

(234)

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,*Member, Madras Medical Council.*

ASSOCIATE EDITORS } Capt. E. S. Gopalan, M.B., M.S.; A.I.R.O., (Madras).
SCIENTIFIC SECTION } Dr. S. S. Rau, M.D., (Bombay).

BOARD OF ASSOCIATES.**Dr. K. Narayana Murthi, M.D.,**

(Medicine)

Dr. B. M. Sundaravadanam, B.A.M.B., F.R.C.S. (Eng.)

(Surgery)

Dr. M. Subramania Aiyar, B.A., M.B.C.M.

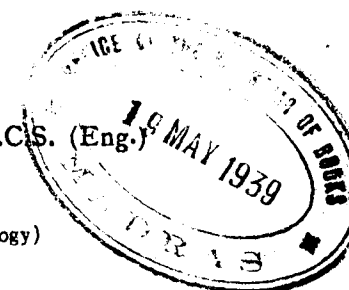
(Midwifery & Gynaecology)

Dr. G. Joseph Gnanadickam, L.M.P.

(Ophthalmic Surgery)

Dr. T. S. Shetty, Z.L.O., D.O. (Vienna)

(Ear, Nose & Throat Surgery)



MENESTRIN CAPSULES

How do Menestrin Capsules prevent pregnancy?

This question is often asked by some members of the medical profession. The flabby and the atonic condition of the muscular wall of the uterus adds to the sodden condition of the endometrium and favours the stagnation of sperm resulting in unhealthy pregnancy in debilitated women. The capsules contain Quinine, Iron, Manganese, Ovary and Thyroid and a few other ingredients belonging to the indigenous system of medicine, so combined as to excite the menstrual cycle in a dormant uterus.

This plain answer was put to test by eminent physicians who are to-day prescribing the capsules to their lady patients who dread pregnancy. To be sure of action the capsules should be taken a week before the expected menses.

The Therapeutic indication for prescribing Menestrin Capsules for Amenorrhoea is quite evident from the action of all its ingredients, a combination of which has been curing patients suffering from inveterate Amenorrhoea due to any causes functional or otherwise.

Available at all Chemists in Madras:

**MANUFACTURED AT THE ORIENTAL RESEARCH LABORATORY,
Vepery, MADRAS.**

Bombay Stockists: Messrs. P. M. ZAYERI & CO., Princess Street, BOMBAY.

Calcutta Stockists:—Messrs Bharatia Medical Stores, Canning Street, Calcutta.

CONTENTS.

	PAGE
Original Articles :	
Madras Medical Council, Review of Proceedings, Nov. 1938 Session By Dr. V. Rama Kamath	253
The Management of Appendicitis Cases By Captain E. S. Gopalan, M.B., M.S., A.I.R.O.	262
Abstracts :	
The VIIIth Annual Conference of The Madras Provincial Subsidized Rural Medical Practitioner's Association	268
Welcome Address by Dr. B. S. S. Prasada Rao	268
Rao Bahadur Dr. T. S. Tirumurthi's Address	272
Presidential Address by Dr. V. Rama Kamath	274
Resolutions	278
Editorial :	
Medical Budget Demands	283
The VIIIth Provincial Subsidized Rural Medical Practitioners' Conference	284
Correspondence, Reports, etc. :	
Our Duty to the Villages By Captain E. S. Gopalan, M.B., M.S., A.I.R.O.	297

DOCTOR!

If Your Treatment is Rational No Disease Can Baffle You!
Much Less Whooping Cough!

What are the Rational Indications For Treating
Whooping-Cough?

The Whoop is due to Spasm caused by the difficulty in bringing out thick tenacious expectoration caused by Bacterial irritation of the Bronchioles.

Hexamin is a safe bactericide. Soda Benzoate and Ammonium Chloride are ideal therapeutic agents for liquifying the viscid phlegm. Belladonna is the safest antispasmodic indicated for children even in large doses. These ingredients are specially indicated for the Rational Treatment of Whooping-Cough.

Koo-Koomin contains all the above ingredients combined with a harmless sedative carried in a demulcent vehicle, a preparation of Glycyrrhiza.

AVAILABLE AT ALL CHEMISTS IN MADRAS :

Messrs. P. M. ZAYERI & CO., Princess Street, Bombay.

" BHARATIA MEDICAL STORES, Canning Street, Calcutta.

Or at : THE ORIENTAL RESEARCH LABORATORY, Yepery, Madras.

THE Medical Practitioner

Annual Subscription { Inland Rs. 3
Foreign Rs. 4 } Single Copy As. 6

Vol. X]

APRIL, 1939

[No. 7

Original Articles.

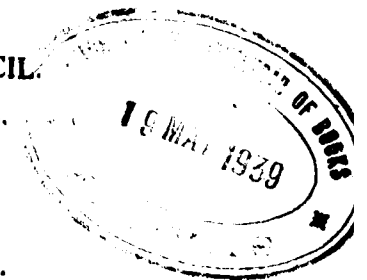
MADRAS MEDICAL COUNCIL.

REVIEW OF PROCEEDINGS.

November 1938 Session.

BY

DR. V. RAMA KAMATH,
Member, Madras Medical Council.



The second annual general meeting of the Madras Medical Council was held on 7th November 1938. There were 44 items in the agenda of which 10 related to registration, 8 to disciplinary action, against registered practitioners and the remaining 26 items were of miscellaneous nature.

REGISTRATION.

Major E. M. Sewell, D. M. O. Bellary objected to his being registered in the Madras Medical Register contending that he was registered in the British Register. It is a matter for surprise why the then Personal Assistant to the S. G. referred the matter to the Council. Though Major Sewell might be ignorant of the fact that Madras Medical Registration Act of 1914 demanded that no one other than a practitioner registered in the Madras Register is competent to hold any appointment as Physician and Surgeon or other medical officer in any institution under the Government or local bodies receiving Government grants or contributions. The Personal Assistant to the Surgeon-General ought to have demanded registration from Major Sewell

before he took charge of his office as the District Medical Officer. In the meanwhile better counsel seems to have prevailed with Major Sewell and he registered himself. The Council therefore recorded the reference.

Till about the year 1930 it was customary with the Madras Medical Council to register foreign nationals though the countries from where they came did not recognise the Indian Medical qualifications. I brought to the notice of the Council for the first time in 1929 section 20 in the Madras Medical Registration Act which prevented the Council to recognise the foreign medical qualifications including those granted in the British colonies in case those countries did not recognise the qualifications registrable in the Madras Medical Register. Ever since the Council did not recommend the registration of foreign qualifications. This was considered as a hardship by Dr. N. Venkataswami Chetti one of the members of the Council, especially in the case of foreign medical missionaries who came to India to serve in mission hospitals and not to practise privately. Dr. Chetti moved the following resolution :

159633
This Council recommends the registration of all Mission Medical Officers who work in the different Mission Institutions in the Presidency irrespective of the condition of reciprocity provided they have got the necessary qualifications approved by the Council".

After a lengthy discussion the Council decided that Dr. Chetti should move a more comprehensive resolution at the next meeting of the council.

Dr. (Miss) C. E. Jamerson one of the lecturers of the Missionary Medical School for women, Vellore, who has been serving in that institution for 15 years complained to the Registrar, Medical Council that she noticed accidentally that her name was not found in the Medical Register though in 1924, she applied for registration, remitting the required fee and registration was not refused to her. The readers might remember that there was a period in the annals of the history of the Madras Medical Council till about the year 1929 when large number of practitioners who remitted the fees for Registration did not find their names in the Register. Evidently Dr. Jamerson must have been such a victim. If this practitioner could produce some evidence that she did remit the fee to the Registrar she would have been registered without any trouble as the Council passed a resolution some years ago that the practitioners possessing registrable qualifications who could produce evidence of having remitted should be registered. As she did not produce any such evidence, her registration was recommended to the Government as a special case and she has been since registered.

Dr. Bernhard Loewenthal, M.D. (Berlin) was refused registration. Dr. J. Ugranarasham, L. C. P. & S., of India was permitted registration by the Government under section 13 of the Madras Medical Registration Act and Dr. S. Ambrose of Martandam (Travancore) was recommended to Government for registration under the same section and has been since registered.

DISCIPLINARY CASES.

Complaint against Dr. A. Seshageri Rao: In the Review of the proceedings of the

Council at the April 1938 session, a case was reported against a practitioner launched by a brother of a married woman, who alleged that the practitioner contracted intimacy with his sister while treating her as his patient for about two months in 1938 or thereabouts. The complaint was filed on 27.7.37. It was mentioned in the review that the practitioner was asked an explanation which was evaded at first. In the meanwhile on 15.9.37 the complainant withdrew the complaint. But the Disciplinary Committee of the Council reported to the Council that it was a fit case to be gone through. Accordingly the practitioner Dr. A. Sheshagiri Rao was summoned to appear before the Council on 4.4.38. Instead of appearing before the Council the practitioner sent a letter denying the allegation of 'vulgar intimacy' and mentioned that some of his enemies were working against him. He also alleged that the complainant's sister was a fallen woman. After prolonged discussion the Council referred the case back to the Disciplinary Committee directing the Committee to obtain legal opinion whether the case be proceeded with when the complainant had withdrawn the complaint. As the Legal Adviser reported that the withdrawal of the case was not fatal to the proceedings, the practitioner was asked to appear before the Council at November 1938 session and as the practitioner did not appear nor was represented, by his pleader the case was decided *ex parte*. The Council found the practitioner guilty and directed the Registrar to erase his name in the Register.

This is the first case in the annals of the history of the Madras Medical Council where the Council took the extreme step of removing the name of a practitioner from the Register. It was indeed a good case for defence and the practitioner might have as well defended himself.

Complaint against Dr. S. Gopala Rao L.M.P. : Sri. W. M. Sreeramulu Naidu, Manager of Messrs Duff & Co., (Egmore, Madras) complained that his firm had been receiving prescriptions given by Dr. Gopaul Rao, in which some unknown

symbols were used and they could not dispense the prescriptions. It was alleged by the complainant that Dr. Gopaul Rao used these symbols with a view to direct such prescriptions to a particular pharmacy called Egmore Pharmacy. The complainant sent six prescriptions issued by Dr. Gopaul Rao in support of his allegation. The allegation was supported by one Mr. Ranguraja Rau Pinglay. The practitioner was asked by the Registrar to submit his explanation to the Council which he did. He said that he was interested in his nephew who was in Egmore Pharmacy as the latter was entirely depending upon him for his subsistence. He wrote his prescriptions on the leaves of a pad bearing the name of the said pharmacy insisting on his patients to go to the particular pharmacy. He added that he did not derive any benefit from the Egmore Pharmacy and that he used abbreviations to save time. Dr. Gopaul Rao was summoned to appear before the Council which he did. The President gave the following verdict on behalf of the Council :

"This Council finds you guilty and you are warned."

Information against Dr. Miss Saraswathi Bai, M.B.B.S., D.G.O. Information was received by the Registrar that Dr. (Miss) M. K. Saraswathi, M.B.B.S., D.G.O., had distributed notices to the public through a local firm Messrs K. C. Bal & Co., Pharmaceutical Chemists, Cannanore, inviting the attention of the public to her professional skill and in proof of his allegation sent one such printed handbill. The practitioner when asked by the Registrar to explain said that she was practising in Coimbatore till she was approached by Messrs Bal & Co., to settle in Cannanore, who told her that there was a real need in Cannanore for a practitioner of her attainments. She denied the allegation that the handbills in question were distributed at her instance and mentioned that she had no knowledge that Messrs Bal & Co. did so. She added that soon after she came to know about the hand bills she stopped their circulation and sent to the Registrar the bundle containing undistributed

notices. She requested the Council to accept her explanation and drop further proceedings. The Disciplinary Committee was unanimously of opinion that the practitioner was guilty and recommended to the Council that she might be summoned to appear before the Council and warned. Accordingly she was summoned to appear before the Council. Her pleader appeared for her and expressed regret and requested the Council to excuse his client taking into consideration her youth. The Council found her guilty and warned her.

Complaint against Dr. P. Venkatagiri, M. D. & C. M. : One Mr. C. Vijayaraghavachariar of Messrs Vijayam & Co., Thambu Chetty Street, Madras, complained to the Council that Dr. Venkatagiri insulted him and his doctor H. L. Narayana Rao when both of them went to Dr. Venkatagiri's residence at or about 10.30 to 11 P.M. on 12th September 1937 with Mr. Vijayaraghavachariar's child which was seriously ill. The complainant averred that he 'did not go there without previous intimation The Doctor's house at that time was in full movement with lights etc., inmates moving and the outer gate was kept open'. It was also said in the complaint that Dr. Venkatagiri was sent for through his servant and he came to the verandah and 'poured forth in vehement and indecent language all possible abuses for having come and disturbed him at that time.' Dr. Venkatagiri who was asked by the Registrar to explain stated that on the 12.9.1937 Dr. H. L. Narayana Rao asked Dr. Venkatagiri at 5 P.M. to pay a visit to Mr. Vijayaraghavachariar's child which was till then attended to by Dr. Narayana Rao and Dr. Guruswami Mudaliar but as Dr. Venkatagiri was not well he could not comply the request in spite of a second call at 9 P.M. that day. He said that he retired to bed that day at 9.30 P.M. due to his illness, that his son and another student were reading at the time on the verandah and the gate was open due to a breach in the wall. Dr. Venkatagiri said that all the inmates in his house were disturbed after the arrival of the party with the sick child and that he

questioned Dr. Narayana Rao why he brought the patient in spite of Dr. Rao's knowing that Dr. Venkatagiri was ill and there was a risk of the children in his house catching the infection from the sick child. Dr. Venkatagiri added that finally he asked Dr. Narayana Rao to go away and seek the help of some other consultant. The Registrar on his own accord asked Dr. H. L. Narayana Rao in writing to explain the circumstances of the case which he did after several reminders. Dr. Narayana Rao said in his statement at the very outset that the delay in replying to the Registrar was partly due to his absence from Madras and partly due to the delicacy he felt in the matter. Regarding the incident Dr. Narayana Rao stated "that though the doctor referred to was unduly and unexpectedly severe and out of his usual mood that night he was obliging in the matter of treatment whenever I went to him. Further, he is senior in profession, a highly paid officer, closely related to me, with some social status and influence. Hence I do not wish to draw him in this unfortunate affair and so I requested him (Vijayaraghavachariar) to drop the matter. Mr. Vijayaraghavachariar took me to task for the incident and I am sorry that he has taken further steps in the matter in spite of my request. Of course the regrettable incident happened that night, but most of it concerns me rather than the patient and I thought it better to avoid any developments in the matter. I do not wish to put in black and white anything with regard to this regrettable incident in reply to your letter. But if you want to have my view in the matter, I shall be glad to see you in person and explain the whole affair than stating it in open correspondence".

The Disciplinary Committee to whom the case was referred was unanimously of opinion that no case was made out against Dr. Venkatagiri. The Council decided to drop further proceedings. The Medical Council is a tribunal like other courts are when it sits in judgment regarding disciplinary cases against the registered practitioners. Nowhere it is said in the Medical Registration Act that the Regis-

trar has power to demand explanation from anybody else except the practitioner complained against. In this case it was irregular to ask a witness to send an explanation as such an irregularity was likely to prejudice the proceedings. The Medical Council has supreme statutory authority to deal with the registered practitioners against whom there are complaints of infamous conduct in a professional respect. In this case from the records before the Council it could not be said that there was any ill feeling between the practitioner complained against and the person who complained till the complaint was made. It may also be said that there was a *prima facie* case or else the President of the Council would not have started the proceedings. The Medical profession would have gained much if the case was gone through by the Council and then if verdict was given.

Information against Dr. H. M. Rau, L. M.P., D.D.S., (U. S. A) : The Registrar received information that Dr. N. M. Rau was advertising about himself in the Madras Mail and the Hindu. He was asked to explain his conduct by the Registrar. Dr. H. M. Rau mentioned in his statement that before he settled in Madras, after his return from Europe and America he had two Dental clinics at Guntur and Bezvada. He did partial and temporary dentures for his patients before he went abroad and promised them that he would attend to them after his return. But as he changed his mind and settled in Madras he thought it was his duty to inform his patients about the same and for this purpose he made an announcement in the Madras Mail merely mentioning about the change in his address. In The Hindu he published about his Dental College as it was a 'non-profit making institution'. He regretted he was not aware of the Warning Notice published by the Madras Medical Council as he had no occasion to practise medicine and surgery as he took to dentistry from the very beginning of his career. He confessed he made a mistake and promised not to repeat the same.

The Disciplinary Committee were of opinion that notification of change of

address might be allowed once but they objected to advertisement of Dental College with his name and qualifications and recommended to the Council that he might be warned. The Council agreed with the Committee summoned the practitioner and warned him.

MISCELLANEOUS ITEMS.

Reciprocity : It was mentioned in the previous Review that the Agent, M. S. M. Railway addressed a letter to the President of the Council informing him that the medical staff with the L. M. P. qualifications in the Railway Service in Marmagao were not permitted by the Portuguese Government to exercise their profession. On a reference to the Portuguese Government the President was informed that in case Portuguese Medical qualifications were recognised in India the Portuguese Government would recognise the Indian qualifications. The Portuguese Government were asked to submit to the Madras Medical Council the syllabus of Portuguese Medical Degree. The request was complied with. At present the Portuguese Government recognises the University Medical degrees of Madras, Bombay and Burma and the Diploma course of the Rangoon Medical School as well as the L.C.P.S. Diploma granted by the College of Physicians and Surgeons, Bombay. But they do not recognise the L.M.P. Diploma of Madras. It now transpires that there was correspondence on this subject between Portuguese and Madras Governments in 1928 and as the former would not recognise the L.M.P. Diploma the Madras Government dropped the idea of recognising the Portuguese Medical Diploma. The Council decided to inform the Portuguese Government that the L.M.P. Diploma of Madras was in no way inferior to the L.C.P.S. Diploma of Bombay which the Portuguese Government recognised.

Medical Register : At present there are a large number of practitioners who have not intimated to the Registrar the change in their addresses and consequently the Medical Register contains lot of incorrect addresses. It also contains the names of practitioners who are dead. To

enable the Registrar to keep the Register up-to-date as far as possible the Council requested the Government to amend section 11 of the Medical Registration Act so that the Registrar might on his own accord remove the names of the practitioners if and when they are addressed by the Registrar they do not intimate to him the change of addresses and in case a defaulting practitioner wished to get himself into Register he should pay Rs. 5/- as a fee. The Government passed the following order on the subject :

The Government consider that it is not necessary to amend Section 11 of the Madras Medical Registration Act, 1914 (Act IV of 1914) in the manner suggested by the Madras Medical Council in the letter read above. They, however, consider that the following rules may be made under section 24 (1) (v) of the Act.

The following notification will be published in the Fort St. George Gazette :—

NOTIFICATION.

The following draft of certain amendments to the rules published with Public Department Notification No. 673, dated the 15th December 1914, at pages 1719 to 1728 of Part I of the Fort St. George Gazette, dated the 22nd December 1914, as subsequently amended, which the Government of Madras propose to make, in exercise of the powers conferred by clause (v) of sub-section (1) of section 24 of the Madras Medical Registration Act, 1914 (Madras Act IV of 1914) is hereby published, as required by the said sub-section (1), for general information.

2. Notice is hereby given that the draft will be taken into consideration on or after the 1st March 1938 and that any objection or suggestion which may be received with respect thereto before the said date will be considered by the Government of Madras.

DRAFT AMENDMENTS.

In the said rules, under the heading "Rules under clause (v) of sub-section (1) of section 24—For the compilation and publication of the Medical Register and connected matters"—

(a) after rule 3, the following rule shall be inserted, namely :—

"3-A. (1) Where the address of any practitioner is not known or is found to be incorrect, the Registrar shall write to the practitioner at his last known address and ask him to furnish his correct address. The Registrar may also make other endeavours to ascertain the correct address.

(2) If no information regarding the correct address is received from the practitioner or from any other authentic source, the words 'Address unknown' shall be entered in the address column of the register against the name of the practitioner.

(3) Where authentic information is available that a practitioner is dead, the Registrar shall omit his name from the Register.

(b) In rule 4, for the words "printed as above" the words "printed as laid down in rule 3" shall be substituted.

The Council did not approve the action of the Government and passed the following resolution:

"This Council requests the Government to reconsider their orders and approve the amendments to section 11 suggested by the Council as a similar provision exists in the Medical Acts of the Medical Councils of Bengal, Bihar, Bombay and the Punjab. This Council also requests the Government to issue an order directing all the Registrars of Births and Deaths to report the deaths of Medical Practitioners soon after their registration to the Registrar, Madras Medical Council, as is done in the case of the Madras Nurses and Midwives Council, so that the names of the dead medical practitioners may be deleted from the Madras Medical Register from time to time".

Medical Registration Act Amendments: In view of the Madras Medical Registration Amendment Act 1938 a set of draft rules for election of members under Section 5 (1) (f) and of Vice-President of the Council under Section 5 (g) were called for by the Government. The Council adopted suitable rules consistent with the amended Act to be forwarded to the Government.

Medical Representatives to Manufacturers: The question whether registered practitioners can represent manufacturers of proprietary goods came up before the Council for a second time. Council received information that a medical graduate representing Messrs Horlicks Ltd., took part in a public demonstration about Horlicks Malted Milk. On enquiry it was found that the medical graduate representing Messrs. Horlicks Ltd. did not actually take part in the demonstration and his legitimate duties were to see medical men and canvass their support for Horlicks Malted Milk. Canvassing for proprietary goods

amongst the members of the medical profession by registered practitioners had been held by the Madras Medical Council as not infringing Medical Ethics though it is mentioned in the Code of Medical Ethics para 22 part II published by the Madras Medical Council that "It is a grave breach of professional propriety for a medical practitioner to take part in the manufacture or sale of a proprietary food or medicine"

Building for Medical Council: The Medical Council office is now located in the Surgeon-General's office and the meetings are held in the room occupied by the Surgeon-General with great inconvenience to all concerned. The Council therefore requested the Government by a resolution to grant a contribution of Rs. 10,000 for a separate building for the use of the Council and make provision for this amount in the Budget Estimate for 1939-40. The Government declined to consider the question of the grant in connection with 1939-40 Budget.

L. M. S. Degree not recognised by F. M. S. Government: In the last Review it was said that the Hon'ble the Premier of the Madras Government forwarded to the Madras Medical Council a letter received by him by one Dr. V. R. Menon, L.M. & S., Asst. Medical Officer, Carey Island, Port Swettenham, F. M. S. complaining that the F. M. S. Government did not recognise the L. M. & S. Degree of the Madras University. The Madras Medical Council declined to take any action as the question of reciprocity outside Madras Province is to be decided by the Medical Council of India. The Madras Government have since addressed the Government of India pointing out to them that L.M. & S. Degree of the Madras University is recognised by the Medical Council of India and under Sec. 13 of the India Medical Council Act 1933, the L. M. & S. qualification of the King Edward VII Medical College, Singapore had been included in 2nd Schedule of the Indian Medical Council Act and it was but proper that the Medical Council of India should take suitable action for the recognition of the Madras L. M. & S. Degrees by

the F. M. S. Government. In this connection I should express my regret that the information gathered by me at the time I reviewed the proceedings of the Council last that the Medical Council of India did not recognise the L. M. & S. Degree of Madras was incorrect.

Standardization of Medical Education: At the Conference of Public Health Ministers held in Madras on 29.12.37, the conference passed the following resolution:

"This Conference is of opinion that it is highly desirable in the interest and safety of the public that medical education in whatever system may be, should be standardized and no one who has not attained certain standard of medical education should be allowed to practise."

The Government of Madras communicated this resolution to the President, Madras Medical Council, requesting him to place the same before the Council and obtain and furnish its views on the resolution. The Council had appointed a Committee consisting of Drs. M. R. Guruswami Mudaliyar, U. Krishna Rau, T. S. Tirumurti, T. Satakopan and V. Rama Kamath to go into the question and report to the Council.

Andhra M.B.B.S. & L.M.S., Degrees, recognised by the Bombay Medical Council: Though the first batch of the Andhra Medical graduates must have come out of the College 12 years ago they did not feel the necessity of getting themselves in the Bombay Medical Register till about two years ago when one of the graduates was refused registration by the Bombay Medical Council as the Andhra Medical Degrees were not in the Schedule of the Bombay Act. This graduate wrote to me about this and I requested the Registrar, Madras Medical Council to correspond with the Bombay Medical Council informing the Council that the Andhra M. B. B. S. Degree was in no way inferior to the Madras M. B. B. S. It was now reported to the Madras Medical Council that the Bombay Government have ordered that the Andhra Medical Degrees to be included in the list of registrable qualifications.

Improvement in the Teaching of Hygiene: The Central Advisory Board of Health

recommended to the Provincial Medical Councils and the Medical Council of India in their proceeding dated 22nd and 23rd June 1937 that the curriculum of study in Hygiene should be improved. The Madras Council unanimously expressed its opinion that the present standard of education in Hygiene was quite sufficient.

Council Committees: Drs. T. S. Tirumurti, U. Krishna Rau, Y. Suryanarayana Rao, T. Satakopan and the President were elected as members of the Disciplinary Committee till the present Council is dissolved and Drs. M. R. Guruswami Mudaliyar, V. Rama Kamath, N. Venkataswami Chetti, Miss. O. M. Mohahan and Lt.-Col. Mahadevan were elected as members of the Registration Advisory Committee for the same period.

Vaccination Certificates: It might be remembered till about a year ago vaccination certificates issued by registered practitioners had to be countersigned by the Port Health Officers, Medical Officers belonging to Public Health Department including the Health Officers of major Municipalities and Civil Surgeons. At my instance the Madras Medical Council was the first to protest against this insult to the medical profession. The Government of India yielded partially and now vaccination certificates issued to passengers going to any foreign ports excepting to East and South Africa, Iraq and Saudi Arabia need not be countersigned. It is indeed most humiliating that the Government could not persuade the Government of the latter ports to do away with countersignature of vaccination certificates though they succeeded to add to the list of officers who could countersign the Railway Medical Officers and Military Medical Officers. It is also said in the order that the countersigning officers should possess qualification recognised by Medical Council of India. The official position and not the medical qualifications seem to secure the safety of vaccination certificates—a most ridiculous test indeed. While recording this order the Council unanimously reiterated its protest against the countersigning of vaccination certificates.

Practitioners to preserve patients' secrets: The Managing Agents, the Meenakshi Insurance Co., Ltd., made a reference to the Medical Council whether a registered practitioner could give information about the condition of health of his patient (a person to be insured) when the practitioner is not the doctor who grants the medical certificate for Life Assurance. The Council decided to point out to the Company para 24 part II of the Code of Medical Ethics published by the Council which runs thus:—

"A medical practitioner is under an obligation to his patient to preserve his secrets, and in legal matters should, except with the patient's consent answer questions only at the express direction of the judge or Magistrate presiding in a Court of Law."

Prosecutions under the Indian Medical Degrees Act: For the last several years the Madras Medical Council has been pointing out to the Madras Government its inability to conduct prosecutions under the Indian Medical Degrees Act and requesting the Government to undertake this work. But the Government have been adamant and refused to take over this responsibility. At last the Government asked the Medical Council if it could forgo the annual grant of Rs. 1,000 in case the Government undertook to conduct the prosecution. The grant of Rs. 1,000 was for the special purpose of balancing the yearly Budget of the Council. Therefore the Council decided to inform the Government accordingly and requested the Government to conduct the prosecutions.

House Surgeons and Physicians: In the Review of the proceedings of the Council September 1937 session it was said that the Council passed the following resolution to enable newly passed medicos to have the benefit of hospital experience on a large scale.

"The Government be requested to afford more opportunities for house appointments in the existing Government institutions and to publish the names of the hospitals where such facilities are available".

The Government reply to the above request is quoted below:

"The President of the Madras Medical Council is informed that there is a practical financial difficulty in providing accommodation for additional house surgeons and house physicians. Without such accommodation on the premises of the hospitals, the appointment of house surgeons and house physicians will be of little use. The question of increasing the existing number of house appointments will, however, be considered if and when the Surgeon-General reports that it is necessary to do so from the point of view of hospital administration and submits proposals in respect of each institution".

Full time Permanent Registrar: From about the year 1932 and earlier soon after the Medical Council came into existence till about the year 1924 the Registrar, Madras Medical Council was a part-time officer. From the year 1933 till the end of 1939 the part-time officer was one from the office of the Surgeon-General. As the Government recently decided not to permit their servants part-time work except under exceptional circumstances, the Council had to appoint a Registrar from outside the Surgeon-General's office. Accordingly the Council appointed a full time Registrar on a salary of Rs. 150 a month.

Legislation to prevent Assumption of Bogus Degrees: In the Review for September 1937 session it was mentioned that the Council suggested suitable amendments to the Indian Medical Degrees Act so as to prevent persons assuming bogus titles similar to the recognised medical degrees and diplomas such as M.B.H., M.D.H., F.R.C.S. (India). The Government accepted the draft amendments of the Council partly and have added a few amendments of their own. But they propose to postpone legislation till the Registration of practitioners of Indian Medicine is complete. The Council deferred consideration of this subject till the Government actually decided to amend the Act. It is a pity that the Provincial Governments either here or elsewhere have not realised the urgent necessity for amending the Indian Medical Degrees Act in spite of their knowing the danger to the public from persons who assume bogus medical qualifications.

Excise Rules stiffened against the practitioners: The readers might remember that a letter under the caption 'An Excise

Riddle' from Dr. T. Narasinga Rao, Hindupur was published in the December 1937 issue of The Medical Practitioner. The practitioner was in a dilemma as to what the expression 'use in practice' really meant with regard to the preparations of Indian Hemp which had to be prescribed in mixtures. After tedious correspondence he was informed by the Excise Department that 'use in practice' covers only the actual direct administration of the drugs in injections, surgical operations or other emergent cases by or in the presence of an approved practitioner. It does not include the dispensing of mixtures containing manufactured drugs from the dispensary and such issues by an approved practitioner from his dispensary shall amount to sale for which a licence has to be obtained. Comments were made in The Medical Practitioner that 'use in practice' should also mean dispensing of Indian Hemp preparations in the prescriptions and a letter was addressed to the Commissioner of Excise to this effect. In the meanwhile Dr. Narasinga Rao was advised not to charge for Indian Hemp preparations if they were included in the prescriptions. The Government also was requested to give a liberal interpretation to the term 'use in practice'. The Government instead of interpreting this term liberally have since passed an order removing Indian Hemp prepara-

tions from the list of 'Manufactured Drugs' and the registered practitioners have been deprived the liberty of keeping a limited quantity of Indian Hemp preparations without license which liberty they have been enjoying hitherto. In addition to The Medical Practitioner protesting against the action of the Government, the following resolution was moved by me at the Madras Medical Council and was communicated to the Government:

"The Madras Medical Council requests the Government not to exclude the preparations of medicinal hemp from the list of the manufactured drugs which registered medical practitioners are permitted to possess as per the existing excise rules for the use of the profession, as contemplated in G. O. Ms. No. 2718, Revenue, dated 19th October 1938."

It is really unfortunate that when the Madras Province is enjoying democracy under the Congress Regime the medical profession should be deprived of a right enjoyed by them during non-democratic days. It is up to the profession to take up this matter and I appeal to all the existing Medical Associations to agitate against the stiffening of excise rules against the members of the medical profession.

As in previous reviews items of routine official nature not concerning the medical profession have not been mentioned in this review.

ELIXIR ANEMONE CO.

A specific for Hysteria and allied disorders.

Elixir Anemone Co. is a compound of valerian anemone and gold with Vitamin B in the form of orange juice. This is the original formula of a leading neurologist of America, Dr. Theodore Alderman, M. D.

Obtainable at all Chemists or with the Sole Agents:

Messrs. KRISHRAJ & CO.,

8, Bunder Street, MADRAS.

THE MANAGEMENT OF APPENDICITIS CASES

By

CAPTAIN E. S. GOPALAN, M.B., M.S., A.M.R.O.,
Surgeon, "Subbalakshmi Memorial Clinic," Coimbatore.

Three important problems confront the practitioner in a case of appendicitis. They are (1) Is the case, in question, a genuine case of appendicitis? (2) If it is one, when is the operation to be done: immediately or later on? (3) What should be the scope of the operation in a particular case? An intelligible answer to each of these crucial questions, is an important desideratum, in these days of conflicting counsels. This conflict of precept is noticeable in the current medical literature and also in the multi-author manuals of surgery. In the Post-graduate surgery, edited by Rodney Maingot, the second question is answered emphatically by two authors, in different chapters, in diametrically opposite ways. This is indeed very confusing. As in all topics, providing heated controversies, from the medical fanatics of opposite schools, wisdom will always be found, in the centre or middle school, which will not swear by any pet slogans but will consider each case on its merits. Verily this school represents the oft quoted dictum of Sir Roger De Coverley of Addison "Much might be said on both sides." But appendicitis is a matter of life and death and non-committal remarks will not help us to a rational decision, in a particular case, at a particular time. In this article, I shall attempt to answer these questions, in the light of my experience and study.

IS IT APPENDICITIS?

"All that glitters is not gold." All cases of pain in the right iliac fossa are not necessarily cases of appendicitis. Nor in genuine cases of appendicitis, the signs and symptoms are identical, following the classical text book like description.

DIAGNOSIS: In a typical case of appendicitis coming on acutely, there is usually to begin with, a generalized pain

in the mid-abdomen, round about the umbilicus, with vomiting, constipation, a slight rise of temperature a pulse rate only very slightly above the normal. Later on even in the course of 12 to 24 hours, the pain gradually becomes localized to the right iliac fossa, with a temperature between 99 to 101 degrees, vomiting, commencing leucocytosis etc. If left alone, with or without expectant treatment, many cases gradually resolve and do not re-manifest themselves for months or perhaps for years. But it is impossible to predict, which particular cases, will have this most favourable termination.

There was in the olden days, an unholy controversy on the medical *versus* the surgical treatment of appendicitis. Now this question has been practically settled in favour of surgery. Now-a-days, cases of appendicitis, are rightly admitted straight into the surgical wards. After all, the vermiform appendix is a vestigial organ, meant only to create mischief to the all-powerful man. It is a contemptible little thing, which has gained a notoriety, far out of proportion to its role in physiology. So much so, one hears of prophylactic appendicectomies in European countries. But most of the modern surgeons, opening the abdomen for any purpose, always have a go at the appendix, if it is reasonably accessible. Removal of a normal appendix is one of the easiest operations, in operative surgery, in marked contrast to an appendix buried in adhesions and entombed in an abscess cavity. So there is no dispute in regard to what judgment should be meted to an appendix which has begun to manifest mischievous propensities.

It is not my purpose to go into the aetiology of appendicitis. Formerly appendicitis was split and unintelligibly classified into several varieties such as catarrhal, sub-acute, chronic, etc. But for all practi-

cal clinical purposes, it is enough, if we recognize (1) acute appendicitis obstructive and non-obstructive (2) sequel to the first condition giving rise to relapses and (3) chronic appendicular disease, a distinct entity, which never gives rise to an acute attack but which is always grumbling and murmuring. This third variety seems to be familiarly common in those who are made suddenly to change their diet and routine of life, as in the case of a C-class prisoner, in the jails for political reasons. This remark of mine is based on the general impressions I formed during the civil disobedience movement in the early years of this decade, when the number of operations performed for chronic appendicular disease, was striking amongst the middle class gentlemen who underwent imprisonment in the jails. I do not know if the introduction of butter-milk, ordered by the present Government, may have any effect in the incidence of this variety. This chronic appendicular disease is not characterized by any acute or fulminating attacks. Its symptoms are manifold and usually, in these cases, prolonged investigations are made. Sometimes the cases are mistaken for peptic ulcers, cholecystitis, etc. An exploration usually reveals a chronic, thickened and fibrosed appendix, sometimes retrocaecal, sometimes adherent to the peritoneum over the psoas sheath giving rise to psoas spasm, sometimes adherent to the peritoneum over the ureter giving rise to urinary symptoms, etc.

The obstructive type of acute appendicitis so ably described by the late Sir David Wilkie, is the type that is responsible for many of the serious complications and sequelae of this disease. The obstruction may be caused by an inspissated faecolith obstructing the proximal part of the lumen, or there may be a kink due to old adhesions, or the lumen may be obliterated by previous inflammation and destruction of the mucosa. Whatever the cause, a cul-de-sac, having its opening into the caecum, closed, is a dangerous condition. The products of inflammation, distend the closed cavity and brings on rupture and perforation at or near the tip of the appendix. The

highly virulent contents escape into the peritoneal cavity and may set up localized or generalized peritonitis. The incidence of general peritonitis, is greater in cases when the appendix lies free in the peritoneal cavity with the tip pointing towards the spleen (the so-called splenic position). When the appendix is of the pelvic type, the symptoms may be pelvic, simulating acute salpingitis in women. A localized pelvic abscess may form which may be recognized by a rectal examination. In every case of suspected appendicitis, a rectal or vaginal examination as the case may be, must never be omitted. A rupture of a retrocaecal appendix may cause bizarre symptoms. I know of a case where the tip of the appendix was situated near the liver and was the cause of a sub-phrenic abscess which in turn eventuated in an empyema thoracis on the right side.

But the commonest sequel of an acute appendicitis is either immediate resolution or the formation of a local inflammatory mass brought about by adhesions between the coils of gut, omentum, caecum and appendix. This inflammatory lump, occurring in the right iliac fossa, with a history of an acute attack of more than 2 or 3 days' duration, is an example of a missed valuable opportunity. In most such instances, so far as my experience, in the Madras General Hospital goes, the attending physicians are not to blame. Self-treatment and quackery are in most instances responsible. In a controlled population met with in the army and the jails, it is rare that an acute appendicitis case is missed. Especially among the European soldiers, working in India, appendicitis is very common, and it is a pleasure to state that practically all the cases are invariably subjected to appendicectomy within 24 hours, some even within 12 hours. Under such conditions the operation, ordinarily is simple and the results excellent. But in the Madras civilian population, such early operations are a rarity. Again and again, we were privileged to see only lumps in the right iliac fossa, with a temperature running to 100 to 103 degrees. The treatment of this condition

has given rise to any amount of controversy, the pendulum, swinging one way or the other according to the prevailing fashion. This will be discussed fully when I proceed to discuss the second question.

Vague pain felt all over the abdomen round the umbilicus, localizing within 12 hours in the right iliac fossa, and local tenderness in the right iliac fossa, due to local peritoneal irritation, is very characteristic in the majority of cases.

In cases of chronic appendicular disease with or without a palpable lump in the right iliac fossa, pressure on the left side of the abdomen over the descending colon, brings on pain in the right iliac fossa. This sign is characteristic and I have verified it in many cases. The pain is due to the gas displaced from the descending colon, through the transverse colon to the caecum.

Another sign known as Altschulers' (1) sign is described in cases of retrocaecal appendicitis. It is simply the observation of decided tenderness and definite circumscribed muscle spasm localized over the right pelvic margin. The method of eliciting is as follows:—"The third, fourth and little fingers of the left hand are laid on the outer border of the ilium and the left index finger on the inner border. If the index finger is very gradually moved over the soft parts from the anterior superior spine downwards, every case of retrocaecal appendicitis shows a definite, often very painful sensitivity usually restricted to a small area. In severe cases there is also very definite muscle spasm in the same place, sometimes higher and sometimes lower. The abdomen is usually not sensitive to pressure and the usual points of tenderness are absent." The contrast is particularly striking when the left side is examined in the same manner and not the slightest tenderness is elicited.

In the olden days a lot was said about the white cell blood count in cases of appendicitis. While in a case of any progressive inflammation, increasing leucocytosis is to be expected, that should not in any way deter us from doing the

right thing at the right moment. In really fulminating cases, the white cell count may even be normal or below normal perhaps due to the unexpected onslaught.

I am not going to dwell on the results and sequelae of missed appendicitis cases, as my object is to stir the profession to a realisation of the immense advantages of an early diagnosis and a prompt radical treatment.

DIFFERENTIAL DIAGNOSIS: While in most cases, the diagnosis of appendicitis, is simple enough, there are many pitfalls, some serious and others not so. Right-sided lobar pneumonia, and right-sided diaphragmatic pleurisy have been mistaken for appendicitis due to careless examination. Every case of suspected appendicitis should undergo a thorough examination of the chest. Such mistakes have occurred with serious consequences to the patient. Even, in my experience, some cases of pneumonia prepared for laparotomy have been saved from a catastrophe by an examination of the chest. Renal colic has been mistaken. Many innocent appendices have been removed, without relief of symptoms only to find later on, evidence of stone in the renal pelvis or ureter. Epididymo-orchitis has been mistaken. Early Pott's has been mistaken. But mistaken diagnosis in the case of lesions of other intra-abdominal organs, is not serious, provided, in the absence of a demonstrable pathological lesion in the appendix, the whole abdomen is properly explored and the lesions properly dealt with. It is sad to relate that cases of cystitis, ureterocystitis, and even a case of acute gonorrhoea have been mistaken for appendicitis. These mistakes are the result of slipshod physical examination, likely to occur in the hands of young surgeons, out to do record work, in abdominal surgery. Some surgeons have a contempt for the stethoscope and the physician. One day they will surely come to grief on account of some misadventure on a medical lesion which a stethoscope or a physician might have revealed.

Appendicular lumps, have also to be differentiated from cases of Tuberculosis of the caecum, malignant disease of the cases of the caecum, regional ileitis, carcinoid or argentaffine tumors of the appendix, mesenteric adenitis tubercular and non-tubercular, psoas abscess as a result of Pott's disease of the spine, Sacro-iliac tuberculosis, nephroptosis or the so-called floating kidney, localized lumps in connexion with tubercular peritonitis, Iliac adenopathy containing metastases from carcinoma of the rectum, prostate and bladder etc. In a case which presented itself with a hard lump in the right iliac fossa 4 or 5 years ago, the first impression was proved erroneous by a careful examination and history taking. The patient had his right little toe amputated some years previously and there was a scar in the right inguinofemoral region, evidently an incision for removal of the glands. The patient gave the history that there was a dark tumour of the little toe and swelling in the groin for which the two previous operations were performed. On a careful reconstruction of the entire pathological history, it became evident that it was a case of malignant metastasis from a primary malignant melanoma of the right little toe. Radium pad was applied to the metastatic lump which shrank temporarily. But in a few months the lump grew with renewed vigour and the patient succumbed. Another case presented itself with a hard bony lump in the right iliac fossa. It turned out to be a case of osteogenic sarcoma from the iliac bone. Metastases in the iliac bone from cases of carcinoma of the breast, thyroid, prostate, or kidney may deceive the most careful practitioner. These are very rare but cases do occur now and then. Sometimes I had even occasion to think that anything may grow from anywhere since the human structure is developed from a single fertilized ovum.

VISUALIZATION OF THE APPENDIX: In most cases barium sulphate administration and visualization are not necessary. In a few doubtful cases especially in cases of chronic appendicular disease, attempts at visualization are justifiable. When an appendix fills completely, and

obviously changes its position from time to time, in the serial radiographs, it is practically certain that such an appendix is normal. The opposite condition of imperfect filling and fixed position, does not necessarily mean that the appendix is involved in a pathological process, but in conjunction with other clinical manifestation, it may clarify our doubts.

WHEN TO DO THE OPERATION?

So far as cases of acute appendicitis, spotted within 48 to 50 hours are concerned, the opinion is unanimous, that such cases should be done immediately, as an emergency. There is no opposition to this dictum, for the physicians are magnanimous and hand over the cases to the surgeon. No modern physician swears he would be bold enough to treat cases of appendicitis by medical measures alone. In many cases the acute inflammation may subside by expectant treatment and an unscrupulous physician may claim to have cured appendicitis cases by such means on some patients. He may thus succeed in ten cases, but the eleventh case may give a rude shock to his complacency, in which he may find, to his cost, in 12 to 24 hours, the patient with a distended and tympanitic abdomen, a very weak imperceptible pulse board-like rigidity of the abdominal wall, incessant vomiting, no urine, a shallow heaving respiration and with a clear and acute mind right to the very end—unmistakable signs of generalized peritonitis—a reward for foolhardiness and criminal timidity. It must be dinned into the minds of the medical students and the practitioners, if not into the minds of the public that appendicitis, tackled within 48 hours if not within 24 hours, is a very curable condition by operation in 98% of the cases.

In cases of chronic appendicular disease giving rise to various typical signs and symptoms, there is no need to hurry up. The practitioner can take his own time to make a thorough investigation. In such cases the operation will be more or less of an exploratory nature, and in any case, normal or abnormal, the appendix goes.

It is also the consensus of opinion, among all the surgeons that in children and preg-

nant women, the appendix must be removed at any stage. The prognosis in neglected cases of appendicitis in children and pregnant women, is not so good, and hence the need for intervention at any stage met with.

So also in cases of appendicitis with progressive peritonitis, the operation is of the nature of an emergency and there is no dispute about the time of operation.

But it is only in neglected cases of acute appendicitis, seen for the first time after 50 hours from the onset of the attack, that there is great controversy about the immediate intervention or intervention at the so-called quiescent period. Even in these cases, where the localized lump, instead of progressive resolution, shows obvious signs of suppuration, the opinion is solid that the abscess should be drained immediately, in the first instance, without any reference to a later appendicectomy.

