoever made representations to the Government it is evident that the Government rescinded their old order in the interests of the patients.

Indiscrete admission of patients into the State Hospitals is certainly having a baneful effect both on the public as well as on the profession unless the paying patients are made to spend for their treatment in hospitals as much as they would have spent if they are treated at home including the paying of fees to the attending physician. The Government must be aware that in British Hospitals if the rich seek admission for any special treatment, they have to pay the fees for services rendered in addition to boarding and lodging and if the visiting specialist is a full time officer attached to the hospital all the fees go to the institution, if he is an honorary, the fees for services go to the honorary deducting a certain percentage, if hospital materials are used for rendering special service. The Government will do well to consider the desirability of introducing the system of payment as adopted in hospitals in Great Britain. If even the rich public are provided treatment in the State Hospitals at a cost much less to be incurred by them in their homes, there will not be scope or encouragement for starting private institutions and the hospitals are bound to be abused.

Can a Subsidized Practitioner be Punished? :—A subsidized practitioner is not the servant of the District Board and the only document which states about the

conditions of subsidized service is the agreement between the Government, the District Board and the practitioner. Nowhere in this agreement any sort of punishment is mentioned or even contemplated excepting the termination of the agreement. Ordinarily six month's notice has been provided for in case either of the parties wish to terminate the agreement. But the Board can terminate the agreement without notice for any breach in the agreement or for gross breach of conduct after giving the practitioner a chance to defend himself against the charges. But the District Board should obtain the previous approval of the District Medical Officer before terminating the services of the practitioner. In case the District Medical Officer does not agree, matter has to be referred to the Government whose decision is final. But the practitioner can appeal to the Government. As the appeal should go through the District Medical Officer then to the President, District Board; back to District Medical Officer and then to Surgeon-General and finally to the Government, it usually took several months before the appeal reached the Government. In the meanwhile the subsidized practitioner had to hang on without practice. Even if any office did not delay papers more than necessary, it usually took two months for the appeal to reach the Government and in case the practitioner had incurred the displeasure of one or the other officer concerned, the despatch of his appeal took several months to reach its destination and there were occasions when the Government had to send reminders. To obviate this delay the Provincial Subsidized Rural Medical Practitioners' Association made representations to the Government and the Government were pleased to add one more sentence to the clause dealing with the termination of agreement, which runs thus:

"The Board shall not terminate the services of the practitioner before his appeal to Government is disposed of by them provided that the practitioner appeals to Government within one month from the date of receipt of the President's order."

In a large number of cases the District Board terminates the services

of a practitioner who is not wanted by some member of the Board or other and when the professional record of such practitioner is good, the D.M.O. always comes in the way of the proceedings of the District Board President. There is yet another obstacle in the way of the President, he is not to terminate the services of the practitioner even in case the District Medical Officer's concurrence is obtained till the appeal is decided by the Government. So new methods of punishments are now adopted by some Presidents of the District Boards, which are *ultra vires*. In one case the practitioner is fined an amount equal to one month's subsidy. In another his agreement is suspended pending an enquiry against him and issue of final orders. The dispensary is closed and both the village people and the practitioner suffer. In a third case, it is said that charges were framed and enquiry conducted in the absence of the practitioner, concurrence of the District Medical Officer also obtained, the practitioner's services were terminated and subsidy for two months withheld though the practitioner has forwarded his appeal to the Government in time. We did express in these columns once before that if the subsidized practitioners do not suffer more than what they do now, it is due to the fact that District Medical Officers have a joint responsibility in the control of subsidized rural medical service. We wish to draw the attention of all the District Medical Officers that in cases like those mentioned above they would do bare justice if they bring to the notice of the Government through the Surgeon-General any irregular and illegal procedure adopted by the District Board Presidents in conducting proceedings against the practitioners and obtain a stay of such proceedings instead of allowing matters to drift. At the same time we would advise the subsidized practitioners to consult the Executive of their Association in time whenever they are in trouble. Many a time quite simple matters get complicated by not taking suitable action in time.

Public Health Sub-Committee: The readers may be aware that an All-India

National Planning Committee has been formed as a side activity of the Indian National Congress with Pandit Jawaharlal Nehru as the Chairman. This Committee has been subdivided into Sub-committees, to be in charge of industries, labour, agriculture etc., and we are glad that another Sub-committee, to be in charge of Public Health has been recently added to those already formed. This Sub-committee consists of: Col R. N. Chopra (Chairman), Dr. Jivraj N. Mehta (Secretary), Col. S. S. Shokhey, Dr. Bidhan Chandra Roy, Dr. G. V. Deshmukh, Dr. J. C. Ray, Dr. Bata and Col. Abdul Rahaman. The appointment of a lady doctor is under contemplation.

The scope and programme of this Sub-Committee is very comprehensive and seems to be much wider than the plans of the official Central Advisory Board on Public Health as could be judged by the following announcement:

"The Public Health Sub-Committee will deal with the following matters: Prescribing standards of dietary and nutrition for all classes of population; consideration of the nature and incidence of the various epidemics which take a heavy toll of life, and suggestion of ways and means for guarding against these scourges; investigation of the volume and causes of infant mortality, as well as mortality among women and suggestion of ways and means of reducing such mortality; provision of the necessary health unit comprising physicians, nurses, surgeons, hospitals and dispensaries, sanatoria and nursing homes; health insurance; medical training and research; compilation of vital statistics, including those of birth and death rates; cultivation of necessary drugs and production of medicines to provide the necessary preventive or curative aid and scientific surgical appliances and accessories of the national health services; and any other questions connected therewith."

It is very wise of the Congress leaders not to have insisted on Congress ticket for the admission of members into this organisation. It is indeed a happy augury that the leaders have gone a step further by inviting Government officers to serve in the National Planning Committee and it is said that Pandit Nehru has addressed the Central Government for permitting the officials to serve in the Committee. We wish the leaders will also realise the necessity of adequate representation to all

the Provinces especially in such a Sub-Committee as the one representing Public Health as the climate and other conditions of life differ very much in the sub-continent of India.

Indiscipline: It is indeed an unfortunate irony that when Ghandhiji is crying hoarse about indiscipline and corruption the tendency for the spreading of this infection is on the increase. Silly complaints are at times made much of while the most serious ones are condoned. Honest, straightforward, medical officers especially in the mofussil are to be afraid of *budmashes* who make free use of the names of the members of the Government. While in the medical circle itself the questions are raised to the effect what can the D. M. O., the Superintendent of a hospital or the Principal of a Medical College do to so and so? Even the Surgeon-General has his share. At times it is amazing to hear a few saying, "what can the Public Health Minister do to me?" Some recent events have shaken the faith fondly entertained by the public and the medical profession that discipline and corruption will disappear like a mist soon after the Congress assumes the reins of the Government. Those who are honest and god-fearing have been plodding on as usual being not affected by any changes while those who believe that the whole world exists for themselves are seen meddling to effect economy in expenditure, busy talking loud against corruption and are at times expressing surprises why Indians should be paid a pay over Rs. 500/ a month. A few are able to announce the Government Orders before they appear in the Fort St. George Gazette and inspire awe and regard for themselves. It is difficult to apportion the blame when the cry all over is for freedom of action and self-determination. To us it looks that the success of the popular Government depends more upon Government of the tongue. Will the Government be pleased to tell all those officials and non-officials who come in contact with them to talk less of nationalism, democracy, indiscipline and corruption and do more in action to demonstrate their virtues?

Correspondence, Reports, Etc.

AN ADDRESS

By

DR. T. S. SHETTY, M.D., Z.L.O., D.O.
(Vienna)

Under the auspices of the Stanley Medical College Students' Association Dr. T. S. Shetty, M.D., Z.L.O., D.O., (Vienna) an old student of the Royapuram Medical School now the Stanley Medical College delivered a lecture on "Post-graduate Study in the Continent" on 17th July 1939 at 4.30 P. M. Rao Bahadur Dr. T. S. Tirumurti, B.A., M.B., C.M., D.T.M. & H., Principal of the Stanley Medical College presided.

The President introduced Dr. Shetty as one of the most distinguished old students of the institution, who was well-known to the medical profession in this Presidency on account of his splendid work in the Ramnad District where he settled soon after he qualified himself. Some years ago, he went abroad and visited various clinics and specialised in Eye, Ear, Nose and Throat Surgery in Vienna, the Mecca of Medicine, obtaining the diplomas the Z. L. O., and D. O. Dr. Tirumurti said a couple of years ago he had an occasion to go to Chettinad, the centre of the activities of Dr. Shetty on the invitation of the Ramnad Medical Association, to preside over its annual gathering. He was the guest of Dr. Shetty and had an opportunity to see his private hospital in company with his friend Dr. V. Rama Kamath. They were pleased to see a well-equipped E. N. T. Clinic which compared very favourably with some of the State-owned special clinics in the Presidency. Dr. Tirumurti said that it must be a great source of inspiration and encouragement to the students and practitioners who passed out from the Stanley Medical School to see amongst them that evening Dr. Shetty who though not fortunate to be born with a silver spoon in his mouth, was able to work his way out as one of the most successful practitioners. Dr. Tirumurti mentioned that Dr. Shetty made good use of his money which he

earned by dint of hard labour by spending a good portion of it for gaining most valuable knowledge and experience in the foreign hospitals. Not being satisfied with the special knowledge he had in Ear, Nose and Throat Surgery, Dr. Shetty went to Switzerland recently and arrived a couple of days ago after his phenomenal success in passing the M. D. of the Lausanne University in the First Class topping the list of successful candidates amongst whom there were doctors belonging to various nationalities including the English and the American etc. The old *alma-Mater* must be proud of Dr. Shetty who deserved hearty congratulations of the entire profession in this Presidency.

Dr. Shetty gave an idea of his struggles to get a job soon after he passed from the Medical School. His ideal being to live an independent life he had to give up private service and had to take up private practice in a village which had a population of only three thousand. Yet, he said, he was not unlucky and when he was able to save some money he thought he should gain knowledge and experience in the ever advancing medical science and as there were no facilities in India for Post-graduate study or to gain even hospital experience in the case of L. M. Ps, he thought the best thing to do was to go to Vienna which he did and specialized in Ear, Nose and Throat diseases. Unlike in the medical institutions of Great Britain where little or no practical teaching was available even for Post-graduate study, a practitioner who went to Vienna had splendid opportunities of learning and practising surgical work first on the cadaver and then on patients themselves and the fee charged for such work was worth paying.

Dr. Shetty said that in addition to Vienna he visited Czechoslovakia, Hungary, France, Italy, Germany and last Switzerland, and nowhere there was such a barrier for an L. M. P. to appear for the University Degree of M. D., if he knew only the language of the place which in the opinion of Dr. Shetty could

he learnt within a few months. Dr. Shetty added that in Budapest and Prague, a post-graduate could get himself attached to a surgeon by paying him about Rs. 1,000 a month and could do any serious major operations. He regretted that facilities for obtaining higher medical qualifications were denied to L. M. Ps. in their own country. He deprecated the erroneous feeling prevailing in India that there was no scope for work for medical men. He said that he began his life in a village of only three thousand population and it was possible for him not only to get himself appreciated as a general practitioner and later he had had opportunities of doing specialist work especially in Ear, Nose and Throat Surgery. He said that a medical practitioner should not only know his profession well but also be a master of human psychology. A combination of both made a practitioner most successful. The practitioners should strive to be up-to-date in their knowledge and their ambition should be to train themselves in some speciality practice or other. It is indeed a curse that the L. M. Ps. should suffer from inferiority complex in spite of the fact that a large number of them or at least some of them were not inferior to others whose qualifications had a greater market value. To be able to stand the competition or to put it in a better way to be useful to the public, the practitioner belonging to the younger generation should be, Dr. Shetty exhorted his audience, thorough in the art of diagnosis employing all possible tests before coming to a conclusion.

He expected that popular educationists like Dr. Tirumurti and fighting journalists like Dr. Kamath would bestir the medical profession and the public so that the Government and the authorities in charge of the medical education would afford facilities for the L.M.Ps to qualify themselves for higher medical degrees instead of forcing them as in his case to go abroad for the purpose and achieve the same at a very high cost.

He thanked the Stanley Medical College Students' Association for giving him

an opportunity of addressing them. He expressed his gratitude to Dr. Tirumurti for his congratulations and good wishes and closed his address.

The President concluded by expressing his pleasure in hearing Dr. Shetty and said that his hearers would be very much indebted to him for his inspiring address.

Relating to the Post-graduate study in India Dr. Tirumurti said that though he was in entire agreement with what all was said by Dr. Shetty it was very difficult for him to do very much individually in that direction. The Editors of Medical Magazines like Dr. Viswanath and Dr. Kamath could make the people at least think of the desirability of affording Post-graduate training to medical men. The President closed his speech blessing Dr. Shetty and wishing him good luck.

The Secretary of the Students' Association thanked the lecturer, the Chairman and all those who attended the meeting.

THE MADRAS PROVINCIAL SUBSIDIZED RURAL MEDICAL PRACTITIONERS' ASSOCIATION.

Proceedings of the meeting of the Working Committee which met in Madras at the residence of the President on 2nd July, 1939.

PRESENT: (1) Dr. V. Rama Kamath, *President*; (2) Dr. B. S. S. Prasada Rao, *Vice-President*; (3) Dr. M. R. Bhat, *General Secretary*; (4) Dr. C. Kunjunni Nair, *Joint Secretary*, Madras South and (5) Dr. M. Krishna Rau, *Joint Secretary*, Madras North.

1. The Committee approves of the ruling given by the President that the Provincial Committee that existed before the General Body met at Samalkot last April do continue till the new Provincial Committee is formed and that the six months commencing from 1st July 1939 to 31st December 1939 be treated as an extension to the last official year ending 30th June 1939.

2. The Committee is of opinion that the propaganda to increase the membership of the Association be done by the Central Office at Madras and for this purpose a circular be sent to all the Subsidized Rural Medical Practitioners who are neither members of the Association nor the subscribers to The Medical Practitioner requesting them to remit to the Central Office Rs. 5 within 25th July 1939 and informing them that in case they do not do so, the July 1939 issue of The Medical Practitioner will be sent V.P.P. for Rs. 5/4 including postage to recover the membership fee from them.

Resolved also that a statement of account be sent to such of the Subsidized Practitioners who are in arrears of the membership fee of the Association and to the Subsidized Practitioners who are not members of the Association but subscribers to The Medical Practitioner requesting them to clear their dues to the Association and to The Medical Practitioner respectively so as to enable the Association to regularise the membership before the beginning of the next official year.

3. In view of the proceedings of the Committee No. 2 relating to the method adopted for doing propaganda to increase the membership of the Association, the Committee requests all the District Branches not to give effect to the resolution No. 24 passed by the General Body at Samalkot last April relating to the said propaganda.

4. The committee regrets that the Secretary-Treasurer of the Ramnad District Branch has not remitted to the Central Office the membership fee and the subscription to The Medical Practitioner collected by him from the Subsidized Practitioners in Ramnad District in spite of repeated reminders and authorises the President to take such action as is necessary to collect the amount from the said Secretary-Treasurer.

5. The President is requested to draft a memorandum to be submitted to the Government relating to such of the important resolutions passed by the

General Body at the last Conference held at Samalkot.

6. Resolved that the Honorary Members provisionally elected at the last Conference at Samalkot be enrolled as such in case their acceptances are sent to the General Secretary on or before the 15th August by the Proposers and Seconders of the respective Honorary Members after which date the enrolment of Honorary Members be not done.

7. Consideration of the following resolutions given notice of by Dr. M. R. Bhat:

(i) Resolved that the July issue (The Official Journal of the Association) The Medical Practitioner be sent one copy each to every member of the Association either on pre-remittance of Rs. 5 or by V. P. P. on receipt of acceptance card as the case may be.

(ii) That the District Branch Secretary-Treasurers be requested to send monthly reports of the activities of the Branch so as to reach the Head-Office on or before the 5th of the succeeding month.

(iii) That District Branch Secretary-Treasurers be requested to submit the following returns to the Head-Office on or before the 15th July 1939 (form appended).

(iv) That all G.Os available relating to Subsidized Rural Medical Relief Scheme be issued as supplement to the September issue of the Journal and supplied to all the members.

(v) That the Editor, The Medical Practitioner be requested to include the General Secretary of the P. S. R. M. Ps' Association as one of his Associate Editors of the Journal.

(a) The resolution No. (i) was not moved by the mover as the Committee passed a resolution on this subject appearing in the proceedings as No. 2.

(b) No. (ii) and (iii) were dropped without discussion.

(c) No. (iv): Resolved to request the Government to supply to the Association all the existing orders regarding the Subsidized Rural Medical Relief Scheme so as to enable the Association to prepare a manual on the Subsidized Rural Medical Relief Scheme embodying therein the Government Orders.

(d) No. (v) resolution was passed.

8. Consideration of the resolution was given notice of by Dr. M. Krishna Rau:

"Resolved that the District Branch Secretary-Treasurers be requested to send details of all the dispensaries in their respective Districts regarding Subsidies drawn by the practitioners, staff employed, and the furniture and other contingencies allowed, etc." (A form to be compiled).

The committee decided that there was no need for considering this resolution as the forms for admission into the P. S. R. M. Ps' Association contains all the information required by the mover in his resolution.

9. The President and the General Secretary are authorised to print 600 copies of the Memorandum and Rules of the Association as amended by the General Body at the last Conference held at Samalkot.

10. Resolved to authorise the President to conduct the proceedings of the Committee by circulation when the President considers that there is no need for summoning a meeting of the Committee.

There was an informal discussion about the necessity to start a fund to make provision (i) for the dependents of the Subsidized Practitioners in case of sudden death or bodily disability; (ii) starting of a central stores in Madras to supply the medical and surgical needs of the members of the Association; (iii) provision for a guest house for accommodating the members of the Association when they or their patients come down to Madras; (iv) publication and circulation of the duties and responsibilities of Subsidized Practitioners to the village folk to be printed in Tamil, Telugu, Kanarese, and Malayalam and supplied to the members of the Association for distribution in their villages.

It was decided that all the proposals discussed be incorporated in the circular letter to be sent to the non-members of the Association as referred to in item (2) of the proceedings passed this day.

GOVERNMENT OF MADRAS EDUCATION AND PUBLIC HEALTH DEPARTMENT

(Abstracts from two Government Orders.)

G. O. No. 1608 Dated 4th May 1939: The contribution made by the Thottavaluru Panchayat Board of Kistna District has been stopped.

G. O. No. Ms 2378 P.H. Dated 6th July 1939: The action of the President, District Board, North Arcot in transferring subsidized practitioners from one place to another especially from the Government subsidized to the District Board subsidized dispensaries and vice versa has been ordered to be irregular.

(Both G. Os in full will be published in the next issue, Ed.).

THE QUNTUR DISTRICT MEDICAL ASSOCIATION.

The General Body meeting of the Association was held on 20th May '39 at Narasaraopet, Major W. Happer, I.M.S., presiding. The meeting commenced with the reading of minutes of the previous meeting by the Secretary Dr. G. V. Hanumantharao and also the statement of accounts with the auditor's report by the Joint Secretary Dr. P. C. R. Raju, for the year 1938-39.

Dr. A. Umapathi Mudaliar delivered an interesting address on "Skin alterations on the fingers with reference to various abnormalities in the constitution of man." He said that he had been constantly applying his attention for the past four or five years in his practice to the clinical phenomena of the changes in the surface feeling of the skin on the dorsum of fingers in a variety of diseases both chronic and acute as Asthma, Tuberculosis, Hemiplegia, Leucoderma, Malaria, Strangulated Hernia, Cancer, Peptic Ulcer, and Diarrhoea etc. He said with emphasis that he noted invariably the skin changes as rough smooth thick and thin to feeling. The speaker added that one could develop in time a special tactile dexterity to differentiate the various degrees in the skin changes in the fingers. He proceeded that smooth and thin feeling

indicated a bad prognosis as opposed to rough feeling. Some cases demonstrated by the lecturer were examined by the audience. A lively discussion followed in which all doctors took part. He was asked many questions and the following were some of them.

1. Were such changes found elsewhere in the body excepting the fingers? Were toes in particular seen affected in any of the cases?

2. If fingers were considered to be most moving and active and as such affected mostly as pointed out by the lecturer why not the tongue not affected, since it is most active and possess the same epithelium as skin?

3. How heredity be established in the affection of children and how far anaemia and other maladies of pregnancy would not act on the new born adversely? How it could be accounted that a mother with 5 per cent Haemoglobin count had brought forth a baby with cent per cent Haemoglobin count? The lecturer laboured much to explain in an empirical way but failed to convince the audience.

It was agreed that Leucoderma has nothing to do with intestinal disorders and also it was pointed out in the discourse that internal secretions of various glands had to do a lot in such reactions on the skin. Finally the President concluded that the whole question was a novelty by itself in clinical diagnosis of cases and would require a thorough research to establish certain fundamentals.

The members dispersed after dinner at 8.30 p.m. and the host was profusely complimented.

A SCHEME OF HEALTH INSURANCE.

FOR MUNICIPALITIES.

Prepared by the Vizagapatam Independent Medical Practitioners' Guild.

ABSTRACT

1. All people with an income of Rs. 100 and less a month are to compulsorily join the scheme.

All those with an income of Rs. 101 to 200 can join the scheme at their option.

All those with an income above Rs. 200 are debarred from joining the scheme.

Compulsion is necessary as people do not understand the advantages of the scheme in the beginning and do not join it voluntarily if left to themselves.

2. The following membership fee shall be collected as a tax by the municipality, from all those with an income of

Rs. 25 or less per month.

Rs. 1-8-0 per year per family.

Half this is to be collected from the head of the family and the other half from the employer in all cases of employment of a month and over.

This works out to be less than 5 pies per head per month.

Actually it is less than 3 pies in all cases of employment.

Rs. 26 to 50 per month.

Rs. 1-8-0 per year for the head of the family, 0-12-0 per year for each dependent.

Rs. 51 to 100 per month.

Rs. 1-8-0 per year for each member of the family.

Rs. 101 to 200 per month.

Rs. 3 0-0 per year for the head of the family.

.. 2-0-0 for each dependant.

A family is to be taken as consisting of five members on the average.

3. A doctor is to be paid Rs. 125 per month and allotted 500 families or 2,500 persons to look after in an area subject to the following conditions.

(1) All consultations at his or the municipal dispensary are free.

(2) All visits, when necessary, to the families with an income of Rs. 50 or less per month are free.

Members with an income of Rs. 50-100 per month shall pay a fee of 8 annas for each visit.

All those with an income of Rs. 101-200 per month shall pay a fee of Re. 1/- for each visit.

The visits shall be made at the discretion of the doctor.

(3) Conveyance charges, if the patient's house is more than one furlong away from the residence or dispensary wherever the doctor is present at the time shall be borne by all.

Fees shall be paid to the doctor at the time of visit.

4. Medicine shall be dispensed by the municipal dispensary on the prescription of the panel

doctor, free of charge. (The patients are at liberty to buy the medicines from the local chemists or the doctor's dispensaries, if they so wish.)

5. The panel doctors shall look after their cases admitted into the municipal hospital and shall attend to all urgent cases.

6. The doctor of the area shall co-operate with the health officer for all public health work.

This is the scheme in general.

Rules in detail for the proper working of the scheme, when once it is accepted, can be drawn in consultation with the authorities.

Review.

PRONTOSIL.

A SURVEY OF THE NEW CHEMOTHERAPY.

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Messrs. BAYER REMEDIES LIMITED,

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Our usual experience with the literature supplied by manufacturing chemists has been the exaggerated versions of the virtues of their own products, so much so that medical practitioners, in general, always allow a liberal margin of commission in assessing the veracity of the claims. Indeed some of the claims are nauseating and at times totally repulsive.

But in the case of this publication on 'Prontosil,' we are glad to note that the manufacturers, have courageously admitted the failure of the 'Prontosil' to influence some of the diseases and thus have not claimed superlative virtues. The benefit and life-saving qualities of 'Prontosil' products in streptococcal infections, cases of meningitis etc., have been documentally proved in this publication.

The book is an authoritative review of the scope and uses of the sulfanilamides, and coming from the discoverers themselves, should help the practitioners, in understanding the rationale of this most wonderful modern remedy.

