

281

Indian Medical Journal

Apr 1940



JL
L-2, N06
N40.34.4
123951

B91

391

The Indian



FOUNDED 1906

Medical Journal

Organ of the All-India Medical Licentiates' Association

(With which THE AGRA MEDICAL CLUB JOURNAL is incorporated)

W.A.M.L.A. Session, AHMEDABAD, March Week, 1940

Vol. 34. No. 4

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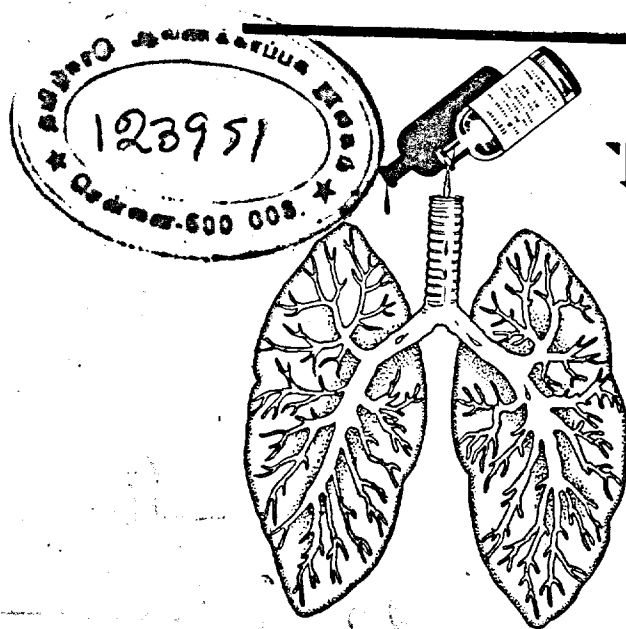
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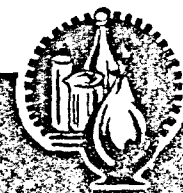
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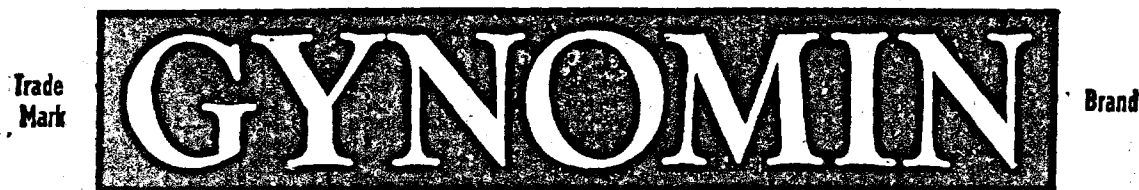
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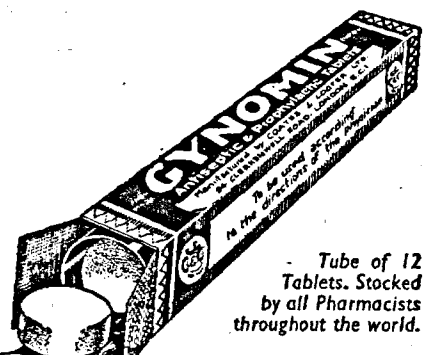
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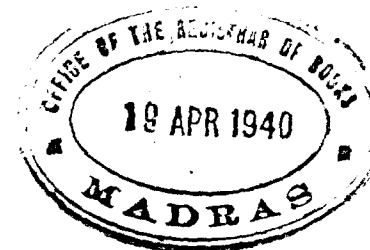
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except on one condition. If an investigation of the heart reveals organic damage the prognosis is that of the pathological condition, but the presence of extra systoles in such a condition does not alter the prognosis in any way. On the other hand if the heart does not reveal any organic damage, barring the presence of extra systoles, this important point sometimes helps in judging whether they are to be taken seriously. Harmless extra systoles usually disappear after a little exercise and are never present with a heart rate over 110 per minute. If they persist at or over a pulse rate of 110 per minute, they are not harmless and are often an expression of early cardiac damage which has not revealed itself on physical examination.

On rare occasions we find that extra systoles are more numerous when the pulse rate is accelerated artificially. In such cases they are sometimes known as "prefibrillatory extra systoles" heralding the onset of auricular fibrillation, if adequate rest is not given to the heart.

The treatment of extra systoles is to lessen the irritability by valeria, bromides and small doses of luminal, and a restriction of carbohydrate and such other measures as to prevent gaseous abdominal distension.

AURICULAR FIBRILLATION

Normally the auricles exhibit a co-ordinated contraction by which they expel their blood into the ventricles. In fibrillation the auricle is virtually paralysed and has lost its power of co-ordinated contraction. It quickens like a jelly. If the immediate cause is the supervention of circus movement it has the ultimate effect somewhat resembling a dog chasing its tail indefinitely (an act which certainly leads to useless waste of energy on the part of the dog). In this way it taxes the heart.

The pathological causes of fibrillation are: (1) rheumatic infection of the heart, (2) arteriosclerotic degeneration of the cardiac muscle with or without hypertension, (3) thyrotoxic disease and (4) acute infections like pneumonia.

The auricle sends out innumerable impulses of varying strength (5 to 600) to the auriculo-ventricular node. Some of these are effective in eliciting a response; others are ineffectual. The ventricle responds by contracting irregularly and rapidly, some beats are so feeble as to be unable to send out even a pulse wave. The whole story is one of tremendous waste of energy owing to the auricles having run amok.

The waste of energy leads to congestive cardiac failure. The irregular beating of the ventricles gives rise to palpitations.

The predominant effect on which to make a diagnosis is the regularly irregular heart and pulse. No two beats of the heart or pulse are alike either in intensity, force, timing, spacing or character.

As the auricles no longer contract, the presystolic murmur in cases of mitral stenosis disappears. Diagnosis is easy owing to the nature of the irregularity. Sometimes confusion arises with extra systoles when they occur very frequently.

If congestive cardiac failure is already present the diagnosis is fibrillation, because extra systoles cannot by themselves give rise to failure unless associated with or implanted upon organic heart disease.

When there is no congestive cardiac failure the diagnosis is also not difficult. If the patient is made to sit up and lie down in bed for a number of times (say 6) his pulse rate will accelerate. Extra systoles are likely to become infrequent or disappear totally. Whereas if the irregularity is due to fibrillation, it will increase.

Treatment: Digitalis is always safe. It cuts off the frequent feeble impulses from reaching the ventricles by imposing a partial block on the auriculo-ventricular node. Result is that the ventricles only receive the stronger impulses and therefore beat more slowly and more regularly. The ideal would be to maintain the heart rate between 70 and 80 per minute.

Quinidine has many contra-indications. It must not be used in cases of mitral stenosis, or cases in which congestive failure is already present, or in cases which show cardiac enlargement. This tends to limit its use greatly. It is however useful in thyrotoxic or arteriosclerotic early cases.

AURICULAR FLUTTER

It occupies a predominant place amongst cardiac irregularities because it is the most difficult to diagnose by physical examination alone, and sometimes even difficult to suspect.

Here the mechanism is the same as in fibrillation except that the circus movement takes place at a slower rate, between 180 to 360 per minute, and there is in addition usually a block in the transmission of impulses from the auricles to the ventricles and the ventricular rate though usually somewhat rapid is regular.

The following case will illustrate the difficulties of diagnosis.

A man was seen with persistent tachycardia. His complaints were that for 3 days previous to being seen he had been suffering from dyspnoea on slightest exertion and he had an uncomfortable sensation of palpitation and forcible heart beats. On examination he had a pulse rate of 120 per minute and early signs of congestive cardiac failure. The

pulse was regular in timing, volume and tension. No cause for the high pulse rate could be elicited or be found until electrocardiograph revealed auricular flutter with 2:1 block.

In such a case if once suspicion is aroused, confirmation is comparatively easy on physical examination.

Normally the pulse rate of an individual varies between 10 to 20 beats on assuming the erect posture suddenly from the recumbent posture, or on mild exercise and rest for 15 minutes, or on inhalation for a few seconds of amyl nitrite. In a case of flutter the pulse rate remains absolutely constant under any of these conditions and remains steady at the fixed figure. If it varies at all it suddenly becomes doubled or halved according to the change in the degree of block.

The treatment is the same as that of fibrillation. A flutter with high pulse rate when digitalised reverts to fibrillation and, if all goes well, to normal rhythm.

HEART BLOCK

There are various varieties and several degrees of heart block.

I would only mention that it may occur wherever the conductivity of the bundle is impaired or lost by fibrosis in diseases which produce generalised fibrosis of the cardiac muscle, chief of which are arteriosclerosis, atheroma of the coronary arteries or syphilis. It may also occur in acute infections like pneumonia or diphtheria. The block by imposing enforced silence on the heart expresses the fact that the heart is diseased or involved when there may be no other indication.

In any case heart block is a rare but serious condition.

The diagnosis of the ordinary varieties are made by the pulse missing a beat and the heart remaining completely silent at the same time.

When all the beats from the auricle are blocked from reaching the ventricles, the ventricle itself takes up a new rhythm which is unchangeable and is about 35 per minute and does not vary with exercise or emotion. During the phases of change from a partial to a complete block we sometimes notice a group of alarming symptoms known as Stokes Adam's syndrome, the principal features of which are unconsciousness, cyanosis, and convulsions following each other in this order and accompanied by a slowly acting heart.

The treatment of the acute attacks is administration of adrenalin (preferably intravenous) and atropine sulph in large doses. During the interval ephedrine (gr. $\frac{1}{2}$) may be given t. d. s. or barium chloride (gr. $\frac{1}{2}$) t. d. s.

As a curative measure we can only employ antisyphilitic treatment if we know the cause to be syphilis.

PAROXYSMAL TACHYCARDIA

Paroxysms of tachycardia occur which begin suddenly, last a few seconds, few minutes, few days, few weeks and end suddenly. If they last more than a few hours, signs of acute congestive cardiac failure develop. The history if carefully enquired into is typical. The abrupt beginning and the abrupt end of all discomfort is the real clue. The pulse rate is usually above 160 per minute.

The attacks usually occur in an otherwise healthy heart, and although the temporary symptoms are alarming the prognosis is good and the patient has no cardiac limitations between the attacks.

We can never be sure of terminating an attack by our treatment, but sudden changes of posture, swallowing of iced water, the act of induced vomiting, pressure over carotid sinus or eyeball, the administration of quinidine, digitalis, carminatives, all these have been both successful and unsuccessful. I had a case which responded thrice to sudden pulling of the tongue, but on the fourth occasion he failed to respond to this measure and suddenly stopped of itself.

PULSUS ALTERANS

Every second beat of the heart is feebler and smaller although the rhythm remains regular.

It is not usually felt at the pulse by palpation. It can be diagnosed by B. P. instrument when and if the pulse is completely obliterated by raising the pressure above the systolic pressure, and when the pressure is gradually lowered the stronger beats will at first come bright. This will be half of the apex rate in number. If the pressure is further lowered the weaker beats will come bright now and the rate will be doubled.

When such a condition is present in a quickly acting heart it is not of much significance. But when it occurs in a slowly acting heart, say below 90, it is of very grave prognostic significance. It is then an evidence of extreme exhaustion of the cardiac muscle, —an impairment of function of contractility.

My experience of Senile Cataract

• Dr. M. L. Bagh, L. M. P.,
Ganji, Ajmer

INDIGENOUS BELIEFS AND METHODS

Senile cataract is a very common disease in our country. The aetiology of the disease is unknown. Probably it is due to some defect in the diet, particularly lack of vitamins.

There is a belief in some places in the north that the disease can be checked or even cured by drinking every morning a chattak (2½ oz.) of warm ghee with some peppers roasted in it, and by putting in the eyes drops of a mixture of sour pomegranate juice and honey which have been exposed to sunlight for a considerable time.

The rationale of this treatment cannot be explained fully, but sometimes it really does good to the patient; and there is no doubt the beneficial result is due to the supply of a good deal of vitamins. The treatment requires a great deal of time and patience and nobody knows whether the benefit is due to the treatment or the cataract itself has checked its progress.

Another common treatment in the north is what they call "Mussulman operation" or "Mahomedan operation". This sort of treatment is done by a community known as "Jarrahs". The technique of operation is handed down from father to son and so on.

This operation is done with a needle. The needle pierces the sclera about 2 to 3 m. m. lateral to the temporal margin of cornea and is passed in to the posterior chamber behind the iris and anterior to the lens. The handle of the needle is then jerked upwards and forwards; thus its point displaces the lens outwards and downwards in the vitreous.

Some "Jarrahs" approach the lens not *via* the posterior chamber, but pierce the periphery of cornea, pass the needle in anterior chamber and then depress the lens downwards by a peculiar jerk.

The after-treatment in such operations consists in daily drops of white of an egg and bandage for 3 or 4 days.

The dangers of the operation are many due to lack of asepsis observed in the procedure. The same needle is used again and again without any sterilization.

The patient may feel temporary relief because the opaque lens has been removed from its place; light can enter the pupil and

fall on retina; but very often such an operation is followed by iridocyclitis, secondary glaucoma or even detachment of retina.

SYMPTOMS AND SIGNS

The modern treatment is the extraction of cataract after an incision in cornea with all aseptic measures. When the cataract is mature and operable, the patient comes with the following signs and symptoms. The patient is an elderly person, about 50 yrs. or so in age. The main complaint is gradual loss of vision. Only one eye may be affected; generally both the eyes are affected; in one the cataract is advanced while in other it may be incipient.

1. The first thing to come to notice is the milky white appearance of the lens.
2. Cornea is quite clear.
3. Anterior chamber is of normal depth.
4. Pupil is of normal size and reacts well to light.
5. Iris does not throw any shadow.
6. The patient is unable to see anything with the mature cataract. Finger movement at a distance of 4" or so from the eye is perceptible.
7. Projection of light must be alright.

SELECTION OF CASES FOR OPERATION

1. Lid margins and conjunctiva should be healthy.
2. On pressing over the lacrimal sac no regurgitation should be obtained.
3. Teeth should not be dirty or carious.
4. Urine examination should show absence of albumin and sugar.
5. Respiratory system should be normal.

OPERATION

The night before operation the patient is given one ounce of castor oil.

Drops of 4% cocaine solution (containing a little adrenaline), every 5 minutes are put 4 times in the eye to be operated, and for the last time in both the eyes.

The patient lies flat on his back on the table and face upwards. The surgeon stands behind the head of the patient.

The eyelashes if long are cut with a scissors, the blades being smeared with a little vaseline to prevent the hair falling in the eye. The area round about the eye including the lids is painted with Tinct. iodine after thorough cleansing.

The conjunctival sac is irrigated with hydrargyri per chloride lotion (1 in 3000).

Fixation: The eye speculum is inserted and the patient is asked not to squeeze or strain.

APRIL, 1940]

SENILE CATARACT : BAGH

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With the fixation forceps in the left hand in case of right eye, and in the right hand in case of left eye, a fold of conjunctiva 1 to 2 m. m. below the lower margin of cornea in the vertical axis is caught and the eyeball is very gently pulled downwards and a little forwards so that the force of the tips of the forceps may not press over the eyeball.

Incision: After fixing the eyeball thus, for the right eye, the cataract knife is taken in the right hand and for the left eye in the left hand.

The handle of the knife rests on the terminal phalanges of the index and middle fingers and is held between the two fingers below and the thumb above.

The knife is held horizontally with the blade pointing towards the surgeon and the point towards the nose of the patient.

Keeping the knife in the same position, the point of the knife is put just lateral to the temporal margin of cornea about 1 to 2 m. m. above a line passing horizontally through the centre of the pupil.

Slowly and gently the knife is now pressed in the same direction and made to penetrate into the anterior chamber. If the knife goes in substance of cornea, the movement would not be free; on the other hand if it goes in the anterior chamber it is very easy to pass it out in the same direction, a little medial to the nasal margin of cornea and about 1 to 2 m. m. above a horizontal line passing through the centre of pupil.

As the knife point comes out of the cornea, after passing through the anterior chamber, practically the whole blade is pushed in so that much of it comes out to the nasal side of cornea. Now with to-and-fro movement of the blade, with a slight pressure towards the blade side, we reach the upper margin of cornea.

When the knife is just at the point of being freed, tilt the blade a little posteriorly and try to take a flap (4 m. m. × 4 m. m.) of conjunctival membrane along with it. Complete the incision by directing the blade forwards. Turn the flap on cornea.

Care should be taken during the to-and-fro movements of the knife not to injure or cut the iris. For this reason the knife should be used with an upward and forward pressure and thus avoid injury to iris.

Iridectomy: The fixation forceps and the knife are now no more to be used and they are given to the assistant to be kept back in proper place.

The patient is asked to look down towards the feet. The surgeon takes an iris forceps

in the left hand and an iris scissors in the right hand.

The closed iris forceps is passed through the incision and loosened a bit as it reaches a m. m. or so above the upper pupillary margin. Here a portion of the iris near the pupillary margin is caught in the forceps and gently taken out of the wound. With the iris scissors in the right hand and its blades held parallel to the body axis of the patient i. e., at right angles to the incision, the caught iris is cut, the blades of the scissors working posterior to the tip of the forceps.

Capsulotomy: Next, through the incision, pass a flat cystotome. As it reaches the pupil, turn the cutting edge towards the lens capsule and give it first a vertical tear and then a horizontal. Do not press too hard.

Delivery of the lens: Take a curette or a spoon and apply a gentle pressure at the lower margin of the limbus. The pressure is applied first by the movement of the curette in a to-and-fro direction along the limbus, and then, as if scraping a wound, with the hollow margin of the curette upwards and pressing up with the blunt or rounded posterior part.

The lens comes out in the anterior chamber and then with a little pressure over cornea at the lower margin of the lens, take the lens out of the incision in the cornea.

Irrigation: The anterior chamber is irrigated with sterile normal saline, so that any tags of capsule or any lens material left behind is washed out.

Iris Reposition: With an iris repositor place the cut margins of iris in proper position and see that the cut margins of cornea and conjunctiva are placed well in apposition so that there may not be any delay in healing.

Take out the speculum gently and ask the patient to close both the eyes.

Atropine-Pad-Bandage: Put atropine 1% in the operated eye, pad and bandage both the eyes. Before bandage apply some sterilized vaseline to the lid margins of the operated eye.

After-treatment: Patient lies quietly on back for 12 hours after which he can lie on the side of the unoperated eye.

For 2 days patient is given only milk diet. If constipated, castor oil may be given or enema. Unoperated eye is opened on 2nd day. Operated eye is opened on 7th day. Dressings are changed every 24 hrs. Instillation of atropine 1% for the first 4 days is beneficial.

(Continued at foot of next page)

A Short Note on Anæmia*

• Dr. A. Bhattacharya, Gauhati

In the normal state of health, destruction and regeneration of the blood cells are going on side by side so that the red cells are kept at about 5 million and the hæmoglobin at 90 to 95%. Thirty trillion R. B. C. are constantly at work in the average person's blood stream. During an estimated span of activity of approximately 30 days, each cell participates 50,000 to 10,00,000 complete gaseous exchanges, more than one a minute. The R. B. C. are finally broken down into iron and bilirubin. It is estimated that about 1 trillion cells are destroyed each day. To sustain the erythrocytes at a normal level, the bone marrow manufactures nearly 1 trillion red cells every 24 hours and for this nearly 1 pound of hæmoglobin is necessary. This necessitates a supply of 100 milligram of iron of which 85% represents the iron salvaged from the destruction of old cells.

There are 4 factors required for the proper formation of erythrocytes and hæmoglobin.

(i) Specific anti-anaemic factor present in normal stomach and liver tissue which is essential for the maturation of the red cells in bone marrow.

(ii) Iron (with a trace of copper and manganese) for hæmoglobin formation.

(iii) Vitamins — vitamin B₁, B complex and C improve the nutritional status of the patients and thus promote the utilization of the required anti-anaemic factors.

(iv) Good diet, consisting mainly of protein, is necessary for the production of red blood elements.

In anaemia, the erythrocyte formation fails to keep pace with erythrocyte loss. For each million deficiency in red blood count there is a deficit of over 1000 c. c. of normal blood.

*Read at a meeting of the Gauhati Branch, A.I.M.L.A. on 19-11-39.

(Continued from previous page)

Patient is advised not to cough or sneeze or strain. If patient feels like coughing, ask him to bite the lower lip as in chewing and it will stop the cough for the time being. If patient feels like sneezing, a little pressure over the cartilaginous part of nose will prevent it.

The patient is discharged on the 8th day with a green shade and dark goggles and asked to come after a month for glasses.

When the gastro-hepatic hormone is deficient, immature and short-lived cells appear in the circulation. Many of these are bigger than normal and so contain more hæmoglobin, anaemia thus resulting is of macrocytic hyperchromic type. In other cases, where iron, copper and vitamins are deficient the R. B. C. are smaller in size and contain less hæmoglobin and the anaemia following is of microcyte hypochromic type.

Symptoms in general are a feeling of quick tiredness; dyspnoea; irregularities of bowels; soreness of mouth and tongue; dilated heart; oedema of extremities; paleness of tongue, palate, tips and conjunctiva; giddiness, headache, migrain, neuralgia, faintness, sleeplessness mental irritability; a feeling of burning sensation in the scalp, soles of feet and palms of hands.

Lack of absorption of the liver principle.—The anti-anaemic liver principle may not be absorbed or may be destroyed when passed into intestinal tract in such conditions as sprue, intestinal parasitic infestations and chronic intestinal obstruction and stenosis, usually due to tuberculosis or cancer.

Lack of storage of the liver principle.—There may be complete inability to store the anti-anaemic principle in liver and the anaemia of megolocytic type does not respond to liver therapy. Partial dysfunction of the liver to store the anti-anaemic principle is seen in pernicious anaemia of pregnancy where the demand upon the hæmopoietic system is usually high and failure to meet such demand ultimately leads to the development of a megalocytic anaemia. In such condition the administration of liver principle is essential.

What is hæmoprietin? The intrinsic factor found in the gastric mucosa, called the hæmopoietin, reacts during digestion with an extrinsic factor present in the protein of food, to form hæmatinic substances which are stored in the liver and also in the spleen and kidneys.

Types of anaemia.—They may be broadly classified as follows:

1. Macrocytic—number of R. B. C. is reduced, size is increased and the colour index high.

2. Normocytic—size and contents of R.B.C. are normal or only slightly increased and the colour index is 1—seen in acute hæmorrhages.

3. Microcytic hypochromic anaemia—R. B. C. are smaller than normal, the Hb value is considerably reduced and the colour index is much below.

4. Simple microcytic anaemia—size of R.B.C. and the Hb contents are slightly decreased.

TREATMENT

Macrocytic anaemias.—Liver extracts and stomach preparations.

Pregnancy anaemia.—may be macro or microcytic. (a) In the former the subject is always a multipara, 23-30 years old. Causes are repeated pregnancies, lack of proper nutrition, absence of protein from the diet, chronic bowel infection, etc. Prognosis during 8-9 months is always grave. Early administration of liver extract, vitamin B complex and Hcl. dil. is very helpful. (b) In the latter the subject is usually an elderly multipara. Causes are frequent pregnancies, prolonged lactation, achlorhydria, insufficiency of iron in food and chronic diarrhoea that retards the absorption of iron and other food principles.

Symptoms are dyspnoea, dyspepsia, nausea, vomiting, indigestion, pallor of skin, palpitation, oedema of dependent parts, night-blindness, etc. Iron and a diet rich in iron, manganese, etc. are efficacious.

Normocytic anaemias.—There is a very progressive failure of the function of the bone marrow. Liver treatment is not effective. Blood transfusion and abundant supply of milk and protein in diet are helpful.

Microcytic anaemia.—Simple and hypochromic anaemias.—This is seen in the course of many diseases not directly of the hæmopoietic system as in chronic hæmorrhage, but in black-water fever, malaria, infections by streptococcus hæmolyticus and infective jaundice, etc.

Treatment—Iron in large doses, acid hydrochloric dil and pepsin.

Tropical anaemia.—is a macrocytic hyperchromic anaemia due to deficiency of the extrinsic food factor. It occurs following simple dietetic failure and in association with pregnancy, syphilis, malaria and intestinal parasitic infestations. Administration of marmite can cure the condition in addition to a correct diet of high protein value.

Hypochromic anaemia.—Following dietetic deficiency it is seen in chronic starvation in lower classes of people due to complete withdrawal of portein and green vegetables from the diet. Too rigid milk diet is a cause of anaemia in infants and children, and the mother of such a case is usually a victim to hypochromic anaemia.

Hypochromic anaemia noticed in aged unmarried girls and young married women, is due to menorrhagia. In such cases menorrhagia improves after the treatment of anaemia with massive doses of iron.

CLINICAL NOTES

(Only a summary is published owing to exigencies of space.—Ed., I. M. J.)

Bacillary Dysentery without Blood in Stool

I had chances to see a few cases of B. Dysentery at Gauhati whose main symptoms were: slight rise of temperature, watery motions 20-30 times a day, slight griping pain around the umbilicus, and frequent vomiting. Repeated examination of stools revealed only cellular exudates and macrophages. No R. B. C. could be seen, and the benzidine test was negative. Blood for malaria parasite was negative. The stool was faintly yellowish, alkaline in reaction, foul smelling at first but very little smell afterwards. These cases were treated with anti-dysenteryphage prepared at Shillong Pasteur Institute, and the symptoms were arrested within 12 hours of phage treatment.

