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**VOLUME V**

**NUMBER 12**

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## JOURNAL OF SOUTH INDIAN MEDICINE.

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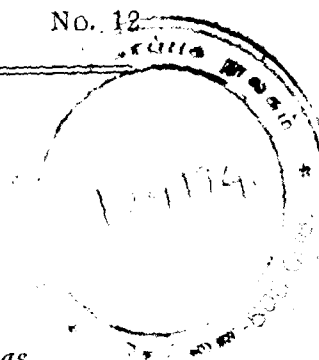
No. 12

### "NUTRITIONAL MYOCARDITIS" A NEW CLINICAL ENTITY

By

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Sometime ago, the writer of this article presented to the members of the All India Medical Conference (Madras Sessions) a few facts regarding the existence of a separate type of Myocarditis, hitherto undescribed in medical literature. It was an ambitious effort but the writer made it quite clear to the co-workers on the subject that arguments for or against this new introduction into the field of cardiology were most welcome.

The subject is brought up once again to the notice of medical men as the writer feels that the extremely short time at the disposal of the scientific section during the sessions did not permit of any discussion on the subject with the inevitable consequence that the matter has gone out of memory of even interested workers.

Aggressive and lengthy debates of no consequence are apt to take up much of the valuable time set up for scientific discussions, no matter how vigilant the presiding person be. However! The unsettled dispute whether the term Myocarditis is always appropriate in talking of certain degenerative conditions of the Myocardium such as anaemic, arterio-sclerotic, hypertensive and even senile myocardial changes had better be left to the pundits of pathology. Unfortunately for them, the morbidity may escape clinical scrutiny for some considerable time. Breathlessness, contrary to popular

view, is by no means an early manifestation. Even at autopsy morbid anatomical readings have been, at times, elusive. To a lesser degree the histopathologist may experience some difficulty in recording the precise change in the heart muscle. On the other hand, a careful scrutiny of the case sheets, especially those which are comprehensive in their description brings out the important fact that while many of the cases of Myocarditis can be "pigeon-holed" under one or other aetiological heads of the disease, a very definite number of them need to be grouped as a separate clinical entity hitherto undescribed. For easier understanding of this statement, the common aetiological groups of Myocarditis (inflammatory or degenerative), are detailed as follows:—

1. *Congenital defects*.—Especially the grosser varieties where the admixture of the arterial and venous blood is very liberal and where the patient is unable to lead a sheltered life and the extremely rare cases of arterio-venous aneurysm where the short circuiting of arterial and venous blood throws a constant, extra burden on the heart, leading to myocardial failure.
2. *Rheumatic*.—either during the acute phase, *vide* remark below concerning acute infections, or during the phase of congestive failure without compensation.
3. *Thyrotoxic*.
4. *Syphilitic*.
5. *Hypertensive*.—Essential, and,  
Renal (inclusive of Gout & chronic lead poisoning).
6. *Epochal*.—pregnancy, menopause & senile.
7. *Arteriosclerotic*.—arteriosclerosis (inclusive of Diabetic).
8. *Anaemic*.—(inclusive of Ankylostomic infection).
9. *Pulmonary*.—Chronic lung disease.
10. *Infective*.—refers only sub-acute Bacterial Endocarditis and to those few cases of acute Infective Endocarditis when the cardiac condition is the central feature.
11. *Deficiency diseases*.—Beri-beri, gross nutritional deficiency either exo- or endogenous causes (famine conditions etc., after a bad attack of dysentery or diarrhoea).

With the aid of pathologists the list can be prolonged, but the clinical wisdom of such a move is questionable. Acute infective conditions are purposely omitted as the myocardial break-down is only one part of the clinical picture. Likewise the chemical toxins are ignored.

