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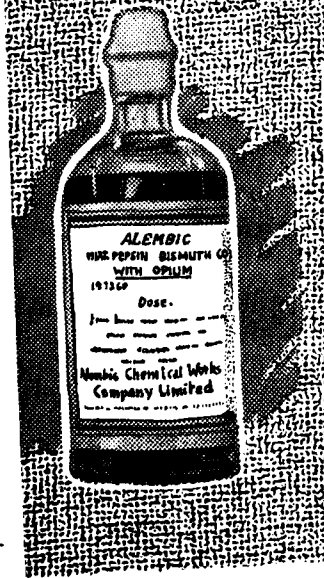
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Original Articles

ABNORMALITIES OF THE CARDIAC ACTION

BY

A GENERAL PRACTITIONER.

In presenting this article the author does not claim to place before the readers anything new or original. The dread about the conditions of heart is made much of by the patients when there is nothing to be anxious about and at times serious conditions of the heart are not detected in time to avert real danger. It is therefore necessary that the general practitioner should have special knowledge of the abnormalities of the action of the heart at his finger tips so as to be able to guide his patients as intelligently as the conditions of the heart demand.

To understand the abnormal action of the heart it is necessary to understand the cardiac mechanism. The heart beats normally at the rate of 72 times per minute. The stimulus for the contraction starts at a special point in the right auricle called the sino-auricular node. It is situated at the junction of the superior vena cava with the right auricle and consists of highly specialised neuro-muscular tissue. The stimulus from the node travels along the auricles like ripples produced by throwing a stone in a pond of water to the auriculo-ventricular node

which also consists of highly specialised neuro-muscular tissue situated on the right side of the inter-auricular septum at the posterior part. From this point the stimulus travels along a definite path, the auriculo-ventricular bundle otherwise known as the 'Bundle of His'. This bundle as soon as it reaches the upper part of the inter-ventricular septum divides into two branches the right and the left which finally end by arborisation with the muscle fibres in the wall of the respective ventricle. This, in short, is the normal path traversed by the stimulus. Irregularities of the heart are produced either when the stimulus arises in a different point or travels along a different path. Such irregularities of the heart may be due to variety of causes. They may be merely functional due to reflexes from the vagus or sympathetic nervous system. Such disturbances seemingly frighten the patients but should not alarm the practitioner. Whereas the irregular cardiac action brought about by the pathological changes in the valves and musculature of the heart are of serious import. An intelligent history of a case and as careful physical examination

of the patient, will enable a practitioner to arrive at a provisional diagnosis relating to the abnormal cardiac action which ought or should be confirmed by delicate instruments such as polygraph sphygmograph, or electro-cardiograph. All practitioners cannot afford to have such instruments but all can train the natural sensory apparatus owned by them to such an extent as to be able to detect and diagnose majority of cases of abnormal cardiac action. It should also be known that an abnormal heart may give a perfectly normal electro-cardiogram but a normal heart will never give an abnormal electro-cardiogram. So electro-cardiogram should only be used as an additional help to diagnose conditions of heart action. It is to be emphasised that the practitioner should not entirely depend upon electro-cardiogram to diagnose abnormal heart action.

Having said so much by way of introduction let me refer to most important abnormalities usually found in general practice.

SINUS ARRHYTHMIA: The irregular action of the heart belonging to this category is considered to be due to unusual sensitiveness of the vagus centre which in its turn sends reflexes to sino-auricular node. This irregularity is usually found in young people especially after acute infectious diseases and far from denoting any danger to the heart denotes the reverse *i.e.*, that the cardiac musculature is sound. In this condition there is generally a definite relationship to respiration. If the patient having sinus arrhythmia holds his breath, the irregular pulse becomes regular. During deep inspiration the heart beats are more frequent than during expiration. The patients complaining of this irregularity should be told that they have no heart disease and no treatment is necessary excepting encouraging the patient that he has no heart trouble.

EXTRA-SYSTOLE: Irregularity of heart may also be due to extra-systole. The irregularity due to this condition can be differentiated from that due to sinus-arrhythmia by asking the patient with an irregular heart action to hold his breath;

if then the heart beats regularly, the case is one of sinus-arrhythmia. This may be confirmed by asking the patient to breathe deeply and counting the heart beats during inspiration and expiration. In sinus-arrhythmia, the heart beats are more than during the expiration. If the irregularity does not disappear on holding the breath and if, when the heart sound is heard, pulse is not felt, the probable cause of irregularity is extra-systole. A slowly acting auricular fibrillation may give rise to the same phenomenon. In this latter condition the pulse is irregular not only in rhythm but also in force and volume and the veins at the neck will be found pulsating. To make one sure that the irregularity is not due to auricular fibrillation the patient may be asked to exert a little to quicken the heart action when in case of extra-systole the heart becomes regular in action. It should be remembered that any exertion in a patient having auricular fibrillation will endanger his life. So in case the practitioner suspects the irregularity of heart's action is due to auricular fibrillation the patient should not be asked to exert himself and the diagnosis should be confirmed only by electro-cardiograph. Extra-systoles are due to the impulse starting at a point other than the sino-auricular node. They may be auricular or ventricular in origin; they may also start in the junctional tissues between the auricle and the ventricle. The most important form of extra-systole is of the ventricular type. These different types can only be differentiated by the electro-cardiograph. In a large number of cases diagnosis can be made by the feeling of the pulse and hearing of heart-sounds at the apex. The normal rhythm is disturbed by the occurrence of a premature beat at the pulse and also at the apex. In a majority of cases two heart sounds are heard synchronous with each extra-systole. These two added to the two normal sounds will give rise to four sounds resulting in two pairs of pulse beats called *pulsus bigeminus*. At times the extra-systole occurs before the cardiac-muscle has had sufficient time to recover from the preceding systole and therefore the premature contraction is not strong

enough to open aortic valves. Consequently only the first sound is heard resulting in three sounds which give rise to three pulse beats known as *pulsus trigeminus*. Very rarely the extra-systole is so feeble that it cannot be heard at the apex nor felt at the pulse. This gives rise to 'intermittent pulse' due to the dropping of the heart beats.

Extra-systoles are most common in the middle aged and the old and rarely in the young people. These are seen more in men than women. Patients having extra-systoles are those having myo-cardial or valvular diseases of the heart; more in the former category than in the latter. Hypertension, focal sepsis, thyrotoxicosis, indulgence in tobacco, tea, coffee or alcohol are amongst subsidiary causes. Indiscrete administration of poisonous drugs like digitalis and aconite may also be counted amongst the causes. Even trivial exertion such as movements in lying posture after a heavy meal may bring about the extra-systoles.

Patients might not be able to know that they have extra-systoles by any symptoms. Some may feel a flutter in the chest and complain of intermittent pulse. Sudden heart action after a pause may give rise to a shock in the region of heart. A few may complain of a "catch in the breath" or "gripping in the throat." It is just possible in cases of pauses in the heart action to have faintness, syncope followed by profuse sweating.

The most important fact in the treatment is to create confidence in the patient. The practitioner should after detecting the causes of the extra-systoles improvise suitable treatment paying special attention to general health. Opinions differ in the choice of drugs in cases where the extra-systoles are due to myocardial changes or valvular disease, quinidine is recommended by some, condemned by as many. So also digitalis. Sedative treatment is well thought of by some others. A judicious choice of one amongst the three courses seems to be the best course.

HEART-BLOCK: If, while examining an irregular heart, the apex thrust is absent and the heart sounds are not heard

and pulse not felt during the pause between irregular beats, the case is very probably one of heart-block. In this condition, the impulse necessary to produce heart action is interrupted and there is defective conduction of the heart. This interruption may occur between sino-auricular node and auriculo-ventricular node (sino-auricular block), between the auriculo-ventricular node and the bifurcation of the Bundle of His (auriculo-ventricular block), at one of the branches of the Bundle of His (Bundle branch block) or in the walls of ventricles where arborisation of the terminal part of the branches with the muscle fibres of the ventricles, takes place, (intraventricular-block). The different varieties of heart-block may be made out by the electro-cardiograph. The block is said to be partial when the time taken by the impulse to pass from the auricle to the ventricle which is generally 0.18 second is prolonged and the block is called complete when there is complete dissociation between the contraction of auricles and ventricles. The auricle may be beating at the rate of 72 per minute; these impulses never reach the ventricles on account of the block. The ventricles take on a rhythm of their own and beat at the rate of about 40 per minute. Whenever the pulse rate is 40 or less than 40 per minute, heart-block should always be thought of. There are a few persons whose pulse rate is always slow; it is said Napoleon had a pulse rate of about 40; but such cases are rare; moreover, the pulse rate in such cases can be increased by exertion, but the pulse rate in heart block cannot be increased, but this test should never be used as it is a dangerous procedure.

Heart-block may occur in acute infectious diseases like pneumonia, diphtheria, acute rheumatic fever, typhoid fever etc. It may be found in congenital conditions when there is a defect in the interventricular septum; but the most important cause is the degenerative conditions of the heart muscle due either to toxæmia, or insufficient supply of blood to the cardiac muscle, coronary sclerosis or in syphilis. Administration of full doses of digitalis brings about heart-block.

The slowing of the heart causes anaemia of the brain and the subject of heart-block complains of giddiness and in complete heart-block specially when it passes from the partial to the complete variety, the syndrome called after Stokes-Adams may occur. This consists of cyanosis, loss of consciousness and epileptiform convulsions with no pulse at the wrist. The person may die during the attack; under favourable conditions the pulse returns at the wrist, the cyanosis disappears and the person regains consciousness.

The treatment consists of giving parenterally adrenaline chloride (1.1000) $\frac{1}{2}$ c. c. or atropine sulphate 1/100 gr. After the attack has passed off, the person should take ephedrine hydrochloride $\frac{1}{2}$ gr. three times a day and lead a quiet orderly life free from mental and bodily strain. The treatment for the causating factors, such as coronary sclerosis or syphilis should also be undertaken.

SINUS BRADYCARDIA: In addition to hereditary factors the following conditions may give rise to slow pulse:

1. Overdose of drugs like digitalis, strophanthus.
2. Increased intracranial pressure, due to tumor, increase of cerebro-spinal fluid or haemorrhage.
3. Convalescence after acute infectious diseases.
4. Decrease of thyroid secretion as in myxoedema and cretinism.
5. Toxic conditions like jaundice, uraemia, diabetes.

Before diagnosing a case as one of heart-block, all the above conditions should also be taken into consideration.

The rate of the heart may be increased. This occurs in:

1. Sinus-tachycardia.
2. Paroxysmal tachycardia.
3. Auricular flutter.
4. Auricular fibrillation.

In sinus-tachycardia, the contraction of the auricles begins at the sino-auricular node. This node though automatic is under nervous influence *viz.*, the vagues and the sympathetic, the automatic starting of the contractions is influenced either by the stimulation or depression of these nerves. Simple tachycardia is found after exertion, after emotion, during fevers, after administration of atropin, injection of adrenalin, ingestion of thyroid extract. Exophthalmic goitre and septic foci causing toxic conditions will also give rise to quick pulse. An important point of diagnostic aid is that it does not start suddenly nor end suddenly. The treatment consists of treatment of the cause.

PAROXYSMAL TACHYCARDIA: Starts suddenly and after varying intervals consisting of a few hours, days or weeks ends as suddenly as it began. It lasts for a long time; signs of cardiac failure, such as dyspnoea, enlargement of liver, etc. occur. In this condition the impulse starts not at the auriculo-ventricular node but at some other point either at the auricle, ventricle or junctional tissues and thus we get the auricular ventricular or nodal tachycardia. Ventricular tachycardia is the most serious of the whole lot. The exact causes of this condition are not definitely known but in majority of cases intemperance in habit *i.e.*, excess in tea, coffee or alcohol may be found in these cases and also focal sepsis. There may be a history of the patients having suffered from acute rheumatism and other infective fevers. Myocardial degeneration and valvular diseases may also be detected in some. The treatment consists of pressure at the carotid artery or eye-ball, bending the body forward and keeping the bent head in between the knees, holding the breath or induction of vomiting. The patient should be kept completely at rest in bed so as to give as much rest as possible to the over-taxed heart. If the ordinary measures, detailed above are unsuccessful, quinidine beginning with gr. 3 and increased to gr. 6; four times a day may be given.

AURICULAR FLUTTER: In this condition the contraction begins at the sino-auricu-

lar node, but they are extremely numerous. The ventricle is not able to contract similarly, so every third or fourth beat reaches the ventricle. If we watch the neck carefully there will be jugular pulsation corresponding to that of the auricles. The pulse is regular but is fast, but never so fast as in paroxysmal tachycardia may be about 150 or so. Treatment consists in digitalisation of the heart and converting the flutter into fibrillation, when it can be controlled by digitalis in moderate doses.

AURICULAR FIBRILLATION: In this condition a circus wave starting from a point other than the sino-auricular node travels round the auricle. The auricle quivers, but does not contract as a whole, there are fibrillary twitchings as it were in the auricle. The ventricle is not able to cope with all the impulses that reach it. It contracts in response to some of them and the pulse is irregularly irregular both in rhythm and in strength. The condition where this is most commonly met with, is mitral stenosis, exophthalmic goitre but may also be met with in acute infectious diseases like pneumonia, rheumatism, diphtheria, etc. If the heart beats are counted at the apex and at the radial pulse, there is always a difference. The condition is a serious one and the treatment in addition to other measures necessary for heart failure is large doses of digitalis,

which produce a condition of heart-block and gives rest to the ventricles. Quinidine may be given in cases due to exophthalmic goitre.

The last condition of abnormalities is what is known as *pulsus alternans*. In this condition we find that in every two beats the second beat is weaker than its predecessor. With the hand on the radial pulse this can be made out. The condition is a serious one and the span of life is said to be not more than two years after this condition is noticed.

Discussion about the abnormal cordiac action cannot be complete unless the findings adduced by special instruments are appended. The author has only attempted to create an interest in the general practitioner with the hope that it will serve as an inducement to make him realise that almost all irregularities in the action of the heart can be made out by an intelligent study of the history of the patient and a careful inspection of the patient followed by palpation, percussion and auscultation. All the same, whenever possible the practitioner should have recourse to the use of the most valuable instruments such as, the polygraph, sphygmograph and the electrocardiograph.

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SIGNIFICANCE OF HOOK-WORM INFECTION IN THE TROPICS.

By

DR. K. V. KRISHNA, M.B.B.S., (HONG KONG).

My intention in contributing this article is for the purpose of emphasising the necessity of diagnosing hook-worm infection at an early stage much before the supervening anaemia manifests itself.

Whether it be the *Ankylostoma duodenale* or the *Necator Americanus* that enters the human host, the initial harm done is the same, though according to Darling, a given number of *A. duodenale* is said to produce a greater degree of anaemia than an equal number of *N. Americanus*. The reader will not, however, be troubled here with a description of the parasites and their habits nor with the course the larvae take in the human host to reach the bowel.

The prevalence of these parasites not only in the tropical and in the sub-tropical regions but also in the temperate zones under favourable conditions should keep any medical man mindful of this dangerous guest while treating patients in the tropics or those coming from the tropics.

Every medical student might have had occasion to see in the post mortem room, the parasites still clinging to the mucous membrane of the jejunum or of the lower part of the duodenum in cases where the subject had been dead only for a few hours, but where the P. M. examination had been long delayed after death, the worms might have been seen loose on the mucous membrane in the above mentioned regions. Their colour might be dark red, brown or grey according to the time that elapsed after their sucking of the blood of their host. In any case the student could not fail to have noticed some punctures, may be with or without slight oozing of blood, in the mucous membrane caused by the bites of these parasites before they moved to fresh sites.

That the sucking of the blood by the parasites and the subsequent bleeding will cause anaemia and its attendant symptoms

in proportion to the anaemia is well-known. It is estimated that a dozen parasites will lower the haemoglobin index by 1%. Daniels considers that the parasites produce a toxin which causes intra-vascular destruction of red cells.

The damage done by the parasites to the mucous membrane is considered to cause also repeatedly renewed bacterial infection; but it may also interfere with the capacity of the mucous membrane to absorb digested food and thus naturally increase the anaemia. It would be unfortunate to think of the possibility of hook-worm infection only after the marked anaemia described in text books is present; for, by that time a lot of constitutional and pathological changes would have taken place making the treatment prolonged and sometimes risky.

Usually it is only anaemia in patients that attracts the attention of a practitioner to make him suspect hook-worm infection. He must remember that in mild cases of infection there may not be any symptoms at all, and those moderately infected do not look anaemic but often complain of mental and physical lethargy, shortness of breath attended with palpitations or there may be only gastric symptoms such as hyperacidity, epigastric tenderness, disinclination to take food or inclination to take more food. There may be slight temperature in the evenings. It is in such and similar cases that the practitioner misses to suspect the hook-worm infection and treats his patients for the apparent symptoms. It should also be remembered that any intercurrent disease such as malaria, does not yield to the usual treatment in a patient who has hook-worm infection unless the infection is eradicated. Even mild ulcers in the skin do not heal in a patient infected by hook-worm. It is only in heavy infection that one sees marked anaemia.

The following cases that came under the observation of the author, will give an

idea how the hook-worm infection is neglected and treated for something else:—

1. An European manager of a rubber estate in Malaya who used to be free from malaria for several years and who had even rosy cheeks, started getting fever. Blood examination showed *B. tertian* parasites. He had regular treatment for malaria, but after short intervals had relapses. His stools were examined and ova of hook-worm were found. Treatment for the expulsion of the hook-worm helped him to get over malaria.

2. An European planter who during his holiday at home was treated by a Harley Street practitioner for digestive troubles and who had temporary relief at the time had a relapse of his digestive troubles when he returned to Malaya. As it was usual to examine the stools of everybody working in plantation, the stools of this planter were examined and hook-worm ova found and the planter was relieved of his digestive troubles after he underwent routine treatment for hook-worm.