Gauhati.

19-11-39.

A. BHATTACHARJEE,

A Peculiar Case of B. Dysentery

A patient aged 24 yrs., female, started having fever (106°F.) and convulsions with tympanities and severe diarrhoea with griping. Blood was negative for malaria. She was put on anti-dysenteryphage in inadequate doses at first. Till the 8th day of the disease there was very little improvement when I began to give sufficient doses of bacteriophage every one hour. On the 9th day, the patient improved greatly.

Note: The disease started in a misleading way, and the dosage of bacteriophage first given was inadequate.

Calcutta.

11-6-39.

PARESH CHANDRA SEN,

A Case of Apyrexial Secondary Broncho-Pneumonia

B, aged 53 years, was admitted into the Mental Hospital, Bareilly, on 16-3-39 for the complaint of malaise and cough with expectoration. His temperature, pulse and respiration were recorded as follows:—

Date	Temperature		Pulse per minute		Respiration per minute	
	M.	E.	M.	E.	M.	E.
16-3-39		108°F	130		40	
17-3-39	98.5	100°F	120-124		42-43	
18-3-39	96.6	100°F	126-120		41-40	
19-3-39	99	98.4°F	124-124		36-40	
20-3-39	99.6	38.4°F	120-120		38-42	
21-3-39	99	99.8°F	126-122		42-49	

The patient died on the evening of 21-3-39. The case was characterised by extreme prostration, breathlessness cyanosis and

(Continued at foot of page 97)

THE Indian Medical Journal

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Vol. 34 | MADRAS: April 1940 | No. 4

The Need for Careful Prescribing

At no time has the need for careful prescribing been so great as it is during these hectic days of war, and in no country is it more pressing than in ours. The reasons are obvious. Our drug industry is in its infancy, and many of the essential drugs, raw and manufactured, have to be obtained from outside. The price of imported drugs has risen very sharply, and equally also of the drugs which are manufactured in our country since the basic raw products and chemicals have to be obtained from Great Britain and neutral countries at a very heavy cost. There is no immediate prospect of our country being able to manufacture the basic chemicals or to find out and prepare substitutes for some of the more important and useful foreign products. The former depends on the development of basic industries while the latter needs much investigation and research, and both would involve an expenditure which the country may not be capable of bearing at present.

There are visible signs of the Government and the industrialists moving to find out ways and means of making up this deficiency. But

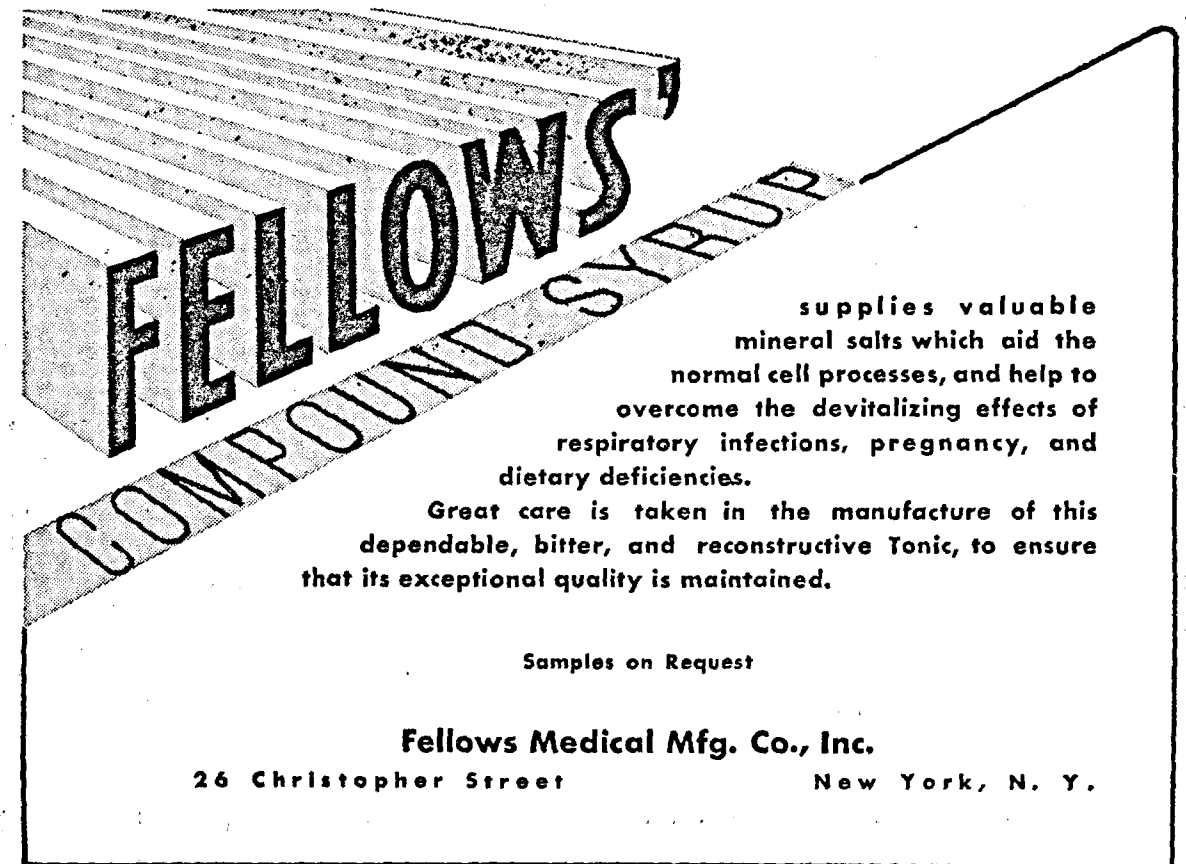
that is a question of time and money. Meanwhile, we have to recognise the present conditions which have brought about a very big rise in the cost of treatment. This the average Indian patient could ill-afford, and he has to be helped somehow or other.

Our physicians must face this drug crisis in an intelligent manner. We have no doubt that they would do so. This is perhaps the time when they can conveniently and profitably shed the habit of fashionable prescriptions, and excessive treatment by drugs. Many factors have contributed to this crazy habit of 'modern' prescribing: commercialization of research, the proprietary allurements and the blandishments of advertising chemists; the easy going complacency of the physicians and the unreasoning importunities of the patients for frequent change of drugs. Even before we anticipated the present war and the inevitable drug crisis we uttered a note of warning in these columns¹ against indiscriminate prescribing:

"The generality of the profession is practising the *materia medica* of manufacturers, and not wholly of the British Pharmacopoeia. Prescription of pharmaceutical drugs has ceased to be a fashion..... In our zest for popularity we are slowly forsaking the science of medicine."

Fashion, of course, dies hard, but now that the opportunities for the exhibition of such fashion have become limited and costly may we appeal to the members of the profession to revert to simplicity in prescribing by avoiding costly proprietary remedies and duplication of drugs? Failure to accommodate this-wise would mean that they are not true to the interests of the patients and the ideals of the healing art. Experience has shown that many drugs are not needed for the cure of any disease, acute or chronic, and that effective cure at a minimum cost can be attained by simple drugs and methods. It is time that we should utilize and test this experience and make our treatment simpler, more pointed and less costly than what would really be the case if we continue to indulge in our habit of promiscuous prescription and shot-gun therapy. The present drug crisis teaches us at least two lessons: we must place greater reliance on drugs of proved value and reacquire the habit of simple prescribing; and the Government must begin to put in genuine attempts to make our country self-sufficient in the matter of supply of at least essential drugs. And if this crisis is utilized to these ends it would not have come in vain.

¹ Ind. Med. Jour., May 1939, p. 137.



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Vitamin K

Between Dam's first recognition of a fat-soluble substance, which he named as vitamin K, four years ago, and the appreciation of its therapeutic value today in the haemorrhagic tendency of jaundice and of the new born much work has been done on the chemical identification of this vitamin and the part it plays in human metabolism. The story may be told briefly. Dam and his co-workers found that chicks fed on a diet deficient in certain fat-soluble compounds, but otherwise adequate, developed a haemorrhagic state which was traced to be due to the fall in the pro-thrombin content of the blood plasma. This fat-soluble compound was later isolated from fish, and a concentrated oil for therapeutic purpose was prepared. But the difficulty and the costliness of maintaining its biological standard led to the isolation of pure vitamin. It was soon found out that natural vitamin K belonged to the group of naphthoquinones with an additional content of phytol. Synthetic vitamin K also revealed a chemical formula of 2-methyl-1:4-naphthoquinone, and although it is not identical with any of the naturally occurring forms of the vitamin it had anti-haemorrhagic properties when tested on chickens². This was in turn found to be due to the rise in prothrombin index of the plasma after the administration of vitamin K, in natural state or its synthetic equivalent. Macfie and others³ found that an intramuscular injection of methyl-naphthoquinone was effective in raising the prothrombin index in cases of obstructive jaundice. Stewart and others⁴ found that vitamin K cholic acid mixture prepared from fresh spinach gave an immediate response in obstructive jaundice by making up the prothrombin deficiency, and thereby preventing the haemorrhagic tendency.

These reports indicate that vitamin K is one of the important factors in maintaining the optimum level of prothrombin in the blood-plasma. It follows that a low prothrombin content is an indication of vitamin K deficiency and that the reinforcement of vitamin K by such diets rich in this vitamin or by administration of its synthetic preparation would raise the prothrombin level, and thereby check or relieve an haemorrhagic state brought about by prothrombin deficiency in the blood plasma.

At present it is reported that vitamin K has been found useful only in haemorrhagic states of the obstructive jaundice and of the

newly born, and that it is valueless in intrinsic diseases of the blood-forming organs such as haemophilia and purpura. It needs also to be emphasized that vitamin K does not relieve jaundice or neo-natal anaemia.

Like anti-sterility vitamin E, vitamin K has just made its debut into the therapeutic world after the usual researches, animal experiments and clinical trials. Whether it is a pyrrhic victory or real we do not know. The question of deficiency states and diseases is too complex to be solved by the labours in the laboratory alone. The human organism is so delicately balanced that it is almost difficult at once to fix with certainty or even with approximate accuracy all the related factors which disturb this balance either by way of gross disease or infection, dysfunction or deficiency. Each link however has to be appreciated and used as soon as it is forged, leaving the addition of further links in the chain to future workers. And from this point of view, the discovery of vitamin K as one of the essential factors in maintaining the prothrombin balance in the blood-plasma is a triumph of human ingenuity, and a step forward in specific therapeutics.

(Continued from page 95)

hoarseness of voice. The sputum was rusty, but the expectoration was scanty. Physical signs revealed broncho-pneumonic patches as evidenced by coarse and moist rales, and crepitations. The diagnosis was confirmed by autopsy.

Mental Hospital, Bareilly.
15-4-39.

M. D. RATHOR.

A Case of Anthrax Simulating Malaria

A, aged 45 years, was of sound health for about a year previously. He got fever with rigor at night on 29-12-38. The temperature continued till 31st morning. One of us (R. K. M.) was called in to attend the case. The patient was found in profound shock. He was talking slowly and perspiring profusely. Pulse feeble and thready. Respiration 86 per minute. Extremities were cold. Nothing abnormal in the lungs was detected. As a routine, the blood slides were taken. He was given an injection of quinine bihydrochloride gr. 10 and atropine sulphate gr. 1/100, the latter to check perspiration. Warm saline per rectum was given. An injection of camphor in oil with ether was also given. The patient expired at 12-30 p. m.

Blood slides showed innumerable anthrax bacilli.

New Dooars Tea,
Estate, 11-9-39.

R. K. MUKERJEE.
N. C. BAGCHI.

² B. M. J., Dec. 23, 1939, p. 1220.

³ Ibid. ⁴ Jr. A. M. A., Dec. 16, 1939, p. 2223.

CURRENT COMMENTS

The Fiction of Creosote

The Council on Pharmacy and Chemistry of the American Medical Association has unravelled the fictitious claims of usefulness of creosote therapy in pulmonary affections.⁵ It has now directed the omission of this drug and its allied preparations from the list of the new and non-official remedies, as its use was found to be based entirely on empiricism and had not been proved to be of marked therapeutic value. Creosote was used by the older physicians in the belief that it acted as a pulmonary antiseptic and diminished the volume of the sputum. Careful and controlled studies by the American Council of Pharmacy now reveal that the volatile phenyle content of sputum after administration of creosote for over a period of five months is almost negligible and that it produces equally little effect in the quantity of expectoration. If to these observations are added the nausea it produces in not a little number of patients the case for giving up the use of creosote in pulmonary affections is indeed very convincing. As our American contemporary⁶ points out: the results of the entire study not only invalidate the reports of other workers who attempted to establish a rationale for creosote compounds in pulmonary disorders on the basis of change in the expired air during the administration of such drugs but also disprove previous claims for symptomatic relief because of the increase in expectoration and appetite or lessening of cough.

The Action of Sulphanilamide

Recent tissue culture studies made by King, Henchel and Green⁷ confirm the previous finding that sulphanilamide acts not by neutralising the toxins but by bacteriostasis which by reinforcing the natural defensive mechanism of the body frees the tissue of the infecting organism, and that, as a consequence of the reduced number of organisms, there is a corresponding secondary reduction in the elaboration of toxic substances such as hemolysin. The authors' experiments were made with three hemolytic strains of beta streptococci in tissue culture media made up chiefly of rabbit plasma and sera. They found that the bacteriostatic effect varied directly with the concentration of the drug and

inversely with the number of bacteria. Put in clinical language, the curative results of sulphanilamide depend on its dose and the extant and virulence of infection. Another interesting observation of these authors is that there is a decrease in haemolysis when bacteriostasis is observed. The inference is obvious that in the absence of bacteriostasis it is likely that either the conjugate derivatives of the streptococci or the conjugate products of sulphanilamide or both may give rise to hemolytic products. These factors may probably account for sulphanilamide anaemia and cyanosis. There are, of course, many other theories as to the cause of toxic action of this drug. But many of them have not been tested and a few others have not stood the test of experimental proofs. The present experiments under review reveal however that apart from its definite bacteriostatic effect it inhibits the wide, diffuse peripheries usually seen around colonies of beta streptococci in tissue cultures, and it also causes the development of abnormal, long chains of streptococci. The fact that the drug acts more or less effectively on different kinds of infection points to the greater probability of its bacteriostatic action than of specific inhibition or detoxication of the offending organism. The more important lesson of these experiments is that the toxicity of sulphanilamide may be due to deficient or absent bacteriostasis when the conjugate products of both the organism and the drug may give rise to the formation of haemolysins and consequent manifestation of corresponding toxic symptoms.

Medical Literature

During the course of his address to the Medical Society of London, Robert Hutchison has, as it were, unburdened the very thoughts which the medical practitioners all the world over are feeling in respect of the unmanageable growth of current medical literature⁸. He quotes Bulloch as estimating that there are over 5000 medical journals of one kind or other in the world. So he asks: Must we sit still and see science suffocated in its own secretions or can we do anything to mitigate the evil? His suggested remedies are: to apply strict birth control in regard to new journals; amalgamate the existing journals; and to suppress some. For his own country he would be satisfied with one good weekly journal catering for the general practitioner and one journal each for every special branch of medicine and surgery appearing at intervals longer than a week and dealing with original work in those

⁵Jr. A. M. A., Jan. 15, 1933 • *Ibid.*, Nov. 11, 1939.

⁷Jr. A. M. A., Nov. 4, 1937, p. 1704.

⁸Lancet, Nov. 18, 1939.



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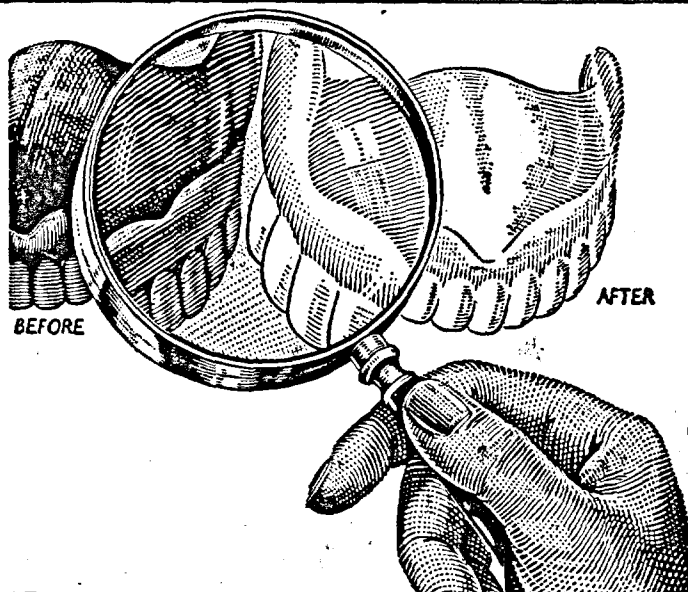
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NOTICE

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special spheres. For a country of continental size like that of ours, we are indeed fortunate in having relatively less number of journals, but that is due not to a wise decision about it but to political and economic causes. Very few medical journals in our country are self-supporting. Some are languishing for want of readable articles and fill up their pages with second-hand matter, mostly of foreign origin. A few are putting up a hectic struggle for existence. Things may probably change for the better in future, but when that good time comes medical journalism in our country should be based on a well-conceived plan, suitable for instruction to the profession and for conveying the progress of medicine in terms of research. The two types of medical journals in our country which can well go into early voluntary liquidation are: those which are sustained merely as a source of living by means of advertisement income, and the medical school and college journals which come to about nearly 25 in number. These journals can by no means be said to be serving or catering to the profession. Their bagatelle editorials, their columns of juvenile poetry, fun and frivolity, sports and college days, and occasional articles of importance do not justify the expenditure involved. On the whole medical journalism in our country may be said to be in its infancy, and therefore certain amount of sympathy and latitude has necessarily to be shown while criticising it. Even granting this, we would be untrue if we do not say plainly that it lacks quality. Its bulk has not however assumed a serious proportion as yet, but its quality requires immediate attention. The essential trouble of the editors is lack of collaboration by good and reliable writers. Those who are fit to contribute their thoughts, experience and work do not do so either as a result of excessive modesty or inordinate pride. Those who are not fit to contribute do inundate the editor with their manuscripts. It is out of these that the editors have to make up their *menu* for the monthly consumption of their readers. This is the *origo mali* in the current medical journalism of our country today.

Pneumo-peritoneum in Pulmonary Tuberculosis

The induction of artificial pneumoperitoneum as an accessory method of pulmonary collapse in the treatment of pulmonary tuberculosis is a comparatively recent procedure. E. G. Brian* gives an excellent but

* U. S. Naval Medical Bulletin, October 1939, p. 591.

brief review of the literature on the subject, the technique of the procedure and a few illustrative cases. He comes to the conclusion that pneumo-peritoneum is practically harmless, and can be effectively used in conjunction with phrenic paralysis in the treatment of pulmonary tuberculosis. The indications are bilateral disease, and extensive adhesions which make artificial pneumothorax impossible or ineffective. The author emphasizes that it is only a supplementary form of collapse therapy, and that the best results are obtained when done as an adjunct to phrenic paralysis. The rationale of this treatment lies in the collapse of the lung brought about by the elevation of the diaphragmatic dome and the elimination of the respiratory diaphragmatic excursions, both being direct mechanical effects of pneumoperitoneum. Complications, it is said, are very rare, and the symptomatic relief of cough and malaise has been observed to be definite and satisfactory. The site of injection selected is usually the left lower quadrant, midway between the umbilicus and the left anterior superior iliac spine; and the air could be injected with the usual pneumo-thorax apparatus. Refills are necessary at weekly or bi-weekly intervals, the average quantity of air which may be introduced at each refill being 800 to 1200 cc. We are not aware of pneumo-peritoneum being resorted to in the collapse treatment of pulmonary tuberculosis in our country, but its rationale as expounded and illustrated by Brain seems to be sound, and the fact that peritoneum has been well-known to tolerate air makes this procedure a practical proposition—particularly in cases of extensive pulmonary adhesions and bilateral disease where collapse by artificial pneumothorax is usually contraindicated or ineffective and impossible. If more clinical evidence of its utility is forthcoming it may well prove to be a definite and useful adjunct to the other measures of collapse therapy.

Unfair

In the supplement to this issue will be found a communication from Dr. Kunj Behari Lal Varma, Provincial Secretary of the United Provinces Branch of the All-India Medical Licentiate's Association, detailing the effects of the resolution passed recently by the U.P. Dufferin Hospitals' Committee. This resolution prohibits such of the lady sub-assistant surgeons who have served for less than three years from undertaking private practice. If this is applicable to others also, namely, lady assistant surgeons with less than three years,

Cardiology

• Dr. Jai Gopal

(16) Treatment of Cardiac Failure

(1)

General Considerations

In discussing the treatment of cardiac failure, it may be mentioned at the outset that no definite rules can be laid down for its treatment as it is a complex problem requiring elucidation of various factors which are to be taken into account for success in treatment.

To ascertain the degree of failure should be our first concern. Breathlessness even under restful conditions carries a gloomy prospect of recovery. Tachycardia, which is responsible for the rapid exhaustion of the myocardial energy, if controlled in time before serious degenerative changes have taken place in the cardiac musculature and before the reserve power of the heart is entirely spent up, is attended with amelioration of symptoms and may be successful in arresting the symptoms of failure and thus afford the patient a prospect of enjoying many years of useful activity. On the contrary in essential tachycardia measures to check it are fraught with danger, because here the rapidity of heart is essential for the main-

service, none could call the arrangement as unfair, because it would then obviously be based on the probability of danger of unguided practice by juniors. It is therefore patently unfair on the part of the Dufferin Hospitals' Committee to have allowed their prejudice to be developed in this vicarious manner, and applied their ban exclusively on junior lady sub-assistant surgeons. Such questions are better left to the conscience and judgment of junior practitioners, rather than controlled by the powers-that-be. The juniors, more particularly women, are not at all likely to undertake cases which are beyond their capacity, but to prevent them from doing so will be unjust and invidious as it would deprive them even of the chances to give help in minor or less serious cases. We entirely agree with the other arguments of our correspondent, and hope that the Dufferin Hospitals' Committee would revoke this unfair order on a second consideration. There is no room for injustice or unfairness in a medical organisation run by women for women.

tenance of efficient circulation in order to compensate for the loss in the force of the left ventricular systole. Cardiac failure associated with bradycardia is a grave combination, and a fatal termination due to coronary thrombosis is not a far-off affair.

Secondly, the mental attitude of the patient towards his illness goes a long way to decide the ultimate success or failure in treatment, and therefore deserves careful study. A sufferer from a grave cardiac lesion, upon whom the serious nature of his disease is hard to impress, would lead a reckless life and may indulge in occupations or activities entailing wasteful expenditure of energies solely with a view to make life enjoyable. But he does so at great peril to himself and forgets the fact that constant sympathetic stimulation is a very expensive luxury. It must be clearly understood that vagal action is necessary for the preservation of life. It is with this object that the vagal action predominates in old age and nature very wisely slows down the activities and brings down the heart rate in order to reserve energy for useful activity during the advanced years of life.

The study of psychological peculiarities in the temperament of a cardiac patient is also a necessity for success in treatment. Patients are seen suffering from cardiac symptoms viz., breathlessness on exertion, cyanosis, and præcordial pains; and sometimes there may be a bed-ridden invalidism with swollen, stiff and painful joints and yet, even on careful examinations, no organic lesion in the heart may be discerned or rheumatic tendency found to account for the symptoms. All these symptoms may be but physical reaction of the body to psychical abnormality of the individual, it being recognised that the physiological functions of the various organs react to the mental state of the individual.

The effect of fear is known to raise the blood pressure and accelerate the heart beat. The effect of emotion, worry, and anxiety is known to cause alterations in the blood chemistry, in the distribution of blood to various organs, changes in the process of digestion, the secretion of endocrine glands, and the muscle tone, resulting in departure from health. Some patients who show symptoms of cardiac nature do not reveal any organic lesion of heart. But the difficulty with these patients is that it is very hard to convince them and to wean them of their delusion concerning heart disease. A good deal of persuasion is required to remove this impression which has taken a firm hold on their mind.

No improvement can be expected, and their chances of recovery are hampered unless their mental attitude towards their symptoms can be changed.

In a woman under my care, symptoms of breathlessness and cyanosis continued for several years while under treatment of several heart specialists and was ultimately cured after the cause was removed, which was worry connected with the marriage of her son, whom she had betrothed to a girl closely related to her, and whose hand the son did not wish. The conflict in her mind lay between loyalty towards the girl and the sympathy with the wishes of her devoted son. This had a profound effect on her mind and was responsible for her symptoms. This fact was elucidated after a long and searching investigation and it was after its removal by bringing about a compromise that the symptoms abated.

Neuro-muscular asthenia occurring in persons subjected to severe mental strain associated with prolonged concentration extending over a period of several years is responsible for bodily weakness, fainting or sinking feeling on moderate exertion. These symptoms are commonly seen among high placed persons possessing huge wealth of material possessions, and high degrees of intellectual capacity, such as great thinkers, scholars, eminent teachers, lawyers and renowned politicians. The nervous system subjected constantly to mental strain produces asthenia of the nerves and the asthenic nerves cannot be expected to carry on efficient function.