E. S. G.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the Month of June 1939.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance on 31-5-1939 ...	90 1 0	Postage ...	3 10 9
Subscriptions from members ...	11 8 0	Telegram ...	0 9 0
Entrance fees from two new members ...	0 8 0	Stationery ...	0 13 6
Advance from the President to meet office expense ...	7 1 3	Amount credited to The Medical Practitioner from the subscription for 38-39 paid by three members ...	1 8 0
		Pay for clerks for May 39 ...	15 0 0
		Contribution paid to Secretary-Treasurer of Trichy District Branch ...	4 0 0
			25 9 3
		Cash Balance : With Savings Bank ...	83 9 0
	109 2 3		109 2 3

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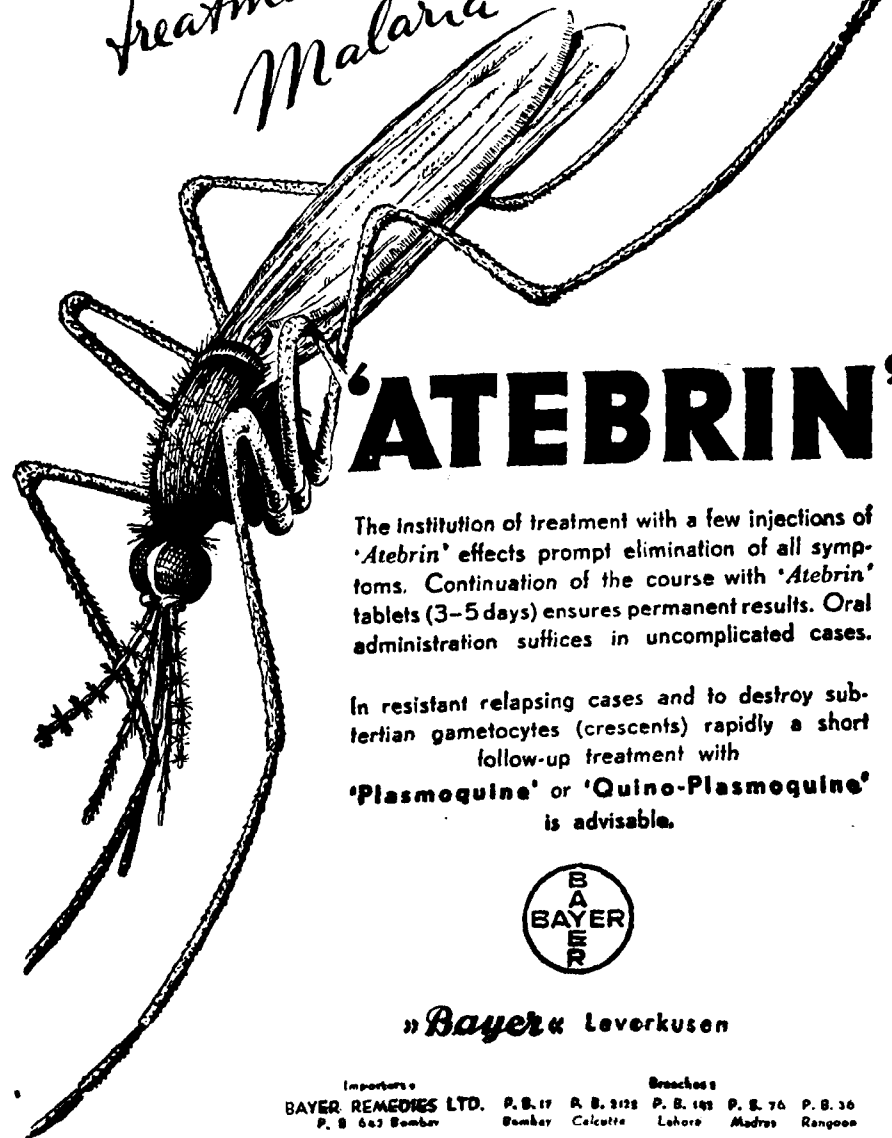
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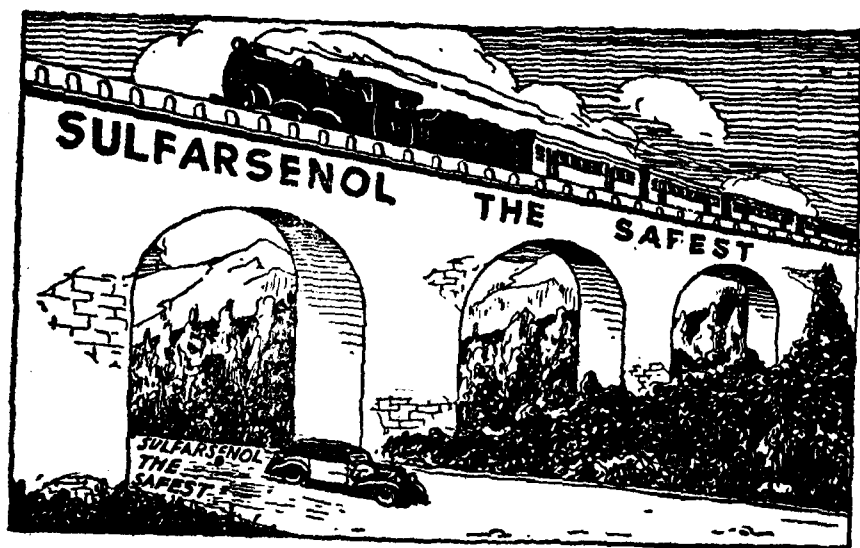
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A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath

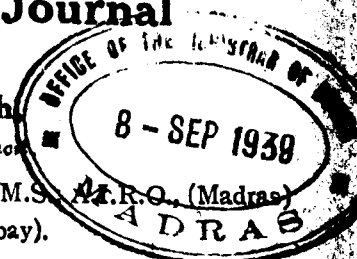
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AUGUST, 1939

[No. 11

Original Articles

MADRAS MEDICAL COUNCIL.

REVIEW OF PROCEEDINGS.

Special January 1939 Session and April 1939 Session.

BY

DR. V. RAMA KAMATH,

Member, Madras Medical Council.

An extraordinary meeting of the Madras Medical Council was held on 6th January 1939 for the purpose of selecting a permanent Registrar to the Council. Dr. H. S. Hensman, O.B.E., M.R.C.S., F.R.C.P., Retired Civil Surgeon was appointed on the scale of pay Rs. 150-10-200. Advantage was taken of this special session to fix provisional dates for the election of the members to the Medical Council to be constituted under Madras Medical Registration (Amendment) Act, 1938, as required by the Government in their memorandum No. 38135-a-2 D-1 P. H. dated 22nd December 1938. The following dates were provisionally suggested by the Council :

1. Publication of the Draft Rules of election and their confirmation on or before the 7th June 1939.

2. Election Proceedings.

(i) Calling for nominations—21st June 1939.

(ii) Last date for the receipt of Nomination papers—3 p.m. 7th July 1939.

(iii) Scrutiny of Nomination papers—8th July 1939.

(iv) Issue of Voting Papers—20th July 1939.

(v) Receipt of Voting Papers—4 p.m. 20th August 1939.

(vi) Scrutiny and counting of voting—11 a.m. 22nd August 1939.

3. Nominations by Government—5th September 1939.

It was further resolved to suggest to the Government that the present Council be dissolved on 30th September 1939 and that of the reconstituted Council might begin to function from 1st October 1939. The Government machinery cannot be rusty but moves very slow and the dynamic influence of Congress has not been able to make the machinery move quicker. As per the programme suggested by the Council, Elections ought to have been over by now. It is said that the President of the Council has sent a reminder to the Government and it is hoped that they will be



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matter will receive the early attention of the Government.

APRIL 1939 SESSION.

Before reviewing the proceedings of the first general meeting of the Council which was held on 17th April 1939, I wish to say a few words about the Medical Register for 1938. As required by the Madras Medical Registration (Amendment) Act, 1938, all the practitioners are grouped in one list in the alphabetical order and not in three parts as was the case before the Act was amended. The number of practitioners on the register as on 31st December 1938 is 6,329 as against 6,085 on the same date the previous year. Six names were removed on account of death, one name was erased on account of disciplinary action, one name erased temporarily was afterwards restored. During the calendar year 1938, 250 practitioners were registered. It is most regrettable that no serious attempts are made by all concerned in removing the blot left in the Medical Register during the black days of the administration of one of the previous Registrars. There are still found in the Register individual practitioners holding two registration numbers and two practitioners having one registration number. The Registrar was authorised by the Council to adopt any suitable procedure to avoid such blemishes. I learn that he addressed many practitioners who own such numbers and the response from the practitioners concerned was very poor. There is another recurring callousness on the part of the registered practitioners neglecting to inform the Registrar the change in their addresses. On account of this indifference, the Medical Register does not contain the up-to-date addresses of the practitioners. It is not possible for me to make a correct statement but I will not be far wrong if I were to say that over 50 per cent of the addresses of the practitioners appearing in the Register are not up-to-date. This indifference on the part of the practitioners could be remedied to a certain extent by the Registrar, at least in the case of those employed in the Madras Medical Department. The Registrar is supplied with the up-to-date editions of Civil

Medical List and he could easily obtain through the Surgeon-General's office the correct addresses of those under local bodies including the subsidized practitioners. I am sure the Railway Medical Department will not grudge to supply the Registrar the addresses of the medical men under their employ. By this means with a certain amount of diligence it may be possible for the Registrar to have correct addresses of a fairly large number of registered practitioners. Excepting a month before and a month after the two yearly statutory meetings, the office of the Registrar cannot have work for more than a couple of hours at the most. The Council has now a full-time Registrar in whom the Council has implicit confidence being a Retired Civil Surgeon with a good official record and it is hoped that no attempt will be spared by him in future to make the Medical Register an up-to-date clean document. I take this opportunity and appeal to the Registered Practitioners to co-operate with him by informing him not only changes in the addresses but also reporting about the deaths of the fellow practitioners. The Register is now full with the names of the practitioners who are dead. The Medical Registration Act has not been of much benefit to the Registered Practitioners. The Registered Practitioners have not been able to enjoy the full rights and privileges of registration. It has been a secluded body with an official element predominating. The amended Act has not gone far to make it really a non-official body. Unfortunately the Indian officials with the exception of one or two in the Medical Council have not as yet realised that the moment they retire from service the invidious privileges they have been enjoying cannot be enjoyed by them and that it is their office and not their qualifications nor registration that counted while they enjoyed the privileges denied to the private practitioners. Though I have been struggling hard to claim equal rights and privileges for all registered medical practitioners I am optimistic. If the members of the profession take keener interest in the affairs of the medical profession and return to the new Medical Council that will be constituted soon, a good team of elected

members, the affairs of the medical profession will be much better than it is at present. To do this the first task before the registered medical practitioners is to purify the Medical Register which is the electoral roll for the purpose of the elections to the Medical Council.

As usual I shall narrate about the proceedings of the April Session of the Medical Council under three heads,—Registration, Disciplinary cases, and Miscellaneous items.

REGISTRATION.

Messrs. Jogneshwar Chatterjee and A. D. Balasubrahmaniam both possessing the L. C. P. & S of India qualification have been registered. Mr. T. K. Sundaram was refused registration as his application reached the Registrar later than the date fixed by the Council for registering practitioners possessing the above qualification. This latter diploma and the one granted by the old Missionary School at Neyyor were recognised by the Council, to be fair to all those possessing these two diplomas, as in the past the Local Government permitted registration of practitioners holding the same. As referred to by me in one of the earlier reviews, in Bombay and some other provinces, the Medical Council is notified as was done in Great Britain soon after General Medical Council came into existence in 1858 that all those who practised Allopathy could be registered in case they applied for registration within a fixed period after the Medical Acts came into force though they were not trained in any recognised institutions. The Madras Medical Council did not do so. This was yet another reason that weighed with the Madras Medical Council to register the practitioners holding the two diplomas referred to above. As the date fixed by the Council is passed the Council will not in future register practitioners possessing these diplomas. The last person recommended for Registration from amongst the practitioners holding Neyyor Missionary Medical School Diploma was Mr. G. M. Samuel.

The Council refused to register Sri. N. M. Kar and Sri. N. M. Datta both possess-

ing the L. C. P. S. Diploma of the (old) National Medical College, Dacca. Sri. V. V. Krishnayya, L. C. P. & S. of Bengal was also refused registration. So also Dr. Loewenthal, M. D. (Berlin).

Before 1929 the Madras Medical Council was indiscriminately recommending registration of practitioners possessing foreign medical qualifications though there existed a reciprocity clause in the Madras Medical Registration Act. Majority of these practitioners were missionary medical men or women. Advantage was taken of this leniency by one or two non-missionary German medical men who got themselves registered. It was then that the Council began to realise its mistake and to be consistent with their new policy even the foreign medical missionaries were refused registration. It is now felt by various Medical Missionaries that giving effect to the reciprocity section, interferes with the good philanthropic work done by the missionaries. Dr. (Mrs) O. M. Monahan, one of the two Medical Missionary nominated members of the Council moved the following resolution :

"The Madras Medical Council recommends to Government that medical missionaries who come from non-reciprocating countries but possess a suitable qualification or degree be admitted to the register of the Madras Medical Council for such time as they continue to work with their medical missions, and do not carry on private practice for personal gain."

The resolution was seconded by Dr. N. Venkataswami Chetri. After some discussion a necessity for an amendment was felt by Dr. U. Krishna Rao who moved the following amendment :

"This Council further requests the Government to so modify the Madras Medical Registration Act, as to enable this conditional registration."

To me conditional registration seems to be not possible in the strict legal sense. The Medical Acts exist primarily to control medical education. The introduction of Reciprocity section in the Medical Acts seems to be not entirely in the interest of standard of medical knowledge in the practitioners. It is very likely that the need for this section was felt to guard the inter-

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ests of the indigenous practitioners as against those coming from a foreign country. The Provincial Councils should automatically register all those practitioners whose qualifications are recognised by the Medical Council of India. So it seems to me the best thing to do is to advise the missionary doctors to get their qualifications recognised by the Medical Council of India.

Awaiting the decision of the Government on the resolution moved by Dr. (Mrs) Monahan the Council further recommended to the Government that a missionary doctor Dr. Lydia Herlufssen possessing the M. B. Ch. B. Degree of Copenhagen and Dr. Miss B. Siebers, M. D., (Chicago University) be permitted to continue their missionary work for a period of two years at present. The latter is a lecturer in the Women Christian Medical School, Vellore. She was refused registration by the Council three years ago but on reconsideration, the council recommended her for registration. But the Government did not grant permission for registration but permitted her to do the teaching work. Such special permission must be obtained by medical institutions receiving Government aid if the staff of the institutions contain unregistered practitioners.

DISCIPLINARY CASES.

Complaint against Dr. P. Gopalachar, L. M. P. : Sri K. Seshacharu, B.A., Special Third Class Magistrate, Bander, Masulipatam preferred a complaint against Dr. P. Gopalachar alleging that the practitioner gave a false certificate. In support of his allegation he mentioned in his complaint that an accused in his court one Ch. Govindarajulu who along with another was charged for voluntarily causing hurt to one K. Jaganadan, the complainant in the case, produced a certificate given by this practitioner, in which four injuries were described. Two marks of identification were noted in the certificate, one—a depressed scar on the forehead; second,—one mole below the left clavicle. The object of filing the certificate by the second accused was alleged to be to prove to the court that the practitioner was in the habit of giving

false certificates. The second accused who produced these certificates had the identification marks described in the certificate but the Magistrate did not see on his body any marks of injuries described in the certificate. The Magistrate added that when the practitioner was summoned before the court and examined he, the practitioner admitted having issued the certificate but "sought to explain it away by the version that the second accused was not the person referred to in it as the identification marks did not tally being in slightly different positions". The Magistrate mentioned that the second accused was sent to the District Medical Officer, Kistna District who saw him three days after the date of the alleged false certificate and the District Medical Officer "intimated that there was no indication of the first injury, a linear wound 1" x 1/8" although there should have been some indications of it on that date...". Dr. Gopalachar when called upon to offer his explanation sent a lengthy statement out of which only relevant and important portions have been quoted :

"I wish to mention at the very outset that the extraordinary interest evinced by the Special Third Class Magistrate, in favour of a person who was originally accused in his Court, permitting him to deduce evidence against me, having recourse to questionable procedure, not usually adopted in any Court of law for such purposes, is highly suspicious.

Even granting that the certificate was false, there was nothing preventing a Special Third Class Magistrate to make out a case and prosecute me for perjury and convict me and after conviction he ought to have reported me to the Medical Council about my conduct. As a trying Magistrate, he had all the facilities to launch a prosecution against me, and give me also a chance to defend myself. If he had the courage of conviction, he would not have hesitated to do so instead of taking a circuitous way of launching a false complaint against me, to the Medical Council, on mere imagination. In this connection, I may also mention that the action of the Special Magistrate, in sending my certificate in question, i.e., Exhibit I to the District Medical Officer of Masulipatam, for his opinion, and without examining him in the Court to prove his opinion, is not only objectionable in law, but is an *ex parte* procedure. The object of the Special Magistrate in forwarding the copies of the opinion of the District Medical Officer, which was not proved against me, to the Medical Council, is only to prejudice the Medical Council against me and

cannot be taken cognisance of, till the District Medical Officer is asked to make a sworn statement, before the Council, and therefore cannot be taken as evidence against me. Moreover, the certificate given by me concerned with the case, C. C. No. 1/37, i.e., Exhibit A, was accepted to be genuine, by the Special Magistrate himself. The Magistrate has no business whatsoever to examine Exhibit I, and record his observations, before it is proved that the certificate was given to the person mentioned in it.

* * *

A Magistrate should not come to a judicial opinion about a crime, unless he has evidence before him, to corroborate his observation. The Magistrate did not, for reasons known to himself, permit me to prove the *bona-fides* and truthfulness of my certificate, which I would have easily done, by producing before him persons bearing similar identification marks. He has rushed to the Medical Council trying to make me a prey, to shield himself from any action, likely to be taken against him for having permitted an irregular and illegal procedure.

* * *

Coming to the certificate itself, I have clearly deposed before the Special Magistrate, who was the trying Magistrate, that the accused No. 2 of C. C. No. 1/37 was not the person to whom I gave the certificate in question, and the marks of identification seen by me in the Court, on the person of accused No. 2 did not exactly tally with the identification marks borne by the actual person who took the certificate from me. I can if necessary produce persons before the Medical Council, having on their body marks of similar description and more or less in identical places. It is surprising that the Magistrate, i.e., complainant against me, who has taken down statements on oaths, with his own hand has curiously failed to observe carefully, the contents of my certificate. The person to whom I gave the certificate, is a resident of Buttaipet (situated in the centre of the town) which fact is mentioned in my certificate, whereas accused No. 2 who is now alleged to be the person to whom I gave the certificate, has stated before the same Magistrate that he was the resident of Chilakalapudi (about two miles away from the town) as could be seen from the copy of the judgment, supplied to you by my complainant.

In the *moffussil* Courts, it is usual that all sorts of devices of questionable nature, are being committed for creating false evidence for or against contending parties and the subject matter of this complaint against me is one such device. The fact that the brother of Accused No. 2 in C. C. No. 1/37 who defended the case, was the person who brought the real man with injuries and made me to issue the certificate should be noted in judging the purpose of the deceptive part played by this Pleader in this case.

I am a young practitioner.....having settled in Masulipatam about six years ago com-

manding a pretty decent practice, both amongst poor as well as the rich. I have been issuing certificates, in the course of my practice and to the best of my knowledge, the veracity of my certificates, has not been questioned by Magistrates of much higher position, including amongst them members of Provincial and Indian Civil Service. I belong to a respectable family and herein enclosed, I am sending certificates of my character and respectability from persons of position, in Masulipatam."

As mentioned in his certificate he appended three certificates one from an ex-President of First Class Bench Court, second from the Presiding Magistrate of a Second Class Bench Court and a third from the Assistant to the District Medical Officer, Masulipatam. The Disciplinary Committee decided to proceed with the case and Dr. Gopalachar was summoned to appear before the Council at its meeting on 7th November 1938. But as he was not well he was asked to be present before the Council on 17th April 1939 which he did. The Council dropped the idea of proceeding with the case but simply sent for the practitioner who was advised by the President on behalf of the Council in these words, "You should be very careful in future when issuing certificates of this nature."

It is doubtful if the Medical Council has power to advise or warn registered practitioners unless the Council constitutes itself into a court under section of the Medical Act. This was indeed a serious case where a Magistrate takes advantage of his position makes some serious allegations against a registered practitioner not in his judgment though he had ample opportunities to charge the practitioner for perjury. The Medical Council exists to guard the honour and prestige of the medical profession. If the Council thought there was no case it ought to have dropped the case and reported the matter to the Government so that persons occupying magisterial position do not condemn registered practitioners as in the case of this practitioner unless the guilt is proved against him in a judicial tribunal.

There was an idea in days gone by that between two opinions—one from an official medical practitioner and another from a private practitioner, the opinion of the official should prevail especially so if he

happened to be a District Medical Officer or a Civil Surgeon. Fortunately this idea has now given place to a just one and all registered practitioners are judged by the merits and other circumstances of the case and not on opinions of registered practitioners in high official position. The Council is occasionally receiving complaints from judicial officials dealing in Criminal Justice against registered practitioners who had to give evidence or issue medical certificate to one party or other appearing before them. A few such judicial officers rush to the Medical Council as was done by a Third Class Magistrate in this case and as the readers will see from another case following, with the pre-conception that if they complain to the Medical Council that a particular practitioner told a lie before the court or issued a false certificate the Council would punish those practitioners complained against. It is a pity that even Civilian Magistrates do not seem to know that the Medical Council while trying registered practitioners is as good a judicial tribunal as any other court and it cannot punish practitioners for infamous conduct in a profession respect on mere reports unless the charges are substantiated by evidence. Unless the Medical Council makes up its mind to report one or two cases to the Government of the nature as against Dr. Gopalachar and the one following, it is not likely the Council can be rid of the inconvenience and annoyance caused to the Council and much more to the concerned practitioners. I feel it is also necessary to enact giving powers to the Council to grant damages to the aggrieved parties in case of vexatious and frivolous complaints. The practitioner complained against has to undergo lot of travelling charges both for himself and his witnesses not to mention the fees to the pleader he may have to engage.

Complaint against Dr. G. Ramayya, L.M.P., Madura: Mr. F.W.A. Morris, I.C.S., Joint Magistrate Dindigul was the complainant. The complaint was as follows:

"I wish to bring to your notice a most serious allegation that has been made against Dr. G.

Ramayya, L.M. & S., Registered Medical Practitioner, Madura. On 16th November 1938 in connection with M.C. No. 63 of 1938 on the file of this court, he gave to one Thavasia Goundar of Pallapatti the following certificate:—"This is to certify that Thavasia Goundar, son of Malaya Goundar of Pallapatti now at Madura is suffering from acute enteritis and is unable to move." This Thavasia Goundar is the C.P. (counter-petitioner) in the above mentioned case. On the strength of this certificate he was not present in Court on 17th November 1938 at 9 A.M. and his pleader asked for an adjournment. The pleader for the other side Mr. A. Ramayyar, Advocate, Madura, stated in open Court that the said Thavasia Goundar appeared before him on 16th November 1938 at about 8 to 8-45 P.M. when he appeared to be brisk, hale and healthy. His Junior Mr. Sarangapani who was also present at the time confirmed this statement.

I therefore request that action may be taken against Dr. G. Ramayya for issuing a false certificate in a professional respect as even supposing the said Thavasia Goundar went to him after seeing the two pleaders, he could not possibly have been in the condition alleged in the certificate.

The declarations of the pleaders Sri. A. Ramayya and Sri. K. Sarangapani in original are enclosed."

This was supported by the declaration of two Advocates, who said that the counterpetitioner was hale and healthy till about 9 P.M. on the day in question.

The practitioner in his explanation said that on 12th November 1938 late at night he was sent for by an Advocate Mr. Sankaranarayana Aiyar who introduced to him Thavasia Goundar. The Advocate mentioned to him that the Goundar had severe loose stools and at the time he saw the patient, he was lying on a blanket.

It is just possible that the Goundar started enteritis after he saw the other two Advocates at or about 9 P. M. We, medical men can conceive that an illness like enteritis might start all of a sudden. It is also possible that the patient might have even taken a strong purgative to deceive the doctor so that he might get a certificate. Even taking it for granted that the certificate was false, there was nothing to prevent the Magistrate to issue a non-bailable warrant against the counter-petitioner and summon the doctor and find out for himself the veracity of the certificate. He

could also get expert evidence on the spot. On the other hand he grants the adjournment asked for on the strength of the certificate and later makes a complaint to the Council expecting the Council to take disciplinary action against the practitioner. The Council rightly came to the conclusion that there was no case proved against the practitioner. How was it possible for the Council to find out on 17th April 1939 whether a particular person had enteritis on 16th November 1938?

Complaint against Dr. George Kuruvilla, L.M. & S. and others: On 12-11-1938 the Registrar received a letter from Dy. Director General, I.M.S., that one Dr. P. T. Joseph, F.R.C.S. was advertising himself. This information was supplied by one T. T. Menon. Evidently he was a candidate for I.M.S. It transpired that the advertisement was inserted in a newspaper by Dr. George Kuruvilla without the consent or knowledge of Dr. Joseph. Then Dr. Kuruvilla was asked to explain. In his explanation Dr. Kuruvilla said that he did not know that informing the public that a particular doctor visits a certain place or would visit a particular institution on a particular date was objected to by the Code of Medical Ethics. He added that he followed the procedure adopted by mission hospitals and to support his statement supplied to the Registrar a notice in Malayalam circulated under the signature of Drs. V. Devanayagam, Y. Abraham, T. Devanathan in which it was mentioned that Dr. T. H. Somervelle would visit certain hospitals on particular days. Of the three doctors only the first was a registered practitioner. So he was asked to explain. In his statement Dr. Devanayagam mentioned that he followed the usual custom of notifying to the villagers the visits of the Medical Missionary from Neyyor to Kundru as the people cherished an intense desire to be treated by Neyyor doctors. He also said that the missionaries were not serving for private gain. Dr. Somervelle sent another letter informing the Registrar that publishing notices of the visits of missionary doctors had been in vogue for 50 years and averred that

the notification served a public purpose and did not bring money to individual missionary doctors. He stated that if the Medical Council objected to the procedure he would stop it and made a suggestion, if a notice in general terms without the names of the doctors would meet the requirements of missionary service. Incidentally he mentioned that the complaint to the Registrar must have been made by an anti-Christian medical man who was 'himself contravening all the usually accepted moral ethics by having a system of touts'. He also stated that "Travancore papers were full of advertisements by qualified practitioners".

The above chain of complaints one author blaming the other when as a matter of fact all were blameworthy, came before the Council and the Council passed the following resolution:

"The Madras Medical Council is of opinion that it is a violation of the Medical Ethics to mention by name the doctor visiting the hospital. This Council requests Dr. Somervelle to send it a list of the qualified and registered medical practitioners who are advertising in the Travancore papers."

Complaint against Dr. Thambuswami Pillai, L.M.P. Nagapatam: On 22-7-1938 a complaint was received from Rao Bahadur K. Raman Nayar, Additional District Magistrate, Tanjore who was on deputation as a special officer to enquire into Port Health Administration, Nagapatam, alleging that Dr. T. Pillai had issued ante-dated vaccination certificates to three passengers by S. S. Rajula. The certificates in question could not be detained as the complainant said that he had no power to detain them. Their identity was verified as per statement appearing in the certificates and copies of certificates procured which were signed by the passengers and as one of them being a minor, his thumb impression was procured. One of the certificate holder mentioned in his statement that eleven more passengers were given ante-dated certificates by the same doctor. Khan Bahadur Hamid Sultan Marakkayar, M.L.C. had also given a statement relating ante-dated certificates. The Government in their Memo No. 23357-4-D. 1 P.H. dated 1st August

1938 have asked that the action taken by the Council should be reported to them in due course. The Government in another Memo dated 9th September 1938 stated that the authenticated copies of the vaccination certificates furnished by the complainant should be deemed quite sufficient for proceeding with the case. The legal adviser to the Council gave his opinion that the vaccination certificates could be proved by the person who prepared the authenticated copies. At this stage the practitioner was asked to explain his conduct. He made a lengthy statement in which he alleged that Khan Bahadur Hamid Sultan Marakkayar was his personal enemy. He also alleged that the latter was a broker of Madura Co., to sell tickets and usually a panic was created that no tickets were available so that the tickets might be sold for higher prices and therefore the passengers were at the mercy of the Khan Bahadur and could be made to give any statement. He added that the shipping company had its own Doctor to issue vaccination certificates and the Khan Bahadur had an interest in it. The Disciplinary Committee members gave their individual opinions when the file was circulated to them, but all agreed to proceed with the case.