Though the controversial issue is thus narrowed down, there are unfortunately cases of unmistakable appendicitis seen after 50 hours of onset, in various pathological states. What should be done in such a case? Each case is an entity in itself and generalizations are dangerous. If for instance I see a patient, intelligent and willing to abide by the doctor's advice and not the conflicting advices of numerous meddle-some relatives and uninvited friends, and if the patient shows signs of localization and the general condition is good, I should certainly wait till the acute condition passes off gradually to a condition, when there is practically no lump, temperature is normal, and the patient is fit for the surgical procedure. Usually this resolution takes two or three months, and the operation can be most satisfactorily performed, at the most convenient time. During the first one or two weeks of observation, the patient is put in the high Fowler's position and nourished on glucose and fluids alone—the so-called Oschner-Sherren treatment. I have had ample experience of this kind of treatment, in the select cases, and I am immensely satisfied with the safety and efficacy of this treatment. Operation carried out in

this interval period, is one of the easiest, in the majority of instances. I have seen big lumps of the size of a mango, gradually disappear with time and patience and in which appendicectomy, done at the proper time, was one of the easiest in surgery. Contrast this with what you can expect in an intervention on the 7th or 8th day, when there is a fair-sized lump. There will be plenty of adhesions, the gut glued together by adhesions will have to be forcibly separated, there will be plenty of oozing, artery forceps will have to be used in plenty, sometimes the surgeon may open an abscess with stinking *B. Coli* pus. There will be a mess, the surgeon loses his temper and swears at the nurse, the assistant, and the poor scapegoat, the anaesthetist. The appendix may come out in bits and in some cases may not be discovered at all, in the hopeless mess. The caecal wall is inflamed and friable, the stitches do not hold and the stump could not be invaginated. Drainage will have to be provided for, on account of the oozing and the opening into septic contents. Faecal fistulae and wound infections are not uncommon sequelae. I have seen both kinds of pictures, the quiet operation at the interval and the operation at any cost, at any time, on any patient. Under the circumstances, I will not be ashamed to be dubbed as a conservative, if I protest the tendency of some surgeons to implicitly follow some great man here and some great man there who acts in a particular manner. I could never forget the living pathological pictures in the two conditions, the ease and the facility of one as against the mess and storm of the other. People have misunderstood the Oschner-Sherren treatment, advocated eloquently by Mr. Hamilton Bailey. The clarity with which Mr Bailey espouses this line of treatment, in select cases, under the select circumstances, is admirable and convincing.

But this is only one side of the picture. Even in my experience, there have been many cases, where the patient, who is willing to submit to any operation at the acute stages, once the lesion resolves and become painless, thinks he is cured and

would not listen to our advice. Such cases are a menace to themselves. The Oschner-Sherren treatment is not meant for this illiterate and stupid type of patient. However difficult the operation might be, when confronted with a patient of such a mentality, there is every justification for immediate intervention.

If the Oschner-Sherren treatment, is decided in any case, the patient must be in a hospital or a nursing home at the "very threshold of the operation theatre", so that, any time, the pulse rate rises, operation can be proceeded with. This treatment is not an example of cowardice on the part of the surgeon, but an example of a conscientious surgeon having respect for pathology. Who will dare to do tonsillectomy in a case of acute tonsillitis with inflamed fauces? Who will dare to incise a case of unlocalized streptococcal lymphangitis or cellulitis? Though the analogy is not quite identical the analogy stands. So I should deprecate rule-of-thumb methods in surgery, particularly in the surgery of appendicitis.

SCOPE OF THE OPERATION.

The scope of operation, at a particular stage of appendicitis has been practically discussed while discussing the previous two questions. I am not going to discuss operative details since the practitioner is interested more in the principles than in the technique, which is the concern of the operating surgeon.

In all cases of acute appendicitis seen within 48 to 50 hours of the attack, immediate operation by the Mac'Burney's incision or the right paramedian incision, whichever the surgeon prefers, and

appendicectomy, has become the standard procedure.

In all cases of chronic appendicular disease, thorough investigation and explorative laparotomy, is indicated.

In acute appendicitis in children and pregnant women, operation at any stage, should be the recognized procedure. So also in cases of acute appendicitis, reporting late (after 50 hours) with increasing pulse rate and tendency to generalization, immediate operation is enjoined. When such a case is subjected to operation there may be occasions when the appendix is not easily spotted. In such cases instead of breaking through fresh adhesions, it may be wise to close the para-median incision, if made, and drain the area by a Mac'Burney incision. In cases of appendicular abscesses, which have no tendency to resolve, immediate drainage is undoubtedly indicated by an incision even outer to the Mac'Burney incision. In cases of frank generalized peritonitis, drainage and enterostomy are the only life-saving measures.

In the controversial cases of neglected acute appendicitis cases the indications for the interval operation on suitable cases, and immediate operation, on persons who cannot be trusted to obey the doctor, have been set forth while discussing the second question.

It is always wise not to swear by any pet slogan but to judge each case on its merits, taking into consideration, the intellectual level and the fidelity of the patient.

Reference. (1) *Lancet*. April 10, 1938; P. 391.

PHONE No: 3034

Dr. S. R. BHAT

M. B. B. S., L. D. Sc. (Calcutta)

DENTAL SURGEON

THE X-RAY & ELECTRO-THERAPEUTIC DENTAL SURGERY

289, Esplanade, Madras. Opposite to Corporation Fruit Market.

The most well-equipped Dental Surgery with all electrical apparatus such as X-Ray, Ultra-Violet Ray, High frequency current etc.

Abstracts.

THE VIIIITH ANNUAL CONFERENCE OF THE MADRAS PROVINCIAL SUBSIDIZED RURAL MEDICAL PRACTITIONERS' ASSOCIATION.

SAMALKOT, EAST GODAVARI DISTRICT.

22nd and 23rd April 1939.

The VIIIth Annual Conference of the Madras Provincial Subsidized Rural Medical Practitioners' Association was held at Samalkot, East Godavari District on the 22nd and 23rd. On the 22nd the proceedings commenced at 10.30 a.m. with the meeting of the Working Committee which formally approved the General Secretary's report for the year beginning 1st July 38 ending 31st March 1939. The balance sheet relating to income and expenditure of the Association as presented by the Treasurer was also approved. The Committee then went through the proposed amendments of the Rules suggested by the General Secretary and passed the same. The meeting of the Provincial Committee which is also the Subject Committee for the Conference commenced at 2.30 p.m. and with an interval of one hour for supper between 8.30 and 9.30 p.m. sat till 2 a.m. the following day. The subjects and resolutions sent through the members of the Provincial Committee of the respective District Branches were gone through in detail. Eleven District Branches out of 22 were represented by the respective members of the Provincial Committee and the resolutions received from the other Districts, not represented in the Subjects Committee, were also considered.

On the 23rd as announced the Hon'ble Dr. T. S. S. Rajan, Public Health Minister did not open the Conference being, it is said, engaged in an important Government work and the inauguration ceremony was done by Rao Bahadur Dr. T. S. Tirumurti on behalf of Major-General N. M. Wilson, Surgeon-General with the Government of Madras who was approached by the Association at the last moment of disappointment to encourage them by his presence at the opening ceremony.

The Surgeon-General was approached on the 21st and as he had already fixed up an engagement on the 23rd he expressed his regret to be present and sent his message of goodwill through Dr. Tirumurti.

WELCOME ADDRESS

By

DR. B. S. S. PRASADA RAO.

(Chairman, Reception Committee)

I am getting up to welcome you all on behalf of the Reception committee, which I do with mixed feelings. You are all aware that the Conference ought to have been opened by the Hon'ble Dr. T. S. S. Rajan, the Public Health Minister. But a couple of days ago, he intimated his inability to attend this function due to, he said, an important Government work. If the intimation came to us a week earlier, we would have either postponed the Conference or requested the next person on the panel who is the Surgeon-General with the Government of Madras, Major-General N. M. Wilson. As the invitations announcing that the Hon'ble Dr. Rajan was to inaugurate the Conference were sent two weeks ago, both to our guests as well as to the members of the Association some of whom live in places where the Postal deliveries are once or twice a week, it was not possible for us to postpone the Conference. So in a desperate condition we had to approach Major-General N. M. Wilson who though he had a previous engagement of attending St. John Ambulance Brigade Parade today, was very kind to encourage us by sending a message of goodwill and nominating Rao Bahadur Dr. T. S. Tirumurti to read his message to us. I should say, Ladies and Gentlemen, we are lucky indeed that we are having the

good fortune of having the blessings of the Surgeon-General and also of Dr. Thirumurti.

Though Hon'ble Dr. Rajan could not be present here in person he has sent us his message of good-will and we are highly thankful to him and hope that the decisions arrived at by the conference will have his kind consideration.

Our Association was brought into existence by the late Dr. Ramasubbu one amongst us serving at Viragnur, Salem Dist, who was the Secretary of the Association from its very inception till the day of his untimely death in 1935. All these years the Association had the support and sympathy from the most popular medical journal in the province. The Medical Practitioner. But alas! the death of our beloved Secretary brought the activities of our Association to a stand-still. Early in 1937 if I remember right I read in the columns of The Medical Practitioner, a request to its Editor, from my comrade Dr. N. Rama Rao of Gollapalli to revive our Association. Dr. Rao must have realised the usefulness of the activities of The Medical Practitioner towards us whenever any one of us was in trouble. Dr. Rama Rao had a good share of such troubles and came out of them with triumph, thanks to the just and fearless criticisms that appeared in The Medical Practitioner when Rama Rao was in danger. We are indebted to Dr. Kamath in helping us most devotedly in rejuvenating our Association in 1937 July when under his able guidance five of our comrades Drs. Vittaldas Pai, Govindan, Viswanathan, Shenai and Bhat in the South took up the hint from their brother in the North of Madras, I mean Dr. Rama Rao and organised a Conference in Madras in July 1937 on the eve when the Indian National Congress made up its mind to run the Government of Madras. The then Surgeon-General with the Government of Madras Major General Sir Frank Connor was kind enough to encourage us by opening the Conference. Soon after, when it was announced that Dr. Rajan was to be the

Minister in charge of Public Health, our Association cherished the hopes along with other members of the medical profession that good days were dawning for the medical profession. The Interim Committee of Management of the Association which was selected by the Association drafted a Memorandum and Rules for the working of the Association which were adopted by the General Body at Manachalloor in June 1938.

Thanks to the selfless work of our President and the other office-bearers of the Association, we are now able to say that we have a well organised Association to co-operate with the Government in all possible ways to render medical aid both curative and preventive. A glance at the Memorandum and Rules of our Association by a casual observer will convince him that the aims and objects of our Association are not merely to ventilate the personal grievances of individuals or groups of individuals but to afford to all of us, members of the Association opportunities of service to the people entrusted to our care. And to achieve the aims and objects of the Association, the Association has made it mandatory that we, from all parts of the province should meet once a year. We are also following an unwritten convention that as far as possible the place of our meeting should be a village where there is a Subsidized dispensary. So we met at Manachalloor last year in a village belonging to the Trichy District which was once the centre of professional activities of the Hon'ble the Public Health Minister. This year the East Godavari District Branch invited the Conference to this village where the Public Health Minister recently exhibited his interest and the interest of the Government in Subsidized Rural Medical Service in preference to the L. F. Service quite consistent with the policy of the Government to entrust medical relief on the curative side to the members of the independent medical profession. The Government thus demonstrated that they mind the interests of the public the profession in preference to the ever shifting local politics. It is our fervent prayer that this sound policy will be always

followed by the Government irrespective of vested interests.

We wish you Sir, Dr. Thirumurthi, to convey to your Chief, Major General N. M. Wilson our heart felt gratitude in coming to our rescue by deputing you on his behalf to open the Conference. Please also convey to him the idea that our Association is not run in a trade-union spirit and we are always at his service and command to do our best to make the villagers happier and healthier places to live in. We only want his help to gain more knowledge in ever advancing medical Science which we hope he will not grudge to give us through his various Assistants in the Urban or City Hospitals. The seedlings of the rejuvenation of our Association were watered personally by the Hon'ble Dr. Rajan on the banks of the holy Kaveri at Manachanalloor last year. At a stage when the Association was sprouting into a green plant how happy we feel that the Head of the Medical Department has utilised you as his Purohit to water the growing plant of our Association on the banks of our holy Godavari. We are confident Sir, that under the fostering care of our Public Health Minister who is himself a medical man, the encouragement we are having from the head of the Medical Department and with the blessings of the Purohit like your good-self our Association is sure to grow in strength year after year and bring credit to the noble medical profession.

It was indeed a great relief for us to know from the lips of Public Health Minister at Ellore that neither he nor the Government were responsible to initiate the proposals which appeared in the Government Memorandum 34730-1-D. 2. P. H. dated 30th September 1938 and that this Memorandum was circulated to all of us to find out how far the information supplied to the Government by one of the District Boards could be borne by actual facts. We are highly grateful to the Public Health Minister for the announcement which he made at Ellore on behalf of the Government that there

was no need for us to be frightened by the memorandum and that the Government would never give effect to it especially when only a microscopic minority expressed its willingness to one or other proposals in the memorandum. Even a most pessimistic practitioner amongst us would be convinced that the affairs of Subsidized medical service are not as bad as they were a few years ago. Though the Government have not been pleased to grant us all that we claimed through our representatives, the members of the old Interim Committee of Management and through our President one thing is certain that the Government listened to us and did redress a few of our grievances in the working of the scheme which are of fundamental importance. To my mind the most important grievance which the Government were pleased to solve is the one relating to the termination of our agreement. A President, District Board cannot now terminate the agreement of a Subsidized Practitioner unless the Government decides the appeal against the order of the President. This is indeed a great protection. The other one relates to our rights as citizens. We can now compete with anybody to serve as representative of the people either in any local or provincial body or even in the central legislative body.

The fact that a few of our requests have been complied with should encourage us and we should not stop our constitutional and constructive agitation till the Subsidized Rural Medical Relief Scheme is worked out by the authorities in the spirit for which it is intended. We should convince the Government that renewal of agreement by a short or long term is against the spirit of the scheme so also the conversion of subsidized dispensary into a L. F. dispensary. A Subsidized practitioner goes to a village with an idea of settling there permanently and unless he commits any breach of the conditions of the agreement the nature of such breach being mentioned in the agreement, under no other excuse should he be sent away from the village. A practitioner here and a practitioner there may be benefitted if his dispensary is converted into an L.F.

and he is made the Medical Officer of the L. F. Dispensary. But we should not mind the gain of a few individuals in the interests of the whole scheme. Another most important and fundamental reform for which we should agitate is the control of the scheme. With all due regard to the principles of democracy there is now an agitation at least in some quarters to close the District Boards. The Government know the state of affairs in these local bodies more than we, the oppressed Subsidized Practitioners; it is incompatible with the principles of a healing art that its destinies in the villages should be controlled by an ever viscollating pendulum of village politics which is invariably self-centred. Apart from the individual whim and caprice to which the scheme is subject to there is at present no uniformity in the equipment of subsidized dispensaries relating to staff, building and other minor details such as stationery, etc. To add to this some of the District Boards are having Dispensaries entirely subsidized by the Board. The anomalous existence of institutions serving an identical purpose necessarily gives rise to anomalies relating to their management and equipment. At every Conference we have been demanding a change in the control of the scheme and every suggestion has been turned down by the Government on the plea that so long the District Board pays a portion of the expenditure it should have control. Recently all of us read a suggestion in the Editorial comments of our official journal, The Medical Practitioner that the control of the scheme may be vested in a District Committee consisting of the District Collector, District Medical Officer and District Board President. All interests are represented here and the District Board cannot complain. I respectfully commend this suggestion to the Government and trust the Conference will take up this suggestion seriously. If the fundamental principles and spirit of the scheme are set right the other details such as leave, etc., are of little or no consequence for the Association as a whole.

I will not be doing my duty to my comrades and myself if I do not mention

about a few of our hardships deserving the kind and immediate consideration of the Government. The compulsory attendance of the practitioners at the dispensary from 7 to 12 in the morning is not necessary at all. Even in the biggest Government Institutions such as the Madras General Hospital the outpatient department is open from 7 to 10 A.M. This hardship will be more keenly felt when the practitioner has to attend to public health work also. After 11 A.M. scarcely any patient is seen in any dispensary. The District Medical Officers may be consulted in the matter and the morning hours may be fixed between 7 and 11 A.M. There are at present loud complaints from all the practitioners deputed for sanitary training that Rs. 25 fixed as an honorarium during the period of training and Rs 15 to be given to them after they undergo the training, is not adequate. No mention was made in the Government Order relating to the training that the practitioner would not get his usual subsidy, yet all the District Boards have withheld the subsidy. Government officers of whatever grade are paid special daily allowances and all other out of pocket expenses when posted for any special training in addition to the actual travelling allowance. It is said that the Government did not even consult the Association before they fixed the meagre honorarium. The sanitary training is not likely to bring us more income. It is in public interest that this training and duty is forced on us. The Government will be doing bare justice if they pay the practitioners their subsidies during the period of training and actual incidental expenditure in addition to the Railway fare. The monthly honorarium for doing Public Health work may be increased to at least Rs. 25. I need hardly point out to an audience consisting largely of medical men the importance of periodical refresher courses. I remember to have read in the press some months ago about a proposal by the Government to the District Boards pointing out to them the necessity of posting subsidized practitioners to Head Quarters Hospital for such courses. The Association is not as yet aware what has come out of this proposal. In the meanwhile almost all the District Branches of our Association have passed

resolutions requesting the District Medical Officers to afford them facilities of training in the Hospitals. Excepting in Trichy District where the D. M. O. seems to have arranged to keep the clinical material and experience at the disposal of the subsidized practitioners of that district nothing so far is heard from other districts. It will be in the interests of the subsidized practitioners and rural public if the Government are pleased to supply this need.

There cannot be an end to our grievances nor my story of our wants can be complete even supposing I am allowed to talk to you for a full day. But it will be cruel on my part to keep talking to you our guests more than what I have done especially in this sultry weather to which many of you might not be accustomed.

Ladies and Gentlemen, you all know we are village practitioners having no ideals of urban life and all of you who are not village practitioners might have observed some acts of omission or commission on our part and I beg of you all on behalf of the Reception Committee to forgive us for our shortcomings. I once again express my pleasure in welcoming you all and request Rao Bahadur Dr. Thirumurthi to open the Conference on behalf of Major General N. M. Wilson.

**RAO BAHADUR DR. T. S. TIRUMURTI'S
ADDRESS.**

Dr. Prasada Rao, Ladies & Gentlemen,

I fully appreciate your feelings of disappointment in not finding the Hon'ble Dr. T. S. S. Rajan, the Minister for Public Health amidst you this morning. You are also disappointed to learn that Major-General N. M. Wilson, Surgeon-General with the Government of Madras, was unable to be present here to-day to open the Confer-

ence. Owing to important previous engagements which could not be postponed, both the Minister and the Surgeon-General have expressed their inability to meet you here this morning and have the pleasure of coming into personal touch with so many of you, doing pioneering service as medical practitioners in the rural areas. I know how inadequately I can fill their place at this Conference or deputise for them, though I consider that you are unfortunate in not having an address from either of them an address full of wise counsel, mature advice and proper lead to the satisfactory conduct of your association's many sided activities. I am happy in the honour and privilege afforded to me by being the medium to convey to you their messages of blessings and encouragement, and sympathy to you and your Association's activities. The following are their messages:—

**THE HON'BLE DR. RAJAN'S
MESSAGE.**

"It is a great pity that I am not able to attend your Conference as promised. I realised the impossibility of it rather late, too late to enable you to make suitable arrangements. I am rather pained that I should put you in an awkward position but I want you to understand that however much I may wish to be with you, it has not been possible for me to do so. In fact, I should not have accepted the engagement but for the persistence of your President who insisted that I should repeat my function of last year. Those of you that have followed the events of last year should know by now that this Government has done a lot more than what has been achieved in the previous administrations. It is not my purpose to recount to you categorically the things we have been able to do but in a general way, I feel that we have given you greater security of tenure and liberated you to a large extent from your environmental influence which were hampering you in the proper discharge of your duties. We also recognised your independent status and as such we have empowered you to take part in political events of your place and have given you the privilege of becoming members of local bodies wherein your advice and suggestions will be available for those institutions. The sanitary training which we are now developing is another feature which, I hope, you will not fail to take full advantage of and whatever may be the value of the remuneration that is offered it is bound to make your work popular and useful, particularly from the preventive aspect of disease. These are some of the few outstanding things which I could mention apart from small benefits in the way

of leave and other things, which you were asking for. I would also like you to remember that this was done not as a result of any big agitation on your part as an organised body, for you have scarcely lived as an organisation for just a year, but as one who knew your difficulties, it was our concern to give you whatever you considered necessary and which we could conveniently give. This we have done. I hope that whatever decision you may arrive at in your Conference it will be reasonable and suggestive of suitable action that may be taken. This is what I want to tell you as an organisation of rural medical practitioners whose position in the future of this country is growing day by day in view of the great attention that is being paid to rural development since this Government came into power. I wish your Conference all success.

**MAJOR-GENERAL N. M. WILSON'S
MESSAGE.**

I am extremely sorry that I was not able to open your annual Conference owing to previous engagements. It would have been a great pleasure for me to have had the opportunity of meeting you all and discussing with you personally your difficulties and disabilities. But I have deputed Dr. Tirumurti to speak for me. I would like him to assure you that I am always ready to help you in every possible way. I hope your Conference will be a happy and successful one. I take this opportunity of reminding you all that you are the pioneers of a great movement that gives medical relief to the rural population and your services are greatly appreciated by all of us.

We are all aware that our country is mainly an agricultural country in which 90 per cent of the population live in the villages. The main industry of the country is agriculture and the prosperity of the country as a whole is bound up with the prosperity of the agricultural populations in the villages. The present Government fully realises the great importance of rehabilitating the villages and the work of village reconstruction has been taken by the Government in right earnest. Increasing attention is being paid to village industries, to improvements in agriculture and to the health of the cattle, without which agricultural industry cannot make any headway. All these must necessarily depend on the good physique, better nutrition and better health of the village population. In this great and noble work of village reconstruction, in making the villages happier and healthier

places than they are at present and in the prevention of the drift of population from the villages to urban areas, you, the rural medical practitioners, have a great part to play. You are now called upon to take up further responsible duties as village health officers in addition to the curative medical duties, which you have been performing. You are required to evince greater interest in all the health welfare activities in the villages. Noble is your mission and service is your motto. I am sure your work will receive increasing appreciation and greater gratitude not only from villagers, whom you serve with zeal and enthusiasm, but also will receive due recognition by the Surgeon-General, Director of Public Health and the Minister for Public Health and through them by the Government.

I advise you to make helpful and constructive suggestions in all the resolutions which you may pass for being forwarded to the authorities concerned. The messages of the Minister and the Surgeon-General which I have just now read to you, will convince you that they are interested more than anybody else in your welfare and that they have appreciated the services which you have rendered so far, in spite of the difficulties and disabilities under which you have been labouring.

I am glad to note that many of your major and minor grievances have already been redressed. I am sure your request that the subsidy should be continued during the period of the Sanitary training to which you will be deputed in batches, will be favourably considered by the Government. You will be glad to know that the Surgeon-General has asked me to announce to you that he is drawing up a scheme for a refresher course for you, which will be of immense benefit to you professionally and which he will forward to the Government for necessary approval and sanction. Your future is bright and you have a very sympathetic Minister and a Surgeon-General, who will support you in all your reasonable demands which could be met from the united resources of the Government.

I request you to throw off your inferiority complex and consider yourself as missionaries in a great and worthy cause and for a high and ennobling purpose. Do not rate your subsidy as equivalent to a pay or a salary for the work, which you do. It is but an honorarium or pocket money to defray your initial incidental expenses. You have to depend on popularising your medicine among the villagers and on your private practice among the people, who can afford to pay for your professional services.

I wish you success at this conference and wish that your association will expand its usefulness in all possible directions and progress from strength to strength in the coming years and thus play a worthy part in the building up a great country and a great India.

PRESIDENTIAL ADDRESS

By

DR. V. RAMA KAMATH.

I must first express my gratitude to all the 21 District Branches of the Provincial Subsidized Rural Medical Practitioners Association for having appreciated my humble services to the Association by electing me as the President of the Association for the third time. What little I achieved in the past for the Rural Practitioners in particular and for the entire profession in general—for the interests of Rural Practitioners are certainly intermingled with those of the entire medical profession though it may be the lot of the Rural Practitioners to be in villages—I was able to do some work to the medical profession in my triple capacity as the representative of the largest section of the members of the Medical Profession in the Madras Medical Council, as the Editor of a popular medical journal and as the President of the Association whose VIIIth Conference we are celebrating today. I have had exceptional opportunities of service in these three capacities and I took advantage of such service and gave the benefit to those whom I have

chosen to serve. I can afford to be proud for the honour bestowed upon me but I really feel humiliated. The utmost I can do to deserve this honour is to find out new ways and methods of service to the members of the profession to whom I have dedicated my body and soul as a matter of necessity though such necessity began with a hobby.

Ladies and Gentlemen, in 1929 when I stood for the first time for a seat in the Madras Medical Council, the affairs of the Council were not quite sweet and I gave a pledge to my electorate that if I am elected I would start a journal primarily to redress the grievances of the members of the profession in whatever position they were. The then Secretary of the Provincial Subsidized Rural Medical Practitioners Association, the late Dr. Rama Subbu L.M. & S. was the very first Subsidized Practitioner who collaborated with me and wrote in the very first issue of The Medical Practitioner about the defects of the Subsidized Rural Medical Relief Scheme and ever since the columns of the journal have been utilised to redress the grievances of the practitioners belonging to this scheme. Realising the usefulness of the services of The Medical Practitioner, the Association at their Conference held in July 1937 Madras requested me to make it as the Official Journal of the Association which I did ungrudgingly. I went a step further and to do propaganda for the Association sent copies of the Journal free even to such of those who did not pay the subscription which was fixed at Rs. 2 for the R.M.P's. whereas others have to pay Rs. 3 a year. A popular journal gives its subscribers exceptional opportunities to express their views on any topic either of scientific or general importance and is the best medium to let know the authorities the opinion of the members of the profession on any topic concerning the policy of the Government relating to medical administration or medical practice in the hospitals or outside. Soon after The Medical Practitioner was recognised as the official organ of the Subsidized Practitioners' Association

I approached some eminent members of the profession to form a Board of Collaborators to write scientific articles in the journal so that the journal may be made useful to the general practitioners especially to those serving in the villages. I am glad to tell you that I could get eminent members of the profession, specialists in medicine, surgery, midwifery, ophthalmology, diseases of ear, nose and throat. A Physician and a Surgeon amongst the collaborators are the honorary officers of the Madras Government General Hospital. Having secured the services of such eminent members of the profession to form a honorary team to serve the profession through the journal I am now attempting not without hope to secure the services of such teams throughout the Province to help the Subsidized Practitioners in their professional work and it is my ambition to start Cottage Hospitals in suitable centres where the services of Specialists could be made available at week end at other times the work being carried on by the Rural Practitioners. To visualise my plans, the first thing I thought I should do was to organise the Association on a sound basis. The Association has a splendid memorandum and as useful rules embodying its aims and objects. It was not an Association started only to redress the grievances of the practitioners. It will not be out of place for me to place before the audience some of the aims and objects of the Association to make them realise that the Association is not a trade-union. I shall quote a few of the aims and objects of the Association :

1. Promote unity and comradeship among the Subsidized Rural Medical Practitioners.
2. Co-ordinate the experience of individual or group of Members about medical profession as gained in the Rural areas.
3. Study, formulate and disseminate such professional experience.
4. Study public health problems in various centres with a view to lay out Public Health measures for the promotion of Health and longevity of the people living in villages.

5. Subscribe, print, publish and distribute journals, books and pamphlets and other literature.

6. Hold meetings, conferences, exhibitions, discuss and formulate the problems of Medical Relief and Public Health in rural areas.

7. Organise Cottage Hospitals wherever there is public demand and local effort and contributions are forthcoming.

8. Amalgamate or enter into working agreement with any other Association Union or interest carrying or proposing to carry on any business within the objects of this Association.

9. Deal as a corporate body with authorities responsible to administer the scheme of Rural Medical Relief and Public Health in Rural Areas as well as similar corporate bodies interested in this scheme.

But unfortunately the Subsidized Rural Medical Relief Scheme has been run by the authorities in such a way that it has deprived all zeal and spirit of service from those who joined the scheme and having no definite rules as in regular service those belonging to the subsidized service are in a most deplorable condition at times being worse than most dependent persons. Though the spirit and principle of the Scheme are sound the execution of the scheme by the authorities has taken away the real life of the scheme and majority of the Practitioners I find are either callous or lukewarm to their own interests. All the same by my personal contact with them, I was very much consoled to observe that the latent instinct of spirit of service which is inherent in the noble medical profession is not extinct in them in spite of their being forced to conditions of Indentured service which Government in season and out of season calls by the name of Independent Service.

In my personal talks, in my writings in The Medical Practitioner, and in my public addresses I have been inculcating on the Rural Practitioners the value and power of the healing art in not only relieving and curing human ailments but correcting society as a whole, a gift no other profession can claim. I thought and rightly so that if majority of subsidized practitioners are brought up to a high level of efficiency

in the profession their grievances are likely to dwindle as the healing art would come to their aid in this direction. When this idea was working in my mind I read one day a Government Communique asking the opinions of District Boards if they could at their expense depute subsidized practitioners for refresher courses to the City Hospitals. Nothing having come out of it at least one of the District Board President having openly expressed the inability of the District Board through the News-papers I thought the best thing to do is to rely on self-help. At the instance of the General Secretary of the Association the Trichinopoly District Branch of the P. S. R. M. Ps' Association passed last August a resolution requesting the D. M. O. Trichy to afford the Subsidized Practitioners clinical training both medical and surgical including operations on penultimate Saturdays at the Government Head Quarters Hospital. Resolutions similar to the one passed by the Trichy Branch have been passed by all the other existing 21 branches of the Associations and the Surgeon-General has been kind enough to accord sanction to hold classes at the District Hospitals but I have no news that such classes are held anywhere else except in Trichinopoly District Hospital. In the meanwhile I had occasions to see a few of the District Medical Officers majority of whom happened to be Europeans and I am most happy to tell you that their conception of the ideals of subsidized rural medical relief scheme are really laudable. One of them spent over three hours with me suggesting to me ways and means to improve the lot of the practitioners without asking the authorities to increase their emoluments; he said if they are really made independant which they were said to be, village medical relief could be extended without proportionate financial commitment. He was an ardent enthusiast of the Subsidized Rural Medical Scheme and I had really to learn much from him. At my request a scheme has been drafted by Lt. Col. Cox, D M.O., Coimbatore for 15 days intensive refresher courses, for the R.M.Ps., in the Coimbatore District and it has been submitted to Surgeon-General for approval. It is expected that the

Surgeon-General who has a soft corner in his heart for the R.M.Ps. would approve the scheme and recommend the same to the Government and the Government would be pleased to grant 15 days leave with subsidy when the practitioners attend the refresher course. I may here mention that in England the Panel Doctors who are in much better circumstances than the Subsidized Practitioners are not only paid special allowances while undergoing refresher courses for a much longer period but their substitutes are also paid by the Government.

PUBLIC HEALTH WORK AND THE R.M.Ps.

The Government cannot expect to work out the Public Health Act successfully without the help of the Subsidized Rural Medical practitioners and the Government are posting them for necessary training in batches. It was expected that the Government would be humane in exacting Public Health work from the Subsidized Practitioners but it looks as if they are taking undue advantage of their helplessness. Even a most humble wage earner is consulted these days about his wages before he is asked to do any work but the Government did not find it necessary to consult the subsidized practitioners what the actual expenditure was likely to be when they had to be outside their villages to undergo Sanitary training. They are not even to get their monthly subsidy and have to be satisfied with Rs. 25/- a month to live in Madras and to go about to the various Hospitals including the Poona-malle Health Unit. Even a most humble Govt. servant deputed for any special training gets not only his pay but additional daily allowances. After undergoing the training they are to get Rs. 15 for doing Public Health work. The Daffadars of the Public Health Department get better remuneration, than that has been sanctioned to Subsidized Practitioners doing Public Health work and enjoy better liberties. The Subsidized Practitioners have brought their grievances to the notice of the Government and it is expected that the Hon'ble Dr. T. S. S. Rajan who is a medical man himself would protect the prestige and status of the Medical Profession and

recommend them to the Government for fair play. A discontented band of even indentured labourers in the persons of Subsidized Rural Medical Practitioners cannot be expected to do work by threats when they are not able to keep their bodies and souls alive.

CO-OPERATIVE HEALTH UNITS.

Recently the Government published a scheme for giving rural medical relief on co-operative lines which they styled the Co-operative Units Scheme. It is not clear in the communique whether the scheme is meant for all classes or only to the necessitous poor in the villages. If it is to the necessitous poor I could at once say it is an eyewash. If it is not for the necessitous poor the scheme smells of socialised medicine at the cost of the medical profession and under the dictation of an outside agency which is not the medical profession. It was said somewhere by the Minister in charge of labour that the Government intended to enact legislation to introduce this scheme. I hope the Government will not introduce forced labour on the members of the medical profession. In the matter of taxation the Government complain that the agriculturists in the villages pay proportionately more revenue to the Government than the rich merchants in the urban areas and the Government are introducing new taxes to equalise the taxation burden but with regard to medical relief the Government forget the same principle and do not afford proportionately more medical relief by full paid agencies as in urban areas and wish to introduce co-operative health units scheme in the villages where the illiterate villagers do not know the A B C of co-operation. If it is the intention of the Government to introduce medical relief on co-operative lines, urban areas are better suited and not the villages.

As mentioned by me a little while ago it is not known whether co-operative Health Units are to serve the necessitous poor in the villages in which case I should say the existing Subsidized Scheme is the ideal to serve them. For, it is an incumbent duty on each Practitioner to treat 30 poor patients a day whereas in the co-operative health units scheme there is

no provision for the treatment of the poor. Another defect in the scheme is that the rich will take undue advantage by enlisting themselves as Members and get the services of qualified Doctors for little or nothing and those who are the Directors might not even pay the 4 annas for the visits and the Doctor who is the creature of the Directors will be afraid to report if 4 annas are not paid. It may be a sound principle if the health units depending on paying capacity of its members are graded as Class I, Class II, Class III or only one Class and the members made to pay according to their paying capacity. There cannot be objection if the fees for services rendered by the Doctor go to the funds of the Unit. But a certain percentage not less than 25 per cent should be paid to the Doctor in the interests of the patients or else the Doctors will not have interest in the work.

To my mind the best scheme to give medical relief to the poor village folk is the existing Subsidised Rural Medical Relief Scheme modified and extended by getting the help from the co-operative societies and the modification I suggest is the introduction of subsidy on Grant-in-aid principle, a practitioner being paid on the bulk of work turned out by him.

I am extremely sorry that though I intended to put before the Conference a well designed Grant-in-aid Scheme based on facts and figures giving a rough idea of immediate expenditure, and the future financial responsibility of the Government on a five or ten years plan, I could not do so partly due to my illness and partly due to the confusion on account of the unexpected disappointment from the Hon'ble Dr. T. S. S. Rajan who indicated his inability to open the Conference at the last moment. I therefore commend the Scheme to the Association suggesting that I may be permitted to place the same before the Provincial Committee at the earliest opportunity so that the Association may place it before the Government, pointing out to the Government the advantages of the scheme in preference to the proposed Health Units Scheme, where there is no scope or inspiration for the members of the medical profession to work schemes of public utility.

Resolutions.

Amendments to the existing Rules.

I. Resolved that the following amendments to the existing rule approved by the Provincial Committee be adopted.

Rule 5 (c)—Every ordinary member shall pay a subscription of Rs. 5 for the financial year and in addition an entrance fee of Rs. 4 (for the new admission) and shall receive a copy of the official organ, *The Medical Practitioner* without any charge.

Rule 7.—Substitute '8 days' in the place of '15 days'.

Rule 9 (a)—In this rule 'District' means 'Revenue District,' and in the place of a 'month' substitute 'sufficiently early' and delete the words 'Vice-President and other ex-officio members'.

Rule 9 (c)—Substitute 'by the President' in the place of—'in consultation with the Working Committee'.

Rule 9 (e)—In the place of '15 days,' substitute '10 days'.

Rule 10 (a)—Delete the words 'The General Secretary and five' and in their place substitute the word 'six' and add at the end of the existing rule 'The office bearers for the official year shall be selected by the President from amongst the members of the Provincial Committee and excluding the President they are: a Vice-President, a General Secretary, two Joint Secretaries, a Treasurer and an additional member. The names of the Working Committee shall be declared by the President within 15 days after the date of the yearly conference'.

Rule 12 (a)—Delete the sentence beginning with the word 'this' in the first line as far as 'committee' in the 3rd line and substitute by the sentence 'The General Body meeting shall ordinarily be held once a year during X'mas holidays in a District to be approved by the General Body at the annual meeting. The place and date to be fixed and announced later by the Working Committee'. Delete the sentence appearing in the sixth line beginning with the words 'Office-bearers' and ending with the word 'approved' in the 7th line.

Rule 12 (c)—In the place of '30 days' substitute '10 days'.

Rule 12 (d)—In the place of 'eight' substitute the word 'five'.

Rule 14 (f)—Substitute the following rule in the place of the existing one:

'Out of the yearly membership fee of Rs. 5 collected from each member in the District Rs. 2 should go towards the funds of the official journal, *The Medical Practitioner* and out of the remaining Rs. 3, Rs. 1-8 should go to the Provincial Fund and the other Rs. 1-8 should be the quota to be paid to the District Branch to which the member belongs. The District Branch

shall not claim any other contribution from the Provincial fund and each District Branch should have a fund of its own to be contributed by the members of the District Branch in any manner the District Branch decides.

Rule 16.—The financial year shall be from 1st January to 31st December.

II. Resolved that the report submitted by the General Secretary and the balance sheet by the Treasurer for the period ending 15th April 1939 be adopted and approved.

III. The Conference congratulates the Public Health Minister for successfully passing the Public Health Act in this province and leading a way for other provinces to follow and appeals to the members of the medical profession including the Subsidized Practitioners to co-operate with the Government in all possible ways for the successful working of the provisions of the Public Health Act.

IV. (a) Resolved to request the Government to bring all the Subsidized Rural Medical Practitioners directly under the control of the Government and provincialise the existing dispensaries now subsidized by the local bodies.

(b) This Conference respectfully points out to the Government that there is no necessity of renewing the Agreement year after year or at varying periods as such a procedure is against spirit of the Rural Medical Relief Scheme and in case a Subsidized Practitioner commits any breach in the terms of the agreement there is a specific provision provided in clause 12 of the agreement by which his services can be terminated.

(c) This Conference requests the Government to limit the working hours of the rural dispensary from 7 to 11 A. M. as after 11 A. M. patients do not turn up to the Dispensary.

(d) The Conference requests the Government that the Practitioner be supplied with medicine to the net value of Rs 360/- excluding the freight and other incidental charges.

(e) Resolved to request the Government to delete the word 'including' occurring in clause 7 of the Agreement in line 3 G. O. No. 3510 dated 4th October 1938 appendix 1 and 2 and substitute therein the word 'excluding' as otherwise the practitioners cannot attend the meetings of the District Medical Associations which are generally held either on penultimate Saturdays, Government Holidays or Sundays or otherwise direct local bodies to treat the days that the practitioners attend these meetings as working days.

(f) Resolved to request the Government that the lien expressed in clause 7 of the Agreement be raised to one year or more in case the Subsidized Practitioner wishes to undergo special post-graduate courses depending upon the period of courses; during which period he being allowed to keep a substitute of his own approved by the District Medical Officer.

(g) This Conference respectfully represents to the Government that the transfer of Subsidized Rural Medical Practitioners from one Dispensary to another without mutual consent of the practitioners is against the principle and spirit of the Subsidized Rural Medical Relief Scheme, nor is the principle of converting a subsidized dispensary into either a L. F. dispensary or a dispensary of any other system is consistent with the spirit of the scheme.

(h) The Conference requests the Government that in case of a vacancy in Local Fund Medical Service the Subsidized Practitioner should be preferred to a stipendiary who may be provided in the vacancy created by the appointment of a Subsidized Practitioner.

V. The Conference brings to the notice of the Government that notwithstanding the direction in G.O. No. 3483 P.H. dated 1st October 1938 the Presidents of Local Board have been invariably reluctant to equip all the rural dispensaries maintained by them with necessary surgical, dental and midwifery instruments in accordance with the recommendations made in G.O. No. 761 P. H. dated 7-4-1925 which alone if supplied is to remain as the property of the Local Board concerned and form the permanent equipment of the Rural Dispensary.

VI. The Conference regrets to note that the Government had declined to treat the period during which the practitioner is required to undergo training in Public Health Work as on deputation and disallowed the usual subsidy for the period even though the practitioner undergoes such training wholly in Public interest and requests the Government to reconsider the reasonable claims of the practitioner and allow him his usual subsidy during the period under training in addition to the honorarium which is necessary to supplement his expenditure at the training centres.

VII. This Conference views with great regret that in spite of the repeated assurances from the Government that suitable Subsidized Practitioners will be appointed to L.F. service when vacancies arise, the Coimbatore District Board and also the Tanjore District Board did not adhere to the G.O. on the subject on the plea of having reserved Sub Assistant-Surgeons.

VIII. The Conference requests the Surgeon-General to recommend to the Government that drugs like Atropine, Dionine and such other drugs required for the treatment of the external diseases of the eye which are very common among the poor in the villages may be supplied to such of the Subsidized practitioners who indent for the same.

IX. The Conference requests the Surgeon-General to recommend to the Government that when a subsidized practitioner has to attend any emergent case outside in a patient's house during working hours he might be permitted to do so recording such cases in the register.

X. This Conference is of opinion that there is a real need of a midwife to help the Subsi-

dized practitioner in midwifery work and it is not possible nor practicable for him to get the help of the midwife attached to the Child Welfare Centre though situated in the same village or near by; so it will be advisable in the interest of all concerned that a midwife should be attached to a subsidized dispensary who may also be entrusted with the Child Welfare Work.

XI. Resolved to inform the Government that the proposed Co-operative Health Units Scheme will not provide medical relief to the necessitous poor in the rural areas as is provided in the existing Subsidized Rural Medical Relief Scheme where it is incumbent on the practitioners to treat a day at least 30 necessitous poor free of charge and that the Subsidized Rural Medical Relief Scheme may be improved and extended with the help of the common good fund and other financial help which the Government consider to take advantage of in the Co-operative Health Units Scheme. Even in the interest of the medical profession the Conference considers that it is humiliating to hand over the control of medical relief even on co-operative basis to a non-medical agency on conditions of service which are likely to tell upon the honour and prestige of the profession when it is known that the whole scheme has to depend upon the selfless work of the members of the medical profession.

XII. This Conference requests all the Presidents of the District Boards in the Province to send copies of the proceedings relating to the Subsidized dispensaries under their respective control to the Secretary of the respective District Branches of the Provincial Subsidized Rural Medical Practitioners' Association so as to enable the Association to get posted with all the District Board proceedings and to file the same along with the G. Os received by the Association.

XIII. Resolved to request the authorities concerned to appoint a dispensary servant to every dispensary which has an attendance of 30 or over per day.

XIV. Resolved that the following practitioners be admitted as Honorary Members provisionally:

Dr. K. Vittal Shetty, Mangalore; Capt. E. S. Gopalan, Coimbatore; Dr. Chandu, M.L.A., Malabar; Dr. G. Ramaiengar, Vizag; Dr. Pattabhi Sitharamayya, Musulipatam; Dr. D. S. Ramachandra Rao, Bezwada; Dr. M. Rangayya, Ellore; Dr. H. V. Jogayya Sarma, Ellore; The Hon'ble Dr. T. S. S. Rajan, Trichinopoly; Dr. S. Sankara Raman, Cuddalore; The Hon'ble Dr. U. Rama Rau, Madras; Dr. D. V. Venkappa, Madras; Dr. V. C. Kamaraja, E. Godavari; Dr. T. Kanakaraju, E. Godavari.

XV. (a) Resolved to request the General Secretary to publish by the end of January every year a register of members on the roll of the Association as it stands on 31st December in the preceding year.

(b) Resolved to reiterate the recommendations of the Provincial Committee to the

District Branches that the Secretary-Treasurer of the District Branch should also be the representative of their District in the Provincial Committee and a Joint-Secretary-Treasurer should be elected to act for the Secretary-Treasurer and also as a member of the Provincial Committee whenever necessary.

XVI. The Conference while expressing their deep sense of disappointment on account of the Hon'ble Dr. T. S. S. Rajan's inability to open the Conference on account of important Government work, expresses its gratitude for the sympathetic message sent by him.

XVII. The Conference expresses its sense of gratitude to Major-General N. M. Wilson, Surgeon-General with the Government of Madras for having come to the rescue of the P. S. R. M. Ps. Association in deputed Rao Bahadur Dr. T. S. Tirumurti, Principal, Stanley Medical College, Madras to open the Conference on his behalf as at the time he was approached with a request to open the Conference he had already a fixed up engagement.