The type of Myocarditis under discussion does not altogether come under the list given above. The basis of these is certainly nutritional, but the deficiency which is mainly exogenous produces a clinical picture quite unlike that of Beri-beri (having no neurological signs and symptoms) or hunger or famine oedema. The central theme is that of gradually deteriorating myocardium as evinced by the functional deterioration of the heart to the exclusion of any involvement of the other system. Signs of cardiac failure without congestion—*viz.*, progressive breathlessness, lassitude, palpitation etc., are conspicuous. Dropsical cases are not accepted under this heading as the differentiation between this group of cases and those with so-called hunger, famine or war oedema is arbitrary. The name Nutritional Myocarditis is suggested. The Cardiac and cardinal signs and symptoms of this group of Myocarditis cases differ in no way from the various other groups. Emphasis may however be laid on the following facts:—

Hospital class of people are usually stricken. Males predominate. The artisan rather than the labourer is the victim. Fifth decade (40 to 50) appears to be the vulnerable period. Poor (in caloric value) food is more often the cause than no food. Irregular hours of dieting is one of the factors. The signs and symptoms are those of cardiac failure without congestion. Left ventricular failure, nocturnal dyspnoea and cardiac asthma. These symptoms precede right ventricular failure with congestion. Enlargement of the liver is an early feature. Serological tests are negative. The conducting tissue is rarely or never disturbed so that regular rhythm is much commoner though now and again one comes across slow fibrillations. B. P. is below normal and postural fluctuations are common. Often the cases are prone to vasovagal attacks, though true syncopal attacks are possible when slow fibrillation has set in. Screening usually shows a slightly enlarged heart affecting the left ventricle more often. The electro-cardiogram reveals the usual evidences of myocardial failure such as low voltage, inverted T waves in the leads that count (I and II).

Cases go downhill rapidly and congestive failure often with attacks of left ventricle failure sets in within a year.

Prognosis is usually bad owing to the poor economic outlook of a large majority of these cases, the end coming on within two years. Cases well treated and able to rest may be kept going for 5 years.

Only one case of this variety of myocarditis came up for autopsy—the heart and the other viscera showed surprisingly few changes except those agonal changes which have little to do with the main cause of death.

The microscopical appearances of the section, it must be admitted was not very helpful either. The only consolation for the writer is that the findings of one autopsy do not prove the case either way.

*Summary:—*

1. A new type of Myocarditis seems to exist in this part of the world, hitherto undescribed in the books pertaining to cardiology.
2. Nutritional defect appears to be the main cause of this morbidity, though the condition is entirely different from other nutritional diseases, such as beri-beri, hunger or famine oedema, epidemic dropsy, etc., in so far as the brunt of the attack is on the heart.

An effort is made to give a clinical description of the disease though the writer is fully conscious of the danger of inferring far reaching conclusions from such scanty material available; but it is hoped that this paper would induce other people to come forward with their observations.

## NOTES ON PUBLIC HEALTH

(Issued by the Principal Information Officer, Government of India)

### ANTI-MOSQUITO WORK IN DELHI.

#### VALUE OF INSECTICIDAL SPRAYS.

A large scale experiment in two villages near Delhi (Jangpura and Nizamuddin), with a total population of approximately 6,000, was undertaken, by the Malaria Survey of India, to determine the value of insecticidal sprays in the control of malaria.

The results suggest that, with effective organization and adequate supervision, attempts to control malaria in rural areas in India with spraying operations are feasible at a *per capita* cost which compares favourably with that of mosquito control by temporary anti-larval measures. This method is likely to prove of great value, especially for isolated communities where anti-larval measures are impracticable, and where the vector species of anophelines rests in dwelling places in the day-time. Detailed results of the experiments are under publication.

Comparative tests were carried out with five different insecticides and as regards breeding in wells, about 30 wells were selected at a time and dusted with varying quantities of one per cent Paris green—Soap Stone mixture. Dusting was done by means of a hand-blower. The wells were kept under observation for about eight days after dusting. The procedure was carried out on four different occasions and it was found that one puff of the blower for every foot of the diameter of the well was enough to control the breeding in the wells, (75 puffs of the hand-blower were able to blow out about 2 oz. of the Paris green mixture). Twenty other wells were selected and treated with petrol. This was repeated four times and it was found that three-quarters of an ounce of petrol for every foot of diameter was enough to control breeding in about 70 per cent of the wells.

Adults were bred out from eggs on five different occasions in the laboratory in September and October and it was found that the larvae took from five to seven days to develop from egg to pupal stage. This shows that in order to control breeding in the wells, treatment with Paris green or petrol has to be repeated every fifth day.

Experiments were conducted in Delhi on the application of Paris-green from aircraft. The results have been published in the records of the Malaria Survey of India.

