

MEDICO, SURGICAL SUBQUESTIONS

VOL IX

NO. 3

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# MEDICO-SURGICAL SUGGESTIONS

Vol. IX.

MARCH 1940.

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## BERIN



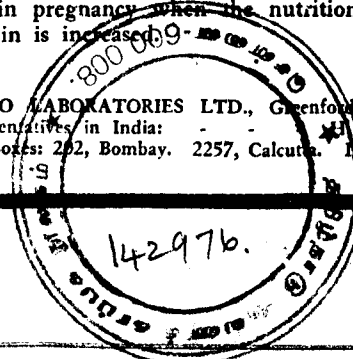
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# MEDICO-SURGICAL SUGGESTIONS

A MONTHLY JOURNAL OF PRACTICAL MEDICINE & SURGERY  
Editor: Dr. P. R. Venkappaya.

VOL. IX MARCH 1940 No. 3

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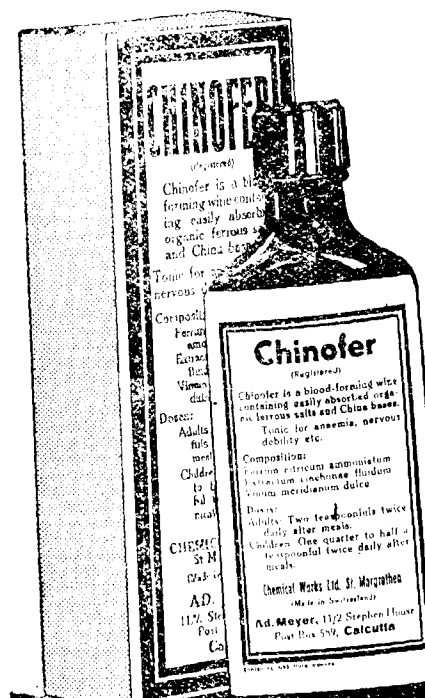
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Figure of Osiris  
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## MEDICO-SURGICAL SUGGESTIONS

VOL. IX

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### Original Articles.

#### "ANALYTICAL NOTES ON URAEMIA"

BY DR. S. K. GUPTA, B.D.S.C., B.O.

Laboratory Clinic.

(Analyst) Railway Road, PASRUR, (Pb.)

#### DEFINITION.

It is a toxæmia which may occur in any form of nephritis or anuria.

Theories:—Four in number.

(1) Accumulation in the blood of substances normally excreted by the kidney.

(2) Decomposition of such bodies forming toxic product.

(3) Abnormal product from disturbed renal metabolism.

(4) Localised oedema of the brain (old view of Traube).

#### CLASSIFICATION.

Foster describes three forms of uræmia:—

1. Retention type. 2. Cerebral oedema type. 3. Toxic or epileptiform type.

The first two present a failure of excretion of water, salt and nitrogenous material. The third has an additional quality namely an element foreign to normal metabolism which causes toxæmia and he has succeeded in isolating a toxic base which causes convulsive seizures in animals.

Clinically we may divide it into three types:—

(i) Acute. (ii) Chronic. (iii) Latent.

*Acute type* may occur in any form of nephritis. Bradford thinks that it is specially associated with contracted white kidney in young subjects.

*Chronic Type* occurs in arterio-sclerotic and granular kidneys.

*Latent type* occurs in anuria.

## SYMPTOMS.

For convenience we may divide the symptoms under cerebral, dyspnoeic and gastro-intestinal manifestation :—

*Cerebral Symptoms.*—(1) *Coma*—onset gradual or rapid often preceded by headache, drowsiness, delirium, vomiting, twitchings of muscles, particularly in the face and hands. The tongue furred and the breath very foul and heavy. Pupils contracted. Knee jerks—increased. Temperature—subnormal. In some of these cases a condition of stupor persists for weeks or even months.

(2) *Convulsions*: Onset abrupt or preceded by headache and restlessness. Fits usually resemble epilepsy without initial cry. Fits recur rapidly and in the interval the patient is usually unconscious. Temperature 100 but may rise. *Uraemic anurosis*—blindness without any rational changes follow and may persist for several days. Sometimes *uraemic deafness* supervenes which usually occurs in connection with persistent headache, nausea and other gastric symptoms.

(3) *Acute Mania*.—May come on without warning and may end in Coma. Patient becomes noisy, talkative, restless and sleepless.

(4) *Delusional Insanity*: (*Folie Brightonne*) Delusions of persecution are common and the patients may commit suicide. Excellent clinical reports have been issued on the subjects from several of the asylums. The condition is of interest medico-legally. Profound melancholia may also supervene.

(5) *Local palsies*:—In the course of chronic nephritis, hemiplegia, aphasia or monoplegia may come on spontaneously or follow a convulsion.

(6) *Of other Cerebral Symptoms*:—Headache, often occipital and extends to the neck. It may be an early feature and associated with giddiness. Other nervous symptoms of uraemia are *intense aching of the skin*, numbness and tingling in the fingers, cramps in the muscles of the calves, particularly at night. An erythema may be present.

*Uraemic Dyspnoea*:—Palmer classified it into four varieties: (a) *Continuous* (b) *Paroxysmal* (c) *Both types alternating* and (d) *Cheyne-stokes* breathing. The attacks of dyspnoea are most commonly nocturnal. Patient may sit up, gasp for breath and show great distress. Occasionally the breathing is noisy and hissing. The cheyne stokes type may persist for weeks or months.

*Gastro intestinal Symptoms*:—Onset—abrupt, uncontrollable vomiting, nausea, hicough, more rarely diarrhoea and followed by uraemic dyspnoea and cerebral symptoms and coma ending the scene.

*Uraemic stomatitis* in which the mucous membrane of the lips, gums and tongue is swollen and erythematous.

*Chronic Uraemia*: Persistent presence of milder symptoms of uraemia. Headache slight, restlessness, insomnia, wasting with dry skin and shallow complexion are usually present. These may continue for many weeks and end in one of the three ways:—

(i) Terminal infection, namely acute paritonitis, pericarditis, pleurisy, meningitis, or endocarditis.

(ii) Acute uraemia. (iii) Temporary improvement.

*Diagnosis*:—*Blood Analysis* and the test of the functional capacity of the kidney by phenol-sulpho nephthalin urea are of great adjunct both for diagnosis and prognosis. Non-protein nitrogen above 120 mgms, urea nitrogen above 80 mgms, and creatinine above 4 mgms. for 100 c. c. of blood point to the retention type. In the "Oedema" form there may not be any increase. In Uraemia the elimination of phthalin is nil or only a faint trace in two hours. In patients with chronic nephritis in whom the elimination in two hours is below 10 B.C. there is grave danger of uraemia.

*Differential Diagnosis*:—Here we should distinguish uraemic coma from:—

*Causes of coma*:—a, e, i, o, u, cardiovascular changes.

Don't, Forget, my, Lad.

a—alcohol poisoning, e—Epilepsy, Eclampsia.

i—Injury, G.P.I. o—Opium poisoning. u—Uraemia.

Cardiovascular changes:—Haemorrhage.

Embolism, thrombosis, stokes adam Syndrome.

Don't—Diabetic Coma.

Forget—Specific fever.

My—Meningitis.

Lad—Lead poisoning.

*Prognosis*:—Uraemia is always serious. Recovery is frequent in acute than in chronic form. Epitileptiform convulsion in acute nephritis and in pregnancy recovery is not uncommon. But when occurring in chronic nephritis, recovery is very rare.

*Treatment*:—Induce sweating by hot air bath, hot poultices or pilocarpine injection. *Saline purgative*. Nitro-glycerine to reduce the B.P, venesection, saline infusion. *Opium* for restlessness, insomnia, delirium and convulsions. In severe convulsions *chloroform inhalation* is needed. Water is to be given freely by mouth, by drop method, by the bowels and by hypodermic injection when urgent.

Grandin states that *irrigation of the bowels with hot water* is most useful. When there are signs of acidosis *Sodium Bicarbonate* one dram a day should be given. *Lumbar puncture* is often useful and can be done without hesitation.

## SKIN DISEASES OF INFANCY\*

A. CHAKRABARTI, M.B., F.R.E.P.S. (C).

Calcutta.

In this paper I shall attempt to deal briefly with the incidence of some common diseases of the skin in infancy as are met with in the course of everyday practice. The diseases of the skin in infants may be congenital or acquired.