XVIII. This Conference expresses its gratitude to the Chairman, Reception Committee, Dr. B. S. S. Prasada Rao, and other members of the Reception Committee for the splendid reception accorded to the delegates and guests who attended the Conference.

XIX. The Conference thanks the President, District Board, East Godavari for placing the

Samalkot District Board High School buildings at the disposal of the Conference.

XX. The Conference expresses its appreciation of the kind and valuable services rendered by the Head-Master and other staff of the Samalkot Board High School in assisting the Reception Committee to make the Conference a success.

XXI. This Conference thanks the East Godavari District Medical Association for co-operating with the Rural Medical Practitioners in conducting the Scientific Section of the Conference.

XXII. Resolved that the following members be elected to the panel for Presidentship for the next official year; 1. Dr. M. R. Bhat, 2. Dr. B. S. S. Prasada Rao, 3. Dr. K. Vittaldas Pai.

XXIII. Resolved to accept the invitation of Dr. R. Doraiswamy, Representative, Chittoor District Branch that Chittoor District be the next venue for the Conference.

XXIV. Resolved to advise the District Branches to do intensive propaganda for enrolling new members to the Association by approaching every Subsidized practitioner in the District and out of the amount collected after deducting expenditure, the balance to be paid to the District Branch and the Provincial fund in proportion of 1 : 2.

WEBSTERS PHOSPHATUM

RECONSTRUCTIVE

AND

HOMOSTIMULATIVE TONIC

Composition.

Cal. Phosph.	.02 gm.	Avonin	.12 gm.
Sod. Phosph.	.14 gm.	Xanthoxylin	.15 gm.
Kali. Phosph.	.30 gm.	Orange Juice	1.2 gm.
Mag. Phosph.	.20 gm.	Apple Juice	1.2 gm.
Lecithin 12 gm.			

Therapeutic Indications

- (1) Phosphaturia:—It is an unfailing remedy if given in tablespoonful doses before food and given persistently.
- (2) Billiousness, Waterbrash, Giddiness, Loss of appetite etc:—A tablespoonful in half an ounce of water three or four times a day correct the whole condition in a remarkably short time.
- (3) Uncontrollable Vomiting, especially in malarial fever and also in any condition yields promptly to one or two doses of Webster's Phosphatum; may be combined with adrenaline.
- (4) Chronic rheumatism, Myalgia, etc:—In these conditions it may be considered as a specific.
- (5) Neurasthenia, Tired feeling, Nervousness, Trembling of the hands, Inability to concentrate, etc., all showing want of nerve tone:—Tablespoonful of Webster's Phosphatum undiluted before food twice or thrice a day is positive to show its effect in a month's time.

Obtainable at all Chemists or with the Sole Agents:

Messrs. KRISHNAJ & CO., 8, Bunder Street, MADRAS.

THE Medical Practitioner

Vol. X]

APRIL, 1939

[No. 7

MEDICAL BUDGET DEMANDS

FROM

A VALIANT MINISTER.

When the Hon'ble Dr. T. S. S. Rajan demanded at the last Budget Session of the Madras Legislative Assembly that the Government be granted a sum not exceeding Rs. 91,22,800 a member belonging to the European group moved a cut motion to discuss the policy of the Government relating to Medical Department. Ten members of the Assembly sitting opposite to Government Benches and one woman member belonging to the Congress party took part in the debate. The Government was criticised that sanitary condition in the General Hospital, Madras was not satisfactory and that in the same hospital the nursing and menial staff were inadequate. It was pointed out by another member that the King George Hospital at Vizag should be treated as a Presidency Hospital and well equipped to suit the needs of Andhra Districts. The Leader of Opposition and another said that the policy followed by the Government in laying down five years tenure of office to the honoraries had deprived the General Hospital of the valuable experience of the seniors and therefore it was said that the patients seeking admission into the General Hospital were likely to suffer. The Leader of opposition pleaded specially for one of the honoraries who was replaced by a junior. A Mohamedan member went a step further and said

that the Honorary system would not supply to the people the Services of Specialists. This member complained that his community was not adequately represented in the medical service and one or two bitterly complained that there was not fair representation to the various communities meaning thereby that even in honorary service the Brahmins predominated. There were at least two members, one of whom was a medical man himself who brought to the notice of the Government that the Subsidized Practitioners were not fairly treated by the Government especially relating to the subsidy for doing Public Health work and it was suggested that Rs. 30 a month should be the minimum the Government should pay the practitioners to do this work. One of the members spoke on behalf of the medical licentiates and wished that the Government should treat them in par with the medical graduates especially those who underwent five years training. Inadequate accommodation at the Government Mental Hospital, at Madras came in as part of the discussion by a member. The 'step-motherly treatment' accorded by the Government to the Indian Systems of Medicine was vehemently stressed by more than one member of whom one belonged to the Congress Party. Need for better scope for the treatment of patients suffering from Tuberculosis, Leprosy was also part of the debate. The valiant Minister, Dr. Rajan, was not perturbed the least in defending the Government policy relating

to all the issues raised by the members of the Assembly excepting the remuneration to Subsidized Practitioners doing Public Health work. Regarding the treatment of patients at the Government Hospital he said he would prove with the help of statistical records that in spite of want of cleanliness and inadequate menial staff complained of by the European member and in spite of the adverse circumstances prevailing in India relating to the economical conditions of the people very good work was turned out at the Government General Hospital which compared quite favourably with the work of hospitals in the advanced countries in the west. He agreed that there was not sufficient nursing staff which he said was due to dearth of trained nurses. Regarding the communal representation in medical service paid as well as honorary, the Minister began well by saying that in making appointments, considerations of caste or community were not taken into account as medicine was a science and its practice was an art and therefore it was not everybody that could be made a medical man because he belonged to a particular community. But at the end due perhaps to political reasons the valiant Minister faltered and said that instructions had been issued that those communities that were not represented in the service should be given preference. We would warn the Minister not to react unconsciously to accusations of over-representation of a particular community. The best man only should be chosen for medical service irrespective of community. There is nothing to prevent the members of any community from qualifying themselves to their utmost for paid as well as honorary service. Those who fight for communal representation are selfish to the core. Supposing a ten of a particular community get fat

salaried jobs under Government do these ten distribute their wealth among the members of the community. They do not. Why then talk of percentage, over-representation and under-representation. The communalist virus has established itself and threatens to destroy the social organism in India. What has religion to do with material ends or aims. The so-called religions have lost their religiousness and rank materialism is speaking under the cloak of religious fanaticism. What is religion except an attempt at the comprehensive explanation of a prime motive force of this universe call it God, Allah or Ishwara. The human masses like herds of sheep slavishly mistake the form for the spirit and place artificial values on modern pretenders of religions. Religion is a matter for individual introspection and self-realisation. It should never separate man from man. It should never be used for material ends. Medical men at least should endeavour to become rationalistic philosophers. The recent scenes exhibited on the floor of the Madras Assembly relating to communal representation in medical service are most nauseating and a rational and enlightened posterity at no distant future will laugh with ridicule at these performances. We wish the medical profession comes to the rescue of the Government when they yield to rank politics as against rational science.

It is a pity that the members who attacked the Government on their policy relating to honorary medical service concerned themselves with the interests of a few individuals in the medical profession not minding the interests of the public and the medical profession as a whole. For their purpose they harped too much on the plea that the public were likely to lose the benefit of specialists service and ripe experience of those who had been working in

hospitals as honoraries for a number of years. Before the introduction of honorary system on a large scale there were a few paid specialists one for each subject all of whom were attached to the Government General Hospital. Now the public can get the services of specialists in all three Government Hospitals in the City and also at some of the mofussil hospitals, the large majority of whom are honoraries. The public must be thankful to these honoraries for placing their services free at the disposal of the public in the Government institutions without additional financial commitment to the public finance. Regarding the five years tenure to honoraries, we wish the members of the legislature and others realise that the number of patients treated outside Government Hospitals are thousand times more than those treated in the hospitals and they have to depend on the services of private practitioners and not the few medical men working in the hospitals as paid or honorary officers. The five years tenure will give opportunities for a large number of private practitioners to get hospital experience for treating their patients outside. The training they receive in the hospitals, will encourage them to equip themselves well for treating their patients when their tenure expires. These honoraries will also realise the advantages of institutional treatment and are likely to start private hospitals and nursing homes for the benefit of their patients. A few such institutions have come into existence already and many more will sprout out soon. These private institutions will necessarily relieve the congestion in State hospitals. The well-to-do would prefer treatment in private institutions instead of in the Government institutions. Regarding a particular honorary who was discharged from General Hospital after sixteen years service, the Minister rightly said

that if the period was extended it would be difficult to recruit even a single practitioner in future for honorary service as any other honorary would claim the same privilege. So the Minister said that such experienced physician should make room for others to get similar experience in Government institutions. Regarding the physician who took the place of this senior honorary the Minister said; "*A man of equal reputation and knowledge, a more vigorous man, a man who had rendered valuable service to the country had been appointed.*"

The member who spoke about Vizag King George Hospital would have done better service to the Andhra Medical Profession if he pressed that in this institution the Government did not so far introduce honorary medical service on a large scale though there was available a large number of medical graduates passed out of Vizag Medical College. The Minister was not quite correct when he argued that the Government did never promise to raise the status of medical licentiates to that of the graduates after they underwent the five years course. We would request the Minister to refer to the report of a Government Committee on this subject of which the then Surgeon-General Major-General Sir J. W. D. Megaw was the Chairman. The Committee did unanimously recommend to the Government that a medical licentiate of five years training should be treated as a medical graduate for purposes of recruitment to Government Service if he possessed the Intermediate standard in general education. The Minister might have pacified this member by mentioning that the Government had been treating all the medical licentiates in par with graduates while recruiting them to honorary service as Assistant Medical Officers.

We appreciate the courage of the Minister in bringing to the notice of the members of the Assembly the real state of affairs about the Government Indian School of Medicine. We trust these words of courage will be followed by action and this hybrid institution which is bringing discredit to medical science without in any way encouraging the popularity of indigenous systems of medicine is abolished. Any amount of artificial propaganda by interested persons would not convince disinterested members of the public who knew anything of medical science that the products of this school could take the place of scientific trained medical men for giving medical relief nor could they believe that the reckless statements made in the lay press that the students of Government Indian School of Medicine received better training in Biology, Chemistry and Physics. There has been a well planned persistent effort on the part of some to make the usefulness of this institution appear as what it is not. There was a time when a surgeon of some reputation was requested to do operations in this institution. In the practice of Midwifery and Ophthalmology and allied subjects the western methods are followed entirely. Such and similar means adopted at this school have earned for it false popularity. It will not be out of place if we were to mention that some of the well meaning but fussy members belonging to the western system of medicine did add to the false impressions that the students belonging to the Government Indian School of medicine are capable of understanding and following scientific discussions entirely based on western system of medicine by addressing these students on subjects which it was not possible for them to comprehend as votaries of a system or systems whose conception of the

causes and aetiology of diseases were quite different. We are second to none in the patriotic zeal to encourage the growth of indigenous systems but we should detest the mischievous propaganda that is going about to make people believe things which are untrue. The only way and at the same time the best way of encouraging indigenous systems is to create special chairs in the existing Medical Colleges for the teaching of Indigenous systems and we should request all those who are interested in the growth of scientific system of medicine to strengthen the hands of the Public Health Minister to bring about this happy end.

THE VIIIITH PROVINCIAL SUBSIDIZED RURAL MEDICAL PRACTITIONERS' CONFERENCE.

From a glance at the proceedings of the Conference of the Subsidized Practitioners at Samalkot reported in the Abstracts columns in the current issue, it may be said that the Subsidized Practitioners seem to be quite alive to their sense of responsibilities to curative as well as preventive work in the villages where they have settled with the help of Government subsidies. It is also noteworthy that the Public Health Minister who, though he could not attend the Conference on account of 'an important Government work', was pleased to send a message in which the concluding sentence runs thus :

"This is what I want to tell you as an organization of rural medical practitioners, whose position in the future of this country is growing day by day, in view of the great attention that has been paid to rural development, since this Government came into power."

So far so good, what is more encouraging is the sympathetic personal concern of the Minister in the subsidized practitioners. Referring to the

redress of some of the grievances of the practitioners, the Minister declared :

"I would also like you to remember that this was done, not as a result of any big agitation on your part as an organised body, for you have scarcely lived as an organisation for just a year but as one, who knew your difficulties, it was our concern to give you whatever you considered necessary and which we could conveniently give".

The subsidized practitioners are very lucky indeed that the Hon'ble Minister does not wish to dub them as agitators for he said '*it was our concern to give you whatever you consider necessary*'. It is very kind of the Minister that he does not consider the several meetings held by the District Branches of the P.S.R.M.Ps' throughout the province, two conferences held under his patronage and the written representations made by the Association to the Government at various stages as amounting to agitation but as legitimate activities to consider what was '*necessary*'. To our knowledge the P.S.R.M.Ps' Association or its office-bearers including the President did not so far express anywhere that what all they got these 20 months from the Hon'ble Minister was due to their agitation. The President of the Association made it plain to his hearers last year at the Manachanallor Conference what high hopes the members of the medical profession especially the rural practitioners had been entertaining about their future soon after they knew that Dr. Rajan was to be their Minister. The President said :

".....Such of you who attended the last conference at Madras on 10-7-1937 entertained very high hopes about the future development of the Subsidized Rural Medical Relief Scheme when you learnt that the leader of the Congress party had made up his mind to run the Government of this Province. A few days later your joy knew no bounds when you heard that Dr. T.S.S. Rajan was to be the Minister in charge of Medical Portfolio. And when the Hon'ble Dr. Rajan was entertained by Trichinopoly District Medical Association soon after the announcement of his office was made and when references were made by him about the Subsidized Rural Medi-

cal Practitioners in reply to an address made by one amongst you on the day of the entertainment, many of you were in a state of ecstasy. For you heard for the first time in the history of Subsidized Rural Medical Service, a member of the Madras Government declaring that you were independent private practitioners for all purposes. Later the same day at the very entertainment when your comrades in the Trichinopoly District heard the Minister telling them that the two objectionable clauses prohibiting Subsidized Practitioner from taking part in civics and politics introduced in the agreement for the first time in January 1937, should find no place in the indenture of your service, you thought that the dawn of independence envisaged by the Minister was not a mirage."

The very organisation was rejuvenated on account of the fact that the Public Health Portfolio is in the hands of the Hon'ble Dr. Rajan and if the President of the Association was persistent to request the Hon'ble Dr. Rajan to open the Conference this year, it was for the purpose of making the organisation stronger as it was sincerely believed that the presence of the Public Health Minister for a second time in the midst of Subsidized Practitioners would be a fillip to the callous and unwary practitioners who are outside the Association. Dr. Prasad Rao, Chairman, Reception Committee did acknowledge with gratitude on behalf of his comrades the benevolent acts of Dr. Rajan which he said should encourage them to persistently '*consider*' what was necessary to make the Subsidized Rural Medical Relief Scheme a success. Dr. Rao used the word '*agitate*' in the place of the word '*consider*' which was substituted by us to be consistent with the spirit of Dr. Rajan's message. The credit of the success can never be claimed or will never be claimed by them so long the Hon'ble Dr. Rajan whom they rightly consider as their own, is in charge of Medical Portfolio.

The Subsidized Practitioners are indeed under a deep debt of gratitude to Major-General N.M. Wilson, Sur-

geon-General with the Government of Madras for having deputed Rao Bahadur Dr. T. S. Tirumurti to open the Conference on his behalf as on 20th April when he was approached to inaugurate the Conference he had fixed up another engagement on the 23rd. As mentioned by Dr. Prasada Rao, the Chairman, Reception Committee, Major-General Wilson's name was the third in the list of Panel which the Reception Committee formed to request those in the Panel to open the Conference in the order the names appeared in the Panel, in case anyone declined. The Hon'ble Minister in charge of Local Self Government was the first in the list, the second was the Hon'ble Public Health Minister, the third was the Surgeon-General. So it was that the Association had to approach the Surgeon-General to come to their rescue which he did splendidly. In his message he styles the Subsidized Practitioners as 'the Pioneers of a great movement that is medical relief to the rural-population' and concludes his message by saying, 'your services are greatly appreciated by all of us'.

True to the saying 'everything happens for the best,' we hope the Subsidized Practitioners would be consoled that though the Public Health Minister was unavoidably absent at the Conference, they had the benefit of two messages, one from the Hon'ble Dr. Rajan, the Public Health Minister and another from Major-General N. M. Wilson, the Executive authority to work out Dr. Rajan's sympathies towards the Subsidized Practitioners. Though they could not be present in body they were at the Conference in spirit to bless them and their organisation. The deputy of the Surgeon-General paraphrased the two messages so poetically and forcibly that the subsidized practitioners were likely to forget their disappointment in not

having the Public Health Minister amongst them and must have gone on merely to consider what was *necessary* to be put before the Hon'ble the Public Health Minister *as reasonable proposals, suggestive of suitable action*.

It is indeed a most fortunate and happy augury that the organisation of Subsidized Practitioners is attracting the attention and sympathy of eminent members of the profession outside their fold. It is as happy a coincidence that the P.S.R.M.Ps' Association anticipating such sympathies and co-operation from the members of the profession outside their fold, did make provision for the admission of such members as honorary members of the Association allowing them rights and privileges equal to those enjoyed by regular members. As many as 14 members of the profession were enrolled as honorary members at the last Conference and as time goes on it is very likely that the number will increase and even outnumber the regular members. One such eminent member of the profession Dr. Ramachandra Rao, M.A., M.D., President, Andhra Medical Association, delivered a lecture under the caption, 'Medical Competition and Co-operation.' Dr. Rao stressed the need of the former to gain and enrich scientific knowledge and the latter for the exercise of the scientific knowledge, the members of the profession working in the spirit of brotherhood, co-operating with each other instead of competing. Dr. S. M. Trasi, M.B. & C.M., Retd. Professor of Midwifery & Gynaecology, Vizag Medical College delivered an interesting lecture on Rural Obstetrics and Hygiene. The P. S. R. M. Ps. Association should be grateful to these two gentlemen showing a lead to others. Dr. Trasi suggested the necessity of starting a mission of retired Government Medical Officers to serve as hono-

rary consultants to rural practitioners. The President of the P. S. R. M. Ps. Association must feel very hopeful that his vision of starting Cottage Hospitals is likely to take a definite shape. It will not be out of place to mention here that another eminent member of the profession, Capt. E. S. Gopalan, M.B., M.S., A.I.R.O., who has also been proposed as honorary member had already started a village Health Unit in a village called Vedapatti, five miles from Coimbatore to give medical relief to the village folk. The Public Health Minister will, we hope, appreciate the little good work turned out by the P. S. R. M. Ps. Association at least to the extent of popularising village medical service. Let him concern himself about the organisation and not those who may temporarily guide the practitioners. He will soon realise that the P. S. R. M. Ps. Association is so well organised that even within two years of its rejuvenation, the members of the Association are made to feel self-reliant and time will not be long when the President who happens to be an outsider will make room to one in the fold and if the alien President did not come

out of the Association earlier it was because the members of the Association forced him at Manachalloor to guide them for some time more when he actually tendered his resignation feeling perhaps that so long as a medical man of the versatile abilities as those possessed by the Hon'ble Dr. Rajan was in charge of the Medical Portfolio there was little or no need for agitation especially regarding rural medical relief as the Congress Government was keen in the welfare of the villages. So we wish to disabuse from the mind of the Hon'ble the Minister for Public Health that neither the Association nor the office-bearers including the President wish to take any credit for what the Government did these twenty months for the Subsidized Rural Medical Practitioners and what a folly it will be on their part even to think of defying the cherished views of the Hon'ble the Public Health Minister when it is known that a large majority of Subsidized Practitioners have to depend entirely on the bounties of the Government even for their sustenance.

Correspondence, Reports, Etc.

OUR DUTY TO THE VILLAGES IN THE MATTER OF HEALTH AND MEDICAL RELIEF.

VEDAPPATTI HEALTH ASHRAMAM,
COIMBATORE TALUK

BY

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

A medical man is essentially qualified for rural reconstruction. He has in his make up, a knowledge of all the basic sciences, humanities and human nature. Especially when he engages himself in curing and alleviating pain and physical distress, not merely for a little personal

profit, but with the idea of serving the needy and the helpless, he is respected and his advice listened to. A medical man in the position of one holding a bureaucratic authority, getting a fixed salary from the Government, is considered as one who has to do his duty and is looked at with awe and not with respect. The medical man may be very well-intentioned but the stigma that he is an alien never leaves the mind of the peasant and the cultivator. He can never believe him to be his brother. So also the medical men, who get a comfortable salary, for rural health and medical relief, never realise their deeper obligations to the rural society. They think that their duty ends when they

prescribe medicines and treat the sick. A voluntary medical worker, on a subsistence allowance, who proceeds to look after the entire material, physical and moral welfare of the villagers, and who, by example, shows that even coppers offered voluntarily for medical services can sustain a humble rural institution, is sure to be embraced, as a brother. A beggar with a property of three pies will be prepared to part with one pie, if given relief, in contrast to a wealthy man of three lakhs of rupees. It is a tragedy that medical men of talent crowd in towns where they are everyday overpowered by municipal and state institutions, thanks to the utter disorganization of the medical profession and the undue privileges, hitherto accorded to the salaried medical men attached thereto. I persuaded, in vain, many of my junior medical men, to settle in villages, irrespective of initial help from the Government and local boards. They will rather starve in towns rather than lead a villager's life. So far as I am concerned, villages are always attractive in spite of their utter insanitation, apathy and the so-called 'dull life'. Though for the last one decade, I was fully engaged in the study and practice of surgery, as a speciality, in the busiest hospital, in the presidency town, I decided some two years ago, to engage myself in village work, in a village south of Adyar, near Madras. But destiny inexorably, pushed me out of Madras, and planted me in Coimbatore. Ever since I settled in Coimbatore one year ago I was on the look out for a suitable village to try my experiments in village work. After several choices, in some of which, I met with opposition from unexpected quarters, I finally chose Vedappatti, a village about five miles from Coimbatore and having about 10 villages all round within a radius of 2 miles from the centre. The population may be about six or seven thousand, and the majority of the people are comparatively poorer than the other villages near Coimbatore.

I took on lease one acre of dry land, a little detached from the village and put up a thatched shed 30 feet by 20 feet in the centre. I have built three rooms by

bamboo thattis each 10 feet square, within the shed itself. One of the rooms is the examination room, the second is the dispensing room and the third dressing room. At present I have begun to attend the Ashramam for two hours every evening. Later on, I hope, to settle myself, in the village and do continuous work.

The Ashramam was inaugurated on the Tamil New Year's Day (14.4.1939) by Rao Sahib Dr. Y. P. Vasudevan, District Health Officer, Coimbatore. The function was very well attended and was presided by Rao Bahadur P. S. G. Rangaswamy Naidu, the biggest landlord of the village, and an active supporter of the scheme. Dr. Y. P. Vasudeva Iyer, in formally declaring the Ashramam open, promised his full support for the Ashramam. He also stressed the need for self-help, cleanliness of air and purity of water. He also condemned the wanton defilement of places and roads.

The President said that Vedappatti was a proper centre for medical relief and that it was a great blessing that an ashramam had been started. He wished that the ashramam should grow bigger and bigger, and promised his full support.

The following are the relevant clauses about the working of the Ashramam:—

AIMS.

1. It is started to inculcate by example and precept methods of healthy living, under rural conditions.
2. Greater emphasis will be paid on the preventive aspects and measures to promote health, physical, mental and moral.
3. Free medical service to the deserving poor of the village and neighbourhood. An outdoor dispensary will be started for the present.
4. The Ashramam will lend its moral and, if possible material support to other ameliorative and educational activities by any other agency or agencies Government or non-Government.

MANAGEMENT.

1. The Ashramam will be maintained by donations. Any amount will be thankfully accepted. The ashramam may receive subsidies from Government, local boards or panchayats, provided its non-official and voluntary nature is recognised and irksome conditions are not imposed.

2. The management, will be in the hands of a chief, his nominee and the successive nominees of the future chiefs. The chiefs must be qualified medical men.

3. The accounts of the ashramam shall be kept separately, but at any future date, any surplus not needed for the ashramam may be utilised for in-patient medical aid to the poor or for promoting public health, in the locality served.

4. The chief may appoint salaried whole-time, part-time or honorary medical officers and other servants, when there is need for the same. The chief himself will work honorarily so far as the ashramam work, is concerned, but may take, when

funds permit, an honorarium not exceeding Rupees fifty per mensem, inclusive of conveyance allowance.

SCOPE OF MEDICAL SERVICE.

1. Persons whose monthly income is below Rs. 25 are entitled to free medical service. Even these persons are requested to contribute their mite out of their free will.

2. Out-patient service to persons getting Rs. 25, and above but below Rs. 50 may be undertaken for reasonable charges to be paid cash. The Ashramam, as such, will not provide treatment for others, but may disburse medicines prescribed by medical practitioners, for payment.

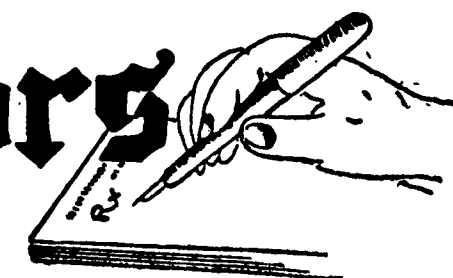
3. Visits to persons getting below Rs. 25, at their houses will be free, or for a nominal fee, if they are living within a range of two miles from the ashramam. The Ashramam will not concern itself with the treatment of patients of means, at their houses.



Modern Medical Practice Demands
a high Standard of Purity

Doctors

Prescribe with
Confidence



ZANDU'S B. P. Products and Pharmaceuticals where quality, Purity, Uniformity and Therapeutic Activity stand Supreme, supported by a Guarantee, to conform with B. P. Standards.

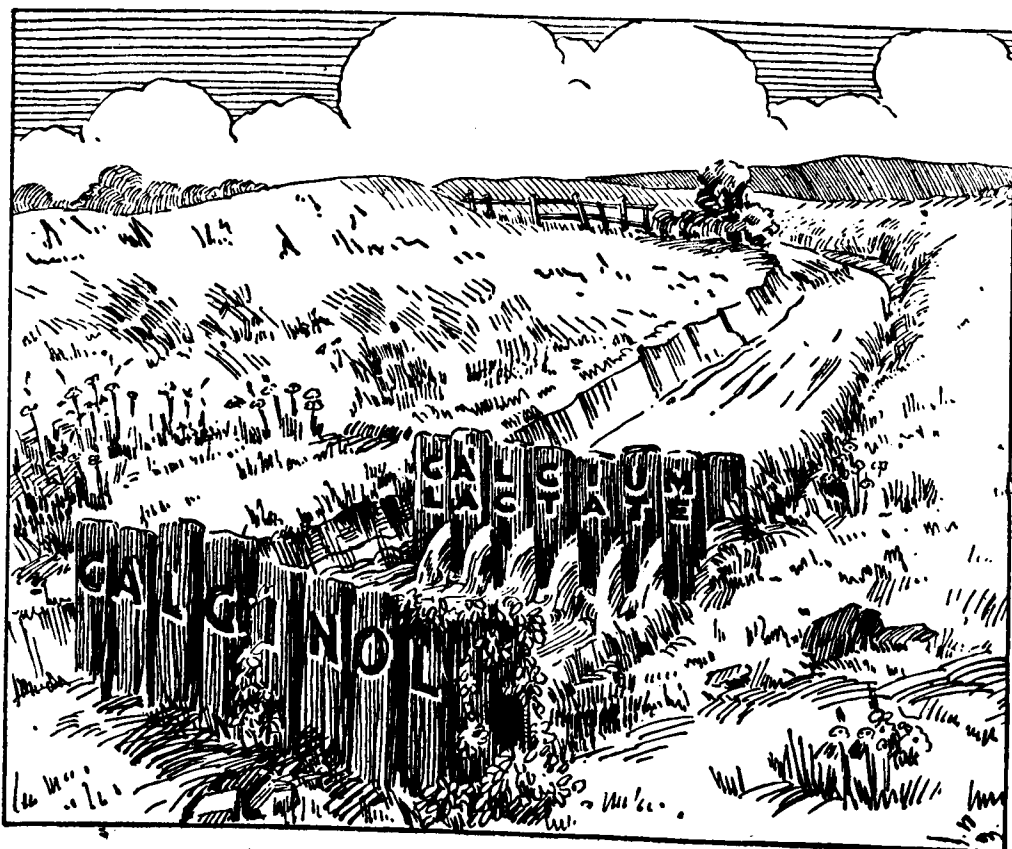
Special Concession Rates Offered to Charitable Mission Hospitals.

"ZANDU" Brand Products are obtainable from:

The Chief Agents: **Messrs. DAMODER & CO.,**

78, China Bazar Road, G. T., Madras.

And also from their Sub-Agents in Madras Presidency.



To swallow Calcium is not sufficient.

To retain it is more important.

Yet Calcinol costs no more to attain this result.

The satisfied physicians are prescribing it regularly and our samples and particulars will perhaps encourage you to try it.

CALCINOL

Agents:

RAPTAKOS, BRETT & CO., LTD.

Bombay

Calcutta

THE RESEARCH LABORATORY,

HARRIS ROAD, MADRAS.

Microscopical, Cultural and Bacteriological Examinations of Blood, Sputum, Urine, Faeces etc., done.

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

Stock and Autogenous Vaccines prepared.

Sterile Solutions for injection always in Stock.

Please apply for further particulars to:

THE MANAGER.

THE MEDICAL BULLETIN

Empire Automobile Bldg., Queen's Road, Bombay 4.

VALUABLE FORTNIGHTLY JOURNAL
FOR THE GENERAL PRACTITIONER
ARTICLES BY EMINENT MEDICAL MEN
USEFUL ABSTRACTS
INTERESTING NEWS.

Many, many Doctors read it. Write for Sample copy now.

Annual Subscription—Rs. 5—post free.

Antiphlogistine

The Denver Chemical Mfg. Co., New York.

THE PERFECT
POULTICE AND
DRESSING FOR
INFLAMMATION
AND
CONGESTION.

JOURNAL OF THE INDIAN MEDICAL ASSOCIATION

EDITED BY

SIR NILRATAN SIRCAR, KT., M.A., M.D., D.C.L. etc.,

With the help of A Strong All-India Editorial Board

The Official Monthly Publication of the Indian Medical Association.

FEATURES. 1. Original Articles. 2. Case-Reports. 3. Society Proceedings. 4. Valuable abstracts from leading medical journals from all over the World.

PUBLISHED ON THE FIRST DAY OF THE MONTH

Annual Subscription: Rs. 6. Post free.

Free to Members of the Indian Medical Association.

AN EXCELLENT MEDIUM FOR ADVERTISEMENT

For particulars, write to:

SECRETARY,

SAMAYAYA MANSIONS,

1-A, Hogg Street, Calcutta.

BRIDGING A GAP

There is no doubt that the sudden cessation of a regular use of alcohol necessitates adjustments to compensate for the mental and physical loss sustained, and some degree of psychological guidance on the part of the medical attendant as well. It may often happen in districts where Prohibition has been introduced that the physician will be asked to prescribe his accustomed stimulant for a patient who feels that he cannot do without it.

Such cases will seldom if ever be alcoholics, and the degree of physical derangement suffered by the omission of alcohol from their diets may seem inconsiderable—though of course the effects are cumulative.

Hall's Wine is the ideal tonic stimulant to help the transition in habits. Its calorific value is much higher than that of unmedicated Wines or Spirits. This makes it a valuable food, suitable for the most delicate digestions, since grape sugar and alcohol require no activity of the digestive system for assimilation. The medicated elements of Hall's Wine also improve the general metabolism.

The mental and nervous distress caused by breaking the alcohol habit is much alleviated by Hall's Wine. Its gentle stimulus is very marked and the rapid increase in haemoglobin content of the blood which it promotes improves the patient's condition in a most encouraging way.

Where a tonic food and stimulant is indicated, Hall's Wine may be prescribed with perfect confidence.

HALL'S WINE

Tonic Restorative

Distributors: J. HALLEY & CO., LTD.
P.O. Box 133, Calcutta, P.O. Box 34, Lahore
P.O. Box 34, Karachi, P.O. Box 466, Bombay



★ ★ ★ ★ ★

HW. 93

IN THIS ONE WAY WE CAN HELP!

We are determined to sell only those goods which have proved to be the best of their kind—in

SURGICAL INSTRUMENTS

All our instruments are made with micrometric exactness of regular Carbon Steel, "Surgico" Rustless Steel and Krupp "V 2 A" Patented Rustless Steel—useful for AMPUTATION, POST-MORTEM, DISSECTING, DRESSING, DIAGNOSTIC, FISTULA, HERNIA, EYE, EAR, NASAL, DERMAL, ORAL, TONSIL, DENTAL, TRACHEAL, LARYNGEAL, STOMACH, INTESTINAL, MIDWIFERY, GALL BLADDER, RECTAL, PROSTATIC, PHIMOSIS, VESICAL, URETHRAL, URETERAL—AND INSTRUMENTS FOR EVERY CLASS OF SURGICAL WORK—ALSO

HOSPITAL REQUISITES

of absolute uniformity, absolute dependability, supplies that will do their work well, satisfyingly well—all at a fair price and latest.

HYPO AND SERUM RUSTLESS NEEDLES
KALMERID SURGICAL SUTURES
ANAESTHETIC APPARATUS
MICROSCOPES AND ACCESSORIES
LABORATORY APPARATUS AND GLASSWARE
ADHESIVE PLASTERS IN VARIOUS SIZES
STAINLESS STEEL HOSPITAL WARE
SYRINGES FOR ASPIRATION AND INJECTION
HIGH PRESSURE STERILIZERS, PORTABLE AND STANDARD
SURGICAL RUBBER GOODS OF BEST MAKES
HOSPITAL FURNITURE—SELECTED QUALITY
SICK-ROOM UTENSILS OF EVERY KIND
ELECTRO DIAGNOSTIC SETS
SPHYGMOMANOMETERS OF RELIABLE MAKES
SURGICAL AND DISPENSING SUNDRIES
CONTRACEPTIVE PRODUCTS OF H-R MAKE
ARTIFICIAL LIMBS, DEFORMITY AND FRACTURE APPARATUS,
SPLINTS, ELASTIC HOSIERY, ABDOMINAL SUPPORTERS,
HERNIA TRUSSES, SUSPENSORIES, CRUTCHES, ETC.

All selected merchandise described and illustrated in our current 500-page Catalogue. Copies mailed upon request to Hospitals and Surgeons. Whatever you need you will find it here. Quality is our foremost consideration and prices are kept at the lowest level consistent with the highest quality.

BOMBAY SURGICAL CO.

"The Quality House"

New Charni Road,.....BOMBAY.

Telegram: "SURGICO."

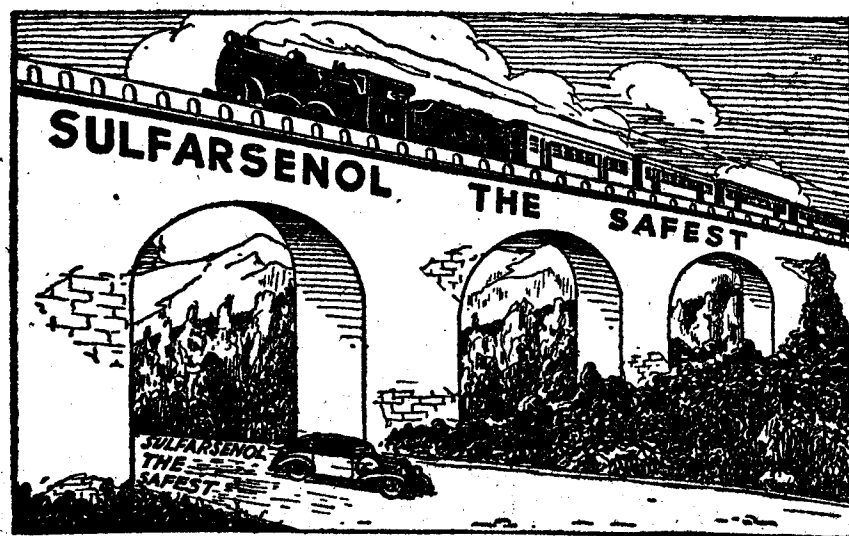
[Telephone No. 41936]

We undertake REPAIRING, SHARPENING and PLATING work.

*Patients prefer
painless
injections!*



ARSENO-SOLVENT
ensures
painless administration of
SULFARSENOL



The Anglo French Drug Co., (Eastern) Limited,
POST BOX No. 460 — BOMBAY.

Printed by Mr. M. S. Ekambaram, Manager, Soliman & Co., Triplicane, Madras and Published by the Managing Editor, Dr. V. Rama Kamath, 117, Park Road, High Road, Madras.

934

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

ASSOCIATE EDITORS } Capt. E. S. Gopalan, M.B., M.S.; A.I.R.O., (Madras).
SCIENTIFIC SECTION } Dr. S. S. Rau, M.D., (Bombay).

BOARD OF ASSOCIATES.

Dr. K. Narayana Murthi, M.D.,
(Medicine)

Dr. B. M. Sundaravadanam, B.A.M.B., F.R.C.S. (Eng.)
(Surgery)

Dr. M. Subramania Aiyar, B.A., M.B.C.M.
(Midwifery & Gynaecology)

Dr. G. Joseph Gnanadickam, L.M.P.
(Ophthalmic Surgery)

Dr. T. S. Shetty, Z.L.O., D.O. (Vienna)
(Ear, Nose & Throat Surgery)



MENESTRIN CAPSULES

How do Menestrin Capsules prevent pregnancy?

This question is often asked by some members of the medical profession. The flabby and the atonic condition of the muscular wall of the uterus adds to the sodden condition of the endometrium and favours the stagnation of sperm resulting in unhealthy pregnancy in debilitated women. The capsules contain Quinine, Iron, Manganese, Ovary and Thyroid and a few other ingredients belonging to the indigenous system of medicine, so combined as to excite the menstrual cycle in a dormant uterus.

This plain answer was put to test by eminent physicians who are to-day prescribing the capsules to their lady patients who dread pregnancy. To be sure of action the capsules should be taken a week before the expected menses.

The Therapeutic indication for prescribing Menestrin Capsules for Amenorrhoea is quite evident from the action of all its ingredients, a combination of which has been curing patients suffering from inveterate Amenorrhoea due to any causes functional or otherwise.

Available at all Chemists in Madras:

MANUFACTURED AT THE ORIENTAL RESEARCH LABORATORY,
Vepery, MADRAS.

Bombay Stockists: Messrs. P. M. ZAYERI & CO., Princess Street, BOMBAY.

Calcutta Stockists:—Messrs Bharatia Medical Stores, Gunning Street, Calcutta.

CONTENTS.

Original Articles :		PAGE
Diagnosis of Some Common Acute Abdominal Emergencies By Dr. B. M. Sundaravadanam, B.A., M.B., F.R.C.S., (ENG.)	...	293
Rural Obstetrics and Hygiene By Rao Sahib Dr. S. M. Trasi, M.B. & C.M.	...	296
Pyelonephritis in Pregnancy By Dr. K. Pana, M.B., B.S. (FR.)	...	301
Abstracts :		
Iodine Therapy in Diseases of the Eye, Ear, Nose and Throat By Edward Podolsky, M.D.	...	303
Sulfanilamide in Otolaryngology	...	305
Notes on Therapeutics, Diagnosis and other Medical Subjects :		
The Aetiology of Tropical Macrocytic Anaemia	...	306
Treatment of Pellagra with Nicotinamide	...	307
Acute Gonorrhoea Treated with M. & B. 693	...	307
The Problem of Disruption of Abdominal Wounds and Post Operative Hernia	...	307
New Bones for Old	...	308
Surgical Treatment of Pain	...	309
Editorial :		
The New Order Relating to Public Service and Private Practice	...	311
Diploma Hunting	...	313
Municipalities and Medical Relief	...	313
News and Comments :		
Government Proposes University Disposes	...	315
A Healthy Reform, Faulty in Execution	...	316
Miscellaneous Utterances	...	317
Suppression of Quackery	...	318
Col. Rahaman's Shafa Khanas	...	319
Propaganda relating to Public Health Act	...	320
Democratisation of Medical Service	...	321
Is the New Order another Ineffectual G. O. ?	...	321
Leave Out of India	...	322
Is it a Retrograde Step ?	...	322
Rural Reconstruction	...	323
Correspondence, Reports, etc. :		
Government Doctors and Private Practice—New Order Issued	...	325
Meaning of Consulting Practice	...	326
Legislation to Check Quackery	...	326
Is it another Ineffectual Government Order ?	...	327
Leave Out of India	...	327
Statement of Receipts and Charges of the P. S. R. M. Ps' Association	...	329

THE Medical Practitioner

Annual Subscription { Inland Rs. 3
Foreign Rs. 4 } Single Copy As. 6

Vol. X] MAY, 1939 [No. 8

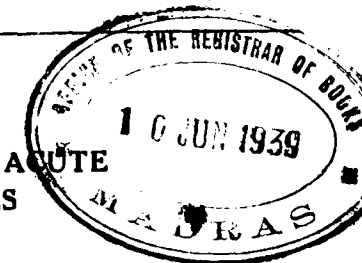
Original Articles.

DIAGNOSIS OF SOME COMMON ACUTE ABDOMINAL EMERGENCIES

By

DR. B. M. SUNDARAVADANAM, B.A., M.B., F.R.C.S., (ENG.)

Honorary Surgeon, Government General Hospital, Madras.



The commonest symptom in an acute abdominal emergency is pain of sudden onset. Early diagnosis is very important in these conditions as the life of the patient often depends on correct early diagnosis and prompt surgical intervention.

Before coming to the diagnosis proper, it is essential to understand the significance of abdominal pain as this symptom is common to several conditions with very different pathological phenomena.

The visceral peritoneum is completely insensitive whereas the parietal peritoneum is highly sensitive including the mesentery and the mesocolon. Any irritation or inflammation of the parietal peritoneum gives rise to pain. The peritoneum on the under aspect of the diaphragm, when irritated, gives rise to pain referred to the tip of the shoulder, the path of the impulse being along the phrenic to the fourth cervical segment and thence along the supraclavicular nerves. True visceral pain is brought about by increased tension in the muscular walls of the hollow viscera and

usually by increased peristalsis. This type of pain is manifested in cases of acute intestinal obstruction and in biliary colic.

"Referred Abdominal pain" must be defined as pain projected from a deep seated point of stimulation to the somatic (or cerebrospinal) sensory nerves on the surface of the body." Whenever an organ becomes inflamed, there is always reflex rigidity of the abdominal wall overlying it; this rigidity is due to direct stimulation of the parietal peritoneum by the inflamed viscus.

In pure visceral pain in the early stages, there is no rigidity or tenderness of the abdominal wall. The pain is vague, dull and not well localised. As a rule, it is always due to obstructive lesions. The commonest example of this is the pain experienced in acute intestinal obstruction where there is no rigidity or tenderness of the abdominal wall. Definite rigidity or tenderness of the abdominal wall always means there is inflammation of the underlying peritoneum—a localised peritonitis. This helps us to

differentiate between a case of pure obstruction from one of pure inflammation.

Diagnosis of Acute Abdominal Emergencies:—The chief symptoms and signs in relation to the diagnosis of the common abdominal emergencies will be discussed:

1. **INTRA PERITONEAL HAEMORRHAGE:** (a) Penetrating wounds as stab wounds or bullet wounds give rise to haemorrhage when a large vessel is injured or by injuring the liver or spleen or any other vascular organ. Rigidity and tenderness develop over the site of the injury and a rising pulse rate with general symptoms such as pallor, restlessness, and shallow respiration are diagnostic of haemorrhage. Dullness in the flanks on the side of the haemorrhage and shifting dullness when the haemorrhage is extensive, can also be elicited. Perforation of hollow viscera may be present at the same time and should not be missed. In these cases signs of peritonitis of rapid onset are present. Loss of liver dullness detected early in the case is suggestive of perforation of an air-containing viscus. On the other hand, loss of liver dullness, when there is marked distension of the abdomen, is not pathognomonic of perforation and can be noted in late cases of intestinal obstruction.

(b) Subcutaneous rupture of spleen or liver occur especially when the organs are enlarged and are rendered soft by disease. Here very trivial violence may be enough to cause the rupture. Signs and symptoms of haemorrhage are present.