Selection of an appropriate remedy for use in a given case of cardiac failure is necessary for success in treatment. An indiscriminate use of a cardiac stimulant may be harmful. This fact may be explained by giving a definite example. In an acute illness of a short duration such as pneumonia, the reserve power of heart is not much reduced, whereas the peripheral arterioles are dilated due to toxic vasomotor paresis.

The circulation fails because the heart makes ineffectual efforts in propelling the blood through dilated arterioles. The use of adernalin by constricting the peripheral arterioles and thereby augmenting the circulation would be beneficial to the patient. On the other hand an alcoholic stimulant which acts by dilating the peripheral vessels would be positively harmful. Let us take another instance of a case of valvular disease of heart with dilatation behind the diseased orifice and

commencing decompensation. The use of strychnia by its influence in raising the blood pressure brought about by constriction of the peripheral arterioles would act like a whip to the dying heart, whereas digitalis by its inhibitory action resulting in the slowing of the pulse, and by virtue of its prolonging the diastole affords the much-needed rest to the tired heart muscle; and because under its influence the blood pressure is not raised, no extra work is thrown on the heart and in this way the combined effect of digitalis would be beneficial to the patient. In another type of failure which commonly affects the intelligentia viz., angina pectoris, be it the result of neuromyocardial asthenia or the outcome of a prolonged and continuous mental strain in a person with a highly strung nervous system associated commonly as it is with high blood pressure, or be it myocardial degeneration (fatty or fibroid), or anoxaemia connected with coronary infarcts or spasm, the main feature generally seen is rise in blood pressure. The use of amyl nitrite here is beneficial to ward off the attack. On the contrary the use of cardiac stimulants which act by raising the blood pressure viz., strychnia and adrenaline, would be positively harmful and may even destroy life. In the early stage of chloroform administration, the heart may stop due to the onset of ventricular fibrillation, the result of toxic action of chloroform, and here the use of adrenalin would be detrimental as it reflexly stimulates the vasomotor nerve endings; whereas if this is used in the circulatory failure occurring in the later stage of chloroform poisoning, it may save life. It is now evident that the same cardiac stimulant may at one time be beneficial, whereas if used indiscriminately may be harmful. Therefore it is obvious that the selection of an appropriate stimulant is necessary in the successful treatment of cardiac failure.

Most cases of failing heart, no matter what part of the heart is diseased and whatever is the nature of its cause, die either of a severe fit of acute dyspnoea (cardiac asthma) or general anasarca due to passive venous congestion combined with orthopnoea. Though death may be due to any one of these two causes, the need for ascertaining a definite aetiological factor is essential for efficient treatment. Merely to label the disease as aortic regurgitation or mitral stenosis is not sufficient. The cardiac diagnosis does not end here. The settlement of the following points is necessary to decide the line of treatment, as well as the adoption of measures

(D) 'BLOOD EXAMINATIONS AS A GUIDE TO TREATMENT' by
THE REV. R. M. BARTON

The quick response of the blood picture to changes in the patients' condition makes it a valuable guide during treatment, especially so as these, generally speaking, precede the clinical symptoms.

The importance of leucocytic reaction and sedimentation rate is emphasized. A blood index based on (1) the neutrophile-lymphocyte ratio, (2) the mononuclear-lymphocyte ratio, (3) the percentage of neutrophils of Stabkerning and (4) the percentage of Westergren one-hour sedimentation reading, has been used for the last seven years at the Madanapalle Sanatorium and has served as a valuable guide in assessing the condition of the patient under ordinary sanatorium treatment.

Adverse changes in the blood indicate either some complication or the spread of the disease in the diseased or the contralateral lung or may suggest that too much exercise is being done. But to be of real value blood examinations must be made at regular intervals, and be made by experienced blood workers.

DISCUSSION

In the discussion following the papers, several speakers stressed the importance of control of treatment by X-ray, although it was recognized that frequent X-ray examination of patients was not always possible for the general practitioner. A number of speakers showed also how important clinical observation and physical examination were, in addition to X-ray examination, and several spoke of the value of blood examinations. As in diagnosis, so in control of treatment, one method alone was insufficient, and if the patient was to get the best treatment X-ray examination, physical examination, blood examination, and observation of clinical symptoms, must all be employed.

Treatment

'ARTIFICIAL PNEUMOTHORAX' by
DR. D. V. MUTHU

Nowadays nobody questions the value of collapse therapy or the merits of the underlying principles, though there is slight diversity of opinion as to how soon it should be employed in an individual case. Decision should be made taking into account the history of the case, the course of the disease, and its character, as revealed by examinations and constitutional symptoms.

Indications for artificial pneumothorax are mentioned. As this operation in a great majority of cases makes a patient free from tubercle bacilli it assumes extra importance for public health reasons. It also reduces the stay of the patient in a sanatorium and enables him to return to work early and it has therefore a great social value.

'THORACOSCOPY' by
DR. P. V. BENJAMIN

Artificial pneumothorax is not successful in every case and 40 per cent of its failures are due to adhesions, which are often distributed over the diseased part of the lung making a selective collapse impossible.

Two types of thorascopes are described and the advantages and disadvantages of diathermy and galvanocautery are discussed and the difficulties of cutting adhesions in certain situations are brought out.

A recent acute onset is a contra-indication to the operation. A complication after the operation is pleural effusion, but its frequency is not more than in artificial pneumothorax.

Review of the results of 210 operations in 186 patients at the Madanapalle Sanatorium shows that by artificial pneumothorax 53.5 per cent of the patients became bacilli free, whereas the figures after cauterization of adhesions were 63.7 per cent. The operation, therefore, improves the expectation of life and saves many a patient from serious operations like thoracoplasty.

'THORACOPLASTY' by
DR. W. G. JONES

It is emphasized that it is an error to adopt this operation as a last resort or to delay it because it is considered to be too drastic and therefore too dangerous for Indian patients, while it is no less an error to consider it to be so easy as to suppose that every surgeon can perform it. This operation needs to be known and used in India more than it is at present. Its risks are small with skilled and experienced surgeons, and it offers considerable chances of cure to that large group of cases that cannot benefit by pneumothorax or phrenic surgery. While its application is chiefly to unilateral cases, it can be used in conjunction with contra-lateral pneumothorax and phrenic interruption in many bilateral cases as well. To most, if not to all, chronic cases in which pneumothorax has failed, thoracoplasty offers the shortest road to cure and a good prognosis can be rehabilitated for work.

'PHRENIC NERVE OPERATION' by
DR. R. VISWANATHAN

These are used to produce temporary or permanent paralysis of the hemi-diaphragm. It is a component procedure in the armamentarium of collapse therapy. It has its limitations and the results will depend on the judgment exercised in its application. Various indications for the operation are mentioned. A modified technique for the operation with the patient sitting in a dental chair is recommended.

DISCUSSION

Surgical treatment.—In discussion, several spoke of complications in artificial pneumothorax treatment, and some described the apparatus, which they are using, designed to avoid some of the accidents possible in giving artificial pneumothorax. In home treatment of tuberculosis, too, artificial pneumothorax must have a place, because early treatment and prevention of spread of infection were urgent, and a simple apparatus was necessary for this. Some discussion took place on aspiration of pleural fluid and replacement by air. Hemoptysis following artificial pneumothorax was mentioned by several.

In the discussion of thoracoscopy, the advantages and disadvantages of the direct and indirect vision type of apparatus were brought out; the complication of subcutaneous emphysema, the question of cauterizing adhesions which did not keep open a cavity and when the sputum had become negative, and the control of subsequent refills by X-ray were also raised.

In the discussion on phrenic operations, the general consensus of opinion was against phrenic operations as the operation of choice; there was a risk of irresponsible operation just for the sake of doing something and because it was an easy operation. It still had a place in a small number of cases in which other measures had failed. Some discussion took place on the position of the patient during operation—sitting up or lying down.

Thoracoplasty.—In a vigorous discussion there was criticism of Dr. Jones' opening paper, some speakers not agreeing that the percentage of patients in whom thoracoplasty was indicated was as high as that sug-

SUPPLEMENT TO

THE INDIAN MEDICAL JOURNAL

MADRAS

APRIL 15, 1940

Vol. 2, No. 4

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The Evils of Competitive Medical Practice

• Dr. P. Gurumurthi, L. M. P.

[Following are extracts from the Presidential Address of Dr. P. Gurumurthi, L. M. P., delivered at the 8th Andhra Medical Conference held at Vizianagaram on 25th Feb. 1940. In the course of his address he deals with the evils of competitive medical practice and urges that it should be replaced by Health Insurance on a co-operative basis, as in Holland. He does not see much good in the new-fangled honorary system of medical service and considers it as bad as "private" practice. He believes that the State should employ medical men on a decent living wage to look after the health of the people. He laments the existence of too many 'pathies' and urges for the consolidation and evolution of a national system of medicine for our country. He believes that the wrongs done by the Indian Medical Council Act cannot be righted till political power is completely in the hands of our representatives. Dr. Gurumurthi's address is a refreshing document, and deals with various medico-political questions in a realistic spirit—from the point of view of the under-dog, and not of the vested interests in the profession,—Ed., I. M. J.]

Gentlemen, since we met last at Ellore, the world with its competitive states is dragged into a war. The peace of the world has been given a rude shock. This is due to the present structure of our socio-political organisation which is based on competition and profiteering, backed by force and violence. Until this present order is changed and the world is taught to recognise non-violent economics, there can be no enduring peace in this world. The evils of the present economic system have crept into every phase of human life. One of the evils which this order has brought about is antagonism amongst individuals, though the natural order—the order ordained by Providence—is mutual aid. The underlying motive for doing anything has been, unfortunately, profit, but not service or usefulness of the thing done.

To illustrate my point, I shall take up the question of medical relief and health, and focus before you the possibilities for the creation of a social order different from that which now prevails. The knowledge of medical science, which has been won through the sufferings of countless generations, is sought to be monopolised by a few, instead of being made available and accessible freely to one and all. Doctors acquire this useful knowledge—the heritage of all—and enter into competition with one another in selling it. It is neither good for the doctor nor for the patient. *The prevalent organisation makes the doctor a tradesman. He has advice and service to sell.* A society, which compels the doctor to be a tradesman, and to make the lives of the people a part of the trade, must take the consequences. Doctors

have useful services to offer. Society causes them to be hungry when people are hale and healthy; and to be thriving when people fall a prey to disease. This is unsocial, nay, inhuman! Many doctors are poor and are worried constantly over the rent and grocer's bill. You can picture to yourself the state of mind of such a doctor. No sickness anywhere! I am starving! Is this not ghastly? "Sickness, suffering, and death should be no body's advantage. Nobody should look to them as the hope of his livelihood. An injury to one should be felt as an injury to all. Nobody should be making profit out of the suffering of others. There is enough medical knowledge for all. To bestow it freely cannot exhaust it. It is infinite. Only human and humane channels, through which it may flow out to those who need it, are all that are required. Neither the doctor nor anyone else should be compelled to have as his aim of life the making of money—this is indeed deadly!" In the present state of affairs eking out livelihood has become primary, and service to the patient secondary. *Doctors must be recovered from this competitive practice.* The health protection under individual economic competition should be ended. In some parts of the world it has become obsolete. We must wrest it from its secular moorings and endeavour to spiritualise it in our lives. We want spiritualised doctors, Municipalities, Local Boards, and co-operative organisations as in Denmark, and the State, above all, should administer health agencies and supply medical relief to the civil population. The possibilities of true Co-operative Medical Society are illustrated by the Volharding Society at the Hague in Holland. It was established in 1882. It has a department of insurance against sickness and death. In 1934 it had 1,24,000 members connected with its medical sections. The society employs 40 doctors, 45 nurses and many druggists and technicians. It has a well-equipped hospital clinic, polyclinic, a dental clinic and two drug stores. There are all facilities for diagnosis and treatment which make possible the team work so necessary to produce the best results in modern medical science. Experts in various fields bring the newest knowledge supplemented by modern scientific appliances to bear on medical research. Methods for the best treatment of the patient are provided. Everything is up-to-date. Each adult member must pay Sh. 5 to 20 a year for full medical service of every speciality. Members' wives who are confined at child birth have bread free for one week, and groceries free for 2 weeks. This service, we are told, is superior to that provided by the British Health Insurance at twice this cost.

HONORARY SYSTEM

The honorary system which is being introduced into our hospitals and dispensaries is, I am afraid, not at all a good substitute for the present order. The patient has disappeared from the picture in this as well as in some other matters like consultation and treatment from Government Medical Officers. The welfare and the finances of

the practitioner—private or public, if I may say so—bulk and loom larger in our minds than the welfare of the citizens. A man is put in charge of a hospital or dispensary without any emoluments. He is asked to eke out a living. This is the basis of honorary system. The doctor will have to be constantly on the look out for those who may be able to pay him, if he wants to drive away the wolf from his door. The result is that service, which should be the prime motive in his work, disappears from his mind. I would, therefore, urge that this system also should be abandoned being as bad as "private practice." The State should train year after year enough medical men to meet the requirements of the country and employ them on a decent living wage to look after the health of the people. Persons who are prepared to work in a missionary spirit alone should be recruited to this service on terms something like those of the members of the "Servants of India Society".

Unless people are healthy and hale, the State cannot be efficient in any sphere of activity. It must deteriorate in all directions. The cost of ill-health will be enormous. Nothing like a balance sheet can be drawn up to show the annual loss suffered by the nation through sickness and accidents. In England, where health conditions are much better than in our country, the total economic burden of ill-health is estimated at something more than £ 6 per head of the population. This is apart from the misery and suffering which people are subjected to and which no statistician can ever compute. It was found in England, in the year 1935, that over 62 per cent of the prospective recruits were below the comparatively low standard of physique required for the army, and they have launched the national fitness campaign to ensure the adequate minimum standards of national nutrition. If any such survey is undertaken in our country I am sure the number of persons who can satisfy such standards of physique will be far less, perhaps only 2 to 3 per cent would come to the required standard. This lack of fitness makes it impossible for them to lead full and useful lives; and they are always a potential liability to the country. Therefore, it is the duty of the State to look to the people's health covering every phase of human needs, like provision for the prevention and relief of sickness, water supply and drainage, proper housing and parks, maternity and child welfare, and good many other things.

All this means money. It may be questioned as to how we have to meet this enormous expenditure. My answer is the State has to find it in the interests of its people. The State collects taxes and it is the duty and primary concern of the State to provide free medical aid to all. To prevent drink evil, to restore people to saner and sober life and to balance our budget, have not the Government resorted to fresh taxation? Are we not taxed for every service rendered by the Government including primary education? Let

the Government resort to what I may call "Health-Tax", which will per head be less than the doctor's fees. Demand it from the people in proportion to their incomes, agricultural or otherwise—people below a certain income being exempt. Let free and up-to-date medical aid be provided to all people—rich or poor—displacing the present arrangement where the rich and influential get everything, while the poor men go to the wall.

In private general practice the average doctor cannot afford to give what is best and up-to-date and the average patient cannot afford to buy all that medical science could do for him. Here lies the social injustice. The poor man's son when he is sick with a serious disease is more apt to die than the rich man's. I do not for a moment grudge the rich man having it; but let the poor man also have it in equal measure. Let the poor man have as good a chance as the rich man. So long as money is the link between the doctor and patient, this cannot be done.

POST-GRADUATE COURSES

Medical science is making rapid advances. The medical practitioners should acquire this knowledge in the interests of suffering humanity; otherwise they will be stagnating. Refresher courses should be frequently held at Vizagpatam where there are all the facilities for teaching. Medical practitioners should make it a point to attend these courses and enlarge their outlook and improve their scientific knowledge. At a previous session of the conference we requested the authorities to make such an arrangement. It has not been heeded so far. Let us once more request them to help us in the matter.

ALLOPATHY, UNANI, AYURVEDIC AND HOMEOPATHY

It must be admitted that every one of these systems is based on a scientific principle. It may be that those practising them have not had a thorough scientific training. It is necessary that they should be given a thorough training without which nobody should be allowed to practise medicine. There are as many "pathies" as there are isms in this world. This is distressing. The people are confused and confounded. It is, therefore, necessary that some investigation be made and a common system evolved in the interests of humanity.

INDIAN MEDICAL COUNCIL ACT

In spite of repeated requests and protests from all concerned, the Central Government have not effected the necessary amendments to the I. M. C. Act. This **Black Act** has been on the Statute book for over seven years and our cry has been a cry in the wilderness. The Act should be so amended as to provide for (1) a majority of elected members, (2) an All-India Register and (3) the inclusion in the Register the names of all persons included in the provincial Registers as demanded by the last All-India Medical Conference.

In these days of democracy, to have nominated members on any body is odious; and to have them in a majority is simply obnoxious and undemocratic. To exclude from recognition 75 per cent of the medical practitioners in the statutory Provincial Medical Registers is equally undemocratic and illogical. I am afraid these wrongs cannot be righted till political power is completely in the hands of our own representatives and till Swaraj is attained.

Gentlemen, a few words more, and I am done. Our country is a land of villages, which have been neglected for centuries. There are a few "haves" and many "have-nots". The villagers are steeped in ignorance, illiteracy, indebtedness and superstition. The death-rate in the country is appalling. Mortality of infants and of women in child-bed is the highest when compared with any other country. Therefore, it is our duty to rouse the people from their slumber. We must rouse a passion for health in them. To preach health to the poor and under-fed is a hypocrisy. Let us make the best of a bad bargain. The doctor should no longer be a "medicine-man" but be a "health-man." Few diseases can be cured. But many can be controlled and prevented. The doctor should become public-minded and carry the gospel of health and sanitation and medical relief to the very doors of the people. Doctors should take an active part in public affairs. They should get themselves elected to the various local and legislative bodies. With their knowledge of men and things, with their knowledge of human-mind and human-psychology, they may be able to do something for the people. The health-officers have not been given sufficient opportunities or facilities to carry on their work with zeal and earnestness. The Madras Public Health Act—thanks to the efforts of our distinguished friend Dr. T. S. S. Rajan who by abolishing the L.M.P. grade brought about a uniform standard of medical education in the province, and democratised the Madras Medical Registration Act by effecting the necessary amendments to it, empowers Health Officers to exercise the functions of the executive authority in matters relating to Public Health. I hope our friends will come to their own and do their best to improve things. Gentlemen, let us all strive our best to raise the standard of our nation's health. A lamp that fails to radiate light is dead. A man or woman who fails to send forth some vital quality into the world, by which the world shall be brought little nearer to the great goal of the kingdom of God, that one is dead—no matter how much noise he or she may make. Let us therefore, do our best to humanity.

A Comparative Study of Different Systems of Medical Relief—Foreign and Indian*

• Dr. A. Viswanathan

MEDICINE AND ITS ENVIRONMENT

PROF. TIRUMURTHY AND FRIENDS, Let me at the outset thank the Stanley Medical College Association for giving me an opportunity to address the students of this College on a series of subjects of definite medico-political importance, which ought naturally to form at least a short part of their medical curriculum but which unfortunately is allowed to suffer from complete neglect and inattention. I think, Sir, that study of medicine is incomplete without the study of environment under which medicine has to be practised—social, cultural, economic, and political environments which medical men have inevitably to face in their everyday practice and to adjust their position according to the force and volume of such factors. Medico-political science is nothing more and nothing less than the study of such environments which surround the medical men in active practice. We have got very few amongst us who have made this subject their speciality and given their full time for the consideration and planning of the medico-political future of the profession. The result is that our profession, in spite of its acknowledged abilities in the field of professional work, does not know where it stands in relation to its environment. We hear of the inability of the people to pay for medical services. We hear so much about the unemployment of medical men. We hear so loudly of the undercutting and unfair competition among the members of the profession. We know of many medical statutes which do not confer any real semblance of statutory rights and privileges which the medical men in free countries enjoy. We hear the echoes of the historic quarrel between the medical graduates and licentiates whenever we touch the services or the medical education of our country. We hear of the hospital privileges being abused by the Government Medical Officers and the rich aristocracy of our land. We see a wave of enthusiasm for honorary medical service without understanding its moorings. We have not postulated the right and the needed relationship between the State and Medicine, and it is anything but satisfactory today. On the top of this all, comes the heart-rending cry of millions of our poor countrymen from nearly 50 lakhs of villages in our country, of suffering and dying from avoidable diseases. Nearly 33 crores of rupees are spent every year by the eleven provinces of our country on medical relief and public health work. This is the gist of the state of medical politics and this is the environment which encircles the medical men of our country to-day. You would therefore easily understand, when I referred at the very beginning to, the importance of studying this environment

* Being a lecture delivered at the Stanley Medical College Association on 18th Jan. 1940. The series will be completed in the subsequent issues of the supplement.

and of finding suitable remedies for the disease which both the body and the soul of the profession is suffering today in our country, and to transmute by our own energy and intellect, by our own work and organisation the present environment into one which would place the medical profession, the Government and the people with common aims and purposes so far as medical relief and public health work are concerned, and with agreed modes and methods of working out such aims and purposes.

Therefore, I have given precedence to the subject of medical relief among the subjects I have been booked to lecture, because, in my opinion, it is the first subject of importance in the field of medical politics. Just fancy a country of 400 millions, with 42,000 practitioners, with 6000 and odd hospitals of all kinds, with something like medical relief reaching only 35 millions of people, with more than 6 millions of people dying every year due to non-fatal diseases—thus leaving nearly 365 millions without any kind of medical relief, suffering in silence and dying without the solace of medical attention—and you will find that what medical relief now available is like the effort of an ant to carry the Himalayan load on its shoulders. This ant of medical relief today has neither the strength nor the stature, neither the perspective nor the vision, neither the desire nor the hope to share and to steer the huge-burden of relieving the ills to which the flesh of the Indian humanity is heir today. Unless medical relief in India expands in scope and extent, in quality and quantity, the vital statistics and the mortality report will be repeating every year the same old doleful story. There is absolutely no doubt that the existing system of medical relief in our country is altogether ill-organised, incomplete and inadequate and does not stand comparison at all with what is being achieved in this matter in other countries of the world, particularly in Europe, Russia, and America.

DEFINITION OF MEDICAL RELIEF

A comparative study of systems of medical relief that are current in some of the more advanced countries in the world of today is essential to make us realise the exact position which our country occupies in this picture, and to give us some clue as to the best possible and practicable methods of approach. But before I take you through some of the essential details of foreign systems of medical relief and compare them with those in our country I would like to define exactly what is meant by medical relief. That day had gone for ever when we thought of medical relief in mere terms of curative medicine. The historic difference between curative and preventive medicine is being obliterated today, although I admit the degree and

(Continued at foot of page 46)

The Role of General Medical Practitioners Under The Madras Public Health Act*

• Dr. K. Rama Rao, Medical Officer, Corporation of Madras

The Madras Public Health Act has been brought into force during the month of March 1939. This is an Act intended to advance the public health of this province. Let me briefly relate the circumstances that helped the passage of this Act. The proposals to introduce public health legislation in this province have been under the consideration of the Madras Government for many years. At one time the view prevailed that it would be sufficient to make suitable additions and amendments to the existing Acts governing Local Bodies, viz., the Madras City Municipal Act, 1919; The Madras Dist. Municipalities Act, 1920; and The Madras Local Boards Act, 1920. So amendments were drafted on this basis. It was, however, decided subsequently to introduce a compact and separate bill containing such provisions as were essential for the advancement of public health, existing Acts being left unaltered as far as possible. A draft bill was accordingly published in 1929 but its legislative consideration was postponed pending the introduction of the constitutional reforms which then seemed to be imminent. The bill was revised by the Director of Public Health during 1936-37 in the light of subsequent alterations in the statute law and other political and social developments. The Bill as revised by the Director of Public Health reached the Government some months after the Congress Ministry assumed office. It then underwent a careful and prolonged scrutiny by the then Minister, the Hon'ble Dr. T. S. S. Rajan. Some important provisions were added to it. It was finally introduced in the Legislative Assembly on 28th December 1938 and after a brief speech by the Hon'ble Minister of Health and the Premier who characterised it as a "Death Relief Bill", it was referred to a Select Committee. In the light of certain criticisms, some modifications were effected by the Select Committee. Thus the important clauses relating to control of venereal diseases were unfortunately deleted. On the whole, however, the Bill has been well received by the legislature, the press and the public, and was finally enacted.

How can and how should the general practitioners help in the successful working of the Public Health Act is a question for discussion this evening. Their help is required for the following chief purposes:—

- (1) preparation of vital statistics.
- (2) Control of epidemics.
- (3) Public Health propaganda.
- (4) Vaccinations and inoculations.
- (5) Control of venereal diseases.
- (6) General survey of special diseases.

*Being a lecture delivered at the opening of public Health Campaign of the All-India Medical Licentiates' Assn., Madras Branch on 3-3-40. Dr. C. S. Govinda Pillai, Health Officer, Madras Corporation, presided.