3. A young European priest belonging to S. P. G. Mission in Malaya was referred to three eminent European practitioners by the Bishop of the Mission for his complaint *viz.*, general disinclination for work and occasional attacks of fever in the afternoon. He was carefully examined and also his stools and the three practitioners finally thought that he was a neurasthenic and perhaps home-sick and that a holiday might do him good. As the priest was really ill, he lost faith in the three practitioners and on observation it was found that he was suffering from hook-worm infection. Stools were examined six times and at the last examination only ova of hook-worm were detected. This priest was in the habit of visiting the members of his congregation in the rural areas. Suitable treatment was adopted for the expulsion of the ova and the priest continued to work in his congregation very energetically for the next 12 years without any leave for home-sickness.

4. In a rubber estate a register used to be kept in the hospital with a page for every labourer that came in for treatment,

showing the date of admission and the sickness. As several labourers came in very frequently the routine examination of the stool of each patient was made at every admission. When once patients were treated for hook-worm, they generally became much less frequent visitors to the hospital.

5. In another rubber estate, several labourers were coming into the out-patient department complaining of lumbago, pain in the body or slight fever. A labourer loses his wage on the day he does not work. To find the real cause of these troubles, the patients were detained in the hospital till the evening, administered an aperient and the stools examined. Most of such patients showed ova of the hook-worm. Such of the patients who underwent treatment for hook-worm never complained afterwards of any vague symptoms.

6. A practitioner in Malaya serving as a *locum tenens* was very enthusiastic while talking about work, but he always did very little work. He was an honest man, though. The author told him jocularly once, "You must have hook-worm; have your stool examined." He replied, "I will not be surprised if I have." A discussion arose and the *locum* opined that treatment was not necessary in cases of mild infection, that is, cases in which there were no marked signs of anaemia. Suffice it to say that this medical man in whom ova of hook-worm were found, turned out to be active and did very good work after treatment was given.

7. A boy was being treated for tertiary yaws. In the usual course his stools were examined and as hook-worm ova were present, he was given treatment for the same, besides the administration of 914. The case progressed satisfactorily, but even after a long period, a big ulcer that became small refused to show further signs of healing. There was no progress with several kinds of altered dressings. The stools were then examined, and there were still ova of hook-worm. Once again hook-worm treatment was given and the ulcer rapidly healed.

The striking beneficial effects observed in the above cases would convince the

practitioners in the tropics and in the subtropics about the necessity of making a routine examination of stools of all the patients that come for treatment under him. A large majority of labourers employed on the plantations in Malaya come from India, China and Java and in 70 to 90% amongst them hook-worm infection was found, though the recruits looked apparently healthy. Knowing as everybody does that in Indian towns where streets and lanes are allowed to be used as public

latrines, the practitioners can imagine about the widespread infection by hook-worm in India. The practitioners should also realise that the object of treating a patient is not merely to relieve the symptoms of the disease, but to find the underlying causes and conditions that provoke or enhance a particular disease. It therefore behoves every practitioner in India especially those who have much to do with the rural population to examine the stools of their patients as a routine measure.

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FAMILIAL TUBERCULOSIS.

By

DR. KRISHNAN PANA, M.B. & B.S. (Fr.)

Bangalore.

The contagion of tuberculosis from man to man is certain; many convincing instances are reported as to how the tubercle bacillus penetrate and how it comes to the organ most affected, especially the lung. For a long time it was admitted that the germs pre-exist in the organism at birth alone bringing forward the theory of *hereditary tuberculosis*; but, that theory is disputed and an important role is attributed to the contagion of tuberculosis.

The contagion is often observed in conjugal life, and the husband or wife victim of T. B. give out every day an infinite number of the bacillus through his or her sputum; The contamination is not, of course; the only factor that plays the role of tuberculation, as in that case, in a family where the parents are tuberculated, all the children ought also to be tuberculated. But more often than not observation shows that the children are not equally contaminated, some become tuberculous, some do not. From investigations carried out in this country, as well as in western countries, it was disclosed that in a family where the fathers and mothers are tuberculous, the proportion of their children affected with T. B. after contact are 60 to 63 per cent, and the proportion is only 55 to 57 per cent in the case where one of the parents is affected with the disease.

The question of heredity in the tuberculosis was admitted long before the idea of infection originated. Even after the discovery of the bacillus by Kock, to defend that misconception the frequency of tuberculosis in children of consumptive parents was brought forward. Tuberculosis is not inherited. The unfortunate inheritance is simply a tendency to the disease, or a susceptibility of constitution, which increases an individual's liability to the affection. Some authors persist in

considering the T. B. as an hereditary disease, but the severe and astute investigations of Kuss and the latest works of Calmette explain clearly the scarcity of hereditary tuberculosis. The hereditary in the matter of T. B. has only a doctrinal interest; in practice, it does not go further than the laboratory sphere.

The hereditary tuberculosis through infected ovaries cannot be admitted, because no tubercular bacillus was detected in foetus about less than four months old, that is before the placental circulation takes place, and that, not a single investigation had been reported relating to tuberculous infection in foetus through the uterus.

The hereditary infection of paternal origin through spermatic infection is also not acceptable; because firstly, the sperm very rarely contains T. B., its presence in it is not even established; secondly, the possibility of ovular infection by spermatic T. B. had never been demonstrated.

The transplacental contagion on the other hand is considered baseless as proved by experiments on animals and experience gained in human infection.

However, exceptionally cases do exist of congenital tuberculosis with macroscopic lesions, more often there exist foetal bacillosis simply histologic or revealed only by inoculation. These rare positive cases cannot give ground enough to certify the existence of the contagion by this way; Further the clinical arguments advanced in favour of the heredo-contagion are no more convincing, so the heredo-predisposition and the contagion seem to be quite enough to explain the frequency of tuberculosis in children of consumptive parents.

The theory of Baumgarten alleging that the tuberculosis apparent begins sometime after a latent or hidden tuberculous infection is correct, but it is the result of an auto-infection resulting from the existing hidden lesions, which lesions cannot be taken as congenital. They are the result of a contagion. The bacillary heredity of T. B. never exists and we have heard lately Dr. Frimodt Moller, confirming the exactitude of that argument.

It is indisputable that children born to tuberculous parents may have dystrophic disorders as in other wasting diseases, such as syphilis, alcoholism, etc. These disorders are manifested in the form of organic mal-formations as thoracic deformities, lack of growth, mitral or pulmonary strictures etc.; also in digestive disorders or defective assimilation. These heredo dystrophic para-tuberculous manifestations ought not to be confounded with heredo-predisposition. For instance, a child of a phthisical parent without being dystrophic in any way, becomes phthisical, while one belonging dystrophic parents is not affected by the disease.

It seems difficult, however, not to admit a specific predisposition to the disease owing to the effect on the embryo at any period of its development, of soluble products formed in the organism of tuberculars. Clinically amongst the heredo-tuberculars there exists a good many showing all at once a great receptivity to the infection and a ground relatively resistant, their parents having simultaneously transmitted their predisposition as well that special state of resistance. On the contrary, some others are not only exposed to the tuberculosis but once contracted, are resisting the disease much less and often develop serious forms of tuberculous infection. There exist some who, having contracted the disease in their infancy are carriers of tuberculous lesions called hidden lesions, well covered, well encysted. There are others in whom the hidden or latent infection may suddenly burst into an acute infection. Therefore, in assessing infection in children born to tuberculous parents, one should know that there are

factors which determine the mortality of such children apart from the danger of contagion. It is believed by tuberculosis specialists that over 75 per cent of Indian population may have tuberculous infection; yet, all the 75 per cent do not fall a victim to the disease. The same factor applies to children who are the descendants of parents suffering from tuberculosis. There may be hidden encysted infected lesions in the body of the children without any manifestation of tuberculosis just like the presence of seeds of vegetation in a rock or rocky soil which never sprout or grow unless the rocky soil is converted into a fertile one encouraging the lurking seeds to grow. Tuberculosis affects only such of the children who are run down either due to unhygienic surroundings, nutritional defects or due to other intercurrent disease or diseases. The assumption that because the parents with their children live or lived in open-air houses in a country or town cannot make the children immune nor will the infectivity of children born to phthisical parents in cities be more than in those children whose parents live in rural areas. Investigations conducted by the continental workers in anti-tuberculosis campaign have proved that in case of children the tuberculosis infection is not accidental as in adults but always has been from the parents or others living in the family. It is common knowledge that children who appeared hale and healthy suddenly succumb to an attack of tubercular meningitis due to family contamination. In cent per cent of tubercular infection in children, the determining cause can be usually traced to positive familial infection. Tuberculosis in children has never been the result of a casualty or accident; it came directly from parents or any other member in a family. All the same, contamination is not the only factor that gives rise to tuberculosis in children. If that were so, all children coming in contact with contagion in a family should be victims of the disease. Fortunately it is not the case.

Investigations carried out in families of tubercularised children show that, in 175 tubercular families there were 787 chil-

dren, of whom 165 died of tuberculosis; 73 were clinically declared affected with the disease which takes the percentage of morbidity and mortality to 60 per cent. Another investigation gives the following results: there were 88 families of consumptives with 164 children: 75 of those children were ill or died of T. B., the percentage in this case was 45 per cent which is smaller than the first investigation, that is because 82 children of the second families were isolated for several purposes and were not subjected to contamination.

From this, the authors of the above investigations concluded that in a family where the fathers and mothers are tuberculous, the proportion of their children affected with the disease after contact are 63 per cent and the proportion is only 57 per cent in the case where one of the conjoint is the only one affected with T. B.

If we admit the average number of 60 per cent of mortality or morbidity of children of consumptive parents, there remains evidently a minority of 40 per cent children contaminated. We have to admit, that other causes than the bacillus act here in determining tubercular infection in children. And they are, as referred to above—unhygienic surroundings, nutritional disorders and intercurrent diseases such as whooping cough, measles, influenza etc.

It has also to be noted that moderate infection, if well sustained, gives a certain degree of immunity. In between the smaller number of cases which acquire immunity and a much larger number that succumb to massive infection there is a pretty big group of cases who have limited and hidden lesions which are spontaneously cured.

Undoubtedly, a large share of the most serious constitutional diseases from which adults suffer have their foundation laid in infancy. It needs no argument to establish the fact that protection of children from the infection of tuberculosis is one of the most important items in the

campaign against tuberculosis. With healthy children the hereditary tendency to pulmonary disease may be overcome and the contagion uprooted if children are removed from the ground of infection.

It is essential that the descendants of phthisical parents are strengthened to resist the infection by the bacillus tuberculosis.

Even the new born and nursing babies should be taken away from the mothers' care if the latter are consumptives. Those children ought to be taken to an Open Air Institution or permanent boarding houses away from the town and kept under medical control. On the continent, children so isolated have developed in health and strength as well and even better than the children born to non-tuberculous parents.

The contamination of tuberculosis is the important factor and the role of family contagion stands predominant. The separation of the healthy children and their infected parents, relatives or friends at an early date is the best measure of prophylaxis against the terrible scourge of tuberculosis. The children born weak of consumptive parents ought to be advised to be well taken care of even after their separation from parents so that they may be firm on the ground legated to them by their diseased parents.

In conclusion, all those noble-hearted citizens who promptly volunteered to fight the great scourge of the White-Plague with their mite, and those in charge of Tuberculosis Clinics and Sanatoria crusaders of a great cause, have to fight tuberculosis not only at the Tuberculosis Dispensaries and Sanatoria but also in each and every house and each and every nook and corner of the streets where a good number of T. B. stricken beggars live in hovels with as many children amongst them, who are a real and dangerous source of infection. No campaign against tuberculosis can be complete or even satisfactory unless the children of whatever age are separated from an infected family and well looked after.

NOTICE.

Subscribers of The Medical Practitioner are requested to note their registered numbers appearing on the postal wrapper of the Journal while corresponding with the Managing Editor.

Abstracts.

FROM THE INDIAN MEDICAL GAZETTEE, SPECIAL TUBERCULOSIS NUMBER.

October 1940.

The following are the abstracts from The Indian Medical Gazettee which publishes the activities of The Tuberculosis Association of India. The specialists in Tuberculosis who have been associating themselves with anti-tuberculosis campaign conducted by The Tuberculosis Association of India have contributed articles to the Special Tuberculosis Number published by the Indian Medical Gazettee. As The Medical Practitioner is interested in the campaign against tuberculosis, abstracts from the articles appearing in The Indian Medical Gazettee are published for the benefit of the readers of The Medical Practitioner.

The first article is by Dr. C. Frimodt-Møller, Medical Commissioner of the Tuberculosis Association of India. It is about "A Scheme of Control of Tuberculosis in India by Organised Home Treatment." This scheme was published in its entirety in the August 1940 issue of The Medical Practitioner.

CHRONIC NON-TUBERCULOUS INFECTIONS OF THE LUNG.

By A. C. UKIL, HEAD OF THE DEPARTMENT OF CHEST DISEASES, MEDICAL COLLEGE HOSPITAL, CALCUTTA.

The author quotes statistics to prove that even in special tuberculosis hospitals mistakes in diagnosis are made as at the time of admission such patients they showed signs and symptoms not dissimilar to those of pulmonary tuberculosis even including x ray appearances. As examples he mentions the following chronic pulmonary infections which might be confused with pulmonary tuberculosis.

1. *The sequelae of unresolved lobar pneumonia* such as delayed resolution with prolonged convalescence, 'apical catarrh', abscess, bronchiectasis, chronic pulmonary fibrosis and empyema may give rise to signs and symptoms which are confused with chronic pulmonary tuberculosis and pleural effusion of tuberculosis origin. In cases of delayed resolution in lobar pneumonia the mottled x-ray appear-

ance is not unlike that of tuberculous infiltration.

2. *Some sequelae of broncho or lobular pneumonia, due to streptococcus and influenza bacillus*, are more liable to become chronic, simulating changes met with in broncho-pneumonia of tuberculous origin. The location and distribution of lesions, repeated sputum examination of stomach waste sediments in infants and children, blood and x-ray examination combined with the clinical observation should be taken into consideration in arriving at diagnosis.

3. *Chronic bronchitis of infective origin*, the infection being from upper air passages (tonsils, nasal sinuses) damage the bronchial mucosa and walls giving rise to repeated attacks which become chronic and give rise to variety of signs and symptoms simulating pulmonary tuberculosis.

Chronic bronchitis should not be neglected whatever be the age of the patient as bronchitis may be associated with phthisis. Elderly people with chronic pulmonary tuberculosis have signs and symptoms of chronic bronchitis. Careful examination for the presence of sepsis in nasal sinuses and nasopharynx should be made out in addition to repeated investigation of sputum. Radiography of chest and examination of blood should be had recourse to. In majority of these cases, eosinophilia was marked and more in cases of less than one year duration.

4. *Bronchiectasis largely due to infection* may be confused with pulmonary tuberculosis in patients who give a history of hæmoptysis, chronic cough, expectoration, pain in chest and in advanced cases fever, dyspnoea and emaciation. In addition to the repeated investigation of sputum an intelligent history and clinical

observation should help the practitioner in arriving at diagnosis remembering that bronchiectasis may also present itself both in upper as well as lower portions of lungs. The chest skiagraph shows thickened bronchial trunks or honey-combed appearance. Lipoid bronchography would reveal non-tuberculous bronchiectasis in a marked manner.

5. *Chronic Pulmonary abscess* may be the result of pyogenic organisms reaching the lungs from septic foci somewhere in the body of the patient or might have been aspirated from upper air passages. The bronchogenic abscess usually follows pneumonia, influenza or a foreign body; may occur in chronic pulmonary tuberculosis or may complicate a degenerating growth in the lung. Cough of a productive nature, often with blood tinged sputum with certain amount of marked foetor, fever, chest pain and loss of strength and appetite are the most common symptoms. The symptoms may appear intermittently subsiding with the drainage of pus. The sputum associated with abscess is abundant and purulent and if collected in a bottle separates into three layers—a layer of sediment at the bottom, a top layer of frothy mucoid or muco-purulent material and an intermediate layer of thin tubid greyish or slightly sanguinous fluid. Tubercle bacilli are absent in these cases.

Differentiation from pulmonary tuberculosis has to be made from history, signs and symptoms and appearance of tubercle bacilli in the sputum. Examination of nasal sinuses should not be neglected. Lipoid bronchography following bronchoscopic examination should be had recourse to. In chronic pulmonary tuberculosis, extension of the disease may be noticed in the opposite lung unlike in cases of lung abscess.

6. *Some rarer chronic pulmonary infections such as syphilis, hydatid cyst, mycosis* may also be confused with pulmonary tuberculosis. In pulmonary syphilis there are no characteristic symptoms. The usual symptoms are those of chronic inflammatory process in the lung. Radiologically, gummata, unless large enough may not be shown on the x-ray film; so

the diagnosis of the interstitial or indurative form is not characteristic: the following differential diagnosis should rest on the criteria:

(i) A history of primary infection and evidence of lesions elsewhere in the body, (ii) absence of serious symptoms, (iii) persistent absence of tubercle bacilli in the sputum of gastric contents, (iv) positive Wassermann reaction, (v) response to anti syphilitic treatment, (vi) radiological appearances and (vii) general considerations. The author reminds the readers that pulmonary tuberculosis and syphilis may co exist.

Hydatid cyst of the lung may reach considerable size before any symptoms are produced. The right lower lobe is the commonest site. Symptoms such as dry cough, small repeated hæmoptysis, pain in chest and irregular low fever may be present. The case may be seen before or after the cyst bursts into a bronchus and signs may vary accordingly.