2. **PERFORATION OF GASTRIC AND DUODENAL ULCERS:** It is very important to make early diagnosis as the prognosis is good in the first few hours if surgical treatment is promptly carried out. The common notion that a patient with a perforation of a gastric or duodenal ulcer is in a state of collapse with a thready and rapid pulse and covered with clammy perspiration is entirely wrong. The patient feels severe pain at the time of the perforation and for a short time after, is in a state of agony. But the pulse

rate is absolutely within normal limits, between 70 and 80. On examination there is rigidity and tenderness in the epigastrium and the patient often complains of a sensation as if the epigastrium has been drawn up. The severity of the pain abates during the first few hours after perforation but the pulse rate slowly rises after the first few hours. The rigidity and tenderness in the epigastrium persist and have a tendency to spread to the other regions of the abdomen. Rarely and especially in late cases, when the abdomen becomes distended and the patient toxic, the rigidity and tenderness may completely disappear. If the patient is intelligent, he will give a history typical of a chronic ulcer, but often no such history is forthcoming. The remarks about loss of liver dullness set forth in a previous paragraph, apply to this condition also. Another very important physical examination that is commonly omitted but should be done in every case of acute abdomen is auscultation of the abdomen. In cases of intestinal obstruction, there is marked increase in the peristaltic movements of the gut whereas in perforation and peritonitis, there is silence all over the abdomen but the heart sounds and breath sounds may be heard very clearly on auscultating over the abdomen. The later stages of perforation are manifested as marked general peritonitis.

After duodenal perforation sometimes, the contents tract down into the right iliac fossa along the groove to the outer side of the ascending colon and cause pain in the right iliac fossa, simulating a case of acute appendicitis. Examination of the epigastrium reveals rigidity and tenderness and the initial central generalised pain of acute appendicitis is absent in these cases.

Perforation of Typhoid ulcers should be diagnosed very early for successful surgical intervention. Once there is onset of peritonitis, even though localised to the right iliac fossa, the prognosis is bad. A sudden rise in the pulse rate with tenderness in the right iliac fossa should be enough to diagnose perforation, especially in the third week of the fever.

3. **ACUTE APPENDICITIS:** In a typical case it is easy to diagnose the condition. The sudden onset of severe pain around the umbilicus, more or less colicky in nature, followed by nausea or vomiting with a rise of temperature, and the pain settling down after a few hours in the right iliac fossa is absolutely characteristic of acute appendicitis. Variations in the position of the appendix, determine the sites of maximum rigidity and tenderness.

The common conditions which have to be differentiated from it are basal pleurisy, lesions of the right ovary and Fallopian tube, and renal lesions such as renal colic, pyelitis, pyonephrosis, etc. As the details of differential diagnosis are generally discussed threadbare in the text books, only a brief reference is made to this condition although it is the commonest abdominal emergency we meet with. Immediate appendicectomy is advocated in all cases unless the case is seen late when the patient is obviously recovering from the attack.

4. **ACUTE INTESTINAL OBSTRUCTION:** Even now cases are too often seen late. It is rare to see a case of a few hours' duration. Often it is of some days' duration rendering the prognosis bad. The cardinal symptoms of acute intestinal obstruction are:—

(1) pain, colicky in nature at first and becoming more or less continuous later on.

(2) vomiting, first of gastric contents and later on of bile and other intestinal contents.

(3) complete absence of passage of flatus or faeces and

(4) slight distention of the abdomen.

An enema should always be given in every case of suspected intestinal obstruction. If the result of the enema is good, a second enema should always be given half to one hour after the first one as the first enema may simply wash out the

lower bowel, the obstruction being situated higher up. The second enema is really the diagnostic enema and if the result of it is nil, then the case is one of definite obstruction. The passage of flatus after the enema is administered should be very carefully noted as even the smallest amount of flatus passed is against there being complete obstruction.

The site of distention, the presence of any swelling over the site of any of the hernial orifices and the presence of any tumours palpable in the abdomen, should all be noted. The age of the patient and the previous history of the patient are also equally important. From a consideration of all these points, the probable cause of obstruction may be made out, whereas in an equal number of cases, no such definite conclusion can be arrived at. The treatment is immediate laparotomy and relief of the obstruction, the details, of course, will vary, depending on the cause of the obstruction. Faecal vomiting is not uncommonly met with and is simply the harbinger of death the case should have been treated very much earlier.

THE COLICS: In cases of the colics, whether intestinal, biliary or renal, the patient experiences severe abdominal pain, accompanied by vomiting, the degree of the latter depending on the severity of the symptoms. The site of the original pain and its radiation point to the variety of colic. The patient is writhing in agony and is completely restless, in great contrast to a patient with peritoneal inflammation who keeps still and resists all attempts at movement. An injection of 1/100 gr. of Atropine Sulphate can be given in all these cases and it stops the pain or diminishes it to a great extent. In any case of severe abdominal pain, an injection of Atropine can always be given. In a case of colic, when the patient is having severe pain, provided the diagnosis is certain, morphia and atropine can always be given and gives immediate relief to the patient.

RURAL OBSTETRICS AND HYGIENE

By

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

Retired Professor of Midwifery and Gynaecology, Vizag Medical College.

The importance of obstetrics is best appreciated from a study of comparative obstetric deaths maternal and neonatal of different countries. They are highest in India except perhaps in China. In other countries, there has been a steady fall year by year. If one looks into this death-rate of city and town hospitals, it is mostly in cases brought too late from outlying parts, first messed about by the barber woman or handled by local midwife or unsuitably attended by a general practitioner. If, therefore, obstetric mortality is to be appreciably reduced, one has to go to the root of the problem, that is, improve rural obstetrics. Till recently all attention was centred on cities and towns and all official or private efforts were confined to developing these, providing or increasing amenities such as education, sanitation, medical relief, transport facilities etc., to city and town dwellers. The village and villagers were forgotten and left severely alone to fend for themselves and remembered only for revenue collection. Little wonder that the village, once the active primary unit of the body politic, steadily deteriorated and is now of little count except for economic exploitation by others. Chronic poverty, debt, illiteracy, bad sanitation and ill-health have sapped its vitality. In the words of the Sabarmati Sage "Little do town dwellers know how the semi-starved masses are slowly sinking into lifelessness. They will have to answer for this crime against humanity unequalled in history." Speaking of rural sanitation he says, "The village cleanliness is bad, the villages are dung-heaps, streets and roads so dirty that for a sensitive man, it is painful to walk barefooted" and I may perhaps add, "without holding his nose". It was left to this foreseeing Vishwamitra the universal friend without distinction of caste, creed, colour—with his long clear vision

into the future to sound an emphatic, timely note of warning and hammer into our dulled consciousness the prime importance of the village as our economic backbone and to stress our need to concentrate on making the village self-contained. In his words again, "Just as Hinduism goes if untouchability stays even so will India perish if the villages perish." No truer words were ever uttered. His agonised appeal seems to have at last touched a cord of public conscience. Efforts are now made by the Congress Governments for rural uplift and reconstruction and in this important national work the rural practitioner has no mean part to play, living and working as he does among the villages as one of them as their confidant and adviser in health matters available to them at all times within their means, in short as the backbone of our profession, the expert and specialist being generally beyond the means or reach of the poor villager. It is time, therefore, he woke up to his public duties and responsibilities and bestirred himself ready to do his bit in addition to and apart from the mere exercise of his calling for livelihood. He does not yet seem to appreciate the importance of obstetrics nor to be keen to keep himself up to the mark in it. No doubt the bulk of his practice is medical, with a sprinkling of less surgery or perhaps *vice-versa*. It is true also that in this, due to few emergencies he has time to think and alter both treatment and surroundings and conditions under which he has to apply it to his cases so as to suit them best while his obstetrics practice is practically all emergencies delayed or obstructed labour mostly, often of doubtful prognosis, needing urgent relief generally under very depressing surroundings and conditions. Calls are generally sudden, unexpected, at unusual hours about midnight. Thus

obstetric practice is also more exacting and taxing often also comparatively less remunerative. The chronic poverty of the villagers, their insanitary habits, ignorance, superstition and traditional dislike of male help, with the easily available cheap barber woman, make rural obstetrics difficult. Also, after the marble floored spick and span, labour room, the Schimmelbusche high pressure steam steriliser, adjustable tilting table, and numerous assistants and nurses working with clock-work precision in the hospitals he was trained in, he suddenly finds himself confronted in his rural obstetric practice with primitive conditions of life and thrown on his own resources, having to extemporise everything at a moment's notice. It takes time and considerable resourcefulness to adjust oneself from the ideal to the primitive. These unfavourable factors are apt to damp his keenness for obstetrics and make him reserve it as just a second string to his bow. But obstetrics is by no means less important than its sister subjects, rather, I should say both from humanitarian and from politico-socio-economic points it is more important. For, one has to handle two lives each time; both responsibility and credit for good work are thus doubled. Also the efficiency or otherwise of the obstetrician is reflected not merely on the present but on the coming generation as well, since the mother is the reservoir for supply of individuals to the nation. The great efforts of Totalitarian States—to encourage marriage and maternity, with special allowances—bears this out if proof is needed. I think I have said enough and do not want to waste your time on more arguments for the urgent need of improvement of rural obstetrics.

NOW ABOUT WAYS AND MEANS: The two most concerned in rural obstetrics work are the rural midwife and rural practitioner. I mention midwife first, as it is she who takes all normal cases about 90 per cent of all labours and has to recognise abnormalities and get timely help in the 10 per cent abnormal ones. By rural midwife I do not mean barber woman to eliminate whom from our obstetrics either she must be properly trained,

registered and compelled to follow our methods or replaced by a properly trained midwife, for every large village or groups of smaller ones. I say properly trained, because, the present average midwife, rural or urban, falls far short of the standard. This may be due to the low cultural and moral standard of the class from which she is now drawn. Be that as it may, her sense of duty and responsibility leaves much to be desired, she is apt to take things too easy once she has passed out, caring little to keep herself professionally fit, becomes slipshod in work, inclined to give the go-by to a sepsis and antiseptics and with some rare exceptions soon gets rusty often unable to read the thermometer, count pulse, or recognise foetal heart or foetal parts not to speak of even gross abnormalities. Many are woefully wanting in the technique of conducting even normal labour, such as delivery of head after crowning, doing little more than tying and cutting the cord, both often carelessly, after the patient delivers herself and often not even applying a dressing to the cord stump. The perineum has to take care of itself. They are often not above meddling with the third stage soon after child birth to save them the trouble of waiting nor above questionable dealings with the ignorant poor villagers. This is no exaggeration. In my paper at the VII Andhra Medical Conference I gave some instances of bad rural midwifery and also of corrupt practices in hospitals too and even suggested an anti-corruption drive. For improvement of the midwifery service I suggested, recruitment of material of better cultural and moral standard such as our high class widows. Widow marriage is now legal but the proportion taking advantage of it, is as yet not high. Many with children to support or past marriageable age or not marrying for other special reasons, are often thrown on the uncertain goodwill of churlish relatives for a precarious livelihood. Divorce too for Hindu women is coming up and may soon be a settled fact. Many from this available material may gladly join the midwifery service, if only this way of escape from the constant anxiety of their difficult position ensuring them an honourable

independent honest means of livelihood, is pointed out to them and they are made to realise its advantages by means of some propaganda. If the Congress, used to such propaganda, takes it up in right earnest there is no reason why it should not succeed. For the present incumbents I suggest—

(1) much stricter supervision of their work,

(2) periodical compulsory intensive refresher courses,

(3) efficiency bar tests. All real not mere *namkavaste*

and (4) deletion of those found undesirable or hopeless incorrigibles.

For the probationers I suggest more and better attention to the practical side of training than mere by heart from books, as a test during examination, and an inspection of their record book of cases they have done.

NEXT ABOUT THE RURAL PRACTITIONERS: An adequate post-graduate obstetrics training is essential during House-Surgeoncy. A rural practitioner must be well up to handle all emergencies though he is not expected to be an all round expert or specialist. But he must have obstetric training without exception and let him choose any other his subject for his main practice for training himself during the House-Surgeoncy. I found House-Surgeons generally unwilling to take obstetric training.

There are in each District one or more experienced retired officers, some of them specialists. I suggest that, instead of letting their valuable experience die with them, it may be made available to the rural practitioners in the respective Districts by appointing all willing retired officers honorary itinerant consultants for their Districts on bare travelling charges and I hope that in course of time, once this gets into working order, it may develop into something like a medical mission of the retired officers and later still, it may grow into an all India Medical Mission, if the various Districts and provincial branches are linked together and properly organised,

—too Utopian an idea perhaps of a hair brained eccentric. But, however, farfetched and chimerical the all India Mission hope may appear, the District one at least is not impossible and if adopted, will raise the efficiency level of rural medical service and bring considerable financial relief to the poor villagers. For, there are many lesser surgical conditions both in obstetric and gynaecologic practice, also in general practice for which patients still go or have to go to city and town hospitals at great inconvenience and expense in a strange place, often getting into debts. Under guidance of itinerant consultants the rural practitioners can successfully attend to these patients locally, benefitting their own pockets and saving the patients expensive and inconvenient journeys to distant hospitals in strange places. In return for the free service thus rendered to them by the consultants, the rural practitioner's rich patients may bear the consultant's travelling charges and also contribute something to the Congress hospital fund for the prospective 'Indian Medical Mission' to be started in course of time by the Congress. At the same time the consultant may also inspect the midwife's work. So much for rural obstetrics.

NOW ABOUT RURAL HYGIENE AND CONSERVANCY: Whatever may be the conditions in the exploiting, foreign militant, industrial countries for us here, the village is still our economic backbone and the health and efficiency of the villager, our main source of economic production and the measure of our economic well-being. I have already described in Gandhiji's words, the present wretched village sanitation and villagers' health. These call for urgent attention. What part has the rural practitioner in it? There is much he can do. Rural sanitation, maternity and child welfare, anti-malarial work including spleen index, venereal diseases, hook-worm disease, leprosy, tuberculosis, survey of prevalent diseases for a rural health index and for geographical distribution of diseases or other clinical research, to give a few examples. Any or all these he may take up as a side issue, if and when he can, in his leisure time. Government

is already tackling the rural, protected, portable water supply question. Then there remain the disposal of excreta and other refuse, sullage and drainage. For the disposal of excreta, the suggested much praised bore latrine is not suitable as a village community latrine, as only one can use it at a time. A movable field-trench latrine is simple, cheap, efficient. It may be used by more than one at a time and disposes of the excreta as manure once for all and at once, is more suitable. A long trench is dug along one side of a field or plot of waste land, 1 foot wide, $1\frac{1}{2}$ to 2 feet deep with an open or roofed tarred tatty enclosure partitioned into compartments with movable doors, for privacy. The loose earth of the trench is heaped up close by in a smaller enclosure and provided with a few tin shovels. Use of the latrine and immediate covering of their excreta in the trench with enough loose earth from the heap close by should be made obligatory on all under penalty. The rural practitioner or other authority may have to enforce these simple rules at first by frequent periodical inspections and propaganda. When the trenches are nearly full, fresh ones are dug near by and the enclosure shifted till the entire field or plot is used up. Then another field or plot is taken up for the latrine and the manured one is taken up for cultivation and so on in rotation. This immediate disposal of excreta as manure, simple and easy seems more suited for village condition than compost-making, which takes labour, time and cost and therefore better suited for cities and towns without facilities for trench latrines. Once the villagers realise the value of the trench latrine as an immediate manuring agent, they are bound to take to it readily in their own interest and there is every hope of curing them of their habit of laying their excreta indiscriminately anywhere and everywhere on street corners and sides, play-grounds, parks, before and around neighbour's houses in preference to their own, for the benefit of others' noses, without distinction be they friends or foes and committing nuisance in public, in utter and callous

disregard of all propriety, a funny but revolting habit not unknown even in towns and cities, not merely in children but adults, males and females even educated ones.

NEXT ABOUT DRAINAGE AND CONSERVANCY: Underground drainage is out of the question in villages. However, much can be done by judicious application of simple surface drainage principles. In houses, for example, sullage from bath and washings from kitchens, can be led and distributed, by suitably branched surface channels, with proper gradient, to trees, plants near by in the garden cultivated for domestic purposes. The water soon partly soaks through (partly evaporates by 3 or 4 p.m. or earlier, leaving no stagnant pools to breed mosquitoes. The tulsi plant plentifully cultivated reduces the mosquito pest. Often tulsi plants in flower pots in every verandah and room clears a house of most mosquitoes as its peculiar odour is disliked by them. Similar principles may be applied suitably modified to suit the various conditions for village drainage in general. Combustible refuse may be burnt in a suitably sized incinerator, which may also serve for supply of hot water and the ashes valuable as deodoriser and manure added to the earth heap for use in the trench latrine.

Of late volunteers have been going about the village, slum cleaning, street sweeping and village cleaning and there is a talk often even for compost-making. Whatever the value of volunteer service from a sentimental or from a public spirit and charity point, the possibility of finding and maintaining an adequate constant unfailing supply of such service for all villages in India seems doubtful. Until villagers and slum dwellers are taught the relation between dirt and disease and the adverse effect of insanitation on their health and made to realise the importance and value of sanitation in their own interest, I fear the slums and villages will soon be as bad as before after every cleaning. There is a suggestive saying in Canarese, about the Indian temperament. It says, "I will lie down as one dead, if some one

will carry me about" meaning that as long as one's work is done by others, one is inclined to take it easy and not exert oneself. It looks better therefore to teach the villager self-reliance, in sanitation and ultimately make the village panchayat responsible for village sanitation. If not, when and how is he to learn his social duties and responsibilities? The rural practitioner can do much in this direction by talks, lectures, advice, etc., demonstrating to him, the direct relation between dirt and disease, sanitation and health etc., with examples from his practice, within the knowledge of the villager, which are more likely to appeal to him and convince him more effectively, than any number of academical lectures by Health and Sanitary officers, or legislative measures. Chronic poverty, debt, ill-health and illiteracy have destroyed his initiative and made him a fatalist and given an indifferent if not a pessimistic outlook on life. One's health and circumstances do color one's outlook on life. However, what with rural uplift, better water supply and sanitation, literacy drive, debt relief and land tenure legislation of the Congress Governments, better days are dawning for the villager and if his health and circumstances improve, his outlook on life will become more hopeful and he will become an active helper in these and many other matters.

Lastly it is a surprise that subsidized rural medical practitioners are sent away from their villages to Madras to undergo

Public Health training at the risk of their practice and incurring special expenditure while an easier and more suitable way involving no fresh expenditure was available. The District Health Officers and their Assistants who are expected to tour through the District might have been entrusted with guiding the rural practitioners practically in their duties regarding sanitation in the villages as part of their duties. The improvements effected in rural parts may be maintained in their annual reports so as to enable the Government and the public to know the volume of work turned out in villages regarding public health in rural areas. Such a course will give the rural practitioners opportunities of practical training on the spot suitable to local conditions and stimulate his initiative. A mere academical training for a month will be something like academic study in a medical college without hospital training. After all Village Sanitation is not a very complicated affair. No underground drainage, water carriage system, septic tank, revolving sprinkler etc., are to be expected in villages. Why then this cumbersome proposal of disturbing every rural practitioner from his village involving hardship to the practitioners and extra expenditure when a direct, easier and more practical course is open without any expense at all, especially as the rural practitioner is already qualified in Hygiene and what he wants is only practical training suited to various rural conditions under which he has to work?

PHONE No: 3034

Dr. S. R. BHAT

M. B. B. S., L. D. Sc. (Calcutta)

DENTAL SURGEON

THE X-RAY & ELECTRO-THERAPEUTIC DENTAL SURGERY

289, Esplanade, Madras. Opposite to Corporation Fruit Market.

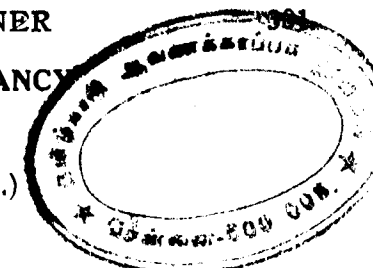
The most well-equipped Dental Surgery with all electrical apparatus such as X-Ray, Ultra-Violet Ray, High frequency current etc.

PYELONEPHRITIS IN PREGNANCY

By

DR. K. PANA, M.B., B.S. (FR.)

Bangalore.



Is Pyelonephritis, existing in pregnancy? Its existence was a subject of long discussions. If, indeed, no one contests that Pyelonephritis exists during pregnancy the next question is to know if its presence is only a simple coincidence during pregnancy or is a probable pathological phenomenon during the course of pregnancy and not a matter of mere accident.

I think like others that there exists something else than a mere accident in that coincidence.

A pregnant woman is especially liable to infection of the upper urinary tract. The disease usually occurs after the fifth month of pregnancy and not infrequently in the puerperium. In the latter event it is liable to be mistaken for uterine infection.

AETIOLOGY: During pregnancy, certain atonic changes occur in the uterus, ureters and large bowel.

The atonicity of the uterine muscle is a beneficial process. At full term the uterine muscle becomes even more irritable and it contracts vigorously.

On the other hand the atony of the ureter is not a beneficial physiologic phenomenon, because dilatation and relaxation of the ureters through compression of uterine contractions and movements of foetus. Therefore the ureters, especially the right one have a tendency for the stasis of residual urine and subsequent infection of the same. It does not matter if the residual urine is in the kidney, pelvis, ureter or in the bladder. These are the static and dynamic conditions favouring the outburst of pyelonephritis. In any of these places when urine collects it invites infection with micro-organisms especially

the bi-coli or coli-bacillus. In pregnant women the bi-coli are absorbed by the intestinal mucosa with extreme facility; the driving back of the intestines and constipation, the fecal stasis, the rubbing of the moving foetus, all these events create erosions on the intestinal epithelium and allow the bi-coli to penetrate into the blood.

On the other hand the quantity of the urinary excretion is also another important factor in the production of ureter erosions. Poor in water but rich in salts owing to specific disorders of the basal metabolism the urine is probably concentrated as to form micro-crystals of which the oxalate of calcium is the most dangerous producing erosions on the ureters.

SYMPTOMS: Thus we know now the aetiological conditions favouring the attack of pyelonephritis in pregnant women. It occurs frequently. But its symptomatology in pregnant women is less characteristic; often it is very circumspect. The presence of pus can be detected in the urine of the woman without apparent troubles.

However, usually when we question such patients they complain of pains or at least a sort of uneasiness at the right lumbar region; there exists often certain disorders of the bladder inducing one to think of cystitis. At the beginning of pregnancy there manifests often frequent feelings to pass urine consequently the patient through fear drinks less fluids. Such a tendency attendant with vomiting and pyalism makes the urine more concentrated and exasperates the disease.

The urine tests show three consecutive periods: irritation, inflammation and infection. It is in this latter period that the pus is detected in the urine; it has its source not from the bladder which is

not inflamed but from one of the ureters, the right usually. This is proved from the results of catheterism when in the urine obtained from the ureter the presence of the pyogenic agent which is usually the *bi.coli* is easily detected. Such an infection at times goes undetected and disappears rapidly after delivery.

At other times there exists a crisis of pyelic retention bringing on fever by crisis ranging between 101° and 103° which fever, after a few days subsides and everything returns to normal again, whatever may be the treatment that followed. On other occasions the fever persists, the patient complains of severe pains all along the ureter whose exploration is rendered difficult owing to the uterine mass. The fever is highly oscillating and the general condition of the patient is badly affected; cachexia sets in, followed by uremia and death if not attended to in time.

PROGNOSIS: The prognosis of pyelonephritis in pregnancy is often not bad; but sometimes the woman after delivery conserves a certain amount of pus in the urine which if not properly checked will end in chronic pyelitis requiring sooner or later an operation on the affected kidney.

In some chronic cases the ureters become fibrotic and dilated and their peristaltic activity is reduced. This is called "the fixed ureter of pregnancy." It is very difficult to get rid of infection in this type of ureter.

TREATMENT: In the treatment it is necessary to determine if we are dealing with a pyelonephritis or pyelo-urethritis; they are not always easily differentiated for they often merge into one another.

It is advantageous to the patient to drink plenty and urinate quite frequently. Her bowels should be kept regular and

free from constipation not with drastic purgatives but exclusively with mild laxatives such as paraffin liquid, agarol, nujol, etc. Meantime her urine must be kept clean as much as possible with urinary antiseptics as methylen blue, hexamine or "Uroxyll" (C.D.C.).

The last one is the most effective and very reliable preparation which I can highly recommend. In three of the cases I happened to treat recently "Uroxyll" had acted as a most soothing remedy for pains and irritable urinary conditions.

Combined with sulfanilamide it combats the infective process and decreases the possibility of spread.

The retention of the urine demands the immediate evacuation of the calyx by vesical distention or catheterisation of the ureters. The first process gives usually good results even in cases of severe types; it is simple, safe and requires only a syringe, a rubber sound and saline. If this process, after two or three days treatment, fails to give satisfaction, one has to choose the method of catheterisation which, if unsuccessful too is to be given up without delay and the woman's life must be saved by artificial termination of pregnancy.

The occurrence and the persistence of an increased N. P. N. in the blood in the absence of vomiting plead in favour of artificial termination of pregnancy.

My conclusion is that the pyelonephritis is extremely frequent in pregnancy. If it is benign it tends to disappear spontaneously after delivery. In some cases it persists even after delivery. So it is advisable to keep the patients under observation and treat them properly as long as they require the treatment and avoid later complications imposing nephrectomy.

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.

Abstracts.

IODINE THERAPY IN DISEASES OF THE EYE, EAR, NOSE AND THROAT

EDWARD PODOLSKY, M.D.

Brooklyn, N. Y.

In diseases of the ear, eye, nose and throat, iodine in one form or another has proved to be a very valuable drug, either as an antiseptic or as a therapeutic agent. It may be used to advantage as a local application, or it may be employed for general systemic effects. In either case, iodine is of decided benefit.

EYE. The tincture of iodine offers a very satisfactory means of disinfecting and cauterizing corneal ulcers. A small piece of absorbent cotton is wound firmly on an applicator so that the end of the cotton tuft will be pointed. The applicator is dipped into the tincture of iodine and exposed to the air for a few seconds so that there is no excess upon the filtration margins, after local anesthesia has been applied to the eye. It is usually necessary to repeat the cauterization several times on successive days.

An efficient iodine lotion, instead of the tincture, may be made up from iodine 2.4 grs., potassium iodine 2 grs., water q.s. ad ounce.

This preparation may be applied to the corneal ulcer in the manner outlined above. Best results are obtained when the ulcer is of recent origin and has not invaded the cornea to any great depth.

Several years ago Pedraja devised a new and effective method of treating phlegmonous dacrycystitis. He curetted the sac and filled it with iodine fumes. After dabbing the wound dry with gauze, the iodine fumes were allowed to enter the sac. Because of its irritating properties, iodine was not used in its liquid form.

A chalazion will disappear if treated with Churchill's Tincture of Iodine every two or three days. One must be careful, however, to touch only the lesion. Colloidal iodine is more suitable for eye work than any other preparation. In this form it

can be combined with boric acid. It is useful for instillation, one drop, three times daily in conditions like chronic conjunctivitis or keratitis.

Internally, iodine as Lugol's Solution, may be used with good results in the treatment of iritis. In this disease the process may be arrested if treatment is undertaken very early. Exudates and adhesions are sometimes prevented, obviating the necessity for iridectomy at a later time.

EAR. Iodine is one of the most useful of local applications in ear diseases. A successful means of aborting furuncles of the ear is as follows: The small area at the seat of the furuncles is swabbed with a narrow wad of cotton slightly moistened with the following mixture: Iodine crystals dram ss; acetone minims cv.

In chronic otorrhea a mixture of iodine 1 per cent in boric acid affords a valuable adjunct to the therapy of chronic uncomplicated suppurative otitis media, associated with marginal perforation and granulation. On filling the meatus with the iodine and boric acid the profuse discharge lessens rapidly, frequently after the first application, and within a week or so the otorrhea becomes odourless. In some cases the discharge ceases completely.

NOSE. For acute rhinitis an efficient mixture for allaying the inflammation is made up as follows: Iodine crystals gr. ss; gum camphor; menthol aa gr. v; oil tar rectified minims vi; liquid petrolatum ounce i; M. Sig: 2 or 3 drops in each nostril every half hour. In chronic cases instil three drops three times daily. The preparation may be used also as a nasal spray.

In Germany Koelreutter recorded excellent results from the inhalation of iodine gas in acute catarrhs, acute suppurations

of the nose, nasal sinuses and ear, glossitis and vasomotor rhinitis. He used a wide-necked bottle containing substances of iodine gas. Metallic iodine must not be used, as gas from it produces a caustic action.

Another simple iodine mixture which has proved to be of value in rhinitis and rhino-pharyngitis is a 1 per cent solution of tincture of iodine in glycerine, preferably combined with one-quarter of one per cent of phenol. As in these cases the submaxillary glands are generally implicated as well, it is of advantage to apply also a 5 per cent solution of tincture of iodine in liquid vaseline to the swollen glands. Tincture of iodine acts almost as a specific in adenoidectomy to abolish the possibility of postoperative infection.

In chronic rhinitis with nasal hypersecretion, good results have been obtained with iodine-therapy at the hands of Sternberg. He uses a solution of 5 per cent sodium iodide containing traces of free iodine and he gives this as subcutaneous injections of 1 cc. three times at varying intervals. Under this form of treatment there is actually a lessening of the secretion, as well as an improvement of subjective symptoms such as headache and difficulty in breathing.

Particularly good results are obtained from Sternberg's treatment of vasomotor rhinitis. The nasal disturbance improves a few hours after injection. The secretion decreases or ceases, the swelling disappears, relieving respiratory difficulties. Usually the sense of smell is considerably improved. The duration of improvement after one injection varies in different individuals. In some cases it lasts three months, while in others a second injection is necessary after a day or two.

THROAT. For tonsillitis local applications of iodine are of distinct value. As a gargle one may use: Potassium chloride, drams ii; phenol, drams i; tincture of iodine, drams ii; Dobell's solution, ounces vii. M. Sig: One tablespoonful in one-fourth glass of hot water as a gargle four times a day.

As a direct application to the tonsils, the following is often effective: Iodine

crystals, gr. v; potassium iodide, dram ss; glycerine, drams vi. M. Sig: Apply to tonsils daily.

In post-operative infections following the removal of the tonsils, manifesting itself by persistent hyperexia, undue sloughing of the tissues, and symptoms of general sepsis, iodine in the form of the tincture swabbed over the throat produces a marked subsidence of symptoms. The application may be repeated once or twice a day for several days, if necessary. It has also been found that the spasmodic coughing and extreme difficulty in swallowing, which occasionally result from injury or infection of the uvula during tonsillectomy, are also promptly remedied by a few applications of tincture of iodine. Another good remedy is:

Tincture of iodine; tincture of myrrh, aa ounce i. M. Sig: Twelve drops in a wineglassful of water. This may be used very effectively as a gargle or spray.

Iodine as an internal remedy in throat infection is also of value. A good mixture is purified iodine crystals 0.3 gm., potassium iodide 3 gm. and distilled water, 30 cc. For children upto ten years of age the dose is five drops; for older children and adults, 8 drops; for stout and heavy-set patients, 10 drops, in a quarter glassful of water, a half glassful of water to be drunk afterwards. For prophylactic purposes one dose daily to be taken at the first sign of infection is recommended.

In acute tonsillitis, especially where the streptococcic strains of bacteria are predominant, iodine is almost a specific. Intensive medication is required, thirty or forty-five minims every two hours, despite the fact that reaction causes discomfort. Under this form of medication, pain, discomfort and temperature are lessened. Given early its action is abortive in one or two doses; in most cases within 24 hours. A typical crisis occurs with perspiration and rapid fall in temperature. Continuation of average medication, thirty minims three or four times daily, insures a rapid recovery and safeguards the heart and joints from involvement.

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

SULFANILAMIDE IN OTOLARYNGOLOGY

The dramatic results obtained with sulfanilamide in otolaryngologic conditions have prompted workers to intensify their investigations with the prime objective of overcoming existing confusion. Schenck recently reviewed the literature, calling attention to the important clinical aspects of the new drug, including an account also of experience gained in the laboratory and in other fields of medicine.

It is amazing to find that so much material dealing with sulfanilamide has been recorded in such a brief period. It appears that considerable attention was at first directed to its mode of action. In this connection, while various opinions are held, the conclusions of Osgood and Brownlee are of practical clinical importance. "The continuous presence of a low concentration of sulfanilamide is more effective than the intermittent presence of a high concentration. The smaller the number of organisms, the greater is the effectiveness of the drug, and therefore therapy should be instituted at the earliest possible moment. Small doses at frequent intervals to maintain the concentration of the drug in the body fluids above 1:100,000 at all times are more effective than large doses at longer intervals. Therapy should not be discontinued until cultures are negative; if viable organisms remain, recrudescence is almost inevitable, and the administration of the drug must be resumed."

Studies on clinical effects and more particularly on dosage have been made. The impression has been gained "that about forty-eight hours is required before maximum therapeutic effects can be gained with sulfanilamide or its derivatives." The selection of a four-hour interval for maintenance doses is based on the fact that the absorption of sulfanilamide is apparently complete from the gastrointestinal tract in four hours. The indications for administration of the drug by routes other than oral have been defined by some authors, but there is as yet no consensus of opinion on this

phase. The unnecessary side effects must be seriously considered, although it is generally agreed that overdosage is the significant causative factor.

One must give due attention to the toxic manifestations of the drug. It seems that in animal experiments the tolerance of sulfanilamide is high, especially when given by mouth or subcutaneously. When administered intraperitoneally, however, toxic properties are observed. Schenck states that certain toxic manifestations with full doses of sulfanilamide or related compounds have been recognized since their first clinical use. While the milder symptoms require no discontinuance of the drug, it must be thoroughly recognized that deaths have been repeatedly reported in the literature. This fact alone implies necessary caution and a careful consideration of mitigating factors at all times.

The wide usage of the drug in otolaryngology is prompted often by the hopelessness of the existing condition. In no other speciality is there a greater need for improved therapy. Sulfanilamide has been tried in nearly every disease met with in the field, but the most favorable effect is experienced when the infection is primarily due to hemolytic streptococci.

More recently experiments have been carried out with a derivative of sulfanilamide, sulfapyridine. While available evidence points to its effectiveness in severe pneumococcic, severe staphylococcic and Friedlander's bacillary infections, Long concludes that we do not yet know whether the drug is as effective or superior to sulfanilamide in the treatment of hemolytic streptococcic, meningococcic, gonococcic for Welch bacillus infections.

From our present knowledge and experience we are justified in believing that medicine generally and otolaryngology in particular have gained in their therapeutic possibilities by the introduction of sulfanilamide. Time will doubtless help to explain many of the confusing points still before us.

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

Notes on Therapeutics, Diagnosis and other Medical Subjects.

THE AETIOLOGY OF TROPICAL MACROCYTIC ANAEMIA.

L. E. NAPIER, I.M.G.

Jan. 1939, P. 1.

It is assumed that in tropical macrocytic anaemia as well as in pernicious anaemia, the pathological changes that occur in the erythron are brought about by the deficiency of a haemopoietic principle (haemopoietin) which is a combination of two factors, the intrinsic factor normally present in the gastric secretions, and the extrinsic factor normally present in food; in pernicious anaemia the former is absent or deficient and in tropical macrocytic anaemia the latter. The author after discussing the recent work, considers that in tropical macrocytic anaemia, the deficient substance is not identical with Castle's extrinsic factor but is an independent haemopoietic principle.

Similarities:—The points of similarity are, that they are both macrocytic anaemias with the signs and symptoms common to all anaemias that the raw-beef tontue of pernicious anaemia does occasionally occur and more frequently there is only some tenderness in tropical macrocytic anaemia, that loss of appetite, dyspepsia, and low irregular fever are common in both, and finally that response to oral or parenteral treatment with crude liver extract is a common factor.

Differences.—(1) The outstanding point of difference is the absence of neurological symptoms in tropical macrocytic anaemia.

(2) Red cells: The mean cell volume in both conditions is high, but in tropical macrocytic anaemia the mean cell diameter is only slightly above normal. Poikilocytosis is also less marked in tropical macrocytic anaemia. In pernicious anaemia there is usually a slight initial reticulocyte increase 3 or 4 percent, but in Will's experience, this is never the case in uncomplicated tropical macrocytic

anaemia. While references are made frequently to the presence of megaloblasts in the peripheral blood, the present writer has never seen the typical haemoglobinized megaloblast of pernicious anaemia in the peripheral blood in case of typical macrocytic anaemia, though occasionally he has seen the basophilic megaloblasts that occur in normal in bone marrow.

(3) White cells: Leucopenia, which is constant in pernicious anaemia was not constant. Neither has the characteristic inversion of the polymorphonuclear lymphocyte ratio, nor the right handed shift in the Arneht count, characteristic of pernicious anaemia, been noted frequently in tropical macrocytic anaemia.

(4) Van den berg reaction: In pernicious anaemia the indirect Van den berg reaction is usually positive. It is never positive in tropical macrocytic anaemia and the author has seen many negative reactions.

(5) Gastric analysis: Complete histamin fast achlorhydria is, for practical purposes, always found in pernicious anaemia but not so completely in tropical macrocytic anaemia.

(6) Sternum puncture: The author has only very rarely seen haemoglobinized megaloblast, the characteristic cell of pernicious anaemia, in a case of tropical macrocytic anaemia.

(7) Treatment:—

(a) Yeast extract or marmite alone in sufficient doses will produce a haemopoietic response and eventually a cure in tropical macrocytic anaemia.

(b) Anhaemin, which even in small doses produces a good response in pernicious anaemia, sometimes produces no haemopoietic response in true cases of tropical macrocytic anaemia.

(c) The insoluble (saturated ammonium sulphate) fraction of campolon comparable to anhaemin is inactive in tropical macrocytic anaemia and produces a maximum response in pernicious anaemia.

The soluble fraction of campolon produces a maximum response in tropical macrocytic anaemia and surprisingly in, pernicious anaemia.

(d) Campolon and other crude liver extracts produce a maximum response in both conditions.

TREATMENT OF PELLAGRA WITH NICOTINAMIDE.

A. CECIL ALPORT., P. GHALIOWNGUI
AND G. HANNA.

L. December 24, 1938, P. 1460.

The dose administered was 1. O. G. by mouth or O. 5. G. by injection daily.

The authors conclude as follows:—

(1) Fifteen patients with pellagra and dermatitis and two with presumably pellagrous stomatitis were treated with nicotinamide.

(2) Nine of these were given an ordinary hospital diet, with or without marmite, during a short control period, and there was either no improvement or the condition became aggravated.

(3) Nicotinamide effected great improvement in the acute mucous membrane lesions and a slower improvement in the acute skin conditions, chronic skin lesions in friction areas and chronic atrophic changes in the tongue were only slightly affected. The appetite, mental condition, and general physical health of all the patients were improved by this treatment.

(4) Headache, itching, and warmth of the skin followed treatment in some cases and one patient had colic after the administration of 1. O. G. of nicotinic acid, but the same dose of nicotinamide led only to transient headache in two patients.

ACUTE GONORRHOEA TREATED WITH M. & B. 693.

J. G. MCGREGOR ROBERTSON.

L. December 24, 1938, P. 1463.

(a) 1. A urethral smear is taken.

2. The patient is then questioned about toxic effect.

3. Anterior lavage with one in 10,000 solution of potassium permanganate is given.

4. A day's supply of O. 5. G. tablets of M. and B. 693 according to the dosage described below is issued. The patient is warned against sulphur containing articles of diet and the taking of salts. He was also warned to spread out his tablets into 4 doses: 2 tablets after breakfast, 1 after mid-day meal, 1 with food in the late afternoon, and 2 after the evening meal. The dosage was maintained at 3. G. daily for the first 5 days and was then dropped to 2. G. daily for the next two days. The total dosage was therefore 19. G. in 7 days.

(b) Delay in starting is unnecessary and undesirable.

(c) With M. and B. 693 the daily urethral smear did not show the granularity and loss of definition seen with suphanilamide; but often the gonococci disappeared in 24 hours or, if they persisted, were usually extracellular. Urethral discharge disappeared in 4.5 days on the average.

(d) About 45 percent of patients complained of toxic effects (headache, nausea, dizziness, rash, dyspnoea); but the toxic effects of M. and B. 693 were less than those of sulphanilamide.

(e) All the patients were cured of urethral discharge in 3 weeks, but it is too early to say how many were finally cured of the infection. In judging cure, prolonged observation is preferable to provocative tests.

(f) The only gross complication arising during treatment was epididymitis in one patient. Another patient developed folliculitis.

THE PROBLEM OF DISRUPTION OF ABDOMINAL WOUNDS AND POST OPERATIVE HERNIA.

A. O. SINGLETON AND
T. C. BLOKER. J.A.M.A.

Jan. 14, 1939. P. 122.

The most common causes of disruption and hernia are (1) infection and haema.

toma, (2) delayed wound healing, (3) faults of the suture material, including allergic reactions thereto and hypoproteinemia (4) coughing, vomiting and gaseous distension and (5) faulty anatomic incisions.

For upper abdominal operations, the most satisfactory, is the incision described by Sloan. In the modified Sloan's incision, the rectus muscle is retracted laterally and the posterior rectus sheath and linea alba cut transversely in the direction of their fibres.

Another lateral transverse incision, which is extremely satisfactory, is this. This incision is used on the right side for operations on the biliary passages, and on the left side for operations on the splenic flexure of the colon, and particularly for splenectomy. The incision begins near the mid-line, obliquely downward and outward just below the costal margin, almost to the iliac crest just posterior to the anterior superior spine. This is in the direction of the fibres of the internal oblique muscle. The anterior sheath of rectus muscle, is cut transversely and the muscle freed from the sheath for a short distance above and below. The incision is continued across the fascia of the external oblique muscle for two or three inches in line with the cutaneous incision, and the external oblique muscle is retracted toward the mid-line, and its posterior sheath is split from the linea alba laterally into the internal oblique and transversus muscles. The internal oblique muscle is split and the transversus and peritoneum cut in the same incision. This gives an advantageous exposure of the gall-bladder, bile ducts, appendix and pyloric end of the stomach on the right side. The wound comes together and is quickly and easily sutured in layers without tension. The wound may be considered unanatomic in that the ninth and tenth inter-costal nerves may be injured when cut or retracted out of the way. A numbness results over an area of skin below the incision for a few weeks but soon disappears. For splenectomy this incision has been the source of particular satisfaction.

NEW BONES FOR OLD.

E. W. HEY GROVES.

Lt. Jan. 14, 1939. P: 69.

Every autogenous graft undergoes three phases: death, invasion by the granulation tissue, osteoblasts, and blood vessels of the host; and homogeneity of the tissues of graft and host. Almost certainly it is not the whole truth; for, if it were true, then a big animal bone would give the same results as a piece of living bone, when used as a graft. When such a graft is buried in a living bone and is surrounded by the latter on every side, the dead and the living graft behave similarly. But if on the other hand the graft is made to fill a gap and has contact with living bone only at its two extremities the living graft will survive and become incorporated in the skeleton, whereas a dead animal bone would be absorbed or extruded.

Revitalisation of bone:—We usually think that a sequestrum is necessarily doomed and must be removed. This is an error. Orell, the inventor of os purum and os novum, has successfully carried out the daring experiment of removing a large portion of diseased bone, boiling it for 20 minutes, and then replacing it where it has survived and functioned.

Matti's grafting of spongy bones:—A comparatively recent method of increasing the rate and extent of bone growth, especially in dealing with ununited fractures, consists in using spongy bone, rich in vital elements, to supplement bone repair.

Os Purum and Os Novum:—Orell, a Swedish surgeon, on the basis of the death and resurrection theory, argues that, if the bone graft is a mere scaffold a piece of purified dead bone will not only serve the purpose but will save time and the operative removal of bone graft. From animal bones therefore he produces various pieces of dead bone, which are purified by chemical and mechanical processes but not boiled. This he terms os purum. It is used in various bone operations in which the graft is placed in complete contact with living bone; particularly in various types of arthro-

desis, when the struts of os purum have proved very useful in bringing about a bony union. But he has ventured a step further. He argues that, if the addition of vital elements is to be the next stage in making the dead graft live, then this stage too can be initiated before the transplant is made. This can be done by implanting a piece of os purum of the necessary size and shape under the periosteum of the patient's tibia. Three months later the animal bone is removed, and it is found, by this time to be covered with adherent granulation tissue.

SURGICAL TREATMENT OF PAIN

JULIAN TAYLOR.

L: November 19, 1938 P. 1152.

To understand pain we must consider the distribution of the posterior root fibres in the spinal cord. The entering nerve fibres have different fates according to their functions. Those concerned with

pain sensibility end in the homolateral posterior horn of grey matter and come into relationship with the nerve-cells that control the axons of the contralateral spinothalamic or antero-lateral tract.

Here then we have a chance of attacking the pain path above the centre of increased reflex activity in the cord and experience shows that section of this tract in the cord is a sure way of giving complete relief in any form of intractable pain whose severity justifies an operation of the magnitude of laminectomy, the results being as constant and good as those of root section are inconstant and bad.

His cases illustrate the truth of Mr. Trotter's dictum that where the sheath of a nerve has been penetrated the axons are so affected in their functions, that no peripheral measures are likely to be of avail; but where a nerve sheath is merely compressed from the exterior, local measures such as relief of pressure are likely to be completely adequate.

WEBSTERS PHOSPHATUM

RECONSTRUCTIVE

AND

HOMOSTIMULATIVE TONIC

Composition.