The average general practitioner in our country, owing to depressing economic conditions, does not usually take any lively interest in public health and allied organisations. The Government also have been tardy to recognise the importance of the practitioner, and to help him out of his economic struggle with a view to make him useful to the society and the State. In the evolution of an efficient public health organization in this country it is, therefore, essential that the State should provide adequate facilities for the general practitioners for public health work. The recent instance of the Madura Municipality in having opened a Public Health Laboratory for the benefit of the general practitioners in that town is an indication that the Local Bodies are realising and trying to discharge their share of responsibilities and duties towards the improvement of the position of the general practitioner, and through him the general health of the city or town. It may be pointed out that in certain States of America the Public Health Department calls in periodical conferences of the general practitioners to discuss with them all important matters relating to public health. If this is copied in our provinces, I am quite sure that public health work will show tangible results. The successful control of the recent typhoid epidemic in our city, made possible by the help and co-operation of the general practitioners who at the request of the Corporation took care to diagnose correctly by Widal's test and to notify the disease, is an instance of the kind of useful help of the practitioners and shows what could be achieved by collaboration in public health work.

VITAL STATISTICS

Vital statistics in India though improved to a considerable extent is still defective as is pointed out by the Public Health Commissioner in his latest report for the year 1937. This subject has not been, in my opinion, effectively tackled by the recent Public Health Act. The medical practitioners in Western countries are called upon to certify deaths and are paid by the State in order to get correct notification of diseases for the preparation of vital statistics. This is an obvious duty of a responsible Government and I believe it would not be in the interest of public health if the subject of vital statistics receives comparatively little consideration. The Government ought to take the help of the practitioner in this respect, and pay him for due and proper notification, as is done in all Western countries.

CONTROL OF EPIDEMICS

While there are some very good provisions in the Public Health Act regarding the control of epidemic and other communicable diseases, the Act is however lacking in stress with regard to

the help from the general practitioners. This omission is of course not intentional. But I hope that healthy conventions will be created by the way of the Public Health Department working in conjunction with the general practitioners in combating epidemics and other communicable diseases. That will be in accord with the modern trend in Public Health work.

PROPAGANDA

No legislative health measure may be of any avail unless the public co-operates whole-heartedly. In the case of Public Health Act, the co-operation of the general practitioners is required for its successful working. More depends on the help of the Rural Medical Practitioners who may be considered as our first line of defence against disease.

PROPHYLACTIC VACCINATION AND INOCULATION

Each practitioner has got to play an important role in the matter of protecting the community against communicable and epidemic diseases. He should avail himself of the free supply of protective vaccines and the like. This is one of the ways by which he can help the successful control of epidemics. It is often the case that vaccination or inoculation is pushed on intensively in times of epidemics with the help of general practitioners, but it is equally important to immunize the people during inter-epidemic periods. This would offer safer, better and larger protection to the community.

CONTROL OF VENEREAL DISEASES

This subject will be dealt with by Dr. Ratnavelu who has specialised in it.

As I mentioned earlier, certain important clauses relating to compulsory notification of venereal disease has been deleted by the Select Committee. This has made the control of venereal diseases somewhat difficult and uncertain. It is a pity that the dangers of venereal diseases are still not realised by the people of our country. Needless to say that the improvement of the health of a nation or community depends upon the solution of this important question. According to the report of Sir John Megaw, there are nearly 13 millions who are affected by syphilis and gonorrhoea in our country. There seems to be therefore no justification for the deletion of original provisions from the Public Health Act for compulsory notification of venereal disease by the Select Committee.

Even the smaller countries like Sweden, Denmark and Norway have effectively controlled the incidence of venereal diseases to a very great extent with the help of medical and social associations. Our Association intend studying these foreign systems of control and publish suitable literature for public information at a very early date.

CONTROL OF CERTAIN SPECIAL DISEASES

Leprosy and Tuberculosis are more or less effectively dealt with by the British Empire Leprosy Relief Association (Indian Council) and the recently formed Tuberculosis Association of India, respectively. It is the duty of every

practitioner to interest himself in these organisations and thus keep up the high traditions of the medical profession for service to the people.

As regards other major infectious diseases, the Act lays down obligation on the part of the general practitioners to notify them to the proper authorities. The diseases mentioned in the Act are (1) Acute Influenzal pneumonia, (2) Anthrax, (3) Cerebro-Spinal Fever, (4) Chicken Pox (5) Cholera, (6) Diphtheria, (7) Enteric, (8) Leprosy, (9) Measles, (10) Plague, (11) Rabies, (12) Relapsing Fever, (13) Scarlet Fever, (14) Small Pox, (15) Tuberculosis, (16) Typhus.

CONCLUSION

I have but touched the fringe of the problem regarding the role which general practitioners have to play in matters of public health. A successful and hearty collaboration between them and the Government and/or Local bodies is a desideratum which either of them should not grudge to offer in the interest of the greatest good of the greatest number.

THE MADRAS MEDICAL COUNCIL ELECTION

(MAY 1940)

K. KRISHNAMURTY, L. M. P.,

E. N. T. Specialist, L. N. Hospital, Chodavaram, Member, All-India Medical Licentiates' Association, Assistant Secretary, Indian Medical Association.

Dear doctor,

I am standing for one of the seven seats to be elected by the Registered Medical Practitioners under Section 5. (f) of the Madras Medical Registration (Amendment) Act, 1938.

- Now that the constitution of the Madras Medical Council has been democratised there is every scope for removing some of the statutory disabilities of the Registered Medical Practitioners.
- I intend devoting myself to the alleviation of the disabilities of the medical licentiates in the matter of certification, insurance examination etc., and to the equalisation of statutory rights and privileges between a Registered Medical Graduate and a Licentiate.
- I intend also to raise the question of the constitutional relationship between the Provincial Medical Council and the Indian Medical Council in view of the spirit of, and statement of reason for, the recent Amendment of the Madras Medical Registration Act which is: to abolish distinction between the different classes of medical practitioners.
- My activities in the organised Medical Associations have enabled me to acquire personal knowledge of the disabilities and difficulties of the profession, and of the Licentiates in particular.
- I therefore solicit one of your seven votes and request you to influence your friends to do like-wise.

6-4-40

ADVT.

Yours Sincerely,
K. Krishnamurty.

Reorganisation of Agra Medical School

● Dr. Kunj Behari Lal Varma, Provincial Secretary, All-India Medical Licentiates' Association, U. P.

The U. P. Government issued a press note in December 1938 appointing a Committee of 13 members to consider and make recommendations regarding reorganisation of Agra Medical School along with other allied matters in the following words:—

"The Licentiateship Course at the Agra Medical School extend to a period of four years—a period which is insufficient for training in the modern practice of Medicine and Surgery and that the present Licentiateship Course is therefore, not recognised by the General Medical Council of England (G. M. C.) or by the Medical Council of India (I. M. C.), that the Association of the Medical Licentiates, the United Provinces Medical Council and the United Provinces State Medical Faculty have all been pressing for raising the course to five years and the Government have therefore decided that the course at the Agra Medical School be raised from four to five years."

This shows that the old students of the institution, as represented by the Association of Medical Licentiates and the activities of their representatives in the U. P. Medical Council and the U. P. State Medical Faculty, had been continuously agitating for raising the curriculum of studies at the Agra Medical School from four to five years in conformity with the standard laid down by the G. M. C. and subsequently by I. M. C.

It is unfortunate that none of the representatives of the three public bodies mentioned in the above press note was appointed by the late Hon'ble Minister on the Medical Reorganisation Committee in spite of the repeated representations of the U. P. branch of the All-India Medical Licentiates' Association although, in a Committee of 13 members the Hon. Minister took as many as six non-official medical graduates and subsequently one medical graduate of Bombay was co-opted as member by the Committee itself. It is an open secret that many of these medical graduates held prejudiced views against L. M. Ps.

It is also unfortunate that memorandum submitted by the U. P. branch of the All-India Medical Licentiates' Association did not seem to have been considered by the Reorganisation Committee and the committee's report has not so far been published for public criticism, while attempts are being made to give effect to the recommendations contained therein. The object of the Committee's report is to create another Medical College like the one at Lucknow and this practically shuts out medical education to the children of middle and poorer classes by raising the annual tuition fee from Rs. 30/- to Rs. 130/- per year and hostel fee from Re. 1/- to Rs. 4/- per month, and further provides no facilities to the old students of the institution to qualify for the new qualification or for specialised clinical training similar to post-graduate studies.

The facts that the Agra medical school is one of the largest and the oldest medical centre in the United Provinces with a history of 86 years behind it, and that it draws students from the middle and poorer classes from rural areas are acknowledged by the Reorganisation Committee itself. The proposed enhancement of fees is therefore most unfair as it would seriously curtail opportunities of medical education to the middle and poorer classes and medical aid to the masses living mostly in the rural areas. To convert the Agra Medical School into another University Medical College on stereotyped lines would not only be mere waste of public money but against the best interests of the masses and highly detrimental to the cause of spread of medical education and medical relief in U. P. The recommendations of the Reorganisation Committee are evidently calculated to give a death blow to the aspirations of the medical licentiates of U. P. instead of imparting them standard medical education as is given to the licentiates in England and other civilised countries for which the U. P. Licentiates had been agitating for two decades. The U. P. Medical Council and the U. P. branch of the All-India Medical Licentiates' Association have both recently protested against the hasty way in which the U. P. Government were rushing with the reorganisation scheme without inviting public criticism*. The regulations of the Medical Council of India provide that it is open to any medical teaching institution to impart medical education in accordance with the recommendations of that Council irrespective of the fact whether that teaching institution is affiliated to a University or not. Since the Agra Medical School has more than sufficient clinical material in its attached hospitals, as admitted by the Reorganisation Committee, and being under the direct management of the Governing body of the State Medical Faculty, it can very well introduce and conform to the curriculum of medical studies as laid down by the Indian Medical Council and thus advance the spread of medical education and ameliorate the long-standing grievances of the medical licentiates of the United Provinces.

*The U. P. Medical Council, in its meeting held in November 1939 protested as follows:

The Council brings to the notice of the Government that they have sanctioned the scheme of reorganisation of the Agra Medical School without obtaining the opinion of the Council which is primarily concerned with medical education. It further requests the Government to consult this Council before considering any re-organisation of medical education in the Province.

The U. P. Branch of the A. I. M. L. A. also protested, Vide Ind. Med. Jr. supplement, April 1939, pp. 73-74.

I have also given notice of a resolution to be moved in the U. P. Medical Council meeting to be held on 18th March 1940 to the effect that, while endorsing the raising of the standard in conformity with I. M. C. regulations, the Agra Medical School should not be affiliated to the University but should be under the control and guidance of the U. P. State Medical Faculty, and that the annual tuition fee at the Agra Medical should under no circumstances be raised. I am also suggesting the opening of practical courses in Dental Surgery and in Ayurvedic and Unani Pharmacology and Materia Medica.

† Except in the United Kingdom there is no licentiate medical education in any 'other civilised countries' Ed. I. M. J.

MEDICAL COUNCILS

The following are extracts from the minutes of the Medical Council of India for the year 1938-1939.

JAPAN—RECIPROCITY OF RECOGNITION OF DEGREES WITH

The Ministry of Foreign Affairs, Japan, have the honour to inform the British Embassy that reply has now been received to the effect that there is no objection to the recognition in Japan of Indian medical qualifications in so far as they are included in table "J" of the British Medical Register.

AMERICAN UNIVERSITIES—RECOGNITION OF MEDICAL QUALIFICATIONS

The Executive Committee resolved to advise the Medical Council of India that the Medical Council is prepared to recognise ONLY such qualifications as are in the Second Schedule of the Indian Medical Council Act, 1933 for teaching appointments in clinical subjects.

The Executive Committee further considered that the pre-clinical subjects of Physiology, Biochemistry and Anatomy should be taught in the medical curriculum by persons holding medical qualifications. But the Executive Committee agree with the opinion of the Syndicate of the Madras University that for the teaching of Physiology, Biochemistry and Anatomy the Syndicate of the Madras University may favourably consider the Ph. D. or M. Sc. in these subjects of recognised Canadian or American Universities as constituting eligibility for appointment to the staff of the Missionary Medical College for Women, Vellore.

BOMBAY MEDICAL PRACTITIONERS' BILL X OF 1938

"That the Executive Committee agree with the opinion of the Central Government that under clause 33 of Bombay Medical Practitioners' Bill of March 1938 as read with section 7 (i) of the Bombay Medical Act VI of 1912, it would be possible for the holder of a degree of a country which is not recognised under the Indian Medical Council Act—because no scheme of reciprocity exists between that country and India—to become registered in Bombay and thus in other Provinces of India."

"The Committee further agree that this may render sections 13 and 14 of the Indian Medical Council Act inoperative, and, therefore, recommend to the Council that the Central Government may be requested to bring to the notice of the Provincial Governments that it would be undesirable to give recognition to foreign qualifications not included on Schedule II to the Indian Medical Council Act, 1933.

L. M. P. DIPLOMA HOLDERS EXEMPTION FROM PASSING PRE-REGISTRATION EXAMINATION

"The Executive Committee recommends that such L.M.P. diploma holders of Madras who have taken five year course and have passed the Intermediate examination may be exempted from passing the pre-

registration examination in Physics, Chemistry and Biology."

RECOMMENDATIONS ON PROFESSIONAL EDUCATION

"That the Committee recommend that the Council recognises the following examinations and that these be substituted for (ii) and (iii) on page 1 under 1. General:—

(a) The Intermediate Examination in the Medical Group of a British Indian University which includes a practical test.

(b) The Intermediate Examination in Arts or Science of a British Indian University with Physics, Chemistry and Biology and which shall include a practical test in each of these subjects.

(c) B. Sc. Examination with Chemistry of British Indian University if Physics and Biology have been taken in the Intermediate examination with a practical test in those subjects.

(d) The Intermediate Examination held by the following Boards of High School and Intermediate Education with Physics, Chemistry, Biology which includes a practical test in each of these subjects:—

(1) Rajputana, Central India and Gwalior.

(2) United Provinces.

(e) Any other examination which in scope and standard is equivalent to the Intermediate science Examination of an Indian University taking Physics, Chemistry and Biology including a practical test."

RECIPROCITY OF RECOGNITION OF MEDICAL DEGREES

The Council noted the correspondence carried out under the direction of the President with the following Countries regarding reciprocity of recognition of medical degrees:—

Victoria, New Zealand, Prince Edward Island, Nova Scotia, Manitoba and South Africa (Union of).

RECOGNITION OF M. B., B. S. DEGREES OF ANDHRA UNIVERSITY

"That the Executive Committee having considered their Inspectors' Reports for 1935, 1937 and 1938 on the Courses of Instruction and Examinations at the Andhra University, together with the University's observations thereon, and having noted the improvements carried out since the last inspections, and after considering the views of the President resulting from his visit in January 1939, recommend that the M.B., B.S., degree of the Andhra University be recognised with effect from December 1, 1938 and placed on the First Schedule to the Indian Medical Act, 1933. The Committee further recommend that at the end of two years a further inspection of the Medical College, Vizagapatam be carried out with special reference to the progress of the extensions and improvements which the Council consider necessary so as to place the facilities for teaching on a more satisfactory basis. The Council will then consider as to whether such further progress as might have been made justifies the continued recognition of Andhra medical degree."

Capt. Mukerji, seconded by Dr. Jivraj Mehta moved:—

"Representatives of the Press and Visitors not exceeding six at one time, may be admitted to meetings of the Council, provided they have obtained the permission of the Secretary."

After discussion the matter was referred to the Executive Committee for consideration.

"Delete the second sentence of Regulation 33 of the Regulation of the Medical Council of India and substitute it by the following:—

"The detailed proceedings of the meetings shall be kept in the office and a copy of the same shall be supplied to any member who may ask for it."

On a motion by Dr. Erulkar, seconded by Col. Stott it was decided that the matter be referred to the Executive Committee for their consideration.

PHARMACOLOGY AND THERAPEUTICS OF AYURVEDIC AND UNANI SYSTEMS—INCLUSION IN MEDICAL CURRICULUM

Moved by Capt. Mukerji and seconded by Dr. Prasad.

"The Council requests the Executive Committee to collect opinions from the Heads of the Pharmacological Departments of all the Medical Colleges in India and of the Calcutta School of Tropical Medicine regarding the possibility of inclusion of the study of Pharmacology and Therapeutics of the Ayurvedic and Unani systems of Medicine in the curriculum of Pharmacology and Therapeutics as contained in the Recommendations of Professional Education of this Council and to circulate all opinions so collected amongst the members of the Council before its next meeting."

On a vote by show of hands the motion was lost.

HOSPITAL BEDS FOR PROFESSOR OF PHARMACOLOGY AND THERAPEUTICS

Read.—Letter No. 148 S. G., dated the 21st June, 1938 from the Inspector-General of Civil Hospitals, Punjab, regarding the question whether the professor of Pharmacology and Therapeutics should or should not have charge of hospital beds for the clinical teaching of Therapeutics.

Resolved.—"That the consideration of the matter be postponed pending the receipt of the General Report of the Inspectors on these subjects."

FORENSIC AND PREVENTIVE MEDICINE (HYGIENE), BOMBAY, MARKING IN

"That the Executive Committee is of opinion that the marking in the subjects of Forensic and Preventive Medicine (Hygiene) should be separate. The written papers may be in two sections; the oral examinations should be separate as at present but the candidates should secure the minimum marks prescribed for each of these subjects separately both in the written and oral, as well as, 50% in aggregate separately."

PUNJAB UNIVERSITY—EXTENSION OF THE COURSES OF INSTRUCTION IN PATHOLOGY

Read and Recorded.—Endorsement No. 6333-37, dated the 2nd July, 1938, and letter No. 7516 dated the 6th August, 1938, from the Principal,

King Edward Medical College, Lahore, stating that the course of Instruction in Pathology will be extended from two to three years from the commencement of the next session (October 1938) and that the examination in the subject will be held at the end of the 4th year as a part of the Third Professional M. B., B. S. examination.

INSPECTORS—ASSOCIATION WITH BOMBAY MEDICAL COUNCIL NOMINEES

Read.—Letter No. G/29-584, dated the 24th February 1939, from the Registrar, Bombay Medical Council suggesting that as regards the medical examinations of the Bombay University two nominees of that Council be associated with Inspectors appointed by the Medical Council of India to inspect the Medical Colleges in the Bombay Presidency.

The Committee approved of the draft reply put up by the Secretary stating that there is no provision either in the I. M. C. Act, 1933, or in the regulations framed under Section 13 of the Act, under which the suggestion could be accepted. It was also apprehended that the adoption of the suggestion would affect the independent nature of the Inspectors' Reports.

Abstract of the Proceedings of the Council of Medical Registration, Bengal, at their Meeting held on 17-1-39

The term of members under clauses (f) and (g) of section 4 of the Bengal Medical Act, having expired, since the date of the last meeting, the following gentlemen were elected at the election held in the meantime:—

Drs. S. K. Mukerjee, S. C. Sengupta,

Similarly the following gentlemen were elected under clause (f):—

Drs. Taraknath Ghosh, Kalikinkar Sengupta, Santoshkumar Chatterjee, Basantakumar Ghosh,

2. The revised regulations for the Licentiate Examination, raising the course to 5 years and requiring I. Sc., as the preliminary qualification which were recommended in March 1937 were awaiting Government orders pending the views of the All-India Conference at Delhi on Medical School Education. The Council have proposed a deputation to wait on the Hon'ble Minister in charge to explain the urgency of the question.

3. The Budget-Estimates for 1939-40 approved by the Council showed that against an expenditure of Rs. 14,535/- (besides free printing at the Government Press. the receipts from registration fee etc., would amount to Rs. 8,250/-. The Council therefore needed a Government-grant of Rs. 6,280/- or at least Rs. 6,000/- (besides free printing), as against Rs. 4,500/- hitherto taken as the normal grant. A loan of Rs. 2,000/- taken from the Faculty in 1936-37 would still remain unpaid. At their previous meeting the Council had proposed to Government to receive a deputation from them to explain the financial position.

4. Dr. B. C. Ray, was elected as representative of the Medical Council, in the Bengal Nursing Council.

5. The following members were appointed to form the Penal and Ethical Cases Committee:—

1. Lt. Dr. Col. T. C. Boyd, 2. Dr. B. C. Ray, 3. S. K. Mukherjee, 4. Dr. J. C. Chatterjee, 5. Dr. A. D. Mukherjee.

6. The following members were appointed for the School Inspection Committee :—

1. Dr. Lt. Col. T. C. Boyd, 2. Dr. S. K. Mukherjee, 3. Dr. K. S. Ray, 4. Dr. J. C. Chatterjee, 5. Dr. A. D. Mukerjee.

7. The following members were appointed for the Examination (Faculty's) Inspection Committee on behalf of the Council :—

1. Dr. S. K. Mukherjee, 2. Lt.-Col. B. G. Mallya,

8. The Council at their previous meeting had resolved that in the present conditions of the Ronaldshay Medical School (Burdwan) and Lytton Medical School (Mymensingh) their affiliation could not be continued further. Both are Government Schools, and on intimation from the Surgeon-General that action was being taken to remove the main defects, the Council extended the affiliation by one year, and in the meantime a further report from the Inspection Committee as to the progress made would be examined.

Abstract of the Proceeding of the Bengal Council of Medical Registration, at their Meeting held on the 8th August, 1939.

1. The Council considered that it was desirable that the country of qualification, particularly when the qualification had been obtained from a foreign country, should be mentioned along with the abbreviation used for medical qualifications, so that the public might not be misled and they expected that a convention would be gradually established by registered medical practitioners if they follow this practice.

2. The Council decided that Government be moved to obtain legal opinion as to whether they could under the authority of Sec. 18 (a) examine the medical qualifications of a foreign country which was not covered by the British Medical Acts.

3. Government Notification announcing the election of Dr. B. C. Ray, as a member of the Bengal Nursing Council was recorded.

4. The following resolution of the Standing Inspection Committee was adopted:—

Resolved that the Committee recommend that no action should be taken for the inspection by them of medical schools outside Bengal; and that where any such institution desires to continue its recognition in Bengal, it should be sufficient that the institution is recognised by a Medical Council in any province in India, with which this Council has reciprocity of registration.

5. Lt.-Col. J. C. De was appointed a member of the Standing Inspection Committee and the Penal & Ethical Cases Committee in place of Col. Boyd, transferred.

6. The Council recorded the report by the Registrar that Biseswar Das, a compounder who had given a medical certificate posing himself as a registered medical practitioner had been prosecuted under Section 29 of the Bengal Medical Act, 1914 and had been convicted and sentenced to pay a fine of Rs. 15/- in default to undergo simple imprisonment for two weeks.

(continued from page 40)

the extent of this obliteration differs in each of the countries I am going to refer. Even this essential and inevitable obliteration does by no means convey the content and purpose of medical relief, nor does it in any manner convey the complexity of means and methods by which we can obtain a reasonably qualitative and quantitative measure of medical relief. Medical relief is indeed a multi-faceted problem and

each facet has got its own subordinate problems. But the more important facets of medical relief are MEDICAL RESEARCH, MEDICAL EDUCATION, MEDICAL AND PUBLIC HEALTH ORGANISATIONS with a view to produce a maximum state of health in the individual, and in the nation as a whole composed of such individuals. *The principle participants in medical relief are the Government, the medical men and the people.* It is obvious therefore that if we are to give a just and reasonable assay of the quality and extent of medical relief in any country we have necessarily to consider (1) its population (2) the number of medical practitioners available (3) the attitude of the Government (4) the response from the people, besides the equally important factors such as (a) the output of applied and academic research (b) the state of medical education (c) the existing organisations for effecting medical and public health relief. This is the back-ground and the picture which my mind fancies whenever it wants the full view of medical relief. Let us apply these criteria and find out approximately the state of medical relief in some of the foreign countries, and in our own.

(To be continued)

PRIZE THESES

Notice

The subject for Dr. Joseph Benjamin Prize of the value of Rs. 35/- (Rupees Thirty-five only) for the year 1939 is POST-PARTUM HAEMORRHAGE, ITS CAUSES, SIGNS, SYMPTOMS, PREVENTION AND TREATMENT; and Dr. P. S. Ramachandrier Prize of the value of Rs. 25/- (Rupees Twenty-five only) for the year 1939 is OTITIS MEDIA, ITS CAUSES, SIGNS, SYMPTOMS, DIAGNOSIS AND TREATMENT.

The date of receipt of the above theses is extended till the end of June 1940.

The subject for Dr. Joseph Benjamin Prize of the value of Rs. 35/- (Rupees Thirty-five only) for the year 1940 is DIAGNOSIS AND TREATMENT OF ACUTE ABDOMEN; and Dr. P. S. Ramachandrier Prize of the value of Rs. 25/- (Rupees Twenty-five only) for the year 1940 is USES AND ABUSES OF CHEMO-THERAPY.

All bonafide members of the Association can compete. Intending competitors are requested to write papers from a practical point of view, and in lecture style, and the same should not exceed one thousand typed lines or their equivalent. The theses should be despatched to **Dr. Jamiatram B. Desai, No. 52, Pritam Nagar, Ahmedabad**, so as to reach him on or before the 30th June and 31st October 1940 respectively.