## CONGENITAL LESIONS.

*Nevoid conditions.*—These are all due to defects of development. Some are apparent at birth and some develop only after some time has elapsed.

A. Vascular Nevi—consisting of blood vessels. Under this group we have :—

1. Capillary Nevi—portwine stain.

A localised area of skin in which superficial small blood vessels are permanently dilated. They may be situated on any part of the body but usually on the scalp, face and neck.

2. Cavernous Nevi—strawberry mark.

They are raised and seem to be a collection of vessels. They are dome-shaped, purple or deep-bluish in appearance, partly cutaneous, and partly subcutaneous, being soft and compressible. When the child cries they swell up due to the engorgement of the dilated veins. They are common on scalp and face but may occur anywhere. They may be present at birth or may be noticed sometime after birth. This type is generally not noticed in adult subjects, because they usually disappear spontaneously as the child grows up. So this type of nevus should not be interfered with during childhood.

B. Vascular Nevi—consisting of lymphatic vessels. Lymphangioma circumscriptum.

This type is a rare form. They consist of a group of vesicles in the corium formed by the dilatation of lymph vessels. This type is usually noticed at birth but may not appear until puberty. They are usually found on neck, trunk, upper limbs and sometimes on tongue. They are discoloured, raised above surface, and look like herpetic lesion.

*Treatment.*—Treatment of this type of nevi should be on the idea of damaging the endothelial lining of vessels.

*Local application :*

1. Application of carbon-dioxide snow over the lesion.

2. Application of radium by a skilled hand. If it is available, it is the method of choice, because it produces no pain and practically leaves no scar.

From the Medical College Hospital, Calcutta.

Read at the Ro-union meeting on the 17th December, 1938.

*Injection :*

1. Injection of one or two minims of tincture iodine in the centre of the nevus. They don't get septic but they are painful.

2. Injection of a few minims of dilute hydrochloric acid in various parts of nevus in one or two sittings. (GOLDSMITH).

3. Injection of a few minims of the froth liberated by shaking sodium morrhuate with distilled water.

*Operative method.* Excision of the whole lesion with a margin of healthy area—but the drawback is post-operative scar. Diathermy or cautery may be also used in certain cases.

## C. Non-vascular Nevi :

They may be grouped as pigmented and non-pigmented. In the group of pigmented nevus it may be again divided into: (1) Hairy, (2) Non-hairy, (3) Plain or (4) Raised.

These nevi develop at or soon after birth or may develop later. They are common and usually multiple. The hairy pigmented type may be extensive and when it covers the trunk and upper part of the arm it is called "jacket type," when it covers the lower part of trunk and upper part of the thigh, it is called "drawer type," and when it covers both the areas it is called "bathing suit" type. The soft nevi may be non-pigmented, and may form small tumour like masses. The pigmented nevi have no tendency to spontaneous cure and sometimes become malignant. It is really a potential carcinoma. Intensely bluish black mole should be left alone, or should be widely excised. It very often becomes malignant. A pigmented bluish black mole at the sole of the foot is more dangerous than a similar one on the face from the point of view of secondary metastasis. Because the lesion on the foot is always subject to trauma which flares up its malignancy.

*Treatment of Pigmented Mole.*—It is best to leave them alone, but if they are at the sites of trauma, they should be excised along with an area of healthy margin.

The freckles which we meet with on the face of young individuals developing at or after puberty are really latent nevi showing themselves by the action of sunlight. (GOLDSMITH).

*Nevus Unis Lateralis.*—It is usually a nevus of warty nature. It is situated unilaterally and runs in a straight line as a long strip.

*Ichthyosis Hystrix.*—It is an exaggerated form of linear nevus. It is warty and rough like alligator skin.

*White Mole.*—It is a depigmented patch and often mistaken for a patch of leucoderma or leprosy.

*Xerodermia and Ichthyosis.*—(Fish skin—scaling like fish). The exaggerated form of xerodermia is called ichthyosis. Xerodermia is a condition of dryness of skin often hereditary. Their condition is worse in winter. They feel better in warm weather. In this condition the child is born with red, scaly and dry skin. Xerodermia

is quite common. In its severe form when the child bends his elbows and knees, they crack and bleed. The most exaggerated form is where the child is born prematurely and appear to be encased in an armour of horny plates so called "Harlequine Fœtus." They don't survive.

Dermatitis due to external irritants is commonly seen in patients of xerodermia and ichthyosis. According to BARBER some degrees of ichthyosis is found in about 25 per cent of those who exhibit multiple symptoms of allergy. Treatment is not satisfactory. Thyroid by mouth improves the condition in some cases. External application of some lubricant as liquid paraffin or vasoline as palliative is much helpful and appreciated by the sufferer.

*Tylosis.*—A hereditary and familial palmer and planter hyperkeratosis. The thickened area of skin of palms and soles is yellow in colour and apt to crack. This is generally noticed on the third or fourth year of life.

*Xerodermia Pigmentosa.* It is a congenital skin condition of light sensitiveness. It is the invisible ultra-violet sun's rays which produce this condition. It causes lesion on skin resembling X ray exposure on normal skin. The subjects are quickly sunburnt and freckled. The effects on skin is dryness, pigmentation, telangiectasis, keratosis and finally epithelioma. Protection of the skin from the exposure to sunlight is essential as prophylactic for this condition.

*Epidermolysis Bullosa.* This condition appears at birth or soon after. The epidermis is easily split up. The slightest trauma produces a bleb or blister on a non-inflamed base. Whenever the patients are knocked or injured they get blisters. You will invariably find scars of old injury at points exposed to trauma, e.g., elbow, knees, etc., as evidence of old trauma. In a few cases they may not appear till late in life. Sometimes they are mistaken for congenital syphilitic manifestation.

*Albinism.*—A congenital absence of pigment from the skin, eyes, and hair. Owing to the absence of pigment they suffer from eye troubles, e.g., photophobia, nystagmus. They are easily sunburnt. Some also do suffer from nervous trouble.

*Adenoma Sebaceum.*—This condition may not appear until adolescence. It is characterised by pin point yellowish or reddish, translucent, waxy papules situated on the flush areas of the face and often associated with capillary telangiectasis, other congenital anomalies or mental deficiency. Sometimes these subjects suffer from epileptiform fits due to occurrence of similar growth on the meninges.

*Monilethrix.*—is a rare congenital and hereditary condition characterised by dryness, fragility and sparseness of the scalp hair. The hair shaft has got fusiform swellings separated by narrowed atrophic segments. The hair tends to break off at those delicate internodes.

#### ACQUIRED INFECTIVE CONDITION.

*Scabies.* It is very common in our country, mostly amongst the poor. When I was attending a skin clinic at Vienna, DOZENT MATRAS told me one day that during prewar period it was difficult to have a case of scabies for demonstration. But now they are very common amongst the poor due to the unhygienic condition of their living. The scabotic lesions are primarily papulo-vesicular but later due to secondary infection it forms pustular and crusted lesion with dermatitis. It is often mistaken for syphilitic rashes, eczema, erythema multiformi, pediculoid infection, impetigo contagiosa, urticaria. It is contagious, caused by infection with an animal parasite called *acarus scabei*. The infection spreads by close contacts as sharing the same bed and using the infected linen. The sites of lesions are generally on webs of fingers, wrist, ulnar border of hand, elbow, shoulder, knee and ankle joints, abdomen and genitalia but in infants the lesions may be anywhere on the skin even on scalp or face (in adults it does not occur on face and scalp). The lesions on skin may be some vesicular, some pustular, some crusted and some weeping areas with dermatitis. There may be general malaise or even some rise of temperature due to secondary infection.

If history is taken and other members of the family who handle the child are examined, you will find that some other members are also suffering from the infection. One word of caution! I like to emphasize that while investigating whether any contact is suffering from the infection or not, I have invariably found that they at first deny it. But on detail enquiry and examining the contacts you will find that there are other members also suffering from the infection, may be in mild degree. Treatment is very simple in these cases. Firstly, treat the secondary infection, if any, by some antiseptics such as a 2 per cent hydrarg. ammoniata in ointment form, and then undertake the time-honoured sulphur treatment. The other contacts should be also treated at the same time to avoid re-infection. The strength of sulphur should be about 4 to 6 per cent in children to avoid sulphur dermatitis. The success of sulphur treatment depends on following the instructions carefully. Initially a good bath, scrubbing with plenty of soap and hot water followed by application of ointment throughout the body for three successive days without bath. On the fourth day again a bath with plenty of soap and hot water followed by changing of all used linens and at the same time the used linens should be disinfected by boiling to avoid reinfection.