Cal. Phosph.	'02 gm.	Avonin	'12 gm.
Sod. Phosph.	'14 gm.	Xanthoxylin	'15 gm.
Kali. Phosph.	'30 gm.	Orange Juice	1'2 gm.
Mag. Phosph.	'20 gm.	Apple Juice	1'2 gm.
Lecithin 12 gm.			

Therapeutic Indications

- (1) Phosphaturia:—It is an unfailing remedy if given in tablespoonful doses before food and given persistently.
- (2) Billiousness, Waterbrash, Giddiness, Loss of appetite etc:—A tablespoonful in half an ounce of water three or four times a day correct the whole condition in a remarkably short time.
- (3) Uncontrollable Vomiting, especially in malarial fever and also in any condition yields promptly to one or two doses of Webster's Phosphatum; may be combined with adrenaline.
- (4) Chronic rheumatism, Myalgia, etc:—In these conditions it may be considered as a specific.
- (5) Neurasthenia, Tired feeling, Nervousness, Trembling of the hands, Inability to concentrate, etc., all showing want of nerve tone:—Tablespoonful of Webster's Phosphatum undiluted before food twice or thrice a day is positive to show its effect in a month's time.

Obtainable at all Chemists or with the Sole Agents:

Messrs. KRISHRAJ & CO., 8, Bunder Street, MADRAS.

RATIONAL CALCIUM-THERAPY

CALCINOL

TABLETS

POWDER

GRANULES IRRADIATED

DRAGEES WHIPPLE PLAIN

DRAGEES WHIPPLE IRRAD.

DRAGEES R.B. PLAIN

DRAGEES R. B. IRRADIATED

AMPOULES

The enthusiastic appreciation by a great number of physicians of the favourable therapeutic results from CALCINOL seems to have fully justified their confidence in it.

If you happened not yet to have experienced the favourable action of CALCINOL — not yet to have enjoyed the satisfaction of using a calcium preparation ready to be applied to all the requirements of your cases — not yet to have realised that it costs no more to use this reliable and handy calcium preparation, then please ask us to satisfy with our samples and particulars your intention to try it.

ACIDOSIS

PREGNANCY

LACTATION

DENTAL CARIES

RICKETS

BONE & GLAND TUBERCULOSIS

PULMONARY T.B.

Agents:
For India — Burma & Ceylon
RAPTAKOS BRETT & CO., LTD.
Bombay. Calcutta.

THE Medical Practitioner

Vol. X]

MAY, 1939

[No. 8

THE NEW ORDER RELATING TO PUBLIC SERVICE AND PRIVATE PRACTICE.

The Medical Practitioner may rightly feel encouraged that yet another reform to restrict private practice to whole-time Government Medical Officers, for which it has been agitating ever since its birth ten years ago, has now taken a definite shape, the Government having ordered that the reform is to take effect from 1st January 1940. The members of the independent medical profession cannot take this reform as a victory nor should the State-paid doctors take it as a defeat. Both should feel that the reform was in the right direction for the healthy and harmonious evolution of the profession as a whole, whose development was very much hampered by the unwholesome and unhealthy competition between two artificial sections. The view taken by the Government that their medical officers were allowed to engage in private practice in the past owing to the absence of sufficient number of qualified private practitioners, was the argument used by us for the past one decade and it was perhaps possible for the present Government to think in the way we have been doing these ten years on account of the existence in the Cabinet, of a private medical practitioner in the person of Dr. Rajan. To allow even consulting practice to whole-time officers of the Government is bad in principle but as the profession came into existence in India as a State-paid service to serve the

interests of the Government and not so much for catering the medical needs of the public, it may perhaps take a decade more when the Government will be quite justified to abolish the concession of even consulting practice to whole-time officers. While discussing the subject in these columns last October, we pointed out that 'Consulting Practice' as defined by the Government in their Order No. 2232 Public (Services) dated 22-11-37 'seems to be too wide for the present purpose.' The very first clause in the definition of 'Consulting Practice' ran thus:

"Examination in his consulting room of patients who come to him in a matter dealt with by his speciality either with or without professional introduction."

We are glad to note that the Government in the Press Communique published by the Ministry of Public Information on 27-4-1939, have once again defined what 'Consulting Practice' means and the readers will note the fundamental difference between the old and the new definition. The first clause in the new definition runs thus:

"Examination in his own private consulting room, or at any place other than the Government institution where the medical officer is employed, of patients who are brought to him through the introduction of or in the company of a registered private medical practitioner."

We have published in the Correspondence columns both the new and old definition of 'Consulting Practice' for the benefit of our readers.

We also said in October, "that the officers now in service should as far as

possible not be subjected to undue hardship" and suggested that, "the Consulting Practice should be allowed to all the members of the Madras Medical Department from the existing Sub-Assistant Surgeon upwards". We had to make this suggestion as it was said at the time that the 'Consulting Practice' would be permitted only to Civil-Surgeons and Specialists and we are happy to note that our suggestion had the desired effect. This reform is bound to create certain amount of discontent in service as it destroys an age-long practice. It has also to be said that even before the introduction of this reform there were in Government Service officers in all grades who did not abuse the privilege of private practice but the few that abused them did so ruthlessly without even minding the rules of Medical Ethics. Running of the nursing homes by State-paid officers in high position next perhaps in rank to Surgeon-General or even a prospective Surgeon-General was the climax of the abuse. What hit the general practitioners hard was the running of chemist-shops by the medical officers and their serving as consultants to chemists and soliciting practice through them. Though sign-boards hanging prominently in such shops bearing the names of the consultants had to be removed some years ago, the actual abuse of the privilege of private practice is still going on and will go on even under new order, especially in the City of Madras where it has been possible for a few lucky medical officers to have almost permanent tenure of office without being disturbed by transfers as is the case with their less fortunate brethren in the moffusil. The former have established themselves so securely that a few amongst them even declined to be promoted as Civil-Surgeons. Evidently the pay and other emoluments of the

Civil-Surgeon cannot attract them. It is said that a few have the required influence and in addition the patronage of chemists which will enable them to employ private practitioners to serve the purpose of introducing patients. It is therefore very likely that the new order of the Government will be set at naught under the very nose of the Government. So it is highly desirable that the Government should lose no time in transferring their officers periodically even those serving in teaching institutions as Professors and Lecturers. There are at present three Medical Colleges and there will be no difficulty in effecting the transfers. Such a reform which is long overdue will also allay the discontent now prevailing in the Medical Department on account of a few enjoying the permanent tenure in the City for no fault of the large majority in the moffusil who are transferred periodically. We wonder if the Congress Government are aware that it has been possible for raw Assistant-Surgeons fresh from Medical College in temporary service to have themselves posted as Assistant to Professors of Medicine, Surgery, who later qualified as M. Ds or M. Ss whereas their seniors in permanent service were left alone in the moffusil and a few Junior Assistant-Surgeons in permanent service serving in the Government General Hospital could get study leave to go abroad and immediately after their return were able to supersede many seniors by being appointed as specialists in the cadre of Civil-Surgeons. It was expected that such anomalies would not continue under the Congress Government. We hope the Government will note the urgent necessity of transfers in City Hospitals which while giving effect to an existing healthy rule of periodical transfers, will also tend to have less loop-holes in the exercise of the New Order.

DIPLOMA HUNTING.

All throughout India there is at present a great tendency in medical men to go to British Isles and collect as many qualifications as possible with little or no aim about the future use of such qualifications. The tendency is more in medical men in the paid services as they can take advantage of study leave and get the qualification at the expense of the State. We least object to our young men going abroad and work for technical perfection in any special subject side by side with theoretical studies. And incidentally a higher post-graduate degree or diploma may be obtained. But are these the objectives of our map? A few may have these, but the majority go and return with the definite object of enhancing their status in the official hierarchy or to compete successfully in the all-India medical services, or in expectation of a safe special berth in one of the specialities in the provincial medical service. The opportunities for acquiring a high degree of technical skill in the several branches of medical science are very limited in the British Isles. The tendency of some of our men seems to be to collect as many divergent diplomas as possible so that, when occasion arises, they may be able to fit themselves into any hole or corner. The Madras Government in the past had been mainly responsible in granting study leave to their medical officers most indiscriminately. The test employed to select candidates was not so much the departmental need but favouritism with the result that at present there are at least a few who cannot be engaged to do the special work for which they possess the hall mark of a qualification. In the matter of selection for study leave seniority or previous professional experience did also not count. There is at present a large number of young medical men especially in Bombay and Calcutta with high British qualifica-

tions doing little or nothing. We desire that Indian money and Government money must be spent for legitimate purposes of acquiring a high degree of practical technical skill on a subject chosen before hand with some definite aim. For example there is absolutely no need for numerous M.R.C.Ps in medicine or F.R.C.S's in Surgery. The Indian Universities must concern themselves with post-graduate degrees and diplomas. If at all medical men go out of India they should do so with the definite object of specialising in subjects like chest surgery, neurological surgery, orthopaedics, etc., for which there are at present very few opportunities in India. And moreover two years at a minimum, must be spent in an institution under a leading personality in the particular branch. After their return such of those who went with Government expense should be put in charge of special clinics attached to teaching institutions so that India may become self-contained to afford training to medical men in various specialities in medical science.

America has made tremendous advances in neurological surgery and men from England and the continent, go to America to study the subject under the American leaders. Sauerbruch's chest clinic in Berlin is another world-famous centre for chest surgery. We can understand the Government and medical men spending their money for studies at these and similar institutions but we cannot but protest at the mad race of diploma hunting particularly at the English universities and corporations.

MUNICIPALITIES AND MEDICAL RELIEF.

Considered quantitatively, the Corporation dispensaries at Madras, and the Municipal dispensaries of the provincial towns which disburse medicines to

crowds of people, who cannot afford private treatment, are successful and popular, the popularity being counted on the members disposed in a couple or triple of hours. But what is the real truth? What is the standard of quality? That medical man who can lay his fingers on his heart, and can say, that he practices scientific medicine, in dismissing at the rate of 100 patients an hour, must really be a super man. Barring such men who pretend to be infallible, the majority of medical men are ordinary human beings, who must use their different senses of sight, touch and hearing, if not some essential instrument such as a clinical thermometer to come to a provisional diagnosis, at the best. This fundamental process of inspection, palpation and auscultation even excluding percussion, should take at least three or five minutes. If it is so, how can a man, in his senses, believe that scientific medicine is practised in these dispensaries. These dispensaries, in our opinion, are an eye-wash and degrade, scientific medicine, to the level of third rate quackery. Nor are the Government out-patient departments of hospitals free from this practice. The bringing down of the scientific medicine to the mire of licensed charlatanism, must be stopped before it is allowed to do greater harm to the body politic. What is the best way to stop this rot?

All the towns are well supplied with private medical practitioners, majority of whom, are leading a dreary existence, thanks to the unholy competition from municipal institutions, Government institutions, and the medical personnel of those institutions. The municipalities spend not negligible amounts in doing this third rate work. Why not municipalities, utilise the services of these famishing private practitioners, for giving treatment to the poor on a subsidy depending on the number of cases treated? A distri-

bution of this work, among all the practitioners of the localities, without extra cost, not only conduces to the enthronement of medicine to the scientific pedestal, but also gives the tax-payer, double or treble the worth of his tax. The practitioners also are enabled to get a substantial extra income. If this argument is accepted, the municipal dispensaries may be abolished for good.

But the municipalities need not stop with the abolition of the dispensaries. They can utilise their finances for providing institutional treatment to the poor, where such facilities are lacking or insufficient in the Government institutions. To man these in-patient institutions, private medical practitioners can be had in abundance on an honorary capacity. As it is, the private practitioner, is hit in several subtle ways. If private practitioners are allowed to have the complete control of the out-patient and dispensary treatment of all the citizens they will willingly shoulder any additional responsibility.

In this connexion, the starting of a laboratory, for the clinical work of the medical practitioners, by the Madura Municipality, is a very highly commendable measure. Work which can be better done by individuals, must be left to individuals. Auxiliary work such as laboratory facilities, X ray facilities, and organised institutional treatment, may be done by corporate bodies like the Government and municipalities. It is in this rational division of labour and the differentiation of the orbits of activity, that the purpose of medical relief and public health depends. Overlapping, whether well meant or ill meant, will destroy the foundations of the very system, we want to improve. Will the Government and the municipalities ponder over the implications of this vital question? Better late than never.

News and Comments

Government Proposes University Disposes: The Government must have had a very hard task in the matter of selecting Honorary Medical Staff to various hospitals especially to the premier institution in the City, the General Hospital. It was an open secret that almost all the Superintendents of the Government Hospitals both in the city and mofussil hospitals recommended to the Government the retention of the existing staff without exception. A few at least ought to have done this as routine duty which at times lacs in responsibility. But the Government did not forget their responsibility in sticking to their new policy of five years tenure of office ordinarily to all honoraries. This was naturally resented in some quarters, may be on sound principles of their own or principles of vested interests including communal. This matter was even pushed on the floor of the Legislative Assembly and the Public Health Minister was able to answer all the imaginary charges against the Government quite suitably.

In the meanwhile we learn that the Madras University has instituted an enquiry through it is said the Principal, Medical College, to make sure that students for clinical training should not be posted under Hon. Physicians and Surgeons who were not recognised as possessing the minimum qualifications laid down by the University. It is also said that the Principal who is the member of the Syndicate addressed a letter to the Registrar, Madras University regarding qualifications of Lecturers in Clinical Subjects and got a reply informing the Principal that the Syndicate resolved that the qualifications and attainments of Clinical Lecturers in Hospitals, should be the same as possessed by the Professors, or Lecturers and that they must have practised the speciality for four years after having obtained the qualification. It is not known when the Syndicate came to this decision and if the decision of the Syndicate had the approval of the Senate or if the Syndicate can pass 'rules regarding appointment to teaching staff in the University and in the Colleges' without the

sanction of the Senate. We may mention that in the rules published by the University of Madras, nowhere it is said that either the Professors and Lecturers should 'have practised the speciality for four years after having obtained the qualification'. The preamble of the rules runs thus:

"For Pre-Registration: Professors, Lecturers, and Assistants to Professors should have a first or second class Honours degree in the subject they teach. Demonstrator should have a Degree in the subject they demonstrate,

Teachers in all other subjects should be medical graduates. This might be relaxed in very exceptional cases, for Physiology, Anatomy and Biochemistry. Persons possessing M.R.C.P. or F.R.C.S. or M.C.O.G. will be considered as equivalent to medical graduates. The professors and Additional Professors should have had teaching experience in their special subjects."

It is mentioned at the outset that Professors, Lecturers and Assistants to Professors should have a first or second class Honours degree in the subjects they teach. We are at a loss to understand what the University means by Honours degree when such a degree is not instituted as yet for any medical qualifications. It is also said that 'Persons possessing M.R.C.P., F.R.C.S. or M.C.O.G. qualifications will be considered' as equivalent to Medical graduates. In other words this means that the latter foreign qualifications are equivalent to M.B.B.S. degree of the Madras University. Yet we find in the list of qualifications for Professors of Medicine and Surgery the University is insisting on M.R.C.P. and F.R.C.S. respectively. This is a side comment to point out some inconsistencies in the rules regarding qualifications.

To come to the subject proper even if the Syndicate can prescribe qualifications to the teaching staff in the Colleges when and as the Syndicate considers it necessary without the final sanction of the Senate, we wish to point out to the Syndicate that man makes the qualifications and qualifications themselves do not count to judge the capacity of the man. The University has recognised this dictum and have been appointing B. Ls as examiners for M. L.

degree. Though an M.B.B.S. has not yet been appointed as an examiner for M. D. or M. S. degree, persons holding qualifications of M.R.C.S., L.R.C.P. which is only equivalent to M. B. B. S. had been examiners for M. D. degrees of the Madras University. This may be past history. Even this day there are Professors in the Medical Colleges who do not possess the qualifications prescribed by the University. Evidently the University minds the capacity of these Professors and not the hall mark of higher qualifications prescribed by it. This is as it should be. Yet under such circumstances it is really strange that all at once the students posted for clinical training under a Honorary Physician possessing M.D. degree were suddenly asked to quit his wards. We wish the Syndicate send for the application made by this candidate to the Surgeon-General as a candidate for the post of Hon. Physician, Government General Hospital. The Government who selected this candidate finally are expected to know the rules framed by the University and the conventions observed by the University regarding the qualifications of Professors and Lecturers in the Medical Colleges and must have been satisfied that this particular Hon. Physician had the necessary qualifications and attainments to give bed side clinics to the students working in his wards. We could say with some knowledge of facts that after the Honorary Scheme came into existence, no Honorary Physician appointed by the Government to the staff of the Madras General Hospital possessed at the time of his appointment the qualifications and experience (even in research work) as those possessed by this Honorary Physician from whose wards the students undergoing clinical training were sent out. The University may even make a referendum to the students who were attending his wards for a few days, if the clinical teaching of this Honorary Physician was not interesting and instructive.

More than anything else we are concerned with the prestige of the Government and also about the loss of clinical material to the students for which the Government is spending a large amount

of money. We know as a matter of fact that the Surgeon-General has been getting exemption on behalf of Government for such of the Professors of the Medical Colleges who did not satisfy the rules. We wish the Government do the same in regard to this Physician who satisfies all the rules so far published by the University of Madras so that the students might not lose valuable clinical material in the General Hospital on mere technical if not imaginary grounds.

A Healthy Reform, Faulty in Execution : One of the items of the Scheme of Reorganisation of Medical Department by the Congress Government, was the creation of the office of Almoner in the Government General Hospital, Madras as a trial measure for a period of six months. The Government gave instructions to the Surgeon-General to select a Sub-Assistant Surgeon to function as Almoner. The Government also mentioned in their order the duties of this officer. He is to attend the Out-Patient Department in the morning, see the progress of work in that department, check the nursing orderlies, ward boys, ward ayahs and other menials and prevent corrupt practices. In the In-Patient Department he is to check the income of the patients admitted and make confidential reports to the Superintendent about any untoward happenings observed by him in the hospital. Even before the Congress came to power we have been advocating the necessity of appointing Almoners in State Hospitals so that such an appointment may serve as an efficient screen to prevent the rich taking undue advantage of the State charity in the hospitals. Before suggesting the need of the office of the Almoner in the hospitals we took some pains to know the duties of this office in the hospitals in Great Britain and were very much disappointed indeed that the Government allotted responsibilities and functions to this office not conveyed by the actual meaning of the word and its later history. The literal meaning of the Almoner is an official distributor of alms. The word alms, again, means charitable relief of the poor and this relief in the hospitals is free treatment. Therefore the main

duty of this office in Great Britain is to admit into the hospitals only the poor for free treatment. This duty enjoins the knowledge of the paying capacity of patients to be admitted into the charitable institutions. It is said that at present this office is held invariably by women in Great Britain perhaps for their gentle ways. Nobody can find fault with the Government for appointing a man but the Government have gone too far in prescribing duties to this office which are to a certain extent detrimental to the existing administrative machinery. We do not mean any disrespect to the cadre of Sub-Assistant-Surgeons when we say that it was too much for the Government to expect a subordinate medical officer to check corruption in an institution consisting of officers far above him, even it be that he is to submit confidential reports to the Superintendent. We will not be surprised that the person selected for this office will one day or other on his own accord report about his incapacity to function as an Almoner. It must have been indeed a very hard task for the Surgeon-General to select a Sub-Assistant Surgeon to do duties expected of him by the Government under the name of Almoner. We did prophesy soon after the appointment and its functions were announced that the experiment was very faulty and is bound to be a failure and we repeat our opinion now after the appointment is made. The Surgeon-General had no choice to select a right sort of man for doing duties expected of him by the Government. We did point out in these columns that the Almoner should not be a medical man much less one from the grade of Sub-Assistant-Surgeon. If the Government allotted to the Almoner the duties done by such an officer in the Hospitals in Great Britain and asked the Surgeon-General to select a person and if such a person did his duties well as expected of this office, the experiment would have been a success and the Government would have earned lot of money from the paying patients if the Almoner was in charge of admission into the General Hospital and was the officer to assess the income of patients admitted.

The method of assessing of income and receiving of money from patients now carried on in the General Hospital is indeed a bad principle in audit. If the Government empowered the Almoner to check who is poor and who is rich at the time of admission, the real and higher corruption in the General Hospital might have been efficiently prevented if not minimised. When the appointment of a Lay Secretary which we have been suggesting for several years in these columns was also an accomplished fact, we suggested to the Government that it would be wise to entrust this office the duties of Almoner also. This would have been an experiment worth venturing without additional expense. Even now it is not too late to mend matters if the Government are pleased to do so.

Miscellaneous Utterances : As expressed by us once before in these columns, public functions give opportunities for the members of the Government to explain to the public the policy of the Government and get the popular support. The function is at times made the starting point of many other topics unconnected with the main function. The opening of a new Allopathic Rural Dispensary by the Hon'ble Dr. T. S. S. Rajan, Public Health Minister at Mamandur, a village seven miles from Conjeevaram on 22.4.1939, was one such function. The connecting links from one topic to another give the public opportunities of knowing what the Minister has actually at heart about other matters in which a particular section of the public is concerned. The miscellaneous utterances of the Public Health Minister at Mamandur Rural Dispensary were very interesting indeed. After warning the villagers that because there was a new dispensary they should not contract new diseases, on the other hand live a healthy life, obeying the laws of nature and in course of time turn out the new building a centre for preventing diseases, he changed his topic and gave out what he had in his mind about Subsidized Rural Medical Practitioners whom he described as a 'new creation' we may add 'of the Government.' He rightly said that they occupy

the position of bats not being servants of the Government yet being under the Government control. The Minister added that they had no security of tenure and though they were required to give free treatment to the necessitous poor, 'unfortunately what usually happened' the Minister declared, 'was both the well-to-do and the poor came to the dispensary for free treatment and the former got preferential treatment. Those who possessed influence should be given special treatment or the doctor would get into trouble'.

It is clear from the above statement of the Minister that he is aware that the life of the Subsidized Practitioner is far from being happy. He cannot get money from the rich because if he demanded fees from them he 'would get into trouble'. May such a practitioner be styled independent and can he command an independent livelihood? The answer cannot but be 'no'. Yet the Government cannot find their way to make the subsidized practitioner really independent by removing the control of local bodies over them. By doing so the groaning poor villagers may be expected to be 'looked after first' in the subsidized dispensary.

The next topic about which the Public Health Minister spoke that day was about 'efficacy of faith'. 'No medicine' the Minister declared 'could ever cure a disease. Faith alone could do so. Even the lay hearers of the Minister would have realised that day that though there was much force in what the Minister said about faith cure, faith cannot be the only factor in curing a disease. The belief of the Minister in the faith-cure theory must perhaps have the origin from his perusal of the statistics of 'Out-Patient Departments' a description of which is given in the Editorial appearing in this issue under the caption 'Municipalities and Medical Relief.' It was indeed very opportune that the Editorial comments on out-patient medical relief should appear along with the comments of the Public Health Minister on Faith-Cure. We trust that the Public Health Minister will be true to his belief in

Faith-Cure and find out ways not to waste public money in running wasteful Out-patients-Departments.

The next topic was about the Public Health Act, then the Prohibition and last the justification of the New Taxes. The Minister concluded by saying that the subsidized practitioners should bestow more care on the preventive side of medicine and that 'the rural practitioners might be compelled to do preventive work on pain of dismissal later on but not now'.

We are at a loss to understand the implication of words 'later on but not now' and are very much pained indeed that the Public Health Minister should feel it necessary to throw out a threat to the subsidized practitioners none of whom so far to our knowledge refused to do Public Health Work. On the other hand the following resolution was unanimously passed by the Subject Committee of the Conference of the subsidised practitioners on the very evening when the minister threw out the threat.

"The Conference congratulates the Public Health Minister for successfully passing the Public Health Act in this province and leading a way for other provinces to follow and appeals to the members of the medical profession including the Subsidized Practitioners to co-operate with the Government in all possible ways for the successful working of the provisions of the Public Health Act".

This reminds us of the innocent lambs which keep licking the feet of those who feed them not knowing their fate in the immediate future. Yet we trust that the threat of the Public Health Minister is not of serious import and of a nature generally used by a loving parent whose threats have no literal meaning.

Suppression of Quackery: In the Correspondence Columns of the current issue there appears a letter addressed to the Editor, by a practitioner from Ramachandrapuram suggesting the urgent need for introducing a Bill for suppressing quackery. Medical quackery is fairly common throughout this Province and we may add throughout the country but we are told that surgical quackery prevails

notoriously more in Andhra Districts. We are unable to adduce reasons why surgical quacks should thrive in these Districts more than anywhere else. The Government could certainly be able to find out the specific causes for the existence of a larger number of quacks in Andhra Districts especially those dabbling with Surgery.

The need for suppression of quackery through legislation has been one of the items of discussion in these columns and if we did not persist in this agitation more than we have been doing, it is due to want of response from the profession. A few years ago we suggested to the Government to bring into existence a Licensing Board to grant license to anybody who wished to practise medicine including the qualified practitioners as there were many qualified practitioners who did not mind to get themselves registered. We also suggested that the Licensing Board should have representatives of all systems of medicine and a Government official having legal knowledge and that this body should be vested with disciplinary powers to cancel licence of such of those who practise medicine by adopting methods they were not expected to know. We did also bring to the notice of the Government that such a Licensing Board was working satisfactorily in Siam. The creation of a Licensing Board of the composition suggested by us is as simple as its working and we repeat our suggestion to the Government who are very keen about the welfare of the people especially of the village folk. And it is for the profession to press the need of Legislation to suppress quackery, before the present popular Government who cannot refuse to do anything conducive to the welfare of the people.

Col. Rahaman's Shafa Khanas: The word rural usually connotes cheapness. Col. Rahaman, the Chief Health Officer, Bopal, could not therefore but start a cheap Medical Relief Scheme for Bhopal Rural areas which he calls Shafa Khanas, perhaps a dignified Urdu name for medical institutions under a hakim. Col. Rahaman's Scheme is to supply a hakim for a unit of 6,000 village population and

a hospital for a population ranging from 40 to 50 thousand. These hospitals are to be under the control of two fully qualified doctors. The Shafa Khanas and village hospitals will be the feeders for the well-equipped State Hospital in Bhopal. The basis of his scheme depends upon his calculation that 83 per cent of the illness in the State is amenable to very simple treatment if it is given in time, 13 per cent of cases require institutional treatment and the remaining 4 per cent specialist treatment. Such a calculation looks all right in print but the actual facts concerning diseases are quite different whether it be in Bhopal or elsewhere in India. If the Colonel believes that ignorance, dirt and squalor are more in villages he should concede that the chances of existence and spreading of diseases are equally more in rural areas. He can also conceive that the neglect of the diseases in patients either due to poverty or want of proper diagnosis drifts them to graver conditions requiring specialist treatment. Consequently in cheaper institutions specialist treatment will be multiples of his present calculation of 4 per cent. He should realise that the chances of early treatment of diseases at the Shafa Khanas will not be on sound lines and that nature is always a more kind and quicker healer of ailments than the half qualified doctors who treat diseases on wrong diagnosis. Social diseases such as Leprosy, Venereal diseases and even Tuberculosis are as rampant in rural areas as in urban. To this must be added many more diseases due to defects in nutrition. If the Bhopal State or any other State or Government is really earnest or sincere about the welfare of the village folk whole time fully qualified medical men should be put in charge of Village Health Units and not the practitioners of a Hybrid System from whatever place they are imported. Or else the Rural Medical Relief will be an eye-wash and multiply diseases instead of eradicating them. All the same Col. Rahaman's plan of supplying a medical man for a Unit of 6,000 population and a hospital for institutional treatment for a population of 50 thousand is worth the consideration of all States and Governments.

Propaganda relating to Public Health Act: The Parliamentary Secretary to the Public Health Minister, Mr. A. B. Shetty has been collaborating with his Chief whole-heartedly by visiting several Districts and addressing the Medical Associations and exhorting the members of the medical profession to co-operate with the Government in the working of the Public Health Act. Mr. A. B. Shetty selected almost all the Head Quarters stations in the Ceded Districts and only Guntur in the Northern Circars. From the reports in the press it looks as if Mr. Shetty had patient hearing every where except in Guntur where the Secretary, District Medical Association asked the Parliamentary Secretary some pertinent questions which demanded some solution.

The first question related to the impropriety on the part of the Government in not consulting the existing District Medical Associations before the introduction of the Public Health Bill in the Assembly especially when the Act contained some penal clauses relating to the practitioners.

The next question related to the absence of any provision in the Act of supervision over the Public Health Staff by medical practitioners even the State-paid, as the staff are likely to go scot-free for acts of omission and commission on their part.

The third query was relating to Guntur town itself. The Secretary complained that the Guntur Municipality had not provided all the amenities expected of a municipality such as a good supply of water, efficient conservancy and drainage system, infectious diseases hospital, adequate number of sanitarily fitted public latrines. Under such conditions the Secretary questioned if the Government was justified to give effect to the sections of the Public Health Act in Guntur.

The fourth question was about prosecutions and claiming damages from the Public Health Staff who exercised powers in excess of those contemplated in the Act. The Secretary said that if a member of the Public Health Staff is to be proceeded against for having harassed any citizen the

latter should obtain the sanction of the Government. He asked why such a sanction not provided for prosecuting the citizen. In the opinion of the Secretary even the sanction of the District Collector would have been enough for the purpose.

The fifth in regard to section 79 of the Public Health Act was a very important question as it affected the members of the medical profession. Section 79 reads thus:

Every physician or other person treating, or examining with a view to treatment, a person having a venereal disease shall, at the first visit:—

(a) impress upon such person the necessity for treatment until the cure is effected;

(b) instruct him in regard to the measures necessary for preventing the spread of the disease; and

(c) furnish him with such other information relating to the disease as may be provided by the Director of Public Health.

If a medical practitioner fails to give instructions to the person having venereal disease and fails to give the required information, he may be prosecuted and fined Rs. 20. The Secretary, Guntur District Medical Association rightly asked the Parliamentary Secretary what was the criterion to base the prosecution, was it the statement of the patient or anything else.

The sixth and the last question related to section 80 of the Public Health Act. The section runs thus:

'Every medical practitioner registered under the Madras Medical Registration Act, 1914, and included in a panel published by the Government for the purposes of this section shall be bound, at the instance of a person desirous of obtaining a certificate under this section and on payment of a fee of five rupees, to examine such person, and if he finds that such person is not suffering from a venereal disease, or has been cured thereof, to furnish to such person a certificate to that effect in the prescribed form'.

The question was asked why penalty was not provided for this section and if the person who got the certificate did not pay the fee what was the remedy.

The Parliamentary Secretary is a quiet unassuming person by nature and was

perhaps not prepared to such heckling judged from his experience in other districts which he visited.

Soon after the Public Health Bill was published we suggested in these columns to provide for local Advisory Bodies consisting of Public Health Staff and private practitioners on the lines suggested by the British Medical Association in Great Britain. Such bodies while popularising the Public Health measures would have created a feeling of comradeship between the preventive and curative sections of medicine for public good and the Secretary, Guntur District Medical Association or anybody else in future would not have complained against omissions and commissions in the Act and would have adjusted matters amicably.

Democratisation of Medical Service: Year after year when we were reading reports of the annual meeting of the Mysore Medical Association, we were wondering if there existed independent medical profession in Mysore State and whether it is possible for the independent medical profession to thrive with equal status along with State-paid practitioners. The annual report of the Association read by the President, the Senior Surgeon to the Government of Mysore, was an account of the medical administration of Mysore State. The annual meeting was always opened by the Dewan. So the whole show looked like a family gathering of the Mysore Medical Department, where laudable and as noble ideals were placed before the gathering both by the Senior Surgeon, the President and the Diwan relating to medical problems both preventive and curative. It is said that discussion of scientific subjects is also part of the programme of the annual gathering. From the administrative point of view such gatherings must have had very good effect but from the point of view of the evolution of scientific medical profession we should say such official professional gatherings retard the growth and the prosperity of the profession as a whole. One hears of able Surgeons and Physicians as State officials but soon after their retirement nothing is known

about them. But in countries where the independent medical profession is known more than official medical profession, the fame of the members of the independent medical profession, is heard till to the last day of their existence. This means much to the evolution of the profession. It is just possible that the fat pension or the large amounts saved by whole time officials in this country that makes them lose their interest in the profession soon after they retire. So it should be the duty of the State to encourage independent private practice and not State-paid practice in the interests of the public as well as medical profession. It is just possible that a few private practitioners here and there in Mysore State eke out their livelihood as dispensing practitioners but it will be impossible for any highly qualified Physician or Surgeon to make even a hand to mouth living in the existing State of affairs of hospital administration in Mysore State where the State Hospitals are more than private houses to the high paid officials and the non-officials who resort to scientific system of medicine are naturally attracted by the hospital doctors. We are glad that the independent medical practitioners of the Mysore State have made up their mind to strive for an honourable independent existence and they did well to request the Hon'ble Dr. T. S. S. Rajan to inaugurate their very first conference. We hope the wise words of Dr. Rajan that the introduction of Honorary Service in State Hospital pays the independent medical profession indirectly and pays the State directly, will catch the imagination of the Dewan of Mysore who, will realise that there is no justification for the existence of a medical college and a school in the State unless the independent medical profession is encouraged and the only way to encourage its members is to offer them Honorary posts in State Hospitals and eventually replace all the officials doing curative work by non-officials. We are glad that the Diwan the Senior Surgeon, the ex-Senior Surgeon and other State Medical Officers attended the function.

Is the New Order another Ineffectual G. O.? This is the question asked

by a City Practitioner who wrote to us last August complaining that though Non-clinical Professors and their Assistants are prohibited from private practice altogether as per G. O. No. 2232 Public (Services) dated 22-11-37 an Assistant to the Professor of Pathology, Madras Medical College and an Assistant to the Professor of Bio-Chemistry of the same college did not respect the G. O. We commented on this subject last August under the caption 'An Ineffectual G. O.' and sent our comments to the then Surgeon-General and received a reply from his Personal-Assistant that the G.O. did not effect those already in service. We were rather amused at this reply and thought within ourselves that if the G. O. did not effect those who were in service what was the purpose of the Government to pass the G. O.? But just at that time we learnt that the Government were intending to restrict private practice wholesale we therefore did not press the matter further. From the wording of the New Order, it is clear that the restriction applies to all belonging to Madras Medical Service even before the date of the New Order. It is also clear that the interpretation of the Surgeon-General as communicated to us by the Personal-Assistant cannot be consistent with the spirit of the New Order. For additional information on the subject we refer the correspondent to the Editorial on this subject appearing in this issue.

Leave out of India: There appears in the 'Correspondence Columns' a letter from a moffusil Assistant-Surgeon belonging to the Madras Medical Service under the caption, 'Leave out of India' which speaks for itself. It is a sheer waste of Government money and energy of the Madras M. D. or M. S. if he is granted leave out of India to qualify for M.R.C.P. or F.R.C.S. respectively as the Medical Department or the applicant for leave is not likely to be benefitted by these superfluous qualifications. As stated by this correspondent the very object of the Government to encourage its officers to qualify for the local higher medical qualifications will be frustrated. The old history of Study Leave and other

details on this subject have been explained in the Editorial appearing in the current issue under the heading 'Diploma Hunting'. The Correspondent is not correct in saying that we were responsible to induce the Government to stop granting of Study Leave to the members of the Madras Medical Service by the Government. We did not do so, but we did repeatedly point out to the Government the injustice done to the seniors by the Government selecting quite juniors for granting Study Leave and that most indiscriminately with no regard to departmental needs till at last, a few years ago, the Raja of Bobbili, the then Public Health Minister announced on the floor of the Legislative Assembly that the Government would pass orders so that Assistant-Surgeons over ten years standing only would be selected for Study Leave. Recently, perhaps as a matter of economy Study Leave was given up and leave out of India for those who are eligible for leave, has been substituted for enabling members of service to go abroad for study purposes. As it is very likely that higher qualifications will count in future in addition to merit and experience for the selection of Civil-Surgeons, the suggestion made by the moffusil Assistant-Surgeon is worth the sympathetic consideration of the Government and if it is given effect to, lot of discontent now prevailing in the Medical Department is likely to disappear and the Congress Government will justify its regime for justice and fair play.

Is it a Retrograde Step? We learn that on the recommendation of the Superintendent, Government General Hospital, the Government have substituted an Assistant Surgeon in the place of a Civil-Surgeon to do the duties of the Resident Medical Officer, General Hospital as an experimental measure for six months. This change does not seem to have been brought about as a economy measure but to have perhaps a younger officer to do the arduous duties expected of the Resident Medical Officer in charge of the biggest General Hospitals in India. In days gone by this post was reserved for a juniormost European I. M. S. soon after he was posted to Civil side. This was more or

less a training ground for him not only for professional training but also for learning ways and habits of the Indians with whom he had to deal in the course of his professional career. It was during the Great War when there was a paucity of I. M. S. officers members of the Madras Provincial Service acted as R. M. Os. for the first time. Later, during the Panagal Ministry many of the appointments till then held by the I. M. S. were thrown out to the members of the Provincial Service, one such appointment being the Resident Medical Officer, General Hospital. The duties of the Resident Medical Officer are not only arduous but onerous. Apart from the professional emergencies he has to deal with at any time of the day or night at a moment's notice, he has to control the staff of the hospital of all grades and while doing so, maintain the dignity with those below him and respect with those of his rank. A person in the grade of an Assistant-Surgeon however clever he may be professionally, may not be able to maintain the prestige and dignity of the position of the R.M.O. unless the Superintendent takes upon himself all the responsibilities of this office which have to deal with officers above the rank of the Assistant-Surgeon. We admit that a Civil-Surgeon nearer 50 might not be quite fit to stand the strain of the R.M.O. unless he shirks work but the Government should choose a Civil-Surgeon nearer 45 for this post and keep him in the General Hospital only for five years and not indefinitely to suit his domestic or other circumstances. Without meaning any disrespect to the cadre of Civil-Surgeons, we should say that if some of the Civil-Surgeons were not found up to the mark, the Government is mainly responsible, as Assistant-Surgeons are not given equal opportunities of service in the City Hospitals to acquire necessary skill and experience especially in Surgical practice. If the Government took care in giving fair and equal opportunities of training in the Government General Hospital to all the members of the Provincial Service in the cadre of Assistant-Surgeons, there would not have been a difficulty to choose comparatively young, energetic and efficient Civil-Surgeons to serve as Resident Medical

Officers of the General Hospital. Even when the Honorary Medical Relief Scheme reaches its zenith, the post of the Resident Medical Officers in all State Hospitals will have to continue for the sake of administration of the hospitals and these posts will not clash with the interests of the Honoraries as the Resident Medical Officers are debarred even from Consulting Practice. So in the interest of the efficient administration of the General Hospital, the prestige of the office of the Resident Medical Officer of the biggest State Hospital in the province which is also a teaching institution, the Government will be well advised not to transform the post of the Resident Medical Officer of the General Hospital to an Assistant-Surgeon. It will not be out of place for us to mention that it will be also rather harsh on the part of the Government to lessen one more post in the cadre of the Civil-Surgeons in the Madras Medical Department which will soon be absorbed into the Honorary System, if the Government do not reserve the post of R.M.O. General Hospital for a Civil-Surgeon.

Rural Reconstruction: Ever since Rural Reconstruction has become the subject of all India importance engaging the attention of the Viceroy down to the humblest village official, of the leaders of all existing political parties to the rank and file in such parties, of others who concern themselves of nothing else excepting the hobby of regenerating the Indian villages (to this last group belong the Christian Missionaries to a large extent), we never heard any speaker on public platforms who spoke on Rural Reconstruction or saw in the reported speeches in the Press, anybody stressing the importance of the members of the medical profession in the stupendous work of Rural Reconstruction. We are also disappointed that the Government of Madras do not seem to have realised the usefulness of the rural practitioners and have not so far utilised their services in the programme of Rural Reconstruction. We were very glad to read a summary of an address delivered by Dr. Galen Scudder of the American Arcot Medical Mission, Ranipet, at the yearly Missionary

Conference at Kodaikanal on the need of the Ministry of Healing and pointing out that the Christian Medical Service should take a central place in Rural Reconstruction. Dr. Scudder was perfectly right in appealing to the Christian Medical Service in the way he did as he was addressing an audience only of Christian Missionaries and we will not be wrong in appealing to the Indian Medical Profession of all religions to take up a prominent part in Rural Reconstruction which the members of the profession in rural areas could do while exercising their profession even if they are not wanted by other organisations doing this work be it Government, Semi-Government or private bodies, majority

of whom having a political outlook. That the spirit of service is inherent in the medical profession was demonstrated by Rao Sahib Dr. S. M. Trasi, Retired Professor of midwifery and gyneacology, Vizag Medical College who in his address to the Subsidized Practitioners who met in Conference at Samalkot on 22nd April 1939 gave them not only sound and practical advice about Rural Obstetrics and Rural Hygiene, two most important subjects relating to Rural Reconstruction but volunteered to do missionary service as their consultant with no remuneration suggesting to other retired medical officers to follow his example.

CAMERON PRIZE FOR PROF. DOMAGK.

"At a meeting of the Court of Edinburgh University the Senatus reported that the Cameron prize for 1939 had been awarded to Dr. Gerhard Domagk, Institute for Experimental Pathology and Bacteriology, I. G. Farbenindustrie, Elberfeld, Germany, in recognition of his discoveries—the well known Prontosil—which initiated the treatment of diseases of bacterial origin by compounds belonging to the sulphonamide group.

The Cameron Prize is awarded to a person who, in the opinion of the Senatus has in the five years immediately preceding the award made any highly important and valuable addition to practical therapeutics."

ELIXIR ANEMONE CO.

A specific for Hysteria and allied disorders.

Elixir Anemone Co. is a compound of valerian anemone and gold with Vitamin B in the form of orange juice. This is the original formula of a leading neurologist of America, Dr. Theodore Alderman, M. D.

Obtainable at all Chemists or with the Sole Agents:

Messrs. KRISHRAJ & CO.,

8, Bunder Street, MADRAS.

Correspondence, Reports, Etc.

GOVT. DOCTORS AND PRIVATE PRACTICE.

NEW ORDER ISSUED.

The following Press Communique has been issued by the Ministry of Public Information:—

The question of abolishing or restricting the concession of private practice allowed to whole-time medical officers belonging to the Madras Medical Service and the Madras Medical Subordinate Service has been under consideration of the Government for some time past. Government medical officers were allowed to engage in private practice in the past owing to the absence of a sufficient number of qualified private medical practitioners. With the growth of an independent medical profession in recent years, the condition has ceased to exist. Further, under the scheme for the reorganisation of the medical services, honorary medical officers will replace full time paid medical officers as and when vacancies arise in the Provincial and Subordinate cadres of medical officers and in order to encourage private medical practitioners to take up honorary appointments, and to provide sufficient scope for private medical practice to develop unhampered, it is necessary to prohibit paid wholetime Government medical officers from engaging in private practice. It is, therefore, hereby ordered—

(1) that the privilege of private practice allowed to whole-time medical officers of the Madras Medical Service and the Madras Medical Subordinate Service should be withdrawn from 1st January 1940 provided that

(a) if a private medical practitioner calls in a Government medical officer for consultation and help, the latter should be permitted to give his service and to charge a fee and take it, subject to the condition that he should submit to Government through the Surgeon-General before the 10th of every month, a statement showing the cases in which he was called in in the

previous month, the name of the private medical practitioner who requisitioned his services and the fee realised in each case, and remit to Government 5 percent of such income;

(b) the rule does not apply to women medical officers.

2. With reference to paragraph 1 (1) (a) the consulting practice allowed and the conditions relating to it are defined in the appendix.

APPENDIX

I. "Consulting Practice" shall mean:—

(1) Examination in his own private consulting room, or at any place other than the Government institution where the medical officer is employed, of patients who are brought to him through the introduction of or in the company of a registered private medical practitioner;

(2) In cases of patients who have not got their own general practitioner and who wish to seek medical aid in cases of emergency, it is open to a consultant to take such cases even though the patient has not been introduced to him by a registered private medical practitioner;

(3) The treatment of patients at the request of, or in the presence of, a registered medical practitioner;

(4) Operations in a patient's house or in a nursing home or elsewhere, except the Government institution in which the officer is employed, with the intervention of a registered private medical practitioner. The cost of the after treatment should be included in the original operation fee. The case should be handed over to the general practitioner from the commencement of convalescence;

(5) The above shall also apply to the consulting practice of the Director of the Barnard Institute of Radiology, General Hospital, Madras, or any whole-time radiologist employed by Government.

II. No medical officer, specialist or other, employed by Government shall engage in private practice other than consulting practice as above defined.

III. (1) A Government servant working in a place where there are no medical practitioners, who is suddenly called to attend an urgent call, is not prohibited from attending on such a case, but such attendance should be independent of any consideration of fees that might be paid by

- the parties. If after attending the case, the Government officer finds that the party can pay, he may send a bill for his services. After realisation of this amount he should make a monthly return of such visits together with the information regarding the fees received. Such work shall be undertaken without prejudice to an officer's hospital duties, subject to such instructions as may be issued by the Surgeon-General or Government in regard to such practice.

(2) In places where medical officers in Government employ are working, and there is an urgent call in the case of a woman in labour, the Government medical officer shall attend such cases and after attendance send a bill for his fees, if the parties are able to pay, and shall include such cases in the monthly return of private practice.