22-3-'40

K. J. BHATT,
Secretary, Gujrat Branch, A.I.M.L.A.

LETTERS TO THE EDITOR

Private Practice of Lady Doctors in Dufferin Hospitals in U. P.

The Committee of the Dufferin Hospitals (U. P.) has passed a resolution to the effect that the lady Sub-assistant Surgeons in sub-charge of larger Dufferin Hospitals should not engage themselves in private practice for three years after their medical qualification, even during their off-duty hours. This is obviously unjust for the following reasons:

(1) It is not imposed in the case of junior lady Assistant Surgeons.

(2) It is likely to diminish their opportunities for gaining knowledge and skill and thus thwart their initiative to improve their professional knowledge through consultation with experienced practitioners.

(3) It will indirectly help the private practice of lady doctors belonging to other cadres.

(4) Many medical women fresh from school or college start private practice, and even qualified midwives are free to engage in private practice.

(5) The imposition of such a restriction is against public interest and calculated to deprive medical aid to maternity cases of middle class and poor families who cannot afford to engage lady Assistant Surgeons or who do not want admission to Dufferin Hospitals for private reasons.

(6) No such restriction exists in the case of male Sub-assistant Surgeons.

(7) The restriction is invidious because whenever a lady doctor in charge of a Dufferin Hospital goes away on casual or privilege leave, the lady Sub-assistant Surgeon works for her and has to take up all sorts of cases including private cases.

It would be an act of bare justice if the Committee reconsiders and rescinds the resolution in question.

MEERUT,
12-2-40. K. B. L. VARMA
PROVINCIAL SECRETARY, U. P.,
All-India Medical Licentiates' Association.

All-India Medical Licentiates' Association Family Fund.

The All-India Medical Licentiates' Association Family Fund was started in the year 1911. It was registered under the Provident Society Act 1912, in the year 1926. The fund carried on the business of rendering mutual help to the families or assignees of its deceased members on a dividing scheme.

The carrying on of insurance business on the dividing principle has been prohibited under section 67 of the Insurance Act (Act IV of 1938). The fund cannot receive any premium towards the said

policies according to the said Insurance Act. Under the circumstances it is to be decided what course is to be adopted and who is competent to take such steps. In my opinion there are two courses open to the Fund, viz.,

(a) To send the fund into liquidation.

(b) To re-organise and to convert it into a provident society to conduct insurance business on scientific schemes.

1. The Fund can be wound up under section 88 sub clause 4 of the Insurance Act by a resolution passed by the A. I. M. L. A. which in my opinion is the proprietor of the fund for the purpose of the said section. The directors as well as the managing committee cannot be termed as the proprietors of the fund. No such power has been vested in them and the resolution for voluntary winding up or for reorganisation must be passed by the A. I. M. L. Association.

2. The task of re-organisation of the Fund can be undertaken, and for that purpose rules of the Fund should be reframed so as to be in conformity with the provisions as laid down in section 74 of the Insurance Act. This must be done before 30th June 1940 as required by sub-section 2 of section 74 of the said Act. The Act came into force on 1st July 1939, and 12 months expire on 30th June 1940. Schemes for insurance business should be obtained from any actuary who would verify them to be actuarially sound. The New Rules should be passed by the Association and will have to be approved by the Superintendent of Insurance without which they will remain invalid. No rule will be approved by the Superintendent of Insurance if in the opinion of the Superintendent of Insurance it would unfairly affect the rights of the existing members of the Fund. In order to ascertain the powers of the Directors, the Managing Committee and the Working Committee, I have read the rules of the Fund and also the 28th annual report of the A. I. M. L. Association family fund. The powers of all these Bodies are very limited. None of them is empowered to take any such step whereby they may bind the entire body of members of the Fund. At page 7 of the Rules, the duties of all these Bodies have been mentioned, and no such power as to alter the fundamental object of the Fund above has been conferred upon them. It appears that all these Bodies including the Working Committee derive authority from the A. I. M. L. A. only and therefore they cannot exercise any power which has not been conferred upon them by the General Body of the Association.

To repeat what is obvious, and what is legally and morally the right position, the Working Committee cannot by itself liquidate the Fund or convert it into Insurance Concern. If the Working Committee takes any such step that would be unauthorized, *ultra vires*, not binding upon the Fund and at its own risk.

(Sd.) MANOHAR LAL KAPUR,
General Secretary A. I. M. L. A.

SERVICE NOTES

Punjab—January 1940

- Dr. Mohd. Yusuf Khan, Medical Inspector of Schools, Simla to Isolation Hospital, Simla.
 „ Mohd. Mohsin Ali Abbasi, M. B. B. S., s/c Ripon and Police Hospital, Simla, promoted Assistant Surgeon.
 „ Dina Nath Chaddah, General duty, Mayo Hospital, Lahore, engaged as temporary S. A. S.
 „ Diwan Chand, General duty, Civil Hospital, Karnal, granted 4 months' leave.
 „ Bishambar Das Sharma, Machhiwara Dispy., to Baghapurana Dispy., Ferozepore Dist.
 „ Rup Narain Narula, Baghapurana Dispy., Ferozepore Dist. to Barapind Dispy., Jullundur Dist.
 „ Mohd. Sarfraz, Barapind Dispy., to Kunjipura Dispy., Dt. Karnal.
 „ Bhagat Ram Puri, General duty, Civil Hospital, Gurdaspur, to Shakargarh Dispy., Gurdaspur.
 „ Gokal Chand, General duty, Civil Hospital, Montgomery, to Jawalamukhi Dispy., Kangra Dist.
 „ Kurshid Alam, General duty, Civil Hospital, Sialkot, engaged as temporary S. A. S.
 „ Girdhari Lal Chopra, Hansi Dispy., Hissar Dist. to Hariana Dispy., Hoshiarpur Dt.
 „ Balmokand Vaid, Hariana Dispy., Hoshiarpur Dt. to Hansi Dispy., Hissar Dt.
 „ Gurdit Singh Atariwala, General duty, Civil Dispy., Lahore to Police Hospital, Lahore.
 „ Gurdial Singh, General duty, Civil Hospital, Multan to Jalalpur Pirwala Dispy., Dist. Multan.
 „ Shamsher Singh, General duty, Civil Hospital, Multan to Reformatory Farms Dispy., Burewala, Dist., Multan.
 „ Manmohan Singh, General duty, Civil Dispy., Lahore engaged as a temporary S. A. S.
 „ Iqbal Hussain Randhawa, General Duty, Civil Hospital, Jullundur, engaged as a temporary S. A. S.
 „ Girdhar Datt, from leave to General Duty, Civil Hospital, Multan.
 „ Ram Sarup Gupta, extension of leave for 1 month.
 „ Sadiq Ali Bokhari, General duty, Civil Hospital, Sargodha, to Hujra Dispy., Montgomery Dist.
 „ Md. Abdullah, died on 10-1-40 while on leave.
 „ Md. Shafi, General duty, Civil Hospital, Montgomery, engaged as a temporary S. A. S.

U. P. (P. S. M. S.)—January 1940

- Dr. R. N. Mehrotra, from leave to R/D Lucknow, and then to Jail and Police, Unao.
 „ Mahesh Chandra Sharma, Ikauna, Bahraich to Bhinga Dispy.
 „ Jagat Narain Mathur, R/D Bahraich, to Ikauna, Bahraich.
 „ Abdul Hai, J. and P., Unao to R/D Lucknow.
 „ Bankey Behari Gupta, from leave to Atrauli, Aligarh.
 „ P. K. Bhattacharji, Atrauli, Aligarh, to Haidergarh, Bara Banki.
 „ A. C. Bharadwaj, Haidergarh, Barabanki to leave.
 „ Damodar Singh, R/D Bara Banki to Daryabad, Bara Banki.
 „ Rasik Behari Lal, Daryabad, Bara Banki, to Sadar Hospital, Bara Banki.
 „ Bhagwat Prasad Srivastava, Maharajanji, Rai Bareilly, to leave.
 „ Shyam Lal Agarwala, from leave to R/D Bareilly.
 „ Maharaj Bahadur Nigam, J. and P. Cawnpore, to leave.
 „ S. K. Dwivedi, R/D Cawnpore to J. and P. Cawnpore.
 „ Brij Lal Sharma, Shikohabad, Mainpuri to Sadar, Mainpuri.

- Dr. Narayan Sharma, new recruit to Shikohabad Dispy.
 „ Zainul Abdeen Faruqi, R/D Etawah, to Bharthana, Etawah.
 „ Bhagwati Sahay, Bharthana, Etawah to Sadr. Etawah.
 „ Shanker Deo Varma, Hapur, Meerut to leave.

U. P. (Sub. P. H. Service)—Jan. and Feb. 1940.

- Dr. Om Prakash Srivastava, extension of leave 3 months.
 „ Prem Singh I/C T. D. on reserve in Ballia.
 „ Indrajeet Singh Tyagi, from leave to Ballia as M. O. I/C T. D. No. 10.
 „ Prakash Bhanu Saksena, Meerut to M. O. I C T. D. No. 4, Kheri.
 „ Sri Ram Gupta, granted leave for 2 months from Kheri.
 „ Jagan Nath Prasad, from leave to Jaunpur reserve.
 „ Jeewan Prasad Sarain, Mirzapur to Ballia to epidemic duty.
 „ Gokul Prasad Rathore, from leave to Muttra reserve.
 „ Mangal Sen, from Allahabad to Gorakhpur.

Bengal—15-12-39 to 14-1-40

- Dr. Jogendra Nath Mazumdar, from Kalna to Police Lock-Up Hospital, Calcutta.
 „ Abdul Monaim, Tippera, held charge of the Chandpur Subdvn. and dispy. from 8th to 10-10-39.
 „ Benoy Bhusan Chakravarty, Jessore, held charge of the Jhenidah Subdvn. and dispy. from 13 to 15-10-39, from 4th to 8-12-39, and from 12th to 15-12-39.
 „ Jatindra Nath Sanyal, Khulna, held charge of Bagerhat Subdvn. and dispy. from 3-7-39 to 3-8-39.
 „ Mate Lal Das Gupta, Berhampur, held charge of Bagerhat Subdvn. and dispy. on 10-10-39.
 „ Suresh Chandra Ghosh, Faridpur, held charge of the Gopalganj Subdvn. and dispy. from 4th to 6th Decr. 1939.
 „ Syed A. H. Fazlur Rohim, Mymensingh, to Sherpur Dispy. on 5-12-39.
 „ Priya Nath Ghosh, Rangpur, to Nilphamari Subdvn. and Dispy. on 17-11-39.
 „ Bhujendra Mohon Choudhury, Dinajpur, held charge of Thakurgaon dispy. on 28-11-39.
 „ Nripati Bhusan Roy Choudhury, held charge of Baraset Subdvn. and dispy. on 4 and 5-12-39.
 „ Karunamoy Banerjee, Rajshahi, held charge of Natore Subdvn. and dispy. on 9-12-39.
 „ Dr. Kazi Shamsul Huq, Mymensingh, held charge of Tangail Subdvn. and dispy. from 27th to 30-11-39.
 „ Romesh Chandra Ghosh, Jalpaiguri, held charge of Alipur Duar Subdvn. and dispy., on 12th and 13-12-39.
 „ Promatha Nath Ghosh, Dacca, did the duties of M. O. Surgical Ward, Mitford Hospital, Dacca.
 „ Bhuban Mohan Sen Gupta, Burdwan, held charge of Asansol Subdvn. and dispy. on 12-12-39.
 „ Harsha Nath Bhattacharjee, Mymensingh, held charge of Jamalpur Subdvn. and dispy. on 13-12-39.
 „ Santi Lal Roy, Calcutta, did supy. at S. N. P. Hospital, Bhowanipur, from 22-10-39 to 22-11-39.
 „ Suresh Chandra Ghosh, Faridpur, held charge of Gopalganj Subdvn. and dispy. from 12th to 14-12-39.
 „ Bata Krishna Chakravarty, Khulna, held charge of Bagerhat subdvn. and dispy. from 21st to 25-11-39.
 „ Nirmal Chandra Das Gupta, Bhowanipur, to Serajganj, Pabna.
 „ Joesh Chandra Chakravarty II. Mymensingh, to Jessore.
 „ Jatindra Mohan Mazumdar, Jessore, to Dacca.
 „ Sudhir Kumar Bagchi, Dacca, held charge of Manikganj Subdvn. and dispy. from 26th to 30-11-39.
 „ Debesh Chandra Das Gupta, Chittagong, held charge of Cox's Bazar Subdvn. and dispy. from 24th to 28-11-39.
 „ Syed A. F. Fazlur Rohim, Mymensingh, held charge of Sherpur Dispy. on 13th and 14-12-39.
 „ Bozlul Hason, Noakhali, to Chandpur, Tipperah.

(Continued at foot of next page)

ASSOCIATION NOTES

Proceedings printed below refer only to the Committee and Branches of the All-India Medical Licentiates' Association unless otherwise stated.

Bombay: (7) Minutes of the General Body Meeting of the Bombay Branch of the A. I. M. L. Association held on 3rd December 1939 at Dr. U. B. Narayana Rao's Consulting Rooms, Girgaum, Bombay.

Dr. G. G. Wadhvani was in the Chair.
 Minutes of the last meeting were read and confirmed.
 Surgeon General's reply to this office No. 742/39 dated 27th July 1939 re. Govt. Hospitals and General Practitioners was read and recorded.

Consideration of the Bombay Dental Practitioners Act (Draft Bill) was postponed pending the report thereon by the Sub-Committee appointed by the Managing Committee.

Resolved that Drs. G. G. Wadhvani and U. Shesha Rao, President and Hon. Secretary respectively of the Bombay branch be authorised to open an account with the Bank of India Limited from the amount standing in the name of the President and Secretary in the Kanara Bank Ltd., Drs. A. D. Mastakar and U. Shesha Rao respectively.

(8) Minutes of the General Body Meeting of the Bombay Branch, A. I. M. L. Association., held at 4-30 P. M. (S.T) on Sunday the 7th January 1940 at Dr. U. B. Narayana Rao's Consulting Rooms, Girgaum, Bombay 4.

Dr. G. G. Wadhvani was in the chair.
 Minutes of the last meeting were read and confirmed.
 General Secretary's Circular No. 45 dated the 28th December 1939 sending his message of good-wishes to the Members of the Association was read. The Hon. Secretary was requested to send a reply to the General Secretary thanking him for his good-wishes and inspiring message and sincerely reciprocating the same to him.

Bombay Provincial Secretary's Circular No. 1 dated the 31st December 1939 regarding the election of office-bearers of the Bombay Provincial Branch was read.

The General Body unanimously passed the following resolution:—

“The Branch heartily congratulates Drs. A. D. Mastakar and U. Shesha Rao on their elections as President and Provincial Secretary of the Bombay Provincial Branch for the ensuing year.”

On learning about the order of the Bombay Municipal Corporation to keep the Municipal Dispensaries open on Sunday evenings also, the following resolution was unanimously passed:—

“This House learns with regret that the Municipal Dispensaries are now by order being kept open on Sunday afternoons also and whereas it has now become customary with the Medical profession to observe a common holiday on Sunday afternoons it is hereby resolved unanimously that the Bombay Municipal Corporation be requested to cancel this order.

Further resolved that the copies of the above resolution be forwarded to (1) Mayor of Bombay (2) Municipal Com-

- Dr. Abdul Wasit, Chittagong, to Feni, Noakhali.
 „ Md. Jamiar Rahman, Rangpur, held charge of Nilphamari Dispy. from 6th to 8-12-39.
 „ Nripati Bhusan Roy Choudhury, held charge of Diamond Harbour office Dispy. on 5-12-39.
 „ Md. Arfan Ali, Noakhali, held charge of Harishpur Dispy. from 10th to 12-12-39.
 „ Bhujendra Mohan Choudhury, Dinajpur, did the duties of S. A. S. Police Hospital in addition to his own from 26-8-39 to 27-9-39.
 „ Anath Nath Tarafdar, Nadia, did the duties of S. A. S. Sardar Hospital, from 15th to 23-8-39.
 „ Suresh Chandra Das, Darjeeling, held charge of the Bagdogra dispy. from 16th Aug. to 8-10-39.
 „ Nripati Bhusan Roy Choudhury, held charge of Bashirhat dispy., on 19-12-39.
 „ Jatindra Nath Sanyal, Khulna, held charge of Bagerhat Dispy. from 9th to 19-12-39.
 „ Gour Mohan Ghosh, Pabna, granted leave 1 month.

missioner (3) Chairman of the Medical Relief Committee (4) Executive Health Officer, Bombay Municipality for favour of information and action.”

It was suggested by Dr. U. B. Narayan Rao that all the non-member licentiates also should be invited for clinical meetings on alternate months with a view to bringing in all the Licentiates into closer contact with the Association while affording them chances to attend the clinical meetings.

This suggestion was unanimously accepted and the Hon. Secretary was requested to make necessary arrangements for the same.

On the motion of the President Dr. G. G. Wadhvani, the house agreed to co-opt two members (residents of Bombay) to the Trust already appointed by the Branch to maintain and operate the account at the Bank of India Limited and Drs. U. B. Narayan Rao and M. E. Meherji were duly co-opted as additional members of the Trust.

Dr. U. Shesha Rao proposed to give an AT HOME to the members of the Branch at the next meeting. This was seconded by Dr. A. D. Patel. On being put to vote it was carried unanimously.

Bombay Provincial Election, 1939-40: Dr. Jamiatram B. Desai, President of the Gujrat Branch, writes:

Votes for the election of the President received were 11; eight votes were in favour of Dr. A. D. Mastakar and they were as follows:—2 from each of Ahmedabad, Bombay Suburban and Poona, 1 from Sholapur, 1 from Nasik. Thus, Dr. A. D. Mastakar gets the majority of votes and becomes the President of the Bombay Provincial Branch.

Out of the eleven voting papers received for the election of the Provincial Secretary, 7 votes, namely, Bombay, Bombay Suburban and Nasik two from each and 1 from Sholapur were in favour of Dr. U. Shesha Rao and he thus becomes the Provincial Secretary by majority of votes.

Ahmedabad: At a public meeting of the Independent medical profession the following resolution protesting against the I. M. C. Act was passed

“Resolved that members of the Independent Medical Profession of this City in a Special General Meeting held on 20th September 1939, under the joint auspices of the Ahmedabad Medical Society and the Gujarat Branch of the All-India Medical Licentiates' Association, strongly reiterate their emphatic protest against the exclusion of the Indian Medical Licentiates, who form the majority of qualified medical men in India, whose names stand on all the Provincial Medical Registers, and who bear the brunt of medical relief work throughout India, from the scope of the Indian Medical Council Act, XXVII of 1933, whereas Licentiates of the Society of Apothecaries, London, and Licentiates of the Apothecaries, Hall of Dublin, have been included in the Act.

This Meeting again appeals to the Government of India, all the members of the Indian Legislative Assembly, and all the members of the Indian Medical Council, to take immediate steps to remove the injustice that has been done to this worthy class of Indian Medical Licentiates by amending the present Act, so as to include Indian Medical Licentiates also within its scope. And that copies of this Resolution be sent to the Government of India, all members of the Indian Legislative Assembly, and all members of the Indian Medical Council, under the signature of the Chairman of this Meeting, and to the Press.”

24 Parganas Branch (Bengal): 1. Monthly meeting held on 18-11-39. Dr. S. S. Sircar presided. 6 doctors were present.

Proceedings of the previous meetings held on 3-9-39 and 20-9-39 were read and confirmed.

Resolved that the annual meeting of the Branch be held on 10-12-39 and it was provisionally arranged to hold the same either at the residence of Dr. H. C. Paul or B. K. Paul at Dum-Dum Jn.

2. Annual meeting held on 17-12-39. Dr. A. D. Mukherjee presided. 27 doctors attended.

Proceedings of the last meeting held on 18-11-39 were read and confirmed.

The annual report of the Branch was read and the following office-bearers were elected for the year 1940: Drs. H. C. Pal-President, S. S. Sircar-Vice-President, K. K. Dut-

Jt. Secretary, S. N. De-Secretary, L. M. Dutt-Treasurer, Managing Committee; S. N. Mitra, P. K. Das, K. K. Seugupta, S. N. Dasgupta, B. Bhattacharya, A. T. Chakraverty, Rabindra Nath Sengupta and Kanai Lal Pal.

3. Meeting held on 16-1-40. 8 doctors were present. The Proceedings of the last annual meeting were read and confirmed.

Drs. K. K. Dutt or S. N. De and S. N. Mitra were elected as delegates of the Branch to the forthcoming Bengal Provincial Conference at Krishnagar in March '40.

The Branch wishes to nominate Dr. Abibhusan Mukherjee to be the President of the above Conference.

The statement of accounts was audited and passed. Total receipts were Rs. 20-12-9 and expenditure was Rs. 15-13-6, leaving a balance of Rs. 4-15-3. The Branch collected Rs. 68 from 15 members of the Association and remitted the same to the Treasurer.

4. Monthly meeting held on 18-2-40. 6 doctors were present.

The house recorded its deep sympathy with Dr. A. K. De in the sudden death of his mother on 8-2-40.

The minutes of the last meeting were read and confirmed. Letter from the General Secretary, Reception Committee, Bengal Provincial Conference was considered and Dr. K. Dutt was requested to reply suitably.

Nadia (Bengal): Monthly meeting held on 10-12-39 Dr. B. Bhadra was in the chair. 12 doctors were present.

Proceedings of the last meeting were read and confirmed. Resolved that 24th and 25th March 1940 be fixed to hold the Bengal Provincial Medical Licentiates' Conference at Krishnagar.

A Sub-committee with Drs. K. Roy, H. Sen, D. Bose and B. Bhadra was formed to proceed with the conference matter.

Office-bearers for 1940: Drs. K. Roy—President, B. Bhadra—Vice-President, D. Bose—Secretary and Treasurer, J. Roy—Assistant Secretary, A. Tarafdar—Auditor. Members: Drs. R. Sanyal, L. Pramanick, B. Ghosh, D. Bagchi, D. Adhikary, B. Majumdar, S. Haque.

The Branch accounts for the month of Nov. 1939 was examined and passed.

2. Monthly meeting held on 7-1-40. Dr. D. Bagchi presided. 16 doctors were present.

Dr. H. N. Sen's letter dated 15-12-39 re. election of office-bearers: considered and resolved that the resolution re. election of office-bearers in December 39 be confirmed as fresh election was considered unnecessary by majority of votes and that Dr. Sen be informed accordingly.

The proceedings of the last meeting were read and confirmed.

Branch accounts for the month of Dec. 39 were examined and passed.

Circular No. 45 of 3-1-40 from the General Secretary was appreciated by the members.

This Branch opined that Dr. S. C. Mukherjee, M. L. C., of Birbhum be elected as President of the Bengal Provincial Medical Conference, and Drs. K. R. Roy and D. Adhikary be elected as delegates from this Branch to attend the conference.

Resolved that a Health and Scientific exhibition be held along with the Bengal Provincial Conference and Drs. K. R. Roy and D. Adhikary were deputed to arrange for the same.

3. Meeting held on 11-2-40. Dr. K. R. Roy in the chair. 9 members were present.

Minutes of the last meeting were read and confirmed.

Branch accounts for the month of Jan. 40 were considered and passed.

Considered the circulars Nos. 2 and 3 from the General Secretary re. holding of the Annual Conference of our Assn. at Ahmedabad during the ensuing X-mas and the members were glad to know the same.

Preliminary arrangements in connection with the coming Bengal Provincial Conference were made.

Resolutions for the next Provincial Conference were read and discussed.

Letter from the Secretary, Calcutta Branch, was placed on the table and discussed.

4. Special Propaganda meeting held on 13-2-40. Dr. K. R. Roy President. 15 doctors attended.

Dr. K. R. Roy requested the doctors to enroll new members for the Mother Association so as to increase the strength of the licentiates.

Members discussed all affairs about the next Provincial Conference and the Health and Scientific exhibition.

Members were requested to work for the success of the Conference.

Dacca (Bengal): Monthly meeting held on 10-12-39. 8 doctors were present.

Proceedings of the last meeting were read and confirmed.

Resolved that Dr. D. N. Basak be the Secretary of the Branch.

Resolved that this meeting learns with deep regret the sad demise of Dr. Monmohan Sett, an active member of this Branch, and expresses its sincere sympathy and condolence to the members of the bereaved family.

Considered the circular Nos. 29, 30, & 31 from the General Secretary and resolved that (i) the G. S. be requested to supply one almirah to keep office papers and files; (ii) the General Secretary be informed of the following: Income—local subscriptions—Rs. 40. Expenditure—Salary, Commission, Puja and miscellaneous Rs. 40. (iii) Ref. Cir. No. 31, the allied subjects were discussed on 23-6-38 and 12-12-38. This branch does not want any insurance Company at present but recommends offering scholarships to the deserving licentiates for research work and higher studies.

Prizes and medals as distinction of honour may be awarded from the general funds to the deserving candidates, but there should not be any admission fee.

Rangpur (Bengal): 1. Meeting held on 29-5-39. 8 members were present. Dr. J. C. Lahiry was in the chair.

Proceedings of the last meeting were read and confirmed.

Interesting discussion took place re. the uses of Protosil in private practice.