When the case came before the Council after a lengthy discussion the Council passed the following resolution :

"In view of the vaccinated persons having left for Penang, and in view of the fact that the Port Health Officer allowed them to proceed on board the S. S. Rajula on 22nd May 1938, this Council is of opinion that no useful purpose will be served by now re-opening the question and investigating the case."

As it was an important case which if gone through would have given lot of information to the Council about the affairs relating to the issuing of vaccination certificates and the part played by the Public Health Department and the Shipping Company apart from the guilt or innocence of the practitioner complained against, I demanded a poll with the following result :

For:—Drs. U. Krishna Rao, N. Venkataswami Chetti, (Miss) Ida Scudder,

(Mrs.) O. M. Monahan, Lt. Cols. C. A. F. Hingston and V. Mahadevan.

Against:—Dr. V. Rama Kamath.

Neutral:—Dr. Y. Suryanarayana Rao.

Information against Dr. H. R. Sadasiva Rao, L. M. & S.:—The Registrar, Medical Council informed that Dr. H. R. Sadasiva Rao, Retd. Civil Surgeon published an advertisement in The Hindu that "Jaykar X-ray and Electro-Medical Institute will commence work from Monday the 20th February 1939." Under the advertisement the signature of H. R. Sadashiva Rao (Retired District Medical Officer) appeared. When the practitioner was asked to explain he said that the purpose of the publication was not to canvas but only to serve the purpose of a signboard. He justified his action and added that "persons like Premiers, other Ministers, Surgeon-General, etc., have been taking part in opening similar private institution" and as an example cited the function of the opening of Dr. P. Rama Rao's Cancer Institute by the Premier. In the end he said that if the President considered the announcement as opposed to ethics, he requested the President to excuse him. The Council passed the following resolution :

"Dr H. R. Sadashiva Rao should be warned"

The Council also requested the President to publish a warning notification in the lay and Medical Press informing medical men that all advertisements—including even the opening of private institutions, inviting lay-men to attend functions connected therewith and the publication of same in lay papers—by registered medical practitioners will be considered as advertisements under section 6 of Warning Notice and will be dealt with accordingly.

Appeal by Dr. A. Seshagiri Rao, Masulipatam:—The readers might remember as reported in the Review of Council's Proceedings November 1938 session, appearing in the April 1939 issue of The Medical Practitioner that the name

of this practitioner was ordered to be erased from the Register by the Council. It was mentioned in the Review that this was a good case for defence and that the practitioner did not care even to put in his appearance before the Council. The practitioner appealed to the Council on 2-2-1939 to restore his name. It is a pity that even after the lapse of 25 years since the Madras Medical Registration Act has been on the Statute Book, the practitioners are ignorant of the sections of the Act. In disciplinary cases appeal to the Government has been provided for against the decision of the Council, which should be preferred within three months from the date of the decision of the Council. The Council has no power to review its own order. It is highly improbable whether the practitioner would have succeeded in his appeal as he did not care to defend himself before the Council. All the same the Registrar ought to have rejected his appeal on the day he received the same advising the practitioner that the appeal should be forwarded to the Government.

Information against Drs. W. J. Fernandez, L.M.S. and N. V. Govindaswami Pillai, L.M.P.: Dr. M. Subrahmaniam Aiyar, M.B. & C.M., brought to the notice of the Registrar that the above mentioned practitioners had issued to Messrs. G. Martirosi & Co., certificates about the good effects of St. Antony's Balm. The Council did several times warn practitioners that issuing of such certificates was against the Code of Medical Ethics. The Council therefore ordered that explanations be called for from these practitioners.

Complaint against Dr. K. Satyanarayana Rao, L.M.P., Anakapalle: The District Medical Officer, Vizagapatam in his letter dated 16th February 1939 reported to the Registrar that the practitioner associated himself with an unqualified practitioner Sri. K. Narasimha Rao whose name was erased from the Madras Medical Register (as being registered by fraudulent means) and performed an obstetrical operation on a Mohammadan woman and had furnished wrong and false information involving another registered practitioner

and a registered midwife. The Council decided to proceed with the case. As the matter is *subjudice* it will be reported after it is being tried by the Council.

Complaint against Dr. Richard Appel M.D.: Lt. Col. C. A. F. Hingston, after some preliminary correspondence finally submitted a complaint against Dr. Appel on 13th February 1939 alleging that Dr. Appel violated the provisions of Code of Medical Ethics in having attended on the Yuvaraja of Mysore on or about 27th December 1938 while he was under the treatment of Lt. Col. Hingston as alleged by him. Dr. Appel was asked to furnish his explanation and in his reply mentioned that the Yuvaraja consulted him as early as in 1936 and when he came to Madras in December 1938, His Highness consulted him in his (Dr. Appel's room) on 27th December 1938 when Dr. Appel came to a conclusion that the illness was so grave that it was advisable to see the patient at his residence which he did on alternate days after 28th December 1938. Dr. Appel added that it was only on 10th January 1939 he was informed by his Highness that Col. Hingston was consulted for a cold when he was advised to undergo further treatment from Dr. Cherian. Dr. Appel stated that he was not bound to inform Col. Hingston about his treating the Yuvaraja as it was a pretty long time after the Yuvaraja consulted Col. Hingston that Dr. Appel had to treat him for quite a different illness.

The complaint as well as the reply from Dr. Appel were placed before the Council and the Council decided to drop the matter.

Complaint against Dr. Mani of Hosur: One Mrs. Thiruvengalamma of Kelamangalam made a complaint against the practitioner alleging that he at the instigation of a prominent person Mr. Sampangirama Setty issued a false death certificate without seeing or treating the patient. She added that Mr. Sampangirama Setty was the assignee of the deceased whose life was insured by the Oriental Life Assurance Company Ltd. In support of her complaint she produced a statement

signed by seven persons said to be close relatives and friends of the deceased. She also sent a statement later from Dr. Vasudevamurti, L.M.P., Denkanikota that he attended on the deceased on the day of his death. The Oriental Life Assurance Co., which was addressed to, informed the Registrar that they accepted the certificate granted by Dr. Mani as valid and genuine and that the claim amount has also been paid. Dr. Mani in his explanation mentioned that he saw the deceased once at the request of Mr. Sampangirama Setty as the latter had some interest in the deceased since his wife, had reassigned the policy to Mr. Sampangirama Setty; and as the latter did not pay her any money out of the policy amount she had complained against the doctor as a sort of revenge. The Council came to the conclusion that there was no case against the practitioner.

MISCELLANEOUS ITEMS.

G. O. No. Ms. 215 P. H., dated 20th January 1939: In this G. O. the Government turned down all the recommendations made by the Council to them for amending certain sections of the Madras Medical Registration Act, 1914 so as to enable the Council to turn out work more quickly especially the work relating to disciplinary cases. While recording the G. O. the Council passed the following resolution:

"This Council recommends to Government the need for amending the Madras Medical Registration Act to provide for the appointment of an Executive Committee consisting of not less than five resident members with the President as the convenor to do the executive functions of the Council".

G. O. No. Ms. 3981, dated 4th November 1938: The Government by this G. O. informed the Council that they could not comply with its request to suggest to Government of India that the vaccination certificate granted by all registered medical practitioners need not receive countersignature.

At my instance, the Madras Medical Council was the first to protest against the

procedure of counter-signing the vaccination certificates. The Government of India yielded partially and counter-signature on vaccination certificates issued to passengers going outside India was abolished excepting in case of passengers to the East and South Africa, Iraq, and Saudi Arabia. While recording this order I requested the Council to reiterate its protest against the countersigning of vaccination certificates which the Council did unanimously at its meeting held on 7th November 1938. This resolution was conveyed to the Local Government with a suggestion that the Government of India might be requested to do away with countersigning of vaccination certificates altogether. It is indeed most humiliating that the Government could not find its way to honour their own Statute, the Madras Medical Registration Act, the humiliation is felt the more when the Government of India could get the consent of the Governments in charge of the ports mentioned above that the Railway Medical Officers and Military Medical Officers could grant the vaccination certificates and also countersign them. This is certainly a blot on Provincial Autonomy. Too much advantage of the helplessness and the resulting callousness of the independent medical profession is taken in this country. It is desirable that the independent medical profession should have recourse to revolutionary methods as in politics for establishing equal rights and privileges to all registered practitioners.

L. M. & S. Degree of the Madras University obtained after 1892 not recognised by the Non-Federated Malay States: Some time ago as reported in one of the Reviews of the proceedings of the Madras Medical Council, the Hon'ble the Premier of the Madras Government forwarded to the Madras Medical Council, a letter received by him from one Dr. V. R. Menon, Assistant Medical Officer, Carey Island, F. M. S., complaining that the F. M. S. Government did not recognise the L. M. & S. Degree of the Madras University. The Council declined to take any action as the question of reciprocity outside the province is to be decided by the Medical

Council of India. The Madras Government pointed out to the Central Government that the L. M. & S. Degree of the Madras University is recognised by the Medical Council of India and that it was but proper that the Medical Council of India should take suitable action for the recognition of the Madras L. M. & S. Degree by the F. M. S. Government. It now transpires that this matter was referred to by the Central Government to the Executive Committee of the Medical Council of India which passed the following resolution at its meeting held on 25th October 1938:

"That in accordance with the scheme of reciprocity agreed to between this Council and the Federated Malay States, Indian qualifications are recognized in the States as and when such qualifications are recognized by the General Medical Council of Great Britain. As the L. M. & S. Degree of the Madras University is registrable in the United Kingdom if its holder began professional study before January 1st, 1892, and as it has ceased to be granted since 1935 no steps can be taken for its further recognition in the Federated Malay States."

After the above decision of the Executive Committee was communicated to Dr. V. R. Menon, the L. M. & S. degree holders in F. M. S. have submitted a memorial to the Prime Minister requesting him to do everything possible for the recognition of L. M. & S. degree by the F. M. S. Government. It is ridiculous that L. M. & S. degree granted after 1892 which is recognised by the Medical Council of India cannot get recognition by the G. M. C. though as a matter of fact the standard of Medical Education after 1892 has been steadily rising higher. The prestige of the Medical Council of India more than anything else demands that the Medical Council of India should procure reciprocal recognition of L. M. & S. Degree by all countries, the medical qualifications of which are recognised by the Medical Council of India. It is hoped that the Madras Government will pursue the matter. The memorial to the Premier was placed before the Council and the Council decided to refer the matter once again to the Medical Council of India.

Dying declaration—Responsibility of Private Medical Practitioners: Dr. T.

Kanakaraju, L.M. & S., of Ramachandrapuram wished to know from the Medical Council the responsibilities of private medical practitioners relating to dying declaration. The Council opined that the private medical practitioners are in the same position as State-paid medical officers relating to their responsibilities in taking dying declaration from their patients.

Indian Medical Degrees Act, 1916, Amendment: The Personal Assistant to Surgeon-General informed the Registrar that the Government called for definite proposals for the amendment of Indian Medical Degrees Act and requested the Registrar to place the matter before the Council.

The Council informed the Government that the Indian Medical Degrees Act, 1916, may be amended on the lines suggested by the Government as well as by the Medical Council.

Rao Bahadur Dr. T. S. Tirumurti's Resolution:

"As the volume of work has increased and consequently it is desirable and necessary that the Medical Council should meet more often in the year in order to effect quicker disposal of the complaints and other subjects which have to be dealt with by it at its meeting, this Council resolves that it should meet at least once every quarter, i.e., in March, June, September and December each year."

"This Council also resolves, in order to give effect to the above resolution consistent with its present financial position and the increase in the number of members in the future that the moffussil members of the Committee be given a lower rate of travelling allowance (to be fixed by the Council) for the purpose of attending the meetings of the Council".

The resolution was seconded by Dr. V. Rama Kamath, and after some discussion, was put to vote, with the following result:—

For: Rao Bahadur Drs. T. S. Tirumurti, V. Rama Kamath, and Lt. Col. V. Mahadevan.

Against: Drs. Y. Suryanarayana Rao, Miss. Ida S. Scudder, Mrs. Olive M. Monahan, and N. Venkataswami Chetti.

Foreign Medical Practitioners: The Delhi Medical Association forwarded to Madras Medical Council a resolution passed by it on 11th March 1939 which runs as hereunder:

"The Delhi Medical Association is of opinion that immigration of Foreign Medical practitioners to this country is prejudicial to Indian interests. In view of the statement made by Sir G. S. Bajpai in the Central Assembly that permission to practise medicine or the appointment of non-Indian doctors was primarily the concern of the Provincial Governments, the Delhi Medical Association requests the Medical Council of India, the provincial Medical Councils, and the Provincial Governments to maintain the status-quo in the current schedule of registrable

qualifications and to take active steps to stop this immigration. It enjoins on Sister Associations as well as qualified practitioners of the Scientific Western System of Medicine to beware of covering such Foreign practitioners in India."

The following resolution was passed:

"The Council endorses the views of the Delhi Medical Association and forwards the resolution of the Delhi Medical Association to the Government for consideration and necessary action."

As in the past the Review contains only the items which concern the medical profession. The items of a routine official nature have not been included in this Review.

NOTICE.

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THE ENDOCRINES IN GENERAL PRACTICE

By

DR. S. S. RAU, M.D.

There is hardly any necessity to impress on the minds of the medical practitioners the importance of the study of Endocrinology which has been advancing with amazing rapidity and there is hardly a medical man in the whole world who in his daily practice does not have recourse to organo-therapy. I have in a brief and concise way dealt with this subject hoping that my observations gathered from various authors will be of some use to the readers.

PITUITARY GLAND.

This is the queen of the endocrines. It presides over the destinies of almost all the other endocrines and the effects of her sway are felt far and wide in the human system. It consists of three parts, the Pars anterior, the Pars intermedia and the Pars posterior.

The Pars anterior is the most important of the three and consists of three kinds of cells, the chromophile which do not take in any stain, the eosinophile which take in the acid stain and the basophile which take the basic stain. The following hormones are secreted by it.

(a) *The growth hormone:*—If this is secreted in more than normal quantity gigantism results if the epiphysis have not united, if later, acromegaly results. In the latter condition the lower jaw, the upper jaw, the zygoma, the bones of the hands and feet enlarge, so much so, that the features change beyond recognition, the skin becomes rough, the hair coarse, and in some cases a dorsal kyphosis develops completing the picture akin to the gorilla, the human ancestor.

If the secretion is less, dwarfism results; but since the other secretions are also affected the dwarfism is associated with other features associated with those anomalies. The most important of these

is dystrophia adiposo-genetalis otherwise known as Frohlich's syndrome.

(b) *Gonadotropic hormone:*—This secretion is responsible as its name indicates for the development of the gonads or the sex glands. In the male it is responsible for the development of the testes and the other accessory sexual apparatus, spermatogenesis, and the appearance of the secondary sexual characters, *etc.*, the growth of hair on the face, pubes, the change of voice *etc.* In the female, it is responsible for the appearance of materials for the regularity of the menstrual cycle and the development of the ovaries and the other female sexual organs.

The gonadotropic hormone in the female consists of two parts Prolan A and Prolan B, the former is secreted during the first part of the intermenstrual period and is responsible for the maturation of the ovarian follicle and the secretion of oestrin which causes proliferation of endometrium. During the latter part Prolan B is secreted, which is responsible for the rupture of the ovarian follicle and its transformation into the corpus luteum which later through its secretion the luteal hormone, produces changes in the uterine mucosa making it suitable for the implantation of the fertilized ovum. If fertilisation has not taken place, it atrophies and degeneration of the uterine mucous membrane takes place leading to menstruation. If fertilisation takes place it persists as the corpus luteum of pregnancy.

Disturbance of the secretion of this hormone leads to infantile condition of the sexual organs and disorders of menstruation in women. A secretion resembling the gonadotropic hormone is found in the urine of pregnant women and in large quantities in the urine of pregnant mares. This is most probably secreted

by the placenta as it is found in the urine of women suffering from hydatidiform mole and chorion epithelioma. The difference between the pituitary hormone and the substance found in the urine is that the latter contains a little oestrin (ovarian follicular hormone) and also that it does not act in the absence of the pituitary body.

Advantage is taken of the action of the gonadotropic hormone upon the ovaries in producing ripe ovarian follicles, in the Aschheim Zondeck test and Friedman's test for diagnosing very early pregnancy. The principle of both the tests consists of the fact that the urine of a pregnant woman even as early as the third week of pregnancy if injected into immature animals, produces mature ovarian follicles full of blood within two or three days. The mouse is used in the former test and the rabbit in the latter test.

Practical use is made of the anterior pituitary like hormone which is found in the urine of pregnant mares. Injections are given in cases of under-development of the sexual organs both in the male and female, and in functional haemorrhage of the uterus with promising results.

(c) *Thyrotropic hormone*:—The Pituitary exerts its influence on the thyroid gland also. In cases of diseases of the pituitary the functions of the thyroid gland are deranged e.g., in acromegaly the temperature is below normal. In Dercum's disease and in Frohlich's syndrome abnormal deposits of fat occur.

(d) *Adrenotropic hormone*:—Disorders of the pituitary affects the suprarenal cortex. In Lusting's disease there is found to be hypertension and pigmentation also.

(e) *Lactogenic hormone*:—Injections of anterior pituitary increases the milk.

(f) *Diabetogenic hormone*:—There is a lot of controversy and uncertainty regarding this hormone. In acromegaly in which there is a tumour of the eosinophile staining cells of the anterior pituitary there is lowered tolerance for sugar and

there is glycosuria but injections of pituitrin (which is an extract of the Posterior pituitary) produces glycosuria provided there is glycogen in the liver cells.

Disfunction of the Pituitary produces the following diseases:—

(1) Gigantism and acromegaly. This has already been referred to.

(2) *Dercum's disease*:—In this condition there are painful fatty tumours over the body attendant with fainting fits.

(3) *Dystrophia adiposo genitalis*:—also known as Frohlich's syndrome. As the name indicates, the patient is fat and there is want of development in the external and internal organs of generation. There is mental weakness also.

(4) *Cushing's syndrome*:—In this condition there is increase of fat in the body, hypertension, excess growth of hair, polycythaemia and kyphosis. The condition is due to the development of hyaline tumours of the basophile cells. These tumours are sometimes not visible to the naked eye.

(5) *Simmond's Disease*:—Here there is progressive emaciation; all the structures of the body atrophy—the bones and the skin show the changes at first. The jaw shrinks, the teeth are shed, the skin becomes wrinkled, and the hair falls.

In those cases where the tumour formation is the cause of the pituitary disease and where the tumour is large e.g., in acromegaly neighbourhood symptoms on account of pressure occur. These are headache) blindness—either total or partial on account of pressure on the optic nerve or optic chiasma and widening of the sella turcica of the sphenoid bone.

The diagnosis of pituitary disease is helped to a large extent by the configuration of the body. Whenever there is excess of growth or the reverse, whenever there is excess of fat or extreme emaciation, whenever there is precocious or under-development of the genitals, pituitary disease has to be thought of as one of the probable causes. Signs of intracranial pressure like headache,

hemianopia and x-ray of the skull help in the diagnosis.

Treatment of pituitary disease is not very satisfactory. A lot may be done to relieve the condition. Medical treatment consists in supplying the deficient secretion e.g., the thyroid for excess of fat, the gonadotropic hormone for deficient sexual development and x-ray treatment in the case of tumour to diminish its size. Surgical removal of tumours has met with a fair amount of success in the hands of experts. The neighbourhood symptoms of pressure have been ameliorated.

The Pars intermedia is thin and consists of basophile cells. It is believed that the posterior lobe has got no secretion, but the secretion of the Pars intermedia is transmitted to the Pars nervosa or the posterior lobe which consists of neuroglial tissue and ependyma. There are four important principles in this secretion. They are:—

(1) *Vasopressin*:—This increases the blood pressure and is used in cases of surgical shock and in such conditions where there is peripheral fall of blood pressure.

(2) *Antidiuretic*:—This is associated with the vasopressin. Injection of this principle produces diminution of urine and is specially useful in the disease called diabetes insipidus.

(3) *Oxytocic*:—This has got a pronounced action in contracting the unstriated muscle fibres e.g., of the intestines bladder and uterus at the time of labour.

(4) *Glycolytic*:—Injection of pituitrin (post pituitary extract) is antagonistic to insulin. If an injection of pituitrin is given glycosuria occurs. It is useful in combating the shock of insulin coma.

The vasopressin and oxytocic principles of the posterior pituitary have been isolated and are available in the market for therapeutic purposes. The antidiuretic glycolytic factor have not been separately isolated.

Diabetes insipidus is a disease of the posterior pituitary in which large quantities of urine of low specific gravity (1005 and less) are passed. There is intense thirst also. The urine contains no sugar. Syphilis is found to be a cause in some cases. Injections of pituitrin control the diuresis and give relief to the patients.

THE PINEAL GLAND.

The functions of this gland are not known with any amount of certainty. It atrophies at the age of puberty.

THE THYMUS.

This gland which is situated in the chest behind the manubrium sterni in the chest is of importance in that it is hypertrophied in certain cases and produces dyspnoea known as thymic asthma. These subjects are bad for general anaesthesia and sudden deaths occur. It is better to take a skiagram of the chest in case of children in whom hypertrophy of the gland is suspected before resorting to general anaesthesia. The gland begins to atrophy at the age of puberty.

THE THYROID GLAND.

This important gland is situated in the neck in contact with the thyroid cartilage and trachea. In some abnormal cases a part of the gland is situated in the retro-sternal position. It consists of two lobes, the right one being the larger and more superficial. Microscopically each lobe consists of number of vesicles lined by cubical epithelium, and containing a colloid material in which iodine is present. The secretion consists of an active principle called thyroxine containing iodine and an amino acid called tryptophane.

The functions of the thyroid gland are governed to a large extent by the thyrotropic principle of the pituitary. They are:

(1) *Rate of metabolism*:—When the secretion is in excess, the metabolism is increased. Basal metabolism is the energy output when the body is at complete rest, 12 to 18 hours after a meal. This is necessary for carrying out the processes of respiration, circulation, and the various

secretions and excretions. Any exertion either physical or mental etc., increase metabolism rate. When thyroid secretion is decreased as in myxoedema the metabolic rate is decreased.

(2) *Rate of heart beat*:—This is increased when there is excess of secretion and decreased when there is diminished secretion.

(3) *Emotional and nervous control*:—Hyperthyroidism increases the emotional and nervous excitability. There is great mental irritability leading sometimes to acts of suicide or homicide. Fine tremors develop best seen in the fingers. In hypothyroid on the other hand, there is great mental hebetude and loss of memory.

(4) *Control of blood sugar*:—Thyroxine is antagonistic to insulin. Whenever there is excess of thyroid secretion or whenever excess of thyroid is given by mouth glycosuria develops.

Derangements of the thyroid gland lead to the development of the following diseases:

- | | |
|-----------------------------------|---|
| A. Excess of secretion | } Exophthalmic goitre (Grave's disease) Toxic adenomatous goitre. |
| B. Decrease or loss of secretion. | |
| C. Simple goitre. | } Myxoedema, cretinism. |

Exophthalmic Goitre:—It is also known as Grave's disease or Basedow's disease. The characteristic features are:

(a) Great mental excitement and fine tremors.

(b) Tachycardia and palpitation. After some time on account of excess of work and also probably toxæmia, the myocardium degenerates and there is dilatation of the heart. The auricular musculature if it degenerates first, gives rise to auricular fibrillation.

(c) Metabolic rate increases and hence the person becomes emaciated. The perspiration increases.

(d) The thyroid gland enlarges often unequally the right lobe more than the left. The patient who is generally a female finds that the girth of her neck is increasing.

(e) There is protrusion of both the eyeballs giving the patient a look of fright. The winking becomes less and the upper eyelid does not follow the eyeball on looking down.

(f) There is glycosuria.

This condition is mostly found among women at about the age of 35. Emotional stress and strain and the mental stress of civilisation are laid down as the cause of the disease.

In a well developed case, the diagnosis is extremely easy. Early cases may be mistaken for aortic regurgitation on account of the throbbing arteries and capillary pulsation; but the diastolic murmur in the aortic area or the second left intercostal space near the sternum and conducted downwards towards the sternum is wanting as well as the heaving apex beat which is seen and felt displaced downwards and outwards.

The emaciation and glycosuria may suggest diabetes; but the tachycardia and tremor are not found in it. The thyroid gland should always be auscultated. In every case of Grave's disease there are effective murmurs heard on it systolic in character.

Treatment:—This is medical and surgical.

(a) *Medical*:—All septic foci should be carefully searched for and removed. The patient should have a quiet life free from the stress and strain of modern life. Bromides and luminal are given if there is great excitement. Lugol's iodine in doses of 10 minims per day is found to be very beneficial at first, but later on is found to be not very efficacious. It should always be given before a surgical operation.

X-ray exposures give a certain amount of benefit, but great care should be taken

not to injure the skin, lest a scar should be produced. Radium is found to have a better effect.

Operation of a partial nature is found to have the greatest amount of benefit. The heart condition especially auricular fibrillation is greatly benefitted. Digitalis and quinidine if given after operation are effective though not found to be so before. Too large a portion should not be removed lest myxoedema may develop later.

Toxic Adenomatous Goitre:—In this condition which resembles Grave's disease, auricular fibrillation is more common but exophthalmos is very late in appearance. The nervous excitability is also not very common. The condition is due to hyperthyroidism superimposed upon a simple goitre.

Treatment consists in giving Lugol's iodine and partial thyroidectomy.

Myxoedema:—In this condition the thyroid gland either atrophies completely or the secretion is decreased. It is found more among women than men. The subcutaneous tissue contains a substance resembling mucin but there is no pitting on pressure. The oedema is hard. The skin is dry. There is a boggy condition about the lower eyelids and a malar flush in well marked cases.

The temperature and the pulse rate are less than normal. Sugar tolerance is more than normal and the basal metabolism is less. The speech is thick and the mental activity diminished. In the case of women amenorrhoea sets in.

In a well marked case the diagnosis is not difficult. The condition has to be diagnosed from nephritis by the examination of the urine. The determination of the basal metabolism whenever possible is an aid to diagnosis. In doubtful cases the effect of thyroid gland medication may be resorted to.

Prognosis is very good if treatment with the thyroid gland is started as soon as possible and kept on throughout life. Thyroid gland is the best example of an

endocrine having a specific effect when given by mouth.