MEANING OF CONSULTING PRACTICE.

As published in G. O. No. 2232 Public (Services) dated 22-11-1937.

Explanation :—For the purpose of this rule—

1. "Consulting Practice" in a member's speciality shall mean :—

(i) examination in his consulting room of patients who come to him in a matter dealt with by his speciality either with or without professional introduction ;

(ii) treatment of patients who have previously been examined in his consulting room or who have previously been introduced to him by a registered practitioner, in a recognized nursing home. In the latter case the registered practitioner who introduced the case need not be present during the visits of the member to the nursing home but the former should be informed of the course of the case ;

(iii) examination and treatment of patients in their own houses at the request of another registered practitioner either orally or in writing ; attendance on such patients should not be continued except in consultation with or at the request of the registered practitioner who introduced the case ; and

(iv) if the speciality includes surgery, a patient can be operated on in the patient's house or in a nursing home without the intervention of another registered practitioner unless one has already introduced the case. The after-treatment may be done in a recognized nursing home without intervention but if it is done in the patient's house it must be done only in conjunction with another registered practitioner. If the speciality does not include surgery, only such operations as would commonly be done in the hospital wards of his speciality may be performed by the member ;

(2) the expression "consulting practice in his speciality" as applied to the Director, Barnard Institute of Radiology, Madras, or a whole-time Radiologist shall mean—

(i) examination and treatment of patients with his own apparatus in his consulting room situated at a place other than the Government institution in which he is employed ; and

(ii) examination of patients elsewhere than in his consulting room or the Government institution in which he is employed, at the request of or in company with a registered practitioner ;

(3) private practice in the member's own speciality shall mean examination and treatment during off-duty hours of patients at their own houses or in the member's own consulting room with or without the introduction of another registered practitioner ; attendance of patient being restricted to the practice of the subject for which he holds his hospital appointment.

If the speciality includes surgical treatment the medical officer may operate on a patient in a nursing home or in the patient's own house and conduct the after-treatment himself. If his speciality does not include surgical treatment he may perform only such minor operations as would normally be done in the hospital wards of his speciality.

LEGISLATION TO CHECK QUACKERY.

SIR,

The Medical Practitioner deserves the appreciation of the members of the medical profession, especially the independent section of it for advocating many reforms affecting the life and prosperity of the profession. Almost all of them are being given effect to by the Government, the latest in the series about which there were grave doubts being the one relating to the restriction of private practice to Government Medical Officers. Some time ago I remember to have read one or two Editorials in The Medical Practitioner about need for the suppression of quackery. We were all expecting that during the period when Public Health Bill was on the anvil of Legislative bodies in this Province you would bring to the notice of the Government that the Public Health Act could not be worked satisfactorily especially that part of it relating to on Social Diseases unless quackery was done away with. The profession also expected that the Public Health Minister would include a few more sections

in the Act for the same purpose. So long quacks can treat patients, the statistical returns relating to diseases, will be faulty and many diseases will go undetected not to speak of other evils associated with quackery.

Quackery is now a serious menace to public safety especially in villages. Being unchecked in the field of medicine the quacks are practising Surgery also unhampered and the slaughters committed by them while practising Surgery go unpunished if by chance they are detected. Instances are a legion. I will only quote two such recent man slaughters.

(1) A particular quack's speciality was tapping of hydroceles. Once he tapped hernia for,—any swelling in the scrotum must be hydrocele according to his diagnosis—with the inevitable result that peritonitis set in and eventually the patient succumbed. Post-mortem examination was also conducted in a State-Hospital. The quack surgeon was committed to Sessions only to be let off after an elaborate trial.

(2) In another case a quack gave an intravenous injection of Silagit which is considered by native physicians as a specific for gonorrhoea. Before the needle was removed from the vein, the patient fell down dead. The Police did not prosecute this quack as it was said that there was no provision in the Indian Penal Code, to book such a crime.

The Madras Public Health Act is the first of its kind in India introduced in this province and all credit goes to the Hon'ble Dr. T. S. S. Rajan, the sponsor of this all comprising health measure. It is earnestly hoped that Dr. Rajan will not lag behind to introduce a suitable Bill to suppress quackery.

T. KANAKARAJU, L.M. & S.,

RAMACHANDRAPURAM,

15th May, 1939.

IS IT ANOTHER INEFFECTUAL GOVERNMENT ORDER ?

SIR,

I brought to your notice, last August that the Assistant to the Professor of Pathology, Madras Medical College and Assistant to the Professor of Bio-Chemistry of the same College could not practise as per G. O. No. 2232 Public (Services) dated 22-11-37 and yet they were having general practice. I saw your comments also in the August 1938 issue of The Medical Practitioner under the caption 'An Ineffectual G. O.' Will you please let know your readers through the columns of your esteemed journal if the New Order restricting private practice to Government Doctors will permit Non-Clinical Professors, their Assistants and non-Clinical Lecturers to have Consulting Practice or will they be prohibited private practice altogether as per G. O. No. 2232 referred to above. Many of us apprehend if the New Order can be given effect at all in case of those who are already in service as was interpreted by the Surgeon-General relating to G. O. 2232 quoted above. Even in case it effects those already in service such of the Government Medical Officers who have been lucky to be in Madras all through their life time have ways and means to nullify this or any other order in the way it was done regarding G. O. No. 2232 quoted above.

Anti-Favouritism.

LEAVE OUT OF INDIA.

I trust you will not be annoyed if I say that you were partly responsible to induce the Government to do away with Study Leave that was granted to the members of the Madras Medical Service. In lieu of this the Government have been granting leave out of India to those who wished to qualify themselves with British medical qualifications. Of course both the Study Leave, and Leave out of India were out of reach to the unlucky Assistant-Surgeons who are working in the mofussil stations. Those working in the City hospitals were the lucky few who got these favours for the mere asking. There is now another

hardship recently introduced I do not know at whose instance. I am told the Assistant-Surgeon who will be given leave out of India for qualifying himself with English qualifications must be an M.D., or M.S., or one who has passed his preliminary F.R.C.S. The ostensible reason for this move it is said, is to encourage medical graduates to respect the higher qualifications available in their own province. This argument is as flimsy as it is inconsistent with the patriotic sentiment of assessing equal values for foreign and indigenous medical qualifications. The Madras University prescribes M.D. or M.S. as the qualifications equivalent to M.R.C.P. and F.R.C.S. respectively to hold the appointment of professors in the Medical Colleges. Then why should Government prefer M. Ds. or M. Ss. to grant Leave out of India to those who are only M.B.B.Ss. I am afraid if the Hon'ble the Public Health Minister knows that temporary Assistant-Surgeons fresh from College got chances to qualify themselves for M. D. and M. S. qualifications and the senior permanent Assistant-Surgeons in the moffusil could not aspire to these posts not having the chance of being transferred to City Hospitals as it was not possible to appear for these degrees unless one works in the City teaching institutions. That being the case the juniors in service have now better chances to have higher foreign qualifications having been fortunate to be an M.D. or M.S. already. When the time comes for the selection of Civil-Surgeons the seniors will be hard hit for no fault of theirs as the juniors will be considered as better qualified.

Favouritism which has led to various anomalies in service was the rule during

the regime of old Government. All of us are meekly submitting ourselves to the various reforms introduced by the Congress Government which have reduced our prosperity to a great extent. We have done it without grumbling in the larger interests of the profession and the Public Health Minister did acknowledge this in his inaugural address at Bangalore on 22-5-39 when he opened the Mysore Independent Medical Practitioners' Conference. It is likely that neither the Minister nor the present Surgeon-General are likely to know the past sufferings of the moffusil Assistant-Surgeons and I make the following suggestion for their kind and sympathetic consideration through your valuable columns as I am afraid of direct action for obvious reasons.

The Assistant-Surgeons above ten years service feel it delicate to compete with young graduates for M.D. or M.S. degrees and work in the wards of the City hospitals under the Assistant-Surgeons who are very junior to them. So the Government may be pleased to relax the rule in the case of such Assistant-Surgeons and grant them Leave out of India for Study purposes for not more than two years in the course of their service.

The intention of the Government to encourage the higher qualifications of the local University will be satisfactorily fulfilled if the Government do not grant leave to their officers holding M. D. and M. S. degrees to go to England for qualifying for M. R. C. P. and F. R. C. S. qualifications except when and as services are required in the Medical Department of persons with special qualifications not available in this country.

*A Moffusil Assistant-Surgeon,
In a retiring mood.*

NOTICE.

An Omission: We regret that the name of Dr. Y. Suryanarayana Rao was by mistake not printed in the list of Honorary Members, P. S. R. M. Ps'. Association published in the journal last month. (Ed.)

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.

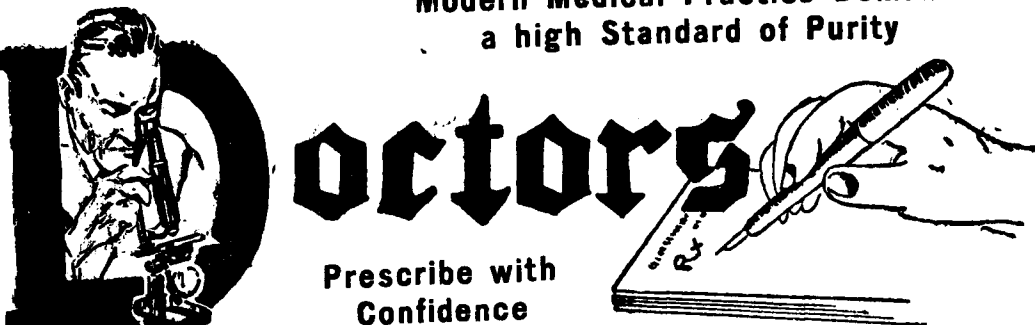
Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the Months of March & April 1939.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance on 28-2-1939 ...	126 8 9	Postage ...	9 10 9
Subscriptions received from the members ...	107 4 0	Telegrams ...	1 10 0
Entrance fees received from 9 new members ...	2 4 0	Contribution paid to District Branches :-	
		Rs. A. P.	
		Malabar ...	20 0 0
		North Arcot ...	11 0 0
		Tinnevely ...	8 0 0
		Kurnool ...	3 0 0
		Vizag ...	1 0 0
			43 0 0
		Pay for two clerks @ Rs. 10 and Rs. 5 for February and March. Amount credited to The Medical Practitioner from the subscription received from 35 members ...	30 0 0
		Printing Charges ...	17 8 0
		Stationery ...	9 4 0
			0 2 0
			111 2 9
		Cash Balance :	
		Savings Banks ...	124 2 0
		Cash in Office ...	0 12 0
			124 14 0
	236 0 9		236 0 9

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

Modern Medical Practice Demands
a high Standard of Purity



Doctors

Prescribe with
Confidence

ZANDU'S B. P. Products and Pharmaceuticals where quality, Purity, Uniformity and Therapeutic Activity stand Supreme, supported by a Guarantee, to conform with B. P. Standards.

Special Concession Rates Offered to Charitable Mission Hospitals.

"ZANDU" Brand Products are obtainable from:

The Chief Agents: **Messrs. DAMODER & CO.,**

78, China Bazar Road, G. T., Madras.

And also from their Sub-Agents in Madras Presidency.

ON shortening convalescence

Especially after a long illness, the patient's will-to-get-well is offset by habit. Anxieties have been set up during sickness which need to be controlled and dissipated. Long medical experience endorses the use of an alcoholic restorative in such cases, both for its immediate stimulus and its food value.

Hall's Wine has a much greater thermal-energy value than non-medicated wines or spirits, and it commands greater confidence from the patient, especially when you prescribe it.

No digestive activity is required to absorb grape sugar or its derivative alcohol. But the tonic elements in Hall's Wine improve metabolism still further, and facilitate the absorption of its rich iron-content.

Not only convalescents, but every patient who suffers from slight or serious anaemia will benefit from a course of Hall's Wine.

In all stages of convalescence, Hall's Wine may be prescribed with perfect confidence.

HALL'S WINE
Tonic Restorative



Distributors: J. HALLEY & CO., LTD.

P. O. Box 133,
Calcutta.

P. O. Box 84,
Lahore

P. O. Box 34,
Karachi

P. O. Box 466,
Bombay

HW 78

IN THIS ONE WAY WE CAN HELP!

We are determined to sell only those goods which have proved to be the best of their kind—in

SURGICAL INSTRUMENTS

All our instruments are made with micrometric exactness of regular Carbon Steel, "Surgico" Rustless Steel and Krupp "V 2 A" Patented Rustless Steel—useful for AMPUTATION, POST-MORTEM, DISSECTING, DRESSING, DIAGNOSTIC, FISTULA, HERNIA, EYE, EAR, NASAL, DERMAL, ORAL, TONSIL, DENTAL, TRACHEAL, LARYNGEAL, STOMACH, INTESTINAL, MIDWIFERY, GALL BLADDER, RECTAL, PROSTATIC, PHIMOSIS, VESICAL, URETHRAL, URETERAL AND INSTRUMENTS FOR EVERY CLASS OF SURGICAL WORK—ALSO

HOSPITAL REQUISITES

of absolute uniformity, absolute dependability, supplies that will do their work well, satisfyingly well—all at a fair price and latest.

HYPO AND SERUM RUSTLESS NEEDLES
KALMERID SURGICAL SUTURES
ANAESTHETIC APPARATUS
MICROSCOPES AND ACCESSORIES
LABORATORY APPARATUS AND GLASSWARE
ADHESIVE PLASTERS IN VARIOUS SIZES
STAINLESS STEEL HOSPITAL WARE
SYRINGES FOR ASPIRATION AND INJECTION
HIGH PRESSURE STERILIZERS, PORTABLE AND STANDARD
SURGICAL RUBBER GOODS OF BEST MAKES
HOSPITAL FURNITURE—SELECTED QUALITY
SICK-ROOM UTENSILS OF EVERY KIND
ELECTRO DIAGNOSTIC SETS
SPHYGMOMANOMETERS OF RELIABLE MAKES
SURGICAL AND DISPENSING SUNDRIES
CONTRACEPTIVE PRODUCTS OF H-R MAKE
ARTIFICIAL LIMBS, DEFORMITY AND FRACTURE APPARATUS,
SPLINTS, ELASTIC HOSIERY, ABDOMINAL SUPPORTERS,
HERNIA TRUSSES, SUSPENSORIES, CRUTCHES, Etc.

All selected merchandise described and illustrated in our current 500-page Catalogue. Copies mailed upon request to Hospitals and Surgeons. Whatever you need you will find it here. Quality is our foremost consideration and prices are kept at the lowest level consistent with the highest quality.

BOMBAY SURGICAL CO.

"The Quality House"

New Charni Road.....BOMBAY.

Telegrams: "SURGICO."]

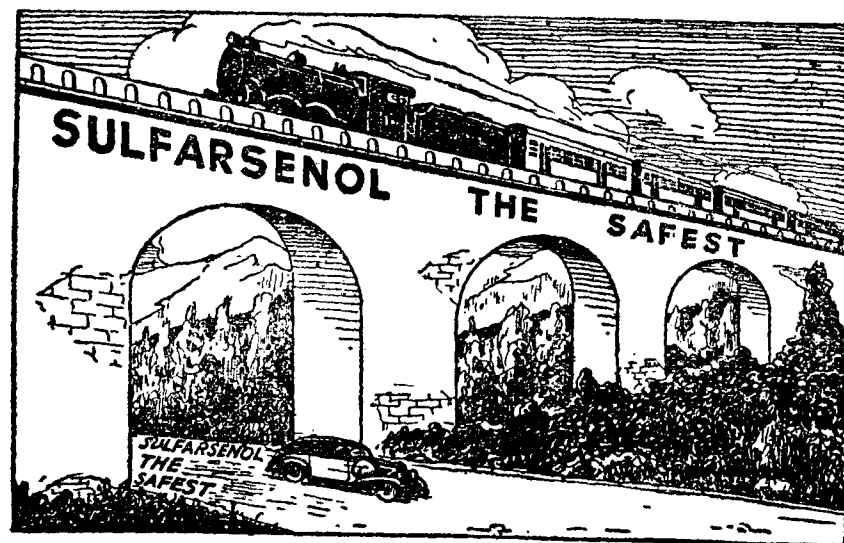
[Telephone No. 41936

We undertake REPAIRING, SHARPENING and PLATING work of every kind.

*Patients prefer
painless
injections!*



ARSENO-SOLVENT
ensures
painless administration of
SULFARSENOL



The Anglo French Drug Co., (Eastern) Limited,

POST BOX No. 460

BOMBAY.

Printed by Mr. M. S. Ekambaram, Manager, SOLDER & Co., Triplicane, Madras and Published by the Managing Editor, Dr. V. Rama Kamath, 147, Purasawalkam High Road, Vepery, Madras.

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

ASSOCIATE EDITORS

Capt. E. S. Gopalan, M.B., M.S.; A.I.R.O., (Madras).

SCIENTIFIC SECTION

Dr. S. S. Rau, M.D., (Bombay).

BOARD OF ASSOCIATES.

Dr. K. Narayana Murthi, M.D.,

(Medicine)

Dr. B. M. Sundaravadanam, B.A.M.B., F.R.C.S. (Eng.)

(Surgery)

Dr. M. Subramania Aiyar, B.A., M.B.C.M.

(Midwifery & Gynaecology)

Dr. G. Joseph Gnanadickam, L.M.P.

(Ophthalmic Surgery)

Dr. T. S. Shetty, Z.L.O., D.O. (Vienna)

(Ear, Nose & Throat Surgery)

MENESTRIN CAPSULES

Doctors advise ladies dreading pregnancy to take Menestrin Capsules a week before the expected Menstrual Cycle, the time when the fertilised Ovum settles in the Uterus.

Over 5,000 doctors have tried Menestrin Capsules for the treatment of Amenorrhoea and as a Contraceptive and found them successful. It was only after getting this opinion that the Menestrin Capsules were offered for sale.

Available at all Chemists in Madras:

MANUFACTURED AT THE ORIENTAL RESEARCH LABORATORY,

Vepery, MADRAS.

Bombay Stockists: Messrs. P. M. ZAYERI & CO., Princess Street, BOMBAY.

CONTENTS.

Original Articles :	PAGE
Children's Diarrhoea in Summer By Dr. K. Narayanamurthi, M.D. ...	333
The General Practitioner and Common Eye Diseases—V (G. J. G.) ...	341
Some Common Ear Diseases By Dr. C. N. Narayanan, Z.L.O. ...	345
Abstracts :	
Epistaxis Etiology and Treatment By James P. Rigg, M.D. ...	351
Notes on Therapeutics, Diagnosis and other Medical Subjects :	
Toxic action of the Sulphanilamides on the Liver. A Warning ...	356
Mapharside in the Treatment of Syphilis a Clinical Study ...	356
Extrapleural Pneumothorax ...	357
The Prophylaxis of Tuberculous Empyema ...	357
Editorial :	
General Medical Service for the Public ...	358
News and Comments :	
New Order Changeth Giving Place to Old ...	361
Admission into Medical Colleges ...	363
Male Nurses bring down Registered Practitioners ...	364
Correspondence, Reports, etc. :	
New Order Changeth Giving Place to Old ...	365
P. S. R. M. Ps' Association ...	366
Statement of Receipts and Charges of the P. S. R. M. Ps' Association ...	367

THE Medical Practitioner

Annual Subscription { Inland Rs. 3
Foreign Rs. 4

Single Copy As 6

Vol. X]

JUNE, 1939

JUL 1939
No. 9
TADRA

Original Articles.

CHILDREN'S DIARRHOEA IN SUMMER

By

DR. K. NARAYANA MURTHI, M.D.

Honorary Physician, Government General Hospital, Madras.

When the Editor suggested to me that an article on diarrhoeas in children would be very useful during the season when diarrhoea is the prevailing disease in children, I was in a fix to decide under what head line the article should appear, as all the diarrhoeas occurring in children during the summer cannot always be classified as Summer Diarrhoea or Infantile Diarrhoea otherwise known in text books as Cholera-Infantum or Epidemic Diarrhoea. That diarrhoea attacks children more in summer throughout the world nobody can deny. Equally true it is that the mortality rate in children due to diarrhoea is the highest in the summer though diarrhoea prevails in milder forms all the year round. It is mentioned by Holt and Holland that in the New York City the deaths for a period of five years due to Measles, Scarlet fever, Pertussis, Typhoid and Diphtheria for all ages were 12,439, whereas deaths due to diarrhoea of children under two years for the same period were 13,351. In the existing conditions of the working of Public Health Administration in this Province and in all Provinces in India it will not be possible to make any accurate statistical statement about diseases or deaths due to diseases but it may be safely said that all the Provinces in India are paying a very heavy toll of deaths on account of diarrhoea in children and that these deaths occur mostly in summer.

I have therefore chosen to call the article 'Children's Diarrhoea in Summer'.

ÆTIOLOGY : It is to be noted that children under two years are more vulnerable to the attacks of diarrhoeal diseases than those above that age. This may be due to the fact that the younger children have to withstand a proportionately heavy load of digestive processes required by a growing body. So any chemical, mechanical or bacteriological disturbance is likely to tell upon more on the delicate structure in children under two years.

Though diarrhoeal diseases are met with in all seasons it must be within the experience of the medical practitioners that the incidence of the disease is highest in the hot season. It was considered at one time that heat increases the bacterial contamination of cow's milk. But in countries where greatest attention is paid in pasturising and sterilising milk there still remains a high mortality from this disease in summer. It is now considered that heat itself has direct effect on the infants, being a powerful depressant disturbing the healthy metabolic activities and predisposing the infants to infection from bacteria usually found in the food or the utensils used in feeding.

Children in cities especially where a large section of women are employed in industries suffer from diarrhoea to a large

TWO TRIED REMEDIES

— PRESCRIBED BY DOCTORS WITH CONFIDENCE —

I ZAMA FOR ECZEMA II

I KOO-KOON FOR WHOOPING COUGH II

Give them a trial when other remedies fail and convince yourself of the truthfulness of the statement.

Available at all Chemists in Madras

OR

At The **ORIENTAL RESEARCH LABORATORY,**
Vepery, Madras.

PHONE No: 3034

Dr. S. R. BHAT

M. B. B. S., L. D. Sc. (Calcutta)

DENTAL SURGEON

THE X-RAY & ELECTRO-THERAPEUTIC DENTAL SURGERY

289, Esplanade, Madras. Opposite to Corporation Fruit Market.

The most well-equipped Dental Surgery with all electrical apparatus such as X-Ray, Ultra-Violet Ray, High frequency current etc.

extent. This is due to the artificial feeding in addition to other common conditions in City life such as poverty, bad food, bad hygiene and ignorance of mothers regarding care of infants. The most important aetiological factor in the causation of diarrhoea in children is artificial feeding. It is found out that less than 5 per cent of breast fed children suffer from diarrhoea and that fatal cases of diarrhoea in breast fed children are very rare. Having discussed the general aetiological factors that give rise to diarrhoea in children it is necessary to have an idea as to how far bacteria alone are responsible as a causating factor. Many types of micro-organisms have been isolated from the stools in different epidemics and it was found that *Bacillus Proteus vulgaris*, *B. coli*, *Streptococci*, *B. Enteritidis*, various strains of dysentery bacilli, Morgan's bacillus, members of the Paratyphoid group are the commonest organisms found in the stool. Though there may be organisms or a group of organisms in the intestinal flora in disorders of intestines, these do not multiply and produce serious disturbances unless they get favourable conditions to multiply and these conditions as already mentioned are bad food, bad hygienic surroundings, and the summer heat. The irritating substance that actually produce diarrhoea are not organisms so much as are their products such as fatty acids derived from the sugar and fat of the food. The altered conditions mentioned above evidently depend upon the changes in the secretions in the stomach, liver, pancreas and the intestines. It is just possible that the atmospheric heat depresses the vitality of the child to such an extent that the normal secretions in the gastro-intestinal tract are either altered or diminished with the result that the food instead of being digested, stagnates and affords an excellent media for the bacteria to grow and multiply. There arises at times a doubt whether prevalence of diarrhoea during summer is due to direct contagion. From the history we get from the parents that simultaneously two or three milk fed children suffered from diarrhoea instead of one after the other in houses with good hygienic surroundings and where milk is

expected to be well boiled, it is possible that the toxins given out by bacteria and not bacteria themselves may not be responsible for the onset of diarrhoea.

CLINICAL FORMS: Clinically children's diarrhoeas may be grouped under three headings depending upon the symptoms: (1) The mild type with local symptoms but without marked constitutional symptoms, (2) the severe type with local symptom and severe constitutional symptoms and (3) Cholera Infantum. The three forms are to be mentioned for the purpose of description but usually one merges into another.

THE MILD TYPE: Children under six months usually start with gastric as well as intestinal symptoms indicated by vomiting and purging. In older children the gastric symptoms are usually absent. Diarrhoea is preceded with colicky pain and tympanitis as could be judged from the sharp cry, restlessness and drawing up of the legs. If the stools are large they may be three or four a day if they are small they may be more frequent ten to twelve a day. The colour is at first yellow, then yellowish green and finally grass green. This colour is due to the presence of bile pigment, biliverdin. If milk was the food of the child, masses of undigested fat in the milk are present. The reaction of stool is invariably acid. The odour is acid or foul. The stools are frothy but do not contain blood or slime. Fever if present does not rise above 101°F, other constitutional symptoms are very mild if present. In older children all the above symptoms are milder.

The course and termination depends upon the previous condition of the patient, the nature of the exciting cause and the treatment adopted. An otherwise healthy child may be all right in three or four days. If rickety and delicate an attack of diarrhoea in hot season may predispose the child for further attacks of diarrhoea or other intercurrent diseases.

THE SEVERE TYPE: This may come on as a recrudescence after a mild attack in hot weather especially in an impro-

perly treated child or may develop suddenly. To begin with there may be no gastro-intestinal symptoms at all and the child may be laid up with high fever ranging from 102° to 106°F attendant with restlessness. Or there may be signs of stupor with sunken eyes and weak pulse. There may also be excitement and convulsions. Vomiting may be an early important symptom and as soon as diarrhoea starts the fever may drop down considerably and also the nervous symptoms. Usually the baby has insatiable thirst; vomiting does not generally last long in older children but in infants it is a persistent and troublesome symptom there being an inclination to vomit even without taking food. The stools are preceded by colicky pain. The colour of the stools is yellow to begin with; later on green, gray or even brown. They are passed with lot of flatus and are foul. Later on the bad smell may disappear especially when they become mucoid. This happens when the lesion travels down to ileum and colon and the stools may even contain blood. In most favourable circumstances, under good treatment, an otherwise healthy child shows signs of improvement after two or three days of anxiety. The stools which might have been ten to thirty a day may be now only four to six and they gradually assume normal character. The younger the infant the graver the prognosis. In the graver cases, the temperature and vomiting continues, prostration gets marked along with other constitutional symptoms. The effect of dehydration are now very marked as is indicated by depressed fontanel and sunken eyes. The skin is dry and has no elasticity. When pinched up in fold this remains for several seconds. The urine is scanty or may be suppressed altogether. At this stage coma may set in and the infant succumbs either to exhaustion attendant with convulsions or hyperpyrexia. Attacks of intestinal indigestion which begin with severe constitutional symptoms attendant with high fever but without diarrhoea to begin with usually take a serious turn. All the above symptoms may become subacute or chronic with the lowering of temperature finally the patient may waste

away and die of any intercurrent disease such as broncho-pneumonia, nephritis etc. Even in this variety, children over two years stand the disease better than the younger children.

CHOLERA INFANTUM: It rarely occurs in children who have been previously healthy. The choleric form symptoms come on very rapidly and a child considered healthy may be at death's door within a few hours. The child is seen in great prostration with a steady rise of temperature before vomiting and purging start. Vomiting may be the first symptom which is soon followed by diarrhoea. The stools are at first one or two per hour and pale brown in colour and offensive. Later they are serous with little or no smell and are colourless in fact resemble the rice water stools. The first stools are acid and when it becomes serous they are neutral or alkaline. The child is losing weight markedly day by day on account of loss of water which is considered to be 20 to 35 ounces a day depending upon the age of the child. To the extent of the loss of the body fluid the supply of sodium chloride is diminished. The child has the facies of a cholera patient. At the early stage the symptoms are of nervous irritation—child crying and rolling from side to side moving arms and legs with no purpose. At this stage it has incessant and insatiable thirst, drinks water or food only to vomit. Later the nervous excitement gives place to dullness and stupor ending in coma or convulsions. Temperature rises depending upon the severity of symptoms. In patients who recover it ranges from 101° to 102° and in fatal cases rises to 105° or 106° and before death may reach even 108°F. In the latter cases there is clammy perspiration and cold extremities not unlike those noticed in Cholera. Pulse rapid, weak and even imperceptible, respiration irregular, frequent or stertorous at the last stage. Tongue at first coated; later turns dry and red and looks like a piece of flesh. Urine scanty and later suppressed. There may be albumin in the urine and even tube casts. At times the body tempe-

rature may be normal or even sub-normal but rectal temperature may be high. The nervous symptoms may be due to cerebral anæmia, cerebral venous hyperæmia and uræmia. A remarkable condition called sclerema when the skin and underlying fat become cold and hardened has been described in books, the appearance has been compared to that of half frozen cadaver.

In the course of severe diarrhoea as in cholera infantum acidosis, may start due to dehydration as is evidenced by 'air hunger' and characteristic respiration attendant with piercing cry. Majority of children who develop these symptoms die. Though acidosis is controlled by the administration of Soda bicarb by mouth, skin or vein, the diarrhoea does not cease but on the other hand increases so also vomiting.

DIAGNOSIS: As many febrile diseases in children especially, the exanthemata, pneumonia, etc., start with acute gastric and intestinal symptoms it may often be difficult to make out if the digestive symptoms are primary or secondary. Usually when the digestive symptoms are secondary they abate after a day or two though other constitutional symptoms may steadily increase. So we have to carefully watch the case for some time. At times the nervous symptoms attending acute indigestion are so severe that it may be rather difficult to exclude meningitis unless a lumbar puncture is made. Acute cases where colon is involved may resemble intussusception. In the latter the onset is more sudden; collapse vomiting and passing of blood are noticeable without temperature and tumour can be felt in the abdomen which is rigid.

PROGNOSIS: This depends on the previous health of the child and the types of intestinal indigestion from which the child is suffering. Children suffering from malnutrition fall a victim even to mild attacks. The prognosis depends also upon the surroundings of the child, and whether or not prompt and suitable treatment is afforded. Severe forms attendant with dehydration and

acidosis are indeed very serious. A persistent vomiting with or without high fever is a bad prognostic sign. Children suffering from rickets, whooping cough or any such diseases usually do not fare well. In cholera infantum the prognosis is always very grave.

PROPHYLAXIS: A clear understanding of the ætiology of diarrhoea in children and the causes of its occurrence in graver forms in summer should convince the physician of the importance of prophylaxis. The first item in prevention is to provide hygienic surroundings and insist on the maintenance of sanitary conditions in cities where heat is often great, the air and water impure and the food not always fresh. It is true that the medical profession has no control over public health but lot of work could be done by them in creating a sanitary conscience in the parents of children.

The second item in the prophylaxis relates to food and feeding. Maternal nursing should be encouraged by all possible ways always remembering that the fatal cases due to diarrhoea are less than 5 per cent of the total number, no matter how bad the surroundings and how ignorant the mothers. Breast feeding requires but little experience and even the mothers of low grade intelligence amongst the poor do not require to be taught as to how to nurse their babies. But artificial feeding is certainly a tedious task and not very successful even amongst the rich and educated people. Artificial feeding itself may not bring on intestinal indigestion but improper feeding does it undoubtedly. Mothers should be advised to avoid overfeeding during days of excessive heat. They must be told that during summer, children should be given less food and more water between the feedings. It is well mothers know that children feel as thirsty or perhaps more than adults and they can demand this only by crying and therefore a child's crying should not be always construed to be due to hunger and the child overfed.

Doctors will have to take up the role of social workers which they really are and

tell the rich amongst their patients to build sheds here and there to distribute pure milk to poor children and make these centres for educating poor mothers on matters of infant feeding and hygiene. Doctors could do this philanthropic work much more effectively than is being done by a few well meaning but fussy lay social workers.

The depressing effect of summer heat on children should be borne in mind and whenever possible delicate children should be sent to cooler places. This may even be done as a curative measure while an attack is on and does not yield to suitable rational treatment. There is already a tendency in Indian mothers to keep children indoors for every illness. They must be told that fresh air is of the utmost importance as part of treatment no matter how much fever or prostration there may be. Children who are unable to walk should be restricted to bed till they are all right and strong enough to walk.

DIET: The successful treatment of diarrhoea in children depends to a large extent on judicious selection of food and feeding. It should be remembered at the outset that during the early stage of acute cases, digestion is practically arrested and food in any form should not be given at this stage. Though in breast fed children the severe forms of diarrhoea are extremely rare, if such children get diarrhoea attendant with vomiting, nursing should be withheld so long as there is disposition for vomiting. Thirst may be allayed by giving small quantities of rice water and barley water. If these are refused or vomited the best thing to do is to starve the child completely for a few hours even for a day. After the stomach has been allowed rest the child may have the breast feeding for two or three minutes at a time and given in the interval rice water, barley water or diluted butter milk. The butter milk should not be too sour and should be carefully prepared in clean sterile vessel. The best thing to do is to prepare butter milk by the addition of Lactic acid a teaspoonful to a pint of milk. The acid should be dropped gradually and milk

stirred all the while and kept aside for sometime. Artificial powdered butter milk such as Eledon is now available in the market and will be a good substitute as it contains fat and carbohydrates in required quantities. When the breast fed child shows signs of improvement the mother may nurse the child once in four hours and between the feeding given plain water or rice water sweetened with sugar or glucose. Later nursing may be gradually increased till the breast taken exclusively.

In the case of artificially fed children all food especially milk should be immediately stopped. The duration of starving the children depends upon the amount of vomiting. Later when the vomiting is controlled, the older children may be given plain arrowroot conge without milk but sweetened a bit. To this may be added butter milk. There are a few cases when vomiting is a prominent symptom persisting for a number of days. In these cases it is advisable to have recourse to nasal feeding through a rubber catheter allowing the food only by drops. If this successful large quantities may be allowed till the vomiting completely stops. It is necessary that soon after vomiting stops the child should be properly nourished to make up for the constant drain on the system which is deprived of water. Any amount of patience will not be too much in the matter of feeding. There should not be undue hurry to rush to diet soon after the symptoms are better. The food should be gradually increased first giving the child $1/4$ the usual quantity of food and the intervals between feeding should also be gradually decreased from four hours to two hours depending upon severity of symptoms and the quantity of food taken. The experience of pediatricians seems to be that butter-milk is an ideal diet during the course of acute symptoms and during convalescence. In houses where pure butter milk cannot be had and the people cannot afford to pay for artificial butter milk powder (Eledon), albumen water will be a good substitute. To prepare albumen water the whites of two or three eggs may be stirred in a pint of clean water to which

may be added a teaspoonful of brandy. This is both stimulating as well as nourishing. If there is no indication to add brandy a tablespoon of lime juice may be added to the albumen water. The albumen water should not be stored in close mouthed bottle but kept in a glass jug covered with a piece of thin muslin. Or else it is likely to decompose soon. In older days raw meat juice was also a favourite diet. A pound of beef, mutton or chicken is well minced and poured in a pint of cold water and made to stand for a couple of hours. Then the meat should be well squeezed and the juice strained and slowly heated to the boiling point, stirring the juice all the while. Any fat found at the top is skimmed off and sufficient salt added. A few teaspoons of this are given either plain or diluted. These naturally prepared albumen foods are very much to be preferred to various artificial substances. It should also be remembered that in case of artificially fed children as soon as vomiting stops breast feeding is the ideal diet.

Usually in actual practice especially in poor and middle class houses a choice between arrowroot congy, whey, albumen water or meat juice has to be made. If motions are very foul, frothy, it is advisable to depend upon carbohydrate diet plain arrowroot congy (without milk) to begin with and then same congy with 1/4, 1/3, 1/2 the quantity of boiled milk added on to it. On the other hand if the stools have a sour acid smell without being foul, albumen water, meat juice may be chosen. On no account any food however ideal, should be forced on the child if it does not like the same. No hard and fast rules can be laid down about diet. The rationale to be followed is to try a suitable food and watch the stools. The nature of the stools, the condition of the patient should be the guiding factor in selecting the food.

MEDICAL TREATMENT: The important factors to be remembered in the treatment of diarrhoea of children in summer that the diarrhoea is a result of relaxation of the blood vessel walls in the intestine on account of the high heat upon splanchnic nerves and to irritant materials

derived from germs due to defective secretions of the digestive juices. The indications for treatment are, first to attend to the hygienic surroundings and after having done that, to find out the causes for the failure of digestion and absorption which cause dehydration and intoxication. So if there be a history of the child having taken indigestible food, the stomach and the entire intestinal tract should first be cleaned off the remnants of undigested food and the irritating and toxic substances produced by altered secretions due to chemical and bacterial action. Therefore, food should be withheld till vomiting is controlled and no attempt should be made to stop discharges. To begin with, if the patient is seen early it is always safe to give a mild purgative. Divided doses of calomel or grey powder may be given. Pulvis Rhei Co. also answers the purpose very well. If vomiting is persistent even after starvation, stomach wash may be had recourse to. Osler speaks of this in his book 'in the very warmest manner'. Text books make mention of castor oil to evacuate the intestines but in 99 per cent of cases it is vomited immediately. Irrigation of the large bowel is another method advocated by Osler. This is accomplished by inserting to the rectal nozzle of an enema can, a soft rubber catheter preferably of the female pattern. Through this catheter the inflow should be directed into the rectum. By the side of the rectal nozzle another rubber tube of larger caliber should be inserted into the anus to serve as an outflow tube. The solution to be used may be normal saline or boric acid a dram to a pint. The temperature of the solution should depend upon the body temperature of the patient. If fever is high the solution may be used cold or ice cold. If body temperature ranges from 100 to 102° F, the temperature of the solution may be 100° F. The colon irrigation is another device to reduce high temperature. The irrigation should be done every four hours and the bowel washed till clear solution comes out of the outflow tube. Stomach and bowel wash may have to be adopted in cases when vomiting and purging cannot be controlled

by other means as in cases of cholera infantum.

No reliance can be placed on drugs as antiseptics or astringents. It is considered by some that small divided doses of calomel, grey powder or podophyllin resin do a good deal in restoring the normal secretions of the gastro-intestinal tract by first acting on the liver. They say any one of these may be continuously used till discharge from intestines changes its colour from pasty white to that of bile. The advocates of this treatment say that if astringents are given before the intestinal discharge turns to bilious colour, the toxic symptoms will aggravate and the fever also will rise high. This has been my experience to a large extent. The present tendency to rush to patent intestinal antiseptics or astringents which are described in laudable terms and in persuasive language in advertisements should be checked at least in cases of diarrhoea of children. Next to calomel, the drug which has a reputation is bismuth. It has been invariably my experience that whenever Bismuth Subnitrate was prescribed the low fever rose up and the toxic symptoms became worse. Bismuth Carb. is tolerated better and some give it in large doses ranging from 10 to 20 grs. every two or three hours to a child one year old. I rarely use any preparation of Bismuth, for, my first experience with Bismuth Subnitrate has made a very bad impression on me.

The drug which I rarely use in case of children is opium. If at all I feel an urgent indication for it, I use only the Tint. Camphor Co. Opium does certainly more harm than good. If it is given before the intestinal tract is thoroughly evacuated especially when its contents are foul, it will certainly lead to graver danger. Even the advocates of opium therapy will do well to avoid opium altogether in the acute stage of the disease. In cholera infantum serious symptoms develop with such great rapidity when the administration of medicine by mouth or rectum is impossible, one has to resort to Morphia hypodermically preferably in combination

with Atropine. A child one year old may have 1/80 gr. of Morphia every two hours till symptoms are controlled. It is my opinion that Indian children do not tolerate opium well.

When the colour of the stools turn bilious by the administration of calomel, grey powder or podophyllin resin, one or other prescriptions (all for a child one year old) mentioned below have been tried by me with varying success. To begin with, especially when there is a history of the child having been given some bad or heavy food, I give 1/4 gr. dose of calomel every hour till 2 grs. are given then reduce the dose to 1/16 gr. every two hours or four hours and keep it on till the stools turn yellow. In case there is no vomiting I prescribe

R/
Calomel grs. 2,
Salol grs. 6.
Pulvis creta Aromat grs. 16,
make 8 powders

one in honey every four hours. Later reduce calomel to gr. one and increase Pulvis Creta Aromat to grs. 20 or 30. Grey powder may be substituted for calomel but the dose may be double. If in the meanwhile, the stools contain slime and blood, I take in that case is involved and give the child, one year old, the following:

R/
Gum Acacia dr. 1.
Ol. Rœini, dr. 1.
Salol. grs. 5.
Spt. Cinnamomi m. 5.
Aqua Chloroform. oz. 1.

1/8 the part every two to four hours depending upon straining, the less the straining the longer the interval of the dose.

For diarrhoea without slime any one of the following may be tried:

R/
Acid Sulphurici Aromatici m. 10.
Tint. Camphor Co. m. 40.
Ext. Hæmatoxylon Liq. m. 30.
Syr. Zingiberis. drs. 2.
Aqua Chloroform. oz. 1.

1/8th part every four hours.

If the tongue is coated it is advisable to give an alkaline mixture instead of acid.

R/

Pulvis Creta Aromat.	grs. 30.
Ext. Hæmotoxylon Liq.	m. 30.
Tint. Kino.	m. 20.
Tint. Camphor Co.	m. 40.
Syr. Zingiberis.	drs. 2.
Aqua Chloroform add	oz. 1.

1/8th part every four hours.

In some cases the above remedies only check the diarrhoea for the time being and the diarrhoea returns soon after they are withdrawn. This is due to want of tone in the intestines and the following has been found useful in these cases :

R/

Pulv. Rhei	grs. 4
Resinae Podophylli	grs. 1/8
Pulvis Ipecac	grs. 1/2
Pulvis Creta Aromat	grs. 15
Ft. pulv No. 8.	

One for a dose thrice a day in honey.

Controlling the temperature is another indication in diarrhoea of children. If ice to the head and cold sponging does not bring down the temperature in case of high fever especially in cholera infantum bowel irrigation with ice cold water should be had recourse to. At times it so happens that the rectal temperature is high and the body temperature is subnormal. In these cases patients should be given hot drinks, external heat to be applied by means of hot water bottles or friction of limbs resorted to.

At the very early stage when there are no signs of prostration the following mixture will not only check the vomiting but also the high fever :—

R/

Tint. Aconite.	m. 5,
Vin. Ipecac.	m. 2.
Tint. Ziberis Forte.	m. 3.

Spt. Aron Aromat.	m. 15.
Spt. Aether nit.	m. 15.
Spt. Chloroformi.	m. 15.
Aqua Camphor add	oz. 1.

1/8th part every 2 hours for four doses and then every 4 hours.

For restlessness and insatiable thirst and also for convulsions the following mixture gives good relief :

R/

Pot. Citras.	grs. 15.
Pot. Bromide.	grs. 20.
Chloral Hydras.	grs. 8.
Tint. Hyoscyami.	m. 20.
Spt. Aether Nit.	m. 20.
Spt. Aron Aromat.	m. 20.
Syr. Zingiberis.	dr. 2.
Aqua Camphor add	oz. 1.

1/8th part every 2 hours for the first four doses and then every four hours.

Dehydration and the resulting complication especially acidosis is yet another condition to be guarded against. In all forms of diarrhoea especially in cholera infantum, the great drain of water and salts must be prevented. Sterile normal saline 10 ounces subcutaneously should be given twice a day for a child one year old. This may be combined with 5 per cent glucose. Some advocate saline by the drip method through nose by means of a small rubber catheter allowing 10 to 15 drops per minute. On no account dehydration is to be neglected.

When acidosis is diagnosed alkalies (Soda Bicarb) should be given to render the urine alkaline. 15 grs. doses may be given every two hours. If it is not possible to administer it by mouth it may be given intravenously. For prostration and collapse in cholera infantum ether and brandy may be tried hypodermically. Judicious administration of brandy by mouth should be had recourse to from the very commencement in severe cases of diarrhoea.

THE GENERAL PRACTITIONER AND COMMON EYE DISEASES—V

(G. J. G.)

CORNEAL ULCER.

As mentioned in the previous paper, corneal ulcer is the foremost cause of blindness in adult life among the working classes in India. Inflammation in any other part of the body, unless very serious, does not result in the impairment of its functions, but in the cornea, an ulcer leaves a scar which obstructs the vision if anywhere near the centre making the eye practically blind. The anxiety of the treating doctor is doublefold. He has to try his best to heal the inflammatory condition and may succeed with the greatest difficulty, but in the end, the patient goes home grumbling because in spite of all his suffering and expenses, the vision is bad or nil and in addition there is an ugly scar left in the eye. If the patient's other eye had already been lost due to any cause, the misery of the man and his family can be imagined. The poignancy of the whole affair is this ulcer starts with a small and scarcely noticeable trauma to the cornea, which if it had been treated properly and in time would not have gone to the destructive stage. Hence the need for proper care and attention during the earlier stage of the ulcer when the general practitioner is most likely to see it.