2. Meeting held on 20-9-39. 11 members were present. Dr. B. C. Lahiry presided.

Resolved that this meeting records its emphatic protest and deep resentment against the Indian Medical Council Act of 1933, and respectfully urges on the Govt. of India to amend the said Act immediately to include the medical licentiates within its purview.

3. Meeting held on 30-9-39. 6 members were present. Dr. J. C. Lahiry occupied the chair.

This meeting places on record its deep sense of sorrow at the demise of Dr. Hrishikesh Lahiry, M. B., and conveys its deep condolence to the members of the bereaved family.

4. Meeting held on 10-12-39. 9 members were present. Dr. J. C. Lahiry presided.

Proceedings of the last meeting were read and confirmed. Discussion took place re. the use of veratrine in eclampsia and its advantages and disadvantages in private practice.

Mymensingh (Bengal): 1. Meeting held on 17-12-39. 10 members were present.

Discussion re. the Family Fund took place and postponed for the next meeting.

Resolved to approach all the doctors personally to join the Association and to issue appeal to that effect.

2. Meeting held on 29-1-40. 10 members attended.

Resolved that this Branch expresses its deep sorrow at the death of Rai Saheb Dr. Satish Ch. Gupta of Jalpaiguri.

Resolved that Dr. Abibhusan Mukherjee be the President of the Bengal Provincial Conference.

Following doctors were selected, but any two of them will represent the Branch at the ensuing Bengal Provincial Conference: Drs. T. N. Bhattacharjee, S. K. Sarkar, Amulya Ch. Sanyal, B. Chaudhuri.

Contingent bill from 1-7-39 to 31-12-39 amounting to Rs. 3-10-3 was scrutinised and passed.

This Branch recruited 9 members as a result of their propaganda.

Resolved to vote for Dr. T. N. Bhattacharjee in the ensuing election to the Bengal Council of Medical Registration.

3. Meeting held on 23-2-40. 8 members were present.

Resolved to contribute Rs. 10 towards the ensuing Bengal Provincial Conference Fund.

Propaganda bill amounting to Rs. 18 was passed.

Resolved to move in the Bengal Conference the following subjects: introduction of five years' course, in medical schools; formation of a committee to recruit more members and to look after the working of the branches; request Mother Association's financial help to the Branches for doing propaganda; request the Government to increase the percentage of promotion of Sub-assistant Surgeons and to appoint medical licentiates in the rural medical relief work.

Tinsukia (Assam): 1. Managing Committee meeting held on 10-12-39. Dr. G. C. Sil presided.

Monthly account for the month of Nov. 39 was passed. Propaganda scheme chalked out by the Secretary was approved and the expenditure sanctioned.

2. Annual General meeting held on 17-12-39. Dr. D. C. Chakravarty presided. 9 members were present.

Proceedings of the last meeting were read and confirmed. Branch Secretary read the 2nd annual report.

Branch account for the whole of last year was passed.

Office-bearers for 1940: Drs. K. M. Ganguli—President, S. C. Barooah—Secretary. Managing Committee Members: Drs. N. B. Kar, S. C. Ganguli, D. C. Chakravarty, S. N. Dutta, G. C. Sil.

Prov. Secretary's circular No. 16 of 15-11-39 was discussed.

Following scientific demonstrations were made: (1) An unusual type of skin eruption, just after delivery by Dr. S. C. Ganguli, (2) A case of peculiar measles-like eruptions by Dr. G. C. Sil and (3) A case of purpura haemorrhagica by Dr. B. C. Baruah.

3. Managing Committee meeting held on 4-2-40 with Dr. S. N. Dutta in the chair.

Accounts for the months of Dec. '39 and Jan. '40 were passed.

Propaganda bill also was passed for payment.

Gauhati (Assam): Meeting of the Medical Education Advisory Committee held on 27th and 28th November '39 at Shillong. Col. Phipson presided.

The Committee adopted the resolutions passed in the Delhi Medical Education Conference to have only one uniform standard of medical education and recommended the same to the Assam Government to raise the B.W. Medical School of Dibrugarh to the status of college from 1943 with 5 yrs. course and I. Sc. with biology as a premedical qualification. The following sub-committee was formed to work out the said details: Col. Allen, Executive Engineer of Dibrugarh, Dr. B. Barua, R. B. Dr. P. Ghosh and Dr. K. L. Ghosh.

The Committee also recommended to the Government to increase the seats for biology in the Cotton College, Gauhati and Muraichand College, Sylhet, with provision for stipends.

The question of starting a medical school at Sylhet was abandoned, and the intended building be utilised for a bigger hospital with post-graduate course.

2. Monthly meeting held on 16-1-40. 6 members attended. Dr. D. R. Sen presided.

Contingent bill for the months of Nov. and Dec. '39 for Rs. 16/2/- was passed.

This Branch requested the members to contribute their mite in response to the appeal from the Secretary, Re-Union Committee, Dibrugarh.

Read the letter from the Hon'ble Dr. M. N. Saikia, Minister, Shillong.

3. Meeting held on 7-2-40. Dr. G. S. Das presided.

G. S. Circular No. 45 was read and circulated.

Members were requested to remit their subscriptions to the Mother Association and the Branch.

Discussion about Pneumonia took place.

Contingent bill for Rs. 2/1/- was passed.

4. Emergent meeting held on 13-2-40. Dr. P. C. Dwara presided.

Resolved to request the Government of Assam to raise the B.W. Medical School into a college from 1943, in view of the recommendations of Indian Medical Council and the Delhi Medical Education Conference. And the intended medical school building at Sylhet be utilised for a well-equipped hospital with post-graduate training.

Tingri Valley (Assam): 1. Meeting held on 19-11-39 with Dr. J. C. Dutta in the chair.

Minutes of the last meeting read and confirmed.

The Secretary read the proceedings of the Prov. S. C. Meeting held on 15-10-39 at Dibrugarh.

Resolved to contribute Rs. 12 to the Provincial Secretary to circulate the Tingiri Valley scheme to all the tea estate doctors, aggregating to 123 doctors only.

Secretary read out the accounts of the Gauhati Conference.

Dr. S. C. Dutta exhibited eight cases of vitamin A deficiency in its different stages. The detailed information and demonstration of phrynoderma cases were appreciated by all.

2. Scientific meeting held on 17-12-39. Dr. J. C. Dutta was in the chair.

Minutes of the last meeting read and confirmed.

Dr. K. P. Hare delivered a lecture on "Modern conception of anaemia, its causation and classification in Assam" demonstrating with microscopic slides.

3. First Annual General meeting held on 28-1-40. Minutes of the last meeting read and confirmed.

Contingent bill from Oct. to Dec. '39 amounting to Rs. 2-3-0 was passed.

The Secretary read the annual report for 1939 and it was unanimously accepted.

Office-bearers for 1940: Drs. D. D. Sarma Baruah—President, S. C. Dutta—Secretary, H. C. Das—Jt. Secretary and Treasurer. Managing Committee members: Drs. J. C. Dutta, M. A. Hazrika, P. C. Dutta. Provincial Standing Committee members: Drs. K. C. Bhattacharjee, D. D. Sarma Baruah.

Resolved that the local subscription of the members be Rs. 5.

Dr. S. C. Dutta demonstrated a case of syphilitic rupia.

The Annual Report. This Branch was opened on 23-1-39, worked for the betterment of the tea estate doctors and for the Mother Association. Began with 5 old members; now the strength is 16. During the year 12 meetings were held: 7 ordinary meetings, 3 scientific meetings and 2 managing committee meetings. Scientific papers were read in all meetings and were published in the *Indian Medical Journal*. All the meetings were well-attended.

This Branch carried out the dictates of the Mother Association and submitted scheme for the betterment of tea estate doctors in Assam.

The Branch collected and remitted the subscriptions of the members to the Treasurer. It did propaganda within its means but the response was not satisfactory.

The authorities of Keyhung Indian Club were kind enough to allow meetings to be held in their premises and our thanks are due to them. Most of the meetings were entertained with refreshments by Dr. H. C. Das.

Jorhat (Assam): 1. Meeting held on 11-1-40. 8 members were present. Dr. B. B. Sen Gupta presided.

The scheme for the improvement of the tea estate doctors was discussed and passed and the Provincial Secretary was requested to do the needful.

2. Meeting held on 21-2-40. Dr. A. Hakim was in the chair. 7 members were present.

Read Circular No. 20 from Prov. Secretary. Resolved to protest against having a medical school at Sylhet but supports the recommendations of the Medical Education Committee of Assam to raise the B. W. Medical School into a College from 1943, and condemns the idea of splitting the college into 2 divisions, viz., 2 years at Dibrugarh and 3 years at Sylhet, as the same is detrimental to the interests of the students.

This meeting is of opinion that another college, if need be, be established in Surma Valley by the Government.

Accounts for the months of Dec. '39 and Jan. '40 were audited and passed for the payment of Rs. 3-8-0.

Read circular Nos. 2 and 3 from the General Secretary and noted the contents.

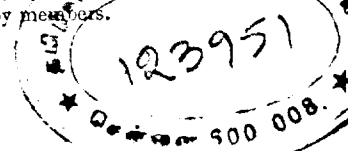
Jullundur (Punjab): Meeting held on 7-1-40 with 7 members.

Proceedings of the last meeting were read and confirmed.

The scheme of touring in rural areas and the transfer of certain dispensaries to the Health Department was discussed and it was decided to gather the attention of other medical officers in the Punjab.

A clinical note on the latest treatment of local sores was read and appreciated by members.

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Proceedings of the last conference of the Ind. Med. Association, held at Lahore was described by Dr. Dal Singh to the members.

Karnal (Punjab): Meeting held on 14-1-40. Dr. M. L. Kapur was in the chair. 7 doctors were present.

Dr. Khan Chand Wohra read a paper on Gastro-intestinal neurosis and illustrated 3 practical cases concerning the same.

Bilaspur (C. P.): Emergent meeting held on 17-12-39 with Dr. P. H. Sant in the chair. 7 members were present.

Prov. Office-bearers for 1940: Drs. K. P. Sen Gupta—President, I. B. Basu—Secretary, and Member of the Prov. Standing Committee—Dr. P. H. Sant.

Branch Office-bearers for 1940: Drs. P. H. Sant—President, M. N. Sen Gupta—Secretary.

Gwalior (C. I.): Meeting held on 3-11-39. Dr. D. V. Venkappa, President of the Mother Association was entertained. He spoke on the necessity of strengthening this old organisation. He, at a meeting of the Gwalior Medical Association, stressed on the desirability of amending the Ind. Med. Council Act, the need for uniform standard of medical education and starting of medical industries with medical men supervising the same. It was a grand reception with 70 doctors present.

Bareilly (U. P.): Meeting held on 25-12-39 with Dr. Babu Ram in the chair. 4 members were present.

Proceedings of last meeting were read and confirmed.

This Branch regretted its inability to hold the Provincial Conference at Bareilly.

Office-bearers for 1940: Drs. Babu Ram—President, P. N. Saxena—Vice-President, Shiam Behari Lal Gupta—Vice-President, R. S. Farga—Secretary, I. B. Chatterjee—Organising Secretary. Executive Committee: Drs. I. A. Ghani, Rathor, P. L. Jain, K. Sahai.

Contingent bill from 1-11-39 to 24-12-39 was passed.

Resolved that the Government be requested to reconsider the order stopping the allowance of the medical officers for attending the compounders' training class. This stoppage of honoraria has very harshly affected the M. Os., as it is an extra work. Copy of the above to be sent to the I. G. C. H., (U. P.) and to the Secretary, Medical Deptt. to U. P. Government through the Prov. Secretary.

Madras: An Urgent Committee meeting held on 7-1-40. Dr. D. V. Venkappa occupied the chair. 9 members were present.

Resolved that this Association congratulates Dr. K. Jaffar Khan, I. M. D., member of our Assn., and Medical Officer Corporation of Madras, on the eve of his selection to army medical service by the Government of India and further requests the Secretary to give a tea party as early as possible and to incur the necessary expenditure from the local fund of the Branch.

Accounts for the month of Dec. 1939 amounting to Rs. 9-8-0 was passed unanimously.

30th Conference of the All-India Medical Licentiates' Association, Ahmedabad.

Reception Committee

MANAGING COMMITTEE MEETING

The first meeting of the managing Committee of the Reception Committee of the ensuing 30th Annual Conference was held on 12-2-40 at the Prarthana Samaj Hall at 4 p. m. under the presidency of Dr. B. G. Mehta.

Dr. B. G. Mehta explained the general sense of the meeting.

The idea of sending a questionnaire as to *who is who of the Association* was discussed and it was unanimously resolved that such a questionnaire be sent to the General Secretary of A.I.M.L.A. for circulation among the Branches with a view to facilitate the work of electing suitable Office-bearers at the ensuing 30th Annual Conference. This may be put up before the General Meeting for sanction.

A propaganda committee was proposed by Dr. M. K. Pandya and seconded by Dr. R. K. Zaveri consisting of (i) Dr. B. G. Mehta—President, (ii) Dr. Nalinikant M. Vyas, and (iii) Dr. A. P. Shukla, with power to co-opt more members, and passed unanimously.

Question of collecting funds was discussed and it was considered and finally decided that batches should be formed to collect the subscription.

Dr. S. A. Subedar's letter was read and it was resolved that he could not be allowed travelling allowance for attending the Reception Committee Meetings.

PROPAGANDA COMMITTEE

A Propaganda Committee meeting was held on 15-2-40 at 2-30 p. m. at Dr. K. J. Bhatt's residence under the presidency of Dr. B. G. Mehta when the following work was considered.

To get a circular appeal printed for circulation among the Licentiates of Gujarat and Kathiawar. It was decided, and the General Secretary was empowered, to get 1500 copies and 1000 covers printed.

It was also decided to collect names and addresses of Licentiates in service by writing to the Civil Surgeons of Ahmedabad, Surat, Rajkot, Kaira, and Broach, to the Chief Medical Officers of Jamnagar, Bhavnagar, Junagadh, Rajkot, and Porbandar States, to the Health Officers of various Municipalities and Presidents of Local Boards.

12-2-40

K. J. BHATT,
General Secretary,

gested in the paper; some considering there was an over-emphasis on surgical methods as against non-surgical methods of treatment of pulmonary tuberculosis. In reply, Dr. Jones stated that the aim in treatment was to use methods which produced the best results and he believed that in a large number of patients it was proved that thoracoplasty did do this.

'GOLD TREATMENT' by DR. Y. G. SHRIKHAND

While a good deal has been said for or against the use of gold, the fact that it is still used is evidence of efficacy in suitable cases. Of the various preparations in the market the choice lies between sanocrysin and solganol.

Gold treatment is of special value in exudative lesions, but in selecting cases attention should be paid to the extent of the disease, resistance of the patient and efficacy of his eliminative mechanism. While large doses are harmful, smaller doses are useless and a plan for proper dosage is suggested.

Intra-pleural injections of gold salts with repeated aspirations have also been used with good results in the treatment of pleural effusions complicating pulmonary tuberculosis.

DISCUSSION

The question of treatment with gold preparations evoked much discussion, some maintaining that there was little evidence of its producing any good results, others maintaining that after a considerable experience over many years they were convinced that it was of value, especially in fresh exudative lesions and as an aid in controlling disease in the contra-lateral lung during artificial pneumothorax treatment. Dosage and complications, and contra-indications were discussed.

At the end of the discussion the question of carbolic injection was raised and the experience of those who had tried it was against continuing this treatment, as also with cadmium sulphite.

'Prognosis and After-Results'

DR. P. V. BENJAMIN

It is pointed out that in the general population the prognosis of tuberculosis is good, but in an individual in whom the disease has become manifest a great many factors—age, sex, type of the disease, presence of tubercle bacilli, complications both tuberculous and non-tuberculous—have to be considered. The influence of an early diagnosis, appropriate treatment, and proper after-care cannot be over-estimated.

Figures for the after-results of patients discharged from different sanatoria are given and show improved prognosis under modern methods of treatment.

DISCUSSION

A short discussion served mainly to emphasize what was already in the paper, together with some mention of family history, nutrition, and the question of urban and rural origin.

'Classification of Stages of Pulmonary Tuberculosis and of "Discharge" Results'

DR. A. C. UKIL

An intelligent basis of classification is not only useful in assessing prognosis and in advising treatment, but essential in comparing results of different methods of treatment followed by workers in different institutions in the country.

With modern advances in the methods of diagnosis and assessing prognosis, different countries have adopted

different types of groupings, which are more or less amplification of the Turban-Gerhart classification.

Information collected in India shows that except the Madanapalle group of sanatoria, no two institutions followed any uniform standard. Discrepancies in the criteria followed by different institutions are pointed out in the paper.

A classification of the adult type of pulmonary tuberculosis based on radiological extent of the disease is suggested.

DISCUSSION

The difficulty and at the same time the necessity of some standardizing of the classification of case records was well brought out in the discussion which followed the paper. A simple method of classifying the condition of the patient on admission and also on discharge were both required, as too detailed a classification would only lead to greater difficulty in standardization and comparability of records.

'Causative Factors in the Development of Tuberculosis Disease'

DR. B. K. SIKAND

The factors which turn infection into disease and also those which determine the course of the disease in a particular individual are not all well understood. Detailed surveys over a large number of areas and for prolonged periods can alone supply the information.

Absence of bovine infection in India is pointed out and the effects of race, age and sex on the incidence of disease are discussed. Environmental conditions, the effect of bad housing and poor nutrition as causative factors are stressed. Bad housing and the unhygienic habits of the people provide the ideal condition for massive dose infection. Defective nutrition both in quality and quantity which is well known in India by its pauperizing action on the human physiology may represent a real tubercularizing agent.

DISCUSSION

In discussion, the multitude of causative factors raised, only showed how little is really known as to what are the real factors in the spread of tuberculosis. One factor seemed certain, an open case *plus* overcrowding.

'Spread of Infection and its Prevention'

DR. K. S. SANJIVI

In the Western countries the campaign against tuberculosis is fought on two points—bovine and human sources. Absence of bovine infection in India is mentioned by some workers, but the number of studies on bovine infection is totally inadequate to warrant any dogmatic assertion. The human type of infection spreads mainly through the sputum. The infection may be direct, or indirect, through dust, flies, food and utensils.

Exogenous infection is now believed to play a more important role in the adult type of the disease. The open case must therefore be the focus of our attention, both in his own interest and in the interest of the community. An intensive search for open cases should therefore be organized and the aim of all treatment should be to render open cases bacilli-free.

Importance of co-operation of the general practitioner, the public health department, and tuberculosis hospitals in finding open cases and detecting contacts with early signs is stressed. Figures from Madura are given where, with the co-operation of the public health department, 81.3 per cent of the contacts of known cases have been examined.

DISCUSSION

Discussion tended to deal mostly with the question of infection in institutions and specially among the staff of institutions treating tuberculous patients. Regular examination of nurses and doctors and others in contact with patients was recommended, but the use of masks suggested by some was not generally accepted.

'Tuberculosis Clinic'

DR. K. VASUDEVA RAO

A tuberculosis clinic is the pivot of an anti-tuberculosis scheme and the clinics should be scattered throughout the country—a clinic for every 50,000 of the population. These should be located in the crowded areas of the city. The building should be simple and all facilities for X-ray and bacteriological investigations should be available. The functions of the clinic, in regard to diagnosis, treatment of cases, contact examination, and as centres for care and after-care and for education and propaganda, are discussed. The strength and the duties of the staff are described and a budget estimate for the recurring and non-recurring expenses of a clinic is given.

DISCUSSION

A short discussion centred mostly on tuberculosis health visitors, their training, their work, and the number needed.

'The Work of Care and After care Committee'

DR. T. J. MANI

Work of the care and after-care committee at Bangalore is described and compared with schemes in other countries. The Bangalore committee has made provisions to help needy patients with diet and special medicine, though this is not ideal, it is the best that can be done in the absence of sufficient hospital accommodation. As regards employment of arrested cases a small factory where patients can work under medical supervision is advocated. As regards the care of infants institutional separation is the one adopted in Bangalore, because familial boarding may not work satisfactorily. Preventoria for older children are necessary, but the financial position does not permit a move in this direction.

'Ex-Patients' Colonies'

THE REV. R. M. BARTON

The success of modern methods of treatment of tuberculosis has raised many new problems. No doubt lives of many patients are prolonged but so is also the infectiveness of many of them, because the treatment in many patients does not produce permanent arrest or cure. An early return to unsuitable work and unhygienic surroundings not only leads to frequent relapses, but is dangerous to the family and the associates of the patients. In order to produce the best results both from the individual, and from the community's point of view, an individual who is permanently damaged by tuberculosis must be able to live and work in a sympathetic and happy atmosphere, under a disciplined freedom with a suitable employment that provides security to the patient and his family and in a place where he knows that he can get help whether in health or sickness.

Reference is made to several schemes of after-care and rehabilitation in the Western countries, and the main principles on which the famous Papworth Village Settlement scheme is based are mentioned.

The activities and the growth of the Panipuram ex-patients' colony at Arogyavaram near Madanapalle where at present 12 patients (two with families) are living are described. Attention is drawn to the importance of proper selection of cases, and the correct choice of the industries.

DISCUSSION

The necessity for care and after-care committees was agreed upon, as also ex-patients' colonies, but doubts were expressed by some in discussion whether managing bodies of institutions could be convinced of the need, or if money could be found; suggestions were also made of various possibilities for colonies. But if the need is recognized by the leaders in tuberculosis work, and they had vision and enthusiasm, there seemed no reason why colonies should not be established, but they must be built in connection with treatment institutions.

'Institution and Home Treatment' by

DR. R. H. H. GOHEEN and DR. R. K. KACKER

The vast majority of those afflicted with tuberculosis are found in their homes. This will continue to be true even when a large number of institutions representing various links in the chain of a complete anti-tuberculosis scheme are established. Home treatment therefore assumes a role which cannot be over-estimated. This can, however, only be provided with the co-operation of the general practitioner, who should be adequately instructed in regard to the methods of early diagnosis, treatment and of protection of contacts. He should be able to adapt an average home for proper segregation and should judiciously and tactfully effect a change in the patient's and family's dietary, which is very often unbalanced on account of ignorance of the correct facts. In fact, the entire economy of the patients has to be safeguarded.

Need for co-ordination of home treatment with institutional treatment is stressed. Of the many functions of sanatoria, their importance as training centres for doctors and centres for propaganda is emphasized.

'Tuberculosis Survey'

MAJOR G. F. TAYLOR

Brief summary of tuberculosis surveys done in India is given and main conclusions which can be drawn from these surveys are mentioned. A plea for surveys all over India was made, as these not only help to define the extent and nature of the problem and of the causes of the spread of the disease in the community, but are useful also in detecting open cases. Survey work is moreover an effective educational measure, as it awakens and directs public opinion to the problem and opens the way for proper legislative measures.

DISCUSSION

In discussion, further information was given of surveys in different parts of India, of experience with tuberculin which had lost its potency, and of the dangers of using a 1 in 100 dilution in routine surveys. The necessity of tuberculosis clinics being properly staffed so that they could carry out surveys, was emphasized. Some discussion took place also on the type of disease as found by examination of patients, and at post-mortem examination.

'Propaganda and Educational Campaign'

DR. A. R. MEHTA

Ignorance about everything scientific is too well known in India but the ignorance about the causes and methods of prevention of tuberculosis is colossal; and if there is any one weapon which can be of greatest use in the fight against the disease, it is the educational campaign.

The broad principles of educational campaigns are mentioned and it is emphasized that attention should be focussed on the child. Health education should form part of the school programme, and must be associated with proper instructions of the teachers in hygiene.

THE MADRAS MEDICAL COUNCIL ELECTION

(MAY 1940)

Y. SURYANARAYANA RAO, L. M. P.

MEMBER, MADRAS MEDICAL COUNCIL,
" DISTRICT TUBERCULOSIS COUNCIL,
" DISTRICT LEPROSY COUNCIL,
PRESIDENT, DISTRICT R.M. PS' ASSOCIATION,
SECRETARY, ANDHRA MEDICAL ASSOCIATION,
" DISTRICT MEDICAL ASSOCIATION,
EDITOR, DISTRICT MEDICAL BULLETIN,
MEMBER, ALL-INDIA MEDICAL LICENTIATES'
ASSOCIATION, AND INDIAN MEDICAL ASSOCIATION.

Dear Doctor,

I am a practitioner of twenty-five years' standing, successful in my practice, sincere in my efforts and unremitting in my endeavours at safeguarding the interests and welfare of the profession, contributing to the progress and prosperity of its members in all possible ways, and fighting for their statutory rights and privileges as registered medical practitioners.

2. My long and varied experiences and activities in the many organisations noted above have enabled and inspired me to continue to serve the profession and work for its well-being. During my previous membership in the Madras Medical Council I availed myself of every opportunity to further the consolidation of the profession, to protect its statutory rights and privileges and to safeguard its other interests, in co-operation with my other colleagues in the Council. Much yet remains to be done, and the democratic constitution of the new Council that is now being formed under the provisions of the Madras Medical Registration (Amendment) Act, 1938 gives scope for better and more effective work than what was really possible in the old Medical Council. This has induced and encouraged me to seek re-election to the Council.