Cretinism:—By this is meant thyroid deficiency during infancy. The children of myxoedematous or goiterous parents develop the disease. Nothing special is observed for about six months when the first signs begin to appear, the child does not lift up the head, crawl, sit up, stand and talk at the proper time. There is found to be backwardness in all these things.

In a well developed case, the stature is found to be small about two to three feet. The physiognomy is that of a dull person, the mouth is kept partially open with the tongue slightly projecting out, there are supra clavicular pads of fat, the skin is dry and the hair sparse. There is constipation. The mental condition is far below the normal.

The condition has to be diagnosed from other condition of dwarfism e.g., foetal and renal rickets, coeliac disease, and congenital heart disease. In foetal rickets only the upper and lower extremities are short, the rest of the body is of normal growth. The examination of the urine in renal rickets, the fatty stools in coeliac disease, the cyanosis and examination of the heart in congenital heart disease give the clue to the diagnosis.

Treatment:—Thyroid extract should be given early before mental condition deteriorates. The prognosis is then very good.

Simple Goitre:—In this disease the thyroid gland is enlarged, but there is no hypersecretion. If this occurs then toxic goitre results. The disease is found mostly among women living in mountainous parts where there is want of iodine in the articles of food and where the water is contaminated with human excreta. So it is both an infectious as well as a deficiency disease. The children of goiterous parents become cretinous.

Except for the enlarged goitre there are no symptoms. The disease can be prevented by giving iodine in common salt and preventing contamination of

water. Lugol's iodine 10 minims for the whole day given internally in the early stages will cure the disease.

THE SUPRARENAL GLANDS.

It consists of two parts, the cortex and the medulla. The cortex consists of several layers and polyhedral cells in a connective tissue network and the medulla of chromaffine cells.

The gland elaborates a hormone which has the following functions:

(1) Increase of blood pressure. The peripheral arterioles contract and the blood pressure increases: but the coronary arteries and the bronchioles dilate.

(2) Increase of rate of the heart.

(3) Metabolism of Sodium and Chlorine.

(4) Metabolism of pigmentation.

(5) Transformation of glycogen into glucose.

The cortex of the gland is necessary for life: without it, life cannot exist. Increase of secretion of the suprarenal produces increase of blood pressure, precocious development of the sexual organs in children and virilism in the adult.

Decrease of secretion produces, low blood pressure extreme weakness, pigmentation of the skin and mucous membrane, increased excretion of the Sodium and Chlorine and great emaciation.

The medulla of the gland elaborates the principle which increases the blood pressure and the rate of the heart and transformation of glycogen into glucose while the cortex is chiefly concerned with the muscular vigour and the metabolism of Sodium, Chlorine and pigment.

Addison's Disease.—In this disease, there is atrophy of the adrenal mostly due to tuberculosis but malignant disease or other causes play a part also.

The patient complains of extreme weakness and inability to do any kind of

work either mental or physical. On examination there is found to be great emaciation, pigmentation of the skin at the exposed parts and parts where there is irritation or pressure *e.g.*, at the place where the garters are worn or where braces come in contact with the skin. The mucous membrane of the mouth shows also pigmentation. The blood pressure is low, the systolic coming down as far as 100 mm. and the diastolic 60. The temperature is sub-normal. Examination of blood shows deficiency of sodium and chlorides in the blood. In some cases there is troublesome vomiting.

The cases have to be diagnosed from (1) Malignant disease: Here though there is great emaciation, there is no pigmentation. The blood pressure is not so low and the cause either cancer or sarcoma will be found after careful examination. It should be always kept in mind that some cases of Addison's disease are due to cancer of the supra-renals.

(2) Tuberculosis: Here also there is no pigmentation and such a fall of B. P. except in the last stages; careful examination will reveal tuberculosis of some internal organ.

(3) Arsenical pigmentation: The mucous membranes are not affected here. The hair and the nails on analysis show traces of Arsenic.

(4) Argyria: History of taking silver. The mucous membranes are not affected.

(5) Pellagra: In this condition the pigmentation is mostly confined to the dorsum of the hand and foot. The sore tongue, diarrhoea and mental symptoms are characteristic.

(6) Haemochromatosis: Here there is pigmentation, cirrhosis of the liver and glycosuria.

Treatment of Addison's disease consists in giving injections of extracts of the cortex and sodium chloride.

PARATHYROID GLANDS.

These are four in number and are situated on the posterior aspect of the

thyroid glands. The secretion is known as Parathormone and is necessary for the metabolism of Calcium and Phosphorus. Normally the serum calcium is 9 to 11 mgm. per cent and the serum Phosphorus 3.5 mgm. per cent. When there is excess of parathyroid secretion as for example by an adenoma, the serum calcium rises and the serum Phosphorus decreases. The serum calcium being derived from the bones, the bones become rarefied and pathological fractures occur. The disease is known as Osteitis fibrosa of Von Recklinghausen. Rarefaction of the bone occurs in Osteomalacia also, and local rarefaction of bone; but in both these conditions the serum calcium is not increased. Treatment consists in removing the tumour if any or if there is no tumour to remove two or three of the glands according to the severity of the symptoms. If the patient does not consent for operation x-ray may be applied to the glands. Sometimes symptoms of tetany appear after the operation for which injections of calcium or even parathormone must be had recourse to.

If the secretion of the Parathyroids diminish tetany appears. The serum calcium is below the normal and the serum phosphorus above the normal. There is great nervo-muscular irritability. There is a tonic spasm of the muscles especially of the extremities. The hand assumes the obstetric position *i.e.*, flexed at the metacarpo-phalangeal joints and extended at the interphalangeal joints the thumb being apposed in the hollow of the palm. The foot is plantar flexed. There are attacks of broncho-spasm and carpo-pedal contractions. The facial muscles go into twitches on tapping the facial nerve and the muscles of the hand on tapping the nerves in the bicipital sulcus. The electrical excitability of the muscles increases.

Treatment consists in giving injections of calcium gluconate intravenously and Parathormone intramuscularly. Life may be prolonged in this way; but if all the parathyroids are destroyed the case is hopeless because even these injections become ineffective after a short time.

THE GONADS.

These are the testes and the ovaries.

The testes are at first in the abdominal cavity in the foetus but later on descend into the scrotum. Sometimes the descent does not take place when the child is born. This condition called cryptorchidism prevents spermatogenesis although the internal secretion is produced. The anterior pituitary hormone is most probably responsible for the descent, because injections of this hormone cause the testes to descend in those cases in which there is organic obstruction to the descent.

The testes consists of two kinds of cells in addition to the supporting stroma. The first kind is found in the seminiferous tubules and is concerned in the production of spermatozoa and the other the interstitial cells which produces the testicular hormone concerned with the development of the secondary sexual characters *e.g.*, the growth of hair, the change of voice, the appearance of the hair on the face, axillary and pubic regions and the desire for copulation. If castration is done, the secondary sexual characters do not appear, and there is a tendency towards copulency. If castration is done after puberty the changes are slight except of course that the person is impotent. Tying of the spermatic cord causes the degeneration of the spermatogenic cells whereas there is no change in the interstitial cells. The testicular hormone is called testaterone.

Anterior pituitary hormone contains a gonadotropic principle which is capable of increasing the secretion of the interstitial cells of the testes. This hormone is found in the urine of males.

Voronoff has succeeded in restoring physical activity and sexual power in old people by grafting the testes of the higher apes in them; but the effect lasts only for a short time the grafts atrophying after a variable period of time.

The ovaries in women in addition to the production of ova are concerned with the secretion of two principles the oestrin

and progestrin. The oestrin is most probably formed by the ripe graffian follicle and is concerned with the proliferative changes which occur in the uterine endometrium previous to menstruation. The progesterone or progestrin as it is sometimes called is found by the corpus luteum between and prepares the proliferated endometrium for the reception of the ovum. If fertilization occurs, the fertilized ovum is implanted on this prepared endometrium and the corpus persists as the corpus luteum of pregnancy up to term but if not it degenerates and with its degeneration, the uterine mucosa also degenerates with the result that bleeding occurs on account of the rupture of the capillaries in it. This is called menstruation.

As referred to in the earlier portion of the article, oestrin is found to a small extent in the urine of pregnant women and animals especially the mares. In chemical structure it resembles the sterols. It is quite necessary for the attainments of puberty, for the development of the uterus and for the proper occurrence of the menses. It is prescribed for infantile condition of the uterus, primary amenorrhoea and disorders of menstruation.

Progesterone is obtained from extracts of the corpus luteum. It is used in cases of menorrhagia and sterility because menstruation (bleeding) can occur only without it and because its persistence is necessary for the development of the foetus.

A proper understanding of the internal secretions, their functions, their chemical formulae and their synthetic production have gone a great way in the advancement of medical science and thereby the amelioration of human suffering.

To summarise without making use of the proprietary names the hormones are made use of in the following diseases :

Anterior Pituitary Hormone:—(1) Defective growth both physical and mental in young children. Cryptorchidism, infantile condition of the ovary and uterus leading to sterility, menorrhagia of a functional

nature, development of breasts and production of milk.

Posterior Pituitary Extract:—For contracting the unstriated muscle especially of the uterus in labour and after parturition e.g., in primary uterine inertia where there is no obstruction in the passages, in post-partum haemorrhage and symptomatic relief in menorrhagia and metrorrhagia, in tympanitis when there is no obstruction or ulceration of the intestines, in relieving a full bladder when the cause is due to want of contraction of the bladder muscles.

For increasing the peripheral blood pressure e.g., in surgical shock or collapse from any cause.

For controlling diuresis in diabetes insipidus.

For relieving hypoglycaemia in insulin shock.

Thyroid Extract:—This is the only glandular extract which can be given by mouth with full effect, though the ovarian extract and corpus luteum extract also have got a certain amount of beneficial action when given by mouth. Its specific effect is found in cases of myxoedema and cretinism. In cases of obesity due to thyroid disorder it is also very useful.

Parathormone:—The extract of the parathyroid glands is of great use in tetany. Given by intramuscular injection its effects are felt within a few hours.

Cortical Extract of Suprarenal:—This is of great use in Addison's disease and in conditions of asthenia due to suprarenal deficiency.

Extract of Suprarenal Medulla:—This is commonly known as adrenalin and is of great use in relieving asthmatic attacks, in combating fall of blood pressure in shock, and in hypoglycaemia due to excess of insulin. Locally it acts as a haemostatic.

Ovarian Extract:—It is useful in disorders of menstruation resulting in

amenorrhoea, dysmenorrhoea, want of development of the uterus, gonorrhoeal vaginitis, senile pruritis, disorders of menopause, e.g., flushes, hypertension, mental disturbance.

Corpus Luteum Extract:—Menorrhagia, vomiting of pregnancy, and habitual abortion not due to any specific cause are greatly benefitted by it. A combination of both ovarian and corpus luteum extracts,

the former being given for the first three weeks after menstruation and the latter during the last week is useful in cases of sterility due to functional causes of the ovary and uterus.

Extract of testes:—This is found very useful in cases of cryptorchidism and infantism due to want of sufficient development of the testes. It is also of some use in cases of enlarged prostate.

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Abstracts.

ON THE EFFICACY OF THE GONADOTROPIC HORMONES IN THE TREATMENT OF WHOOPING COUGH.

BY K. VENKATACHALAM AND A. N. RATNAGIRISWARAN.

From the Medical College, Madras.

It is characteristic of whooping cough that its incidence is confined chiefly to children below 10 years of age, though occasionally it has also been reported in old people. Persons above the age of 10 and right through healthy adult life are generally immune to the disease, in spite of living in intimate contact with infected children, even though they might not have been attacked previously by any disease having the vaguest semblance of whooping cough. Second attacks in children have also been recorded though only rarely. Further, the vaccines prepared from the organisms isolated from the droplets or the upper respiratory passages of infected children have not been as effective therapeutically as they ought to be if the disease were caused only by infection.

These considerations suggested that, besides any immunity that might have been acquired, there is some other factor which is peculiar only to the period of life between the age of 10 and the end of the adult age that determines the power to resist an attack of whooping cough during this period. One of the dominant features of life at this stage is the activity of the sex glands, and the assumption that the immunity displayed is associated with such activity would be justified, if it could be demonstrated by any means that a temporary stimulation of the activity of the gonads in persons of the susceptible age would act as a curative, as well as a

prophylactic, agent. Results of the clinical trials carried out so far have provided sufficient evidence for the correctness of this view.

In the clinical investigation reported in this paper, the stimulation of the gonads was effected either by the oral administration of a standardized preparation of the gonadotropic hormones of pregnancy urine which is described in detail below, or by the injection of Antuitrin 'S'. The latter could not be tried as a routine measure on account of the prohibitive cost and was resorted to only when the oral medication had been ineffective.

The standardized preparation of the hormones for oral administration was prepared in this laboratory by a modification of the method of Davy (1934). Pregnancy urine was acidified with glacial acetic acid to a pH 5 using bromocresol-green as the indicator. The urine was centrifuged or filtered if it did not become clear by centrifugalization. To every litre of the clear urine 10 g. of active charcoal was added and the mixtures shaken continuously in a mechanical shaker for eight hours. The pH. was again adjusted to 5 and the charcoal containing the adsorbed hormones was filtered under suction on a hardened filter paper moistened with 1 per cent acetic acid. It was washed well with water till the wash water was neutral to litmus, dried, and stored in a vacuum desiccator at a temperature of 15°C.

Table of cases treated with the gonadotropic hormones

Number	Race, sex and age, in years	Duration of symptoms, whooping and vomiting in weeks	Total leucocyte count, per c.mm.	Lymphocytes, percentage	Treatment	REMARKS
1	H. M., 1, 6/12	3	16,000	55	Charcoal adsorbate of the hormones, in honey, orally, 5 gr. 4 times daily for 5 days.	Symptoms relieved.
2	H. M., 1, 10/12	2	20,000	56	Do. for 4 days.	Do.
3	H. F., 2	4	22,000	62	Do. for 6 days.	Do.
4	H. F., 1, 4/12	3	18,000	58	Do.	Do.
5	H. M., 1, 3/12	6	21,000	70	Do. for 8 days.	Do.
6	H. F., 1, 7/12	4	15,000	50	Do. for 5 days.	Do.
7	H. M., 1, 6/12	5	24,000	70	Do. for 8 days.	Ineffective.
					Antuitrin 'S', 0.25 c.cm. daily for 6 days.	Symptoms relieved.
8	H. M., 2	6	22,000	60	Charcoal adsorbate orally for 6 days.	Do.
9	H. F., 3	4	25,000	64	Do. for 8 days.	Do.
10	H. F., 2	6	26,000	70	Do.	Ineffective. Failed to cure.
					Antuitrin 'S', 0.25 c.cm. daily for 8 days.	
11	H. F., 1, 10/12	8	30,000	72	Charcoal adsorbate orally for 8 days.	Failed
					Antuitrin 'S' for 10 days.	Do.
12	H. F., 3	6	20,000	66	Charcoal adsorbate orally for 8 days.	Cured.
13	H. F., 3, 2/12	8	22,000	66	Do. Do.	Failed.
					Antuitrin 'S' for 10 days.	Do.
14	H. M., 4	2	15,000	46	Hormones orally for 6 days.	Symptoms relieved.
15	H. F., 2	4	28,000	70	Both oral and parenteral administration	Failed.
16	H. F., 2	4	20,000	62	Hormones orally for 8 days.	Symptoms relieved.
17	H. F., 1, 1/12	4	16,000	48	Do.	Do.
18	H. M., 2	5	12,000	50	Charcoal adsorbate of hormones for 6 days.	Cured.
19	H. M., 2, 6/12	4	16,000	48	Do. for 4 days.	Do.
20	H. F., 2	4	12,000	50	Do. Do.	Do.
21	H. F., 1, 6/12	2	15,000	52	Do. for 6 days.	Cured.
22	H. F., 1, 10/12	6	20,000	65	Do. for 8 days.	Ineffective.
					Antuitrin 'S' 0.25 c.cm. for 6 days.	Symptoms relieved.
23	H. F., 2, 8/12	4	28,000	70	Do. for 8 days.	Failed.

Abbreviations used: H.=Hindu; M.=Male; F.=Female.

The activity of the preparation was tested in each case by the usual biological method using 13 days old, immature, female white rats as the test animals. The rats were selected from a litter in which the animals attained sexual maturity 40 to 50 days from the day of birth. The char-

coal adsorbate suspended in distilled water was poured down the throat of the animal by means of a fine pipette. Based on our findings, a rat unit was taken as the minimum amount of the product which produced opening of the vagina and oestrus on the seventeenth day of age, when the ad-

ministered orally in eight equal doses during four consecutive days. One rat unit was contained in 10 milligrams of the preparation.

Five hundred to nine hundred rat units, the exact requirement depending upon the virulence of the disease and the individual variations, were usually found sufficient to alleviate the characteristic symptoms. Where parenteral administration was indicated, 0.25 c.cm. of Antuitrin 'S' was injected daily. After six to twelve injections, the vomiting and the whooping stopped completely. The residual cough was treated symptomatically. The criterion of cure applied was the total disappearance of the whoops and vomiting and a diminution of the cough.

All the cases reported herein were treated under our personal supervision and guidance.

A perusal of the table will show that in all the cases the blood picture had been typical. There was a marked leucocytosis of 12,000 to 30,000 per c.mm. with 46 to 76 per cent of lymphocytes. Twenty cases out of 23, or 87 per cent, were cured by oral treatment with the hormones or by injection of Antuitrin 'S'; in three cases, or 13 per cent, either treatment failed. The proportion of probable cures to failures in this series is 5.1:1. In the therapeutic doses prescribed, the preparation of the hormones did not produce any undesirable symptoms.

No case of whooping cough in old age has come to our notice so far.

The administration of the hormones as a prophylactic measure to contacts conferred immunity on them.

In another series of 113 cases which were treated by qualified allopathic medical practitioners in the city and the mofussil, 70 cases were reported to have derived benefit by the oral medication and 13 more by the injection of Antuitrin 'S', as judged by the alleviation of the distressing symptoms such as whooping, vomiting and cough. Blood examination

could not be carried out in those cases for lack of laboratory facilities. The percentage of cures in this series works out to 73.5 per cent.

For the whole series of 136 cases which have been treated with the gonadotropic hormones of pregnancy urine, the percentage of cures effected is 80.3.

In cases where treatment by the parenteral route was called for, the failure of the oral method was probably due to a co-existing gastrointestinal disturbance that might have interfered with the absorption of the hormones. In the other cases which were resistant to either form of treatment, the cause of the failure might have been an imbalance of the endocrines preventing the gonadotropic hormones from exerting their usual effects. Also in those rare cases where adults have been reported to have been victims of whooping cough a possible explanation is the malfunction or dysfunction of the gonads.

The relief from the most distressing symptoms of whooping cough effected in such a short time as about a week, by the administration of the gonadotropic hormones appears to warrant the conclusion that in these hormones has been found a useful and unsuspected remedy for combating the harassing disease.

Summary.

On the ground that whooping cough is a disease that shows a preference for attacking children below 10 years of age, and old persons occasionally, and that adults are invariably immune to it, it was considered probable that the power to resist and overcome the disease might be closely associated with the activity of the sex glands, the dominant feature of adult life. Based on this assumption, treatment with a charcoal adsorbate of the gonadotropic hormones of pregnancy urine or with Antuitrin 'S' was carried out in a series of 136 children and yielded satisfactory results in 80.3 per cent of the cases. The drug was also found to be effective as a prophylactic remedy.

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I.M.S. MUST GO.

"I.M.S. must go" was the gist of a discussion on the floor of the Madras Legislative Assembly on 9-8-1939 when one of the members of the Assembly, Mr. T. T. Krishnamachari moved the following resolution:

"This Assembly recommends to the Government to convey to the Secretary of State for India that, in the opinion of this Assembly,—

(i) the recent orders issued by the Secretary of State for India reserving certain specified posts in the Provinces to officers of the Indian Medical Service are contrary to the spirit of Provincial Autonomy, nor are they in conformity with the principles of equity and efficiency;

(ii) the rights reserved by the Secretary of State for India in regard to members of the Indian Medical Service and even in regard to the details of their postings and the duties to be carried out by them, are entirely contradictory to the essential principles of autonomy which the Provinces are supposed to enjoy; and

(iii) the extension of protection of rights to officers recruited subsequent to 1928 and particularly to those who joined after 1931 and who have already had sufficient warning and notice in regard to the changes in the administration in India, is wholly unjustified and is in direct contravention of the spirit of the constitution;

and that these orders should therefore be revoked at once.

The immediate exciting cause that made the member to move the above resolution was the notification published by the Government of India dated 4th May 1939 containing the rules made by the Secretary of State of India in regard to I.M.S. (Civil Branch) under the Government of India Act. The local Government are obliged to keep 19 British I.M.S. out of a total of 42 I.M.S. including seven unspecified posts. But it was open to the Government to say whether they wanted the latter seven. The

stations and posts have been specified and the Government have no option to say whether they were competent to hold the posts in the stations and for duties specified. Nobody could deny the I.M.S. anomaly in Provincial Autonomy. The fact that this anomaly was sanctioned by a Statute, the Government of India Act, 1935 seems to have heightened the intensity of feelings of constitutionalists of the type of the mover of the resolution whose clarity in presenting his arguments to the house was so much appreciated by the Hon'ble the Public Health Minister that he, the Minister not only congratulated the member but expressed that the mover of the resolution was worthy to occupy the position of a Minister in charge of Medical Portfolio, though this member was occupying a seat on the opposition benches. When the resolution was put to vote there was not even a single dissentient voice. Two European members took part in the debate one of whom eulogized the I.M.S. for the "unblemished service and first class devotion to duty", the other argued that the house could not question the competency of the powers of the Secretary of State so long he did not go in excess of powers granted to him by the Government of India Act, 1935 and said that the present Government knew the limited Provincial Autonomy before they assumed office. We do agree with this member to a certain extent but neither he nor the other European member could say a word against the spirit of the resolution. The mover of the

resolution threw a suggestion that other provincial Government should do what Madras Government had done and we find from Newspapers reports that the suggestion is catching and even the non-Congress Governments will join in the agitation. All the same we cannot hide the feelings amongst the officials in the medical department below the rank of civil-surgeons that they are not as happy under the Indian superior medical officers as under the European. This feeling is prevalent in almost all the other departments of the Government. Alongside the move for Indianisation of medical services, the Government and the members of Legislature should not lose sight of the feeling referred to above which cannot be said to be imaginary and more than anybody else officers who have got into the shoes of the I.M.S. and are likely to get into them should always remember that officers who are under them are their own brethren, Indians whom luck and fortune did not favour to the extent the higher officers are favoured by them. Provincial Autonomy cannot mean rule by brown bureaucrats.

PUBLIC HEALTH AND THE DOCTORS' RESPONSIBILITY.

Last month we discussed in these columns the responsibility of the Government in working the Public Health Act and said that the Government should treat the Medical Profession as a limb of the Public Health Ministry. Sir T. Vijiaraghavachariar who on 19th August, '39 delivered the inaugural address to the Stanley College Medical Union and who has valuable experience of men and things having travelled far and wide in both the hemispheres, gave a vivid picture of the want of sanitary conscience in the people in India and exhorted the younger generation in the medical profession that they should hold themselves responsible for the Government's actions as the Government were and make Madras and other cities decent and sanitary. We cannot add

anything more to the pithy words of advice coming from one of the most respected citizens in India, loved and honoured by the Government and the people alike. He referred to the Provincial Autonomy 'that was working with much energy and wisdom in Madras' and also to a conversation he had with the Hon'ble Dr. Rajan, the Public Health Minister who described to Sir T. Vijiaraghavachariar about the methods employed by him successfully in combating Cholera in a District within a few days. This was possible for the Minister to do as he was a medical man having the authority of a member of the Government. Mere knowledge of preventive and curative medicine could not help a practitioner to create a sanitary conscience in the people unless he has the authority also. We do not suggest that every medical man should be a Minister to educate the public in sanitary laws but we only point out the necessity of the medical men being recognised by the Government and other authorities as their co-workers and make the public feel that their opinions are valued by them. It is earnestly hoped that the Madras Government would not lose the splendid opportunity of the presence of an energetic medical man as one of their members and through him bring about a mass contact with the members of the medical profession as they have been doing in regard to such contact with the public as a whole and make the public realise that the Government and the members of the medical profession are one in relieving human sufferings relating to diseases. All the same the members of the profession should not keep quiet; they should as advised by Sir T. Vijiaraghavachariar create public opinion against the sins of omission and commission of those who are in charge of public health as their position and influence as medical men, are as powerful if not more than those of the members belonging to the local bodies. In fine we should say that creating of a sanitary conscience in the people is the legitimate duty of the members of the medical profession but the affairs of the medical profession are unfortunately so bad in India that the initial leaven for action should come from the Government.

News and Comments

Medical Education in Provincial Languages: On 9-8-1939 Drs. Jivraj Mehta, V. R. Khanolkar, B. B. Yodh, A. S. Paranjpe, G. M. Kurulkar and others submitted a memorandum to the Hon'ble Dr. M. D. D. Gilder, Minister of Public Health, Bombay Government suggesting that the Medical Education should be imparted in Bombay in the languages of the Province, i.e., Gujarati and Marathi. In support of their suggestion and to explain away the difficulties regarding the terminology they relied on the experience of European countries where till the 18th century the medium of instructions for medical education was in Latin and now medicine was taught in 20 different languages and each country vied with the other in producing splendid books on medical science in their own native language. China, Japan, and Turkey are cited as examples in Asia. In China it is stated that though scientific medicine developed under different auspices at different centres and in different languages, the official medium of instruction was in Chinese. Regarding Japan it is said in the memorandum that the Dutch were the original teachers of scientific medicine and when Japanese Universities came into existence German Professors were engaged on 10 to 15 years contract and German was the language in schools and colleges and finally the Japanese Professors have taken up the field of education and after 70 years it was possible in Japan to use Japanese terminology in the teaching of medicine though the books for reference and study continues to be in German language. The memorandum amply illustrated that in almost all the foreign countries there "was a bilingual period in all the universities and that an elaborate preparation of terminology and text-books was unnecessary before the introduction of a new language medium." It is also said that in small countries like Holland, Denmark, Sweden and Portugal where sale of books in their own language is very restricted and cost of publication proportionately high, English, French and German books are used by students to a very great extent, in addition to the books in their own language which is the medium of instruction and examination. The difficulty regarding the terminology was further explained by quoting the example of the Osmania University in the Nizam's State where in spite of a special Bureau appointed by the Nizam's Government the terminology was inaccurate and obsolete and at present English text-books were used but lectures were delivered in Urdu. The Memorandum discussed also the probable difficulty of getting recognition by Medical Council of India and G.M.C. to the medical degrees when the medium of instructions were in vernaculars and ruled out the difficulty as the Usmania Medical College had been recognised by these Councils.