### FACTORS IN SPREAD OF MALARIA SURVEY IN DELHI,

#### MOSQUITOES THAT FLEW THREE MILES.

A detailed survey has been undertaken of the factors influencing spread of malaria in rural and urban areas in Delhi Province. Special attention is being paid to the part played by *Anopheles stephensi* in the transmission of malaria in Delhi. An intensive study of wells in congested urban areas in relation to the sources of *stephensi* breeding, of the resting places of adults, and of the infectivity of this species as compared with *Anopheles Culicifacies* has been carried out.

Three hundred selected wells were examined every week for about three months. Chemical analyses have been made of water samples from numerous wells. A large amount of data has been collected, but has not so far been subjected to detailed analysis.

Prior to the commencement of the anti-malaria campaign in Delhi, very little was known either in India or in any other country about the distance over which culicine mosquitoes could fly, although much experimental work in this direction had been done on anophelines. Experiments carried out in the spring of 1937 with insects marked with coloured powders proved conclusively that culicine mosquitoes could infiltrate into Delhi from a distance of at least three miles.

#### CURE FOR SNAKE BITE THE DEADLY KRAIT.

The anti-snake bite serum prepared by the Central Research Institute at Kasauli is now in demand in Burma, Iraq, Ceylon and Iran which amongst themselves bought 698 tubes in 1937. The general demand for the product continues to rise.

The product is a bi-valent serum prepared against the venoms of the Indian cobra and Russell's viper, which are the snakes probably responsible for the majority of deaths occurring from snake bite in this country. The increase in annual issues is shown by the following figures :--

|      | <i>Tubes.</i> |
|------|---------------|
| 1933 | ... 4,342     |
| 1934 | ... 5,973     |
| 1935 | ... 5,983     |
| 1936 | ... 7,170     |
| 1937 | ... 7,773     |

Further studies have been made on the methods of concentration designed to eliminate fractions which are not of neutralizing value and which tend to produce a deterioration in the physical characters of the serum when kept in the plains for prolonged periods during the hot weather.

Besides cobra and Russell's viper, the venoms of which are neutralised by the anti-venom serum, a snake which is responsible for a large number of deaths annually is the common krait. There would be no difference in principle in preparing an anti-venene for the venom of the snake but practical difficulties exist in immunizing the horses used for the present bi-valent serum.

The chief difficulty is in obtaining a sufficient and constant supply of krait venom. The snake is difficult to keep in captivity and to feed, and so far no reliable source of supply of venom has been found.

#### PLANNING DIETS—NUTRITIVE VALUE OF INDIAN FOODS— YEARS OF RESEARCH.

Those who want to plan diets either for themselves or for others will find their task made easy by the Health Bulletin on "The Nutritive Value of Indian Foods and the Planning of Satisfactory Diets", a second edition of which is just brought out.

Data have been collected about the composition of some 50 more food-stuffs and added to the analyses of some 200 common Indian foods previously given. While there is room for further studies of special varieties of food-stuffs which are consumed in remote localities and have a purely local distribution, nearly all the common and familiar foodstuffs of India have now been investigated.

The publication is a part of the move to popularize the results of nutrition researches. In the early years of nutrition work, the first objective was to get together the scientific data on which practical work could be extended to the homes of the people. This material has since been collected by the workers at the Nutrition Research Laboratories, and is now being made available to the public.

#### MODERN IDEAS ON DIET.

Prefaced by a summary of modern ideas about diet, an account is given in the Bulletin of caloric requirements, and standards suitable for the various age and sex groups in India are suggested. Next, protein, fat, and various vitamins and minerals are dealt with, with special emphasis on the minimum requirements of each.

It is advisable, says the Bulletin, that those who are responsible for the institutional care of children, etc., and all who are concerned with practical nutrition work, should have some idea of the effects on the body of a diet which is ill-balanced and defective..... *e.g.*, of a diet which is largely composed of milled cereals and contains an insufficiency of proteins, mineral salts and vitamins—and which calls for improvement. There is a long list of diseases, common in India, due in some way or other to dietetic causes. Such are beriberi, certain anaemias of pregnancy, keratomalacia, osteomalacia. States of malnutrition which fall short of serious disease are widespread.