Pulmonary mycosis: In this category are included broncho-pulmonary diseases produced by the higher bacteria which include the fungi (Ascomycetes-aspergillus, penicillium, saccharomycetes or yeasts, torula, monilia and oidium; Phycomyces-mucor; and Streptothrix which includes actinomyces). Fungi frequently inhabit the respiratory passages as saprophytes and their presence in the expectoration is not conclusive evidence that they are the organisms responsible for producing clinical symptoms. When present they may complicate the pre-existing disease such as tuberculosis, bronchitis, bronchiectasis, abscess, carcinoma etc. The lesions they themselves produce are so varied and the clinical symptoms may resemble all conceivable lung diseases including those due to neoplasm. Fungus infections may produce changes in the lungs which resemble tuberculosis radiologically and can be differentiated from it by exhaustive bacteriological and other tests. The streptothrix group is the most common and the most important of the fungus diseases of the lung. Biologically the organisms closely resemble the tubercle bacillus and even the lesions which they

produce are similar to those produced by tuberculous lesions. The primary seat of the disease may be the lung or the lung lesions may be secondary to disease of skin, mucous membrane or bones. But constitutional symptoms are much less than what are seen in pulmonary tuberculosis. *Actinomyces* caused by "ray fungus" is probably the best known of the pulmonary mycoses. The lesions are usually unilateral. As the mycotic diseases of the lung resemble several well-organised pulmonary diseases, they can be diagnosed only after a searching investigation, from the history, clinical examination, bacteriological and x-ray evidence. A thorough search for these infections ought to be made in all pulmonary disease that do not fit into one of the accepted diagnostic categories.

Disintegrating or secondarily infected pulmonary neoplasms in the lungs such as carcinoma or sarcoma may, during their disintegrating or secondarily infected stage, present symptoms very much resembling those of pulmonary tuberculosis. Atypical symptoms of pulmonary tuberculosis, repeatedly negative sputum tests for tubercle bacilli, x-ray examination in antero posterior, oblique and later position at intervals of 2 to 4 weeks, bronchoscopic examination and lipoid bronchography are sufficient for making correct diagnosis especially in individuals above 40 years of age.

PULMONARY TUBERCULOSIS AND DIABETES MELLITUS.

BY P. V. BENJAMIN, MEDICAL SUPERINTENDENT, AND U. C. VERGHESE, FIRST ASSISTANT, UNION MISSION, TUBERCULOSIS SANATORIUM, AROGYAVARAM NEAR MADANAPALLE.

The authors base their observation on cases treated at the Arogyavaram Sanatorium for a period between 1918 and May 1940. Out of 157 cases observed by them 133 were men and 24 women. They suggest that diabetic patients after the age of 35 should always be looked for tuberculosis infection.

Type of tuberculosis as studied by x-ray do not seem to be different from that

usually seen in non-diabetic patients excepting that the exudative process is more severe and the lung shows thick shades similar to lobar pneumonia.

Regarding treatment the outlook has completely changed after the advent of insulin and artificial pneumothorax and other measures of collapse therapy. To get good results both tuberculosis and diabetes have to be treated simultaneously. If the diabetes cannot be controlled by diet alone, insulin has to be given remembering that the diet should be more generous. Collapse therapy should be had recourse to in all cases where it is indicated as in non-diabetic patients so also gold therapy. If diabetes is carefully regulated, even surgery is no more dangerous than in the average non-diabetic case. After results of the treatment are not good, Hemoptysis was seen more frequently than in the non-diabetic growth.

SPONTANEOUS PNEUMOTHORAX.

BY W. G. JONES, WANLESS TUBERCULOSIS SANATORIUM, WANLESSWADI DISTRICT, SATARA.

The author describes three kinds of pneumothorax, induced (artificial) or therapeutic, spontaneous or that produced without external influence and traumatic caused by external influences. For all practical purposes he thinks it is enough to recognise two kinds: spontaneous pneumothorax due to some pathological changes and he reserves the spontaneous idiopathic pneumothorax for those cases where there is no evident cause for this condition especially those associated with a focus of necrosis close to the visceral pleura and says that this condition is in majority of cases due to pulmonary tuberculosis. In children, it might be due to broncho-pneumonia, whooping cough, asthma and similar conditions when there is violent cough. The cause of idiopathic pneumonia is not known.

The chief symptoms of spontaneous pneumothorax are pain in the chest, dyspnoea and shock or there may be no symptoms at all. Spontaneous pneumothorax is a most common and serious complication in pulmonary tuberculosis.

Its frequency is said to be in 10 to 14 p.c. cases of tuberculosis. The author warns practising physicians treating tuberculosis by artificial pneumothorax that pressure by air in therapeutic pneumothorax should not be either excessive or negative but should be within physiological limits. Empyema, patent broncho-pleural fistula, congestive heart failure are the complications to be guarded against. Mediastinal displacement may seriously embarrass a weakened heart or an already over burdened good lung. Dyspnoea may be present though not complained of. There may be a lag in the movement of the lung on the affected side, obliteration of intercostal spaces hyper resonant percussion note on the affected side, shifting of the position of the heart. In severe collapse of the lung causing bronchial closure, the breath sounds may be absent.

In idiopathic pneumothorax, chief treatment is rest in bed with morphia for the pain and dyspnoea. Deflation may be necessary when there is positive pressure for recurrence intropleural injection of dentrose is said to seal the rent in the pleura. In tuberculous cases, the first treatment is to relieve dyspnoea by removing sufficient air, oxygen may relieve anoxemia if present. Fowler head-up position is preferable to the head-down position. In less violent cases when it is supposed that there is a small tear, effusion may be induced by the injection of dentrose or sterile olive or paraffin oil 5 to 10 c.c. Effusion should not be aspirated as it will aid in blocking the pulmonary tear; if effusion causes distress a small amount may be aspirated whenever necessary. The author is of opinion that superimposed pneumothorax brought about by therapeutic pneumothorax does not indicate its abandonment. Many cases recover and are none the worse. In cases where there is a tendency of the complication of empyema, the author advises thoracoplasty. He also says that certain cases of spontaneous pneumothorax yield to the crushing of the phrenic nerve. He does not favour the idea of deflation by the ordinary method described in books i.e., inserting of a catheter into the pleural space leaving it open slightly

below the patient's level into a weak antiseptic lotion. The author has devised a special apparatus for this purpose, the use of which is said to give very good results.

TREATMENT OF TUBERCULOUS EMPYEMA.

BY DR. G. SAMUEL, AG. MEDICAL SUPERINTENDENT, WANLESS—TUBERCULOSIS SANATORIUM, WANLESSWADI, SATARA DISTRICT.

The author follows Hedblom's classification of tuberculous empyema:

Group I.—Pure tuberculous empyema without pulmonary tuberculosis.

Group II.—Mixed tuberculous and pyogenic empyema without pulmonary tuberculosis.

Group III.—Pure tuberculous empyema with active pulmonary tuberculosis.

Group IV.—Mixed tuberculous and pyogenic empyema with active pulmonary tuberculosis.

Indications for the treatment of tuberculous empyema:

1. If the underlying lung is tuberculous and requires thoracoplasty for itself, then the empyema (and the lung) should be treated by thoracoplasty.

2. If the underlying lung is not diseased or if it is tuberculous and for itself does not require thoracoplasty, the tuberculous empyema should not be treated by thoracoplasty unless aspiration treatment fails.

3. Thoracotomy should be used only when mixed infection exists and high toxæmia therefrom. It should then be done immediately.

Aspiration treatment: Aspiration once or twice weekly, with air replacement under negative pressure controlled by x-ray examination twice monthly, is advisable. Should any four consecutive films show no appreciable decrease in the pleural cavity, thoracoplasty should be done immediately.

Where thoracotomy and thoracoplasty are both indicated the thoracotomy should be done first, since the patient is thereby put in a much better condition to tolerate the thoracoplasty.

Thoracoplasty for tuberculous empyema is different from that done for pulmonary tuberculosis because: (i) the patients are frequently much poorer risks for surgical shock, (ii) the collapse must be much more complete and calls for much more extensive decorticalization.

We divide the operation into 5 or 6 stages if necessary. We remove the full length of all ribs including the seventh; also in many cases the posterior half or two-thirds of the remaining ribs, exclusive of the twelfth rib. Ribs are removed extra-pleurally, beginning from above downwards. The periosteum of each rib is thoroughly treated with 10 per cent formalin throughout the entire length (instead of only in the posterior part, which is our custom in pulmonary tuberculosis). Sometimes extra-pleural thoracoplasty alone does not entirely obliterate the cavity, then Schade thoracoplasty has to be used for the treatment of the remaining cavity.

The records of the sanatorium contain 17 case reports of tuberculous empyema. Of these, 4 were treated with aspiration alone, 10 with thoracoplasty and 3 are still under treatment. It is too soon to report the results in the former: in the latter 8 cases (80 per cent) have obliterated cavities and completely healed wounds. One death occurred among the thoracoplasty group making a mortality of 20 per cent. The aspiration shows no mortality.

Mortality. Our mortality figure, 20 per cent for treatment with thoracoplasty, is happily low. For example, recently Mattill and Jennings gave a mortality of 33 and 1/3 per cent which is about the rate usually given. We ascribe our high survival rate to the early use of thoracoplasty and more especially to the use of many small stages in the operation. Delay and procrastination in applying radical measure cost human life, especially

in mixed infection when the toxæmia rapidly lowers resistance (to surgical shock) by producing amyloid degenerative changes in the liver, kidneys and adrenal glands.

TUBERCULOSIS IN WOMEN: PREGNANCY AND TUBERCULOSIS.

BY L. S. GHOSH, PROFESSOR OF MATERNITY AND CHILD WELFARE, ALL-INDIA INSTITUTE OF HYGIENE AND PUBLIC HEALTH, CALCUTTA.

The author concludes:

Two forms of tuberculous attack seem likely to affect appreciably the fertility of women of child-bearing age, tuberculous salpingitis and secondary, toxic (sclerocystic) changes in the ovaries, the latter met with frequently in tuberculous disease although not pathognomic of such.

It is not clear to what extent the menstrual irregularity, which features in a considerable proportion of tuberculous women, is significant as an indication of the progress of the disease and the extent of ovarian disturbance.

The importance of considering separately the effects of pregnancy, delivery, and the puerperium upon the course of the disease is stressed.

A study to assess the influence of pregnancy and parturition upon the tuberculous woman with special reference to factors such as early puberty, early and frequent child-bearing, unsatisfactory diet, inadequate rest and medical care, is urgently needed. A sanatorium project with this aim, improved control of patients in the homes by development of the system of care by the generalized health visitor, and standardized reports by private practitioners are suggested as possible approaches to the problem.

As a tuberculous pregnant woman should be under the care of a phthisiologist throughout pregnancy and for six months after delivery, the provision of ante-natal beds for tuberculous women in maternity hospitals and the appointment of honorary phthisiologists to such institutions is

suggested. It is pointed out that delivery in every case should be undertaken by an obstetrician having at his disposal efficient medical resources to reduce muscular strain, shock and haemorrhage, and to arrange for the protection of the infant from infection by the mother.

DIET IN TUBERCULOSIS.

BY K. S. RAY, SUPERINTENDENT, TADABPUR TUBERCULOSIS HOSPITAL, (BENGAL) AND N. N. SEN, ASSISTANT SUPERINTENDENT, TADABPUR TUBERCULOSIS HOSPITAL, (BENGAL).

The authors after criticising the old views on overfeeding of tuberculosis patients with the idea of increasing the weight, mention that increase of weight by itself is not the criterion to judge the improvement in the patients but the increase in weight must be consistent with the improvement in the physical signs and symptoms.

They then discuss about adequate and balanced dietary and advocate a standard of balanced diet with a value of 3,000 calories a day. Besides the requisite caloric value they insist that the food should contain all proximate principles—protein, fat, carbohydrate, vitamins and minerals.

In India where people are mainly vegetarians, milk is the chief source of protein and non-vegetarians are advised to use mutton, game, poultry and fish, the last is a cheap source of easily assimilable protein. Proteins are said to increase respiratory activity and excess of protein diet is to be avoided. Fat unlike protein and carbohydrate does not increase the volume of respiration but inhibits gastric secretion and is not well borne by most patients. It does not possess any specific healing power. Fat in excess should be avoided. Butter is liked by most. Ghee and vegetable oils used for cooking, supply fat and make the food more appetizing. Carbohydrates increase weight more than fat and play an important part in body building.

Vitamins A & D are credited to give the patients suffering from phthisis increa-

sed resisting power. They are derived from fatty food and in addition may be supplied by prescribing cod liver oil adexolin, haliverol etc. Vitamin C must also be taken in the form of oranges or dry ascorbic acid. Cereals combined with green vegetables supply all mineral salts. Condiments may be used in moderation depending on individual taste. Excess of it is apt to upset digestion. Milk and eggs are highly spoken of in the dietary of the consumptive. A quart of milk is equivalent in food value to a pound of lean meat or 8 eggs. Though milk in large quantities is a good food for growing children, Indian patients usually develop flatulent dyspepsia if milk is taken in excess. So enough milk compatible with the patient's digesting capacity should be allowed. Eggs are rather hard for digestion when taken raw. They may be taken, fried, scrambled and boiled. For Indian patients not more than 2 eggs should be given a day. Variety should be the chief factor in regard to diet. Mixed diet containing variety of elements properly cooked, artistically served in dishes, spotlessly clean is the ideal to be followed.

Daily menu: A fixed daily menu should be avoided. Small frequent meals will not give rest to the stomach. Four meals—two principal meals at 11 A.M. and 7 P.M.—is the course recommended.

Half an hour rest before each meal is of great importance. Smoking before meals should be prohibited. If patient is not happy without smoking, it may be permitted after food. Fluids should be taken between meals and not with meals.

"The following is the daily menu for full diet for Indian patients:—

7 A.M.—Buttered toast; half-boiled, scrambled or poached egg; dalia or oatmeal porridge, milk.

11 A.M.—Rice, vegetables curried or boiled; dal; meat curry or stew; chutney; dahi; lemon.

4 P.M.—Milk; fruit; sweets.

7 P.M.—Rice, chapati or luchi; vegetables fried or curried; dalfish curry; milk.

The following list shows the quantity of raw foodstuffs supplied per patient per day at the Jadagnur Tuberculosis Hospital:—

Diet.	Weight.
Rice and atta	... 12 oz.
Dal	... 2 "
Meat	... 4 "
Fish	... 2 "
Bread	... 3 "
Milk	... 24 "
Dahi	... 4 "
Egg	... one
Fruit	... one item.
Butter	... ½ oz.
Ghee	... 1 "
Mustard oil	... 2 "
Potatoes	... 6 "
Green vegetables	... 8 "
Sugar	... 2 "
Lemon	... one

Salt and condiments as required.

The diet, as set forth above, contains approximately 125 gm. of protein, 130 gm. of fat and 470 gm. of carbohydrate and yields about 3,500 calories. The above calculations are based on the quantities of crude foodstuffs and, allowing 500 calories for preparation and cooking, the diet gives about 3,000 calories which is the standard requirement. The cost, excluding the pay of the cook, comes to about 12 annas per head per day.

Diet in complications: (i) In Haemoptysis: Where the sputum is only streaked with blood or the haemoptysis is slight, a little curtailment of the diet is all that is necessary. When the bleeding is active and severe, all solids should be withheld and all feeds should be served cold. Milk diet (2 to 3 pints a day) is usually recommended, but as pure milk does not agree with most patients, it may be conveniently mixed with barley water or fruit juice, or served as ice cream. Gelatin given in the form of jelly is supposed to increase the coagulability of the blood and will be welcomed by many fastidious patients. Twenty four hours after the bleeding has stopped, pudding and porridge may be given even if the patient is bringing up clots. Resumption of ordinary diet should not be too long delayed, as absence of proper nourishment will only help in the spread of the disease.

(ii) In *tuberculous enteritis*:—A pure milk diet is recommended by some, but as milk does not agree with most of the patients it is better avoided. Dry milk preparations are, however, digested by many. Milk may also be given as *dahi* beaten up with water into a drink. Sometimes proprietary milk foods like Horlicks malted milk are better tolerated.

To avoid irritation of the ulcers roughage should be reduced to a minimum. Strained vegetable soup and mashed potatoes serve the purpose well. We combine this with soft rice and lean fish. In no case should vegetable or fruit pips be allowed to be swallowed.

All experts agree in giving a high calcium and high vitamin diet. Food calcium is supplemented by calcium injections. Two ounces of orange juice with ½ ounce of cod-liver oil or a few drops of adexolin or haliverol should be given 3 or 4 times daily. When oranges are not available, tomatoes may be substituted.

(iii) *Laryngeal tuberculosis*:—Special dieting is called for only when there is dysphagia. When this condition develops, the throat should be anaesthetized with cocaine or orthoform before giving foods. When dysphagia is at all severe, pasty, semi-solid foods like porridge or pudding are swallowed with greater ease than either solids or liquids.

A PSEUDO-TUBERCULOUS CONDITION ASSOCIATED WITH EOSINOPHILIA.

By C. FRIMODT-MOLLER, MEDICAL COMMISSIONER TO THE TUBERCULOSIS ASSOCIATION OF INDIA AND R. M. BURTON, PATHOLOGIST, UNION MISSION SANATORIUM, AROGYAVARAM NEAR MADANAPALLE.

The authors describe a condition simulating pulmonary tuberculosis in signs, symptoms and even in x-ray appearance, but not actually tuberculosis and where eosinophilia is an important factor. They call this condition as pseudo-tuberculous condition and admit that they themselves wrongly diagnosed such cases as tuberculous in the beginning. They call this

condition as, "Eosinophila lung." It is characterised by an extensive mottling over both lung fields, usually evenly distributed, the size of shadows is about 2 m.m. with a certain amount of increased striation. The general condition is similar to miliary tuberculosis or to silicosis.

The investigation began from the year 1925 and 600 patients were the objects of observation. In all these an eosinophile percentage of 20 or more as much as 90 percent. was observed. In none of the tubercle bacilli—positive cases there was a typical "eosinophile lung." These were more in number in the males than in females but regarding age there was not much difference excepting the fact that the youngest were more than the oldest. Cough, fever, sputum, loss of weight, pain in chest, haemoptysis, asthma or bronchitis, loss of strength were seen in these cases, the number under each category of symptoms were in the order they are mentioned above, the highest number being under "cough" the lowest under "loss of strength." It was found by the authors that in their series those having intestinal infection did not show "eosinophile lung" with as high a percentage of eosinophiles in the blood as in cases where the intestines were free from infection. *Tuberculin test* also demonstrated that the "eosinophile lung" was generally free from tuberculous infection. Pneumoconiosis has been ruled out as all the patients in the series were not engaged in dusty occupations.