*Impetigo Contagiosa.*—This condition is caused by streptococcal infection. Occasionally staphylococcus infection may also cause it. It starts as a small vesicular eruption. The fluid is at first clear, later it turns turbid. Gradually they become crusted like honey crust, yellowish in colour. It is itchy and spreads by continuity

and wherever the contents of vesicle fluid touches the skin. It generally occurs on face, chest, armpits, but may occur in any part of the body.

*Treatment.*—Stop spreading by avoiding scratching the lesion and treat the lesion by some antiseptic, e.g., Lotio eau d' alibour or 2 per cent hydrarg. ammoniata in ointment form. Sulfonamide preparation by mouth and locally also gives excellent results.

*Intertrigo.*—This form of dermatitis is caused by moisture, warmth, and friction in parts difficult to keep clean and where the skin is of a delicate texture. It is also due to a kind of fungus or streptococcus pyogenes. Treatment is to prevent chaffing of the skin, to keep the part dry by some dusting powder or lotio calamine. Salicylic acid is a good remedy for this, and may be incorporated in powder, lotion or ointment.

*Napkin Eruption—Napkin Erythema.*—It occurs in the area in contact with the napkin. It should be differentiated from intertrigo which is a variation of impetigo, and affects the folds of groin only. This condition of napkin eruption is due to the napkin not being properly washed and caused by the highly ammoniac urine which is corrosive to the skin. The mother says that the urine is highly pungent.

*Treatment.*—(1) to put the napkin in 1-1000 hydrarg perchlor solution before rinsing it finally. (2) hydrarg cum creta by mouth. (3) Locally—To keep the part dry and clean and to apply some soothing lotion, e.g., lotio calamine.

*Monilia Infection—Thrush.*—It produces dirty scaly white lesion on mucous membranes especially of perianal region. It readily responds to salicylic acid treatment.

*Congenital Syphilis and Acquired Syphilis.*—Besides skin lesion the other signs and symptoms of luetic infection should be looked for. The child looks marasmic. In acquired cases hard chancre may be present on genitalia. There may be condylomata and mucus patches. The rashes are coppery in color. The skin of palms and soles may be exfoliated, or there may be bullous eruption, and its appearance is shiny and coppery in colour. The nails may get septic or sometimes they are shed.

*Pemphigus Neonatorum.*—It is a variety of bullous impetigo and may be both streptococcal and sometimes staphylococcal in origin. It is characterised by large blisters on an erythematous base which becomes purulent and extends by contact. It should be differentiated from syphilitic pemphigus which is confined to palms and soles and other signs and symptoms of syphilitic infection are also present.

*Treatment.*—

(1) Bath in mild antiseptic lotion—say 1-16,000 hydrarg perchlor lotion.

(2) Antiseptic application, e.g., 1 per cent or 2 per cent hydrarg ammoniata in an ointment.

(3) Ultra-violet light bath.

(4) Adequate diet with Vitamin A and D.

*Tinea Tonsurans.*—Ringworm of the scalp.

This occurs in children under 14 years of age. It is caused by a kind of fungus "Microsporon Audouini." In our country it is seen generally in children who go to some cold climate as Darjeeling or Shillong and get themselves infected there. It occurs in patches and there is thinness of hair over the area. The area looks scaly and dirty. The hairs are lustreless and brittle. On examining an infected hair with microscope or Woods Light, one is sure about the diagnosis of the fungus infection. The best treatment is by epilation of hair completely by X-Ray exposures.

*Pediculis Capitis.*—This is caused by a kind of animal parasite (Lice) which infects the hair of the scalp. It attaches its eggs to the hairs of the head. It is very common in children. The most common sites are on the back and sides of the head. The irritation caused by the bite of the lice causes scratching and this leads to infection of the scalp with cocci, resulting in impetiginous lesion. Whenever there is impetiginous lesion on scalp especially on back and sides, always look for the presence of pediculosis infection.

Treatment is to clip the hair short or shave and apply Unguentum hydrarg. ammon. (dil.) for a few days.

*Seborrhoeic Eczema.*—It is caused by a fungus called bottle bacillus. The lesions are well defined, more or less circinate erythematous patches covered with greasy yellow scales. The common sites are on scalp, middle of the face, on eyebrows, middle of chest, groins, and flexures of elbow and knee joint. On the scalp the scales are matted together and they are moist. Mother says that the scalp of the child is moist in the morning. Due to scratching there is weeping, crusting and even pus formation due to secondary infection.

It spreads by contiguity. It is sometimes very difficult to differentiate from true infantile eczema. The most definite evidence of the nature of seborrhoeic eczema is its rapid response to treatment with weak sulphur lotion or ointment.

#### ALLERGIC CONDITION:

*Infantile Eczema.*—CZERNY distinguished two forms of diathesis of infantile eczema. The pasty fast type and the thin type. Of the two the former type is frequently met with. It is an inflammatory condition of the skin expressing itself in a wide variety of pruritic lesion, which begin as erythema, papules, and vesicles and in the course of time become exudative, crusted scaly or thickened patches. This is due to sensitisation of the epidermic cells to some substance which is harmless to a normal individual. The substances which

cause it are numerous and difficult and sometimes impossible to identify. CARANSTON LOW used the term "sensitisation dermatitis" instead of eczema. The eczema patient requires two factors for the production of eczema. First, the epidermic cells of an individual must be sensitive or sensitised against certain substance and secondly, the exciting factor the substance itself. The exciting substance may be of external or internal origin (blood borne or even nervous). We have observed that a child who is suffering from chronic discharge from his ear for a long time suddenly develops eczematous lesion on the skin wherever the irritant discharge comes in contact with the skin. This is an example of allergy of external origin produced by the bacteria in the discharge. The discussion of this thing in detail is a lengthy one and I am afraid that time will not permit me to discuss it here. It generally appears in families who suffer from allergic diseases as asthma, hay fever, etc. The inherited familial tendency to become sensitised has been called by COCA *atopy* and the associated type of eczema *atopic eczema*.

It generally occurs in first two years of life. The sites of lesion are generally on forehead, sides of the face, forearms, and legs. At the beginning there is itching and erythematous swelling like diffuse urticaria. Gradually it becomes vesicular (*Vesicular Eczema*). The child scratches this lesion by his hand or against a pillow or bed so that it weeps and oozes serum (*weeping eczema*) which dries up and becomes crusted (*crusted eczema*). The surface gets infected and forms impetiginous lesion (*impetiginised eczema*). Gradually the surface heals up and scaling results (*scaly eczema*). It generally starts on the first year of life, and is very persistent and lasts for months, or may even last throughout life. The lesions do not spread by contiguity, but jump from one place to another.

The pasty fast type of infants are plump, lively and intellectually bright, and otherwise healthy, and more often a male child. They are greedy feeders and look overfed. These types of infants have got a great tendency to developing prurigo (BEISNIER'S prurigo) on back of neck, axilla, bends of elbows and knee.

*Treatment*.—It is very difficult to manage these cases. The following may be tried and good results are obtained:—

If possible the child should be removed to another place which helps wonderfully in the recovery in some cases. To avoid scratching the child's hand should be bandaged or tied to the bed or splints may be put on. Avoid irritants, water, medicated and alkaline soap, protect from changes of temperature, heat and cold, and cotton garment should be worn next to the skin. Some harmless sedative, e.g., luminal in small doses may be administered to allay itching. A mixture containing dilute hydrochloric acid and syrup of rhubarb to help digestion and hydrarg. cum creta powder as an intestinal antiseptic and for correction of constipation may be prescribed. Locally

a tar preparation as liquor picis carbonas 1% to 2% in a zinc cream or paste basis may be applied. The tar preparation should not be continued for more than a fortnight at a time to avoid absorption and damaging the kidney. In obstinate cases occasionally  $\frac{1}{4}$  pastill doses of X-ray works very well. Protein shock treatment may be tried in some cases. Regarding food one must be very careful to insist on timely feeding, to avoid overfeeding and to avoid anything which aggravates the condition. Sour milk or a proprietary food called "Allergilac" may help in some cases nicely. If the child is breastfed mother's diet and gastro-intestinal condition should be corrected if required.