A well-balanced diet is essential if growth and development are to take place normally. The frequency of minor ailments in school children can be reduced by improving the diet. But well-balanced diets are in general more expensive than deficient ones. It is on this point that the nutrition worker encounters the main difficulty. Those who suffer from under-and mal-nutrition usually cannot afford to purchase a satisfactory diet. But even when poverty prevents the purchase of a diet which satisfies modern standards of nutrition, it is often possible to make effective improvements with little increase in cost, and how these improvements can be effected are indicated.

Information is given in tabular statements about protein, fat, carbohydrate, fibre, calcium, phosphorus, iron calories and vitamins and appendices are added with data about the biological value of the proteins of various foods and availability of iron in certain foodstuffs.

#### PROTECTIVE FOODS

Stress is laid on the value of what are called the "protective" foods.

Human beings, and particularly children, cannot thrive at their best on a diet largely composed of cereals such as rice, millet, etc., and insufficiently supplemented by other foods. To make good the deficiencies of such a diet, they must consume fair quantities of foods like milk, green vegetables, eggs, fruits, etc. These are sometimes known as the "protective" foods, since they are rich in proteins, vitamins and mineral salts, and protect the body against the ills which result when the diet is largely based on less nutritious foods, such as milled rice. Cod liver oil which is very rich in vitamins A and D, may be classed as the most valuable "protective" food.

In general, diets in India are defective because they do not contain "protective" foods in sufficient abundance. The aim in public health

nutrition work in general, and planning "well-balanced" diets, must be to increase intake of "protective" foods. The classes in the community which are particularly likely to suffer if their diet is defective are infants and growing children, and expectant and nursing mothers.

It is not only the poor, whose choice in the matter of food is extremely limited who are ignorant and prejudiced about diet. Many people in India and elsewhere, who could afford to consume and feed their children on an excellent diet, do not in fact do so. One can readily find among children of the more prosperous classes cases of serious malnutrition and food deficiency disease.

#### HUNGER NO INDEX.

In drawing up a new diet schedule, or in assessing the value of an existing schedule, it is essential to know whether enough food is being provided. It might be thought that it is easy enough to discover food deficiency, for such deficiency must cause hunger. But experience has shown that human beings can adapt themselves, at a low level of vitality and with their powers impaired, to an insufficient ration, and scarcely realise that they are under-fed. The nutrition worker, in setting up standards of food requirements, ignores this remarkable faculty of the body to adapt itself to semi-starvation. His standard of food intake implies full satisfaction, enough to enable human beings to lead an energetic life at a reasonably high level of working capacity.

There are, of course, many kinds of public health nutrition work besides the planning of adequate diets. The task of the nutrition worker is often to make special additions (*e.g.*, milk, cod liver oil, various vitamin-rich preparations) to an unsatisfactory diet rather than to plan the whole diet afresh. Infant feeding is a subject demanding special knowledge and training. But in all branches of practical dietetics the fundamental principles involved are the same, and understanding of them is essential for successful work in this field.

At the special request of a number of readers, a section dealing with infant feeding, including dietary requirements of infants breast feeding, artificial feeding, weaning and the difficulties of infant welfare work in practice, has been added. In 1935 about 1,250,000 Indian infants died before reaching the age of one year. A high percentage of these deaths was due to malnutrition.

# LEPROSY

## CHAULMOOGRADINE

While Chaulmoogradine tablets may not adequately replace injection treatment of Leprosy, they are nevertheless very useful for reinforcing injection of chaulmoogra preparations, as a maintenance treatment between courses of injections and as a precautionary treatment against relapse following the cessation of injections.

Relapse often occurs through treatment being stopped too soon. Sometimes a complicating disease may suppress the cellular reaction to the B. Leprae, as a result of which the disease may appear to be arrested, but actually is only quiescent.

The administration of Chaulmoogradine tablets at the cessation of injection treatment will serve to maintain resistance to the B. Leprae, and reduce the danger of relapse.

The tablets are composed of salts of the total unsaturated fatty acids present in chaulmoogra oil; they are convenient to take and remarkably free from any deleterious action on the stomach.

COMPOSITION: Gluten coated tablets each containing  $\frac{1}{2}$  gram of the sodium salts of Chaulmoogric and Hydnocarpic acids.