The authors come to the conclusion that the condition may be allergic in origin and stress upon the importance of blood-differential counts in the diagnosis of doubtful cases of tuberculosis.

MODERN MEASURES IN THE MASS CONTROL OF TUBERCULOSIS IN THE UNITED STATES OF AMERICA.

By S. R. A. SHAH, PUBLIC HEALTH DEPARTMENT, PUNJAB.

The author depends upon his experience gained in America and he concludes his observations by saying:—

Before the bacterial origin of the disease was known the public health campaign

against tuberculosis lacked specific direction. Emphasis was laid on the unfavourable conditions of life that helped in producing this disease. With the discovery of the tubercle bacillus the communicable nature of the disease was established, but it took almost two decades before this fact was fully appreciated.

More recently extensive studies on the exogenous mode of infection in human beings and virtual eradication of bovine tuberculosis in the United States have brought the contagious nature of the disease to the fore, and have led to the attention being focussed on the elimination of the opportunity for infection in the mass control of tuberculosis.

The key-note in the modern anti-tuberculosis campaign is to find the open cases of tuberculosis and, having found them, to isolate and treat them. A constant and proper correlation between case finding and case-supervision is essential for the successful conduct of the programme. This is best achieved by having a unified control over the two activities. A close co-operation between the medical practitioner, philanthropic organizations and the governmental public health department is further necessary for the success of the programme.

In the finding of cases, when the means at our disposal are limited, it is best to concentrate on groups likely to yield the greatest results. Examples of such groups are contacts of open cases, inhabitants of congested areas, workers exposed to silica dust, and adults.

School surveys are not a fruitful means of case-finding, but can help in locating source cases in communities where infection rate is not very high.

Tuberculin-testing all members of a community and x-raying the positive reactors is perhaps the best method to detect cases. X-raying is still a very costly procedure. Alternative methods are being devised to cut down the costs without affecting the efficiency in diagnosis.

The isolation of open cases in a sanatorium is of the utmost importance in the

mass control of the disease. A standard of two sanatorium beds per annual death is considered the bare minimum requirement. Where the standard cannot be achieved certain compromise measures are adopted. Treating tuberculosis cases in general hospitals is becoming increasingly popular.

Collapse therapy is now looked upon not only as an individual therapeutic measure, but as a public health procedure of great significance. With its aid, cavities get closed and sputum is rendered negative much sooner than is otherwise possible. This cuts down the spread of infection and also enables the hospital beds to register a quick turn-over of cases.

The after-care of the discharged patient and his rehabilitation into the community are as important as the treatment, but, while the treatment is the best developed and the most successful part of control programme, the follow-up and rehabilitation are the most difficult and least developed phases of the campaign. Vocational training and sheltered occupations seem to hold the best for a solution of the perplexing problem of rehabilitation.

Private practitioners constitute the first line of attack. To be able to diagnose early cases and to administer the latest forms of treatment call for their special training. It is still more necessary in the case of physicians who are to run clinics, hospitals and sanatoria which form the most vital part of anti-tuberculosis programme.

Legislation of 'enabling' and 'coercive' types is considered necessary in the United States to empower the governmental bodies to provide necessary facilities and to enforce such measures as aim at preventing the spread of infection.

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[No. 2

REORGANISATION OF MEDICAL SERVICES.

HONORARY SYSTEM—IV.

DISCIPLINARY CONTROL.

Last three months we utilised these columns for the discussion of the details of Honorary System and expressed our views relating to the nomenclature, qualifications, selection and term of office of those to be recruited in this service. The last but not least important item in regard to Honorary Service is the disciplinary control over those recruited for this service. At present the superintendents of the hospitals are the immediate superiors who report about the work of honoraries and their conduct to the Surgeon-General who is the adviser to the Government in matters relating to the Medical Department and the medical profession. Such reports are at times treated confidential. So long these reports are favourable nothing could be said of them; but when they are adverse and confidential and an opportunity is not given to such of those honoraries whose reports are not favourable and action taken on the adverse reports, the honorary have a reasonable and just grievance. The independent medical practitioners from whom the honoraries are recruited depend entirely on their reputation both in their professional skill as well as character, and not on fat salaries,

consequently when any action is contemplated on the adverse reports against much greater care and consideration should be bestowed than in the case of the paid staff. Unfortunately the reverse has been the rule at least in some cases that came to our notice. We can mention one such instance which took place in the premier institution in the City of Madras, and which was the subject of a libel suit against a leading daily whose Editor inadvertently made some remarks relating to the termination of services of two hon. Asst. Surgeons. It was alleged at the time the two honoraries received the order, terminating their services, that some officer must have made an adverse confidential report against them. But at the time of the hearing of the libel suit, in the Madras City Civil Court, the allegation could not be proved. The fact that till the time when the services of the two were terminated by the Government, none in the honorary service was served with a similar notice, was likely to create unfavourable impressions about them. There are a number of instances in paid service when the Government punished their medical officers for dereliction of duty or bad conduct. But service rules are so stringent that even the most humblest menial cannot be punished without an enquiry and even when punished after an enquiry, there are several grades of punishment before their services are terminated.

In regard to honorary staff there is only one and the final punishment and that is the termination of services. This apart, the paid staff do not in many cases suffer materially as there are items of punishment which do not interfere with their pay and other emoluments but in case of honoraries the one and the only punishment of termination of services materially affects their prosperity and even their future career. These circumstances should be taken into consideration and a suitable method should be devised which while dealing with the conduct of the honoraries, does not expose them more than necessary.

The policy of the Congress Government in fixing the tenure of office of the honoraries to five years, has been a subject of adverse criticisms by a section of official members of the medical profession. They complain that in regard to honorary medical officers working in hospitals attached to medical colleges, the tenure should be for a period till the honorary attains the age of 55 years or until perhaps he is found physically fit to continue his services. We are glad that the present Government seem to continue the policy of their predecessors. It was not suggested in the G. O. relating to the honoraries who finished their tenure of 5 years that they should not be re-entertained even when competent medical practitioners were not available to fill a vacancy that had occurred after a previously appointed honorary had finished his five years term. We did appreciate and even commended this policy when the Congress Government was in power and now appreciate the action of the present Government in re-entertaining an old honorary whose services were terminated about a couple of years ago and who was recently appointed in the place of another who completed his 5 years term.

This re-entertainment would have been less controversial if it were not mentioned in the order that the term of office of this old honorary was to continue till his 55th year. The latter condition has given room for musings and every one who is interested, muses in his own way and gives expression to his thoughts, appreciating or denouncing the present or the past Government. We should say that the five years term is a safeguard which could be taken advantage of by the honorary as well as by the Government. The Congress Government was even over-cautious in prescribing a probationary period of two years to the honoraries so that an unwanted honorary could be sent home quietly. This extra caution was perhaps too much in regard to honorary service of 5 years tenure. Probation is justifiable in paid permanent service where an officer once appointed cannot be removed as easily and without any ceremony as is the case with honoraries. Such and similar safeguards did not exist in the past and consequently the rigidity of reports against the honoraries open or confidential should give place to open advice in the spirit of reformation. Privilege of private practice enjoyed by whole-time medical officers is certainly incompatible with the spirit, inherent in the confidential reports. So long as all the Government medical officers are not saints and cannot be made saints, want of good faith breeds its equivalent which in its turn mars the truthfulness of the reports of whatever nature. It is indeed a fortunate circumstance that for the period when the honorary service has been gradually extending, the successive Heads of the Medical Departments came from provinces outside Madras to whom honoraries have been as little known as the paid Indian medical officers in service and consequently the tendency for bias and

bad faith was very much less than it would have been if the Heads of the Medical Department were officers who rose to this high position from amongst the I. M. S. officers working in this Province. So long the superintendents of the hospitals are as active practitioners as the honoraries are, there is bound to be interested reports due to want of healthy understanding. We have been repeatedly pressing for a most needed reform to combine the post of superintendents of the general hospitals and the principals of medical colleges into one so that the officers in charge of these combined posts mind nothing else excepting the administrative and disciplinary control over both the institutions without being entrusted with the teaching work and not being allowed the privilege of private practice of whatever nature. If this reform is given effect to, it will be possible for this officer to have healthy control over the honoraries also and there will be more peace and efficiency both in hospitals as well as the medical colleges; the evolution of the medical profession would be more scientific and less materialistic. Till this reform is brought about, it will be unnatural to entrust the immediate control over the honoraries to the superintendents of the hospitals or the district medical officers. We would suggest committees consisting of the superintendent of a hospital an honorary of the same institution, a member of the Madras Medical Council (to be nominated by that Council) and a member of the medical profession nominated by the honorary for the time being when he is reported to the committee.

The chairman of the committee should be the Surgeon-General and in the mofussil hospital, a nominee of the Surgeon-General. In each hospital a panel of two honorary medical officers should be brought into existence every year to be elected by all the honoraries in that particular hospital, who is to serve as a member in the above committee. If the verdict of the committee is unanimous, it should be given effect to. If not, the majority and the minority opinion should be communicated to the Government whose decision should be final. In case of honorary officers below the rank of Honorary Physician or Surgeon the preliminary committee for investigation of reports should consist of the superintendent of the particular hospital, the seniormost honorary officer working in the same institution and a medical man to be nominated by the honorary complained against. The report of this committee should be submitted to the Surgeon-General for necessary action. There should be a provision for appeal to the Government against the order of the Surgeon-General which should be submitted to the Government within a month from the date of his decision. There should be no confidential reports at all against the honoraries. Reports of whatever nature should be made to the committees. We trust all concerned in the evolution of honorary system of medical relief would realise that the position of the honoraries is quite different from that of the paid medical officers and that the former officers should be treated in a way worthy of the responsible position they have to occupy in future.

News and Comments.

Medical Council of India: The Associated Special Service published some news last month about the affairs of the Medical Council of India and Dr. B. C. Roy's reply to critics, which he made from the chair while presiding over the last meeting of that Council at New Delhi. It was said that the Council had decided to establish a General Reciprocity Board for negotiating reciprocal recognition of Medical Degrees granted in British Dominions and other foreign countries and to request the Central Government to amend the Indian Medical Council Act, 1933, so as to provide for an all India Medical Register in which will be registered all practitioners, recognised at present by the Medical Council of India and practitioners holding qualifications granted by examining bodies in India other than the Universities and who will be in the Provincial Registers on December 31st, 1947. In the meanwhile, the Medical Council of India intends suggesting to the Central Government to call upon the Provincial Governments to establish uniform standard of University Medical Education in the existing Medical Schools.

In regard to the critics who questioned the utility of Indian Medical Council Act, 1933, Dr. Roy was of opinion that their criticisms were mostly destructive rather than constructive when they said that the Council failed to secure "efficiency at home and honour abroad". At the same time, Dr. Roy admits that, "*our honour abroad is rather at discount*" as a large number of countries with whom the Medical Council of India had been negotiating for reciprocity did not care to reply and some that replied said that they would recognise the degrees if such degrees were recognised by the General Medical Council, Great Britain, which recognition Dr. Roy styles as, "indirect reciprocity". We ask Dr. Roy whether he was justified in condemning the critics who questioned about the utility of the Council of which he is now the President.

In regard to the publication of an All India Register contemplated by the Council we wish to remind Dr. Roy that this

question had been discussed threadbare and given up by the Central Government when the Indian Medical Council Act was on the anvil of the Central Legislature as at the time it was sightly thought that it was unjustifiable to exclude from the contemplated Register practitioners who formed the largest section in the medical profession and were recognised by all the Provincial Medical Councils. Where is the efficiency in the medical profession which Dr. Roy claims, to justify the existence of the Indian Medical Council when this Council minds only about the minority members of the profession leaving out of recognition a much larger section of its members. This apart can Dr. Roy or his comrades in the Indian Medical Council assure the Medical Profession and the public that it would be possible for the Central Government to force the Provincial Governments to transform all the existing Medical Schools into institutions to be recognised by the All India Medical Council when it is so painfully known that the same Council would not recognise the Andhra Medical Degree in spite of the fact that the Council found both the teachers and the taught in the Andhra Medical College not wanting. Dr. Roy should also remember that the Government of the Province from where he hails and where are found the largest number of Medical Schools, would not consider the desirability of closing them in spite of a large number of these Schools being found most inefficient by the Medical Council of Bengal and also by the Medical Profession in Bengal. Dr. Roy must know that the purpose of a Medical Register is not to display the qualifications of those found in the Medical Register but to enable persons requiring medical aid to distinguish qualified from unqualified practitioners as could be seen from the preamble of the British Medical Act which runs thus:—

"Whereas it is expedient that person requiring medical aid should be enabled to distinguish qualified from unqualified practitioners: be it therefore enacted by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords, Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows....."

All the Provincial Councils maintain Medical Registers to enable the public to find out who is qualified and who is not. Regarding efficiency in the profession the same Councils have statutory powers to control medical education both in Schools and Colleges.

Under the circumstances the Medical Council of India with Dr. Roy as its head will do well to seriously consider whether there is a need for such a Council to exist at all and if it should exist whether it should not co-ordinate its functions with those of the existing Provincial Councils instead of its working independent of them. It costs this poor country over a lakh of rupees every year to run the show of the Indian Medical Council which has no funds of its own and depends entirely on the central finance.

Facts versus Law: The readers might remember that we commented in these columns last February in regard to the decision of the learned District Munsiff of Tiruturaipundi in a suit where the contending parties were Dr. Subbaraya Bhat, subsidized rural practitioner, Kilayur, Tanjore District, the plaintiff; and the Government of Madras represented by the Collector of Tanjore and the District Board, Tanjore, represented by its then President Mr. Subbaraya Chettiar, the defendants.

"The Plaintiff allegations are:—The plaintiff is the rural medical practitioner in charge of the allopathic dispensary at Kilayur since 1925. It was established by the defendants under the subsidy scheme. The parties entered into an agreement finally in December 1937. The object of the scheme was that medical practitioners should make the villages their home and settle there permanently and that no dispensary Allopathic or Ayurvedic should be brought into existence in a village where a medical practitioner has settled. In pursuance of this avowed policy of the Government, the plaintiff has, restricting his ambition, settled down as a rural practitioner and has spent the vigorous period of his life. He has put up his own dispensary building at a cost of Rs. 2,000 and has acquired other immovable properties. Under the agreement the dispensary cannot be abolished except for financial stringency or converted into one of another kind; and the plaintiff cannot be sent out except for misconduct or inefficiency. But for some political reasons, the District Board wanted to get rid of the plaintiff and in order to achieve that object, it issued 3 notices to the plaintiff terminating his services for different reasons. In the first notice

dated 30th June 1937 it was mentioned that the Kilayur dispensary was proposed to be converted into an Ayurvedic one; in the second notice dated 6th January 1938 it was stated that the dispensary had to be closed as it was too near to the dispensary at Tiruppundi; and in the last notice dated 24th July 1938 it was said that the District Board had resolved that the rural dispensary was to be converted into an Ayurvedic one and that it had also been approved by the Government. The resolution passed by the Board for the issue of the third notice to the plaintiff was not validly passed as the subject was not in the agenda for that meeting and the notice by the President is also not proper under the bye-laws. Great inconvenience, mental worry and damage will accrue to the plaintiff if the notice is given effect to and the plaintiff is entitled in law to the reliefs prayed for.

"The Government state that its action as administrative authority placed over the District Board by the State cannot be questioned by the plaintiff in a Civil Court, that the contract of service entered into by the plaintiff with the District Board is certainly terminable, that the District Board, for administrative reasons, has thought fit to terminate the services, that the Government as an administrative superior approved the action of the Board, that in a dispute between the District Board and the plaintiff in respect of certain matters arising under the agreement, namely, whether the agreement could be terminated by the District Board in the circumstances of the case and if so, how many months' notice should be given, the Government gave a decision under clause 13 of the agreement and that decisions of the Government are binding on the plaintiff.

"The contentions of the District Board are: The agreement dated 21st February 1937 was not subsequently renewed and the District Board did so purposely for valid reasons. There is therefore no completed renewed agreement in December 1937. The last agreement mentions that the plaintiff is to practise for a period of not less than a year and thereafter for such period as may be agreed upon between the parties but after the expiry of the period of a year, the parties have not agreed as regards the period for which the plaintiff's appointment has to be extended. The Plaintiff, therefore, has no right of suit on the basis of an incomplete agreement. The dispensary is sought to be converted into an Ayurvedic one in response to popular representations. The District Board *bona fide* resolved at its meeting on 28-5-1938 to abolish this dispensary and to establish in its place an Ayurvedic dispensary. This step was taken neither in the personal interest of the members of the Board nor with any political motive behind it. The notice was issued under instructions from the Government. The resolution of the Board dated 28-5-1938 is neither illegal nor invalid. As the action of the Board has been approved by the Government in G. O. No. 2606 P. H. dated 19-7-1938, it is binding on the parties and the plaintiff cannot question the validity or otherwise of the same or can it be

agitated in a Court of law. The plaintiff is not legally entitled to the relief of injunction."

The learned Munsiff declared on 31-1-1940 that the notice of the District Board terminating the services of Dr. Subbaraya Bhat was invalid and in the course of the judgment observed that under clause 13 of the agreement the decision of the Government was final if they related to the terms of the agreement and if it was outside the terms of the agreement, the Civil Court could interfere and render justice to the aggrieved party.

Against the judgment of the District Munsiff the contending parties preferred an appeal to the East Tanjore District Court and the District Judge pronounced judgment on 25-9-1940 modifying the the lower Court's judgment materially, all the same declaring that the notice of discharge of the plaintiff was technically not valid and proper and binding on the plaintiff to the extent his services would be terminated within a year stipulated in the agreement but it none the less operated as a notice for determining his services soon after the agreement year.