It was therefore proposed in the memorandum that two Government Medical Schools at Ahmedabad and Poona should be converted into colleges where Gujarati and Marathi should be the medium of instruction respectively and that English text-books should be used till it was made possible to use correct and accurate terminology in the two provincial languages. For this purpose it was suggested that the control of medical education should be vested in bodies called the Gujarati and Maharashtra Academy of Medical Sciences. These bodies should eventually be the two medical teaching Universities. The staff, including the heads of the departments, professors, readers, lecturers etc., should be carefully selected, care being taken that the selected staff should have "the real faith and enthusiasm for the innovation, in addition to being experts in the subjects." The appointed teachers should not be members of service cadre but should be entertained on 'chair-basis', the occupants of the chairs of clinical subjects should be ex-officio members of the staff of the associated hospital departments. "The departments of the college and the boards of studies shall be the units, which together with certain other representatives shall constitute the Academy. The course leading to graduation shall cover seven years of which two years will be devoted to general preparatory education corresponding to the Intermediate Science

examination and will be spent at a special preparatory college attached to the Medical College. The next two years will be devoted to pre-clinical subjects like (1) Anatomy, Embryology, Histology (2) Physiology (3) Biochemistry etc. and the last three years to clinical and applied laboratory subjects according to the plan and the standards laid down by the Medical Council of India.

The spirit of nationalism which Indian leaders in different professions have been entertaining and which was under restraint during the bureaucratic and semi-bureaucratic days, is now taking a concrete shape in various directions on account of a general feeling that all the provinces are at present governed by popular governments. So it is but natural that Bombay which is the birthplace of Indian National Congress, should have taken the lead to impress on the local Government, the desirability of teaching medicine in the provincial languages. From what appears in the memorandum it cannot be said that the deputationists are unaware of the difficulties in the way before their nationalistic idea can bring forth the results expected by them. India is a continent in itself and the eleven provinces with the adjoining Native States are sub-continent for which there is no parallel in other parts of the world. The chances of India rising as a nation are now being threatened even before its people enjoyed the full benefits of Provincial Autonomy, on account of crude ideas of provincialism though they may be well meaning. So even before India can enjoy self rule there are serious signs of provinces dwindling into sub-provinces on the linguistic basis. The deputationists on the Bombay Minister have not considered the claims of Karnataka in the Bombay Presidency who have been clamouring for a Kanada Province. In Madras the Andhras are up in arms against the present Government and no meeting of both the houses of legislature has been passing without a storm relating to the separation of Telugu speaking districts into a separate Province. In Madras again there are four linguistic areas, the Tamil, the Telugu, the Kerala and the Kanada. In North Indian Provin-

ces there would be the complication of the Hindu and Muslim Medical Universities. Knowing all these difficulties, the leaders in the Congress under the guidance of Gandhiji have rightly chosen Hindi as the common language for India. So all attempts by all leaders in all professions should be concentrated in making Hindi as the common compulsory language in all educational institutions instead of dissipating their energy in provincial languages. It is said in the memorandum that it took Japan where the whole country talks Japanese language to introduce the native language in the University. India under the Congress rule is just laying the foundation of Nationalism against tremendous odds not only from outsiders but from the nation building agencies themselves. Coming to the medical profession, there are lot of troubles which should first receive the earnest attention of the leaders. It is impossible for the State to recognise all systems of medicines and start medical colleges and hospitals to cater to the needs of its votaries. The first and foremost thing that should receive the attention of the leaders is the unification of medical science. There is now an immediate danger of science taking the role of quackery. If the foundation of nation building is made strong and impregnable anything can be attempted and many things could be done, but certainly not till then. We feel that medical profession in India should not be divided on account of linguistic zeal and India the continent and the members of the medical profession in it have much to gain and nothing to lose if all interested in Nation building work concentrate to have one common language for India which should be the medium for imparting medical education also.

Hindi in Stanley Medical College: The anniversary of the Stanley Medical College Hindi Association was celebrated in the College premises on 29th July 1939. Sir Mahomed Usman presided on the occasion. Dr. T. S. Tirumurti, Principal of the College while introducing Sir Mohamed Usman to the Association recalled the fact of Sir Mahomed Usman

acting as the Governor of the province in which capacity he was the Chancellor of three Universities the Madras, the Andhra and the Annamali. Dr. Tirumurti said that the advice coming from such an eminent educationist and one belonging to the family of renowned Unani Hakims would be most useful to the Association. Sir M. Usman justified what Dr. Tirumurti said and exhorted the students that the study of Hindi in either Persian or the Devanagari Script would open up to the medical men the entire field covered by the Unani and Ayurvedic systems and that they could incorporate in their practice whatever was useful in these two systems. Sir M. Usman pointed to the students at the very outset of his speech that it was indeed a very wise decision of the local Government to introduce Hindi in schools and college, and praised Mahatma Gandhi who did solve a most difficult problem of bringing about unity in all castes and creeds throughout India.

It looks as if the students of the Stanley Medical College foresaw what the elders in the medical profession were contemplating in Bombay, for, it is a strange yet happy coincidence that when eminent educationists in the medical profession in Bombay were preparing a memorandum to be submitted to the Public Health Minister of Bombay suggesting to make provincial languages as medium of instruction to teach medicine, the students of the Stanley Medical College should be celebrating the anniversary of the Hindi Association, under the guidance of an eminent educationist in Madras as if to suggest to the leaders in Bombay that Hindi was most suited to be the medium of instructions in the Medical College instead of the provincial languages which are likely to divide the nation. We congratulate the students of the Stanley Medical College who with the support of the Principal of the College and the Superintendent of the hospital attached to the College, have been able to show their patriotic zeal to make India one ideal nation with a common language.

Hon'ble Mr. V. R. Pantulu Versus Hon'ble Mr. C. J. Varkey: Ever since Congress sat on the saddle of the Madras

Government, the Government School of Indian Medicine has been engaging itself in canvassing support from public men, politicians including the members of the Government, for getting support to convert itself into a Medical College of the same status as the other Government Medical Colleges belonging to the Scientific System of Medicine. In addition to this an all-provincial campaign was also conducted by a few interested votaries of indigenous system of medicine making imaginary allegations against the Government that the School of Indian medicine got step-motherly treatment from the Government. The activities in this direction seem to have now assumed features not dissimilar to those employed by political opponents. The recent performance was an inaugural address delivered by Hon'ble Mr. C. J. Varkey, Minister for Education, to the Siddha Students' Association which was followed the very next day by another similar address delivered by the Hon'ble Mr. V. Ramadas Pantulu to the Andhra Students' Association of the School of Indian Medicine. Mr. Varkey said at the very outset:

"That sometimes it was suggested that the Indian Medical School got step-motherly treatment from the popular Government. It was also complained that the School had not been raised to a College. These were problems with which another Minister was concerned. Nor had the Government come to a settled policy in regard to either settling down or unsettling the school. In the circumstances, they would not expect him to talk on the merits of the school. He wanted rather to speak on the merits of the science that was being taught to them."

He added:

"That the Allopathic system of medicine that had now come to this country from the West was only Ayurveda in a different form. Indeed, the West had developed many of its sciences from the germs which the economic, political and commercial breezes had carried away from the East to the West in the ancient days..... Indian philosophy and theology, Ayurveda and many other sciences had found their way to the West in this manner. The West must be congratulated on having accepted these sciences and, what was more on having developed them to a state of perfection. Allopathy had been developed and perfected to such a degree that they could not now recognise the science of Ayurveda in it."

The Minister for Education concluded:

"That the duty of recapturing the country's ancient greatness in the science of Ayurveda lay

upon the students of the School. He did not know how far they were being fitted for this great task, for he had no knowledge of the working of the institution. He would say that just as they had to continue with the Western democratic institution of party government until it could be substituted by an equally advantageous system of democracy suited to India, even so they had to continue with what they had in medicine at the present day until the Unani, the Ayurvedic and the Siddha systems developed to a degree, when they could replace the Western system. That was the justification for the attitude the Government had taken towards the Western system of medicine."

Naturally the wise words of the Minister were not relished by those interested and the very next day Mr. Ramadas Pantulu on the same platform though under different auspices began his address by saying at the outset:

"That the statement of the Hon. Mr. Varkey, Minister for Education, that the Government had not yet settled the future of the school, came on him as a surprise. People were expecting the Government to develop the institution as a first-rate one for the promotion of the study of Ayurvedic and Unani systems of medicine. The Minister's statement would cause considerable disappointment to the people. The Minister had said that the Indian system of medicine should prove their worth and so develop as to justify the replacement of western medicine just as a constitution for India should be such as to be better than the western democratic party system that is now being tried in India."

Mr. Pantulu confessed:

"The present position of the School of Indian Medicine was considered to be very unsatisfactory by the public at large as merely a sprinkling of Indian Medicine added to the British Materia Medica and British Anatomy and Physiology."

He hoped:

"There was no attempt to introduce any elements of Indian Medicine into the Medical College where only the British Allopathic system was taught. The real solution of the future development of Medical Science in India lay in the encouragement of research and study of comparative medicine."

Mr. Ramadas Pantulu concluded exhorting the students to take keen interest in Preventive Medicine.

It is rather unfortunate that the authorities have been losing sight of the present tendency of indiscipline in schools and colleges, culminating very often in strikes. If the Government is made the target of attacks in these institutions the effects of such speeches could be better imagined than described. All the same Mr. Pantulu's observations that only

sprinkling of Indian Medicine was added to the British Materia Medica and British Anatomy and Physiology in the teaching of medicine at the School of Indian medicine and that the real solution of the future development of medical science in India lay in the encouragement of research should receive the attention of the Government who seem to be sitting on fence without adopting boldly what Mr. Ramadas Pantulu wishes them to do. And the best way to do this research for developing Medical Science in India is to close the School of Indian Medicine where there was a mere sprinkling of Indian Medicine, create special chairs in the existing Medical Colleges and make the Science of Ayurveda, Siddha and Unani better recognised. The Education Minister had perhaps this idea in his mind which he could not express as a responsible member of the Government especially so when he was not in charge of the Medical Portfolio.

Unenviable Popularity: The Madras Congress Government is many a time blamed by their own party men in spite of their liberal policy. The affairs of the School of Indian Medicine is one amongst many items where the Government is criticised to be illiberal though more money is spent on the School than was done by the predecessors of the present Government and the Government have been even risking the growth of Science by permitting the students passing out of this school to practise the Scientific System of Medicine (wrongly named in the past Allopathy). This will eventually establish an Hybrid System of Medicine and is sure to undermine the growth of Indigenous System of Medicine on scientific lines. The Government have been employing practitioners of Scientific system in the School of Indian Medicine not to make a comparative study of Medicine but to teach the students special subjects such as Surgery, Midwifery, Ophthalmology, diseases of Ear, Nose and Throat without realising whether the students of the school whom the Principal of the very school condemns as not belonging, 'to a better class' could understand what is taught to them in these specialities. The

result of all this has been that ignorant poor class of patients who are not expected to know "what is what" are being attracted by these special departments connected in the hospital attached to the School of Indian Medicine though they could get much better and really special treatment in the special hospitals run by Government elsewhere in the City. It is needless to expatiate the evil and dangerous effects of such a policy on the health and welfare of the poor masses. The latest activity in this direction is the posting of practitioners possessing the Diploma granted by the School of Indian Medicine for Public Health training. We heard once at Ellore a famous Ayurvedic Pandit Mr. Shastri hailing from the Punjab, tell his audience most forcibly and as vehemently that the votaries of his system did not believe in the causation of diseases by microbes. The success of Preventive Medicine depends entirely on the belief that microbes cause diseases. On the face of the existing Ayurvedic theory we should say that the Government was not justified to compel the votaries of indigenous systems of medicine to believe in a theory antagonistic to the fundamentals of Ayurveda. From what we could judge of the state of affairs prevailing in the School of Indian Medicine we should say that the development of this school on the lines now followed in that School, is a real danger to the growth of scientific medicine. We may surmise that the Government with a Medical Minister as one of their members are not ignorant of the danger ahead but medicine having entered the realms of politics they cannot see and hear in the way others do outside the political whirlwind. It is at times wrong to say that a party is in power though really it is in pain.

An Educationist's Views for Medical College Admissions: Our comments in regard to qualifications of entrants to the Medical Colleges had attracted the attention of an eminent educationist in Bombay, whose views are published in the Correspondence Columns. It is our experience and must be of many in this province that a student with a brilliant career in Arts College did not fare as well in the Medical College and a fairly large

number of medical men who passed out of Medical Colleges with distinctions have not been as successful practitioners. So, the success of a candidate in Arts College or Medical College cannot be considered as the only test for success in after life. But the authorities should have some definite tests for admitting candidates into any service or for admitting them into the technical Colleges especially in India where there are not enough number of institutions for imparting professional education such as engineering and medicine. In a province like Madras there is yet another problem of communal representation, thanks to the Congress Government the addition territorial representation has been abolished. The stringent tests have been ruining the prospects of very bright students in a particular community the Brahmins. A graduate who spends two more years in an University than an Intermediate is expected to have a better grasp of general knowledge. We may go a step further and raise the argument that between two candidates a first class M.B.B.S. and a third Class M. D. to be selected for service or for a research scholarship the M. D. will be surely preferred. Even for honorary service the same rule applies. Taking every thing into consideration we said that it would be fair to place III Class graduates over the First Class Intermediates as after all majority of students passing out of Medical Colleges have to be general practitioners and the success of a general practitioner does not always depend upon his brilliant career either in the Arts or Medical Colleges. All the same the views of our esteemed correspondent are worth the consideration of the authorities.

Justice After Six Years:—In July 1933 some of the subsidized practitioners belonging to Kistna District then working under Taluk Board, Bezvada, were asked to do festival duty during the Pushkaram in 1933. One such practitioner belonged to Thotavalluru village who had to do the duty in the same village. There is a clause in the agreement which the subsidized practitioners have to execute with the District Boards and the Government which lays down that the practitioner doing festival duty would be paid Rs. 5

a day in addition to travelling allowance in case he had to go outside his own village. Accordingly after the festival was over the practitioner of Thotavalluru submitted his bill to the Taluk Board, Kistna through the District Health Officer. But the latter objected to pass the bill mentioning that the practitioner was not entitled to the daily allowance of Rs. 5 as he did duty in his own village. The practitioner represented to the District Health Officer that he was neither a servant of the Taluk Board nor of the Government and that his demand was based on the conditions of the agreement which he had to execute as a subsidized practitioner. Such a statement enraged the District Health Officer and the latter in a communication addressed to the practitioner dated 6.3.1934 said amongst other things:

"The concluding portion of your letter is noted with displeasure. In future you will do well not to correspond with this office in this matter."

Evidently the concluding matter must be what referred to above. The practitioner expressed regret "for the concluding portion" of his letter in a communication addressed to the District Health Officer on 22.6.34. But this would not appease the District Health Officer entirely and the District Health Officer replied seven months later i.e., on 24.1.35 that his claim would not be reconsidered as the Pushkaram Committee was dissolved by that time. Just then the Taluk Boards were abolished and the practitioner addressed to the President, District Board, Kistna first on 15.2.1935. There was no reply till 9.11.36 by which time the District Board was bifurcated and during the interim period the District Collector, Kistna, who was in charge, was petitioned. There was no reply from the Collector also. The practitioner persisted and addressed the President, District Board, Bezwada under which Board he came after bifurcation. The vice-President of the Bezwada District Board addressed the District Health Officer to furnish him all the available records as the Vice-President said that the payment to the practitioner had been delayed for want of records.

Exactly four years passed after Pushkaram festival when the unfortunate

practitioner could see a ray of hope of his getting his legitimate allowances held up by the District Health Officer. Soon after the bifurcated District Board was unified by the Congress Ministry, the Practitioner must have got a little courage and made up his mind to approach the Government direct and for this purpose he appealed to the Government on or about 20.10.1937. The Government could not take cognizance of the appeal as it was not sent through the proper channel. So the practitioner had to re-submit it through the President, District Board, Kistna. But though the President received the appeal in the second week of November 1937 it was not submitted to the Government till 1.7.1939. The subsidized practitioner who has been anxiously awaiting the decision of the Government on his appeal will gratefully receive the news that the Government have ordered the payment of allowance claimed by him. Many a time the subsidized practitioners are arriving at wrong conclusions against the Government on account of indiscretion of the officers under them. If the concerned practitioner had no patience and faith in the Government but kept quiet thinking that the District Health Officer's orders were final or likely to carry more weight than his representation to the Government there would have been miscarriage of justice which was likely to repeat. We are at a loss to understand why the President, District Board, Kistna sat so tightly on the file of this humble practitioner. May it be due to the fact that he thought that the Government would not go against the decision of their officer in charge of Health of a big District?

Who is Delinquent? Two subsidized practitioners were asked by a District Board President to go to Madras for Public Health training on a particular day; nothing was mentioned in the communication as to whom they should hand over charge of the rural dispensary and when. Both these were doing Public Health Work in the villages and the District Health Officer made arrangement to take from them all the records concerning Public Health Work, a week before they were due in Madras for Public Health

Training. Accordingly both of them went to Madras on the due date. A few days later both of them received a communication from the District Board President to hand over charge of the dispensaries to two other practitioners. As the training classes commenced by that time they could not leave Poonamallee Health Unit where they were working at the time. Accordingly they intimated to the President their inability to return to their villages and suggested that a loan of drugs could be got for from any neighbouring L. F. Dispensaries for running the two rural dispensaries and these would be made good from the drugs supplied to the Rural Dispensaries after the two practitioners return to duty. It is said that the District Medical Officer arranged the supply of drugs and the dispensaries were run. The District Board President instituted proceedings against these two practitioners asking explanation as to why their agreements could not be terminated for closing the dispensaries before substitutes arrived. The question naturally arises as to who was delinquent? The subsidized practitioners were not idling away their time; they were deputed for Public Health training and were asked to report for duty on a particular day which they did. It was the duty of the District Board President to relieve the practitioners in time. Any standing order relating to whole-time service cannot be made applicable to rural practitioners who are independent medical practitioners. A rural dispensary is not the property of the District Board but belongs to a particular practitioner and no other practitioner can have access to it. The District Board should have requested the subsidized practitioners to arrange for substitutes and in case it was not possible for them to do so the District Board should have made its own arrangements in time. The subsidized practitioners undertake Public Health training in public interest and for public good. It is rather hard they are to be questioned for the delinquency of somebody else.

A Discovery: We draw the attention of the readers to a discovery made by Dr. K. Venkatachalam and his assistant, Mr. A. N. Ratnagiriswaran belonging to the Madras Medical College Research Unit on the efficacy of the Gonadotropic Hormones in the treatment of whooping-cough appearing in the Abstracts Columns of this issue. Whooping-cough is a malady for which no specific has been found so far and it behoves the members of the medical profession to apply this discovery in practice as the authors of the discovery could not be expected at this stage to say the last word on their findings. The role of Endocrinology in Medicine seems to be as wide as it is unlimited. The great advance in Endocrine-Therapy reminds us of a visit of Dr. H. R. Harrower, the renowned Endocrinologist in America to Sir William Osler in the year 1913. In the course of conversation Sir William Osler seemed to have said: "*The Surgeons have been having their innings during the past ten years or so and now it is medicine's turn. Mark my words, the internal secretions will be the bat with which the runs are made.*" The term Preventive-Surgery has not yet been in vogue to the extent the Preventive-Medicine is and Preventive-Medicine has been developing and making rapid strides. It looks as if the Surgeons have to depend entirely on Physicians even for preventing surgical operations, involving great risks not to speak of the dangers of meddling surgery. From what one reads about the recent advances in Endocrinology we may say that gynaecological operations can be prevented to a great extent if the surgeon dealing in this speciality makes a special study of Gonadotropic Hormones in the female. We congratulate the Research Unit of the Madras Medical College on the quiet and unostentatious work turned out at the Unit but we wonder whether its existence is known to other Units of the Medical College including the General Hospital which is next door to this Unit.

ADMISSION INTO MEDICAL COLLEGES

An Eminent Educationist from Bombay writes: "With regard to the note on admission into Medical Colleges appearing under the column 'News and Comments' on page 363 in the issue of the 'Medical Practitioner' for June 1939, I wish to place my views as under for your personal information:

In the comments you state that "It would be fair to place III class graduates above I class Intermediates."

So far the Bombay University is concerned only those candidates are granted admission to the Medical Colleges who have passed the intermediate examination in Science with Chemistry (both organic & inorganic), Physics, Biology and English or any equivalent examination of any other recognised University in subjects of Physics, Chemistry and Biology. We have practicals in all the three Science objects.

You will permit me to say that it would not be in the interest of medical education to give preference to III class Graduates above I class Intermediates. Whatever may be the practice in Government service, medical education is a different thing. I would any day prefer a I class Intermediate to a III class Graduate. The former has intelligence and ability which the latter has not to the same extent. His spending extra two years in a college for a III class degree does not give him any superiority. My practice is to give the first preference to those candidates who pass their Intermediate Science examination with First Class or high Second Class at the first attempt as this helps to admit only intelligent student to the Medical Course. Students who fail to get admission to a Medical College or who are unsuccessful at the Inter Science examination on more than one occasion generally go in for a B.Sc., course and then try to secure admission to the Medical College. Generally such students are not up to the mark. Another

reason why these students should not be given first preference is that the course of University curriculum is unnecessarily prolonged by admission of B.Sc. students to the Medical Course. If a sufficient number of students who have passed the Inter Science examination with the First Class or high Second class is not forthcoming, then only B.Sc. students with First or Second Class should be admitted to the Medical College. My experience hitherto has shown that preferential admission to the B.Sc. students had not in any way improved the quality of the results of the University Examinations or in other respect as when appointed as House Surgeons or House PhysiciansI do not therefore at all agree with your suggestion or even entirely with the order of preference given in selecting students to the Medical College in Madras. The first preference should be to First class or High Class Intermediates and not to First or Second Class B.Sc's if the medical course is not to be lengthened to nine years after Matriculation from the present minimum period of 7 years".

**GOVERNMENT OF MADRAS
EDUCATION AND PUBLIC HEALTH
DEPARTMENT
(Public Health)**

G. O. No. 1608, dated 4th May 1939

Medical institutions—Rural (subsidized)—Contribution to private practitioners for rendering medical aid in villages within five miles from rural dispensaries—Payment objected to.

Read the following papers:—

From the President, Provincial Subsidized Rural Medical Practitioners' Association, dated 11th December 1938, No. R.M.P.G.-17/239.

From the Principal, Indian Medical School, dated 6th March 1939, No. 678. 2/N.D./39.

Order—No. 1608, P.H., dated 4th May 1939.

It has been reported that the Thottavalluru Panchayat Board is paying a contribution to a private practitioner of Indian medicine for rendering medical aid in a village called Vallurupalem which is about one mile and a half from Thottavalluru where there is a subsidized rural dispensary. On the principle enunciated in G.O. No. 3066, P.H., dated 15th November 1937, that rural dispensaries should not be located within a distance of five miles from each other, it is objectionable that a local body should pay a contribution to a private practitioner for rendering medical aid in a village within five miles of a rural dispensary. The contribution paid by the Thottavalluru Panchayat Board to the private practitioner at Vallurupalem should be stopped immediately unless the President, District Board, Kistna, decides as an alternative to transfer the subsidized rural dispensary at Thottavalluru to some other suitable place, in consultation with the Revenue Divisional Officer and the District Medical Officer.

2. As the payment of such contributions to private practitioners for rendering medical aid in villages within five miles from a rural dispensary, is a waste of public funds, presidents of local boards are requested to take steps immediately either to discontinue such subsidies, or to move the rural dispensary to some other suitable place in consultation with the District Medical Officer and the Revenue Divisional Officer.

(By order of His Excellency the Governor)

G. H. COOKE,
Secretary to Government.

*G. O. No. Ms. 2378 P. H.,
dated 6th July 1939.*

Medical Institutions—Rural—North Arcot District—Transfer of medical practitioners in the dispensaries at Timiri and Ponnai—Action of the President, District Board, North Arcot held irregular—Transfer of medical practitioners

in dispensaries subsidized by Government to dispensaries not so subsidized—Not allowed.

Read the following papers:—

From the President, The Madras Provincial Subsidized R.M.Ps' Association, dated 26th January 1939.

From the President, District Board, North Arcot, No. 1052.59, dated 28th February 1939.

Order:—

Sri W. Gopalakrishnan, the medical practitioner in the rural dispensary at Timiri (subsidized by Government) was transferred by the President, District Board, North Arcot first to the rural dispensary at Ponnai (not subsidized by Government) and subsequently to the rural dispensary at Panapakkam (subsidized by Government) even though there was no provision in the agreement executed by the practitioner for such transfers. Sri P. C. Dakshinamoorthy the medical practitioner in the rural dispensary at Ponnai was transferred back to Timiri even though this was not permitted in G. O. No. 101 R. Public Health, dated 12th July 1938. The action of the President, District Board, North Arcot in having made the transfers without intimating the fact to the Surgeon-General and obtaining the sanction of Government was highly irregular. The irregularity is, however condoned.

2. The President, District Board, North Arcot is informed that the transfer of a medical practitioner in a rural dispensary subsidized by Government to a dispensary subsidized by the District Board should not be made in any circumstances.

(By order of His Excellency the Governor),

G. H. COOKE,
Secretary to Government.

*G. O. No. Ms. 2937 P. H.,
dated 17th August 1939.*

Medical Institutions—Rural—Subsidized—Kistna District—Thottavalluru—Rural Medical Practitioner—Payment of allowance for festival duty done in 6 August 1933—Ordered.

Read the following papers :—

From the Rural Medical Practitioner, Thottavalluru, dated 21.10.1937.

From the President, Madras Provincial Subsidized Rural Medical Practitioners' Association, No. R. M. P. G. 41/624, dated 23.5.1939.

From the President, Madras Provincial Subsidized Rural Medical Practitioners' Association No. R. M. P. G. 43/637, dated 4.6.1939.

From the President, Madras Provincial Subsidized Rural Medical Practitioners' Association No. R. M. P. G. 44/644, dated 10.6.1939.

From the President, District Board, Kistna No. A. 4.2256.39, dated 1.7.1939.