ADVANTAGE: The gluten coating prevents gastric disturbances.

DOSE: One tablet three times a day, which may be increased to six tablets per day in some cases.

PACKING: Bottles of 100 tablets.

## PHARMASOL CHAULMOOGRA

COMPOSITION: A colloidal preparation of Chaulmoogra oil.

| Strengths     | Ampoules      | Vials. |
|---------------|---------------|--------|
| 0.1 per cent. | 2 cc and 5 cc | 25 cc  |
| 0.2 " "       | 2 cc          | 25 cc  |
| 0.5 " "       | 2 cc          | 25 cc  |
| 1.0 " "       |               | 25 cc  |
| 2.5 " "       |               | 25 cc  |

DOSAGE: Begin with  $\frac{1}{2}$  to 2 cc of 0.1 per cent every 2nd day. Gradually increase the dose and interval till 5 cc or more of 1.0 per cent or 2.5 per cent is given once a week.

METHODS: Intramuscular or intravenous as convenient.

ADVANTAGES: No venous occlusions.

The Anglo-French Drug Co. (Estn.) Ltd.,  
P. O. Box 460 — BOMBAY.

## JOURNAL OF SOUTH INDIAN MEDICINE.

MARCH 1939.

### MEDICAL RELIEF.

There is a growing demand in this country for a more adequate medical relief. But the methods advocated for satisfying this need vary. In rural areas it is still very inadequate. It is true that there are a large number of medical men all over the villages and towns. But only a few of them have any real knowledge of medicine. The majority of those who practise the art have learnt it by way of apprenticeship to their ancestors. And this knowledge has been more in the making of drugs than in the study of disease. They cannot therefore be considered generally useful in rendering medical relief. Further, they cannot possibly have any idea of the tremendous advance in therapeutic measures in modern times. Therefore their patients cannot get the benefit of the measures which are so essential nowadays to render relief to the sick. Leaving this class of so called Indigenous Medical Practitioners, fully equipped medical men, graduates and licentiates trained in modern medical institutions are just a few thousand to cater to the needs of over 40 million people living in villages and hamlets scattered over the province with ill-served roadways. We are not so widely scattered in South India as in parts of Australia where medical men can reach patients only by the air. But all the same, many villages could only be reached by foot or by a drive in a precarious bullock cart. Therefore the problem that has to be solved in this country is twofold. One, increasing the number of available medical men, and second, and this equally important, increasing the accessibility of the practitioners. In other words, the economic condition of the rural areas must be such as could support a practitioner in a particular area.

There is a tendency among the public and probably more so among medical men that measures that have been adopted in certain countries of the west would solve the problem. We refer to the different methods of Health Insurance. We believe that the scheme

of Socialisation of medicine was first introduced on the Continent. Then the scheme was adopted in the United Kingdom. And among other countries the United States of America is devising ways and means to introduce a scheme of Socialized Medicine. These schemes are generally opposed by organized Medicine at the inception. The British Medical Association is now reconciled to the scheme, though from time to time it puts forth strenuous efforts to save the profession from the more objectionable features of government measures. In the United States again the American Medical Association has vigorously opposed the introduction of State-controlled Medical relief. We do not say that the profession is unanimously against State interference. There are always groups in all professions who do not like to toe the line with the majority. But that does not make the attitude of the minority more reasonable or sound. But the objection to this State interference in medical relief is from the higher interests of the patients as well as the profession. All thinking people know that the art of medicine apart from the science of medicine is extremely individual, as all art is. Therefore the profession as well as the public feel that in regimented medical relief that friendly feeling of confidence in each other between the patient and the physician will be lacking. Further, the redtape inescapable from bureaucracy is not helpful to the maintenance of honest and cordial relations between the two. And since the good opinion of the government authorities will depend on the proper maintenance of accounts and registers, the practitioner becomes a better accountant and clerk, rather than a helpful family doctor.

But conditions in this country are very different from what obtains in those countries. Elsewhere the number of medical men available is large. But the economic condition of a portion of the population is such that they cannot afford to see a doctor whenever it is necessary. It was therefore felt that the poorer classes of the population should have facilities for being attended to by doctors whenever and wherever there may be need, and the State is therefore compelled to help the poor sick financially. In this country, not only is the economic condition of the great bulk of the population so poor that they cannot afford to see a doctor even once in their lifetime, there is also the additional problem of scarcity of medical men to attend to the sick, poor or rich.