The District Judge penetrated into legalities so thoroughly that he brushed aside the principles of equity and declared that, *a court was not entitled to go into hopes, intentions and aspirations of the Government regarding the Rural Medical Relief Scheme unless the nebulous ideas and aspirations are translated into effective legal phrases in the contract governing the relations between the parties.* When the counsel for plaintiff contended 'that if the Government order expressing hopes and intentions of the Government regarding rural medical practitioners and their permanent settlement in rural areas, were to have no effect.....no man on earth would hereafter place his trust in Government Orders.' The learned District Judge observed "that a Court cannot take into consideration such an argument of shibboleth, like 'put not your trust in princes, put not your trust in Government Orders etc.,' for arriving at the correct legal interpretation of contracts wherein the Government Orders are not expressly made a part". The learned District Judge found fault with the learned District Munsiff for his referring to the preamble of the Government Order relating to the inauguration of the Subsidized

Rural Medical Relief Scheme where it was said that the object of the scheme was to encourage qualified practitioners to settle in the villages permanently and said in the course of his judgment, *"It may be a generous act on the part of the Government to render to the plaintiff that which he could not get legally under the terms of contract. But the law courts are not concerned with such acts of magnanimity, pity, special grace and liability and have to construe the terms of a contract strictly and in cold blooded detachment."* Such and similar trends of legal justifications are seen in abundance in the judgment of the learned District Judge whom law did not permit to utilise humane principles of equity. We cannot pretend to have knowledge of law to the extent possessed by those who practise law or interpret law as judges but from a common sense view it seems to us that the notice served on the practitioner for terminating his services on the ground that the District Board wanted to convert the Allopathic Dispensary into an Ayurvedic one cannot be binding on the practitioner as such a contingent condition could not be found in the agreement relied upon by the judge. If no reason was assigned and the notice merely mentioned that the services of the practitioner were to be terminated because one year term mentioned in the agreement elapsed, the notice would have appeared legally genuine in the strict sense of law applied by the learned District Judge.

Evidence was let in in the lower Court that Mr. Subbaraya Chettiar while he contested for a seat in the local Legislative Assembly the plaintiff was approached by his party (congress) workers to canvass support for the Congress candidate as against another candidate belonging to the Justice party and that the plaintiff refused to comply with the request. The Congress party workers suspected that the plaintiff was actually working for the Justice party candidate and began giving the plaintiff trouble. The first of the series was a resolution passed by the Panchayat Board of Kilayur where the plaintiff has been practising to the effect that the Board wished to have an Ayurvedic or Unani Dispensary. This resolution was convey-

ed to the District Board, East Tanjore of which Mr. Subbaraya Chettiar was the President. Basing on this resolution the President, District Board served a notice of discharge on the plaintiff. But the District Medical Officer would not agree and the Government declared the notice to be invalid mentioning that the practitioner's services could not be terminated on the ground of converting the dispensary of one particular system into that of another and that the service could be terminated as per clause 12 of the agreement which refers to financial stringency, breach in the conditions of the agreement and bad conduct of the subsidized practitioner. A few months later as per evidence let in in the lower Court another device was engineered i.e., shifting of Kilayur dispensary where plaintiff was working to some other place on the score that it was within 5 miles of another dispensary at Tirupundi. But as per a Government Order the dispensary ought to have been shifted elsewhere. Consequently the Government turned down that notice also. By this time the Government introduced a new form of agreement where a clause was added to make it possible for the District Board to convert dispensary of one system into that of another system and soon after the new form of agreement was passed by the Government, Mr. Subbaraya Chettiar, the then President of the East Tanjore District Board revived the old notice of terminating the services of the practitioner and this third notice was the subject-matter of the suit. Soon after this last notice was served on the practitioner who later figured as the plaintiff in the suit and even at the earlier stage before the Government amended the agreement to permit the conversion of the dispensary, the Provincial Subsidized Practitioners' Association protested against the action of the Government as well as of the District Board and strong criticisms appeared in these columns condemning the action of the then Government who it was stated minded politics but not justice and fair play.

Law Courts have to judge taking cognizance of proved facts or circumstances let in as evidence either oral or documentary. The Court cannot see or

hear things outside its walls and each judge decides cases on merits gathered by him. To us who are outside the court and who are in the know of the lot of the subscribed practitioners and who have had opportunities of coming in contact with the ministers forming the Government, it looks that there is perhaps miscarriage of humane justice though not perhaps legal justice. We say this with due respect to the learned District Judge who heard the appeal. He had made it plain in his judgment "that a court cannot take into consideration arguments of shibboleth like 'put not your trust in princes, put not your trust in Government Orders' etc., for arriving at correct legal interpretation of contract" wherein the Government orders have not been made a part. On the other hand the lower Court declared that there was no clause in the agreement to which the plaintiff, the Government and the District Board were parties to justify the order of termination of the services of the practitioner on the ground of converting a dispensary of one system into that of another and therefore the plaintiff's services could be terminated only for reasons given in clause 12 of the agreement i.e., for financial stringency, breach of condition of agreement etc. The view was also expressed by the Government in their order refusing sanction for terminating the services of the practitioner when for the first time soon after Congress elections, the East Tanjore District Board served the notice on the practitioner terminating his services on the plea of conversion of the Allopathic dispensary into one of Ayurvedic or Unani system. Advantage was taken later when the Government amended the agreement by adding a clause to make such conversion possible. This collusive circumstance is not evident in the judgment—perhaps evidence was not adduced for this finding in the lower Court. Though the defendant swore that he did not request the practitioner to canvass votes for him during his election to the Legislative Assembly the learned District Munsiff observed in the judgment, *"But in the circumstances of this case, it appears to me that persons interested in D. W. 1,*

Mr. Subbaraya Chettiar should have requested the plaintiff (i.e., Dr. Subaraya Bhat) to do so and that he did not agree and that they therefore, moved in the matter to see that his dispensary was closed." Later in the course of the judgment, it is said, "The local Congress people, should therefore have made reports to the District Board against the plaintiff and that they should have engineered the resolution in the Panchayat Board." This fact is confirmed by yet another fact that the Kilayur Board passed a resolution soon after it was known that East Tanjore District Board intended to close the Kilayur Allopathic Dispensary, protesting against its closure and mentioning that the Panchayat Board desired to have another dispensary of indigenous system. The members of the Panchayat Board sent also a memorial to the Public Health Minister and also the residents of about 9 villages round about Kilayur. The subsequent proceedings of the then Government appearing in the judgment delivered by the learned District Munsiff disclose that the Government while directing the District Board to give six months notice to the practitioner in order to convert the Allopathic Dispensary into an Ayurvedic one, stated that the Ayurvedic Dispensary should not be opened in case the practitioner continued to practise at Kilayur. This compromising attitude of the Government in not allowing the starting of a dispensary of indigenous system at Kilayur, clamoured for by the people of Kilayur ought to set at naught the *bona fides* of all concerned whose only aim was to drive away Dr. Subbaraya Bhat from Kilayur. Even the learned District Judge stated in his judgment relating to the unhappy Congress Election episode, "I am satisfied that the truth is somewhere in between". It is evident from both the judgments that Dr. Subbaraya Bhat, the aggrieved practitioner was very popular and has been discharging his duties as a subsidized practitioner in a most exemplary way applauded by successive District Medical Officers, Indian and European and responsible non-officials such as the Presidents of the District Board. He was made a

victim for his popularity on account of his neutral attitude during the last Assembly Elections and because he refused to work for the Congress Candidate, Mr. Subbaraya Chettiar when requested. Is this not a strange and fateful irony?

The very fact that the State have established Court of different grades to avoid miscarriage of justice admits such a possibility. Nobody except the Government Secretariat knows all about the Subsidised Rural Medical Relief Scheme and its potential utility to the rural population but the unstable political springs on which any democratic government has to rest temporarily for a short or a long period depending upon their popularity, at times shake the scales of justice on account of party considerations and the ministers who form the Government in their anxiety to have a stable Government in spite of unstable springs have to go out of the way in the interests of longevity of the term of office of the ministers. With all due regard to democracy we should say the longevity or stability of Government should rest on the strong pillars of justice and fair play. We appeal to the present Government on behalf of the subsidized practitioners and in the interest of medical aid in rural areas to go through the two judgments of the learned District Munsiff and the learned District Judge forgetting for the time being that the Government themselves were a party to the suit. It is sometimes said that we cannot have always justice in Law Courts. It may not be due always to an error in judgment, as in this case. But the case as well as the two judgments will undoubtedly demonstrate to the present Government how far politics pervading in rural areas has been responsible to mar the healthy development of rural medical relief scheme. The only remedy for preventing the unhealthy episodes in the rural medical relief scheme is to make the scheme politics proof. This can only be done by provincialising the scheme.

Tuberculosis News: We are thankful to the Medical Commissioner of the Tuberculosis Association of India and its Secretary for supplying us news on Tuberculosis for the benefit of the readers

of The Medical Practitioner which we will be publishing in these columns as and when received.

TUBERCULOSIS WORKERS CONFERENCE: The Second Conference of the workers in Tuberculosis from all parts of India met in New Delhi from the 18th to 21st instant and from a perusal of the proceedings of the first conference which have been since published in a book form we could say that such yearly conferences held under the auspices of the Tuberculosis Association of India, will be of immense benefit to the workers as well as to the patients.

At the second conference one whole day would have been devoted to the discussion of the influence on the spread and development of tuberculosis of such environmental factors as poverty, overcrowding, under-nourishment and occupation of insanitary dwellings and of the effects on the spread of tuberculosis, of legislation including bye-laws dealing with notification, erection of buildings, slum clearance, town planning and the regulation of lodging houses. Other important subjects such as tuberculosis surveys, uniformity of records of classification of patients and the results of treatment would have also been discussed as well as the interpretation of x-ray films and their recording. Further a few clinical subjects dealing with the treatment of certain complications would have also come up for debate.

The conference was opened and closed by Her Excellency the Marchioness of Linlithgow, President of the Tuberculosis Association of India.

The proceedings published relating to 1st conference are a compendium of recent advances on the treatment and prevention of tuberculosis in India and worth going through by the general practitioners. We wish the proceedings be made available to the practitioners at cost price.

TRAINING COURSES: The Tuberculosis Association of India with the help of Bombay and Bengal branches are arranging post-graduate courses in tuberculosis. The Bombay course is from 13th January to 1st February. During the 1st two weeks, lectures and demonstrations will be

held in Bombay at the Seth G. S. Grant Medical Colleges and other institutions and during the 3rd week at the Tuberculosis Sanatoria in Panchagni and Wanlesswadi. The class will be limited to 25 practitioners, out of whom 15 will be candidates from Western India and States and the remaining 10 for those coming from other parts of India.

The Course in Bengal will last from 15th January to 14th February 1941. 30 Practitioners will be trained, 10 seats will be reserved for practitioners in Bengal and 20 for practitioners from other parts of India.

KASALI SANATORIUM SCHEME:—Consequent on the transfer of the work connected with the manufacture and issue of anti-rabic treatment, the Association of the Pasteur Institute have offered to place a major portion of their extensive estate measuring about 30 acres in area at the disposal of the Tuberculosis Association of India, free of cost for the establishment of a Tuberculosis Sanatorium on such terms and conditions as may be mutually agreed upon.

The sanatorium, when ready, will serve as a central institution for:

(a) The modern treatment of pulmonary tuberculosis especially difficult cases requiring advanced surgical treatment,

(b) the training of doctors, nurses and health visitors in the modern methods of diagnosis and treatment of the disease, and

(c) research work in tuberculosis including bacteriological and research.

OTHER MISCELLANEOUS NEWS: The Indian Red Cross Society of Mysore is reported to be doing good work in regard to Anti-Tuberculosis campaign.

The Director of Public Health in Bengal in his annual report warns the public both in rural and urban areas about dust nuisance due to increasing motor traffic and recommends the need of dust-proof roads. He reports 14,668 deaths in the Bengal Province due to tuberculosis giving a death rate of 0.29 per mile.

The National Association for the prevention of tuberculosis, London, have planned an interesting and enjoyable programme for children who are taught the need of fresh air, of teeth cleanliness etc.

without mentioning a word about "Tuberculosis."

At the meeting of the Central Committee of the Tuberculosis Association for India it was decided to elect 5 members to the Central Committee from the affiliated Associations.

It was decided by the Committee to offer Dr. C. Frimodt-Moller an extension of two years after the expiry of his present contract on 30th April 1941 to serve as Medical Commissioner.

NEW DELHI MODEL TUBERCULOSIS CLINIC:—Her Excellency, the Marchioness of Linlithgow opened on 20.11.40 the New Delhi Model Tuberculosis Clinic attached to the Irwin Hospital. In the course of her speech Her Excellency said:

Every one knew that the fight against tuberculosis was a hard and long one and that it could not be combated by clinics and sanatoria alone. It would be a hopeless fight unless they could have co-operation from the public which had been sadly lacking in many places during the last year. The public bodies should get together and work out a joint scheme. She had heard of cases where private practitioners would not report their patients to the clinics and sanatoria for fear of losing their fees. Surely this personal consideration should never be allowed to enter their heads. In Her Excellency's opinion, such consideration was criminal. These practitioners were sending their patients to certain death. She would not use these hard words unless she knew the truth of the accusation.

Her Excellency might have followed the example of the National Association for the Prevention of Tuberculosis, London, relating to her remarks about private practitioners. This Association in their campaign against tuberculosis have planned a programme for children which while dealing with the prevention of tuberculosis does not contain the word "tuberculosis." Her Excellency is not likely to come in contact with private practitioners whom she condemned in strong words. All the same we do not deny she spoke the truth and the truth must have been conveyed to her by her honourable associates in the work against tuberculosis. We take this admonition as a blessing in disguise. All concerned in tuberculosis including the medical workers proclaim on public platforms or in their writings, the necessity of the co-operation of private practi-

tioners. Her Excellency herself said on the 20th instant while opening the New Delhi clinic *"that the fight against tuberculosis was a hard and a long one and that it could not be combated by clinics and sanatoria alone"*. We appeal to Her Excellency to lead a campaign against the "love of money" which is said to be a disease only amongst the private practitioners in India. It is our experience that this disease is wide spread and the contagion came from those who are full-time state-paid private practitioners, or full-time paid practitioners from other funds, some of whom are making money which may be a sum total of all the earnings of independent private practitioners practising in places not excluding the stations where there are Tuberculosis Clinics and Sanatoria. Scientific system of medicine sprung out in this unfortunate country from the Government Medical Departments and not from the Medical Profession as in other advanced countries and so long the medical profession is controlled by Government agency the disease of "love of money" as against love of humanity will prevail.

Concepts of Public Health: The annual report of the All India Institute of Hygiene and Public Health, Calcutta, for the year 1939, is a very interesting document which gives an idea of the modern trends of preventive medicine and the training of public health officers to suit Indian conditions. The subjects dealt with in the report give an idea of how public health concepts amplified these 20 years differ from the old public health measures which limited themselves to the prevention of infectious diseases and their control only. Now the responsibilities of public health work imply a study and control of all factors which affect the health of the community. Treatment of diseases alone is insufficient to ensure the community a normal standard of health. The report after reviewing the modern trends of public health work as above, presses the need for "Controlled Areas," where investigation for the development of "efficient and practicable methods of scientific medical protection through organised community effort and the

provision of opportunity for students to train themselves in the principles and application of those principles and methods." It is rightly said in the report that, "the principles determining the controlled community field in public health correspond exactly to those governing the provision of a teaching hospital to a medical college, presenting investigative facilities and quality and quantity standards for students' self-participation." The report points out that "public health is organised community effort for medical protection and as such, is social medicine, the utilisation of which must be different under varying social-economic conditions although the principles derived chiefly from medical biology are universally similar. Consequently it is essential that organisation for instruction and research must vary from country to country during the levelling up process."

For the salient reasons mentioned in the report it is essential that the training in public health in India should be conducted in India itself. We are glad that the present Director of the All-India Institute of Hygiene and Public Health has boldly and as sagaciously recommended urgent necessary changes in the curriculum of studies for D. P. H. course which if approved and inaugurated would make India self-contained to train public health officers imbued with scientific and practicable imagination to adjust varying social conditions in this sub-continent to the requirements of community welfare. It is most unfortunate that the Madras Government has been contemplating to close the Poonamalee Health Unit which though at its inception was not serving as useful a purpose, has been serving as a model teaching centre after the passing of the Public Health Act when the Government conceived the idea of extending public health campaign in the rural areas with the help of the subsidized rural practitioners to train whom the Poonamalee unit served admirably the purpose so ably enunciated by Dr. John B Grant, M.D., B.A., M.P.H., the new Director of the All-India Institute of Hygiene and Public Health. Dr. Grant has begun his career in the Institute in the right way and we congratulate the Government of

India in the choice they made of a person who has all the necessary qualifications to run the Institute on up-to-date methods being one of the members of the Rockefeller Foundation, who had exceptional opportunities of familiarising himself with the progress in the various Health Institutes in Europe.