Order :—

The President, District Board, Kistna is informed that under the terms of the agreement entered into with the medical practitioner in charge of the rural dispensary at Thottavalluru a daily allowance of Rs. 5 is payable to him for the period he performed festival duty in August 1933 in connection with the Kistna Pushkaram, irrespective of whether the duty was performed at his headquarters or outside it. He is requested to arrange for the payment of the amount due to the medical practitioner as soon as possible.

(By order of His Excellency the Governor)

G. H. COOKE,
Secretary to Government.

WEBSTER'S GASTRIC POWDER

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It is a specific in the form of a powder as per the formulae of Professor Webster, who made a special study of Gastric Catarrh with Hyperacidity and finally succeeded in combining a rather crude compound, which proved to be very satisfactory, not only in his own experience but in that of the many students who learnt at the feet of the late Professor. Though the crude character of the compound may be objected to by some, yet it must be seriously understood that the disease is much worse and the consequences, if left untreated, are greater leading to untold sufferings.

The conditions which directly indicate are present in by far the large number of cases. These are acidity, more or less marked and a sensation of fullness in the stomach after eating but little. The stomach may be sour, burning and painful immediately after eating or an hour or so after eating. These indications can be relied upon notwithstanding many others may be present at the same time. The chief ingredients besides the usual alkalies of Bis., Cal., Sod. are the vegetable alteratives, which exert a curative influence over the totality of the symptoms by restraining Hypersecretion and bringing the Gastric Mucous membrane to its normal tone. Herein lies the difference between other kinds of treatment in vogue, not only does it directly neutralize the acid present but slowly, gradually but certainly it exerts a marked influence on the Pathological condition of the stomach, which produces Hypersecretion and in consequence an ulcerative condition. The pouring forth of excessive Hydrochloric Acid is slowly diminished and the ulcers begin to heal and in course of time a health Mucous Membrane is produced.

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Review.

BOMBAY SURGICAL COMPANY,

New Charni Road, Bombay.

Messrs the Bombay Surgical Company have been advertising their goods in the columns of The Medical Practitioner ever since the journal came into existence and occasionally there were enquiries from the readers of The Medical Practitioner about their surgical requirements which they wished to order from this company and the readers had to be satisfied with our answers for what they were worth. Recently we received from this firm a pretty big volume of their catalogue and also a brochure relating to their factory situated at Mahalaxmi Bridge, B. B. & C. I. Ry., in which amongst other things we find the opinion expressed by the Surgeon-General with the Government of Bombay about the factory belonging to the Company which has been reprinted below for the information of the readers of The Medical Practitioner. The letter speaks for itself and needs no further comments.

The letter from Major-General H. C. Buckley, Surgeon-General with the Government of Bombay was addressed to the Secretary to Government, General Department, Bombay, the contents of which are as follows :—

" I visited by invitation the Bombay Surgical Company, Mahalaxmi Bridge. I examined the various surgical instruments made and also inspected their workshop where the instruments were being manufactured. This is a manufacturing company and as their work is satisfactory are deserving of encouragement. They are manufacturing Instruments within their competence and what they are turning out is of good quality. There are certain instruments such as Cataract Knives and Lithotrites which cannot be manufactured at present in India and this firm does not try to compete against British Manufacture in these lines. It might be possible to do so in the future. What they manufacture is sound and useful and encouraging."

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the Month of July 1939.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance on 30-6-1939 ...	83 9 0	Postage ...	6 8 6
Subscriptions from members ...	41 8 0	Pay to Clerks for June 1939 ...	15 0 0
Entrance fee from eight new members ...	2 0 0	Amount credited to The Medical Practitioner from the subscription for 1939 paid by a member.	2 0 0
		Contribution paid to the Secretary-Treasurer of :—	
		Bellary District	1 0 0
		Malabar District	3 4 0
		Ramnad District	9 0 0
			13 4 0
		Cash Balance :	
		With Savings Bank	83 9 0
		" Office	6 11 6
			90 4 6
	127 1 0		127 1 0

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

a case for the dietician

Diets in India incline towards monotony, which makes their margin of surplus nourishment narrow. Therefore persons who are accustomed to alcohol may very well be dependent on it for some essential part of their food. Prolonged abstinence, without some compensation in the diet, will then cause cumulative deficiency, most likely to come before the physician in the form of gastro-neural symptoms.

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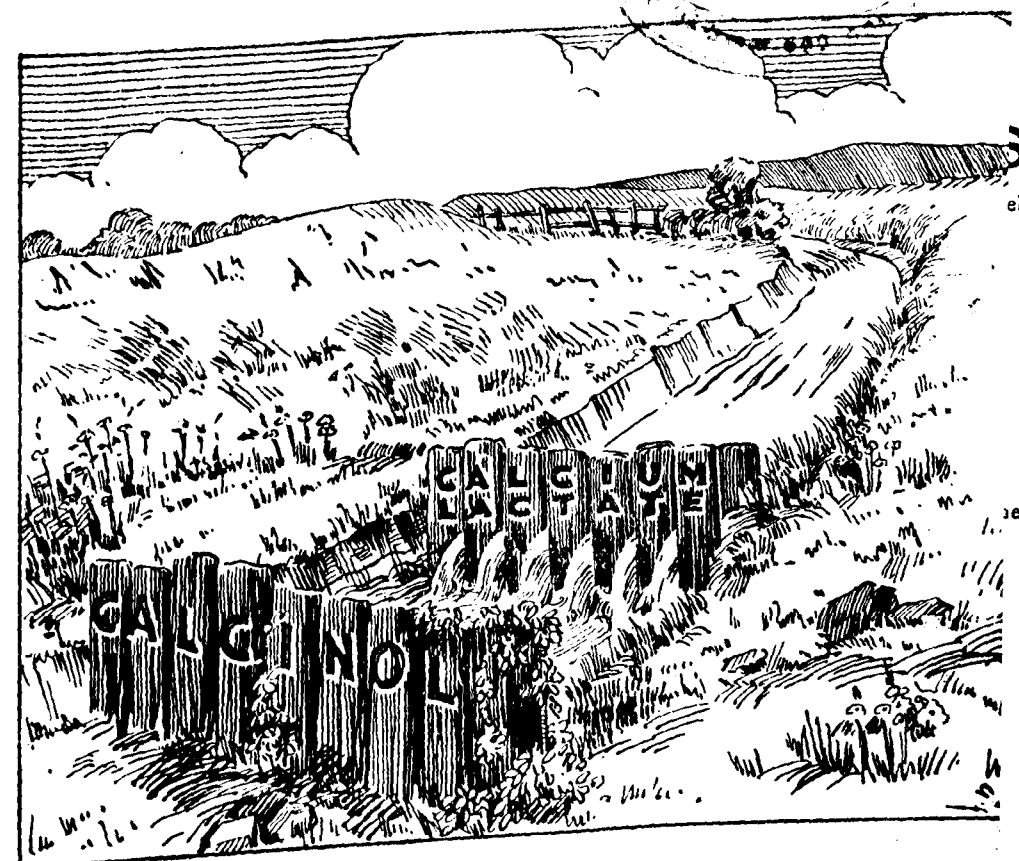
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Original Articles

POST-PARTUM HAEMORRHAGE.

P. P. H.

By

RAO SAHIB DR. S. M. TRASI, M.B. & C.M.

Retired Professor of Midwifery and Gynaecology, Vizag Medical College.

GENERAL CONSIDERATION.

A not infrequent, often alarming complication of labour, is excessive bleeding following child birth. Normally about half a pint, or 'under one pint' of blood is lost in the placental stage. This generally causes no disturbance in normal cases as there is usually an increase in blood in normal pregnancy. Loss of one pint or over is regarded as P. P. H. But these mathematical calculations, though of academic interest, are of little help in practice. One cannot be measuring blood loss, except perhaps as a rough guess, in the presence of bleeding calling for urgent attention. Besides, the effect of blood loss depends not merely on the amount lost, but on the patient's state of health as well. A hyperpyretic, toxæmic or plethoric individual can afford to lose and even benefit by what may prove fatal to an anaemic debilitated patient. The only practical guide is the effect on the patient. Whatever loss, be it large or small, causes clinical effects is P. P. H.

TYPES: P. P. H. may occur in the third or placental stage or any time within 24 hours after child birth (*primary*), or later

(*secondary*). Bleeding may be from injuries to uterus, cervix, vagina, clitoris, bulbar perineum (*traumatic*) or from the placental site (*atonic*). The traumatic type always occurs immediately after child birth (*primary*) and if from uterine rupture is serious, its seriousness being due more to the uterine rupture than bleeding and the treatment is for rupture. The rest are easily dealt with on general surgical principles. The more common and serious type of P. P. H. is the *primary atonic* variety, practically all fatalities from P. P. H. being of this type. In the presence of real flooding, the best of us may at times lose our wits and bungle with disastrous results. Besides, it is not in difficult labours only it is met with, when an obstetrician's help may be at hand.

FREQUENCY: It often occurs in natural cases of midwives also. Its frequency is variously estimated from half to one per cent of all labours, to 3 per cent in midwives cases in the West. It is considerably higher in the East where various debilitating influences are at work to undermine health, such as, climate, poverty, squallor, closely repeated pregnancies, anaemia, hookworm disease,

malaria etc., and few get or can command due care in pregnancy and labour.

One authority credits it with 6 per cent deaths in a Colombo lying-in-hospital. It is therefore worthwhile to see if a simple, fairly sure treatment can be devised for it, both prophylactic and curative, easy to apply even by midwives in rural practice. It is from this view-point that *primary atonic* P. R. P. is considered here.

AETIOLOGY.

To properly evaluate etiological factors and treatment, it is of help to know how nature checks bleeding from sinuses torn in placental separation in normal labour. The structure of the uterus explains this. (1) Its corkscrew shaped arterioles, (2) their winding course through spaces in the net work of its middle muscular coat, with muscle bundles looping round them (living ligatures); (3) the acute bends in its venules (falsiform valves), (4) loss of outer coats of its vessels as they traverse the thickness of their walls towards the placental site, leaving only the delicate intima to form sinuses, thus facilitating their shrinkage into uterine wall when torn, and easy obliteration by uterine retraction; these are all features well suited to cut off blood supply to placental site with firm uterine retraction, after placenta separates. Whatever therefore tends to induce deficient retraction (*atony*) favours atonic P. P. H.

PRE-DISPOSING CAUSES: Exhaustion from prolonged labour, heavy chloroform anaesthesia, multiparity, overdistension from hydramnios or twins, fibroids inversion, debility from ante-partum bleeding or other cause, etc., all predispose to it.

MECHANICAL CAUSES: Retained clots on placenta, fibroids, full bladder mechanically interfere with efficient retraction.

DIRECT EXCITING CAUSES: Hastening delivery when uterus is exhausted, hurrying over third stage before complete placental separation, are direct exciting causes.

GENERAL CAUSES: *General Causes* operating in the East have been men-

tioned. Rare ones are Purpura, Haemophilia, Scurvy, Jaundice and Leukaemia.

SYMPTOMATOLOGY.

Bleeding may occur before or after placenta is expelled. It may be (1) *External*, with intermittent or a steady leak or furious flooding; or (2) *Concealed*: collecting in a flabby yielding uterus, stretching it and causing more bleeding and stretching in a vicious circle. The uterus then feels large, doughy, ill defined reaching above umbilicus. On massaging and squeezing it big clots and a stream of blood are shot out, and the patient may collapse. This concealed type is apt to be missed, if pulse is not watched, or attention is diverted as in reviving an asphyxiated child. Change in pulse, as a warning sign draws timely attention to it.

Clinically three degrees may be distinguished according to effect of blood loss on patients. First degree or mild; second degree or moderate and third degree or severe.

First Degree or Mild:—The first effect of blood loss is on pulse—rise in rate and fall in tension proportionate to the loss. Pulse becomes frequent and soft. Volume may be little altered. Usually third stage pulse is slower than in second stage, even in conditions with high pulse rate. ex-fever, fatigue from long labour, heart-disease or tuberculosis. A rate of 60 or even 50 is not uncommon in the third stage in normal labour. Faster in third stage than in second invariably means bleeding. Record of maternal pulse, with F. H. in second stage is thus important as a guide in this respect.

Second Degree or Moderate:—Here the loss is large enough to markedly affect circulation with more marked effect on pulse and additional signs. Pulse is rapid, small, weak, easily disappears under light finger pressure. Pallor, tendency to cold limbs and subnormal temperature, hurried breathing and thirst occur.

Third Degree or Severe:—This is the gravest type, often fatal. Patient is gray; lips face and skin of leaden hue; body and limbs icy cold; pulse hardly

felt; blank staring eyes; vacant look; great restlessness; patient tossing about, gasping, calling for water, pointing to her white parched tongue, all indicating depletion of vital centres. She may try to sit up in her distress, and fall back dead. Occasionally a full slow pulse may suddenly fail and patient gasp and die in a few minutes, from furious flooding, which is more dangerous than a longer loss from slow oozing, the vasomotor system having no time to accommodate itself to the severe sudden drop in blood-pressure (*fulminating type*.)

TREATMENT.

PROPHYLAXIS:—Bearing in mind the main etiological factor—*atony*—ante natal measures to improve uterine tone are useful. Calcium lactate or gluconate, quinine in tonic doses of i-ii gr. thrice a day in the last month or two of pregnancy. Anaemia, hookworm disease, malaria, scurvy, jaundice, etc., should receive suitable attention and general health improved. In hydramnios early rupture of membranes to prevent or relieve overdistension. Timely help in difficult labour to avoid exhaustion. Never to deliver in the absence of good pains, that is, in uterine exhaustion. Careful management of third stage allowing due time for placental separation, $\frac{1}{2}$ c. c. pituitrin just after child birth, inducing good contraction and retraction, helps placental separation and lessens risk of P. P. H. Experience does not bear out the fear of hour-glass contraction, some entertain about this prophylactic use of pituitrin. As a curative, however, though useful in mild and moderate degrees, it very often fails in severe atony, in which its use is like flogging a jaded horse. A severely exhausted uterus is in need of rest and not stimulation.

Pulse should be watched from time to time in the third stage for timely warning of any commencing concealed haemorrhage. It was customary to insist on a controlling hand on the uterus for this purpose. It is unnecessary. Pulse is a more delicate and accurate guide. In fact modern teaching is that active uterine control may cause premature partial separation of

placenta with escape of retoplacental clot, (an important factor in the normal mechanism of placental separation) and so lead to severe bleeding and atony. In the absence of bleeding, one or two hours is not too long to wait. Spontaneous expulsion has occurred even after six hours or more. If signs of shock appear, but no bleeding, as some times may happen in retained placenta, restorative measures are indicated and not attempts at expression or extraction. When patient recovers, placenta may be expelled spontaneously; if not it may then be extracted.

CURATIVE: With active bleeding the object is to empty the uterus and secure good retraction. For this purpose:

1. The uterus is massaged to check bleeding.

2. Urine is drawn.

3. Clots on placenta if in, expressed or failing it extracted under light anaesthesia massaging the uterus from time to time while the patient is getting under.

4. Hot vaginal douche, or if placenta had to be extracted, hot intra-uterine douche followed by an ounce of sterile glycerine into uterus through sterile catheter and glass syringe.

5. Pituitrin or Egometrin hypodermically and Liq. Ext. Ergot dr. ii by mouth. These measures rapidly followed step by step generally succeed in most cases especially mild and moderate and should be the routine procedure in all bleeding cases.

Third degree cases often fail to respond to these measures, the uterus remaining soft, flabby and ill defined, with momentary feeble contraction on stimulation with massage. In such cases fatal concealed bleeding may occur with little external evidence. It is in these cases of severe atony that the procedure I advocate succeeds. Severe atony being the main feature in these cases, bleeding from the open sinuses of such soft uteri is comparable to paranchymatous bleeding from

perineal tissue wounds. In these, the surgeon brings together the bleeding surfaces in firm apposition with mattress stitches to stop the bleeding and only when this fails or is impossible does he plug. The same principle can be successfully applied here, by keeping the two uterine walls, front and back, pressed together. The 'Ten Teachers' speak very highly of it, saying it is *absolutely efficient*, but *trying* as usually done with a vaginal fist and abdominal hand and no doubt it is, from the cramped position the attendant has to maintain long. Also as long as he has to maintain the pressure he is not available for any urgently needed restorative measures. It can, however, be applied in a few minutes without recourse to vaginal fist leaving the attendant free for restorative measures, if carried out thus:—

(a) The uterus is massaged between palms in front and behind the uterus, through the lax abdominal wall; the hands are slipped down and the lax lower segment compressed and closed between their contiguous ulnar edges.

(b) The uterus is then bodily raised and ante-flexed against front pelvic wall. Closure of the lower segment before raising the uterus prevents suction of air and obviates risk of air-embolism.

(c) A roll pad is placed behind the ante-flexed uterus and on the roll pad, a horse shoe pad enclosing the uterus behind and all sides.

(d) A firm binder is applied over all and fixed from above down. The fundus can now be felt over the symphysis with fingers gently inserted under the lower edge of the binder. The attendant is now free for restorative measures. A small injection of morphia plus atropin or omnopon promotes sleep and rest. The foot of the bed is raised about 18", pillow taken away from under head, warmth applied and if necessary hypertonic saline glucose, rectal, subcutaneous, or intravenous, as per patient's condition. And since blood transfusion is difficult in rural practice, auto transfusion, that is, holding limbs vertically up and bandaging them firmly

but not tightly from the extremities inwards towards the trunk. This auto-transfusion restricts blood flow to limbs and helps to restore blood pressure, and maintains a better blood supply to vital centres along with raised foot of bed and no pillow under head. Coramine is also very valuable.

In fat patients, through whose thick abdominal walls manipulation is difficult, firm vaginal plugging lifts the uterus up and makes abdominal manipulation easier. In furious flooding immediate aortic pressure $\frac{1}{2}$ " below and to the left of umbilicus is a variable emergency first aid measure to temporarily check bleeding till this procedure is rapidly adopted.

The horse shoe pad is easily prepared extempore on the spot with a bed sheet or large towel folded lengthwise, and twisted in opposite directions at either end by two persons and then doubled up when tightly twisted, to form a 'rope'. If too long still, the process is repeated. The resulting thick pad is curved into a horse shoe and applied to the back and sides of the ante-flexed uterus.

After the bleeding is controlled, the attendant should not leave till the patient's pulse is below 100. And after recovery absolute rest should be enjoined for a long time for fear of risk of syncope.

Advantages of the Method Advocated:—

(1) Effectively stops bleeding and keeps uterine walls pressed together closing the cavity against concealed bleeding.

(2) Pads maintaining pressure on abdomen and aorta, restore intra-abdominal pressure restrict blood flow to parts below and maintain better blood supply to vital centres.

(3) Not painful.

(4) Applied extempore at a moment's notice takes only a few minutes and leaves attendant free for restorative measures.

(5) Can be left on for hours if necessary till uterus recovers tone.

(6) Has repeatedly proved successful where routine and other measures failed.

(7) Is a prophylactic in habitual bleeder, applied immediately on placental expression or extraction, before much bleeding occurs.

In fact it deserves to be added as the last step to the routine measures above detailed since it is difficult to predict who would be a bleeder.

(8) Last but not least, easy to apply extempore even by midwives, needs no special appliances and hence eminently suited in general practice both in urban and rural areas.

The various other more elaborate measures described in books have not been discussed here, as unsuitable for general practice.

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THE VENEREAL PROBLEM.*

By

CAPTAIN E. S. GOPALAN, M.S., M.B., A.I.R.O.,

*Surgeon, "Subbalakshmi Memorial Clinic", Coimbatore and
Chief, Vedapatti Health Ashramam, Coimbatore.*

The problem of venereology is linked with the problem of sex. The problem of sex should be viewed objectively in a strictly scientific manner. There should be no delicacy and shrinking from a rationalistic attitude. Sexual desire is a primary and beneficial instinct, which enables man to fulfil his role, in the propagation of his species. It is natural, it is biological and it is no shame for a man and a woman to be mutually attracted to each other. The so-called modern civilized life, with its multitudinous institutions and repressions, may put a thick veil over the problems of sex, but a rationalist, cannot but tear the stifling veil, to have a glimpse of the method of working of the Divine will. Education and self-discipline may tide and inhibit the primeval instinct, but the instinct is inborn and an average individual will certainly be subordinated by the instinct.

Sexual intercourse is a physiological act. It is universal. It exists not only among the higher animals, but also amongst the lower animals and plants. But for this sexual method of reproduction, there will be no beings and no plants on this earth. Perhaps the world will be inhabited by only bacteria and other asexual forms of matter organic and inorganic. Why should this psychological act, which is not attended by any evil, in the animals, lead to such dire diseases, as the venereal diseases, in the human being? It is because man is man and an animal is an animal. From the day man chose the path of civilization, by reason of his creative faculties, nature also has been heaping on him obstacle after obstacle, to warn him, again and again, that he is going astray. Man's creative ability, which distinguishes him

from an animal, is responsible not only for his glorious conquest over nature, but also for the reactionary forces, which threaten to annihilate him. As long as these re-actionary forces are understood and controlled by him, he is safe. But these very demons created by him, will turn against him, if he goes to sleep and lacks vigilance. Alas! there would have been no problem for us, if we had continued as for ever, feeding on the jungle products, and from one tree to the other. That is not to be. God has given us a portion of his creative genius, and, if we had only used this wisely, we would have been happier. This present civilization, I am sorry to say, in spite of its achievements, has not given real happiness to man. It has miserably miscarried in many respects. If these miscarriages are repeated, it will destroy him, not long after. I have to state that this present day civilization, is like a fast-moving automobile without break and steering wheel. You can imagine what would be the fate of the motorist, the passengers, the pedestrians if a motor car has no break and a steering wheel.

MARRIAGE.

The institution of "marriage" is a product of civilization and is a means whereby nature's purpose is achieved by a sort of division of labour. My opinion, judged as a whole, on this world convention though the details may vary from place to place and from clime to clime, is that it is one of the most wholesome products of civilization. It is perhaps the most convenient as well as the most natural method for fulfilling the Divine purpose. No wonder, then, that, everywhere, in this world, marriage and married life, are held in high esteem, and amongst the principal religions of

the world, it is considered a sacrament. If every able-bodied man and woman in the world tied in wedlock at the proper age, to a suitable partner of the opposite sex, and conducts himself or herself true to the pledges solemnly given at the time of the marriage, there need be no venereal problem.

It must be understood that promiscuity alone does not bring in venereal disease. The history of the incidence of venereal disease, shows, that it is only of recent origin, say about 4 or 5 centuries ago. Prior to this, there must have been promiscuity and venereal diseases judging from history were non-existent. As if to protect the very institution of marriage and to warn man against the evils of promiscuity venereal diseases came in at an opportune or inopportune time. It was a grave warning and man did not heed it, he paid for it and is paying for it.

UNBRIDLED CIVILIZATION.

Civilization, as I have understood, is a double edged weapon. It has made man, the supreme arbiter of this earth. It has also enslaved him to an extent, which is indeed appalling. I am afraid that the present trend of civilization if not checked at the proper time will land us in chaos. Let us consider the Red Cross movement. Under the existing conditions, it is absolutely necessary. It would be even an advantage to increase its usefulness. But its existence and its necessity denotes a serious state in the human affairs. Why should there be war? Why should there be famine? Why should there be epidemics? Why should there be congestion? Why should there be starvation in the midst of plenty? Why this madness in armaments? A reply to these questions of a fundamental nature, will also solve the venereal problem in addition to the others. The existence of venereal problem is symptomatic of the morbid condition of our society, based on the so-called modern civilization. Let me not be understood as an inveterate critic of the modern civilization in toto. Some aspects are certainly good, but the other aspects which enables man to crush his brother bringing on its trail accumulation of wealth, luxury on one side and unger on the other, rapid production of

essentials and unessentials, capitalism, glorified monarchies, large scale industries unemployed, congestion of human beings in towns and slums where God's pure air and water cannot be had—these aspects must be controlled by enlightened world opinions.

The venereal problem is inter-twined in so many ways with the minute fabric of the structure of human society, that playing with it, in a superficial manner cannot help us at all. The malady must be attacked at the roots and not at the terminal branches. So, I should suggest the following remedies:

(1) The world as a whole must realize the sanctity of the human soul and body, its inborn right to freedom and self-expression. The arrogance based on race, color, creed, religion, sex etc., must go.

(2) Absolute equality of the sexes must be recognised. The fact that a woman is comparatively weaker than her brother in the physical sense, is no bar to giving her moral and intellectual equality. Man and woman are inalienable partners, fulfilling a divine biological purpose. If this equality is granted, polygamy, recognised and surreptitious brothels, the devadasi system, enforced celibacy and widowhood, must all disappear. Trading on women to cater to the needs of irresponsible bachelors and unfaithful householders must be recognised as a heinous crime by the human society.

(3) Every individual of the world must be given full opportunities of earning an honest livelihood. Many women have to sell themselves on account of hunger. The society must be so re-organised that the lucky ones and the haves must be made to render succour to the unfortunates and the have-nots. Spasmodic doling out by Annadana-Samajams, Kanji Thoddies, and offering some copper to the beggars etc., must be replaced by organised planning to eliminate exploitation. Beggary must be exterminated not by driving out the existing beggars to some other place, but by tackling the fundamental causes of beggary. Invalids, deformed, maimed and old people must not be let loose but must be taken care of by the society. Some of the virulent forms of venereal infection are spread by

* A popular lecture delivered in connexion with the 75th Anniversary of the Red-Cross movement, at Coimbatore on 25-8-1939.

the existence of beggar men and women in our society. You cannot blame these unfortunate beggars. Their existence is due to something rotten in our society.

(4) The sanyasi system among the Hindus and enforced celibacy among the Catholics, are in my opinion, unnatural. It is only given to a few to observe Brahmacharya in its full rigour. Sexual desire is only a fulfilment of the divine purpose and there is nothing unholy. Man and woman are meant to swim the *Sam. sara Sagaram*. Marriage and bringing up a family etc., must be considered as noble as *tapasya* in a cave or nunnery.

(5) The marriage ceremony must be as simple as possible, devoid of stupid expenditure. The dread of expense postpones and spoils, otherwise desirable alliances. By all means let marriages be effected after proper consideration and deliberation, but making it a huge and wasteful *tamasha*, is unholy and ungodly. So many hideous customs have woven themselves around Hindu marriages that temperamental and biological fitness of the couple are not considered at all.