Considering these conditions, any scheme that may be introduced by which a few more medical men may be made available to the villages should be welcome. We feel that the existing policy of subsidised rural medical scheme could be exploited very much more usefully. On the other hand we find that in spite of encouraging words and some immaterial changes in the conditions of that service, there is a certain amount of lukewarmness on the part of local bodies to work this scheme satisfactorily. Nor is the Government much more enthusiastic. In spite of denials about honorary rural medical relief, there is expressed a preference for medical men who are willing to serve in that capacity. In simple words, this means that only those who can get on for some years without financial help from the Government can ever hope to get into this service. An honest and enthusiastic doctor if he happens to be poor stands no chance against another who may be a little more wealthy. To call this self-sacrifice and national interest is a travesty of words.

The Minister for Public Health has evidently another scheme for expanding medical relief. We have no data except the brief report of a speech he made at Ellore at the conference of medical men. The idea of making the people subscribe a little to an organization which will secure the services of a doctor for a small fee whenever necessary is a very plausible one. This is nothing more than the club practice of the west and co-operative organization which is being worked fairly extensively in America. There is no special merit in the schemes. It has been calculated that by these measures a great fraction of the people's money is spent on organization and administration. One may say that co-operative movement is chiefly worked by honorary men. All the same, in all transactions, a percentage of the income is set apart for establishment etc.—when the economic condition of the people is already precarious, could it be wise to adopt such measures? Anyway, since this scheme may be introduced in only a few places to start with, we may learn from actual experience how far this may be availed of to increase medical relief.

## NOTICE.

The German authorities for postgraduate medical instruction have arranged the following international courses for specialists for the summer of 1939:

1. **In Hamburg:** Dermatological and venereal diseases, ray Therapy, Place: Dermat. Univ. Clinic (26.6.—1-7-1939).  
Fee: RM 60.—
2. **In Hamburg:** Radiology (especially X-ray treatment). Place: Univ. Röntgen Institute. (3.—8-7-1939).  
Fee: RM 60.—
3. **In Vienna:** Dermatological and venereal diseases, ray Therapy. Place: Dermat. Univ. Clinic. (26.6.—1-7-1939).  
Fee: R.M. 60.—
4. **In Vienna:** Cosmetics and plastics (dermatological, Surgical, otologicals under-sections). Place: Several Clinics of Vienna. (3.—15-7-1939).  
Fee for the total course: RM 120.—  
A. Dermatological part (3.—5-7-1939)  
Fee: RM 30.—  
B. Surgical part (6.—12-7-1939)  
Fee: RM 70.—  
C. Otological part (13.—15-7-1939)  
Fee: RM 35.—
5. **In Vienna:** Urology. Place: II. Surg. Clinic (Univ.) (17.—22-7-1939).  
Fee: RM 60.—
6. **In Vienna:** Diseases of the teeth, mouth and jaw. Place: Gen. Hosp. (17.—22-7-1939).  
Fee: RM 70.—
7. **In Vienna:** Thoracical Surgery. Place: II. Surg. Univ. Clinic. (24.—29-7-1939).  
Fee: RM 70.—

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8. **In Cologne:** Abdominal Surgery. Place: Surg. Univ. Clin. (31.7.—5-8-1939).  
Fee: RM 70.—
9. **In Bochum and Gelsenkirchen-Buer:** Surgery of accidents and of the limbs including expert opinions on accidents. Place: The Hospitals "Bergmannsheil I and II." (7.—12-8-1939).  
Fee: RM 70.—
10. **In Cologne:** Roentgenology for accident surgery. Place: Univ. X-ray Institute. (14.—15-8-1939).  
Fee: R. M. 30.—
11. **In Cologne:** Orthopedy. Place: Orth. Univ. Clinic. (16.—19-8-1939). Fee: R. M. 50.—
12. **In Hohenlychen:** Plastic surgery; treatment by means of exercises, and compensatory athletics. Place: The Sanatorium. (21—23-8-1939)  
Fee: R. M. 35.—
13. **In Vienna:** The cranium in Roentgenology and clinic. Place: General Hospital. (31.7.—5-8-1939).  
Fee: R. M. 70.—
14. **In Munich:** Roentgenology for internists and surgeons. Place: I. Med. Univ. Clinic (26.6.—1-7-1939).  
Fee: R. M. 60.—
15. **In Breslau:** Diagnostics of the diseases of the digestion and the stomach. Place: Med. Univ. Clinic. (26.—2-6-1939).  
Fee: R. M. 35.—
16. **In Munich:** Diseases of the blood, nerves and joints, of metabolism. Endocrinology. Vitamins. Place: I. and II. Med. Univ. clinic (3.—8-7-1939).  
Fee: R. M. 50.—
17. **In Vienna:** Dietetics. Place: I. Med. Univ. Clinic. (10.—15-7-1939).  
Fee: R. M. 50.—