Provincialisation of L. F. Medical Service: A L. F. Sub Assistant Surgeon under the *non de plume* "A sufferer" has sent us a communication which has been published in the "Correspondence Columns." The letter speaks for itself. The question of provincialisation of L. F. services is not a new one nor can it be said that the Government has not realised its necessity. The district-board engineers were the first fortunate members in the board-service to attract the attention of the Government and their immediate assistants came next. India has been a most unfortunate country in the matter of reforms whatever they be during the days of the bureaucratic Government or the Government by the popular ministers. The reforms usually began at the top and not at the bottom. Consequently the foundation of reforms has been always shaky and many a time topsy turvey. It is the subordinate staff that suffers the most in every service because they have neither the means nor the necessary courage to assert themselves even constitutionally. The department that deserved provincialisation most, was the medical. The staff belonging to this department deal with the lives of the public and they should be controlled only by a superior medical authority. It is true that the Surgeon-General is usually consulted by the local bodies through the respective district medical officers but the Surgeon-General has no control over the medical staff of the local bodies as he has over the staff belonging to Madras Medical Department. Apart from the treatment of patients, the medical officers belonging to the local bodies are entrusted with medico-legal work and due to the predominance of party politics in these bodies many a time the medical officers cannot hold or give independent opinion with the result that law and order are miscarried. In case an unbending medical officer does not wish to deviate from the

path of his legitimate duties, he becomes a prey to the mischievous campaigns of interested parties against him. Elections to local or legislative bodies are occasions when a popular medical officer suffers most. His leaning to one party makes him the enemy of the other and in case he is neutral he becomes the enemy of both. In addition to the sufferings inherent in local bodies, there have been hard hits by the Government who for reasons best known to them reduced the pay of the L. F. medical officers to a scale much lower than that of the Government medical officers in the same grade. They are

like frogs in a well not knowing what is going on outside the well. They have little or no chances of refreshing their knowledge.

The only remedy which is likely to lessen the sufferings of the practitioners belonging to L. F. service is organized constitutional agitation and The Medical Practitioner which was brought into existence specially to guard the interests of the members of the medical profession of whatever qualification and of whatever service is always ready to help the medical officers belonging to the L. F. service.

Correspondence, Reports, Etc.

MADRAS PROVINCIAL SUBSIDIZED RURAL MEDICAL PRACTITIONERS' ASSOCIATION.

BELLARY DISTRICT BRANCH.

Proceedings of the annual general body meeting held at Hospet on 10.11.1940 under the Presidency of Dr. M. Krishna Rao, Secretary-Treasurer.

Resolutions.

1. This meeting places on record the appreciation of the services of Dr. M. Krishna Rao as Secretary-Treasurer and Dr. C. T. Krishnamoorthy Rao as joint Secretary-Treasurer during the year 1940 and unanimously elects them to their respective posts for the year 1941.

2. This meeting expresses complete confidence in Dr. V. Rama Kamath as President of the association during the year 1940 and expresses its approval of his re-election as President for a further period of one year.

3. This meeting is of opinion that Public Health work in the villages is to be entrusted to such of the rural medical practitioners who express their willingness to undertake the same.

4. This meeting is of opinion that the appointment, control and termination of the services of the ward boys should vest in the practitioners in the interest of smooth working of the rural medical relief scheme.

5. Resolved to request that the members of the Dt. Branch to contribute Re. 1-0-0 towards the expenses of the ensuing conference at Malabar to be sent to the Secretary-Treasurer of the Malabar Dt. Branch or Central office.

6. Resolved to contribute Re. 1 per year towards the funds of the Dt. Branch to meet the travelling expenses of the Secretary-Treasurer when attending P. C. meetings.

7. This meeting approves of the resolution No. 12 of the Provincial Committee held at

Madras on September 21 and 22, 1940 and resolves to request the members to contribute Re. 1 per month for 6 months towards Madras Governor's War Fund to be deducted from the Government Subsidy bills and authorizes the Secretary-Treasurer to communicate this resolution to the Dt. Medical officer, Bellary and request him to send the amount so collected towards Ambulance Services through the Surgeon-General.

8. This meeting approves the resolutions passed by the Provincial Committee at Madras on September 21 and 22, 1940.

9. Resolved to request the absenting members to take more interest in the affairs and activities of the association by attending the meetings at least once in 6 months.

10. This meeting requests the rural medical practitioners at Ittaji, Hirehadagalli and Uchanjidug to become members of the association and the one at Rupangudi to pay his subscription for 1940.

WEST GODAVARI DISTRICT BRANCH.

A meeting of the West Godavari District Branch was held at the residence of Dr. D. V. Ratnam on 10.11.40. After the reading of the report by the Secretary regarding the affairs of the district branch, the accounts of the branch as mentioned in the report were approved.

Dr. D. V. Ratnam was elected as the Secretary-Treasurer and Dr. K. Subba Raju as Joint Secretary-Treasurer and the following resolutions were unanimously passed:—

1. This association places on record its sense of appreciation for the services rendered to the association by the previous office-bearers.

2. Resolved to request the P. D. B. to entrust the P. H. work to all the R. M. P's who have undergone P. H. training.

3. Resolved to request the P. D. B. to sanction servants to all the dispensaries whose attendance is more than 50 for the last two years and thus maintain uniformity in the district.

4. Resolved to request the P. D. B. to sanction at an early date the payment of the T. A. due to the R. M. P's that have undergone P. H. training.

5. Resolved to request the P. D. B. to sanction dispensary rent to all the Rural Dispensaries in the district without distinction.

6. Resolved to request the P. D. B. to supply midwifery kits to all the midwives appointed in Rural Dispensaries as they cannot discharge their duties without the kits.

7. This association places on record its respectable thanks to the P. D. B. and D. M. O., West Godavari for duly redressing the grievances of the R. M. P., Doddipatla.

8. This association authorises the Secretary to draft a memorandum of the grievances of the R. M. P's basing on the above resolutions and submit the same to the P. D. B. through the D. M. O.

9. Resolved to urge all the R. M. P's in the district to enlist themselves as members of the P. S. R. M. P's association.

10. This association places on record its deep sense of thankfulness and gratitude to the President of the Provincial association for the valuable services rendered by him to the medical profession in general and the R. M. P's in particular.

MADURA DISTRICT BRANCH.

The annual meeting of the Madura District Branch of the P. S. R. M. P's Association was held at 5 p.m. on 16th November 1940 in the Madura Headquarters Hospital.

1. The minutes of the last meeting were read and carried.

2. The statement of accounts for the current year was read by the Secretary-Treasurer and approved.

3. The following office-bearers were elected unanimously for 1941.

(a) Dr. R. Ramaviswanadhan, Secretary-Treasurer and Dr. C. K. Menon, Joint Secretary and Treasurer.

The following resolutions were passed.

1. Resolved that each member shall contribute Rs. 6 in one instalment to the Governor's War Charity Fund. The amount should be remitted to the President of the P. S. R. M. P's Association, Madras, who will send the same to the Governor's War Charity Fund through the Surgeon-General, being earmarked for Ambulance purposes.

2. Resolved to contribute Re. 1 per member towards the cost of the meeting of the Provincial Conference to be held in Malabar in December 1940. The members are requested to send their contribution, to the Secretary-Treasurer Madura District Branch before the 30th November 1940 to enable him to send the amount to President, Reception Committee, Malabar.

3. *Death and Permanent disability fund:* This meeting is of opinion that the membership being very limited, the contribution to the death and permanent disability fund will be very poor and that it is not opportune to take up the matter at present.

4. Resolved to request the Government to entrust the teaching of Physiology and Hygiene in schools within the jurisdiction of the Rural Dispensaries to the R. M. P's for which an Honorarium of Rs. 20 may be paid.

5. Resolved to request the District Board Madura that as their Resolution No. 149 dated 31st August 1940 sanctioning Rs. 400 per year to such of the Rural Dispensaries which have an average attendance of more than 30, is rather too insufficient; this association requests the President, District Board, Madura, to fix the budget allotment for medicines for such dispensaries to at least Rs. 500 per year, proportionate to the increase in attendance.

6. (a) This meeting requests the Secretary of the District Medical Association, Madura to incorporate the Madura District Branch of the P. S. R. M. P's association as a member of the District Medical Association and that the members are *ipso facto* members of the District Medical Association on a nominal subscription to be paid from this association.

(b) The Secretary-Treasurer, Madura District Branch of the P. S. R. M. P's Association is authorized to communicate this resolution to the Secretary, Madura District Medical Association.

* [We wonder if the Madura District Branch is aware of the fact that the Association has 340 members on its roll. Ed.]

GOVERNMENT OF MADRAS.

EDUCATION AND PUBLIC HEALTH DEPARTMENT. (PUBLIC HEALTH.)

G. O. No. 4286, 14th September 1940.

Establishment—Medical—Claim of rural medical practitioners for appointment as medical officers in local fund medical institutions to be considered only in permanent vacancies—Instructions issued.

READ—the following papers:—

G. O. No. 1956, P.H., dated 7th August 1937.

G. O. No. 211, P.H., dated 16th January 1940.

From the President, District Board, Tanjore, dated 3rd March 1940, C. No. 7718-D. B./40.

Order—No. 4286, P.H., dated 14th September 1940.

In modification of the orders in G. O. No. 1956, P.H., dated 7th August 1937, and clause (11) of the forms of agreement prescribed for rural medical practitioners in G. O. No. 3510, P. H., dated 4th October 1938, the Government direct that a rural medical practitioner should not be appointed as a medical officer in a regular local fund medical institution except in a permanent vacancy. And he should not be appointed unless

(a) he possesses the qualification prescribed for the post and his records are satisfactory, and

(b) no stipendiary, eligible under the rules for appointment in that vacancy, is available.

These orders will not affect the seniority of the existing probationers and approved probationers and their right to be confirmed in permanent vacancies.

2. In order to fill vacancies which are not permanent, local boards are advised to maintain a reserve staff of one or two medical officers selected from rural medical practitioners. If no such reserve staff is maintained and no suitable stipendiaries are available for appointment in temporary vacancies, outsiders may be appointed; but their appointments may be only temporary, and their service will not count for probation nor will it give them any claim to a permanent vacancy.

3. The amendments to the rules relating to the appointment and punishment of officers and servants of local boards and municipal councils proposed in G. O. No. 211, P. H., dated 16th January 1940, will not be sanctioned.

4. The following amendments will be made in the forms of agreement prescribed for rural medical practitioners in G. O. No. 3510, P. H., dated 4th October 1938, as subsequently amended:—

AMENDMENTS.

I. In the form of agreement in Appendix I to the said Government Order for clause (11), the following clause shall be substituted, namely:—

"(11) The practitioner may, on the recommendation of the Surgeon-General or the Principal, as the case may be, be appointed as a medical officer in a permanent vacancy in a regular dispensary under the control of the board or as a reserve medical officer if—

(a) he possesses the qualifications prescribed for the post of local fund medical officer and his records are satisfactory, and

(b) no stipendiary eligible under the rules for appointment in that vacancy is available."

II. In the form of agreement in Appendix II to the said Government Order for clause (11) the following clause shall be substituted, namely:—

"(11) The practitioner may, on the recommendation of the Surgeon-General or the Principal, as the case may be, be appointed as a medical officer in a permanent vacancy in a regular dispensary under the control of the board or as a reserve medical officer if—

(a) he possesses the qualifications prescribed, for the post of local fund medical officer, and his records are satisfactory, and

(b) no stipendiary eligible under the rules for appointment in that vacancy is available."

(By order of His Excellency the Governor)

E. C. WOOD,
Secretary to Government.

G. O. No. 4572, 30th September 1940.

Medical institutions—Rural—Trichinopoly district—Andimadam—Request of the medical practitioner for payment of full remuneration for doing public work—Government interference declined—Condition for claiming remuneration—Approved.

READ—the following papers:—

From the Rural Medical Practitioner, Andimadam, dated 7th November 1939. From the President, District Board, Trichinopoly, dated 13th December 1939, No. 6789-A-4/39.

Endorsement of the Director of Public Health, dated 8th January 1940, R. No. 44872-1/R. M. P.

Order—No. 4572, P. H., dated 30th September 1940.

The President, District Board, Trichinopoly, is requested to inform the petitioner that the Government see no reason to interfere on his behalf.

2. The Government accept the suggestion of the Director of Public Health that the payment of remuneration to a rural medical practitioner for doing public health work should be subject to the following conditions:—

(1) That he should tour in the villages entrusted to him for public health work as often as possible, the minimum being 10 days in a calendar month;

(2) that he should submit to the District Health Officer a weekly diary showing the Public health work done by him during the week; and

(3) that he should visit the villages promptly as often as necessary during any epidemic.

The remuneration bill for public health work should be passed by the president, district board, in consultation with the District Health Officer. Proportionate amount should be withheld for the days on which the medical practitioner is on leave on loss of subsidy. The District Health Officer may recommend a reduction in the amount of remuneration if the work turned out is not satisfactory.

(By order of His Excellency the Governor)

E. C. WOOD,
Secretary to Government.

[Comments on the above order will be made in a future issue. Ed.]

LOCAL FUND MEDICAL SERVICE.

To

THE EDITOR,

Sir,

Your whole hearted advocacy of the cause of the Rural Medical Practitioners has resulted in the substantial improvement in the lot of the R. M. Ps. with prospects of a very bright future before them.

There is an important class of medical men in Public Service in this Province known as Local Fund Sub-Assistant Surgeons whose miserable existence does not seem to have attracted the attention of the Medical Gods that be or the Legislators. In these days of democracy when water-tight compartments in the medical profession are being destroyed with meticulous care, it seems an anachronism to perpetuate the invidious distinction between Civil and Local Fund Sub-Assistant Surgeons.

The tenure and security of service, the scales of pay, the scope afforded for the furthering professional knowledge for the Local Fund cadre are appalling not to speak of the pricks they are often subjected to under Local Board administration. Every class of Public servants and workers have their own unions to safe-guard their interests but the Local Fund medical officers in this Province have as yet none. Will you not lead them to organise their own association? Will not the Local Fund Medical Officers at least now rise from their slumber and organise themselves into a union to safe-guard their interests and better their conditions?
A sufferer.

PROVINCIALISATION OF RURAL SUBSIDIZED SERVICE.

To

THE EDITOR,

Sir,

On the 21st August 1940 when the Surgeon-General presided over the Annual Meeting of the South Arcot Branch of the Indian Medical Association, he rightly expressed that the most important reform that had to be effected in the subsidised service was to transfer the entire control to the Medical Department. It is not only the "most important" but an

"urgent reform" long overdue; and it is hoped that the good and kind Surgeon-General would be able to advise and persuade the Government to have this reform at no distant date, any way before he lays down his office in this province. That all is not well by entrusting its care to the local bodies is positive proof to one who has been scanning the pages of "The Medical Practitioner"—"The Yellow peril" as it is called by some in the premier city of the province. It may, no doubt, be a peril to those who are perverse, but the independent medical profession including the rural medical practitioners are grateful to this journal for guarding their interests, without fear or favour.

That the villages are full of charlatans, mantravadins, quacks, and empty pretenders to medical knowledge and skill, is not beyond the knowledge of every one and these people by their cock and bull stories are unfortunately holding sway over the mass of the ignorant and credulous people. When interests clash, the rural medical practitioners become the target of attack of these loud-speakers. It is against the vicious propaganda of such screaming howlers that the rural medical practitioners have to bring home the scientific truths and carry on their day-to-day work. A man able to command a dozen votes is more powerful in these days than a well-qualified, god-fearing medical man who turns out his work conscientiously. Members of local boards have to depend on vote-catchers and naturally a rural medical practitioner has to depend on the whims and fancies of these people who sometimes go to the extent of even dictation. Vote-catching is an art and it is common knowledge that even nauseating tricks are practised to perfect this art, especially in the villages, and these tricks are sometimes being experimented upon the rural medical practitioners. Those who condemn on public platform the present day soul-destroying dictators as monstrous products of wrong and shame, forget that there are such dictators in disguise living in the villages, trying to dictate to the rural medical practitioners. A rural medical practitioner cannot do propaganda work, he cannot go a

medical ethics and etiquette, he has to stick to certain principles in his work and when he observes all these, not unnaturally, he gets many a time into hot waters for displeasing the lesser gods of the local bodies and their satellites. If one is to have these nerve-racking pricks always, it will be practically impossible to carry on efficient work. The Surgeon-General who is daily coming in contact with both official and non-official medical men and seeing also the files in his office, must have expressed this thoughtful and thought-provoking opinion. The Government have rightly transferred the control over the midwives to the D. M. Os. Why should not the suffering subsidized practitioners enjoy this privilege?

Do we not see thousands of aided schools, where grants-in-aid are given to to the tune of several lakhs of rupees being entirely under the control of the Educational Department. Then, why not the Government do the same thing regarding these aided rural dispensaries, which after all are about 500 in the whole presidency. Politicians and high placed persons in authority in their easy post of prandial orations have been day-in and day-out preaching the ready slogan "go back to the villages". Having gone back to the villages after an arduous and costly course and having worked there all these years, these band of young (now many old) men find their lot harder and harder. One would like to know how many of these orators have sent their sons, nephews, cousins, or sons-in-law to the villages to work there and taste the cup; or how many orators have tasted the village life apart from the organised shows and functions arranged for them?

A Suffering R. M. P.

CENTRAL ADVISORY BOARD OF HEALTH.

Third Meeting.

At this year's meeting which was held in Poona for 3 days from 22nd July 1940 the reports of two special committees appointed by the Board at its previous meetings to investigate the possibility of introducing compulsory inoculation of

pilgrims against cholera and to study the complex questions associated with the prevention of food adulteration in India occupied a large part of the proceedings of the Board.

INOCULATION OF PILGRIMS.

The Board, in adopting the report of the special committee appointed to examine the possibility of introducing a system of compulsory inoculation of pilgrims against cholera, considered that public opinion in favour of anti-cholera inoculation had grown in recent years and that the question of introducing compulsory inoculation could now be considered by Provincial and State Governments without apprehension of any disturbing effects on the minds of the people. The Board recommend that Provincial Governments should select suitable centres in their areas and try out a scheme of indirect compulsory inoculation on lines successfully pursued by the Government of Bombay for the past four years in connection with the Pandharpur festival.

CENTRAL COMMITTEE FOR FOOD STANDARDS.