*Tuberculosis Cutis*.—This is caused by tubercle bacillus infecting the skin. The most common variety which we meet with here in children is tuberculosis verrucosa cutis. Occasionally cases of lupus vulgaris are also met with.

The tubercle bacillus reaches the skin (1) by direct inoculation through some abrasion in the skin as sitting on the floor on dried sputum containing tubercle bacillus. (2) By extension of infection to the skin from underlying tubercular glands or sinuses. (3) Through blood from some broken down tuberculous focus inside. There is often a family history of tuberculosis.

*Lupus Verrucosa Cutis*.—(Tuberculosis Verrucosa Cutis). It is a granulomatous lesion characterised by warty vegetations on the skin. The lesion extends peripherally with warty vegetation at the margin while the centre is atrophic, or the whole lesion may be warty. The growth is superficial, usually does not ulcerate and seldom heals spontaneously. The usual sites are on the buttock, back of the hand, elbow, front of knee, ankle joint and foot. This should be differentiated from late cutaneous syphilide, leprosy, granuloma pyogenicum and vegetating papilloma. Mantoux reaction is positive in these cases. On pressing the area with a glass slide, dark-brown nodular infiltrations are seen. Biopsy confirms the diagnosis.

*Treatment*.—General treatment as in ordinary case of tuberculosis should be instituted. Gerson's salt-free diet, cod liver oil by mouth and Vitamin A, B, C and E are valuable.

*Local Treatment*.—(1) Plaster. The lesion is covered with plaster containing 30% acid salicylic and creosote on adhesive plaster. The plaster is kept for 3 or 4 weeks till it is not soiled. This is an easy, cheap and painless method, and gives excellent results. (2) Excision. It is very good if carried out widely and deeply, and later cauterising the base of the wound. The difficulty is pain and scar formation. It may be done on covered parts of the body. (3) Curetting. Curetting the lesion with a sharp spoon and later filling up the base of the wound with powdered potassium permanganate. The wound is

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dressed. The lesion may be cauterised with acid nitrate of mercury. X-ray may be applied to flatten out the warty lesion.

*Urticaria*.—There are two varieties common in children—papular and bullous; beside these there is a rare variety—urticaria pigmentosa. The papular one is more common. The exaggerated form of papular form becomes bullous.

*Papular type*.—This occurs mostly in summer time and starts as tiny red papules, gets harder and harder with a small vesicle in the centre. If scratched, the lesions bleed and leave pigmented stains. They occur chiefly on face, extremities and buttocks. This condition is usually gastro-intestinal origin. Sometimes if the child is removed to some other place the lesions clear up. Treatment is to remove the patient to some other place. Mild aperient and some intestinal antiseptic by the mouth should be prescribed. The digestion should be corrected and carbohydrate diet should be restricted. Locally some soothing lotion may be applied.

*Urticaria Pigmentosa*.—This is a rare form of urticarial eruption, the lesions of which are more or less persistent and results in brownish or slate coloured stains. The disease usually appears in infancy or early childhood and subsides at puberty. Treatment should be on the line of treatment of ordinary urticaria.

*Pink Disease*—It is a rare disease of unknown origin. It occurs in children under 4 years of age. In this condition there is severe itching of the skin with general erythrodermia. And especially there is swelling and exfoliation of the skin of hand and feet. Extreme photophobia is present and the child is comfortable with some silken garment next to the skin and prefers to be in a dark room. It runs a course of about 3 months.

## 16TH ALL-INDIA MEDICAL CONFERENCE, LAHORE.

### DR. DOULAT RAM'S RECEPTION ADDRESS.

*Ladies and Gentlemen*, During the sessions of the Conference, you will be called upon to apply yourselves to many problems, professional, social and medico-political, and I would not attempt to anticipate your deliberations. There is, however, one question which is uppermost in my mind and which I cannot resist the temptation of giving expression to. I refer to the economic position of the medical profession which lies at a very low ebb, and is, indeed, getting lower every day. It is argued by some that the medical profession is not a money-making profession and that its votaries must work in a missionary spirit. These are certainly the

highest ideals, but, to my mind, gone are the days of yore when the village Moulvi was the giver of all wisdom, and the village Hakim was the purveyor of all health. To-day, things are different, and metaphysical considerations have a very limited appeal. Economics have become the hub of life round which the ability, wisdom and honour of an individual revolve. And yet, it is in this respect that the medical profession has lost its ground. Conditions are so well known that they need not be retold; yet they are so urgent that they cannot be over-emphasized. They have been strikingly brought home to us even by outside observers like Dr. Anderson, the Secretary of the British Medical Association, and Col. Phipson, the former medical head of the Aden Colony. Is it not an irony of fate that though the problems are so chronic and serious we have so far failed to find a solution? It is either that we have not hitherto sufficiently realized the gravity of the disease, or that we have not yet developed enough determination to effect a cure, or that we have not so far discovered the right remedy. If the delegates from the different corners of India, assembled here, in their collective wisdom and combined resolve, succeed in showing the way to the profession out of this gloom, the Lahore Conference will have made great history. To me, the panacea of all our ills lies probably in the introduction of the panel system of practice such as it exists in most of the Western countries.

There are other important questions, too, like the uniformity of medical education, public health, rural medical relief, indigenous systems of medicine, medical preparedness in the emergency of war, etc., etc., which still await solution. These will, certainly, loom large in your deliberations, and I do not propose to burden you with my views at this stage. I would only advise that mere paper resolutions will not carry us a step further. *Words will have to be backed by action before any result is achieved and whatever resolutions we pass at a conference must become our war-cry during the year.* Here, I would like to refer to a matter of very deep gratification to the entire medical profession in the country that for the first time we have as the President of the Indian Medical Council, one of our colleagues of the independent profession, and also a leader of great eminence, Dr. Bidhan Chandra Roy. We hope that under his able guidance and stewardship the profession will achieve that efficiency at home and that honour abroad which was promised to us at the inauguration of the Council.

*Ladies and Gentlemen*, These annual conferences have become important milestones in the growth and development of the Indian Medical Association under whose auspices they are held every year. It is true that the Association has not yet achieved anything momentous or tangible in the various fields of its activities, but, let

it be remembered, that institutions, like individuals, have also their periods of childhood. This period is essentially one of growth and evolution, and, from that point of view, the Association presents a record of which any child should feel proud. Whatever fraternity and fellowship we see in the profession to-day is all due to the efforts and labour of the Indian Medical Association. In this connection, I am glad to be able to say that the Punjab, in general, and the Lahore Branch, in particular, has always been in the forefront of its activities. It is the Punjab alone of all the provinces that has held nine annual provincial medical conferences. In this respect, it beats even Bengal which is the home of the Association. Again, it is the Punjab which has got the largest number of branches except only the United Provinces. Before judging the work of the Association, let it also be remembered that an Association is nothing but a collection of men and women joined together for a common purpose. It is like a biological entity—the more strength its individual units put into it, the stronger it becomes. There is still a great apathy on the part of medical practitioners to join the Association, and this is well reflected in the fact that, out of about 42,000 practitioners in the country, the Association claims only about 3,500 as its members. The Indian Medical Association must become the banner under which every medical man and woman, of whatever caste, creed, or colour, must muster. Then and then alone it can become a virile body with that power which commands and that strength which conquers. I long for the day when such a Conference as this will be designated not as the All-India Medical Conference but as "The Conference of the Indian Medical Association."

*Ladies and Gentlemen,* I do not wish to pursue the usual practice of a long speech. Originally, I intended to follow in the footsteps of the late Doctor Ansari of revered memory whose whole speech, as Chairman of the Reception Committee of the XII All-India Medical Conference held at Delhi in 1935, consisted of a few words of welcome only and nothing else. Such a brevity from a lesser man like myself would perhaps savour of rudeness. At the same time, I do not want to stand longer between you and the President. I, therefore, close by welcoming you once again in our midst. The city of Lahore is a fast developing town, and bids fair to rank with the presidency towns of Calcutta, Bombay and Madras. While it has its attractions, it has also its distractions, not the least being its severe December winter. We have tried to make arrangements for your stay as comfortable as we could, but it is possible that there may be shortcomings, or that we may not have been able to meet all the requirements of the delegates from different climes. On behalf of the Reception Committee, I beg to crave your indulgence.