(6) Marriages must be effected at the physiological age. In women I should ordinarily have the marriage between 16 and 20 years, and in men between 18 and 25 years. Very late marriages must be condemned and it will indirectly contribute to the acquisition of venereal disease especially in the male partner. I have no hesitation in condemning early marriages, also on other grounds.

(7) The society or state must aid married couple in the shape of providing employment of the partners, free education of the children at all stages, free medical relief and advice and special grants in cases of excessive progeny.

(8) I should even suggest taxation of wealthy unmarried men and women to provide succour to men and women who are married and thus fulfil the divine biological purpose.

(9) When mass emigration or migration to foreign lands takes place, there must be purity as regards sex, so far as the population is concerned. In the past predominance of the male sex has contributed liberally to the insidious spread of venereal disease not only among those

who migrated to foreign lands, but also among the innocent women staying at home when their husbands returned with infection.

(10) In the history of venereology, wars have played a most important part in the spread of disease, in even epidemic proportions. It will be so even hereafter but the modern soldier, so far as my experience in the army in India goes, is subjected to such a thorough treatment, that his role in the spread of the disease, will appreciably dwindle. The question of this human madness, is a very large one and a solution of this, though of essential importance in venereology, is outside the scope of the present discussion. Wars are barbarous and contemporary accounts from the blind Japanese and the Abyssinian wars are a deplorable tale of wanton rape on helpless women and young girls. All these are taking place in the name of civilization.

(11) *Industrialization*: Bringing on close contact of men and women is a fertile field for the development of venereal disease. It is essential where a number of women are employed in the industries, that the women should work away from men, under women maistries only. There is some truth in the common scandal that some men maistries are particularly hard on women workers who struggle to maintain their chastity.

(12) *Urbanisation* is an important modern event which is responsible for the spread of venereal disease. So many cases of adultery which cannot take place in villages find a congenial soil in the busy congested towns, where even neighbours may not know each other. Even rural worthies get themselves venerealized in the neighbouring towns, at the public places and brothels.

(13) Prohibition is a measure which will reduce the incidence of venereal diseases, in the long run. Drink and debauchery are allied.

(14) It is fortunate that the common venereal diseases are curable to very near perfection. We have very powerful anti-venereal remedies and a campaign against venereal diseases must, at present start with the eradication of the existing venereal diseases.

(15) Mere starting of venereal clinics in a few hospitals will not solve the problem. The Medical Profession as a whole should be entrusted with this urgent work by placing at their disposal the necessary drugs and laboratory facilities. The Governments move very slowly and always in a half-hearted way.

(16) *Social Service*: A policeman, or a health officer with the policeman's powers are not the proper persons for enforcing anti-venereal treatments. Men and women social workers, should do continuous propaganda in the homes of the affected persons on receipt of information from the hospitals and private doctors.

The Red Cross movement and its funds can be profitably utilised by using the services of private medical practitioners, male and female, as part time health visitors in the various localities. When one of a married couple is affected with a venereal disease the other must undergo

close examination and continuous observation for prolonged periods.

Until in civil life, military standards are attained in the treatment the venereal problem will remain unsolved. Petty half-hearted measures are a waste.

The masses must be made to understand that the mere disappearance of the external manifestations of the disease, after a few injections, is not the criterion of cure. Prolonged treatment on accepted scientific lines, should be urged and enforced. The medical men also should never promise a cure after insufficient treatment.

CONCLUSION.

The venereal problem is thus not an isolated one, but is inextricably associated with the whole range of human activity. It is increasing. Innocent people also fall a victim to its ravages. Eradicate the venereal disease, you can close down fifty percent of the hospitals.

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Abstracts.

IN VIRUS DISEASES, WITH SPECIAL REFERENCE TO TRACHOMA

HANS SCHROEDER, M.D.

San Francisco, Cal.

NATURE OF VIRUS DISEASES

What is a virus disease? The usual concept is that it is a disease caused by ultra-microscopic organisms. As to the nature of these organisms, facts are few and speculations many. We are told that they are a transitional form between living and non-living substances; even that they are possibly a retrograde evolution from bacteria. This latter view is also taken by Burnet. Since their exact nature is not known, some physicians deny their existence. The fact that they have not been successfully cultivated except in the presence of tissue cells has lent some support to such attitude.

The investigation of these substances has been greatly hampered by the minute size of their units. Several of them are only twice the size of oxyhemoglobin. Their cultivation being entirely dependent upon experimental animals or culture on tissues has greatly added to the complexity of the problem. Since the reaction of the host or host cells is here introduced, the results allow various interpretations.

One effect of the virus on the cell is the production of inclusion bodies; however, these are not uniformly present with the same virus and, again, they may be present when no virus disease has been established.

Another effect of the virus is a lasting immunity conferred upon the host in most of these diseases. In spite of the size of these substances there is a certain specificity as to the immunity conferred. An exception to this are smallpox and vaccinia on the one hand, and varicella and herpes zoster on the other.

The species specificity that I have mentioned for trachoma is also described by Craigie for poliomyelitis. It is well to remember at this point the objections Szent-Gyorgyi has to the interpretation of results on laboratory animals in connection with the investigation of vitamins; these laboratory animals do not live under a natural environment.

VIRUS DISEASES AND MALIGNANCY

Before discussing the changes in trachoma I like to digress a moment to consider the relation between virus diseases and malignancy. It is claimed that virus diseases are responsible for some of the lower grades of malignancy, but that no virus has been found in carcinomatous tissue. Since the viruses are electronegative in reaction, this fact would favour the alkalosis theory of the origin of malignancy. This is generally refuted, however. In my investigation on the nature of malignancy I have so far found some twenty reports from the clinic and the laboratories in direct support of my theory that the positive electrolytes are responsible for the control of malignant growths; certain ones favoring growth, while others produce senile changes in the tumor. While it is possible that the malignancy may be initiated by a virus, the absence of it in the carcinomas may mean that the electro-positive elements have neutralized the electro-negative virus and removed it. Yet, we must bear in mind that any irritant, if applied long enough, may initiate a malignant growth.

The report by Schmidt on the adsorption of the virus of foot and mouth disease, as well as other types of viruses by aluminum hydroxide would seem to disprove my contention, but we do not

know what chemical interaction takes place between the aluminum hydroxide and the virus. I reject the claim that aluminum hydroxide goes through the body unchanged; an active substance like aluminum hydroxide is certainly not inert.

According to von Euler the virus of mosaic disease of the tobacco plant represents an enzyme complex, but the problem of virus in human cancer remains unsolved. Baensch states that some believe in an invisible virus, which no one has yet been able to identify. One type of malignant neoplasm that may safely be ascribed to just such a virus is the Rous sarcoma of fowls. It seems probable that metabolic disturbances of organic function also play a part in the pathogenesis of cancer.

PATHOLOGY OF TRACHOMA

Nordman stated that the changes in the lymphatic tissue fall into four groups: (1) Acute inflammation, (2) Hyperplasia, (3) Necrosis, and (4) Induration. I stated that these conditions, except 3, obtain in trachoma. However, this is only relatively true, for where there is inflammation, there is bound to be some necrosis. What I had in mind was the absence of sloughing of tissue.

In vaccinia of the cornea we have, according to Rivers, Proliferation, Degeneration, inflammation. The change of the order from the above is due to the anatomy of the cornea. Since the cornea is avascular, the inflammation is produced by the action of the vascular loops at the limbus in response to the irritation of the cornea.

The most characteristic symptom of trachoma is the hypertrophy of the conjunctiva. The epithelium thickens and there is round cell infiltration. The papillary hypertrophy is due to the chronic irritation. The granules are roundish aggregations of cells with a delicate connective tissue supporting structure; they may be considered a defensive mechanism. The cells at the periphery are lymphocytes, those toward the center are mainly mononuclear epithelioid cells.

After the hypertrophy there is a gradual reduction in size with scarification and shrinkage, leaving a healed trachoma.

PREVENTION AND TREATMENT

Rivers states that quarantine measures are of no value in the prevention of virus diseases. This is generally not appreciated in the management of trachoma. Buffington ably discussed this at length in connection with a former paper. Fuchs states that in most cases trachoma has an insidious onset; that there are spontaneous cures and that the patient never was aware of having had the disease. The acute cases are mostly not uncomplicated cases of trachoma, but secondary acute infections of the conjunctiva by the gonococcus or the organisms of catarrhal ophthalmia. He also states that relapses occur often during regular treatment and without any known cause.

With the advent of sulfanilamide and its derivatives it seems that medical practice has been reduced to a routine employment of this drug in all and sundry infections, and the enthusiasm is still running on the crest of its popularity. It is therefore sobering to hear that most reports on its use in virus diseases are discouraging.

Immunological measures in trachoma we can dismiss when we remember that immune serum has no effect on virus diseases after the virus has entered the cell. We may therefore direct our attention elsewhere. The disturbing feature of what I have to say may be the fact that viruses are proteins and have antigenic properties. However, the catalysts to be considered have no part in the synthesis of the virus, which to my mind is elaborated from proteins of the cell protoplasm; it is the absence of them which makes the synthesis of the virus possible.

VITAMINS

On the basis of the blood changes in trachoma I came to the conclusion that the disease was caused primarily by an iodine and a vitamin C deficiency. The accompanying secondary anemia I wa

not able to correlate at that time. An interesting report by Clough shows that anemia may be caused by a deficiency of vitamin C. He states that this anemia is not relieved by the administration of iron salts or liver extract, but yields readily to the administration of vitamin C. This anemia due to the absence of a sufficient amount of vitamin C is also discussed by King. The anemia of scurvy, a disease in many ways similar to trachoma, responds specifically to vitamin C therapy. The detoxifying action of ascorbic acid on diphtheria, observed in Germany, led Ormerod and Unkauf to use vitamin C in pertussis, another virus disease as considered here, with gratifying results. Similar results were obtained by Vermillion and Stafford.

As an introduction to a description of trachoma I chose Osler's text on the clinical picture of tuberculosis, and showed its striking similarity to trachoma. In view of the very discouraging results in the treatment of tuberculosis since the discovery of the tubercle bacillus, where the disease is regarded as merely an infection with the tubercle bacillus and nothing else, I still maintain that it is primarily a virus disease with the tubercle bacillus as a secondary invader. The encouraging results in the treatment of this disease with vitamin C by Petter and others confirm this position.

From the foregoing it might be assumed that vitamin C or ascorbic acid acts as a specific in virus disease. I do not wish to give any such impression. I believe that the iodine deficiency is just as important in the production of trachoma as is the vitamin C deficiency. The spectacular results obtained with nicotinic acid in the clinical picture of pellagra

made this drug appear to be a specific. After the first enthusiasm waned, however, it was found that there were other factors involved as well.

Recent laboratory experiments by Kashara and associates showed a synergistic action between thiamin chloride and ascorbic acid. They summarize their findings as follows: 1. The antineuritic action of vitamin B is intensified by the simultaneous administration of vitamin C. 2. The growth-promoting factor of vitamin B is influenced by the simultaneous administration of vitamin C. 3. Vitamin B, exerts a protective action on scorbutic guinea pigs.

Attempts at treatment of trachoma with the vitamins, reported elsewhere have failed for various reasons. The principal ones appear to be inadequacy and lack of persistence.

SUMMARY

1. Some theories of virus diseases and several characteristic manifestations of the viruses are discussed.
2. Considerable doubt exists as to the role of virus diseases in imitating malignant growths.
3. A brief review of the pathology of trachoma is given.
4. The relation of vitamin C to virus diseases is presented.
5. Caution is expressed as to the specificity of vitamins in the treatment of virus diseases. 450 Sutter St.

(*The Eye, Ear, Nose and Throat Monthly, August 1939*).

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.

MACROCYTIC ANAEMIA OF THE ACHRESTIC TYPE.

G. M. WAUCHOPE AND M. LESLIE-SMITH.

L: Dec. 31, 1938, P: 1518.

It is "a severe hyperchromic, megalocytic anaemia due to lack of utilization or mobilization from the storage depots in the body of the anti-pernicious anaemia principle as found in the liver" (Wilkinson & Isaacs). The chief characteristic is a poor response, and finally no response, to liver therapy. In most cases free hydrochloric acid is present in the gastric juice and the central nervous system is not involved; sore tongue gastro intestinal disturbance, and pyrexia are absent and there is little tendency to bleed or evidence of haemolysis. There are no spontaneous remissions as in pernicious anaemia and the course is slowly progressive. The Van den Berg reaction is negative or gives an indirect or delayed direct response. The morbid anatomy resembles that of pernicious anaemia with megaloblastic hyperplasia of the bone marrow; adequate anti-anaemic principle is present in the liver.

Differential diagnosis: (1) In Addisonian pernicious anaemia there is always achlorhydria; (2) Megalocytic anaemia associated with steatorrhoea—responds to marmite; (3) Megalocytic anaemia associated with organic lesions of the gastrointestinal tract; (4) Megalocytic anaemia associated with *Bothriocephalus latus*, tropical sprue, or pregnancy; (5) Haemolytic anaemias such as familial acholuric jaundice, sickle cell anaemia, anaemia associated with chemical poisoning or chronic malaria show an indirect positive Van den Berg reaction, a high reticulocytosis, as in the case of lead punctate basophilia; (6) application of X-ray, radium and the ingestion of radio-active substances may produce megalocytic anaemia with a negative direct and indirect Van

den Berg reaction; (7) Chronic sepsis or nephritis and (8) Aplastic anaemia and chronic Myeloid leukemia.

CEREBRAL PARATUBERCULOSIS.

R. C. COHEN AND W. B. WOOD.

L: Dec. 10, 1938, P: 1344.

The authors base their findings on five cases observed by them during the previous two years. The patients were suffering from pulmonary tuberculosis of adult type between the ages 6 and 20. In each instance the pulmonary disease has been mainly exudative and the symptoms of comparatively recent origin. The leading symptoms were headache and lethargy or drowsiness. These preceded or accompanied the onset of fever. Physical signs were few apart from sluggish reactions of the pupils and sluggish or absent knee jerks during the attacks. In three instances a rash was observed erythema nodosum, a generalized simple erythema, and a mixed papular or morbilliform eruption. Symptoms of cerebral irritation were usually absent. Lumbar puncture yielded cerebro-spinal fluid which was under pressure but was clear and sterile and showed no cellular or chemical abnormality. Its withdrawal was followed by a notable relief of the headache. Recovery was uneventful and took from 7 to 14 days. The syndrome is thought to be due to exudation into the meninges of clear sterile fluid and is considered of allergic rather than specific nature. Its affinity with erythema nodosum is suggested. Of the names paratuberculosis, epituberculosis and tuberculosis the authors like the first.

ARTERIAL EMBOLISM.

A Study of Eight Cases.

D. L. C. GRIFFITHS.

L: Dec. 10, 1938, P: 1339.

Sampson Handley (1907) and Moynihan (1907) had each tried vainly to remove clot from peripheral arteries but their attempts had been forgotten and their

suggestions unadopted. Between 1907 and 1925 the Scandinavian surgeons had begun to operate with increasing confidence and success. These were not noticed by the British surgeons. In 1934 Jefferson reported six personal cases. Jefferson's second and fuller paper urged that the operation of embolectomy was an established surgical procedure, capable of producing very good results in the peripheral arteries. The paper is based on further eight cases and describes the first successful British aortic embolectomy and also reports the first diagnosed case of carotid embolism.

The sources of emboli were invariably from diseased conditions of the heart particularly rheumatic carditis. The symptoms usher in with dramatic suddenness with pain, paralysis, cold extremities and complete stoppage of peripheral pulsation. The operation of embolectomy is eminently successful if performed within six hours and not later than 12 hours after the onset of symptoms. Local anaesthesia must be preferred.

AN ACUTE INFECTION OF THE RESPIRATORY TRACT WITH ATYPICAL PNEUMONIA.

A disease entity probably caused by a filterable virus.

H. A. REIMANN.

J. A. M. A.

Dec. 24, 1938, P: 2377.

The author reports on 11 cases with atypical pneumonia symptoms. After several days of mild symptoms of hoarseness and sore throat, the temperature rose in each case, reached high levels, persisted with remissions for the duration of the illness and declined by lysis. In the early period the pulse rate was slow in proportion to the fever. Infection seemed to spread rapidly in some cases and more slowly in others until the trachea, bronchi and eventually the lungs were involved in a diffuse, bilateral process which persisted several weeks and was followed by a residuum which lasted several months. There was involvement of much of the smaller bronchiolar system, as

manifested by dyspnoea and cyanosis in each case but evidence of consolidation was never striking. Tachypnoea was not prominent. In five cases cough was distressing it was hacking, paroxysmal or continual, but in no case was more than a slight amount of sputum raised. The respiratory rate was increased somewhat in each case but not to the degree expected from the extent of the pneumonia lesion. Cyanosis and dyspnoea were noted in all cases. Nervous and other symptoms:—Sweating and drowsiness were most prominent. Headache was present in all, but muscle pains were minimal. Photophobia was distressing in five cases. In two cases nervous symptoms were more severe, with stiffness of the neck, photophobia, intense headache, twitching, somnolence and disturbed reflexes suggestive of meningo-encephalitis and in one case the spinal fluid contained several hundred cells per c.mm.

The only symptoms referable to the gastro-intestinal tract were constipation, abdominal distension and a heavily coated tongue.

The fever lasted from 10 to 43 days in the cases of severe involvement but usually about three weeks. Rales and roentgenographic evidence of pulmonary infiltration persisted in some cases for weeks or months afterwards.

The initial leucocyte count was almost normal. In two cases there was leukopenia. The count usually increased during the course of the fever. The number of polymorphonuclear cells was usually increased relatively and absolutely. Blood cultures never contained bacteria, and agglutinins for other bacillary diseases were absent.

From two patients, an unusual virus was obtained from the nasopharyngeal washings.

Diagnosis:—Typhoid with tracheo-bronchitis; Tuberculosis; Tularemia pneumonia; Miliary tuberculosis; Psittacosis; Influenza; Influenza Pneumonia; Disseminated focal pneumonia.

GOUT FOLLOWING SALYRGAN DIURESIS.

N. L. PRICE.

L: Jan. 7, 1939, P: 22.

The author reports five cases of congestive cardiac failure in which attacks of gout followed diuresis produced by salyrgan. All these gave a history of previous gout. This development indicates a bad prognosis. The attacks of gout appear to be due to the diuresis rather than to the level of the blood uric acid, and it is suggested that the associated disturbance of electrolyte balance is of considerable importance in their causation. Particularly remarkable is the enormous output of water and sodium chloride, in which the mercurials far outstrip digitalis or drugs of the purine group.

AMMONIA GAS BURNS.

G. M. J. SLOT.

L: Dec. 10, 1931, P: 1356.

The author reports six cases of ammonia burns which resulted from an explosion in an ice-cream factory due to the bursting of a pipe conveying ammonia gas. All the patients were considerably shocked on admission and one of them died as a result of extensive burns external and internal. The main post-mortem findings were acute laryngotracheitis, acute tracheo-bronchitis, and acute broncho-pneumonia with evidence of toxemia from the burns manifested by nephritis.

In these cases the primary factor to be treated is the shock. For burns tannic acid treatment should be adopted. An interesting side-light on this accident is the relation it would bear to gas attack in war-time.

BERI-BERI IN LONDON.

JOHN YUDKIN,

L: Dec. 10, 1938, P: 1347.

The author observed a case with beri-beri-like symptoms. He concludes that

the case was due to marked deficiency of vitamin B1. The case was cured by weekly injections of large doses of crystalline vitamin B1 i.e., 2 cm. of benerva forte (1cm=10 mg. crystalline vitamin B1=5,000 international units approximately).

In cases of beri beri diagnosis and prognosis can be assessed by examination of the 24 hour specimen of urine as regards the excretion of vitamin B1. It has been shown that an adult on the average normal diet excretes not less than 10-20 international units daily. Lower values were found in some medical and surgical cases. In conditioned deficiency diseases, excluding polyneuritis, the average excretion was 2.8 I. U. and nutritional polyneuritis 1.6 I. U. Before treatment the patient showed no measurable amount of vitamin. After 3 weeks of treatment the urine excreted 11 units. The author concludes that mild cases due to deficiency of the vitamin—a condition which may be called "Pre beri-beri" is probably not uncommon.

RENAL TUBERCULOSIS.

Prognosis following nephrectomy.

J. L. EMMETT AND J. M. KIBLER.

J. A. M. A.

Dec. 24, 1938, P: 2351.

The results are based on 1131 consecutive cases on whom nephrectomy was performed for renal tuberculosis at the Mayo clinic between the years 1912 and 1932 inclusive. In the first place to make a fairly accurate prognosis, catheterization of the good kidney, to determine the amount of pus being secreted, is imperative. A negative urine in such a case leads to a favourable prognosis and their statistical data indicate that the patient may expect approximately 43.5% chance of a 5 year cure, a 65.2% chance being cured or improved in that period and only a 20.3% chance of death within 5 years. If, in addition the guinea pig test is negative, his chance of dying within 5 years will drop to 13.3%. On the other hand if the guinea-pig test is posi-

tive, the patient's chance of dying within 5 years increases to 41.8% and his chance of a 5 year cure drops to 21.8%. These figures are dramatic and demonstrate that the results differ greatly in cases in which the urine from the good kidney is negative, depending on whether the guinea-pig test is positive or negative. If other factors do not constitute contraindications to surgical operation, and if the excretory urogram of the good kidney is within normal limits, it seems that a positive guinea-pig should by no means be considered a contraindication to surgical measures, although it would considerably alter the prognosis. The common procedure, therefore of performing nephrectomy in such cases without awaiting the report of inoculation of animals, would appear to be justified. But when pus is found in the catheterized specimen of urine from the good kidney the problem is radically altered.

TUMOURS OF THE FOURTH VENTRICLE.

W. MCK. CRAIG AND J. W. KERNOHAN.

J. A. M. A.

Dec. 24, 1938, P: 2370.

The review is based on 82 cases: 31 medulloblastomas, 21 pendymomas, 19 astrocytomas, 4 oligodendrogliomas, 3 haemangio-endotheliomas—2 gliomas of granular layer, 1 epidermoid cyst, and 1 papilloma. The important symptoms were headaches, (79); choked disc (74); vomiting (67) in which there were 19 projectile and 48 non-projectile; ataxia (64); nystagmus (61); diplopia (55); stiff neck (34); visual impairment (31); hiccoughs (8).

The Cushing cross bow incision has been replaced almost invariably by a simple curved incision which is started below the mastoid process on each side and curved upward to just below the occipital protuberance. Sufficient exposure is thus obtained to remove the bone over both cerebellar lobes, the arch of the foramen magnum and the arch of the first cervical vertebra or atlas. In order to obtain adequate exposure of the tumour

sometimes it is necessary to divide the vermis.

There is probably no other group of tumours in which post-operative irradiation is as important as it is in the tumours of the cerebellum and fourth ventricle. The use of frozen sections and staining with polychrome methylene blue have made possible the differential diagnosis of tumours of the fourth ventricle on the operating table. This aids in determining the proper surgical procedure.

TREATMENT OF PRE-ERUPTIVE MEASLES WITH CONVALESCENT SERUM.

J. L. KOHB; I. F. KLEIN, AND
H. SCHWARZ.

J. A. M. A.

Dec. 24, 1938, P: 2361.

The report is based on 24 cases of measles in the spring seasons of 1937 and 1938. At the time of injection, definite Koplik spots were present in all patients and none of the children had previously received any measles convalescent serum. The serum was administered intravenously. Nine other children were given an intravenous injection of an equal volume of normal adult serum during the pre-eruptive stage. In 19 children definite modification was obtained. The effective dose is from 40 to 50 cc. given at least one day before the appearance of the eruption. The injection of convalescent serum on successive days seemed to have an additional effect. Normal adult serum given in equal volumes to that of measles convalescent serum caused no modification. There is no risk in the intravenous injection of large quantities of properly prepared pooled human serum. The therapy is indicated especially under the following conditions: in weak and debilitated children, in those just recovered from whooping cough and other infectious diseases of childhood and in those in whom measles developed during the course of another acute or chronic disease. Such children may thus be spared a severe attack of measles and perhaps avoid a fatal or prolonged illness.

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THE MEDICAL PROFESSION AND THE WAR.

Medical Science has been ever active in waging war against ignorance and disease and has been thus preventing destruction of life. Hitler is now active in destroying thousands and thousands of lives to appease his insatiable hunger of aggression. It is most unfortunate that the German nation noted for its scientific advancement in every walk of life, is now forced by the unscrupulous dictator to abuse their knowledge of science and he has let lose the nation to destroy human lives. Scientists have been active and have been adding day after day to their knowledge with no other aim than to protect lives and advance civilisation. How sad it is that the knowledge of Science is made use of to increase the horrors of war. When the world was less civilised the horrors of war were limited to only those who took active part in the war. Enemies never touched the lives of non-combatants much less of innocent women and children. The latest decree of the Aggressor seems to be mass massacre. When science is made use of to destroy lives through the aerial route, when civilization and religion are no barriers to destruction of human beings and when there is no knowing when and from where we have to meet our enemies and who will be our enemies, it is the duty of the Government under whose protection we are to

defend the civil population against all known and unknown methods of aerial warfare. Anti-air-war-craft machinery and other sound devices to meet the onslaught have been made ready for action at any moment. The Government will be surely in need of the services of the members of the medical profession in large numbers in addition to paid military and civil medical staff to protect the civil population.