18. **In Berlin :** Infectious, heart, circulation and kidney diseases. Place : Rud. Virchow-Krankenhaus (17.—22-7-1939).  
Fee : R. M. 50.—
19. **In Luebeck :** Allergy. Place : Gen. Hospital. (24.—29-7-1939) Fee R. M. 50.—
20. **In Frankfurt a/M. :** Neurology, Psychiatry, Psychotherapy. Place : Univ. Neurol. Clinic. (31-7.—5-8-1939).  
Fee : R. M. 50.—
21. **In Berlin :** Pediatrics : Prophylaxis in childhood, nutrition, diseases connected with metabolism ; neurology, psychiatry, questions connected with children difficult to bring up.  
Hereditary pathology.  
Place : Univ. Ped. Clinic, Kaiserin Auguste-Viktoria-Haus, Kaiser.-und Kaiserin Friedrich Krankenhaus. (26-6.—1-7-1939).  
Fee : R. M. 50.—
22. **In Cologne :** Pediatrics : Infectious diseases and diseases of the circulation and kidneys ; allergy, social welfare. Place : Ped. Univ. Clinic. (3.—8-7-1939).  
Fee : R. M. 50.
23. **In Leipzig :** The old and modern therapeutic tasks of the gynaecologist. Place : Gyn. Univ. Clinic. 3.—8-7-1939.  
Fee : R. M. 70.
24. **In Leipzig :** Functional gynaecology. Place : Gyn. Univ. Clinic. (10.—15-7-1939).  
Fee : R. M. 70.
25. **In Tuebingen :** Otolaryngology, rhinology, laryngology. Place : Otol. Univ. Clinic. (26-6.—8-7-1939).  
Fee : R. M. 150.—(with operation course), without operation course : R. M. 100.—

26. **In Halle :** Ophthalmology. Place : Univ. eye-clinic. (26.6.—1-7-1939).  
Fee : RM 75.—

All courses will be held in the German language.

The number of participants is limited.

Information and prospectus through :

**Aerztliches Fortbildungswesen, Berlin N.W. 7., Robert-Kochplatz 7., Kaiserin-Friedrich-Haus.**

All doctors with full German citizenship (Reichsbuerger) as well as doctors of foreign nationality may take part.

Foreign doctors and German doctors resident abroad receive a 60 per cent reduction in fares on the German State Railways, and through the purchase of "Register Marks" with foreign currency doctors resident abroad will make a considerable saving ; foreign doctors are advised to consult a bank in their own country before their departure.

**THE**  
**Research Laboratory,**  
**Harris Road,**  
**MADRAS.**

Microscopical, cultural and bacteriological examinations of Blood, Sputum, Urine, Faeces, etc., done.

Widal, Wassermann and Kahn test and Complement Fixation test for Tuberculosis, etc., done.

Stock and Autogenous Vaccines prepared.

Sterile Solutions for injection always in stock.

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## ASSOCIATION NOTES.

**The Tinnevely District Medical Association, Palamcottah.**

*(Tinnevely Branch of the Indian Medical Association.)*

The Monthly Meeting of the Tinnevely District Medical Association was held at the Subrahmanya Karayalar Public Library, Palamcottah, on Saturday, the 25th of February 1939. Members numbering 66 including 3 women doctors were present.

After Tea Party and sweet music and thrilling Magic by Prof. Sharma of North India, the meeting began under the presidentship of Lieut.-Col. T. S. Shastry, I.M.S., at 6 P.M.