#### DR. BHUPAL SINGH'S PRESIDENTIAL ADDRESS.

I highly appreciate the honour you have done me by electing me to preside over this conference—the highest honour the profession could bestow on any individual. I have accepted the responsibilities of this office as I feel certain of your kind help and co-operation which alone would enable me to guide the deliberations of this conference successfully.

*Ladies and Gentlemen,* we are meeting under very special circumstances when the whole world is in the grip of a great war. Wars always mean such a severe strain on our profession. Maimed and mutilated humanity cries for help and our profession has to be prepared for the ungrudging service of afflicted humanity without any distinction as to friend or foe. I have no doubt the profession in India will give a good account of itself. Aerial attacks, which are a special feature of modern warfare, have introduced new problems and our duties lie not only with the troops in the battle-fields but also with the civil population even at great distances from the actual seat of war. It becomes incumbent on us to train ourselves up in A. R. P. measures so that we may be able to give intelligent help when emergency arises. You may be aware that the I. M. A. has published two pamphlets on the subject:—

(1) The treatment and prevention of poison gas for the use of medical men.

(2) Air Raid Precautions—household guide for the public.

These give lot of useful information, but they have to be supplemented by arrangements for practical training. Karachi, Bombay, Madras and Calcutta have moved in this matter but as the danger hangs over the whole of India the other provinces should also make arrangements for A. R. P. training. The I. M. A. should also take up its share of the responsibility and draw up a practical scheme of training in A. R. P. measures for medical men and open centres in the various provinces.

As regards service with the troops, I understand that the Government is preparing a scheme of emergency military service for the I. M. S. and the I. M. D. grades. I only hope the conditions will be reasonably inviting and no invidious distinction will be introduced between the permanent and the emergency officers as regards their status and emoluments. A liberal gratuity should be fixed for emergency officers at the termination of their services to make recruitment popular.

Now to come to the various problems of the profession. These have been very ably dealt with by my predecessors year after year and I dare say our problems are not very different from those even to-day. I shall go over some of them as briefly as I can.

## MEDICAL EDUCATION.

As we all know there are two grades of medical education current in India:—

(1) The University education imparted by the Medical colleges affiliated to the various Universities, requiring Intermediate in Science with Biology as pre-medical qualification and a five years' course of training, at the end of which the M. B., B. S. degree is conferred on those who qualify.

(2) The school education imparted by the medical schools under the control of the State Medical Faculties in various provinces requiring matriculation as the pre-medical qualification and a four years' course, at the end of which the diploma known as L. S. M. F. is conferred on those who qualify.

The result has been that in the Medical Profession in India two classes of medical men have grown up—the Graduates and the Licentiates—with their respective superiority and inferiority complexes fostering class dissensions in our body politic. The evil was early recognised by the leaders of the profession and a persistent effort was made to induce the Government to establish one uniform standard of medical education in the whole of India by raising the school education to the standard of college education. The I. M. A. as well, as we all know, took an important part in this by persistently supporting the Licentiates in this just demand of theirs. But the Government could not be induced to agree to this urgently needed reform for reasons of their own. But when the Congress took up the reins of Government in so many Provinces under the new reforms the angle of vision of the Government showed a change. The Hon'ble Dr. Rajan, Ex-Minister of Health, Madras, was the first to initiate the reform by abolishing school education and establishing one uniform standard of medical education—the M. B., B. S. degree—in the whole of the Madras Presidency. The profession cannot be too thankful to him. Soon after, a Conference of Health Ministers of the Congress Provinces was called in Madras and the principle of establishing one uniform standard of medical education was accepted by the Government of the various Congress Provinces. The United Provinces also decided to raise the Agra Medical School to the status of a University College, thanks to the Hon'ble Mrs. Vijay Lakshmi Pandit, Ex-Minister of Health U. P. The other Congress Provinces would have, it was hoped, come abreast in the matter of this reform, but the unfortunate ministerial crisis has upset all our calculations. It is very difficult to say how things will shape themselves now. One can only hope for the best.

## POST GRADUATE EDUCATION.

It is a great pity that there is no arrangement for post-graduate education anywhere in the whole of India except perhaps D. T. M.

course of the Tropical School of Medicine, Calcutta, the D.P.H. of the All-India Institute of Hygiene and Public Health, Calcutta and the L. O. course at the Madras Medical College. The only way open to persons qualifying from the medical institutions in India who want to specialise in any subject is to go out of India to England or other foreign countries. The expense involved is enormous and even prohibitive in the case of the majority of these persons, and so a large number of medical men have to be satisfied with general practice for want of arrangement for post graduate education in India.

Ladies and gentlemen, these are days of specialisation and it is high time that post graduate courses in various subjects should be established in India. The various Universities may, on the principle of division of labour, take up one or two special subjects and make special arrangements for their teaching and practical training in the medical colleges affiliated to them. This will automatically raise the tone of teaching of our medical institutions and consequently that of the medical profession in India. The establishment of a post-graduate college in a central place like Delhi may also be a very desirable proposition.

While on the question of teaching institutions, I may be allowed to say a few words about the selection of suitable teachers for our teaching medical institutions. It is an admitted fact that the selection has not always been on the principle of merit. Vested interests of various services have been allowed to dominate the question of selection of teachers. Since the introduction of the Reforms certain important teaching posts in the various medical colleges under the Government have been reserved for British specialists belonging to the I. M. S. There is no justification possible for their appointment except perhaps provision of fat posts with lucrative practice for British members of the I. M. S. This cannot be condemned too strongly.

Another point which I would like to stress in connection with teaching appointments is that teachers should be wholly devoted to teaching work and the temptations of engaging in private practice should not be allowed to distract their minds. I am convinced that this will raise the tone of teaching in our teaching institutions.

## MEDICAL RESEARCH.

Medical research in India has been the special preserve of the Indian Medical Service. Indians have been practically kept out of it except in the capacity of assistants and it is no wonder that Indian medical men have so little research to their credit. Besides, dissociation of research from teaching institutions have been another serious handicap. Post-graduate teaching and research should be associated more intimately for the benefit of both and all teaching institutions should be made centres of research by providing research

scholarships to capable and ambitious young men prepared to devote themselves to research. I would invite the attention of the Indian Research Fund Association to this aspect of the question.

#### PROVISION OF MEDICAL AID.

It has to be admitted that the provision of medical aid is wholly inadequate in India. It is practically absent as far as rural areas are concerned. There are hospitals and dispensaries established by the Government in urban areas but they are, as a rule, ill-equipped and understaffed. There is no wonder that they do not inspire confidence in the public in spite of the best efforts of the medical officers in charge. The management of the hospitals has been kept too much in official hands and the public has not been associated with it. The result is that public response in the shape of monetary help is meagre indeed. Besides, the administration is top heavy and a lion's share of the Government grant is swallowed up by the pay of the staff and very little is left for medicines and equipment. In order to make the hospitals more efficient and more popular the system of management should be changed and the hospitals should be put under hospital committees representative of the local public. The professional work of the hospitals should be entrusted to honorary agency as far as possible by associating independent practitioners as honorary physicians and surgeons. The independent medical profession has, during the last decade, grown considerably in quantity as well as quality and will, I am sure, be equal to taking charge of the work with credit and it is high time that it should be associated with work in these hospitals. The conditions of honorary system of work, however, have to be revised to make them more honourable to induce independent practitioners to come forward to take up the responsibility.

While on the subject of provision of medical aid to the public, I would like to mention certain schemes which could supplement the hospital system and bring medical aid within the means of the middle classes who are neither deserving of free medical aid in hospitals nor are rich enough to afford efficient medical aid at home. Schemes of National Health Insurance and Public Medical Service have been coming before the I. M. A. for sometime but they have not been taken up in right earnest. It is time that the profession considered these schemes with a view to introduce them even as an experimental measure in a few places.