One cannot be sure when and where a destructive bomb may fall and what havoc it may do either by injuring the people or poisoning them. Qualified medical practitioners cannot be expected to be in readiness in out of the way places and even if they are available, the emergency may be such that they may have to attend at the time more serious and urgent cases. So it is desirable to train lay men and women belonging to all castes and creeds and of every stratum of society in the art of First Aid and Home Nursing. We are glad to learn that Major-General N. M. Wilson, the Surgeon-General with the Government of Madras has been very active in organising St. John Ambulance Brigade Divisions of men and women for meeting war emergencies. We are told that there are now ready eight divisions (men's) 450 strong and three Nursing Divisions (women's) numbering 300 in the Madras City. Many more divisions may be wanting. Even during the days of peaceful life training lay people in First Aid and Home Nursing should be considered as a

We feel it is our duty to point out to the Syndicate that there are at present scarcely half a dozen M.Ss in the whole Presidency and the M. Ds may be a little over a dozen, majority of whom are in Government service and that "Government medical men have a distinct advantage over the private practitioners for special higher study as they can earn while studying. The members of the Syndicate will also please take note that the medical profession is very meagrely represented in the Madras University and the few that are there are officials. The Board of Studies is exclusively a packed body consisting of the staff of the Madras Medical College excepting one Honorary Medical Officer who was just displaced from the General Hospital. Even for full time Professors who alone are in actual charge of Medical Education, the Syndicate does not insist on four years' practice of the speciality after obtaining the qualification, and it is certainly too much at this stage, for the University to insist on higher attainments and qualifications in regard to Honararies than those demanded for Professors. The new regulation of the Syndicate has created an impression, in the non-official medical circles at least, that non-medical members of the Syndicate might not have had the full benefit of the knowledge of the affairs of the medical profession especially of the independent section of it when they approved of the suggestion relating to the Honorary Clinical Lecturers made by one of their medical colleagues. We wonder if the non-medical members of the Syndicate know that there is no such nomenclature as "Clinical Lecturers" described anywhere in the Medical College Calandar. The Honorary Physicians and Surgeons are not shown under the category of the Professors, Lecturers and their Assistants who are the actual teachers. But they appear

under a separate heading: "Medical Officers who give Clinical Instructions to M.B.B.S. and B.S.Sc. Students". In the list below this heading mention is made of officers belonging to Public Health, Veterinary and Town Planning Departments and it must be conceded that all these are Clinical Lecturers as per the interpretation given to the regulation by the Principal. We do not wish to say anything about the officers belonging to the other departments but we find under this category the names of the Resident Medical Officer and the Senior Assistant Surgeon, Government General Hospital. Both these officers either now or in the past did not possess qualifications of a higher value than the L.M. & S., and M.B.B.S., of the Madras University. As per the interpretation given to recent regulation of the Syndicate by the Principal, Medical College these two officers must possess M.D. or M.S. qualification and in addition must have practised their speciality for four years after obtaining the qualification. We are not aware so far that the Principal, Medical College has raised any objection that the M.B.B.S. students should not receive any instructions from these two officers. All the same we have no hesitation to say that the regulation may be well meant. But its application in regard to the present Honorary Physicians and Surgeons is untimely nay unjustifiable. It might be given effect to when the Honorary Physicians and Surgeons appointed by the Government or to be appointed in future are entrusted with the actual teaching work in the class rooms of the Medical College. The sequence of events before and after the appointment of new Honararies in the General Hospital and their coincidences are rather unhappy indeed.

News and Comments

Defence of Honorary System and its Correct Application:

Under this caption Dr. Nimbkar, Honorary Surgeon, Government Ophthalmic Hospital read a paper on 14th instant before the Madras Branch of the Indian Medical Association. After criticising those who were against the Honorary System of Medical Service, the lecturer put before the audience three main interests which were concerned directly in regard to affording medical relief to the public. These were mentioned to be (1) the Government, the philanthropists and the taxpayers, (2) the suffering public rich and poor both in urban and rural areas, (3) the medical profession. He then compared the position of these interests in Great Britain and India and said that the Government, the philanthropists and the taxpayers co-operated with each other in Great Britain with the result that curative part of medical relief was run mainly by private agencies with the help of honorary staff and the preventive medical service was run by the Government. Whereas in India especially in Madras Presidency, philanthropists stood aloof and the Government had been running the hospitals exclusively employing paid staff with the result that the Government did not find money to expand the preventive side of medicine and to spread the benefit of the scientific system of medicine in rural areas. He made a calculation basing upon which he said that over 3 lacs of Rupees could be saved if all the paid staff in the City Government Hospitals were replaced by Honoraries and with the help of this saving over 500 rural dispensaries could be started every year. He added that just at present there would not be a dearth of hands amongst the private practitioners to shoulder this responsibility. He mentioned that unlike in other civilised countries medical institutions were started in India originally for military purposes and to train sub-ordinates to serve under imported British Military Medical Officers and gradually due to the rising of the level of political conscience, many military officers in civil employ were displaced by Civil Surgeons

recruited from amongst the once sub-ordinate officials with the result that there were a large number of military and civil medical officers enjoying high salaries. He observed that no attempt was made by the Government to attract charitably disposed citizens to endow beds or wards in hospitals; on the other hand the wards in all the hospitals in the Madras City were named after retired military officers who once served in those hospitals. In regard to the suffering public the lecturer said that in Great Britain the interests of the poor who alone deserved free treatment in the hospitals did not clash with those of the rich as in India where the rich made free use of hospitals to the detriment of the poor and the hospital staff admitted the rich indiscriminately with the result that there was no encouragement for the starting of well equipped nursing homes.

Relating to general practitioners he said that the Honorary System worked very satisfactorily in British Isles and the interests of the general practitioners were safe in contrast to the state affairs obtaining in Madras where general practitioners were averse to have the benefit of consultation from the paid medical officers for fear of losing their cases as some of them at least demanded a fee not higher than those charged by the general practitioners. He was of opinion that if honorary system of medical service was made to evolve in the way it did in England, the general practitioner would not have room to complain against the consultants working in hospitals. At the end of his discourse he complained that though the scope of Honorary Medical Service has been extended to a large extent by the Congress Government, it had many defects in its working which should be remedied. He deprecated the Government aim that the honorary service was a training ground to the private practitioners and opposed the five years tenure for honoraries. He said that the training ground for the members of the profession should be House appointments and Resident appointments in the hospitals as is the case in Great Britain. The lecturer added that soon after the

two eminent personages, Dewan Bahadur S. E. Runganathan, the Vice-Chancellor of the Madras University and the Hon'ble Mr. C. Rajagopalachari, the Prime Minister. The former addressed the graduates on 7.8.39 when the Madras Medical College Association gave a reception to the out-going friends and the latter addressed them on 4.9.39 when the distinguished graduates received prizes. Rao Bahadur A. L. Mudaliar presided on the first occasion and the Premier on the second.

The Vice-Chancellor said amongst other things:

"..... that what could not be done by individuals could be done by co-operation with others, co-operation not only among medical men themselves but of medical men with other public agencies. This was absolutely necessary if anything effective was to be done in regard to the improvement of public health. Nations were at the present day feverishly preparing for war and were mobilising all available resources for national service. But did they realise that a great and ceaseless warfare was going on silently in their very midst,—the warfare against ignorance and superstition, against disease and suffering? Was it not necessary that they should mobilise their forces just as they did for war? In public health work, medical men would need the co-operation of the school teacher, the government official and the educated citizen. It was because the various agencies for uplift had been working in isolation hitherto that the work had been so little effective. What was wanted was that they should organise their forces on the basis of war for the purposes of peace, building up a new nation, healthy, educated and physically fit."

Dr. Mudaliar said:

"That the future of the medical profession was in the melting pot. Great changes were taking place and were likely to take place. None of them could visualise what these changes would ultimately result in. But they did hope that whatever was done would be first for the good of the country and secondly to help the medical profession to play its proper role in the national welfare and the nation-building programme of the country and that, thirdly, it would bring about a satisfactory sense of security which was essential in a liberal profession such as theirs."

The Premier displayed wit and humour abundantly while pointing out to the graduates their responsibilities in their career. He exhorted students to respect discipline as without it and without regard to their teachers, knowledge would not flow into them. He advised the out-going graduates:

"Not to look upon a patient as a subject of torture or an instrument to make money".....but treat them with love and affection, then alone will you be able to diagnose properly and treat properly. Then alone will the patient be able to assimilate the medicine properly, get you a good name and get other people to pay later on".

The Premier said that doctors had a vast field for service and incidentally mentioned that the war would absorb a good number for military service. He pointed out that there was good scope for research in India for those who could not afford to go abroad. In conclusion the Premier reminded the graduates that poverty and disease were concomitant factors in India and as the finance of the administration was limited the medical profession should co-operate with administration without demanding money.

The gist of advice from the Vice-Chancellor who is the custodian of the University, controlling the training of the medical graduates and from the Head of the Government was that the young graduates had to depend upon their own resources to be useful to themselves and to the public. The Vice-Chancellor went a step further and advised the graduates that they could not render any service to themselves or to the public unless they depended upon the co-operation and sympathy from the public and the Government Officials. The Premier while demanding co-operation from medical graduates gently warned them though indirectly that they should not expect money as a return. The Principal of the College was rather pessimistic in the beginning while he referred to the rapid progress of reforms in the medical department but his talents got better of him and he consoled the medical students and the medical graduates that anything attempted and anything done in national interest "would bring about a satisfactory sense of security". We have been harping on the same string which was used by the Vice-Chancellor and the Premier while they addressed the out-going graduates advising the members of the medical profession to be self-reliant. Medical men of the future generation should not only be proficient in their profession but also cultivate sound principles of business to exercise their profession.

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Chingleput District Medical Association: The Annual gathering of the Chingleput District Medical Association was held in Chingleput on 2.9.39. The Hon'ble Dr. T. S. S. Rajan, Minister for Public Health presided. Dr. (Miss) E. R. Innes of the Vellore Missionary College for women delivered a lecture on "Clinical Observations and Diagnosis in Road-Side and Village Work" at the morning session of the gathering and the Secretary Dr. R. Varadarajan read the Annual Report.

In the afternoon after the arrival of the Hon'ble Dr. Rajan he was welcomed by the Secretary on behalf of the Association and a neat little formal address was presented to the Minister by the Secretary. The Association expressed their gratitude to Dr. Rajan for having found time to honour them with his presence and eulogised the services so far rendered by him as Public Health Minister and assured him their full co-operation in the working of these reforms successfully.

Dr. Rajan thanked the Association for giving him an opportunity to meet a large number of the members of the medical profession. Referring to his activities as the Public Health Minister he said that it was rather not fair that he should speak on that subject and what all he did was to give to the profession the benefit of his experience as a practitioner for 30 years. He felt that all he had done was for the good of the profession though it was just possible that the reforms might have hurt a few which could not be helped in the larger interests of the profession. He then spoke on the ban against the Government Medical Officers in regard to private practice. He justified this action on the part of the Government which he said was necessary in the interests of the profession as a whole. He added that it was not fair that unequal competition should continue between the private practitioners and State-paid doctors when it was known that there were at present over 6,000 qualified practitioners in the province and many more would join the profession. He confessed that free field was allowed to over 20,000 practitioners who practised in the name of indigenous medicine and consequently the lot of the practitioners belonging to the Western System was

really very hard. He expressed his sympathy with the lot of an average practitioner under the present conditions and advised the members of the scientific system of medicine to curb their drift and callousness in not coming forward and saying that certain things which did not belong to the indigenous systems should not be there. On the other hand he said the 20,000 practitioners practising in the name of indigenous system were most vociferous and were pressing for equal status with those belonging to the Western System of medicine. Soon after one standard of University medical education was introduced by him, he thought he cleared the hurdles but he now found that he had many more hurdles to jump over. He deplored the tendency of claiming superiority for any particular system of medicine and belittling the scientific system, as science was same everywhere for all humanity. Dr. Rajan expressed his disappointment that with research and scientific advance the reasons for the causation of many diseases were still obscure. He was of opinion that mind was the chief factor in disease and unless that was studied and set right not only diseases but lunacy also would increase. He incidentally mentioned that mental hospitals were over-crowded and Government found it difficult to find finance to extend these hospitals. In conclusion he said that it was not the plan of God to create diseases. It was the mind that was the cause of the disease and every attempt should be made to correct the mind.

The next item was the reading of papers on medical subjects. Dr. Thambiah, the skin specialist, Government General Hospital addressed the gathering on "Some Practical Suggestions in the Treatment of Scabies" and Dr. Varadarajan, Cardiologist, Government General Hospital, on "Common Diseases of the Heart met with in Madras Presidency".

In his concluding remarks Dr. Rajan congratulated the Association on the good work turned out by them. The President was suitably thanked by Dr. Narayanaswami Aiyar, the District Medical Officer, Chingleput, President of the Association. The function came to a close after tea and a group photo.

It was repeatedly suggested in these columns that the members of the medical

profession should take full advantage of the presence of a medical practitioner in the cabinet and we are glad our suggestion has not been in vain. The Hon. ble Dr. Rajan took part in the annual gatherings of two District Medical Associations this month. After meeting the Chingleput District Medical Association he attended the annual gathering of the Ramnad District Medical Association on 16th instant. It was indeed a matter of disappointment to us that the Chingleput District Medical Association did not take advantage of the Minister in their presence to ventilate at least some of the grievances of the profession both official and non-official. Social gatherings where passion cannot find a place are just the places to be made use of in solving the problems relating to the medical profession. The exigencies of the professional responsibilities are such that medical men find hardly time to sit together and have a heart to heart talk about their affairs. Many meetings of the medical associations have to be adjourned for want of quorum. The Minister's presence at a function usually attracts large number of members of an association and the best use should be made of such gatherings. The effect of discussions without passion at such functions will certainly go a good way in solving many problems and in the moulding of the Government policy relating to medical relief. We are indeed very much gratified that the Minister was not as formal in his reply to the address presented to him as the address itself was. He expressed quite frankly that he was utilising his knowledge and experience of the affairs of the medical profession as he saw them in the capacity of a general practitioner and he introduced reforms in the Medical Administration with no personal motives. The broad lines of policy adopted by Government relating to medical relief could convince the members of the profession that the Public Health Minister is conscious of the sufferings of the members of the medical profession. His statement that he was anxious about the condition of an average member of the profession should convince the profession about his personal knowledge of its affairs. His reference that 6,000 practitioners of Western System of

medicine have to contend against 20,000 practitioners who practise in the name of indigenous system was an exposition of his concern towards the 6,000. He even warned the 6,000 against the drift and indifference towards their own interests. The Medical Practitioner came into existence as an unique organ to serve the profession in a unique way. Its primary concern is to build up a profession worthy of traditions obtaining in other civilised countries and the affairs of this country are such that the profession is suffering not so much for want of field to exercise the profession, not so much for want of scientific knowledge but solely on account of other extraneous circumstances such as the existence of rival interests between official and non-official elements, between several grades and classes even in the non-official section of the profession not to mention the vociferous rivalry of 20,000 as against 6,000 referred to by the Minister. Last but not of least importance are the sufferings of the profession under the grip of the Government and the public on account of its present lot. The Medical Practitioner has been repeatedly mentioning in its columns, the disabilities and hardships under which the independent section of it has been suffering on account of invidious distinctions shown by the Government and other authorities as between the official and non-official sections in the medical profession, relating to the rights and privileges enjoyed by the members of the profession by virtue of their being registered practitioners. The readers of The Medical Practitioner who are members of District Medical Associations or other medical fraternities are made to remember month after month about their sufferings and ways and methods were suggested as to how to combat or prevent them. The Public Health Minister who is one amongst the 6,000 registered practitioners did acknowledge at Chingleput his concern about the affairs of the profession. We trust this would encourage the profession to take full advantage of the presence of a medical practitioner in the cabinet and the profession would make hay when the sun shines.

District Boards and Subsidized Practitioners: With the President of the Andhra Provincial Congress Com-

mittee in the chair a Conference of Presidents of District Boards and Chairmen, Municipal Councils of the Andhra Desa was held in Madras last month. The main object of the Conference seems to be to request the Government to confer on local bodies full powers to deal with persons under their employ in regard to their appointments and punishments etc. Subsidized Rural Medical Practitioners formed an important item of discussion. President, District Board, East Godavari was the first to talk about the subject. The prevailing idea seemed to be that the Presidents, District Boards should have absolute authority over the Subsidized Practitioners as they found the intervening advice and consultation of the District Medical Officers rather a barrier to carry out their rule over the subsidized practitioners. Incidentally the President of the Conference complimented the subsidized practitioner as the major-domo of the President, District Board; later he said that the practitioner was the dhoby of the District Board President. We are at a loss to understand the implication of the compliment. Major domo ordinarily means the chief steward of a household. Such an office seems to have originated in the princely households in Italy or Spain. The word dhoby cannot mean anything more than a washerman. It is hard for us even to guess what the President had in his mind when he complimented the subsidized practitioner calling him first the major-domo and immediately after comparing him to a dhoby. The former is a position worth coveting in individual interest, the latter conveys the idea that the dhoby is a person who washes dirty linen. Such a job on the part of a subsidized practitioner is most hazardous indeed. Washing the linen cannot be bad in public interest but nobody would like to be told that the linen worn by him is dirty. In the report of the proceedings of the conference published in newspapers nothing was said about the interpretation of these two expressions. Surmises which may even surprise the author of the expressions are likely to be made depending upon the knowledge of the lot of the subsidized practitioners under the District Boards.

It is indeed most regrettable that neither the heads of the local bodies nor the individual units who constitute them seem to have realised even under the Congress rule that the subsidized practitioners are independent private practitioners as free as the members of the District Boards are and the subsidy they receive to render free service to the necessitous poor cannot transform them as the servants of the Boards and that any control over the practitioners should be consistent with the terms of the Agreement they execute jointly with the District Boards and the Government. The functions of the practitioners being only those relating to the treatment of diseases, the Government when they started the Subsidized Rural Medical Relief Scheme rightly entrusted the District Medical Officers as their local agents to act through the Surgeon-General, the chief adviser to the Government in medical matters. Even in regard to paid medical officers under local bodies the District Medical Officers have a control over them in professional matters and it is said that on account of the existence of rules and regulations governing local board service the medical officers under the employ of local bodies do not suffer to the extent the subsidized practitioners do. Ever since the subsidized scheme came into existence, the subsidized practitioners have been expressing their desire to be entirely under the control of the Government which literally meant under the control of the Surgeon-General and it looks to us a strange irony that during the Congress regime when there is a Member in the cabinet who is a medical practitioner who knows the legitimate functions of the subsidized practitioners and who has been repeatedly mentioning that these practitioners are independent medical practitioners, the Presidents of the District Boards who entered into these bodies on Congress tickets should attempt to terrorise the practitioners by asking the Government to keep them under the District Board without the intermediary buffer, the District Medical Officer. The Government whose ministers are now in much closer contact with village population than their predecessors, are fully aware of the real state of affairs of the

the scheme. The mouth piece of the Government relating to medical department has been frankly admitting the hardships of the subsidized practitioners. We do not mean to suggest that all the subsidized practitioners are saints. Some of them may be blame-worthy as any human being is but the blame against them must be laid always in regard to treatment of diseases and the only person who could sit in judgment about medical matters is the head of the medical department in a particular district and all disinterested people will ridicule the idea of removing the control of the District Medical Officers over the Subsidized Rural Medical Relief Scheme. It should be known that the advice of the District Medical Officers does not reach the Government direct. It undergoes a scrutiny by the Head of the Medical Department who has nothing to do with party politics. Though *ahimsa* and truth is the burden of song of the Congress it is painful to observe that some members of the local bodies are parties to criminal complaints and prosecutions, the criminal acts even amounting to murder. Apart from free medical service some of the members of the local bodies involved in criminal litigation want the services of the medical men in rural areas and the majority of practitioners in villages being those subsidized by the Government they, the practitioners are compelled to fall a prey either to a most unethical conduct or to the wrath of the interested people and it will be a very mild expression to say that the lot of subsidized practitioners is many times between the devil and the deep sea. We trust the Government instead of yielding to the unreasonable suggestion to remove the control of the District Medical Officer over the Subsidized Rural Medical Relief Scheme, will seriously consider the desirability of transferring the entire control of the Subsidized Medical Relief Scheme to the Secretariat and work the scheme through the Head of the Medical Department.

A Notable Gesture: Within 5 months after the Congress assumed charge of the Government of this province, the Government passed an order extending the Honorary Medical Service Scheme in which the medical licentiates were relegated only the House appointments in State-

Hospitals. There were naturally protests from various quarters and The Medical Practitioner had its share in pointing out to the Government the disservice to this class of practitioners who have not been far behind other class of practitioners in service or in private practice. The agitation had its effect and the Government have been appointing medical licentiates as Assistant Honorary Medical Officers in non-teaching institutions. Recently there was a vacancy in the Government Royapettah Hospital for the post of Honorary Ophthalmic Surgeon the first Ophthalmic Surgeon appointed by the Government 5 years ago having finished his five years tenure. A Licentiate who passed out from the Osmania Medical College 15 years ago and who has been practising Ophthalmology ever since, has been appointed by the Government. The predecessor of the new Ophthalmic Surgeon was a graduate of the Madras University who like his successor has no special academic qualifications in Ophthalmology but got recognised as an Eye Specialist by actual practice. He should be proud that one who served with him as an Assistant for nearly seven years should succeed him, the Government recognising in both merit and experience even without the hallmark of an academic special qualification. The appointment is quite consistent with an old Government order on Honorary Medical Service scheme where the Government said that medical licentiates holding no special qualifications but who were recognised by the medical profession in a particular locality as specialists in any branch of medicine might be appointed as Honorary Physicians and Surgeons in hospitals not attached to teaching institutions. We congratulate the Madras Government on the gesture made by them to the independent medical profession especially to the licentiate section of it that the Government do recognise merit and experience. The new honorary is Dr. T. S. Doraswami, L.M.S. the popular Eye Specialist practising in Madras the worthy brother of Dr. T. S. Tirumurti, Principal, Stanley Medical College. We wish him a successful career as an Honorary Ophthalmic Surgeon and trust he will bring credit to the much-talked-about Honorary Medical Service.

Correspondence, Reports, Etc.

P. S. R. M. Ps' Association.

NOTICE.

The Government have recently passed an order instructing the District Boards to pay the subsidized practitioners undergoing Public Health training, travelling allowance for journeys to and from various places during the course of their training. Though the G. O. was passed in July the order is applicable to all the subsidized practitioners who underwent the training before the date of the order.

V. RAMA KAMATH,
President.

Resolutions passed by the Kistna District Branch of the Madras Provincial Subsidized Rural Medical Practitioner's Association at its meeting held at Bezawada on 9-9-39.

1. This association while thanking the District Board for having renewed the contingencies in its resolution, No. 330 dated 20th July 1939 thinks that it is but proper to sanction the same from the time of their suspension. It therefore requests the District Board, Kistna to give effect to the resolution with retrospective effect instead of from 1st July 1939 as stated in the resolution without the necessity of producing vouchers for arrear contingencies.

2. This association requests the Kistna District Board to give effect to the G. O. No. 2609 P. H. dated 19th July 1939 by supplying forthwith midwifery outfits as specified in the said G. O. to those dispensaries where there are

midwives to whom such outfit was not supplied till now.

3. This association requests the Collector, Kistna District to send a circular to all the Magistrates subordinate to him that the subsidized practitioners may be treated, in regard to their allowances while called upon to give evidence in Criminal Courts, as Government Officers in Grade IX.

4. This association requests the District Board, Kistna to supply an attender to each one of the subsidized dispensaries where the attendance is above 30 a day.

Proceedings of the Business Meeting of the Chingleput District Medical Association held on 2-9-39.

1. The Annual report read by the Secretary was adopted unanimously. The Association recorded its appreciation of the indefatigable and earnest interest taken by the Secretary in his work connected with the Association.

2. Read letter from Dr. V. Rama Kamath, Member, Madras Medical Council, regarding the G. O. prohibiting Registered Medical Practitioners to hold stock of the preparations of Indian Hemp without license.

The Association heartily supported the draft resolution sent by Dr. Kamath to be forwarded to the Secretary to Government, Education and Public Health Department, and to the Commissioner of Excise, Board of Revenue.

3. It was unanimously resolved to elect Dr. Govindkutti Nair as member of the Executive Committee of the Association in the place of Dr. N. S. Parameswaran, transferred.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the Month of August 1939.

RECEIPTS.	RS.	A.	P.	CHARGES.	RS.	A.	P.
Cash balance on 31-7-1939 ...	90	4	6	Postage including V. P. Charges ...	25	12	0
Subscriptions from members (including the V. P. P. Postal charges) ...	195	0	0	Pay to Clerks for June 1939 ...	15	0	0
Entrance fee from thirtyone new members ...	7	12	0	Amount paid to The Medical Practitioner from the subscription for 1939 paid by 38 members.	76	0	0
				Contribution paid to the Secretary-Treasurer of South Kanara District Branch ...	4	0	0
				Stationery ...	1	5	0
				Paid to the President the amount advanced by him to the office in the month of July 39 ...	7	1	3
				Rs. A. P.	129	2	3
				Cash Balance : with Savings Bank 123 9 0			
				With Office to meet V.P., T.A. to W.C. members, Printing charges and pay to clerk etc. 40 5 3			
					163	14	3
	293	0	6		293	0	6

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

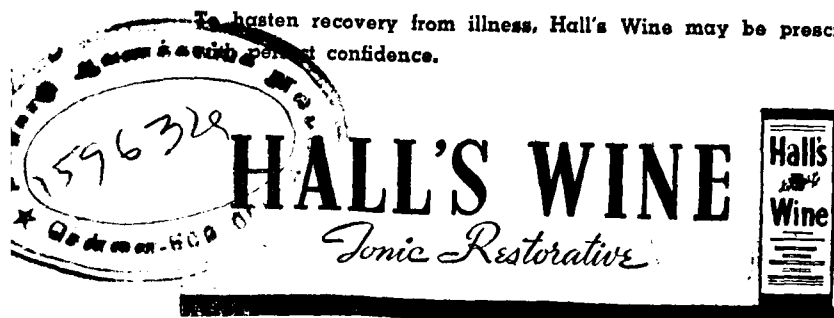
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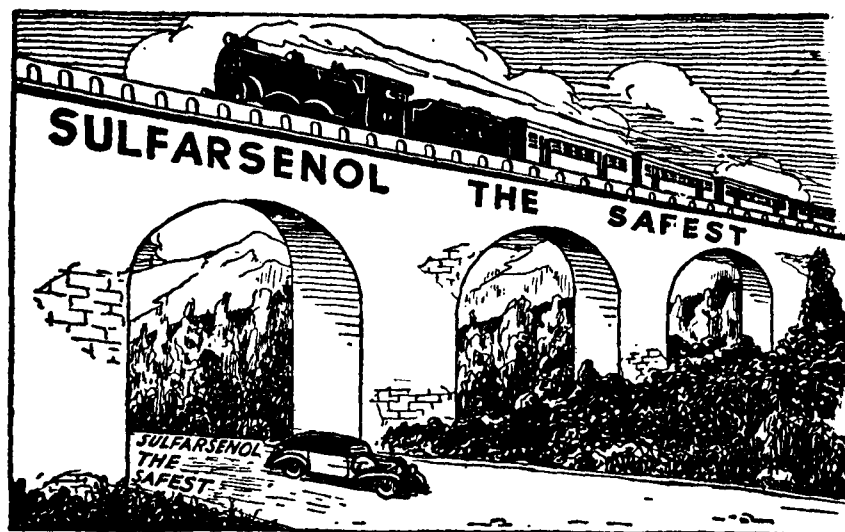
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