3. Now, it is not merely a question of fighting for the removal of the well-known disabilities of the Statutory Medical Practitioners from the forum of the Provincial Medical Council, but it is also a question of sustaining its self-respect and autonomy. Since the passing of the Indian Medical Council Act of 1933, the Provincial Medical Councils have become a mere hand-maid to the former. Representatives to the Indian Medical Council from the Provincial Medical Councils are taken in the name of the latter, although the electors are drawn from only a part and not from the whole Provincial

(TURN OVER)

Medical Register. Not only is this against the legal and statutory purpose and significance of Medical Registration but it is also in direct contravention of the objects and reasons for which the Madras Medical Act has been recently amended, one of them being "TO ABOLISH DISTINCTION BETWEEN THE DIFFERENT CLASSES OF REGISTERED MEDICAL PRACTITIONERS AND TO PROVIDE FOR A COMMON REGISTER." Again, when the Bombay Medical Council suggested, during Feb. 1939, to the Indian Medical Council to co-opt two nominees of the Bombay Medical Council to be associated with the Inspectors of the Medical Council of India while inspecting the Bombay Medical Colleges, it was turned down albeit the fact that the Provincial Medical Acts give the Provincial Medical Councils statutory control over and power of inspection of the medical educational standards and examinations within their area. These new inroads into the statutory functions of the Provincial Medical Councils have to be stemmed before wrong conventions break the spirit and purpose of provincial legislative statutes.

4. My long and humble services to the country in social, economic and medico-political fields, as a member of the Economic Council, the Educational Council, the Excise Advisory Committee, the Jail Visitors' Committee, the All-India Medical Licentiates' Association, the Indian Medical Association and other various organised Bodies of my District bespeak of my interest in public work and of my desire to do public service. The experience gained in these various spheres over a period of quarter of a century has prompted me to dedicate my service to the cause of the profession, and to seek again your co-operation and help in the work that lies ahead.

5. May I therefore beseech you, my dear brother of the noble profession, to be kind enough to extend your choice not only in favouring me with one of your seven valuable votes but also in suggesting to your colleagues within your sphere of influence to cast their votes in my favour, bless me with success in my earnest endeavours to be elected to the Madras Medical Council and thus enable me to continue to render my humble service to the profession?

I shall do my best to cherish and deserve your confidence and good-will.

Tanaku,

Dated, 29-3-1940.

Yours faithfully,

Y. Suryanarayana Rao.

FOREIGN MEDICAL NEWS

Our London Letter

(From Our Own Correspondent)

ALCOHOL AS AN ANTISEPTIC

Last year, an action for damages was raised in the High Court of Dublin by Mr. Kineally and others against Wellcome Foundation Ltd., on the grounds that the T. A. F. (Diphtheria prophylactic vaccine made up of toxoid-anti-toxin floccules) supplied by the defendant was negligently prepared and issued containing tubercle bacilli, and that as a result thereof some of the inoculated children became infected with tuberculosis. During the course of the trial it was proved that the contamination could not have occurred during the process of manufacture and issue but by imperfect sterilisation of syringes and needles used for injection or such other causes beyond the purview of the manufacturer. The judgement was in favour of Wellcome Foundation. The points raised in this trial were so important to the medical profession and in the manufacture of biological products that Bigger and others have now published their investigations on Inoculation Technique in the *British Medical Journal*, Jan. 20, 1940. They have made two points clear beyond any shadow of doubt: (1) "Droplet" infection in inoculation work may occur at any time between sterilisation and inoculation. (2) The carrying of syringes and needles in containers of alcohol or ether is definitely unsafe. The other conclusions of their investigation are: (1) 0.5% phenol used as the preservative in biological products kills all non-sporing bacteria, including T. B., within 7 days. (2) Contamination on the external surface of the rubber cap of a bottle of biological product can be introduced into the contained fluid when the cap is pierced by the needle. (3) Any contamination of the needle or in the syringe may infect the entire contents of such a bottle. (4) Such contamination may occur through inadequate sterilisation, droplet infection, or contact with infected material after sterilisation.

HITLER'S PERSONALITY

The hysterical personality of Herr Hitler has aroused the attention of the reputed psychiatrists, and many books and other publications in the press reveal the complicated nature of his morbid mental make up. I am not a psychiatrist in any sense, but after reading the recent literature on Hitler's mind, one question appears to me as more important than any other. It is this: Is Hitler suffering from an individual disease peculiar to himself alone, or is he but an ugly symptom of a disease which is sweeping the German people off their feet? It is difficult to believe that a single man, however adroit, emotional and perverse, could convert the people to his views and methods of doing things unless the latter are also of the same psychotic type. I admit that the hysteria of Hitler is infectious, but the infection cannot spread if the "powers-of-resistance" of the people

As regards education of the adult, the use of the spoken and the printed word and of devices like exhibitions, cinema films and radio talks are mentioned, but the campaign to be successful should be continuous and the messages should be repeated over and over again in different form and manner.

'Co operation in the Campaign against Tuberculosis'

DR. R. KRISHNA

Tuberculosis is a disease whose tentacles spread into various fields of human activity. The anti-tuberculosis campaign to be successful must have co-operation of all bodies concerned in the prevention and treatment of the disease.

The importance of the general practitioner in establishing early diagnosis and in connection with schemes for organized home treatment apart from a clinic is emphasized. Various forms of co-operation with the maternity and child-welfare organizations, public health departments, and school medical officers, as well as with other social agencies are given.

DISCUSSION

While doubt was expressed as to the value of much of the usual type of propaganda, the discussion generally recognized that a true and well-organized propaganda was one of the essentials of the tuberculosis campaign. The facts should be placed before people, but emphasis should be on the side of hope, and not of horror. Public co-operation in the campaign could only be obtained by the right type and method of propaganda and education, beginning even in the schools.

'Legislation and Tuberculosis'

DR. A. C. UKIL

The growth of sanitary law in the civilized world is traced. History of tuberculosis campaigns in the Western countries shows that the first initiative has been taken by private agencies and the State came later to extend, regulate and co-ordinate action of these bodies especially with regard to finance and legislation. In no country except the United States of Soviet Russia has the State completely taken over the task of the tuberculosis campaign and in most countries a joint action has been favoured.

Tuberculosis legislation in England, especially in regard to notification of cases, provision for an anti-tuberculosis campaign, co-ordination of the administrative machinery of the component parts is mentioned in some detail. Defects in regard to notification of tuberculosis in India are detailed.

The opinion is expressed that the time has not yet come in India for any comprehensive and useful tuberculosis legislation, although it may seem urgent and important. It is suggested that in the interim period the provisions of the Municipal Acts and Rural Health Acts, be administered with zeal and sympathy and that more powers be delegated to the medical officers of health. Legislation for action in regard to factors which indirectly help anti-tuberculosis campaigns such as rural and town planning, slum clearance and housing to prevent overcrowding and insanitary living, especially in urban and industrial areas is favoured. Spitting on the floors and walls on public roads and public vehicles should be made a punishable offence.

DISCUSSION

Discussion emphasized the necessity of educating and influencing municipal and local authorities in tuberculosis matters as one of the most important parts of the campaign. Enabling legislation was in the earlier stages to be preferred to coercing legislation, as legislation should not be too much in advance of public opinion. Later, mandatory legislation should come.

are unimpaired, or at any rate strong enough to smother the seed of infection. Future events alone can prove which is true. As William Brown writes in the *Lancet* (Jan. 20, 1940) the whole question of "Hitler and German people" as a unitary problem needs more data for its solution than are at present available.

NAMING OF BLOOD GROUPS

The Health Committee of the League of Nations, in a recent communication, deprecates the use of old nomenclatures of blood-groups in some British medical journals. The committee points out the great need to use an uniform nomenclature in order to obviate serious mistakes and consequences. The new nomenclature recommended are: O, A, B, and AB. It is also recommended that test sera should be designated A (anti-B) and B (anti-A)—the former to be placed in white glass containers, and the latter in brown.

Our American Letter

(From Our New York Correspondent)

MANAGEMENT OF A BLOOD BANK

The "blood bank" is well named, according to White and Weinstein who gave a review on their extended experiences at the Gallinger Municipal Hospital, Washington. A well-run blood bank is controlled by a book-keeping system resembling that of a financial institution. Blood obtained from relatives and friends of patients who need transfusions is deposited to their credit, placed in safe-keeping, receipted for and checked out only on requisition; it is charged to the department of the hospital which receives it.

No institution, according to the authors, should attempt to maintain a blood bank unless it requires at least three blood transfusions a day. A supply of at least fifteen flasks must be kept on hand in order to maintain all types in normal proportion. One individual, preferably a physician well-versed in transfusions, should serve as banker and be held directly responsible for the operation of the blood bank. He will be assisted by a group of doctors and nurses trained as a team to assume entire charge of drawing and transfusing blood.

The successful management of the blood bank requires adequate laboratory facilities and competent technicians, ample quarters for the donors who come to deposit blood and adequate equipment kept in good order. The refrigeration is the vault of the blood bank. It should have automatic thermal control, to maintain a temperature of 30° F., and space enough to hold conveniently at least 40 bottles or flasks of blood.

The blood donors must be between the ages of 21 and 50 in good health and with negative histories for syphilis, chronic alcoholism and recent illness. They are required to sign a "blood transfusion permit", releasing the hospital from all liability and giving permission to use the blood as the hospital authorities may elect. All samples of blood should be tested by culture, Wassermann test and gross sedimentation test before being used.

Preserved citrate blood is apparently satisfactory for the restoration of blood volume in the treatment of severe traumatic haemorrhage and shock. Blood in storage over three weeks is rarely free from danger and lacks many desirable qualities of fresh blood. Even after five days' storage, the blood may have undergone changes in its cellular elements.

HOW LONG MAY BLOOD BE PRESERVED?

An editorial of the *Journal of the American Medical Association* enables a review of this urgent problem which is even more important in times of war. During the past two years blood has been used for thousands of transfusions. But while the transfusion of preserved blood (from blood banks) has definite advantages, there are also certain limitations to its use. Blood is a living fluid, and processes tending toward autolysis continue even when it is stored at low temperatures. It becomes important to establish the maximum length of time during which such blood can be kept before use, and in this there seems to be no unanimous agreement.

Blood stored in vitro keeps best at temperatures between 0 and 5° C. But even at low temperatures the platelets and leukocytes break down within a period of only a few days. A progressive increase in the fragility of the erythrocytes has been noted as the storage time is lengthened, but manifest haemolysis is not evident until the end of the second week. Scudder and his co-workers have observed a marked shift of the potassium ions from the red blood cells into the plasma with blood kept more than 5 days and feel therefore that such blood should not be used for transfusion. It seems doubtful, however, that the amount of free potassium is sufficient to cause toxic symptoms.

With regard to results of transfusion, it has been found that there is no difference in the incidence of untoward reactions provided the blood has not been kept too long. At the Cook County Hospital the time limit set for the storage of blood is ten days, since a significant increase in the number and severity of reactions was noted when the blood had been kept for longer periods.

Recent indications indicate that blood more than from a week to ten days old is not equivalent to fresh blood. Indeed, with blood that is too old there is even some danger of haemoglobinuria and serious symptoms such as are known to result from the transfusion of incompatible blood. It is evident that the transfusion of preserved blood has acquired an important role. This is a great change in attitude from the opinion held less than two decades ago, when the transfusion of citrated blood even when fresh was looked at askance. However, there are definite limitations to the use of stored blood which should be taken into account. Pending further investigation, a safe limit to set for the use of such blood would be between five and ten days. Perhaps by improving the method of storing blood it may be possible to extend the time limit.

April, 1940]

I. M. J. ADVERTISER



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DRUGS AND CORONARY VESSELS

A great deal of confusion exists concerning the reactions of the coronary blood vessels to many products of metabolic origin and to numerous drugs. L. N. Katz and E. Lindner of Chicago, read a paper before the Section on Pharmacology and Therapeutics of the American Medical Association. They have studied the action of a variety of drugs, salts, bloods of foreign species and temporary coronary ischemia on the tone of the coronary vessels of the dog.

Epinephrine in all doses used caused the coronaries to dilate, indicating an active diminution in coronary vascular tone. On occasions, transient constriction preceded the dilatation. Ergotamine tartrate occasionally caused constriction but had no effect on the coronary dilatory reaction to epinephrine. Piperodimethylbenzodioxane produced an increase in coronary tone and abolished the preliminary constriction caused by epinephrine. Coronary dilatation is the more usual response to epinephrine in man. Dilatation was the only effect noted with all doses of acetylcholine or mecholyl. Atropin abolished or diminished these responses. Glyceryl nitrate (nitroglycerine), sodium nitrite, histamine and caffeine caused marked and persistent coronary dilatation. Some of the other xanthine derivatives (aminophylline, theophylline) produced a similar but weaker effect. On the other hand, pitressin caused a powerful constriction. The results on digitalis are as yet incomplete but they show that in large doses approaching the toxic level a constricting action occurs.

Sodium and calcium chloride produce definite dilatation, the latter giving a more pronounced and longer lasting effect. Potassium chloride had a variable action depending on the concentration used. It is not improbable that the excess of potassium contributes in conditions of haemorrhage, shock and adrenal cortical insufficiency, to the circulatory failure by its constricting action on the coronary vessels. Defibrinated whole blood of sheep, beef and pig caused a marked coronary constriction. This reaction must be due to a coronary constrictor substance in the blood of a foreign species and not, as has been suggested, to histamine which in the dog causes coronary dilatation.

Before calcium can be used therapeutically with safety, evidence must be procured which establishes that its enhancement of cardiac activity is more than compensated for by its coronary vascular action, and the conditions under which its administration becomes hazardous must be more clearly defined.

Our Canadian Letter

(From Our Own Correspondent)

EXCELLENT HEALTH RECORD

The people of the Dominion of Canada continued to enjoy exceptionally good health in 1939. We learn this from a report of the Metropolitan Life Insurance Company which is concerned with their insured.

1938 and 1939, according to this report, jointly, hold the honour of having the lowest mortality rate in the Canadian experience of the Company. Especially noteworthy in the health picture of 1939, in Canada, are the new low mortality rates from tuberculosis, pneumonia, scarlet fever, diarrhoeal diseases, and accidents. Today tuberculosis is number 3 in the list of causes of death of Canadian wage-earners, instead of number 1, as it was only 11 years ago. The current death rate is nearly 7 per cent lower than in 1938, and 45 per cent lower than in 1929.

In this brief period of 10 years remarkable progress has been made in the record for many other diseases. The mortality from pneumonia has been reduced by 19 per cent in a single year and by 55 per cent in 10 years. Influenza, although the death rate has been higher this year than last, shows a decline of nearly 70 per cent in 10 years. The four principal communicable diseases of childhood combined measles, scarlet fever, whooping cough, and diphtheria, have likewise declined: 13 per cent in a single year and 65 per cent in 10 years. 10 years ago, diphtheria caused about as many deaths in Canada, as did the three other communicable diseases combined. To-day, deaths from whooping cough, despite a reduction of 40 per cent outnumber those from diphtheria. The mortality from diarrhoea and enteritis has been reduced by 12 per cent in a single year and by 75 per cent in 10 years. Deaths from puerperal conditions have declined about 25 per cent in 10 years.

The mortality from cancer, however, has risen about 35 per cent in 10 years. The rates for diabetes, heart disease, diseases of the coronary arteries, and chronic nephritis show appreciable rises in 10 years. For all causes of death combined, the 1939 death rate is lower by one quarter than 10 years ago. This is indeed a very favourable health record.

MEDICAL SCHOOLS IN CANADA

At its annual meeting in 1938 the Committee on Medical Education of the Canadian Medical Association brought in a report which was accepted by the members of the Great Council of the Canadian Medical Association and reads, in part, as follows.

In the event of the Council on Medical Education of the American Medical Association publishing a list of approved schools, those Canadian schools wishing their inspection and approval could request this inspection. This would leave each school free to deal directly with the Council on Medical Education of the American Medical Association and thus obviate misunderstandings.

There seems to be a fairly uniform opinion expressed by the various medical schools in Canada that the Canadian Medical Association should share some responsibility in this country so far as medical education is concerned. The majority of the schools, however, feel that the aims and purposes of the Canadian Medical Association are not primarily those of undergraduate medical education which is largely a problem of

the schools themselves. However, it is recommended that, if the Council on Medical Education of the American Medical Association in the future undertakes similar surveys at five or ten years intervals, such as the recent survey, the Canadian schools may take advantage of and be included in this survey. Those schools which are members of the Association of American Medical Colleges could have a representative from this association included in the personnel of the inspection. The remaining schools which are not members of the Association of American Medical Colleges could ask to have a member of the Association of American Medical Colleges included in the inspecting personnel, or some representative from the Committee on Medical Education of the Canadian Medical Association.

It would appear from the foregoing that the approval of medical schools by the Council on Medical Education and Hospitals of the American Medical Association rests with the schools themselves. The Council on Medical Education and Hospitals of the American Medical Association at his last meeting voted that after January 1, 1945 the Canadian medical schools will be included in the Council's classification only at their own request.

MEDICAL PATENTS AND PUBLIC WELFARE

F. Lorne Hutchison, Secretary, Insulin Committee, University of Toronto, gave an interesting survey on the Administration of Medical Patents for the Public Welfare. He believes that it would be a misfortune were it not possible to obtain patents relating to medicaments and that is definitely in the public interest for certain discoveries and inventions in the field of medicine to be patented.

A comprehensive, appropriate form of license is of prime importance. In respect of standards, the prime thing is establishment and maintenance of the highest standards of quality which can usually be done only through regularly subjecting manufacturers' products to laboratory tests carried out as a responsibility of the licensing authority under the patent or patents concerned. Patentees may lawfully fix prices at which goods manufactured under their patent shall be sold. This being the case, it seems obvious that holders of medical patents have both a right and a duty regarding prices. Desirably these prices should be controlled so that there is no exploitation of patents and so that the manufacturer's returns are sufficient to allow him profit that is small but sufficient to keep him satisfied to maintain the quality of his product or even to improve this quality through research. The holders of medical patents are in a particularly good position and have a duty to weed out sins both of commission and of omission in connection with advertising and literature issued by licensees and to co-operate with licensees to the end that printed matter relating to licensed products be phrased so as not to be confusing or misleading.

The mere creation of a board, a committee, a foundation or a corporation to hold and adminis-

INDIAN MEDICAL NEWS

(From Our Own Correspondent)

ADRENALINE PREPARATIONS SOLD IN INDIA

Quite a fair proportion of adrenaline chloride solution sold in India is below *par* in quality and sub-standard in strength.

This conclusion has been reached by the Biochemical Standardisation Laboratory of the Government of India as a result of the study of 30 samples of adrenaline chloride solution (1 in 1000 strength) which have been tested biologically for their purity and potency in course of an all-India Survey of the quality of drugs and medicinal chemicals undertaken by the Laboratory.

Out of 30 samples analysed, as many as 12 specimens (or 40 per cent) were markedly below strength (i.e., less than 75 per cent in potency of a *known standard*). Amongst this lot, 7 samples showed a strength of less than 50 per cent. Two samples apparently contained only about 10 per cent of an adrenaline-like blood pressure raising principle. Only nine samples (or 30 per cent) were found to agree with potency claimed by the manufacturers.

The specimens were secured from practically all over India through the courtesy of the Heads of Medical Administration of the various provinces. Some were secured from the open market by the officers of the Laboratory. Although the total number is small, the samples tested represent almost all the brands manufactured in India and abroad (England, Germany, France, Belgium, Switzerland), and available for sale in the Indian market.

The findings may therefore be considered as fairly representative of the conditions existing in this country so far as the quality of adrenaline solutions are concerned.

The reasons for the poor quality of the solutions are being further investigated in the Laboratory. In the form of a 1 in 1,000 solution in which it is usually offered to the public. Adrenaline, unlike other drugs such as digitalis, ergot, etc., does not rapidly lose its strength in the temperature and humidity existing in India. In the presence of alkali, however, adrenaline has been known to lose its strength, the deterioration being accompanied by a reddish or brownish discoloration.

ter a patent is nowhere nearly enough. There must be full-time activity in connection with administration and control. There must be facilities designed for dealing with the manifold items requiring the attention of any one who is administering a medical patent for the public welfare. If a patent is to be administered for the public welfare, the flag at the top of the pole must always be that of the patient. There are many mistakes. A rather unfortunate thing, in Hutchison's judgment, is that it seems often that a licenser might profit by the experience and mistakes of his fellows who have been licensers before him, and often that is not done.

Excess of alkali is sometimes present in the glass of certain containers (phials, ampoules, etc.) in which adrenaline has been found stored, and it is highly probable that this factor is at least partly responsible for the deterioration of the adrenaline solutions contained. Apart from a strict watch (by biological assay conducted by technical experts) on the quality of adrenaline powders from which solutions are made, manufacturers in India who are usually dependent on the supply of glass containers from outside, should, therefore, do well to test the alkalinity of glass containers before putting in solutions of adrenaline chloride.

The active principle of the medullary portions of the suprarenal glands, adrenaline, is now one of the drugs in daily use in medical and surgical practice. Its most important actions consist of a constriction of the blood vessels with consequent rise of blood pressure, sometimes slowing of the heart, a direct stimulant effect on the heart muscle and relaxation of the bronchial muscles. In the prevention of local haemorrhage, in local anaesthesia and in such conditions as shock, heart failure and asthma, adrenaline is extensively employed and is the mainstay of the physicians and surgeons.

Adrenaline chloride solutions of very poor quality may mean in some cases all the difference between the life and death of the patient. The necessity of a strict control of quality both in the interest of the patients to whom adrenaline is prescribed and of the doctor who expects results from his drugs is, therefore, apparent.

The standardisation for the tests made in the Laboratory was carried out by the accepted biological method of comparing the "Pressor effect" (blood pressure raising property) of an unknown solution with that of a *known standard* in a decerebrated and pithed cat. This method of assay is difficult and requires considerable experience but if carefully conducted, it is capable of yielding results accurate to within 10 per cent of the standard.

A chemically pure, natural, levo-rotatory brand of adrenaline powder with an optical rotation of -50° to -53° in a 4 per cent solution of the N. Hcl (Normal Hydrochloric Acid) which was obtained from the British Drug Houses and certified by chemical and biological assay as up to proper standard, was used as the *reference standard*. Potency ranging between 90 to 110 per cent of the standard has been taken to be within the limit of allowable variation and have been declared as equivalent in potency to the reference standard. Samples not falling within this range have been declared as of poor quality and not suited for therapeutic use in the dosage ordinarily prescribed by physicians.

KASALI RESEARCH INSTITUTE

During the year 1938, the demand for cholera vaccine manufactured by the Central Research Institute, Kasauli, beat all the previous records since 1927. The epidemic conditions were chiefly responsible for the demand which was very heavy

during the months of April to August. To cope with it, the staff at the Institute had to work even on Sundays and other holidays. The Punjab and North-West Frontier Province and the contiguous Indian States and the Army were the main clients. The supplies also went to Afghanistan and Egypt.

The total issues of the prophylactic cholera vaccine approximated 2,000,000 c. c. Of this 1,984,486 c. c. were issued to indentors in India and 10,120 c. c. to foreign countries in the Near East. The issues of the 1938 were eight times as high as in the previous year.

The following figures show the issues over a period of six years:—

	c. c.		c. c.
1933 ...	462,002	1936 ...	731,703
1934 ...	601,590	1937 ...	241,458
1935 ...	1,836,820	1938 ...	1,994,606

The manufacture of vaccines and sera continued on a large scale; and issues were heavy during the year. Prophylactic cholera vaccine and T.A.B. vaccine were manufactured on the largest scale. The preparation and issue of anti-venom serum continued as in the previous year, with the difference that it also captured other markets such as Portuguese India and the Phillippine Islands, in addition to the previous ones—Burma, Ceylon and Iran.

The Army in India remains one of the best buyers of the sera and vaccines of the Institute.

UNAUTHORISED USE OF MEDICAL DEGREES AND TITLES

The Government of Madras have published for the purpose of eliciting opinion, a Bill to amend the Indian Medical Degrees Act, 1916, in its application to the Province of Madras.

The statement of objects and reasons of the Bill says that the Indian Medical Degrees Act, 1916 (VII of 1916), does not contain any provisions to prevent unqualified medical practitioners from assuming bogus titles similar to medical degrees and diplomas granted by competent authorities. There have been cases in which such practitioners have used titles such as D. M. H., M. D. B., F. R. C. S., (India), etc., with a view to misleading the general public into a belief that the practitioners are qualified medical men possessing high qualifications. The assumption of such titles by unscrupulous persons is highly dangerous to society. The question of undertaking All-India legislation for the purpose was under the consideration of the Government of India for a long time, but in 1935 they pointed out that under the new constitution any Provincial Government might themselves undertake such legislation if they felt the need for it. It is, therefore, proposed to amend the Indian Medical Degrees Act, 1916, so as to penalise unauthorised use by medical practitioners of titles etc., implying qualifications in any system of medicine.

It may be stated that this measure was under contemplation when the late Ministry resigned office.