Coming to the question of providing medical aid to the rural areas the task is stupendous. People in villages have begun to appreciate the modern scientific system of medicine and try to avail themselves of it whenever it is within their reach and competence. The spectacle of severe cases like pneumonia, being brought from distant villages to cities and back again must be familiar to all practitioners. That a large number of curable cases die for want of

proper medical aid is a common occurrence. A net-work of rural dispensaries of the modern scientific system should be established, each dispensary catering to the medical needs of the village population within a certain radius, say 5 miles depending on the density of population in that area. A small cess on the families who can afford to pay may be levied for the running expenses of such dispensaries. A practical scheme could be drawn up and put before the various Provincial Governments for their consideration.

#### PUBLIC HEALTH ORGANISATION.

In spite of all the efforts of the Government in connection with Public Health, the fact remains that the public in India is at the sweet mercy of diseases which in advanced countries are being brought under control. The problem of malaria which is causing so much havoc remains unsolved. It cannot be denied that the scourge has enormously increased since the expansion of railways and canals which have disturbed the natural drainage of the country. Cholera takes its large toll every year. Tuberculosis is steadily on the increase and is the cause of unspeakable misery and death. Small-pox continues to do havoc. The problem of epidemics has to be grappled with in right earnest. The health department is in urgent need of great expansion and the money so spent will be sound investment from the point of view of national health. Much has to be done by the government but the medical profession has also to shoulder the responsibility of educating the public in health subjects and thus producing a health sense in the public.

#### AYURVEDIC AND UNANI SYSTEMS OF MEDICINES.

I may be allowed to say a few words about the Ayurvedic and Unani systems of medicine, though I feel I am treading on delicate ground. These were the only systems in vogue in India before the advent of the British and have been holding their own in spite of complete absence of State patronage. That they have had their days cannot be denied. That they could not have been purely empirical but must have been based on scientific truths arrived at after scientific experiments and research is also most probable. But it has to be admitted that, for want of State patronage and encouragement, these systems have not only advanced beyond a certain stage but have actually deteriorated while the modern system has advanced by leaps and bounds. If they have had the opportunity I have no doubt that they would have advanced on the same lines as the modern scientific system and then there would have been no difference of kind between these old systems and the modern system. Efforts have been made during the last decade or two to modernise these systems, for instance at the 'Tibia College' at Delhi and the 'Ayurvedic College' at the Benares Hindu University, by introducing a study of the basic sciences such as Anatomy and Physiology, in the Ayurvedic and Unani teaching institutions and by

providing hospital facilities for practical training of the students; but I am sorry to note that proper stress has not been laid on maintaining standards. This is bound to react unfavourably on these systems themselves. Our attitude towards these systems is one of friendliness. Many of the drugs of these systems reputed to be useful in certain diseases are being put through scientific examination to be utilised if they stand the test of modern methods of experiment and research. Researches on pharmacology on these lines have been carried out in the 'School of Tropical Medicine' at Calcutta by General Chopra and have resulted in lot of useful additions to our knowledge.

#### THE INDIAN MEDICAL SERVICE.

The Indian Medical Service was originally a military service for looking after the Indian Army in times of peace and war. But by and by it was employed to look after the medical needs of the civil officers and the civil population and had charge of public health and medical education also, being the only agency of the modern system available. We must acknowledge the great service rendered by the I. M. S. in those days. But as the medical profession in India grew up and claimed its due share of the opportunities of civil appointments in the state it came into clash with the vested interests of the service. Naturally it was reluctant to give up the monopoly of the higher appointments on the civil side which it had secured. The civil side of the service was justified on the plea of providing military reserve. But this theory was exploded in the last war when a very large number of civil doctors had to be recruited to supply the war-time demand of the army, the number of I. M. S. officers released from the civil side being insignificant. After the Great War the system of Army Reserve of Officers (Medical) was introduced and this should efficiently replace the civil side of the I. M. S. as far as the demand for military service is concerned.

After the introduction of the reforms the Secretary of State for India has, under section 246 (i) of the Government of India Act of 1935, which gives him wide powers to deal with the right and privileges of the I. M. S. issued Resolution No. 205 of 25-3-37 (Defence Department). Under this resolution the civil side of the I. M. S. has been firmly established on the ostensible plea of providing War Reserve and providing medical attendance on British Civil Officers and their families by British doctors. Both these arguments do not stand a moment's scrutiny. But the fact remains that the Secretary of State has utilised his powers well to entrench the I. M. S. securely in the Civil departments of the state. The most objectionable feature of the scheme is the introduction of racial discrimination between the British and the Indian personnel of the service as regards the method of recruitment, the right of transfer to civil side and even the scale of pay. The last has been done very cleverly by

reducing the basic pay and increasing the overseas allowance which has the effect of lowering the pay of Indian Officers and increasing the pay of British Officers compared with the old scale. Another most seriously objectionable feature of the scheme is the provision of British specialists in the main subjects of surgery, medicine and obstetrics as teachers in the various medical colleges of the country as this introduces racial discrimination even in the educational institutions where it is most undesirable. Besides all the important towns in the various provinces have been reserved for British Civil Surgeons. And all this has been done on the eve of Provincial Autonomy!

Ladies and Gentlemen, we have from this platform cried hoarse that the civil side of the Indian Medical Service is an anachronism and should be abolished and that recruitment to the service should be through the door of open competition but it has been like crying in the wilderness. As a matter of fact conditions have been made distinctly worse. These wrongs can only be remedied when real political power passes into the hands of our people. This takes us into the field of politics and is best left to our political savants to deal with.

I would like to make it quite clear, however, that my criticism is directed against the system and not against individual officers of the I. M. S. among whom I can count some very good friends both Indian and European for whom I have the greatest regard.

#### THE INDIAN MEDICAL COUNCIL.

Those who know the history of the creation of the Indian Medical Council will remember that it was established to placate the General Medical Council of Great Britain in the teeth of opposition by the profession in India. The constitution of the Council was such that it was practically an official body. It concerned itself not with the whole of medical education in India but only with the university education imparted at the medical colleges. It wanted to have a register from which it proposed to exclude the Licentiates, who already enjoy the privileges of being on the Provincial Registers. But as the profession stood as one man against this injustice it decided to forego the luxury of a register. There has been a continuous agitation in the profession demanding an amendment of the Indian Medical Council Act to secure increased representation for the independent profession, to include the school education within its purview so that it could be mended or ended and to bring the existing Licentiates on the register but without success.

Ladies and gentlemen, things now appear distinctly more hopeful. Our respected leader Dr. Bidhan Chandra Roy has been unanimously elected President of the Indian Medical Council and we can confidently hope for better times under his able guidance. I would take this opportunity of congratulating Dr. Bidhan Chandra Roy on the honour which he so well deserved.

## UNEMPLOYMENT AMONG MEDICAL MEN.

That there is unemployment among medical men has to be admitted. But when I look into the question closely I cannot help but come to the conclusion that the problem is really one of defective distribution of available medical men. Medical men are generally crowding in large towns while smaller towns and rural areas are in bad need of them. Every young man when he qualifies tries to settle down in large towns, and quite naturally too, because he has been brought up in such a way that he finds life in big towns more congenial. And then every young man is naturally ambitious and he finds there is no scope for his rising up in the profession in small towns and rural areas. Some of these who have extra brains get a footing and ultimately rise. But many of them who are not so gifted find that they cannot make the two ends meet and lose confidence in themselves and form the bulk of the unemployed. On the other hand many young men, who have settled in small towns straight away, have succeeded well. The problem of settling down in rural areas is still more difficult. The Government in many provinces have tried to subsidise practitioners to induce them to settle in rural areas but these schemes have not been very successful. The problem of rural medical relief can only be solved by the establishment of rural dispensaries which will at the same time solve the problem of unemployment among medical men. The public health department also stands in urgent need of expansion and will help to relieve unemployment.

## DRUG INDUSTRY.

We have to admit to our shame how we depend on foreign countries for important drugs and medical and surgical supplies. This was brought home to us in the last war and the manufacture of many drugs and preparations was stimulated. But we were lulled into sleep after the war and the markets were again flooded with foreign manufactures. The war has begun again and the problem is before us in a more acute form. Many drugs to which we have got used are difficult to get. It is a great opportunity for enterprising firms to come to the help of the country. An All India planning is urgently required to go into the whole question as to how to make India independent of foreign countries in the matter of drugs and medical and surgical appliances. The profession has a great responsibility in this respect. An influential committee should be formed by the I. M. A. to devise ways and means for making India self-sufficient in the matter of drugs and medical and surgical appliances. Let us hope good comes out of evil and India is able to stand on its own legs as a result of the stimulus provided by the War.