The Committee on food adulteration had examined the problem from three aspects *viz.*, (1) the technical, including food standards and technique of food analysis, (2) the legislative and (3) the administrative aspect. The Committee has so far considered only the technical aspect of the problem and it is expected that its reports on the legislative and administrative aspects will be made available for the Board at its next meeting. The Committee emphasised the fact that the improvement of methods of food analysis and the prevention of food adulteration in India will have to be a continuous process and that the establishment of co-ordination between the provinces is a matter second to none in urgency. With this object in view the Board recommended the appointment of a standing committee to be called "The Central Committee for Food Standards" which would be in a position to advise the Central, Provincial and State Governments on all aspects of food adulteration. Pending the establishment

of the Central Committee the Food Adulteration Committee itself recommended all-India standards for 17 articles of food, while in respect of a number of other articles, the standards for which are a matter of controversy, the Committee recommended that these should be investigated by the proposed Central Committee for Food Standards.

The existence of different food standards in neighbouring Provinces and States at present interferes with the free flow at trade. The Central Committee should be in a position to suggest standards acceptable to all the Governments concerned, thereby facilitating inter-provincial trade and a uniform enforcement of food adulteration laws.

Another important function of the Central Committee would be the issue from time to time to public analysts of "instructions" incorporating the latest available information regarding methods of analysis. The standardisation of methods is as important as the unification of standards of food purity.

Among other important decisions taken at this year's meeting of the Board, the following are of general interest:

FREE LABORATORY SERVICE.

The importance of laboratory examination for the diagnosis of many infectious diseases cannot be over-emphasised. For instance, in regard to typhoid fever, the recorded statistics of mortality represent only a small fraction of the actual events. The diagnosis of typhoid fever cannot be done, in many cases, without laboratory aid. The provision of a free laboratory service to medical practitioners is essential for a successful campaign against this and many other infectious diseases. The value of such provision was demonstrated in Bombay during an epidemic of typhoid fever in 1938 when the Government of Bombay placed the services of the Hoffman Institute at the disposal of the medical practitioners of the city. In consequence many more cases were reported than had been experienced in previous years and the Health authorities were able to locate with certainty the areas most affected and take effective

measures against the spread of the disease.

The Board had before it a scheme for starting a provincial laboratory service which outlined a system of small district laboratories supported by regional laboratories for groups of districts and by a central laboratory for the province, which would co-ordinate the activities of the regional and district laboratories. The Board recommended this scheme for adoption by Provincial and State Governments, with such modifications as local conditions may require.

THE HEALTH OF SCHOOL CHILDREN.

There are numerous problems associated with the health of school children, for instance, the inculcation of healthy habits, provision for periodical medical examination and correction of the defects discovered during such examination, and the supply of adequate nutrition. It is generally accepted nowadays that systematic attention to the health of the children is an essential preliminary to any really remunerative system of instruction, whether it be in hygiene or other subjects in the curriculum. Further teaching is not likely to be a success if the general school environment does not conform to reasonable hygienic standards. Before a considered policy can be drawn up and commended to the authorities concerned, much information has still to be collected as to the requirements of, and the progress already achieved in different parts of India and the possibility of remedying the defects disclosed at the least possible cost. The Board therefore recommended that a special committee including educational experts should be appointed to report on the teaching of hygiene in schools, primary as well as secondary, rural as well as urban, the medical inspection of school children and their treatment and, in the primary educational stage, also on their nutrition.

THE EFFECT OF BAD HOUSING AND OVER-CROWDING ON TUBERCULOSIS.

There is abundant evidence available from countries where tuberculosis is prevalent, that unsatisfactory housing

conditions and over-crowding tend to produce an increased incidence of the disease, while the transference of tubercular patients from unhealthy to healthy dwellings produces an improvement in their symptoms and the physical signs of the disease. The failure on the part of the local bodies in many parts of India, to enforce the byelaws relating to health matters has been a subject of constant reference in public health reports for a number of years. While rectification of

the defects in an existing slum area may be difficult, there should be no excuse when, after costly slum clearance operations by Improvement Trusts and other bodies, the cleared areas are permitted to be built over without due regard to the requirements of light, ventilation and sound hygienic considerations. The Board therefore strongly urged on all Provincial and State Governments the necessity, in the interests of public health, of strict enforcement of building byelaws.

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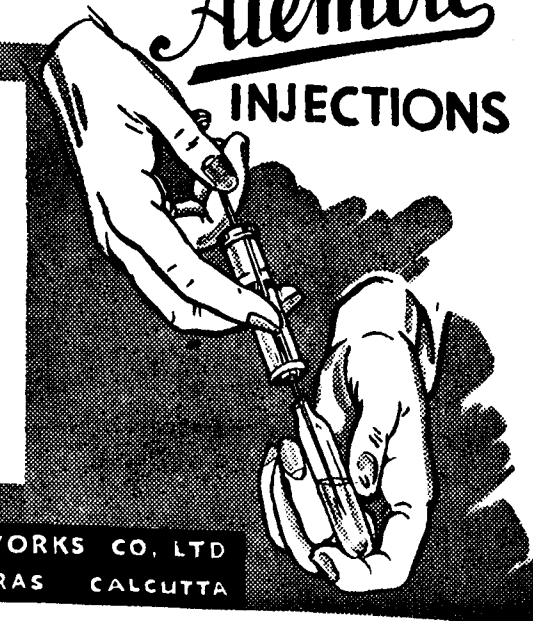
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Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the month of October 1940.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance on 1-10-'40 ...	401 5 2	Postage ...	9 4 6
Subscriptions from members (including V.P.P. charges) ...	87 8 0	Stationery ...	0 10 6
Enrolment fees from 1 new member ...	0 4 0	Pay to Clerk for the month of Sept. 1940 ...	15 0 0
		Amount credited to The Medical Practitioner from the subscriptions paid by members ...	43 0 0
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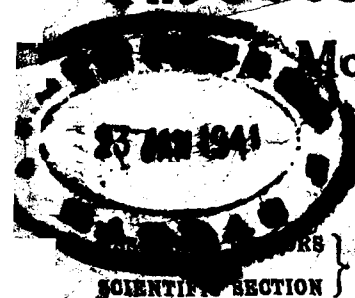
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Vol. XII]

DECEMBER, 1940

[No. 3

Original Articles

THE GENERAL PRACTITIONER AND COMMON EYE DISEASES—VII.

(G. J. G.)

MINOR EXTERNAL AFFECTIONS.

Eczema of the face might also affect the skin of the lids. Owing to the loose areolar tissue underneath, the swelling may be marked. No special treatment is necessary. Only, one has to be careful, when any irritant drug is applied anywhere on the body, it does not get into the eye. For example, Ung. Chrysarobin is often used for the treatment of ringworm. If it gets into the eye by accident especially when applied to ringworm in the face, it causes a severe irritant conjunctivitis.

STYE.

It is a minor affection and is easily recognised by anybody. But, sometimes, it might produce very alarming symptoms when the whole face gets swollen and the pain is terrible. The eyes look normal except for the swelling in the lids, teeth are normal, lachrymal apparatus is normal and one is puzzled. But, if you look carefully, you can notice a localised redness over some part of the lid which will give a clue to the diagnosis. The next day, its presence will be more clear and the diagnosis is then not difficult. The treatment in the acute condition is hot fomentation and aspirin or any analgesic internally at bed time, when the pain is very unbearable. Ordinarily, hot foment-

ation even three or four times a day is very good and that will suffice generally. Yellow oxide of mercury ointment 2 per cent may also be applied once a day. Attention to bowels by way of laxatives, etc., is essential. When the abscess points, it may be opened with a small incision. The incision should be horizontal to the lid margin. Use always a fine sharp knife. After-treatment is practically nil, except for some dry dressings till the wound is covered. Generally, it heals up in three to seven days.

Occurrence of frequent styes might be an indication of error of refraction, disturbance of metabolism as calcium deficiency and constipation, etc. The eyes should be tested for glasses and if there be no error, the general health must be attended to. Successive crops of styes require treatment with autovaccine.

BLEPHARITIS.

Inflammation of the lid margins is known as Blepharitis. There are two types—ulcerative and squamous. The ulcerative type is easily recognised. The lid margins are inflamed and ulcerative and the appearance is that of a weeping eczema. There might be also associated angular stomatitis. By the time the

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patient appears before the doctor, most of the eyelashes would have dropped out. The treatment is application of Silver nitrate solution 2 per cent to the raw area for a day or two and then daily application of White ointment to the lid margins.

Hydrarg Ammon	...	3'00
Zinc Oxide	...	5'00
Tuminol Ammon	...	0'50
Lanolin	...	50'00
White vaseline	...	50'00

Eucerinum may be used instead of lanolin and vaseline.

When the ulcerative condition has healed, the eyelashes should be pulled out—a few every day—and the ointment well rubbed into the hair follicles, as it is here the infection lurks. This should be done for about six months. Otherwise, the condition is likely to recur.

Very often, these patients are undernourished. Vitamins A, B and D are specially indicated. Cod liver oil, hand-pound rice, cold rice in the mornings, butter, eggs, tomatoes, etc., have to be prescribed as a regular diet even after the eye condition has healed.

The other type of blepharitis is seen as small dry scales at the roots of the eyelashes. You are not likely to notice them unless you specially look for them. Itching of the lids is the main symptom complained of. Here also, the treatment consists of epilation of the eyelashes and rubbing in the white ointment. It is helpful when the crusts are hard, to soften them with cotton dipped in warm soda bicarb lotion 2% before removing them.

Some people do not tolerate the mercury in the white ointment. In such cases—and even as an alternative to white ointment now and then—the following ointment may be used:—

Noviform	5'00
Eucerinum	100'00

Very often, blepharitis is due to eye strain caused by an error in refraction. So, in all cases of blepharitis, the eye should

be first tested for any refraction error and the necessary correction made before any medical treatment is undertaken.

Modern civilisation seems to require heavy powdering of the face of girls and even boys. If not washed out regularly and properly, the powder is likely to obstruct the opening of the glands along the border of the lids and thus bring about retention and inflammation.

CHALAZION.

It is a common affection. The meibomian gland in the lids sometimes gets enlarged and it is seen then externally as a round or oval lump protruding under the skin of the upper or lower lid. On evertting the lid, a bluish white patch will show its location. When it is big, it causes much disfigurement and if on the upper lid, the weight causes a partial ptosis and pressure on the eye-ball, thus interfering somewhat with the vision. Otherwise, it is of no serious consequence, unless its contents suppurate when there will be all the signs of inflammation as pain, swelling, etc.

Removal of a chalazion is easy. Put in a few drops of Pantocaine sol. 1 per cent or Cocaine sol. 5 per cent into the conjunctival sac and also infiltrate the area around and inside the chalazion with pantocaine sol. 1:1,000 or Novocaine or Planocaine sol. 2 per cent—with adrenalin as usual. Evert the lid and open out the contents with a vertical incision, i.e., at right angles to the lid margin. A small incision will do. Scoop out the soft gelatinous matter inside with a small spoon or curette (Fig. I). The only difficulty is to keep the lid everted during the operation. A lid clamp or chalazion forceps (Fig. II) will be helpful for the purpose. The eye is bandaged just for a day. For the next three or four days, apply yellow oxide of mercury ointment 2 per cent once a day. No further treatment is necessary.

TUMOURS.

Malignant and a variety of benign tumours occur in the lids. Epithelioma is not uncommon and an early removal

will mean much for the safety of the eye as well as of the patient. Benign tumours are easily removed, but where malignancy is suspected, the case should be sent to the general surgeon immediately for extirpation of the tumour and the infiltrated glands or for deep X-ray treatment if necessary.

PTERYGIUM.

It is a triangular fold of flesh growing over the cornea from the bulbar conjunctiva on the medial or lateral side (sometimes both sides), the apex being directed towards the centre of

DACRYO-CYSTITIS.

It is another common condition neglected by villagers, but which is responsible for the loss of many an eye. Its danger to the eye is discussed in a previous paper (V) on corneal ulcer. Very often, it is discovered only when the patient comes to the doctor for an ulcer in the cornea, or when the lachrymal sac itself is inflamed and the pain is unbearable.

The symptoms of infection in the lachrymal sac are mainly lachrymation, discharge and regurgitation of muco-puru-

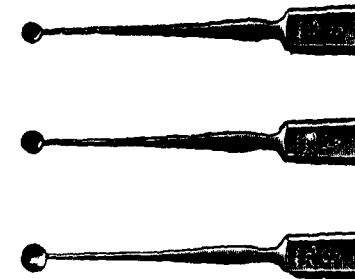


Fig. I.

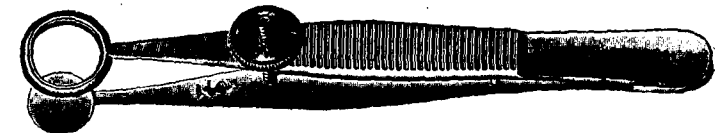


Fig. II.

Such a pterygium must be removed early.

The operation for pterygium requires a detailed description and it will be described in a later article on minor operations.

danger to the eye and it is necessary the practitioner in the villages knows how to do it, as such an operation if performed in time when a corneal ulcer is starting will be helpful to save the eye.

SPASTIC ENTROPION.

Some old people suffer badly from this condition. Their socket is devoid of fat and the skin of the lids is loose and lax. When there is any light irritation in the eye, as for example, from dust or exposure to wind, there is a strong contraction of the orbicularis muscle and a spasm of the muscle and, owing to the loose nature of the skin, the lower lid turns inwards, thus causing further irritation to the eye from the inturned eye-lashes and further contraction and spasm of the muscle. It is more or less a vicious circle. In early cases, if you keep the lid everted with a small bit of sticking plaster, the circle is broken and there might be relief. In long standing cases, an operation is necessary. A triangular or elliptical piece of skin below the lower lid margin may be excised and left without a suture. The cicatrix that eventually results after the wound is healed will keep the lid margin pulled down. A better method is to excise at the same time a few fibres of the orbicularis muscle there. Then, the result is surer still.

But, if a patient does not like an 'operation' in his old age, equally favourable results may be obtained by indurating the lower lid with an injection of alcohol 80 per cent. This should be injected just below the skin along the outer two thirds of the lower lid, about 3 mm. below the lid border. About $\frac{1}{2}$ c.c. will do. The inner third should not be infiltrated, because if that part of the lid gets everted, the punctum will not be in apposition with the bulb and the result will be a disconcerting epiphora. If the patient cannot bear the burning sensation of the alcohol injection, a preliminary Novocaine or Planocaine injection may be given.

The eye is bandaged just for a few hours after the injection. After-treatment is practically nil. The lid is seen swollen the next day, but it subsides in a few days. The operation gives fairly good results without any loss of blood or inconvenience as bandage, etc.

The other kinds of distortions of the lids are secondary to some disease and will be discussed in their respective places.

HERPES ZOSTER.

Eruptions limited to one side of the forehead and severe pain should make one think first of herpes affecting the ophthalmic division of the Fifth nerve. Often, the nasal division also is involved and the defect in the corneal epithelium adds to the suffering. There is photophobia, watering and severe pain. The clear limit of the vesicles to one half of the forehead should make the diagnosis easy. It takes many months for all the symptoms to subside, but the suffering may be mitigated with injections of Pituitrin and vitamin B preparations. For the vesicles, dusting powder may be applied and for the corneal condition, any emollient ointment.

KERATITIS LEGOPHTHALMOS.

In facial paralysis, the patient is not able to close his eye on the affected side. The delicate membranes of the eye, especially the lower part of the cornea and the bulbar conjunctiva suffer both from want of lubrication done by winking of the lids and from exposure to wind, dust and even insects during sleep. There is watering, irritation and sometimes pain. The corneal epithelium becomes thickened, dry and horny and an opacity is produced.

The first instruction to be given to a patient with a facial paralysis is to advise him to keep his affected eye bandaged with a kerchief or a towel whenever he goes to bed. In cases, where a cure of the paralysis is not expected, it is better to stitch up the two lids together leaving a small aperture to see through and for drainage of any discharge. To allay the irritation and watering, any non-irritating, bland ointment may be applied.

The other nerve affections of the eye come under another category and they will be taken up in a later paper.

ACUTE ABDOMEN.*

By

DR. K. C. NAMBIAR, M.B., F.R.C.S. (Edin.), F.R.C.S. (Eng.)

The term 'Acute Abdomen' is rather an unscientific one. It appeals very well to the layman's mind, but does not speak of the pathology behind. It indicates the severity of the illness and that the trouble is inside the abdomen. The causes may be many and varied; but there is a common clinical appearance arising from diverse pathological conditions; and such a clinical entity constitutes the Acute Abdomen.

I do not intend to presume to bring out in this short resume, the manifold aspects of this condition. But I hope to place before you some of the salient points that should interest the general practitioner in special. As you all know, the mortality arising from this condition is high; and late diagnosis makes it higher still. Hence the plea for an earlier diagnosis. The incidence of acute abdomen, as observed from the wards of the General Hospital, Madras, for the last 10 years, is getting lower and lower. This is, no doubt, a notable advance in the efficiency of medical practitioners and the ease and confidence with which the people take to surgery. The days of nightmare for the knife are rapidly receding. And this welcome change contributes a great deal to the cure of catastrophic conditions of the abdomen.

Some are apt to include cases of acute appendicitis and cholecystitis, under this nomenclature. But this is not strictly correct. These conditions may give rise to general peritonitis, and then alone it should be called acute abdomen. The causes of acute abdomen may be classified under two main groups: 1. *Inflammatory*, 2. *Obstructive*. Those beginning with inflammation ends in obstruction; and those beginning with obstruction may end in perforation and peritonitis, if the patient survives the toxic effects of obstruction. Thus it will be clear that the diagnosis of inflammatory

or obstructive lesion may not be possible unless the patient comes in early stages. For example, in a case of perforated duodenal ulcer, the classical board-like rigidity gives way to distension in 24 hours time and the specialist who tackles the case will be well advised to rely on the family doctor's findings at the onset of the illness than his own.