SIMPLE ULCERS.

I classify all uncomplicated and superficial ulcers under this head. They generally start as an abrasion or wound on the cornea. I have dealt in detail with the treatment of such a condition in the previous paper. If the case comes early and the eye is clean, application of Argyrol drops and Zinc sulphate ointment once a day, with the eye bandaged till the epithelium covers over, will heal the condition quite easily.

But, if there be an associated conjunctivitis, the latter should be treated as a regular acute conjunctivitis, with Silver Nitrate solution, etc. (Vide Part III). The eye should not be bandaged in such

cases. By the time the conjunctival inflammation subsides, the corneal condition is healed. Any opacity that is left may be treated with application of yellow oxide of mercury 2% ointment once a day.

Superficial ulcers are also seen as secondary to other diseases. We see them often in the severe forms of acute conjunctivitis. They are seen as superficial grey spots on the cornea with heavy conjunctival discharge. The treatment of acute conjunctivitis is sufficient to heal the condition.

Similar ulcers are seen secondary to Trachoma, Diplo-bacillary conjunctivitis, Phlyctenular conjunctivitis, etc. Smallpox also produces a sort of ulcerative keratitis. These shall be dealt with later under their respective heads.

SEPTIC ULCERS.

What is more difficult to treat is the septic ulcer of the cornea. The patient usually comes a few days after the start of the ulcer. The exciting cause is some superficial trauma, but when the patient comes to you, you see a very red eye, swollen lids, intense lachrimation and photophobia. He is in agony with pain. On closer inspection, you see a pericorneal injection and an yellowish-white area on the cornea with denuded epithelium. The cornea is often steamy and in addition you may see, in severe cases, pus collected in the chamber, which is seen in a half-moon like shape. Its horizontal upper line indicates it is fluid collected inside the chamber.

It is very difficult to check the destructive process of the ulcer at this stage. Treatment in the earlier stages is very much easier. Usually, the start is from a very trivial affection, as slashing of a twig, splashing of mud, foreign body, etc. In fact it might be so trivial the patient himself may not be aware of it. It is not the traumatism but the later

infection that is of practical importance. It is possible the injuring material itself carries the infection to the cornea. Or, people use a lot of quack and dirty remedies which make the injured tissues get infected. Or, the conjunctiva itself is infected and the bacteria there infect the abrasion and make it septic. But, what is very often the source of infection is pus in the lachrymal sac. People with dacryocystitis scarcely care about it. Pus in the lachrymal sac is highly infective and virulent. But, as long as the corneal epithelium is intact, there is no danger. The intact, healthy epithelium is impermeable to pyogenic organisms and forms what is called the first line of defence against bacterial invasion, but the moment there is even the slightest break in the epithelium, the micro-organisms get an immediate entry into the corneal substance and lead the whole eye to destruction. So, it is very necessary in all cases of abrasions or the ulcers of the cornea to examine for dacryocystitis. The doctor's fingers should instinctively go to the sac whenever he meets a corneal ulcer. Gentle pressure over the area of the sac will bring out mucus or purulent secretion through the puncta (See Part II for detail of technique).

The diagnosis of corneal ulcers in the stage in which we usually see them first is easy, but at times it might be difficult. The only other condition it might be confused with is keratitis. It must be remembered in an ulcer, there is a defect in the surface of the cornea, whereas in keratitis the inflammation is deep in the substance of the cornea without any defect or break in the epithelium. There are two methods by which this epithelial disturbance could be detected. Let the patient sit in front of a window. You will then see the reflection of the window on the cornea of both the eyes. In the unaffected eye, where there is no epithelial disturbance, you will see it clear and regular, but in the affected eye, where the surface of the cornea is irregular on account of the ulcer, the reflection will also be seen irregular and jagged. The second method is by staining the surface of the ulcer. If the epithelium is intact,

the cornea does not take any stain. Where there is a defect in the epithelium, the raw area can be stained with fluorescein. Put in a drop of 1% fluorescein and wash the excess in the conjunctival sac with zinc drops. Wait for a minute or two and then you will see a greenish patch over the area of the ulcer.

I am not dealing here with the progress and pathology of the corneal ulcer. It will be beyond the scope of this paper. I shall touch on only practical points.

The prognosis is grave in nearly all septic ulcers. One cannot easily say in which case we can stop the progress of the ulcer and in which case not. My best advice to the general practitioner will be to send immediately to the specialist every case of ulcer of the cornea even if it is in the early stage. The treatment advised here is only for such cases that cannot afford to go to an eye clinic.

A knowledge of the principles of treatment in corneal ulcers is essential before going into the details of the technique.

First of all, the source of infection in the eye, if any, should be removed. If there be a dacryocystitis, or even a mere regurgitation of fluid from the sac, it must be excised immediately. The conjunctival infection must be then attended to. Next, the virulent micro-organisms in the ulcer area itself must be destroyed. Thus far to combat the infection from without; next, we must enable the patient to resist the infection from within. First, we attend to the nutrition of the cornea. Owing to the inflamed condition of the eye and pus in the anterior chamber, the tension of the eye ball is raised and the cornea is put under a stretch. As you know, cornea has no blood vessels and its nutrition is through lymph channels only. When the cornea is under stretch due to raised intraocular tension, there is pressure on the lymph channels and the nutrition of the cornea is thus impaired. This helps a good deal in the spread of the ulcer. But, when we open the chamber and relieve the tension, there is an immediate flow of

lymph into the area and consequent supply of nutritive material and antibodies to fight the invading organisms. Next, the patient's general health and power of resistance must be raised. The worst forms of corneal ulcers are seen most often in people of diminished vitality, especially old people. These are the general principles in treatment. Coming to practical details:—

If there be dacryocystitis, the sac must be excised immediately. This shall be dealt with in a later paper.

Next comes the destruction of the bacteria which we do by actual cautery and then the reduction of the tension of the eye by paracentesis of the anterior chamber. We do these at one sitting. There are various methods of cauterisation. Their selection is a difficult matter for a non-specialist. It is better to follow one simple but sure method, which I describe below.

Anaesthesia is with Pantocaine 2% drops, three or four times, at an interval of about two minutes and adrenalin 1:1000 drops twice. The eye being inflamed, there is some amount of pain still present in the congested conjunctiva but it is bearable for the average patient. Insert the speculum and wash the eye well with Rivanol lotion 1:1000 dilution (an undiluted is quite good for the purpose). This is to disinfect the conjunctiva which is almost always infected. Take a steel cautery—any fine pointed steel piece will do, if you do not have the regular cautery—heat it red hot over a flame and touch the ulcer with the heated end so that the necrosing material over the ulcer including the bacteria is destroyed. Cauterise not only the raw surface of the ulcer but also the yellowish white infiltrated margin of the ulcer where the epithelium might be intact. It is here that the invading micro-organisms lie and so it is very important to cauterise this area particularly. It does not matter even if a bit of the healthy tissue is destroyed. What might appear to be healthy looking area to you might be at the point of infiltration by the spreading ulcer.

The cauterisation must be thorough. Wash the eye again with Rivanol lotion 1:1000 before the next step, namely paracentesis. Fix the eye with a fixation forceps, holding the conjunctiva close to the limbus about the horizontal line and with the other hand, make a small incision—say 2 or 3 mm. into the anterior chamber with a sharp keratome at the lower limbus. The moment the keratome is withdrawn, the hypopyon rushes out along with the aqueous. If it is thick and fibrinous, a little coaxing by gentle pressure on the scleral lip of the wound with a spatula will help it to come out. Remove the speculum immediately, put in drops of atropin 1% solution and Argyrol, apply liberally Zinc sulph ointment and close the eye with a pad.

(This paracentesis is almost always painful. In delicate and nervous people, a retrobulbar injection of Pantocaine solution 1:500 with two drops of adrenalin added to each c. cm., completely anaesthetises the eye. The injection is given from outside the lower lid, midway between the external and inferior recti muscles, the needle going along the side of the bulb to the posterior pole of the eye, where $\frac{1}{2}$ c. cm. of the pantocaine-adrenalin solution is deposited. It is advisable to draw the piston before the injection to be sure that the needle is not on a blood vessel, but this accident is very rare. A very fine, rustless needle should always be used for this purpose).

To raise the patient's resistance, protein shock therapy gives the best and quick results. The patient may be given an intramuscular injection of six to eight c. cm. of sterilised milk. If he is delicate and the febrile reaction will upset him, Aolon or Leucolon may be given instead of milk.

The same night, there is marked relief in pain. The next morning, the eye is left open without bandage. Clean the eye and apply atropin and argyrol drops and yellow oxide of mercury ointment 2%. This has to be continued every morning till the inflammatory condition subsides. If the ulcer shows any sign of further spreading, it has to be cauterised again. If the hypopyon reappears, it has to be let out by paracentesis. The milk injection may be repeated whenever the ulcer shows signs of worsening. There is likely to be some amount of pain every

night till there is a turn for the better. Aspirin may be given to relieve it, except on days when milk injection is given. Hot fomentation may relieve the pain, but it is inadvisable. It is likely to make the ulcer worse. A general tonic, clean bowels, nourishing but digestible food, all help towards a quicker healing. I am now trying Prontosil internally with some favourable results.

It is not all ulcers that have a happy ending or a regular standardised course. Sometimes, the ulcer progresses directly down and perforates the cornea. You find the patient coming to you one morning during the treatment, with the pain relieved, but with a prolapse of the iris through the perforated ulcer. A sneeze or cough had burst the chamber. The pain is relieved because of the relief in tension. The ulcer generally heals quickly alter the prolapse, because when the iris gets attached to the cornea, blood supply to the cornea is established and the destructive process is arrested. The treatment in this condition is simple. Clean the eye every morning gently with wet cotton wool (force will bring about further prolapse), put in a drop of Argyrol and keep the eye bandaged till the prolapsed iris flattens out. I would not advise the general practitioner to meddle with the prolapse. Later, when the eye is quiet, the patient may be sent to an eye hospital to prevent complications arising out of the adhesion of the iris to the cornea.

Sometimes, the whole of the cornea is destroyed and all the iris is pushed forward as a staphyloma, with only a thin membrane keeping it back from bursting. This condition is painful due to increased tension in the eye. The eye is lost and will never regain vision. In this case, just to relieve the pain, a horizontal incision may be made across the bulging mass (with of course preliminary anaesthesia, disinfection of the conjunctiva, etc.). The lens comes out through the incision, also a little vitreous. Close the eye immediately with a drop of Argyrol solution and bandage the eye. Dress the eye with Argyrol drops every

morning and in about a week or ten days' time, the whole thing is flattened out. Till then, the eye must be under bandage.

In many cases after the perforation of the cornea, the infection gets deeper down into the lens and vitreous causing infection of the whole bulb. The whole eye is swollen and protruding and the patient is in intense agony of pain. The only course left open is to eviscerate the eye to relieve the pain. This will be dealt with in a later paper.

It is good to repeat the salient points in the treatment of a septic corneal ulcer, to impress on the reader the main details which he should never forget.

When you see a case of corneal ulcer, do not fail to examine for pus in the sac.

If there be a dacryocystitis, remove the sac first and foremost and that immediately.

Wash the conjunctival sac with Rivanol 1:1,000 before opening the chamber.

Cauterise the ulcer thoroughly, especially the infiltrating margins.

When you see a hypopyon, let it out with an incision in the lower limbus.

Intramuscular injection of milk on the first day (and subsequently if the ulcer gets worse) should never be forgotten.

Atropin drops are essential to give rest to the iris and ciliary body and to prevent later adhesions of the iris on the lens.

The eye is best treated without a bandage except on days when the paracentesis is done.

Hot fomentations are inadvisable.

PROPHYLAXIS.

Every effort must be made in our country to save these eyes of working classes which are lost from corneal ulcers. The education of the general practitioner in this respect is essential in the first instance.

The most important prophylactic measure is the removal of the lachrymal sac if it is diseased. Usually people do not care about it. But, as mentioned earlier, even if very superficial wounds on the cornea occur, the eye is destroyed very soon when the sac is diseased. The operation of excision of sac is absolutely without danger. It is more disinclination than fear to meddle with a condition which does not cause much inconvenience that is responsible for making people so careless and negligent about it.

Poverty also is an important factor. For the sake of the future of the man's eyes and the maintenance of the family,

it is the human duty of the general practitioner to warn and even force every one he may meet with a suppurating lachrymal sac to have it removed at the earliest possible moment.

Secondly, it should be borne in mind, the treatment of a corneal ulcer requires the trained hands of the specialist. When you can send the case on to the nearest eye clinic, please do not undertake to treat the case especially if the other eye is already blind or defective. Not only that, you should also take the pains to see that the patient proceeds immediately. Saving of delay of even a day will mean much in conserving the vision in that eye.

SOME COMMON EAR DISEASES *

By

DR. C. N. NARAYANAN, Z.L.O.,

*Honorary Assistant Medical Officer, E. N. T. Department,
Government Hospital, Ootacamund.*

I shall attempt to deal in a general way, only such of the diseases that are met with in daily practice. Instead of classifying them under the various names as are given in a text book, I shall try to group them according to the signs and symptoms they produce and for which a patient seeks our aid.

Pain, discharge, difficulty in hearing, tinnitus are the common complaints and rarely vertigo of otic origin.

Pain in the ear may be external or deep seated. If external there is a certain amount of pain and tenderness over the tragus and the posterior part of the pinna at its attachment. It is generally due to a foreign body, or impacted cerumen or a furuncle or diffuse external otitis of the meatus.

Impaction of foreign bodies usually occurs in children, the physician called upon to withdraw a foreign body from the external canal is chiefly

concerned with its composition and nature, that is, whether it is organic or inorganic. A bead, pebble or other hard objects of like nature requires different treatment from a bean or a pea, upon which warm and moisture have a rapidly transforming effect. If it be small enough to be freely movable in the canal the safest and the easiest method of getting it out, is free syringing with sterile water or boric acid solution and the success of this method depends on one's ability to pass a sufficient quantity of fluid into the space behind the object, so that, in flowing out, it will have force enough to carry the foreign body before it. The stream of fluid must not be directed with force against the object itself, as that would be likely to drive it still further into the canal. With live insects and worms, they must first be killed to dislodge their hold upon the dermal lining before syringing out. Any weak antiseptic solution would serve the purpose. So would chloroform fumes

* A paper read at the meeting of the Coimbatore District Medical Association on 27-5-1939.

but on no account should it be dropped in the ear, as the pain produced thereby is excruciating. In cases where syringing cannot be employed resort to instruments will be necessary. Here a general anaesthesia would be preferable, since even the most self-controlled adult cannot be relied upon to remain motionless, during the entire manipulation, and there is hardly any moment when the instruments are within the canal, that a sudden movement on the part of the patient may not cause serious injury to the auditory mechanism. If both the above measures fail, resort must be had to surgical exposure of the site of impaction.

WAX: Though the secretion of wax, which acts as an extremely effective barrier against the invasion of the lower portion of the canal and the drum by foreign bodies both animate and inanimate, is a normal process, nature sometimes produces more wax than is necessary. Soap has an irritating influence upon the ceruminous glands leading to hypersecretion. Digging at the ear too often likewise stimulates the glands. A plug of wax may remain for a long time in the canal, out of sight, except when it becomes very large, altogether unnoticed by the subject. Moisture entering the ear may cause the plug to swell so as to entirely close the lumen and even exert pressure on the drum causing pain. If the plug is not impacted it could easily be removed by syringing otherwise complete softening with a solution of Sodii Bicarb, Glycerin, and warm water is necessary before syringing is attempted.

FURUNCLE: It is due to the infection of the hair follicles with staphylococcus. The common causes are trauma and irritation. The pain is spontaneous. The chief symptom is an extremely painful swelling of the wall of the canal which if posterior may suggest the swelling characteristic of mastoiditis. If anterior it may be mistaken for that of parotitis. Manipulation of the auricle increases the pain, when it is so intense already but pressure over mastoid does not. Pain and tenderness over the tragus will differentiate it from

mumps. Chewing and swallowing become almost impossible because movements of the temporomaxillary joint are communicated to the cartilaginous portion of the canal. There may be rise of temperature and marked constitutional symptoms. One exposure to X-Ray usually aborts an attack. Solux light and alcohol 90 to 95 % afford relief from pain. It is not advisable to open it up unless ripe since it takes much longer time to heal than when it bursts of its own accord. Specific vaccine and non-specific proteins do speed up recovery.

Multiple furunculosis will produce a diffuse external otitis. Generally it is due to trauma consequent to too vigorous cleaning of the external canal. But in persistent and intractable cases examination of the urine for sugar is in order.

OTOMYCOSIS: Of all the fungi that infect the ear the most common is the *Aspergillus fumigatus*. The mould is unable to proliferate unless conditions in the canal are such as to supply a moist or macerated epithelium. The spores proliferate rapidly and though the visible products may be removed, permanent eradication is extremely difficult. Careful cleansing of the canal, followed by the application of 1:5000 bichloride of mercury in 95 % of alcohol is effective if used in conjunction with strong Silver nitrate applications.

If the pain is deep seated it is generally due to acute infections of the drum and the middle ear. Pressure over the pinna or the tragus does not produce pain or tenderness.

DRUM-HEAD MYRINGITIS BULLOSA: These are small blisters on the drum membrane. The pain is quite sharp and sudden and the patient will be able to tell you the exact time the pain started unlike in otitis where the pain comes on slowly. The disappearance of pain is also sudden and then you see only spots of blood. The blister may be mistaken for a bulging of the membrane during an acute attack of otitis and may be differentiated by the hearing being normal

and margins of the blister sharply defined. Puncturing the blister with a needle gives immediate relief.

In traumatic rupture of the drum whether direct or indirect severe stabbing pain will be felt at the site of rupture.

Pain due to acute infections of the middle ear is always deep seated, acute and throbbing in character. The pain is not usually increased by the manipulations necessary for the insertion of the aural speculum. When the seat of infection is near the eustachian orifice the patient may complain of occasional paroxysms of pain in the region of the lingual tonsils or sometimes continuous burning in the throat and this would be worth remembering in a case where the inspection of the pharynx appears normal. Paracentesis of the drum gives fairly good relief.

ACUTE MASTOID: The pain and tenderness over the mastoid on pressure and percussion are always constant and originate behind the auricle and radiate toward the teeth and shoulders, the occiput neck and face. Mastication may be painful on account of the involvement of the bony portion of the external canal which is in close proximity to the glenoid fossa. The sternocleidomastoid and other muscles attached to the mastoid account for the pain upon movements of the head. Torticollis may be present and is due to a fixation of the muscles to avoid pain upon movement.

Sometimes the pain in the ear may be due to a reflex cause like a carious tooth.

DISCHARGE FROM THE EAR, may be haemorrhagic, serous or purulent; scanty or copious; odourless or foul smelling.

Bleeding from one or both ears occurs generally in all cases of basal skull fracture. The bleeding is usually of short duration. It may also be due to vascular granulations or erosion of blood vessels occurring in middle ear disease.

A sticky oozing discharge may be due to eczema of the meatus.

A purulent discharge which is or has been copious and associated with deafness from the beginning of the symptoms, is due to acute or chronic suppuration of the middle ear. If chronic it may be due to the presence of polypus, granulations or cholesteatoma, caries of the ossicles or temporal bone, disease of the antrum or naso-pharynx or to constitutional causes such as diabetes, tubercle, anaemia or syphilis.

A purulent discharge which is not and which has never been, copious and deafness, if present, did not supervene till some time after the onset of the symptoms may be due to the external diseases of the ear, acute or chronic.

The discharge occurring in catarrhal otitis is always practically odourless, while that of the chronic suppuration is characteristically foetid. Where there is great neglect of personal cleanliness, the odour may be especially foul, for here the exudate is not only charged with detritus from necrosing bone, but is likewise laden with decomposing epithelial elements from mucous membrane lining of both the middle ear cavity and the canal. In some cases even the thorough cleansing will not dissipate the unpleasant foetor and this persistence would usually be found due to irritating secretion or degenerated cholesteatoma hidden away in some side pocket of the tympanum which the most powerful syringe could not reach.

The amount of the discharge also varies greatly. At times there will be so small a quantity that it may never appear at the external opening. Often again, there will be an abundant flow of thick creamy pus, in which cholesterol crystals and epithelial elements can be detected, giving off a more or less offensive odour, and often causing the patient inconvenience and humiliation. Bacteriological examination of such material will frequently give valuable aid upon the proper course of treatment.

Some indication of the location of the lesion may often be gained from the physical character of the exudate. If it

is markedly mucoid, it is likely that the lower part of the tympanic cavity and the eustachian tube are the parts most severely involved. If thick creamy pus is to be seen, this more probably, has its origin in the vault of the tympanum or in the mastoid antrum. This alone is a very grave sign for the cavities just named are in such close relation to the base of the brain that indications of extensive bone necrosis in this region point to conditions menacing life itself.

A few words about the bacteriology and pathology in middle ear diseases would help to understand the origin and course of the disease. The most common organisms found are staphylococcus, streptococcus, micrococcus catarrhalis, diphtheria bacillus, b. coli communis, pneumo bacillus. This is to be expected in view of the continuous passage of air from the throat to the middle ear by way of eustachian tube. A normal middle ear is in all probability free from micro-organisms. Infection may gain entrance by several routes, the chief among them being the eustachian tube, next to that, interruption of the continuity of the tympanic membrane whether this be traumatic or otherwise. Much less often infection may penetrate the middle ear from fracture of the skull or some injury to the labyrinth, petro-squamous fissure or fascial canal. It may also be blood or lymph borne, though this is not a common mode of infection. Streptococcus is the commonest etiological organism in the majority of acute middle ear infections, and in children under ten years of age pneumo-coccus.

The inflammatory process extending from the tube to the middle ear consists of engorgement and swelling of the mucous membrane of the tube and middle ear. The anatomical configuration of the tympanic membrane plays an important role in the pathologic changes that occur. Owing to the close proximity of the upper and posterior portion of the promontory of the cochlea to the junction of the Sharpenel's membrane with the membrana tensa and the extreme tympanic limit of the external wall of the

aditus, the tympanic cavity, in an acute process is divided into two distinct parts when the swollen membranes covering the above regions come in contact. This contact will in most instances cause retention in the upper portions of the middle ear; i.e., the attic and the inner portion of the aditus giving rise to swelling of the drum in its upper and posterior portion. If the process is one of greater virulence so that the inflammatory reactionary changes are accompanied by transudations, symptoms of tension develop, in which case the entire drum shows marked engorgement, together with the above-mentioned swelling of the upper and posterior part, and actual bulging. In these virulent processes the inflammatory changes extend entirely throughout the mastoid cellular system. This juncture is the turning point as to whether an acute otitis media is going to resolve with or without treatment. Should interference be necessary, which is the free incision of the drum, then the ensuing pathological change is the marked relaxation of the drum with the accompanying pulsation of the hyperemic vessels and the out pouring of large quantities of serosanguinous fluid mixed with varying amounts of mucus. The fluid obtained after the incision of the drum membrane, depends usually on the type of invading organisms, so that in the hæmolytic streptococcal infection it will be principally serosanguinous, while in pneumococcal or influenzal or streptococcus mucosus infection the fluid will be thicker in consistency because of the additional mucus from the nose and the tube. The discharge rapidly changes in character. The blood soon disappears except in the hæmolytic streptococcal or the epidemic influenzal infection, when the bloody discharge is of considerable duration. This point is important in judging the pathologic process that is going on. The change in the discharge is due to the secondary infection that occurs from the canal, which is unavoidable, as well as through changes that may take place in the invading organisms. The changes in the opening of the drum are of the utmost importance and in the main are due to the changes

going on in the middle ear. So marked is the relaxation of the drum in some of these cases, that it may produce complete eversion of the lips of the incision and the swollen membrane herniates. Owing to the closure of the perforation on account of eversion and subsequent retention, combined with further relaxation of the tympanic membrane, the nipple formation with occasionally but a minute opening in the centre becomes very noticeable. The lack of understanding of this pathologic change leads to the therapeutic abuse of re-incision of this portion with no result other than stirring up of an already acute process into a more violent one and early mastoid destruction.

DEAFNESS: May be either obstructive or nerve.

Obstructive deafness: It is due to disease of the middle ear or the auditory canal. It rarely comes on suddenly excepting from impaction of cerumen. If it comes on acutely, it is probably due to acute catarrh of the eustachian tube or inflammation of the tympanum. If the deafness dates from an acute nasopharyngeal catarrh, the tympanic membrane is indrawn, opaque and thickened and inflation by Politzer's bag gives some relief, the disease is the exudative form of chronic catarrh of the middle ear.

If the deafness has an insidious onset with pronounced tinnitus and on inspection the drum membrane is somewhat opaque but practically normal, the disease is probably otosclerosis.

If there be a history of previous discharge the deafness is probably due to perforation or cicatrices resulting from suppurative inflammation of the middle ear, and inspection of the drum confirms this.

Nerve deafness: May be sudden as in Menier's disease, hemiplegia, hysterical or traumatic fracture of the base of the skull involving the capsule of the labyrinth.

Primary inflammation of the labyrinth may supervene with cerebral symptoms

during or various specific fevers meningitic inflammation of the auditory nerve or injury. Without pyrexia, nerve deafness may come on within a few hours in syphilitic disease of the labyrinth and in leukæmia. Acute congestion and acute anæmia of the labyrinth coming on with nausea and giddiness may also cause deafness.

Nerve deafness coming on gradually without any evidence of intracranial disease may be due to toxic causes like quinine, salicin and tobacco, chronic anæmia or congestion of the labyrinth, paresis from chronic concussions from machinery.

Nerve deafness could be differentiated from obstructive deafness by the following points.

Nerve Deafness

Diminished air and bone conduction.
Rinne. P. Webber. N.
Loss of hearing for high tones.
Decreased hearing in midst of noise.
Conversation heard better than watch.
Tinnitus occasional.

Obstructive Deafness

Air conduction only diminished.
Rinne. N. Webber. P.
Better hearing for high tones.
Increased hearing in midst of noise.
Conversation heard worse than watch.
Tinnitus usual.

Sometimes we may have a combination of both nerve and obstructive deafness. In those cases with discharge, the suppurative process is probably spreading into the labyrinth and thus we get signs of nerve deafness supervening over obstructive deafness.

If there be no discharge past or present the most usual conditions are, disease of the cochlea, or ankylosis of the stapes supervening on an old catarrh of the middle ear.

TINNITUS: May be due to impacted wax, diseases of the middle or internal ear.

An impacted cerumen generally produces roaring or humming noise, low in pitch.

If it is singing, hissing, whistling or similar highpitched noise there probably exists some increase of pressure in the middle ear, which is affecting the stapes or producing certain degree of hyperaemia in the tympanic cavity.

Crackling and rattling usually mean accumulation of fluid in the middle ear.

A humming tinnitus worse on lying

down and after food and stimulant is due to arteriolar dilatation. If relieved by lying down or after food it is due to anaemia.

Tinnitus taking the form of various voices or music is due to disturbance in the cortical centre of hearing.

A pulsating tinnitus checked by the compression of the carotid artery is due to arteriolar dilatation within the middle or external ear. And if checked by compression of the vertebral arteries in the sub-occipital triangle it is due to a similar dilatation within the internal ear. If audible on auscultating the head, it is probably an intracranial aneurysm.

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.

BENEFICIAL IN THE COMMON INFLAMMATORY DERMATOSES

Cuticura Ointment merits the attention of practitioners by reason of its marked success in relieving the intense itching of Eczema and other pruriginous eruptions. Indeed, its efficacy in this respect has long been proverbial.

For this purpose Cuticura Ointment may be usefully prescribed as an adjunct to general measures of treatment in the common affections of the skin.

Cuticura Ointment is obtainable from pharmacists throughout the world.

Agents in India for the Manufacturers:

MULLER & PHIPPS (India) LTD., P. O. Box 773, BOMBAY.

POTTER DRUG & CHEMICAL CORPORATION

MALDEN, MASS., U.S.A.

Abstracts

EPISTAXIS ETIOLOGY AND TREATMENT.

JAMES P. RIGG, M.D.

Grand Junction, Colo.

Epistaxis is a symptom—in most instances a local vascular disturbance and rarely physiological. The most common local cause is the enlargement of vessels in Kiesselbach's area, an especially richly vascularized part of the septum. However, a brief study of the anatomy of the septum and lateral nasal wall will show that there may be other areas from which hemorrhage may occur.

ANATOMY

According to Cunningham, the sphenopalatine artery, a terminal branch of the third part of the internal maxillary artery, passes with the naso-palatine branch of the sphenopalatine ganglion from the pterygopalatine fossa into the nose through the sphenopalatine foramen. It crosses the roof of the nose in the mucoperiosteum, passes to the septum and runs forward and downward in a groove on the vomer toward the incisive foramen, anastomosing here with the major palatine artery which enters the nose through the lateral compartment of the incisive foramen (canal of Stenson). It supplies a goodly portion of the nasal concha by its posterior lateral portion and the inferior and posterior portion of the septum by its posterior septal branches (nasopalatine artery).

The anterior and posterior ethmoidal arteries arising from the ophthalmic, a branch of the internal carotid, supply the medial and lateral nasal walls. The posterior ethmoid gives off branches to the superior meatus and upper nasal conchae and anastomoses with the nasal branch of the sphenopalatine artery.

The descending palatine artery, from the internal maxillary, supplies small branches to the posterior portion of the nasal fossa and by its direct continuation

as the great palatine artery passes through the incisive foramen to the anterior portion of the floor of the nasal fossa.

The vestibule is supplied by the superior labial branch of the external maxillary artery to the septum.

Venous Plexuses: Posterior—Drained by the sphenopalatine vein to join the pterygoid plexus; the plexus is drained by the posterior and anterior facial veins. Superior—Drained by the anterior and posterior ethmoidal veins to join the superior ophthalmic vein. Anterior—By small branches to join the facial vein.

In Kiesselbach's area or Little's area the septal arteries, abetted by the terminal branches from the superior labial artery, form a plexus. It is for this reason that irritation to this portion of the nasal mucosa causes a high percentage of spontaneous hemorrhages from the nose.

CAUSES OF EPISTAXIS

According to French, the local causes are:

1. Injury—A blow, fracture of the base of the skull, a foreign body in the nose, operation on the nose, violent coughing, sneezing, nose blowing, and nose picking.

2. Ulceration—Traumatic, syphilitic, malignant, tuberculous, leprosy, and septal deviations with ulceration.

3. New Growth—Adenoid tissue, polypi, fibroma, angioma, and malignant disease.

4. Varicosity of the veins of the nasal mucosa—Multiple hereditary telangiectases.

5. Acute infective inflammation—Severe catarrh, diphtheria, scarlet fever, and influenza.

The general causes are:

1. High arterial blood pressure, as in granular kidney, chronic renal disease, arteriosclerosis, gout, cirrhosis of the liver, and heart disease.
2. High venous blood pressure, as in bronchitis, emphysema, dilation of the right side of the heart in cerebral congestion when blood passes from the superior longitudinal sinus by an emissary vein going through the foramen cecum to the nasal mucosa; in "determination of blood to the head" and in schoolboys and children after taking violent exercise.
3. Altered conditions of the blood, as in hemophilia, pernicious anaemia, purpura, scurvy, leukemia, chlorosis, jaundice, and the onset of acute specific fevers—particularly enteric, scarlet fever, and measles.
4. Alternations in atmospheric pressure—Mountaineering, diving, and Caisson disease.
5. Epistaxis of obscure origin—Often attributed to congestion, and occurring in childhood at puberty, especially in girls as the alleged vicarious menstruation, as the result of sexual irritation in either sex, and in woman at the menopause.

In some cases the bleeding is from both nares. However, in the majority of instances, particularly when the cause of the bleeding is local, it is from one side only. It must be remembered also that epistaxis may occur without any bleeding from the nose anteriorly. If the patient is lying down the effused blood runs down the sides or floor of the nose, passing through the posterior nares and entering the nasopharynx. When this occurs, the patient may cough and spit it up and hemoptysis will take place. If, on the other hand, he swallows the blood he may vomit it later and hematemesis will be observed. Careful anamnesis will usually indicate whether this is true, and it will be confirmed or denied by meticulous rhinoscopic examination anteriorly and posteriorly. Particular inquiry should be made as to any sort of trauma that might account for it and also to the

occurrence of previous attacks of nose bleeding.

I reiterate the importance of careful examination of the nose with the nasal speculum to dilate the nares and of a mirror and lamp to secure good illumination. In many instances the bleeding point can be seen and, whether the hemorrhage be venous or arterial, and it may be noted whether the so-called "seat of election" of epistaxis is a small ulcerated spot on the cartilage of the septum, usually not far from its junction with the ethmoid and vomer. In other cases there is general oozing from the mucous membrane. In cases of septal deviation, an erosion at the point of maximum deflection may be the seat of the hemorrhage. In other cases, the floor of the nose should be inspected carefully. Local irritation due to atmospheric conditions, dryness and crust formation, with the removal of accumulated particles causes a moth-eaten condition of the mucosa. Crusts form again and the continued removal of them will eventually erode a vessel, with subsequent ulcer formation. Over a period of years this may cause a septal perforation. In many cases of atrophic rhinitis, patients have bilateral ulceration about to perforate. This causes considerable bleeding and local attempts to heal the area are usually unsatisfactory.

An endeavour should be made to clear out all blood clots and apply adrenalin or epinephrine to the area. If the hemorrhage comes alone from any particular place, it will slow up or temporarily stop. If in Kiesselbach's area (Little's area or MacKenzie's area), it can thus be ascertained. If not coming from this area, the turbinates should be inspected, using a medicine dropper or suction apparatus to remove the blood. The bleeding spot may be near the attachment of the middle turbinate; if so, a small pad of cotton placed there will usually control it. This is a favorite site in arteriosclerotic cases. Sometimes the bleeding comes from a bleeding polyp half way back on the middle of the septum. Another spot is far back on the convexity of the lower turbinate or near the floor.

Conservative aids in localising the oozing besides packing and suction as mentioned by McAuliffe are: Raise the arms above the head, irrigate the nose with a saline solution at a temperature of 130° or with two or three injections of four ounces of ice water, and pressure under the upper lip by a pad of cotton to control the bleeding from the coronary artery. Old people bleed more often from the ethmoid veins.

Rest assured that any or all of the facilities which we have will not prove satisfactory in every case. In other words we are unable to localize the bleeding in every case, and the hemorrhage may be so profuse that it is inadvisable to attempt too much intranasal observation. Then it is expedient that we pack the nose, or do anything to immediately control the bleeding.

TREATMENT

Every doctor has his own particular method of treating epistaxis, and perhaps most of them are efficacious. I shall suggest a number here which have been used with a degree of satisfaction in case histories presented by those using them.

The posterior sponge packing is done in postoperative cases and those in which there is continued hemorrhage down the pharynx, in those wherein anterior packing and other measures have not proved satisfactory. A soft rubber catheter is passed through the nose on the bleeding side, the end grasped by curved artery clamps in the pharynx and brought out through the mouth so a string may be tied to its end with a sponge attached. The sponge is about three inches long by one and one-half inches thick; the catheter is withdrawn through the nose and the sponge guided into position by the forefinger. I prefer to have three strings tied to the sponge in the center, two to be brought out through the nose and the third through the mouth. The two from the nose are tied around a small gauze sponge at the anterior nares and the tighter they are tied the more pressure is exerted on the posterior packing. The one through the mouth is for convenience in removal and

is taped to the corner of the mouth. I leave this packing in position about twelve hours, occasionally longer; but the possibility of middle ear infection must be constantly kept in mind.

Poult says a very efficient instrument is an ordinary spring clothes pin with a spring. A pad or two of fourfold gauze is placed over the nose and the pin applied until the bleeding has stopped for ten or fifteen minutes.

Seiferth states that after cocaineization he uses a glowing galvano-cautery, trichloroacetic acid, or 50 per cent chromic acid. I have used all of these but prefer the bichloroacetic acid of Kaalenberg applied directly to the area. He also advocates the use of Afenil injected intravenously, which I have used, but with questionable results.

Jackson and Coates advise the use of the chromic acid bead. The bead is made by heating a silver probe in a burner flame until hot, then dipped in chromic crystals, reheated over the flame until a bead forms. This is applied to the bleeding area. I have used this and also the silver nitrate bead made in a similar manner. The excess of the chromic or silver may be washed off with water. The same is true in the use of bichloroacetic acid.

Millet describes the use of a cotton glove finger placed in the nose after being dipped in vaseline; the open end of the glove finger is spread open and filled gradually with small gauze strips. This usually stops the bleeding unless posteriorly, and then the glove finger has not been placed up in the nose far enough. To remove, open the end and reverse the process.

Goodyear gives a comprehensive analysis of the etiological factors of nasal hemorrhage and some practical considerations in its treatment. He suggests the uses of 50 per cent silver nitrate as most satisfactory.

Canuyt and Wolf give a resume of the action on nasal hemorrhage of irradiation of various remote regions of the body. The rays were used from one-half to two and one-half hours in three treatments at about three days intervals; the hand,

thigh, calf, and face were irradiated. They report favorable results.

Monson reports very favorable results from the use of sclerosing solutions. His method is as follows: After anesthesia is obtained he injects small doses of saturated solution (16.6 per cent) of quinine lactate into each of four or five points beneath the mucosa surrounding the bleeding point. The solution (approximately 0.1 c.c.) is injected into the extra-vascular tissues and not into the vessels themselves. I have used this method and also the injection of quinine urea hydrochloride with prompt relief of the condition. In a small series, there have been no recurrences.

Submucous elevation: This method, together with the submucous resection, has proved most satisfactory in my own hands. After topical application of butyn and epinine to anesthetize the bleeding area if and providing it is located in the anterior portion of the nasal septum, I inject submucously a 1 per cent solution of novocaine. Even this is often not necessary. Following this I make an incision with the septal knife anterior to point of bleeding, then elevate the mucous membrane away from the cartilage and bone extending posteriorly at least a centimeter beyond the area of hemorrhage. This will usually control the average bleeding. However, I place in the nares on that side a pledget of cotton or gauze which is left in situ for twenty-four hours and then removed; there is usually no subsequent bleeding. I have done this simple procedure in hundreds of cases and the number of recurrences are relatively few.

In more severe types, especially if the bleeding is posterior, a submucous resection is necessary. This has proved effective in very severe nasal hemorrhage when other methods have proved of no avail. This is recommended by Rainey, and I concur with his findings. In cases of atrophic rhinitis it is beneficial when there is bleeding.

Auto-hemotherapy, the injection of the patient's whole blood below the mucosa in the area of the bleeding, is therapy to be borne in mind. I have used it and found

it worth trying in bleeding from Kiesselbach's area.

Furstenberg uses the silver nitrate bead or crystal, electro-coagulation, packing with cotton or gauze tampons containing coagulose (horse serum), and electro-cautery.

Boies advises against caustics and cautery unless the bleeding is localized, the untoward effects producing a chronic situation which may result in permanent trouble, ending in perforation. The submucous resection gets rid of the underlying cartilage which the ulceration has reached, thus causing a fibrous change in the septal flap which unites without cartilage between. The use of repeated small transfusions in the severe cases has seemed to him definitely beneficial. He is not favorably impressed with thromboplastic materials.

Salinger uses galvanocautery. He has also given the moccasin venom therapy in cases where the cause of the bleeding is unknown and where there is a blood dyscrasia, but the results of the treatment are inconclusive.

Proetz uses the chromic bead for anterior bleeding areas.

Shea classes habit in the manner of blowing and fingering the nose as one of the chief factors; he also gives hereditary tendencies in families as responsible for the severe ones. He advocates cauterization, silver nitrate, trichloroacetic acid, and injection of the site with novocaine-adrenalin.

Babbitt gives a comprehensive suggestion in the use of Simpson swelling pads put in each side of the nose; the pads are moistened with an antiseptic solution and sometimes with saturated gallic and tannic acids. He tries to avoid the use of silver nitrate, chromic acid, or actual cautery as likely to increase ultimate ulceration. He uses 25 per cent trichloroacetic acid with a little 5 per cent cocaine application to avoid the five-minute discomfort. This percentage of trichloroacetic acid leaves the tissues without producing a deep eschar and later trouble. He feels very strongly about changing the anatomo-

mic situation in the nose—namely, the submucous resection, partial or complete.

The reports I have to date on moccasin venom solution do not justify its use, but for persistent recurrent epistaxis, multiple hereditary telangiectasis, and purpura hemorrhagica, it is advocated.

Hume however, makes a platelet count and estimates the bleeding and coagulation time. If the former is low, he uses one-half c.c. of moccasin venom every four hours until normal is attained. He also states: "Our results with moccasin venom when indicated by low platelet count have invariably been successful."

Ligature of the carotid artery is done in those cases where other measures have failed and there is still profuse bleeding. I have performed this on two patients, preceding the operation with a transfusion and following it with another transfusion. The secondary anaemia is also treated by whatever method the consulting internist deems advisable. I have seen many patients who have become exsanguinated from persistent recurrent low grade or profuse hemorrhage from the nose.

The specific fevers and other pathological conditions must be treated, of course as under any other circumstances.

In addition to the above measures, I cannot stress too greatly the necessity for urging every patient with epistaxis, especially those of bleeding arising from the cartilaginous portion of the septum, to use a bland ointment several times daily. Three to five per cent ammoniated mercury, yellow oxide of mercury, vaseline, or vaseline and lanolin (anhydrous) with a saturated solution of boric acid mixed in with it, are all to be recommended. The important point is to urge their use four to six times daily over a period of many weeks. Waldapfel in Vienna urges that this procedure be kept up in cases with ulceration for at least six months or longer. He recommended only vaseline applied six times daily.

SUMMARY

I have attempted to give an analysis of epistaxis from an anatomical standpoint, covering the local and general etiological factors and generalizing its control. Specific measures that have proved satisfactory are described. General health principles are also briefly described.

—*The Eye, Ear, Nose and Throat*
Monthly, May, 1939.

ELIXIR ANEMONE CO.

A specific for Hysteria and allied disorders.

Elixir Anemone Co. is a compound of valerian anemone and gold with Vitamin B in the form of orange juice. This is the original formula of a leading neurologist of America, Dr. Theodore Alderman, M. D.

Obtainable at all Chemists or with the Sole Agents:

Messrs. KRISHRAJ & CO.,

8, Bunder Street, MADRAS.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

TOXIC ACTION OF THE SULPHANILAMIDES ON THE LIVER. A WARNING.

Experience with sulphanilamides, particularly, in America, have brought to light the toxic action of the sulphanilamides on the liver. Two deaths from hepatitis following the use of sulphanilamide have been reported by Bannick, Brown and Fuster. C.F. Garvin reports on four cases of sulphanilamide therapy. Three of these four cases of toxic hepatitis showed an associated exfoliative dermatitis of which one ended fatally.

W. E. Clive reports a fatal case in a university student aged eighteen years who was under treatment in the hands of a careful and competent physician for gonorrhoea. The prescriptions disclosed that 80 grains for the first day, 60 grains for the second day, 40 grains for the 3rd day and 20 grains a day thereafter, were prescribed until 700 grains had been taken. A period of rest from sulphanilamide therapy lasting about two weeks was then ordered. After this interval a second series was started, but was discontinued after 3 days because of gastrointestinal symptoms. But the patient had taken much more than these doses and even during the rest period he had taken the drug. The patient died four days after admission. Autopsy disclosed a typical picture of acute yellow atrophy.

These case reports are disquieting but if the practitioner has a watchful eye on the patient and does not, under any circumstances, permit overdosage, at the same time giving as much fluid, glucose and alkalies as possible, he need not ordinarily fear. Under any circumstance it is unadvisable to entrust the patient with more than a day's supply. And pharmacists who should dispense the drug only on a qualified doctor's prescription, should not take the responsibility for repeating the drug without specific written instructions from the doctor.

MAPHARSIDE IN THE TREATMENT OF SYPHILIS A CLINICAL STUDY.

R. V. RAJAM AND N. VASUDEVA ROW,
L. M. G. Jan. 1939, P: 24.

The authors have reported their experience with this new remedy on 1,000 cases treated in the Venereal clinic of the Government General Hospital, Madras. They quote the following conclusions of Tatum and Cooper on the drug:—

(1) Mapharside is a pure chemical preparation the purity of which can be determined by chemical methods. The arsphenamines and neoarsphenamines on the other hand are chemical mixtures and consequently the toxicity and therapeutic values may vary with each batch. (2) The drug is comparatively stable and becomes less toxic on exposure to air. (3) In rabbit syphilis, the effective therapeutic dose of mapharside is one-fiftieth to one-thirtieth of that required of neoarsphenamines. (4) The chemotherapeutic index (ratio of maximal tolerated dose to minimal curative dose) was found to be higher than that of any other antisyphilitic agent known to them.

Dosage:—The initial dose of an adult male 0.04 Gm. and 0.03 Gm. for the adult female. In early infectious cases the first four injections were given at 4-day intervals and the subsequent doses once a week. The authors deplore that, on an average only 5.65 injections were given for each patient. There were two deaths from the therapy one caused by encephalitis and the other by granulococytopenia.