## THE INDIAN MEDICAL ASSOCIATION.

Before I close I would like to say a few words about the Indian Medical Association. The I. M. A. is the only organisation in India

which provides a common platform for all classes of medical men on terms of complete equality. It was started in 1928 with a small membership and just existed for the first few years of its life, but since the year 1933 it has shown real signs of life and during these last 5 or 6 years it has grown very much in stature and importance, thanks to the untiring efforts of our Hon'y. General Secretary, Dr. K. S. Ray who has been carefully nursing it from its infancy. We can now count as many as 117 branches within its fold, distributed all over India, and the total membership has reached nearly 3500—consisting of all classes of medical men—graduates and the licentiates, Service men and the independent practitioners. Besides it has a few important medical associations as affiliated bodies which, I hope, will soon be converted into branches. But much has to be accomplished still. The I. M. A. being the only organisation which can safeguard the interest of the medical profession in India deserves the support of every member of the profession. How I wish the I. M. A. was *the one* medical organization in India wielding the same influence and power as the B. M. A. in England. I shall earnestly appeal to every professional brother and sister in India to make it a point to join the I. M. A. The Governments in the various provinces have allowed their medical officers to freely join the I. M. A. and their attitude towards it is one of friendliness. You will be pleased to know that in U. P. the I. M. A. has been given recognition as an advisory body to the Government to be consulted in all matters concerning medical aid and public health, thanks again to the Hon'ble Mrs. Vijay Lakshmi Pandit, the Ex-Minister of Health U.P. I feel confident that the other provinces will extend similar recognition in due course and that the I. M. A. will prove itself deserving of the honour and equal to the responsibility put upon it.

Ladies and gentlemen, now that we are growing in numbers and importance we should beware of dissensions in our ranks which are, one has to admit with shame, the curse of all organisations in our country, and should be guarded against. The main stay of all democratic institutions is discipline—self-imposed discipline—without which no organisation can function and flourish. Allow me to stress the need for discipline with all the force at my command. I would just put before you the constitution of the I. M. A. We have the local branches which are the units and are autonomous to a great extent in their internal management. They send representatives according to their numbers to the Central Council in which rightly vest all the powers. It is the governing body of the Association. It derives its power from the branches through their representatives. The decisions of the central council are thus the decisions of the branches. The only sanction it possesses for enforcing its decisions is the sense of discipline of the branches. Its decisions at times may not be in accordance with the wishes of a particular

branch but since the decisions are taken by a majority of votes of the representatives of all the branches discipline requires that they should be implicitly obeyed. I would make an earnest appeal to you to consider this point and keep guard against disruptive tendencies so that the evil may be nipped in the bud.

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**DISEASES OF SKIN.**

**PYOGENIC INFECTIONS OF THE SKIN:** PERCIVAL, H. G.  
*Practitioner*, 142: 55, 1939.

The skin reaction which is characteristic of superficial streptococcal infection, whether primary or secondary, is an exudative one which results in the formation of a bulla. Deeper streptococcal infections promote a similar type of inflammation characterized by the oedema of erysipelas and cellulitis.

*Impetigo Contagiosa.*—Superficial uncomplicated streptococcal infection of the skin causes the disease known as impetigo contagiosa.

Impetigo is an eruption characterized by the development of isolated vesicles or bullæ. The discrete and isolated nature of the vesicles differentiates it from those of dermatitis. The usual localized distribution of either vesicles or bullæ, and their obvious infectivity, differentiate them from vesicular or bullous eruptions of internal origin, such as dermatitis herpetiformis, pemphigus, bullous urticaria, or the vesiculo-bullous exanthemata.

Impetigo may become superadded to an already existing skin eruption, with the result that the characters of both diseases become modified.

In the early exudative state this is best attained by using a 2 per cent. aqueous solution of gentian violet, in conjunction with boracic starch poultices. Gentian violet is painted over the whole affected area once daily, and starch poultices are then applied three times daily. It is most important to be certain that the starch jelly is suitable, i.e., that it is dry and firm (but not too firm) in consistence, like calf's-foot jelly. It should remain a jelly throughout the period of application, and should neither tend to run, nor harden to a cement-like consistence. Failure of impetigo to improve with starch poultices is almost always due to a badly made jelly. The poultices absorb the exudate and so prevent crust formation, and to do this adequately they should be from half to three-quarters of an inch thick. They also soften existing crusts so that these can be easily removed by washing, which should be carried out twice daily. The exudative phase will subside after a few days of this treatment, and no fresh lesions should develop, and it is then, and not before, that a 1 per cent. ammoniated mercury paste should be used. This is applied twice daily, and cleaned off with olive oil prior to each application, soap and water being used after the olive oil only once daily. If the impetigo is first seen when exudation has ceased, the paste may be used straight away. It is advisable to apply the paste spread on calico, either cut in the form of a mask or in suitable strips kept in position with a bandage.

*Streptococcal Perionychia*.—A chronic inflammatory perionychia affecting one or more nail folds may be produced by streptococcus. The condition may occur in association with impetigo elsewhere, a combination which is not infrequently seen in children.

*Treatment*.—This condition does not respond rapidly to treatment. In the early stages it may be necessary to use boracic socks for a few days to reduce the discomfort, edema and purulent discharge. Thereafter the patient should avoid wet work entirely, and only wash the hands twice daily. The local treatment is changed to the daily use of 2 per cent. aqueous solution of carbol fuchsin and the once weekly application of liquid carbolic acid. Both liquids are painted on the nail plate, nail fold, and especially into the cavity between them. A streptococcal vaccine is helpful in perionychia, and should be given in an initial dose of five million, increasing to fifty million at weekly intervals over a period of six weeks. A short course of a preparation containing vitamin D in a concentrated form should be advised, and three times the usual dose given for a period of a few weeks. When the cavity at the base of the nail has granulated and become obliterated, a small dose of X-rays is helpful. A cure cannot be pronounced until the cuticle has been completely reconstituted.

In contrast to the streptococci, the characteristic skin reaction produced by staphylococci is cellular in type. The resulting lesion is a pustule, a furuncle, or a cutaneous abscess, depending on the depth of the infection.

*Treatment*.—As a single pustule occurring on an area covered with strong hair may be the precursor of a prolonged folliculitis, it should be treated with care. It is best to allow it to run its short course undisturbed, so that it becomes, as it were, mummified as a closed lesion. Friction should be guarded against, and if necessary the lesion should be covered over with elastoplast, contamination of the adjacent hair follicles being thus avoided.

When a chronic folliculitis complicated by dermatitis has developed, a prolonged course of treatment will be necessary. The affected area must be shaved, and kept clean. To facilitate this in the first instance, when there may be a good deal of crusting, calico soaked in olive oil may be applied for a few hours prior to shaving. To begin with, greasy applications (with one exception) should be avoided, and their place taken by boracic-starch poultices, or wet dressings of a  $\frac{1}{2}$  per cent. watery solution of silver nitrate. When the intensity of the inflammation and crusting has been reduced by these means a 2 per cent. solution of gentian violet in water is beneficial, and is painted on once daily for two consecutive days, and on the third day starch poultices are used. Gentian violet may be combined with poultices, being painted on every day and the poultices applied to the painted area. The next stage is the application

of crude gas-works tar. It is a curious fact that when tar is applied in ointment form to these cases, pustulation is greatly increased, whereas it can almost always be used with benefit in the crude form as a paint. It is painted on in a thin layer and, after a few minutes, powder is dusted on the surface, and drying is complete in about fifteen minutes. The tar is cleaned off with olive oil after thirty-six to forty-eight hours, and it is either reapplied or starch poultices are used for a day before renewal of the tar. Finally, a 1 per cent. ammoniated mercury or ichthyol paste is used.

Mild cases will often respond up to a point under the twice-daily inunction of a proprietary preparation called quinolor (SQUIBB), the active principle of which seems to be a chlorquinoline compound. This is the only ointment preparation which can be generally recommended in the early stages, and it is most useful in cases which show a limited number of recurring pustules with no dermatitis. Its sphere of usefulness is almost limited to folliculitis of the beard region (sycosis).

A bath should be taken daily, preferably one to which enough potassium permanganate has been added to make the water a bright pink.