REVIEWS AND REPORTS

Midwifery—By R. Christie Brown & Barten Gilbert. First Edition 1940. Price 15 s. net. Edward Arnold & Co., London.

This book is intended for the use of midwives. It starts with general physiological principles of the human body so that, as the author rightly puts it, the midwife may learn her midwifery as a logical sequence of facts rather than that she should attempt to memorise a series of apparently isolated facts. Written in a simple style and dealing with the subject in an analytical manner, it is bound to be useful to the midwives as a reliable text-book as well as a book of guidance in their practice. The authors' claim to make the readers think out rather than memorise the facts is fully justified and achieved by the plan and treatment he had adopted in presenting the subject of midwifery to the students in midwifery.

How to do a Malaria Survey—By Christophers, Sinton and Covell. Revised Fourth Edition 1939. Price Rs. 1/12-. Manager of Publications, Delhi.

The problem and practice of Malaria Survey are minutely and carefully described in this book, and it is probably the only reliable source of information available in our country to the students of malaria, and to the administrators who are keen in initiating malaria surveys in the different provinces of our country. The names of the authors are a sufficient guarantee of the value and utility of the book. It is indeed an indispensable companion to the actual workers in malaria survey. Bold types are used in printing, and the get-up and arrangement of the book are excellent. It is also illustrated.

Lectures on Malaria—By Lt.-Col. Covell. 1940 Price As. 5/- Manager of Publications, Delhi.

This book contains 8 of the selected lectures on Malaria delivered by the author at the International Course in Malariology at Singapore, and slightly revised and enlarged for the purpose of publication. The lectures are on the following subjects: (1) The history and importance of Malaria (2) Transmission of malaria (3) Factors affecting the incidence of malaria (4) Principles and economics of anti-malarial sanitation (5) Malaria species control (6) Methods of investigating malaria (7) Methods of malaria control. We have read and re-read each of these lectures with much profit and not a little pleasure. We heartily recommend it to our readers.

Modern Ocular Therapeutics—By Dr. K. Krishnamurthy, Ophthalmic Surgeon and Director, L. N. Hospital, Chodovaram, Edition 1939. Price As. 8/- Ophthalmological Books Publishing Co., Chodavaram, S. India.

This booklet gives faithfully the current practice of ocular therapeutics followed in several leading

ophthalmic hospitals in our country. As a book of ready reference, and as means of knowing the different methods and drugs employed in ophthalmic hospitals, it is unique and is probably the only publication of its kind in our country. It is indeed invaluable to the ophthalmic practitioners—not to say of the general practitioners and post-graduate students.

Triennial Report of the Civil Hospitals and Dispensaries In Sind (1936-1938)

The report reveals the growing popularity of the hospital medical relief among the people. The number of beds available ranged between 1349 to 1692. The average number of in-patients treated is 38,000; and of out-patients one million. Subsidized system of rural medical relief is reported to be a failure. An alternative scheme was sanctioned under which the Government undertook to give in a grant-in-aid of Rs. 1000/ per annum and provide a medical officer on the usual terms to all District Local Boards opening a new dispensary. How far this has been successful the report does not reveal. The triennium opened with 168 hospitals and closed with 195. Thus there were 27 new hospitals added during the period under report. There were 223 medical officers at the end of the triennium, including those in State, Railways, Local and Municipal Fund; nurses 122; midwives 51; Dais 115. There seems to be an all-round improvement in hospital organisation, and the Ministry of Health deserves credit and appreciation for the same.

Report of Sri Ramakrishna Math Charitable Dispensary, Madras for the year 1939

This dispensary was started in 1925, and during the last 14 years it has been serving the people of the locality in unostentatious manner. For the period under report it treated 16,223 new cases, spent about Rs. 4000 and received donations amounting to Rs. 3000. The report mentions two immediate needs; A permanent endowment procuring a monthly income of at least Rs. 350 to cover the routine expenses, and donations to enable the dispensary to purchase a few necessary outfits and appliances. May we repeat our appeal to our readers to help this dispensary to the best of their abilities?

Tuberculosis of the Upper Respiratory Tract—By F. C. Ormerod, M. D. (Manch.), F. R. C. S. (Eng.). Edition 1939. Price 21/- net. John Bale Medical Publications Ltd., London.

This book is based on, and is the result of the author's experience at the Brompton Hospital. It has got four sections: (1) Tuberculosis of the larynx (2) Tuberculosis of the pharynx and its associated structures (3) Tuberculosis of the nose, accessory sinus and nasopharynx and (4) Tuberculosis of the ear. We dare say that even those who are dealing with tuberculosis of the chest have few chances to observe, study and treat the tuberculous conditions of the upper respiratory tract. As

EXTRACTS

Diagnostic Value of Urinary Hormones

Dodds in his series of articles on "New Endocrinology" in the *Lancet* (*Ibid*) writes: Both oestrogenic hormones can be detected in the urine, but it has not been found possible to obtain progesterone, except in minute quantities, from this source. Pregnanediol, on the other hand, can be easily obtained, and it is probably the excreted form of progesterone, though it is inactive biologically. The excreted form of a hormone is always less active than the hormone itself.

The amount of sex hormones excreted in the urine bears no definite relation to the amount of hormones being secreted. The quantity actually produced in the body or supplied by food is unknown, as is the storage of hormones in the body. By the ordinary methods of extraction only 3-12 per cent of oestrogenic hormone administered can be recovered; the recovery of gonadotrophic hormones is believed to be less than 20 per cent of the amount injected, and the corresponding figure for male hormone is about 10 per cent. In the case of progesterone, which, as we have said above, is thought to be excreted as pregnanediol, Venning and Browne claim that their method will recover between 12 and 46 per cent of progesterone injected.

Thus at the present time it is only where excessive quantities of hormones are excreted that assays of the urine are of value. The chief diagnostic use of urinary hormones today is in cases of adrenal tumours. Both males and females with adrenal cortical tumours are found to excrete excessive quantities of androgens. The normal excretion varies from 5 to 15 mg. "sterone" or 16 to 80 international units, per day, but female patients with adrenal tumours may excrete as much as 100 mg. "sterone" or 250 to 300 international units, daily. Such tumours can therefore be easily and quickly diagnosed by androgen assays of the urine.

By such assays it is also possible to distinguish between cases of adrenal tumours and Cushing's syndrome, since in the latter the androgen secretion is either normal or slightly lower than normal.

R. S. Ferguson claimed that it is possible to divide testicular tumours into five groups by a quantitative assay of the amount of gonadotropic hormones in the urine; but later workers have insisted on the importance

for the ear, nose and throat specialists, chances are greater but the tuberculous lesion may elude their memory while diagnosing. This book will be a reminder and a guide to them as it brings under one cover the various tuberculous lesions of the upper respiratory tract, including the ear where tuberculous lesion is rarely suspected. It gives a detailed account of their pathology, symptoms and treatment with appropriate illustrations. In fact it is these illustrations that give the greatest value and utility to the book, and enhance the impression of the clinical description and experience of the author on the minds of his readers. The paper, print and get-up are excellent, and though this would have certainly contributed to the high cost of the book—for cost is a consideration in these hectic days of war—it is yet worth-paying. We heartily recommend this book to our readers.

of differentiating the type of gonadotropic hormone as well as the quantity. C. Hamburger divides testicular tumours into four groups on the basis of the type and quantity of gonadotropic hormones excreted—namely, seminoma, pseudo-seminoma, mixed epithelioma and polycystic teratoid, as shown in the accompanying table. Since the prognosis and treatment of these various types differ widely, the importance of such hormone assays will be evident.

Number of cases	Diagnosis	Negative	Traces	Hypo-physical hormone	Chorio-nic hormone	Both hormones
42	Seminoma	13	4	25	0	0
2	Pseudo-seminoma	0	0	0	2	0
21	Mixed epithelioma	3	1	0	14	3
10	Polycystic teratoid	4	2	4	0	0

Intravenous Injection of Sodium Salts in Sciatica

Sutton (*Lancet*, Dec. 2, 1939, p. 1168) finds in his small series of cases, that the intravenous injection of sodium salicylate and sodium iodide is of far wider value than is generally realised. It can, he says, rapidly cure uncomplicated cases of sciatica, but is little effective in secondary sciatica. In 20 cases of primary sciatica, pain ceased usually after about ten minutes of injection. If pain returned, it usually did not do so until after eighteen hours or more. If a second injection was necessary, the result was better than that of the first injection. In the 12 cases of secondary sciatica, due to same extraneous pathological condition, pain was diminished, but not abolished usually after about 20 minutes are longer. A second injection tended to produce less effect. Any improvement in secondary sciatica is, he says, probably due to the analgesic action of the sodium salicylate, but in primary sciatica, in all likelihood "rheumatic", the effect of the drug appears to be specific rather than symptomatic. Each injection, which the author gave, consisted of 20 c.c. of an aqueous solution of sodium salicylate and sod. iodide, 15 grs. each.

Cod-Liver Oil Dressings: Their Mode of Action

Lichtenstein (*Lancet*, Nov. 11, 1939, p. 1023) attempts in his article to establish whether or not cod-liver oil has any bactericidal power and says there can be little doubt that the striking results obtained by many authors with cod-liver-oil dressings are due, in some degree at least, to the fact that the oil has a definite bactericidal power. The question, however, arises as to why the use of cod-liver oil in dressings should possess advantages over that of other bactericidal preparations. An important factor in this connexion is the fact that the cod-liver-oil dressing is non-irritant to the tissues. Indeed, so far from damaging these, it supplies them with vitamins and possibly other forms of nourishment, and it mechanically protects the young granulation-tissue and epithelium from damage by the dressing. The stimulation of leucocytes by cod-liver oil, observed by Traxl may also contribute to its beneficial effect. Perhaps these various factors, altogether with its bactericidal action, may explain the clinical efficiency of cod-liver oil in dressings.

In the course of this work it has been found that the bactericidal power of cod-liver oil is substantially

enhanced by irradiation with ultraviolet rays from a mercury-vapour lamp. Parallel with this, the peroxide content is increased. It is to be expected that such irradiated oil may prove even more efficient than the non-irradiated product for clinical use. The irradiated oil should therefore be given a clinical trial. He concludes:

- (1) Cod-liver oil has a definite bactericidal power.
- (2) Irradiation of cod-liver oil with ultraviolet rays greatly enhances this power.
- (3) The bactericidal action of an oil is closely related to its content of peroxides.
- (4) The merits of cod-liver oil dressings are emphasised, and a clinical trial of irradiated oil is advocated.

Differential Diagnosis of Strangulated Inguinal Hernia

Basil Hume (*Lancet*, Dec. 23, 1939, p. 1308) questions why if the diagnosis could be made easily there should be a case mortality of 20—37%, even allowing for the highly toxic character of the bowel exudate. The most important features are the three major symptoms of pain, vomiting, and inability to pass flatus, in conjunction with the absence of abdominal tenderness or of rigidity or of both. Their absence is a most important point in differential diagnosis, for in other acute abdominal emergencies both of them are present.

There are, however, four problems that must be considered in the differential diagnosis.

(1) Are the symptoms, which we assume to be those of acute intestinal obstruction, caused by the hernia? In other words, is the hernia strangulated or merely irreducible? An irreducible hernia does not cause any abdominal pain other than a dragging sensation. It is soft and painful on pressure, whereas the strangulated hernia is tense and tender. If the hernia is associated with acute intestinal obstruction from some other cause, it will have an impulse on coughing and probably be partially reducible.

(2) Is the case really one of hernia? The methods of diagnosis of a hernia have already been discussed, but three conditions should be remembered: torsion of an undescended testes, acute hydrocele in an infant, and acute appendicitis in a hernial sac.

Torsion of an undescended testis.—The following case is given as an example:

A medical man aged 27, had a small right inguinal hernia for years, but it had only occasionally become complete. He was seized after breakfast with a violent pain in the centre of the abdomen, associated with shock and vomiting. In his right inguinal region was a tense and tender swelling, but the emptiness of the right side of the scrotum, the cessation of the vomiting, and the passage of flatus made the diagnosis clear.

Acute hydrocele in an infant.—No one can have been in either general or surgical practice long without having been called by an anxious mother to see her infant, who is having colicky abdominal pains and in whom a scrotal swelling has appeared. You are able to "get above" the hydrocele, and the child, although in pain and possibly vomiting, can pass faeces and flatus naturally.

Acute appendicitis in a hernial sac.—In this case there will be pain and the tenderness over the lump, but the symptoms will be those of appendicitis and not of acute intestinal obstruction.

(3) May we be dealing with two conditions—namely, strangulated hernia and acute peritonitis from some other cause?

A colleague removed a gangrenous non-perforated appendix from a lady, the abdomen being closed without drainage. Four days later, influenza having overtaken my friend I

saw the patient, in whom the doctor in charge had diagnosed paralytic ileus, for she had pain, was vomiting, and had not passed flatus. The pain appeared to me to be more than I should have expected with that condition and vomiting was frequent.

Careful examination revealed a small left femoral hernia, which was tense and tender, and on auscultation of the abdomen increased intestinal sounds were heard. The latter alone would exclude ileus the only alternative diagnosis being a mechanical obstruction by kinking or adhesions. The tense and tender nature of the hernia showed that it was strangulated.

The following case also illustrates how a loop of bowel can be forced into a hernial sac and become strangulated when associated with the increase of intra-abdominal pressure that accompanies acute distension of the intestine.

A woman, aged 70, was admitted with a typical attack of acute cholecystitis, and a large and tender gall-bladder could be palpated. The patient began to vomit twenty-four hours later, and on examination a tense and tender swelling was found in the groin. Two enemas produced no result, and a correct diagnosis was made.

(4) Is it a strangulated partial enterocoele? In a true partial enterocoele (Richter's hernia) and in herniation of Mecker's diverticulum (Litter's hernia) the lumen of the bowel is not obstructed, unless in Richter's hernia more than half the circumference is involved, when the bowel becomes kinked. In all other instances faeces and flatus would be passed. The initial pain may be severe, but colic is commonly mild, and vomiting is neither severe nor persistent, especially since the terminal ileum is nearly always the site in either. The patient often does not consider the symptoms sufficiently severe to seek advice until the really grave event of perforation of the line of constriction into the peritoneal cavity. These herniae are small and nearly always femoral, hence they may be overlooked.

In all cases, unless the diagnosis can be made at a fairly early stage the patient may be doomed. He will succumb to the toxæmia of the strangulation or to peritonitis resulting from perforation. The use of morphia is as dangerous in strangulation as in other acute abdominal emergencies and is more useless. Atropine is more effective than any other drug in relieving the severity of colic.

Otosclerosis treated with Sex Hormone

Bernstein and Leon Gillis (*Lancet*, Dec. 30, 1939, p. 1368) suggest that there is some intimate connexion between the gonadal internal secretion and otosclerosis. The latter is one of the most serious causes of progressive deafness. They give half-a-dozen illustrative cases where the administration of sex-hormones, such as progynon and Testoviron (Schering) and Oestrone and Perandran (Ciba), they were able to arrest sclerosis and restore the hearing of the patient. Out of 56 cases, 31 improved while there was no improvement in 25. Much more work is necessary, they write, to find the best of method of using sex-hormones in otosclerosis, and to know which type, sex or age-group responds more readily. They also suggest that this line of research may also elucidate the aetiology of otosclerosis.

Digitalis and Partial Heart Block.—Because of conflicting opinions as to whether digitalis should be given to patients with partial heart block, Blumgart and Altschule (*Am. Jr. of Medical Science*) observed its effect on nineteen patients from 15 to 72 years of age with congestive heart failure. Digitalis was administered in doses calculated on the basis of body weight; somewhat less than the full Eggleston dosage was administered. Digitalization was accomplished within three to nine

days. Nausea was induced in six cases and in these no significant change in PR interval occurred. In two of these cases, changing 2 to 1 and 1 to 1 responses were present before and after digitalization. Of the nineteen cases studied, the PR interval did not change in eleven, in three a lengthening of 0.02 second and in three a lengthening of 0.04 second occurred, in one the PR interval was shortened by 0.04 second and in another the PR interval was shortened by 0.08 second. No alteration in the orderly sequence of auricular and ventricular contractions occurred except that observed in one case in which occasional 2 to 1 heart block disappeared and normal 1 to 1 response was established. The results demonstrate that digitalis in doses sufficient to induce therapeutic effects may be given in cases of partial heart block without causing interference with the orderly passage of impulses from the auricles to the ventricles. While digitalis and organic heart disease interfere with auriculoventricular conduction, these factors do not reinforce each other and their simultaneous presence does not lead to an additive effect when such doses as used in the present study are utilized. Although digitalis in doses of from 0.1 to 0.23 Gm. to 10 pounds (4.5 Kg.) of body weight did not greatly increase pre-existing heart block in any case of this series, it is impossible to preclude the possibility that occasional or rare instances may be encountered in which this may occur, particularly if dosages approaching toxic amounts are employed. Therefore the authors warn that caution and careful observation should be exercised, particularly if larger doses than those employed by them are utilized.

Pregnancy and Diabetes.—From a study of the records of 353 pregnancies in 242 diabetic women cared for since 1898, White and her associates (*Am. Jr. of Medical Science*) find that, excluding surgically interrupted pregnancies, the fetal mortality in the preinsulin era was 44 per cent and in the insulin era 38 per cent. In the preinsulin era, early and late fetal deaths occurred with equal frequency. In the insulin era, 60 per cent of the fetal deaths were late because of stillbirth or neonatal accidents and 40 per cent because of spontaneous abortion. The authors believe that severe diabetic crises—coma and hypoglycemia—are not at all incompatible with the birth of a living child. Thus among fourteen accidents in late pregnancy maternal coma occurred only twice, in each instance precipitated by infection, and the remaining twelve patients had no signs of acidosis. The latter had taken meticulous care of their diabetes to ensure the birth of a living child. In contrast to this experience, other patients careless of the diabetic routine have had a successful outcome of the pregnancy. It became evident to the authors that stillbirth was not related to diabetes or its specific complication (coma) but was definitely related to preeclamptic toxemia and as time elapsed that the accidents—neonatal death and premature delivery—were also related to the abnormal hormone picture. The relationship of toxemia and stillbirth first became apparent to them when they observed that in many diabetic women the course of pregnancy was uneventful until the sixth month, when at any time thereafter edema, albuminuria and a rising blood pressure developed in the patient. Shortly after the rise of the blood pressure the fetus died and the signs of toxemia promptly disappeared. The entire clinical picture can occur and disappear in as short a time as one week, but it is predicted from four to six weeks by the rise of gonadotropic substance in the serum. Of thirty-five completed pregnancies studied for determination of gonadotropic substance in the serum, nine were of

former juveniles—patients with onset of diabetes before 15 years of age. In only one case did the onset of diabetes occur during pregnancy, and insulin was required in only one. Diabetes was severe or moderately severe in twenty-six. Coma developed in one case and hypoglycemia for three days in one, following the mistaken administration of 279 units of protamine zinc insulin. In general, the control of diabetes was good in all cases. The clinical course in the fourteen cases in which the values for serum gonadotropic substance were repeatedly normal was completely uneventful. Complications developed in the ten cases in which the values for serum gonadotropic substance were supernormal and no treatment was given. Toxemia developed in seven. Premature delivery occurred in the remaining three. In two successive pregnancies in the same case in which values for gonadotropic substance were supernormal but steadily fell—the fall was preceded by a rise of estrogen four weeks prior to the normally expected time. During the first pregnancy well marked signs of toxemia developed. These decreased in severity with the fall of gonadotropic substance. Less well defined signs in the second pregnancy disappeared entirely. The biochemical behaviour in this case gave further presumptive evidence of the probable value of estrogen therapy. Massive doses of estrogen were administered in nine cases in which the values for serum gonadotropic substance were supernormal, from 150,000 to 200,000 international units as progynon B being given and in addition progesterin. Replacement treatment was followed by a drop in serum gonadotropic substance controlled by the size and frequency of the dose of estrogen. No instance of progressive toxemia occurred. Not one woman miscarried. There was a tendency for the serum protein which fell to low levels to rise without change in diet, the weight to fall, the urinary output to be increased, the albumin to be diminished and the blood pressure to fall. Therefore it seems that the test for gonadotropic substance permits one to classify the cases according to hazard and to gauge the effect of therapy.

Vitamin K in Haemorrhagic Disease of the Newborn. Nygaard (*Acta Obstet et Gynec., Stockholm*) reports sixty-six cases of haemorrhagic disease of the new-born which occurred among 9,748 new-born infants. The investigations were induced on the one hand by the observation of a physiologic transitory prolongation of the coagulation time of the blood during the first week of life and on the other hand by the fact that the coagulation time is prolonged in cases of haemorrhage and further by the fact the haemorrhages of the new-born coincide with the period of transitory prolongation of the coagulation time. In view of recent observations that haemorrhages in cases of obstructive jaundice are preceded by a lowering of the prothrombin content of the blood, investigation was made whether the abnormal coagulation of the blood of the new-born could originate in a deficiency of prothrombin. If this was so it seemed reasonable to try the administration of vitamin K, which exerts an antihæmorrhagic effect. For the determination of the prothrombin time the method of Quick was used. In order to determine the physiologic variation of prothrombin during the first week of life, studies were made on thirty-one normal new-born infants. These studies indicated that a normal prothrombin time is maintained during the first ten hours after delivery but that a definite reduction of the prothrombin content becomes apparent during the second half of the first day. This low level is maintained during the following five days. From the sixth day prothrombin returns to the level found at the time of birth. Studies on the prothrombin content of some of

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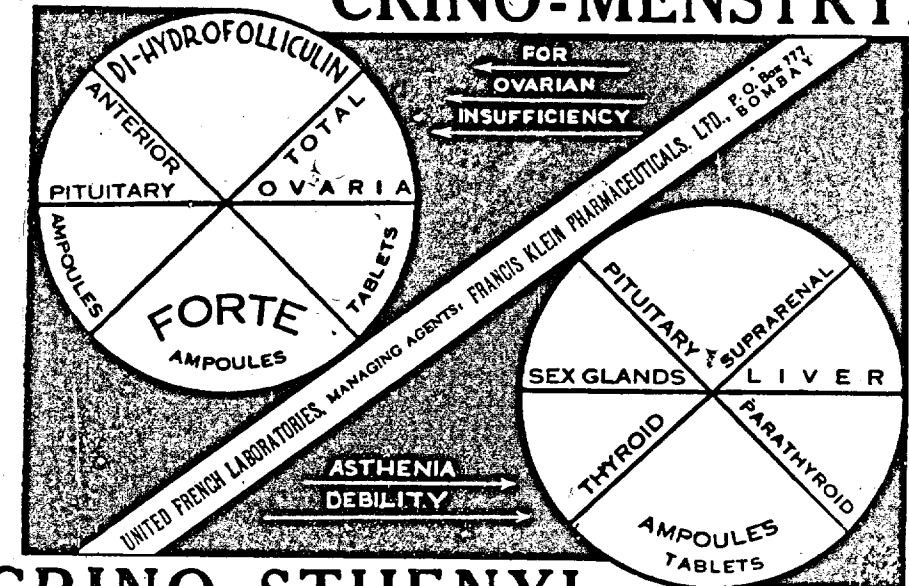
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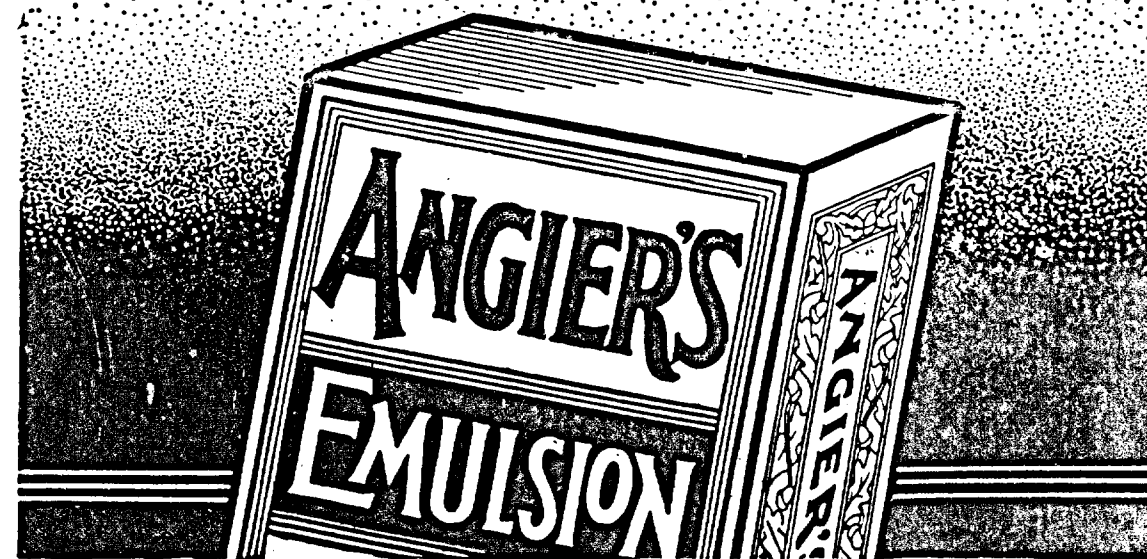
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