Conclusions:—In respect of the rapidity of the disappearance of the spirochaetes from surface lesions and the clinical response of the lesions themselves, mapharside is comparable to the older drugs. As regards reversal of the serological reactions the authors opine that with the drug, it is slower than with neoarsphenamine. The immediate minor reactions were more frequent with mapharside than with neoarsphenamine. With mapharside the nitritoid crises were conspicuous by their absence. There was not a single case of exfoliative dermatitis due to map-

harside, and the other delayed reactions were much less frequently observed than with neoarsphenamine. The occurrence of venous spasm is a unique feature in mapharside therapy and unknown with older drugs. In some cases the pain is shooting up and down the arm and may be present for $\frac{1}{2}$ to 2 hours. This can be obviated by rapid injection of the drug within 15 to 20 seconds.

EXTRAPLEURAL PNEUMOTHORAX

A. MAURER & E. DE. SAVITCH.

L: Dec 24, 1938. P: 1468.

Indications:—Intrapleural pneumothorax and thoracoplasty are the procedures of choice whenever possible. It is well to emphasize that extrapleural pneumothorax can in no way be considered safe or beneficial when the lesion is of a type that cannot properly be treated by intrapleural pneumothorax. It should be reserved for cases where (1) intrapleural pneumothorax is impossible because of pleural adhesions and (2) the patient's general condition does not allow thoracoplasty. In fairly young stabilized lesions at the apex, with slight involvement the contralateral side, the indication for this operation may be considered absolute. The authors are particularly impressed with the potentialities of this operation in children. In pregnant women, too, extrapleural pneumothorax is frequently the operation of choice.

Technique:—Posterior approach is preferable. This gives better clinical results but also avoids the deforming scar which is particularly embarrassing to women. 10 cm of 3rd, 4th, and 5th ribs are removed close to the transverse processes. Care must be taken to do the resection sub-periostally, leaving the periosteum as far as possible intact. Endothoracic fascia is exposed. This is the plane of cleavage. The surgeon proceeds carefully and slowly with the separation of tissue. Separation is carried out both anteriorly and posteriorly. It is particularly important to separate the entire apex and to go as far as possible toward the mediastinal surface.

Haemorrhage remains one of the most distressing and serious complications. The

wound is closed in layers without any drainage. Very careful closure of the wound is most important; any leak may cause subcutaneous emphysema or a fistula. Patient is fluoroscoped on the day following the operation. In the vast majority of cases there is accumulation of fluid. This is aspirated and air is introduced at atmospheric pressure. This is repeated daily for 4 days. After the 4th day air introduced at a positive pressure not exceeding 10 mm Hg. After about a fortnight the fluid usually no longer forms, and the interval between the introductions of additional air may be increased. The results of extrapleural pneumothorax were good in about two-thirds of the cases.

THE PROPHYLAXIS OF TUBERCULOUS EMPYEMA.

L. ROBERTS.

L: Jan. 21, 1939, P: 134.

Tuberculous empyema occurs (1) as a common complication of spontaneous pneumothorax; (2) as an additional complication of artificial pneumothorax; and (3) least often as an invariable consequence of invasion of the pleura by a burrowing tuberculous abscess of the chest wall. In all these circumstances heavy infection is the immediate cause. Purulent effusion occurs in about 10% of the cases of pulmonary tuberculosis. The average mortality for these cases is about 50%. The following prophylactic measures must be adopted:

(1) It is suggested that persistent or recurrent pleural pain over the lesion indicates severe tuberculosis of the pleura which contraindicates artificial pneumothorax. The risk of empyema is sufficiently great to make some other form of collapse therapy advisable.

(2) The object of artificial pneumothorax is relaxation, not compression, of the lung. High positive pressures to stretch the adhesions are not justifiable.

(3) After cauterization of adhesions and adjustment of the collapse, a pneumothorax which remains ineffective should be promptly abandoned and other collapse therapy substituted. Oleothorax and extrapleural pneumothorax are valuable in certain cases.

THE Medical Practitioner

Vol. X]

JUNE, 1939

[No. 9

GENERAL MEDICAL SERVICE FOR THE PUBLIC.

No serious attempts have been made so far anywhere in India by the members of the medical profession or by the existing medical associations to which they belong to formulate a scheme of General Medical Service in the mutual interests of the profession and the public. We do not claim to know the details of the medical service in ancient India but we may say from the facts within our knowledge that before the British Government established hospitals and dispensaries on a large scale, the public depended entirely on the family physician who was generally paid in kind and not in coins. There were no Ministers or politicians who proclaimed to the members of the profession their responsibilities to the public. The rich as well as the poor were looked after by the Vaidyan and both the sections of the public did not forget their duty to their Vaidyan. With the advent of British rule, the Government medical institutions came into existence and have been increasing and with them came the institutions run by local bodies. And to day we have a net work of medical institutions in the city and urban areas and proportionately very very few in rural areas, all these being staffed by medical officers whose number all told is 2,001 the number of medical institutions being 1,233. The total number of registered medical practitioners in the province are 6,329 till 31st December 1938 and the population of the province according to 1931

census is 47,193,502. Roughly there is at present one qualified practitioner for a population of 10,000. But there is a great disparity of the supply of qualified doctors in rural areas and smaller towns and it may be said that on an average the rural population has not one doctor for a population of 20,000. Out of 6,329 existing practitioners 2,001 are full, time officers of the State, Local Bodies Missionary institutions and the Railways, the rest 4,328 depend entirely on private practice, certainly a very small number compared with the number in other civilised countries and their population. We may also mention that the in-patient accommodation is very meagre. There are only about 15,000 beds in all the existing hospitals in the Madras Presidency for a population of nearly 50 millions. Yet it is a strange irony that only a small number amongst the practitioners is above want and the large majority is struggling. The causes for this state of affairs are many. Apart from the existence of quacks and charlatans who by their persuasive tongue are able to prey upon the credulous ignorant masses at times even the so-called educated section, the qualified practitioners have had unequal and unwholesome competition with the State-paid doctors. The existence of several systems of indigenous medicine, is yet another handicap to contend against by the scientific medical profession. The administration of State hospitals and dispensaries which indiscriminately admit patients in spite of the paying capacity of the larger number so ad-

1939]

THE MEDICAL PRACTITIONER

359

mitted and the competition between the scientific practitioners themselves with little or no regard for ethics has brought the scientific medical profession completely under the grip of the Government and the lay public. It is indeed most pitiable that when the unskilled labourers are able to dictate their terms to the public, the members of the scientific profession are drifted to receive whatever is paid to them or serve even without payment those who can afford to pay. The prestige and status of the profession is below par these few years the Government having taken the role of the assessor. All the same the Government have realised their inability to supply medical and even public health service by paid agency and have been introducing honorary system of medical service in State Hospitals with much greater speed than was done by their predecessors and there are at present far greater facilities for the practitioners to gain hospital experience and the facilities are likely to be on increase in the near future and it is hoped, will be on the increase even in the far future, thanks to the driving force of the Minister now in charge of the medical administration. Advantage should be taken of this circumstance and the independent medical profession should devise means and ways to build up schemes for supplying general medical service to the public depending upon the paying capacity of those who are in need of it. Recognising the existing conditions of State Medical Service, we should say the task is indeed a hard one and cannot be ventured unless with the co-operation and collaboration of the Government. All the same the members of the profession should lose no time to start schemes which while differing in their details to suit local conditions, must have sound and uniform principles, service rendered to the members of

public being at reasonable rates depending upon the paying capacity and not on the nature of service rendered, always remembering that the healing art cannot take the place of trade. There is likely to be difference of opinion whether the scheme should serve all the members of the public or a particular section of it whose monthly income is below a certain figure. The members of the medical profession need not waste time on these details but begin starting schemes to suit local conditions which while getting employment to a large number of practitioners will not risk sound principles of ethics, and the prestige of the noble profession. While starting any scheme the most important thing the profession should keep in mind is unity of action forgetting once for all the destructive spirit of rivalry which should be guarded against keeping in mind that the individual spirit of rivalry that is the root cause of the adverse circumstances to which the profession is drifted at present.

We commend to the serious consideration of the members of the profession the following few basic principles adopted by the British Medical Association, which should be kept in view before organising any scheme:

1. That the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness.

2. That there should be provided for every individual the services of a general practitioner or a family doctor of his own choice.

3. That consultants and specialists, laboratory services, and all necessary auxiliary services, together with institutional provision when required, should be available for the individual patient, normally through the agency of the family doctor.

4. That the several parts of the complete medical service should be closely coordinated and developed by the application of a planned national health policy."

Good health does not always mean absence of disease. The responsibility

of the practitioner in regard to prevention of diseases cannot be restricted to infectious diseases only. The ideals of conception of health have been rapidly changing and the general practitioner should keep pace not only with the advancement of treatment of diseases but also should be very attentive "to such factors as housing, water and food supply, the prevention of epidemics and the prevention or abatement of conditions injurious to health". In fact he should be an active social worker with an unlimited sphere of activities which he could more efficiently discharge in the course of the exercise of his profession than the lay social workers, paid or honorary. The specialist who joins the scheme should realise that specialism cannot exist without the general practitioner that the specialist is a complement of the general practitioner and not a substitute for him. He should remember that though the patient has a right to choose his own specialist, it is detrimental more to the interests of the patient if the patient is allowed to take a short circuit to consult the specialist without the intervention of the general practitioner.

Just at present or for a long time to come the independent medical profession will not be able to supply to the suffering public laboratory services and all other auxiliary services including provision for institutional treatment to the extent such services are available in State Hospitals. It is therefore necessary as has been already expressed by us that the members of the profession who start schemes of General Medical Service to the public should seek the co-operation of the State and the State cannot afford to withhold their co-operation as they should be more interested in the development of such schemes by the medical profession without any financial help from the State. The

Government should also realise that it would not be possible for the Government to launch Health Insurance schemes in this country on the lines adopted in Great Britain for various reasons, the chief amongst them being the difficulty of introducing one uniform system of medicine. The best and the only course which the Government would be well advised to adopt relating to schemes of General Medical Service to the public that these schemes are launched by the votaries of particular systems of medicine, the Government taking care that those that start such schemes are not quacks. In places where these schemes are brought into existence by a group of practitioners or a recognised medical association, the Government and even the local bodies will do well to restrict admissions to the Out-patient and In-patient Departments of the hospitals keeping the doors of these institutions open only to the necessitous poor, others being admitted on the recommendation of practitioners who require advice from the consultants and specialists in these institutions and the moment this advice is obtained such patients should be discharged from the hospital. State Hospitals are now abused and if the Government prohibits admission to paying patients unless on the recommendation of private practitioners, the admission in the hospitals will considerably be less and a healthy spirit of comradeship between hospital staff and the private practitioners will be established and in addition the suffering public will have the benefit of continuity of treatment on scientific and rational lines. The Government will also get more money from paying patient than is the case at present.

From the beginning of the next year the G. O. restricting private practice to the State-paid doctors will come into force. A good number of medical practitioners doing honorary work in

State Hospitals have been discharged and in their place others have been appointed. The latter will finish their term after five years. So there will be a constant stream of practitioners getting into the medical profession having experience of institutional treatment. The profession should take advantage of the present new policy of the Government relating to recruitment of honoraries and also the restriction of private practice to the full time medical officers and bring into existence private institutions to supplement the existing Government institutions so that the paying patients do not find the need to enter the latter institutions which are meant only to the necessitous poor. We advise the practitioners both in service as well as in private practice to cultivate the healthy spirit of co-operation and not the unhealthy spirit of rivalry, the one section taking advantage of the other for common good, those in service remembering that soon after they retire all of them have to identify themselves with the common lot of private practitioners. If the present policy of the Government were to continue for two decades and if the private practitioners organise themselves and start schemes of General Medical Service to the public and if the Government encourage these schemes, we can safely prophesy that the Indian Medical Profession will earn all world credit as the pioneers of Socialised Medicine without the intervention of politicians. When it is known that in ancient India, the public both rich and poor depended on the family doctors for medical relief and not on the bounty of the Government, private schemes of General Medical Service run by private practitioners would be quite consistent with the ancient ideals of the people and the task before the members of the medical profession will not be as tough as many of them imagine.

News and Comments

New Order Changeth Giving Place To Old: There was a great feeling of hope and joy not only in the minds of the non-official public but also amongst the official that all sorts of inequalities anomalies and unjust actions will disappear in the Government Departments giving place to justice and fair play. Some recent events seem to have shaken the confidence rightly entertained by the public and the members belonging to the Madras Medical Department where injustice and the reverse of fair play was usually a rule in the past and not an exception as could be seen from a letter appearing in the Correspondence Columns under the caption "New Order Changeth Giving Place To Old." The Correspondent must know that we have been as vigilant in guarding the interests of the official medical profession as we are about the independent medical profession. The Justice Ministry did acknowledge its mistakes in superseding the claims of the seniors both in the matter of promoting junior Assistant-Surgeons as Civil-Surgeons in the teaching cadre and also regarding study leave. The fact that out of three recent posts referred to by our correspondent, two were held by Assistant-Surgeons till the three promotions were notified, should convince the Correspondent and others in service that our criticisms did catch the eyes or the ears of the old Ministry. We do realise that it may not be possible for the present Government to set right all wrong deeds of their predecessors but if the present Government chooses to walk in the grooves which were abandoned by their predecessors such an action is likely to give room to the suspicion that something is wrong somewhere, till it is known that there were very strong reasons for the Government to adopt the policy which was considered in the past as unjust or at least not fair. As has been repeatedly mentioned by us in these columns medical schools and medical colleges followed medical services and as the medical services were primarily intended for military purposes when medical schools and colleges came into existence their primary purpose

was to supply assistants to the military medical officers in the hospitals and teaching institutions. When the Justice Ministry was in power, the Government transferred many of the posts till then reserved for the military medical officers to the Indians in the medical service and increased the provincial medical officers in the cadre of Civil-Surgeons and when the Vizagapatam Medical College was started all the professorial appointments in that College were given to persons in the provincial service and all of them were transformed to the rank of Civil-Surgeons, superseding as many seniors in the Provincial Service with the result that junior officers drew much higher pay than their seniors who continued to be Assistant-Surgeons.

Concurrent with these changes many junior Assistant-Surgeons who were serving in the Madras Hospitals got themselves recommended for study leave and qualified for higher medical qualifications and on their return some specialist appointments were created. At the fag end of the regime of the Justice Ministry, the Government realised their mistake both financial and administrative and they thought that it was possible for England returned Assistant-Surgeons to remain as such and hold specialist jobs which though they did not bring them the pay of Civil-Surgeons, brought them additional status and with it additional income by way of private practice as specialists. Evidently the then Government must have thought that keeping the specialist in the cadre of Assistant-Surgeons was not wrong as all of them got the additional foreign qualifications with the help of public finance. Favouritism and not the needs of the Department was the test for granting study leave. The right thing for the Government to do would have been first to find out the needs of the department regarding specialist posts and then select suitable medical officers in service who have put in a fixed period of service and who had a zeal to go abroad for special training and appoint them as specialists without changing their cadre. This was not done and very junior Assistant-Surgeons got special qualifications of their liking and claimed

supersession as and when they returned from abroad. Even then favouritism not seniority counted when a choice was made from amongst England returned Assistant-Surgeons to be promoted as Civil-Surgeons to hold the specialist jobs. As pointed out by the Correspondent, X-ray department cannot be an exception to the policy of drift and favouritism. It is indeed a serious blot on the Madras Medical Department that a lay technician is the Head of the Radiology Institute having qualified medical men under him. No where in the civilised world such an appointment would be tolerated by the medical profession. The Government have had no plan of their own in creating specialist posts nor did they grant study leave to their officers with the idea of establishing specialist posts. These came into existence as and when some of the Assistant-Surgeons returned with special qualifications. Actually the credit of opening special branches at least in the Government General Hospital should go to the England returned Assistant-Surgeons. There are ways and methods for the Government to get out of the vicious circle now existing in the Medical Department which they have inherited. The Government should create a teaching cadre and should have a list of their officers who are willing to get into the same as and when vacancies arise. There should be a separate cadre for general purposes for appointments in hospitals which are not teaching institutions. Arrangement should be made to train and keep ready officers to fill in posts in the X-ray and other special branches in the hospitals. All officers in whatever section should be given facilities to equip themselves with higher qualifications whether it be in the teaching or general cadre consistent with the needs of the Department as a whole. There is a need for changing the nomenclature of appointments depending upon the duties and nature of work done. Those holding appointments in the teaching institutions should be designated as Professors, Assistant Professors, Demonstrators, Tutors and so forth. Those doing duty in hospitals should be styled as Physicians, Surgeons, Assistant-Physicians and Assistant-Sur-

geons depending upon the duties they perform. Such of the officers working in the moffusil hospitals and dispensaries holding independent charge should be designated as Medical Officers and not as Assistant-Surgeons and Sub-Assistant Surgeons as is uniformly done now. The new policy of the Government restricting private practice to consultation only may demand the necessity of revising the emoluments. It is indeed incongruous to pay special allowances to those doing teaching work. Whatever justification the Government might have had in the past for granting special allowances to those in the teaching line in future after the inauguration of new policy of restriction of private practice, if special allowances are to be given to the Government Medical Officers, those in the general cadre deserve them more than those in the teaching cadre. Officers of the Government holding teaching specialist jobs will naturally command the bulk of consulting practice while those in the general line almost nil.

Time is now opportune to effect radical and rational changes in the Medical Department with a view to bring contentment in service and get rid of anomalies and invidious distinctions when the Departmental Head is a person who came here from an outside Province free from prejudice or favouritism and the Minister in charge of the Department is a medical man who during the short period he has been in office, has made a name to display courage in his convictions with a driving force of his own. Our criticisms are against the policy of the Government and not against individual and we have to mention that the three officers referred to by our correspondent who are recently promoted as Civil-Surgeons are best qualified for the posts and we take this opportunity of congratulating them.

Admission Into Medical Colleges: In the past we had been repeatedly pointing out to the Government that selection of candidates on communal basis was bad and the only test for selection should be the merit of the candidates and when the territorial representation was introduced we protested and brought to the notice of the Government that candidates from

Malabar and South Kanara suffered most and the Brahmin boys of this territory had the greatest hardship. We did also bring to the notice of the Government that there was no need for a selection committee and the work might be entrusted to the Principals who might be given a formula as to how the selection has to be done. During those days the candidates and their guardians had very tough work having to visit the members of the selection committee over and over again till the fate of the candidates was settled by the committee. But our criticisms fell on deaf ears and it was left to the Congress Government to give up the method adopted by their predecessors in having a selection committee for admitting the candidates. The territorial representation has also been given up and though the Congress Government is convinced about the absurdity of communal ratio in the selection of candidates, it has not been given up evidently for political reasons. Excepting this defect the selection of candidates to the Medical Colleges had been going on very satisfactorily these two years, the selection list being prepared according to the merit of the candidates as evidenced by the rank they hold in the university examinations and the marks they score. We should say the selections are fraud proof and no influence or pressure could be brought to bear on the three principals whose work is made easy by a carefully tabulated list which we are told is prepared at the Madras Medical College under the direct supervision of the Asst. Principal. We understand the selection is made in the following order of preference, keeping in view the communal ratio:

- (1) First and second class BSc. or B.A., of the physics chemistry group combined with natural science or physiology or mathematics.
- (2) First class Intermediates, group II.
- (3) First class Intermediates, group I (a).
- (4) Third class B.Sc., or B.A.,
- (5) Intermediates who passed only in the physics, chemistry, combined with natural science or mathematics.

(6) Second class Intermediates, group II.

(7) Do. with group I (a).

Women candidates were classified with men candidates without showing any preference to the sex. Amongst the the candidates who applied 180 were Brahmins, 115 non-Brahmins; 36 Christians including Anglo-Indians; 8 Moham. madans; and 1 Schedule caste. For all three colleges 138 non-Brahmins; 92 Brahmins; 50 Christians and 8 Moham. madans, 1 Schedule caste have been selected including women. Madras Medical College has 53 non-Brahmins, 30 Brahmins, 32 Christians, 7 Moham. madans; Stanley College gets 32 non-Brahmins, 20 Brahmins, 14 Christians; Viaz College will have 22 non-Brahmins 22 Brahmins, 4 Christians, 1 Mohammad. an; 1 Schedule caste man.

With due regard to the method of selection employed we should say it would be fair to place III class graduates above the 1st class intermediates. This will be consistent with the policy adopted by all the departments of the Government in preferring B.A. to Intermediate qualification. It will be conceded by all that the Christian community predominates in the medical profession proportionate to their ratio to other castes and women for women there are more Christian women doctors, next come the non-Brahmin women and last Brahmin and Moham. madan. If the Government has to respect communal justice they should do so regarding the communal women section and the selection of women candidates should be first—Mohammadans, second Brahmins, third non-Brahmins, fourth Christians. We are against communal representation for admission into teaching institutions but as the Government cannot afford to disregard communal ratio for political reasons, we feel it is the duty of the Government to note the injustice done to Brahmin women candidates. We would go a step further

and commend to the consideration of the Government that widows of all communities should be treated with preference.

Male Nurses Bring Down Registered Practitioners:—Entertainment of Male Nurses in the Government Hospitals in the Madras Presidency is now an accomplished fact and candidates are to be recruited so as to commence the the training from 1st July. Nine centres have been selected, (1) Madras General Hospital, (2) Royapuram Hospital, (3) King George Hospital, Vizag, (4) Head Quarters Hospitals in Guntur, (5) Salem, (6) Tanjore, (7) Calicut, (8) Coimbatore and (9) Mangalore. The course is to last for 3 years. The Nurses during the course of training will get Rs. 10/- and second and third years Rs. 15/- as stipends in addition to the ration allowance of Rs. 20/- and dhoby allowance of Rs. 2/- a month. The uniform allowance will be Rs. 25/- a year. Appointment is not guaranteed but the candidate should execute a bond that if required by the Government would serve for four years. Medium of instructions will be as far as possible in Tamil or Telugu, English being used whenever the instructors feel difficulty to express themselves in the two vernaculars. It is not known what arrangement is made for instructing Canarese and Malayalam nurses in their vernaculars. So far so good. But we are amused to learn that the Health Certificates are to be produced by the candidates from Registered Practitioners not below the rank of an Assistant-Surgeon. We hope the Hon. Assistant-Surgeons may come within this list unless he is an Assistant-Surgeon or one above his rank. We wonder if the Hon'ble Minister for Public Health has perused the clause pertaining to Health Certificate appearing in the Government Notification relating to Male Nurses. All his efforts in amending the Madras Medical Registration Act to bring uniformity of status for all Registered Medical Practitioners seem to be of no avail.

Correspondence, Reports, Etc.

NEW ORDER CHANGETH GIVING PLACE TO OLD.

Sir,

The letter kindly published by you in the last issue of your esteemed journal regarding study leave encourages me to approach you with this letter and I appeal to my unlucky brethren in service to take advantage of your kindness and publish in the columns of The Medical Practitioner the grievances in the Medical Department so that the medical world at least might know what is happening in Madras.

Those serving in the Madras Provincial Medical Service have been expecting that the National Congress Government would set right the Medical Department removing all the anomalies and invidious distinctions that are rampant in the Department. The recent announcement of three promotions to the Civil-Surgeon cadre have shaken the hopes entertained by the unlucky members now in the Provincial Medical Service. Members of the latter service are grateful to the Justice Ministry under the leadership of the late Raja of Panagal who made it possible for Indians to occupy the fat salaried posts till then reserved only for the I. M. S. But the Justice Government did not mind the injustice done to a large number of members in the Provincial Service while juniors in the service were promoted to the cadre of Civil-Surgeons superseding the seniors. One could imagine the lot of a senior Assistant Surgeon made to serve under a very junior of his who was lucky to be promoted as a Civil-Surgeon at times even without the hall-mark of English qualifications. One such unlucky Brahmin Assistant-Surgeon got relief recently after serving under his junior for a number of years by being transferred to a separate department. As was pointed by your correspondent in these columns last month many of us were not lucky to serve in the Madras Hospitals under European officers whose recommendations either for study leave or for special appointments naturally carried greater weight with the result that all sort of ano-

malies and inequalities crept up in the Medical Department. Thanks to your fearless criticisms we thought the Government were made to realise the injustice done to a large section of the members in the Provincial Service by the policy of supersessions in the department as the Justice Government felt from the year 1933 that Junior Assistant-Surgeons with special English qualifications could serve as specialists in the cadre of Assistant-Surgeons. But alas! the National Congress Government seem to think otherwise. I wish to show how one such appointment would hit a senior Assistant-Surgeon who did not mind to go out of the City when his turn came to be appointed as a Civil-Surgeon in the general line. He must thank himself for what had happened, if he did not refuse to take his turn of promotion as Civil-Surgeon his position to serve under his junior would have served our purpose very well in demonstrating to the Government, the necessity of re-modelling the Medical Department on sound lines.

The members of the Provincial Service are watching the turn of events which are likely to take place in the Bernard Institute of Radiology within a year. A few years ago a prize appointment was created by the Justice Government and an Assistant-Surgeon who was working in the Institute was transformed into a Civil Surgeon under the designation, Medical Superintendent. This post is likely to fall vacant within a year. There are at present two Assistant-Surgeons in the Department. One of them occupies 119th place in the Cadre of Assistant Surgeons and the other 155th place, the former is an M.D., M.R.C.P., T.D.D., (London) and the other F. R. C. B. (Edin). Both possess the special D. M. R. qualification. There is at present a very senior Assistant-Surgeon holding No. 22 in the list of Assistant Surgeons who, if he were in the general line was eligible to be a Civil-Surgeon. Quite recently a vacancy was created in the Bernard Institute by transferring from the Institute an Assistant-Surgeon, work-

ing in the Institute for a number of years and the Assistant Surgeon with F. R. C. S., (Edin) D. M. R. qualification has been posted to fill this vacancy. The one senior to this Assistant Surgeon who is M.D., M.R.C.P., D.M.R. (Lond.) could not so far succeed to get into X-ray department.

Before closing let me mention one more anomaly which has just occurred in the Govt. General Hospital, Madras. The Government have as an experimental measure posted an Asst. Surgeon to do the duties of the Resident Medical Officer who has been so long a Civil Surgeon. The duties and responsibilities of the R. M. O. General Hospital are quite different from those of the R. M. Os. in other hospitals and the Superintendents in other hospitals have assistants designated as Asst. Superintendents. In the General Hospital there is no post of Assistant Superintendent and the R. M. O. is virtually the deputy of the Superintendent Government General Hospital. There is a post called the Senior Assistant Surgeon. At present this post is occupied by an Assistant Surgeon who holds No. 45 in the list of Asst. Surgeons whereas the Asst. Surgeon posted as R. M. O. is in 73rd place in the list of Assistant Surgeons. It may be said that the latter is a selection appointment. But can the Government forget the human feelings when a senior is forced to serve under a junior for no fault of his.

Is it not possible for the Government to choose a Assistant Surgeon junior in rank to the R. M. O. Assistant Surgeon when such an officer is easily available. We in service highly appreciate your fair comments about this new post appearing in the last issue of your esteemed journal and you were perfectly justified in pointing out that appointing an Assistant Surgeon as an R. M. O. of the biggest General Hospital in India is a retrograde step. As it is, it is certainly incompatible and inconsistent with the Congress principles that the Congress Government should have adopted a policy of supersession which was given up by their predecessors in office.

Justice and Fair play.

P. S. R. M. Ps' ASSOCIATION.

Proceedings of the 2nd General Body Meeting of the Provincial Subsidized Rural Medical Practitioners' Association District Branch, Coimbatore, held on the 10th June 1939. Capt. E. S. Gopalan, M.S., M.B., presiding.

1. Read the letter of the District Medical Officer, Coimbatore, R. O. C. 32/39 to the Personal Assistant to the Surgeon-General with the Government of Madras, Madras.

Resolved to thank Lt. Col. A. I. Cox, I.M.S., District Medical Officer, Coimbatore and Dr. V. Rama Kamath, President, P. S. R. M. Ps' Association, Madras for suggesting the scheme of post-graduate study for the Rural Medical Practitioners of this District and to request the Government to sanction the same at an early date.

2. Read (a) the complaint of the Rural Medical Practitioner, Koilpalayam to the President, P. S. R. M. Ps' Association, Madras alleging interference in his zone of practice by two of his neighbours, one of whom is an L.I.M.

(b) the letter of the President to the Complainant, and

(c) The letter dated 9.6.'39 from the Rural Medical Practitioner, Perianaickenpalayam.

This Association is of opinion that the S. R. M. Ps are private practitioners and are at liberty to practise anywhere according to rules; but resolves to request the members to confine their professional activities as far as possible to their jurisdictional limits in order to avoid unnecessary misunderstanding amongst the members.

3. Since the net anticipated deficit, assuming that all the arrears will be collected, comes to about Rs. 23 this meeting resolves to request each member to contribute Re. 1 (one) as a special subscription.

4. Resolved to request the following members to collect arrears of subscription and future subscription and enroll new members in the respective Taluks, noted against their names. These members are requested to send the subscriptions collected with full particulars, to the

Secretary-Treasurer, Ammapet as early as possible, after collection :—

(1) Dr. S. Ramanathan, Palladam Taluk; (2) Dr. G. A. Chandrasekharan, Coimbatore Taluk; (3) Dr. K. V. Hari Rao, Erode Taluk; (4) Dr. R. Venkataratnam, Dharapuram Taluk; (5) Dr. G. J. Dawson, Bhavani Taluk; (6) Dr. C. K. Subramaniam, Udamalpet Taluk; (7) Dr. T. G. Rajagopalan, Pollachi Taluk; (8) Dr. C. V. Viswanathan, Gobichettipalayam Taluk.

5. This meeting approves the action of the District Representative, Ammapet in representing to the Provincial Committee, Madras, that this Association urges on the authorities the urgent necessity of entrusting the Rural Medical Practitioners with every form of medico-legal work in their respective jurisdictions.

6. In order to protect the claims of the Rural Medical practitioners in future, the District Board President and the

District Medical Officer be requested to supply the District Branch of the Association with a copy of the service register of the practitioners maintained at the offices of the above officers, R. O. C. No. 335/38, office of the D. M. O., Coimbatore, 23-8-38 and Ref. Endr. R. O. C. No. 3367/ C. D. B. of 38 dated 16-10-38.

7. This Association regrets to note that no steps have yet been taken to send the Rural Medical Practitioners of this District for Public Health Training and resolves to request the authorities concerned to expedite the matter.

8. Resolved to request all the members not to pay their subscriptions direct to the Provincial Association, Madras, but to the Secretary-Treasurer, Ammapet of the P. S. R. M. Ps' Association District Branch, Coimbatore direct or through the Taluk Representatives.

9. Resolved to rescind the Resolution No. 7 first part passed by the District Branch on 22.12.1938.

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

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance on 30-4-1939 ...	124 14 0	Postage ...	8 8 0
Subscriptions received from members ...	13 4 0	Stationery ...	1 1 0
Entrance fees received from two new members ...	0 8 0	Conveyance charges paid to Dr. M. K. Bhat, to go to the Minister, Surgeon-General for arranging the opening of the Conference at Samalkot. ...	4 7 0
Advance received from the President to meet the office expense. ...	35 9 0	Pay of clerks ...	15 0 0
		Amount credited to The Medical Practitioner out of subscriptions received from eight members ...	2 0 0
		Contribution paid to Secretary Treasurer of Madura District Branch ...	1 0 0
		Amount lent to Chairman, Reception Committee, Samalkot Conference. ...	16 9 0
		Paid to the President the amount advanced by him to the office ...	35 9 0
		Cash Balance :	
		Rs. A. P.	84 2 0
		With S. B. ...	83 9 0
		With office ...	6 8 0
			90 1 0
	174 3 0		174 3 0

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

WEBSTERS PHOSPHATUM RECONSTRUCTIVE AND

HOMOSTIMULATIVE TONIC

Composition.

Cal. Phosph.	'02 gm.	Avonin	'12 gm.
Sod. Phosph.	'14 gm.	Xanthoxylin	'15 gm.
Kali. Phosph.	'30 gm.	Orange Juice	1'2 gm.
Mag. Phosph.	'20 gm.	Apple Juice	1'2 gm.
Lecithin 12 gm.			

Therapeutic indications

- (1) Phosphaturia:—It is an unfailing remedy if given in tablespoonful doses before food and given persistently.
- (2) Billiousness, Waterbrash, Giddiness, Loss of appetite etc:—A tablespoonful in half an ounce of water three or four times a day correct the whole condition in a remarkably short time.
- (3) Uncontrollable Vomiting, especially in malarial fever and also in any condition yields promptly to one or two doses of Webster's Phosphatum; may be combined with adrenaline.
- (4) Chronic rheumatism, Myalgia, etc:—In these conditions it may be considered as a specific.
- (5) Neurasthenia, Tired feeling, Nervousness, Trembling of the hands, Inability to concentrate, etc., all showing want of nerve tone:—Tablespoonful of Webster's Phosphatum undiluted before food twice or thrice a day is positive to show its effect in a month's time.

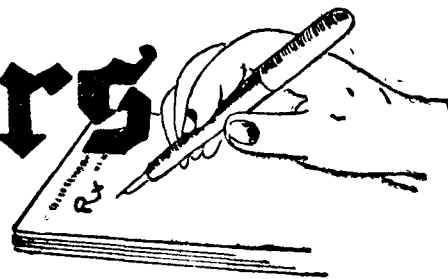
Obtainable at all Chemists or with the Sole Agents:

Messrs. KRISHRAJ & CO., 8, Bunder Street, MADRAS.



Doctors

Prescribe with
Confidence



ZANDU'S B. P. Products and Pharmaceuticals where quality, Purity, Uniformity and Therapeutic Activity stand Supreme, supported by a Guarantee, to conform with B. P. Standards.

Special Concession Rates Offered to Charitable Mission Hospitals.

"ZANDU" Brand Products are obtainable from:

The Chief Agents: **Messrs. DAMODER & CO.,**

78, China Bazar Road, G. T., Madras.

And also from their Sub-Agents in Madras Presidency.



This acid butter-milk in powder form has the continued support of the Profession.

ELEDON places in the hands of doctors an unvarying product which can be used with confidence in every case where fresh butter-milk is indicated in the diet. Acidity in ordinary butter-milk varies considerably... in ELEDON this is constant and the fat content is fixed at 1.3 per cent. In all cases of diarrhoea and dysentery ELEDON will prove an efficient remedy.

ELEDON, either taken alone or in combination with maternal milk, is an excellent food for babies.

For complete literature and samples apply to NESTLES, P. O. Box 396, CALCUTTA, or P. O. Box 180, MADRAS.

A NESTLÉ PRODUCT

A Warning from Polynesia

Most medical men know the story of the New Zealand Mandate after the War, where medical warnings were disregarded. A year of Prohibition in a Polynesian Island brought a steep rise in the infantile mortality rate, with an equally enormous increase in still-births and miscarriages. Scientific investigation revealed that the monotonous diet of the islanders depended entirely on the prohibited "toddy" as their sole source of Vitamin E. Although such an extreme case is unlikely to arise in India, there is no doubt that the sudden deprivation of alcohol will necessitate adjustments in diet among those who have been accustomed to even small regular quantities of liquor.

Hall's Wine has clearly-defined food properties both as a matured wine, extra rich in iron-salts and in its added medicaments, which greatly increase its calorific value. Hall's Wine requires no activity of the digestive system for assimilation, and actually improves the general metabolism.

The physical functions of Hall's Wine are thus to assist a weakened digestion, to provide energy and tone, and to build up hæmoglobin in the blood, while improving its circulation. Its stimulus, though mild, is quite definite, and alleviates the nervous distress of a patient who is trying to do without accustomed alcohol.

Where a stimulant tonic is indicated, Hall's Wine may be prescribed with perfect confidence.

HALL'S WINE

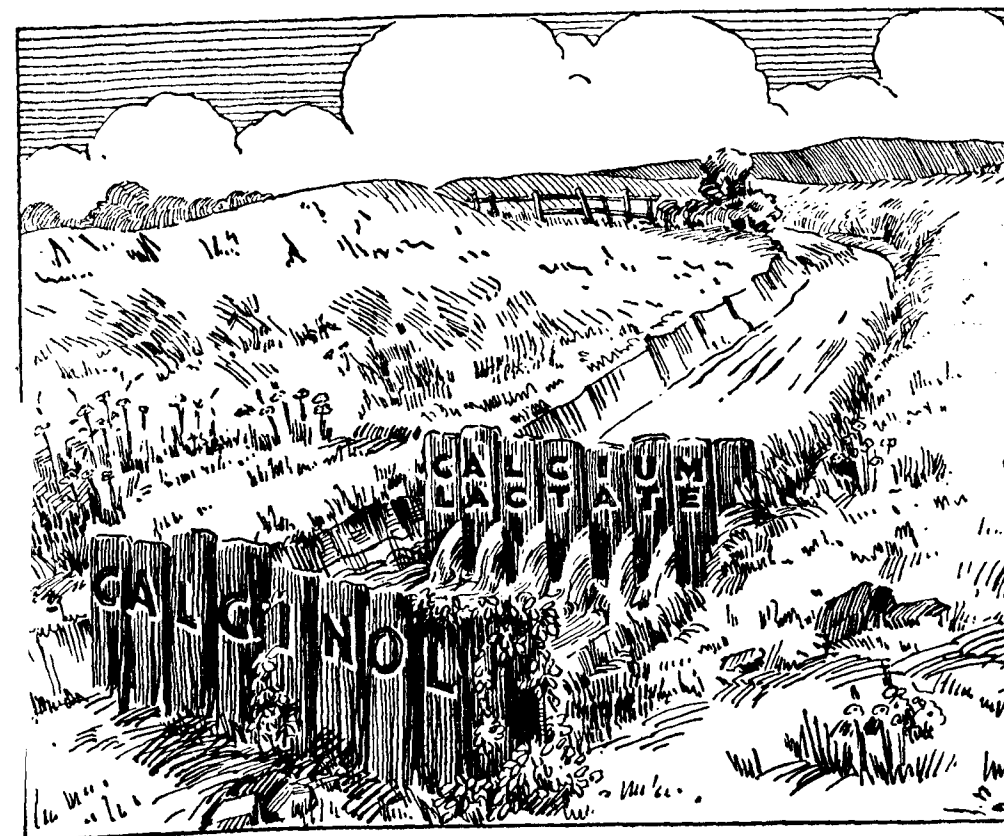
Tonic Restorative



Distributors: J. HALLEY & CO., LTD.,

P. O. Box 133, Calcutta. P. O. Box 84, Lahore. P. O. Box 34, Karachi. P. O. Box 466, Bombay.

HW 94



To swallow Calcium is not sufficient.

To retain it is more important.

Yet Calcinol costs no more to attain this result.

The satisfied physicians are prescribing it regularly and our samples and particulars will perhaps encourage you to try it.

CALCINOL

Agents:

RAPTAKOS, BRETT & CO., LTD.
Bombay Calcutta

THE RESEARCH LABORATORY,

HARRIS ROAD, MADRAS.

Microscopical, Cultural and Bacteriological Examinations of Blood, Sputum, Urine, Faeces etc., done.

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

Stock and Autogenous Vaccines prepared.

Sterile Solutions for injection always in Stock.

Please apply for further particulars to:

THE MANAGER.

THE MEDICAL BULLETIN

Empire Automobile Bldg., Queen's Road, Bombay 4.

VALUABLE FORTNIGHTLY JOURNAL
FOR THE GENERAL PRACTITIONER
ARTICLES BY EMINENT MEDICAL MEN
USEFUL ABSTRACTS
INTERESTING NEWS.

Many, many Doctors read it. Write for Sample copy now.

Annual Subscription—Rs. 5—post free.

Antiphlogistine
TRADE MARK

The Denver Chemical Mfg. Co., New York.

THE PERFECT
POULTICE AND
DRESSING FOR
INFLAMMATION
AND
CONGESTION.

JOURNAL OF THE INDIAN MEDICAL ASSOCIATION

EDITED BY

SIR NILRATAN SIRCAR, K.T., M.A., M.D., D.C.L. etc.,

With the help of A Strong All-India Editorial Board

The Official Monthly Publication of the Indian Medical Association.

FEATURES. 1. Original Articles. 2. Case-Reports. 3. Society Proceedings. 4. Valuable abstracts from leading medical journals from all over the World.

PUBLISHED ON THE FIRST DAY OF THE MONTH

Annual Subscription: Rs. 6. Post free.

Free to Members of the Indian Medical Association.

AN EXCELLENT MEDIUM FOR ADVERTISEMENT

For particulars, write to:

SECRETARY,

SAMAYAYA MANSIONS,

1-A, Hogg Street, Calcutta.

MODERN SURGICAL EMPORIUM

Established twenty years ago to sell quality products and to strive to make the care of the sick and the injured more effective, safer and less expensive.

ALL OUR

SURGICAL INSTRUMENTS

are made with micrometric exactness of regular Carbon Steel, "Surgico" Rustless Steel and Krupp Patented "V 2 A" Rustless Steel—useful for AMPUTATION, POST-MORTEM, DISSECTING, DRESSING, DIAGNOSTIC, FISTULA, HERNIA, EYE, EAR, NASAL, DERMAL, ORAL, TONSIL, DENTAL, TRACHEAL, LARYNGEAL, STOMACH, INTESTINAL, MIDWIFERY, GALL BLADDER, RECTAL, PROSTATIC, PHIMOSIS, VESICAL, URETHRAL, URETERAL AND INSTRUMENTS FOR EVERY CLASS OF HOSPITAL WORK—ALSO

HOSPITAL REQUISITES

of every kind, of absolute uniformity, absolute dependability, supplies that will do their work well, satisfyingly well—all at a fair price and latest.

HYPO AND SERUM RUSTLESS NEEDLES

KALMERID SURGICAL SUTURES, D & G.

ANAESTHETIC APPARATUS

MICROSCOPES AND ACCESSORIES

LABORATORY APPARATUS AND GLASSWARE

ADHESIVE PLASTERS IN VARIOUS SIZES, S.R.

STAINLESS STEEL HOSPITAL WARE

SYRINGES FOR ASPIRATION AND INJECTION

HIGH PRESSURE STERILIZERS, PORTABLE AND STANDARD

SURGICAL RUBBER GOODS, GOODRICH, ETC.

HOSPITAL FURNITURE—SELECTED QUALITY

SICK-ROOM UTENSILS OF EVERY KIND

ELECTRIC DIAGNOSTIC SETS

SPHYGMOMANOMETERS OF RELIABLE MAKES

SURGICAL AND DISPENSING SUNDRIES

CONTRACEPTIVE PRODUCTS, H-R MAKE

ARTIFICIAL LIMBS, DEFORMITY AND FRACTURE APPARATUS,

SPLINTS, ELASTIC HOSIERY, ABDOMINAL SUPPORTERS,

HERNIA TRUSSES, SUSPENSORIES, CRUTCHES, ETC.

All selected merchandise described and illustrated in our Catalogue. In its 500 pages there is more information of value than in any other single volume extant. Whatever you need you will find it here.

BOMBAY SURGICAL CO.

"The Quality House"

New Charni Road.....BOMBAY.

Telegrams: "SURGICO"

[Telephone No. 41936]

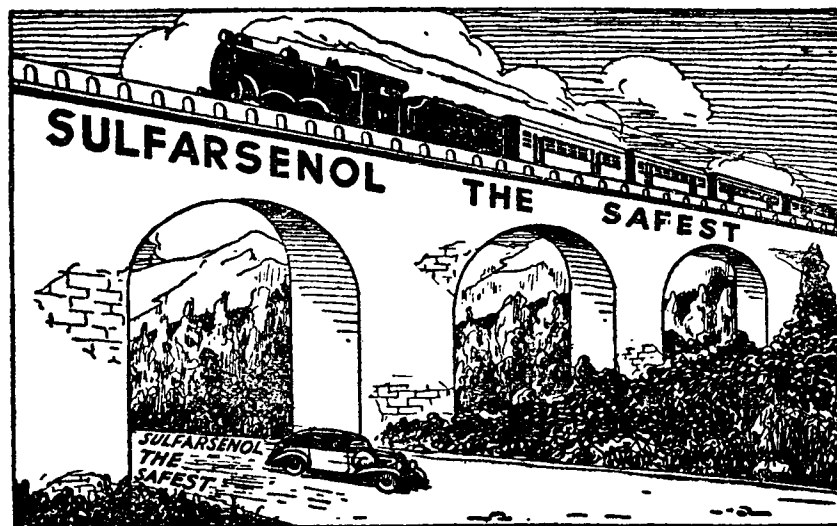
REPAIRING, SHARPENING and PLATING work done in own Factory.

Reg. No. M. 3685.

*Patients prefer
painless
injections!*



ARSENO-SOLVENT
ensures
painless administration of
SULFARSENOL



The Anglo French Drug Co., (Eastern) Limited,

POST BOX No. 460

BOMBAY.

Printed by Mr. M. S. Ekambaram, Manager, SOLDER & Co., Triplicane, Madras and Published
by the Managing Editor, Dr. V. Rama Kamath, 147, Purasawalkam High Road, Vepery, Madras.