The Secretary and Treasurer read out the minutes of the Monthly meeting held at Nanguneri on the 28th of January 1939, which were passed.

The proceedings of the Annual General Body Meeting of the Indian Medical Association held at Meerut on the 28th of December 1938, were read out.

The letter from the Association of Surgeons of India dated 14th February 1939, was read out.

The following were unanimously re-elected as the members of the Central Council of the Indian Medical Association.

1. Lieut. Col., T. S. Shastry, I.M.S.,
2. Dr. L. Mahadevan, M.B.B.S., (Madras), D.O.M.S., (London),
3. Dr. K. Rama Ayyar, M.B.B.S., (Andhra).

Dr. A. L. Ananthanarayana Iyer, M.B.B.S., of Tenkasi, demonstrated a case of post-Encephalitic state Parkinsonian Syndrome, combined with hyperthyroidism in a young adult.

Dr. M. Venkatachalam Chetty, Sub-Assistant Surgeon, read out the following cases which were successfully operated and treated in the Government Headquarters Hospital, Palamcottah:—

1. A Case of Myelitis.

2. A case of Fracture dislocation of Spine.

3. A case of "Open Mouth".

The cases were exhibited to the members. The skiagrams relating to them were demonstrated by Dr. G. N. Kantayya, B.A., M.B.B.S. Each case was fully discussed by the members.

Thereafter Lieut.-Col. T. S. Shastry, I.M.S., summed up the salient and important features of all the cases and their differential diagnosis in detail.

An excellent dinner party brought the happy gathering to a close at 10-30 P.M.

**The Medical Practitioner's Association, Nuzvid.**

A monthly meeting of the above Association was held on Sunday 19th February 1939 at Nuzvid in the local Government Hospital premises at 5 P.M., when Dr. (Mrs.) N. M. C. Seshagiri Rao, presided. The minutes of the previous meeting were read by the Secretary and approved by the members. The members then discussed some important and peculiar case reports during which light refreshments and coffee were offered by Dr D. Satyanarayana of the Government Hospital who was at home to the members. The following case reports and demonstrations were made and discussed.

BY DR. V. ANANTHACHARI, L.I.M.

1. A lady of 20 years emaciated, abdomen distended, and tender and impaired digestion getting a diurnal rise of temperature ranging from 101° to 103° F. Amenorrhoea for the last 4 months micturition scanty and occasionally retained.

All the members individually examined her and opined as one of Tubercular peritonitis.

2. A case of cerebrospinal meningitis in a child of 4 months which proved fatal.

BY DR. N. RAMA RAO.

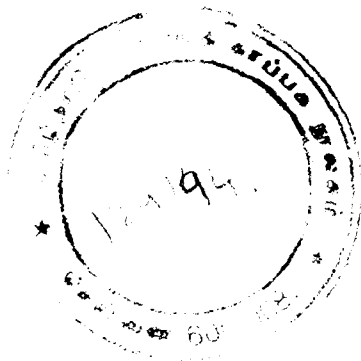
1. A case of Bronchopneumonia in a boy of 5 years persisting for over a month: and resisting all possible treatment: Temperature ranging from 100° to 103° F., both the lungs involved with constant asthmatic breathing: previous history of Amoebic Dysentery of a severe type—Liver at present

palpable and tender: After getting vexed with his treatment and before he was advised to change the place to a better climate, a course of emetin injections  $\frac{1}{4}$  gr. on alternate days gave a marvellous relief and abatement of all the lung condition and the temperature as well. The boy is sleeping well even after the 1st injection and he is alright now. (Examination of sputum originally revealed plenty of pneumococci).

DR. D. SATYANARAYANA demonstrated the following from the Government Hospital.

1. A case of gangrene of fingers and toes in a female during the later days of puerperium.
2. A case of Asthma and post delivery neuritis developed concomitantly during puerperium of a multipara.
3. A case of severe Pernicious anaemia with impending cardiac failure.
4. A preserved specimen of a big tape worm expelled from a patient.
5. A case of Tubercular Bronchopneumonia with symptoms of mucous colitis in a Mohamaden male that has come to attend upon his sickly boy admitted in the same Hospital.

All the members discussed over a long time the above cases and case reports and the meeting came to a close by 7-30 P.M.



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