It is well to reduce the starch and sugar content of the diet in every case, and to ensure a liberal supply of vitamins. Yeast as a source of vitamin and as a general "tonic" has a popular reputation in furunculosis, but it must be fresh and preferably brewers' yeast. Although vaccines are of little use in superficial folliculitis, they are of proved value in furunculosis.

#### *Impetigo Neonatorum (Pemphigus Neonatorum)* :

Although this is a bullous eruption having all the features of a widespread attack of impetigo contagiosa, bacteriological investigations have shown staphylococcus to be the only infecting organism. It is well known that the condition is a dangerous one, that it occurs in epidemic form in institutions at regular intervals, and that the source of infection is usually an adult suffering from impetigo contagiosa.

One per cent. ammoniated mercury paste, the standby in impetigo, is not well tolerated and aggravates the eruption in most cases. The blisters should be snipped and the roofs removed and a daily antiseptic bath containing potassium permanganate or boracic acid should be given. Thereafter the whole body surface should be painted with 2 per cent. aqueous solution of gentian violet, and this should be repeatedly dabbed on the raw areas, from which it may tend to be washed away during the day by the continued exudation.

An alternative to the gentian violet as an application to the raw base of the blisters is 10 per cent. aqueous solution of silver nitrate, which may be repeatedly dabbed on until a black coagulum has formed on the surface

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## Medical News and Notes.

### RESOLUTIONS PASSED AT THE XVI ALL-INDIA MEDICAL CONFERENCE.

1. (a) In view of difficulties experienced as a result of War in respect of supplies of medical requisites in the country, this Conference strongly urges the adoption of measures by the Central and Provincial Governments for encouraging the establishment of factories for the manufacture of heavy chemicals, pharmaceuticals, drugs, surgical requisites, hospital equipments, instruments, and other medical requirements.

(b) This Conference is further of the opinion that unless definite measures of protection lasting for several years are vouchsafed by Government, it would be difficult to prevent the dumping of drugs, chemicals and such other goods at low prices, and even below the cost prices, by huge foreign combines after the cessation of War.

2. This Conference strongly protests that, with the declaration of War, even though stocks were available in the country, manufacturers and importers of drugs, surgical requisites, etc., suddenly raised the prices to the extent of even over 200 per cent, and urges the Government to take such steps as are desirable to prevent the hoarding of materials necessary for the treatment of patients, by wholesale and retail sellers and to make it a penal offence to raise the prices of medical and surgical requisites above a certain percentage over the cost of production in each case which may be prescribed by Government in consultation with representatives of the Indian Medical Association.

3. This Conference welcomes the appointment of a Committee by the Government of India to report, within two months, on measures to be taken for the development of drug industry in India, and strongly urges the necessity of having a representative of this Association on the proposed Committee.

4. In view of the fact that highly qualified Indian medical men in all special subjects are now available, this Conference strongly urges that Indian nationals only should be appointed on the teaching staff of the proposed medical college at Delhi and protests against the arrangements, now under contemplation, to appoint non-Indians to some of the posts in the said College.

5. This Conference urges the Governments of Sind, N. W. F. P. and Delhi to establish Provincial Medical Councils in their respective provinces on democratic lines.

6. This Conference places on record its appreciation of the steps taken to improve the standard of education in medical schools

in some of the provinces, and hopes that all schools still existing will be transformed into well-equipped and well-staffed teaching institutions affiliated to their respective universities as early as possible so that there may be one uniform standard of medical education in the whole of India.

7. Whereas it is the practice of medical practitioners generally not to observe any holiday, this Conference recommends to them to observe a holiday and to close their dispensaries and consulting rooms, at least one afternoon a week, preferably the Sunday afternoon, and further recommends to them to take at least a fortnight's holiday during a year.

8. This Conference recommends that, where a consulting Physician or Surgeon has attended on a patient in consultation with a general medical practitioner, he should not, independently, see such a patient again except in cases of emergency or when the practitioner is not available under special circumstances or at the written request of the practitioner himself.

9. This Conference greatly deprecates the action of several Indian Insurance Companies in lowering their medical examination fees in the face of strong and repeated protests of the entire medical profession as represented by the Indian Medical Association, and calls upon the medical examiners to refuse to examine the cases of such companies' except those cases where the fee is less than Rs. 8.

This Conference further draws the attention of all Insurance Companies to the defects in their business methods whereby the examiner is under the influence of the Agent for obtaining insurance work, and urges them to rectify such defects in accordance with the ethics of insurance.

10. This Conference regrets that nothing has so far been done by the various Governments, Municipalities and other Local Bodies of this country to prevent the abuse of hospital facilities by rich patients. In the opinion of this Conference, expressed more than once, rich patients should not be treated at all in free hospitals and dispensaries whether supported by Government, Municipalities or Private benefactions except by paying fee on sliding scale according to income. This Conference, therefore, urges on the various Authorities concerned to take immediate steps to stop such abuse, and recommends, as a solution of this problem, the introduction of Almoner system.

11. This Conference deprecates the practice by medical practitioners of giving free professional advice to patients in their dispensaries or consulting rooms and requests the local branches of the Indian Medical Association to lay down a minimum scale of fees which should be charged, after giving due consideration to the economic conditions prevalent in the locality. In the opinion of this Conference, free advice should be offered strictly to the genuine

needy and indigent persons who should also be directed to avail themselves of the services of the nearest hospital or charitable dispensary.

12. In view of the havoc and destruction to which the civil population is exposed in modern warfare and the possibility of such happenings in India, this Conference is of the opinion that medical practitioners should obtain the necessary training in the prevention and treatment of poison gas and air raid casualties, and should organise themselves to meet such emergencies or to render help to the Organisations already existing for this purpose.

13. Whereas it has become a habit with the medical practitioners to use proprietary and patent preparations to an increasing extent, most often of foreign manufacture, this Conference recommends to them to use, as far as possible, pharmacopoeial preparations, and to prescribe proprietary or patent remedies only in special cases, preference being always given to those of Indian manufacture.

14. (a) This Conference views with great disapproval the Medical Registration Bill now before the Sind Legislative Assembly whereby it is proposed to place the qualified medical practitioners and unqualified persons without adequate general and scientific training on the same status.

(b) This Conference is of the considered opinion that Hakims and Vaidis should be registered under a separate Act, authorising them to practise medicine after going through a curriculum of studies in institutions recognised by Government or after passing test examinations held under a Board of Examiners appointed by Government.

15. This Conference is of the opinion that paid medical officers in Government, Municipal service, etc., should not be allowed private practice on hospital premises, and further that the whole of fees charged by medical officers-in-charge of private wards or for laboratory, X-ray and other examinations should be credited to the funds of the Institutions or Authorities concerned.

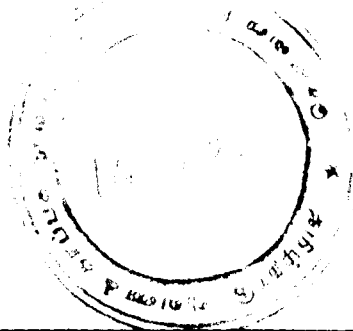
16. The Conference requests the Medical Council of India to pass a resolution suggesting suitable amendments to the Medical Council of India Act, 1933, on the lines proposed by the Indian Medical Association and recommending the same to the Government of India for piloting an official amending Bill, as early as possible, through the Central Legislature.

In pursuance of the above, this Conference requests the Central Council of the Indian Medical Association to do the needful for an early solution of the question.

17. This Conference offers its sincere thanks to (1) the Lahore Branch of the Indian Medical Association for organising the XVI All-India Medical Conference, (2) the Reception Committee for its magnificent arrangements, (3) the delegates, lecturers and exhibitors

for their participation, (4) the authorities of the Dyal Singh College, Lahore, for putting their buildings, grounds and the hostel at the disposal of the Reception Committee, (5) Messrs. Beli Ram & Bros., Lahore, Messrs. Bengal Chemical & Pharmaceutical Works, Ltd., Calcutta, and Messrs. Ranbaxy & Co., Amritsar for their "At Homes", (6) Mr. Dalsukh Pancholi of Empire Talkies, Lahore, for cinema shows, and (7) to Messrs. Jhon Wyeth & Bros., Ltd., for scientific films.

18. This Conference places on record its grateful thanks to Dr. Bhupal Singh for presiding over the deliberations of the XVI All-India Medical Conference.



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