Inflammatory lesions of the peritoneum are by far commoner than *Obstructive* lesions, for producing the clinical entity of acute abdomen. Inflammation in the peritoneum, unlike in other regions, is attended with serious consequences to the individual for various reasons:

1. The area of the peritoneum is very extensive and approximates almost to the skin surface. For this reason, the shock arising from irritation or inflammation of the peritoneum is great indeed. We are familiar with the intensity of shock and collapse resulting from burns extending more than one third the area of the skin surface. Irritation of nerve terminals and absorption of toxic matter over a wide area causes a vital blow to the patient.

2. Such inflammation simultaneously irritates and weakens the nerves and musculature of the alimentary canal, producing paresis of the gut. Due to the stoppage of peristalsis of and the anaerobic activity in the gut, gases accumulate inside the bowels, produce distension and kinks and embarrass the heart. The toxins of *B. Welchii*, generated in the lumen of the bowel and the bacterial poisons in the peritoneum weaken the myocardium. Further a protease is liberated in the wall of the intestine producing profound circulatory collapse. Dehydration, due to vomiting, and bleeding into capillaries through shock become the last straw on the camel's back.

* Paper read before the Chingleput District Medical Association on 23-11-'40.

Fortunately for us, of all the tissues of the body, peritoneum is the most resistant, next to skin. The great omentum acts the Policeman, insinuating its fringes, at the points of attack, enveloping the bacteria and pus, localising the infection and if possible absorbing it. Further the disposition of the mesentery in the great cavity of the abdomen has divided it into compartments such as pouches, gutters and cesspools, localising the infection by holding in defence the invading bacteria or directing them into special channels where they are innocuous. The reflex local rigidity of the abdominal wall and the cessation of movement of the underlying gut, minimises very much the chances of diffusion of the imprisoned germs. Further the inflamed peritoneum readily becomes adherent at the contiguous surfaces and locks up the little locules of pus. But for such natural defences, peritoneal invasion should have been a worse calamity. Here I should sound a note of warning, that the peritoneum of children has a poor resistance. Experience has taught the surgeon to rely upon the peritoneum in looking after itself, so that he no longer swabs, mops or lavages; but removes the source of infections; e.g., appendix or gall-bladder and drains the abdominal cavity. It is now believed that swabbing and lavage are definitely injurious. Local variations in the resistance of the peritoneum have been noted. Pelvic peritoneum has a high degree of resistance, while subphrenic peritonitis is considered a grave affair. This has been one of the reasons for the adoption of the Fowler's position.

Peritonitis may be infective or irritant. The irritant may be due to:

- (1) Blood into the peritoneal cavity, as in cases of ectopic gestation, rupture of the spleen or liver, tear of the mesentery etc.
- (2) Extravasation of bile or hydrochloric acid as in cases of peptic ulcer or gall-bladder.
- (3) Extravasation of urine, as in rupture of the kidney, ureter or bladder.

Some cases of irritant peritonitis subside; while others become infected sooner or later.

Infective Peritonitis. Infection may reach the peritoneal cavity through blood stream when it is called acute primary peritonitis. Rupture or perforation of any part of the alimentary canal directly produces the infection, when the condition is called secondary peritonitis. Germs may travel through the walls of the diseased bowel without any actual perforation. In the female the peritoneal cavity is open to the exterior, through the fallopian tube, which forms an additional path of infection. Penetrating injuries from the exterior may introduce germs into the cavity. Lastly, though rarely, surgical intervention in the abdominal cavity has occasionally given rise to peritonitis. I should take this opportunity to mention that the abdominal muscular defence, is not a marked feature in cases of post-operative peritonitis.

To give you a typical example of an acute abdomen, I would like to invite your attention to a perforated duodenal ulcer, which seems to be the commonest aetiological factor of Surgeons in South India. The patient is usually a young adult, with a history of abdominal pain in the epigastrium, aggravated by food and relieved by vomiting. This time, he is prostrate with pain of unusual severity and the family doctor considers it as an acute exacerbation of his old malady. Alkaline powders give no relief. This may be considered as the first or the preperforative stage. During the second stage of perforation, the pain is suddenly relieved and the patient thanks the alkaline powder, if not his doctor. This is sometimes followed by a quiet interval, when he walks into a hospital, neither the patient nor the doctor knowing what has happened. His pulse is normal, if anything slow; abdomen scaphoid and tenderness present in the epigastrium. The fourth stage of peritoneal invasion is the typical, acute abdomen described in books. The patient lies on his back, absolutely immobile, holds his breath, and appears to be in mortal fear of talking. His face is rather pale, pulse

slow, respiration thoracic, and has board-like rigidity and tenderness in the abdomen. Obliteration of liver-dullness and free fluid in the flanks may be clinically elicited. The immobile nature of the patient is almost an unmistakable evidence. If the patient rolls and cries with pain, it is against the diagnosis. Now the patient slowly, but steadily passes on to the fifth stage of distension, in 24 hrs. time. The rigidity gives way to distension, due to the fatigue of contracting muscles and gradual distension of the gut, arising from paralysis. The last or final stage is reached in 48 to 72 hours, when the patient is bloated up, due to paralytic ileus and presents the facies Hippocratica, due to severe circulatory collapse, toxæmia and dehydration with rapid thready pulse cold clammy sweats, but bright eyes and a wakeful conscience to the very end. The surgeon usually sees the patient, a few hours after perforation while the rigidity is gradually disappearing; but the family doctor sees him earlier, when rigidity is on. For this reason, the specialist will be well advised to go by the findings of the general practitioner than his own. Vomiting in these cases is not a marked feature. It may be present in the early stages due to peritoneal irritation and in the later stages due to toxæmia and paralytic obstruction.

The treatment consists in opening the abdomen, closing up the perforation and putting in a drainage tube in the pelvis. A gastro-jejunostomy at this time if indicated is better not done. 20c.c. of antiperitonitic serum is poured into the peritoneal cavity before closing the abdomen. The mortality of this condition is practically nil, if operated on within 6 hrs. It may roughly be estimated as 25% more with every 24 hours of delay. The responsibility of the family doctor becomes sufficiently obvious from this statement. The earlier the operation, the better for the patient. Here I must state that during the shock, immediately after the perforation, the patient should not be interfered with. In 2 hrs. time, as the patient begins to recover from the shock, it should be considered as the optimum time for surgical interference.

Whatever may be the cause of the acute abdomen, the clinical picture in the later stages is more or less the same. Hence, a preoperative diagnosis of the underlying pathology is often difficult and the operation becomes an exploratory laparotomy. An intelligent peep into the history of the patients' past ailments and the exact site and mode of onset if available, may give us a clue as to the cause. This is often not possible in our country. When the abdomen is opened under a suitable anaesthetic, in a case of acute abdomen, gas, fluid, blood, pus or distended loops of gut may present themselves. Each of them has its own significance. Gas indicates perforation of a hollow viscus. Fluid may be acid in case of the stomach; alkaline and bile stained from duodenum or gall-bladder; or may have a urinary smell in case of rupture of the urinary system. Sero-sanguinous fluid is obtained in volvulus of the sigmoid, streptococcal infections and in the early stage of any other peritonitis. The presence of blood must remind the surgeon of an ectopic gestation, rupture of the spleen or liver, or a tear in the mesentery. Pus with a faeculent odour is characteristic of *B. Coli* infection. Thin brown pus indicates streptococcal. Thick white pus indicates staphylococci or *B. coli*, and green pus means pneumococci. If fluid does not well out and instead distended loops present, it is primarily a case of intestinal obstruction or strangulation.

Intestinal obstruction or strangulation can produce peritonitis in later stages, but the patient usually dies before actual pus formation. On the other hand, peritonitis can produce distension of the bowels, but in the presence of frank purulent pus, inflammation is more likely the cause. The operator aspirates the pus, and follows its tract usually towards the region of the appendix. The areas are packed off and the appendix removed if possible. If the appendix is normal, he follows the right paracolic gutter towards the duodenum and the gall-bladder and sutures the perforation if any; failing this he goes down into the pelvis, aspirates the pus, looks for a pyosalpinx in women or a diverticulitis of the pelvic and sigmoid colon in either

sex. If nothing is found, he should look for acute haemorrhagic pancreatitis. Fat necrosis of the omentum should have already shown itself. Failing to find a pathological lesion, he diagnoses it as a case of primary peritonitis, puts in one or more drainage tubes in the pelvis and flanks and closes the abdomen; and treats the general condition on general lines.

Diagnosis of the presence of acute abdomen is comparatively an easy matter; but determination of the site and nature of the exact pathological lesion may not often be possible without opening the abdomen. Its presence should be determined by the history and discovery of the following clinical signs and symptoms:—

	24 hrs.	48 hrs.	72 hrs.
1. Pain.....			
2. Rigidity.....			
3. Tenderness.....			
4. Vomiting.....			
5. Shock.....			
6. Temperature			
7. Leucocytosis			
8. Hyperaesthesia.....			
9. Distension			

The dotted lines to the right of a particular symptom mentioned above show the periods of time when a particular symptom appears.

A rising pulse rate with a falling temperature is an indication of the spread of peritonitis; while a fall in pulse rate with a rise in temperature is a happy sign of localisation of pus.

Differential diagnosis of acute abdomen from certain other causes producing acute abdominal pain has often to be made. For this reason, they have been classified into three groups. (1) Medical causes; (2) surgical, but not catastrophic; (3) surgical and catastrophic.

(1) MEDICAL CAUSES.

(a) Pulmonary—Pneumonia, dia-phragmatic pleurisy etc.

(b) Alimentary—Indigestion, gas-tritis, colitis etc.

(c) Vascular—Coronary thrombosis, angina P., mesenteric thrombosis.

(d) Metabolic—Diabetes, Tetany.

(e) Infective Alimentary Influenza and Malaria; Tetanus.

(f) Nervous—Vertebral and spinal tumours; tabes dorsalis, etc.

(2) SURGICAL BUT NOT CATASTROPHIC: Peptic ulcer; biliary, urinary and intestinal colics; chronic diseases of the appendix, gall-bladder, colon etc.

(3) SURGICAL AND CATASTROPHIC: Perforation, inflammation, gangrene, obstruction and strangulation of any of the contents of the abdomen.

It will be obvious from the above that elimination of the groups 1 and 2 is essential for the establishment of acute abdomen. The last group constitutes acute abdomen, while the second one may any time become catastrophic.

Having discussed about acute abdomen due to inflammatory causes, it is necessary to point out the role played by obstructive causes that bring about the acute abdomen.

Acute Intestinal Obstruction is not an infrequent cause of acute abdomen. Strangulated and obstructed herniae contribute the major part. Though amongst herniae inguinal hernia is the rarest to get strangulated, it is the commonest variety to get strangulated. Intestinal obstruction may be due to simple obstruction or strangulation. The latter indicates interference with blood supply due to a tight constriction as at the internal ring; or blockage of a mesenteric vessel as in thrombosis or embolism. Mortality of strangulated inguinal herniae is high, about 17%; but the percentage mortality, compared with other types of strangulations is comparatively low, the condition being usually external and early detected. The death in simple obstruction is due to vomiting, acidosis, dehydration and macrobic toxæmia, while strangulation usually means simple obstruction plus vascular interference. If the loop strangulated is large, the patient may die immediately of shock resulting from fluid loss, and traction

of the mesenteric nerves. If of moderate size, from the absorption of proteose in about 24 hours time; if of small size, as in the average case, from gangrene, perforation or gangrene and peritonitis. The mortality of acute obstruction is about 40%, in all cases, volvulus heading the list and strangulated inguinal herniae being the last:

1. Gallstone Obstruction ...	50% Mortality
2. Cancer of the Large Bowel. ...	45% "
3. Adhesions ...	30% "
4. Internal Strangulation ...	33% "
5. Volvulus ...	51% "
6. Intussusception ...	22% "
7. Strangulated Ing. Herniae. ...	16% "
" Fem. Herniae. ...	20% "
" Umb. Herniae. ...	35% "

—Souttar.

The higher the obstruction, the quicker and the severer are the symptoms and the higher the mortality. Tighter and extensive strangulations are exceedingly fatal. More than 90% of strangulations affect the small gut. Simple obstruction of the large bowel due to cancer is nearly always an acute or chronic one; hence, it is advisable in such cases to make an attempt to convert the acute back into chronic obstruction by waiting, repeated enemata and other measures to relieve the congestion above the obstruction. The importance of this becomes obvious, as the mortality of chronic obstruction is very low. The symptoms are usually mild and the danger of waiting is usually much less than is imagined. Functional or paralytic or adynamic ileus is obstruction without actual mechanical obstruction and usually involves the small bowel.

The causes of strangulative obstruction are:—(1) External and internal herniae, (2) volvulus, (3) intussusception, (4) mesenteric occlusion, and (5) tight bands. Sudden relief of such strangulations are attended with disastrous results, due to the absorption of proteos and other toxic material from the obstructed loop. This has been one of the objections to the exteriorisation of a doubtfully gangrenous loop, instead of a resection and anastomosis.

CAUSE OF OBSTRUCTION.

Upper small gut.	Lower small gut.
Acute dilatation,	Gall stones,
Duodenal obstruction,	Cicatrix,
High jejunal kink.	Postoperative paralytic ileus.

Large gut.

Cancer, Diverticulitis,
Adhesions, Strictures,
Hirschsprung's Disease.
Adhesions.

Symptoms: The earliest symptom is acute pain in the abdomen due to forced peristalsis and traction on mesentery. Later on distension of the gut produces a dull aching pain. Vomiting in the early stages is reflex, later on regurgitant (reversed central stream and not reversed peristalsis); and finally toxic in nature. Pain and vomiting are early and acute in high obstructions, while constipation is not a marked feature. On the other hand, constipation is early and marked in large bowel obstruction, enema returns negative. Absence of flatus is the sure test for complete obstruction. The pattern of distension gives a clue to the site of obstruction. Distension of the colon is better seen in the flanks and the ladder-pattern in the small gut distension. Borborygmi on abdominal auscultation indicates to mechanical obstruction and the absence of it to paralytic ileus. Of late, the radiologists have succeeded to a certain extent in diagnosing the seat of obstruction by fluid levels and gas.

Diagnosis must be made of: (1) The existence of acute abdomen, (2) the presence of obstruction, (3) whether it is simple or strangulative and (4) high, low or large gut etc. The surgeon may be able to decide some or all of these points before operation.

If the pain is severe and operation is decided on, morphia may be injected. Large amount of intravenous glucose saline is given to combat dehydration. Stomach wash may be done to prevent aspiration pneumonia, especially if general anaesthetic is being employed. Urine is removed before going to the table. Spinal

anaesthetic is preferable, because the bowel will act soon after the release of obstruction. Some object to its use, fearing the bowel above the obstruction may rupture due to forcible contraction.

The incision will vary with the pre-operative diagnosis, and will be in most cases $1/3$ above the umbilicus and $2/3$ below. If distended loops of sigmoid or transverse colon present in the wound, the obstruction is below such points. Next palpate the internal hernial orifices, and nothing may be seen. Now palpate the caecum; if distended, the obstruction is below and therefore follow up the colon to the rectum (rectal examination ought to have been done before). If collapsed, follow up the ileum to the point of obstruction and dilatation and deal with the condition as required.

I have in the foregoing few pages, attempted to give a brief sketch of certain aspects of acute abdomen, a detailed study of which does not come within the scope of this article. The comparative suddenness of catastrophe and the apparent lack of surgical aid in rural areas form a helpless, disastrous and deplorable problem, at present difficult to get over. However, a lot can be prevented by the general practitioner by correct understanding and close application of the first principles of surgery and by helping the helpless peasants by early and correct advice. At the same time, the undergraduates and the postgraduates, leaving the clinical hospitals must be made to learn in detail all about acute abdomen, no matter he knows the diagnosis of a brain tumour or not. Then that will contribute a real advance to the realm of life-giving surgery.

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Abstracts.

NASAL SINUSITIS: EVALUATION OF THERAPEUTIC PROCEDURES WITH SPECIAL REFERENCE TO CONSERVATIVE MANAGEMENT.

By

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The surgical management of nasal accessory sinus disease is gradually being replaced by conservative procedures. Progress in the study of allergy has so materially changed our views about rhinologic therapy that surgery no longer occupies the important place it has held in the past. There are not a few who still believe operative intervention to be the sole measure for a chronically diseased sinus. The more conservative, however, now take the opposite or at least a middle stand, basing their position on the numerous failures of multiple surgical procedures.

Rational treatment of nasal sinusitis implies the use of such methods which in the opinion of the rhinologist are most appropriate for the individual case. One should not assume a dogmatic attitude. Prejudice against radical surgery in every instance is unjustified, even though most of the sinus operations which have been performed leave much to be desired in satisfactory end results. The present trend toward conservatism can be attributed to a more scientific approach to the problem. There are surgical procedures which, under certain circumstances, must be regarded as conservative. The intranasal operation for maxillary sinusitis may be cited as a specific example.

A recent symposium on nasal sinus disease brought out a diversity of opinions which exists today as it did twenty-five years ago. In spite of the fact that the external operation has numerous proponents, Hempstead, after gathering 1,634 cases from the literature, states that a good result was obtained in 97 per cent of the cases by the intranasal window

operation. As compared with the external operation, the procedure advocated by Hempstead cannot be classified otherwise than conservative. There are other similar examples, but this one is familiar to all rhinologists and obviously is in point.

NONSURGICAL MEASURES

The fallacies of the earlier treatment of nasal sinusitis are now well recognized. With increasing knowledge of nasal and sinus physiology the changing trend in therapy is a natural sequence. Foremost among the therapeutic innovations is the postural instillation of isotonic solutions in the nose. The displacement method of Proetz and the head-low treatment of Parkinson represent more effective approaches to rational sinus therapy. The Proetz technic is becoming more accepted as time goes on. Results have warranted more frequent utilization of this procedure, and because of its simplicity it is applicable under circumstances which will not permit resort to other methods.

In the hands of some rhinologists, suction irrigation has produced gratifying results. Hays believes too many antra are opened and washed out and that operative procedures do not afford permanent benefit. He advocates the suction-douche, which he has found will cure many cases and be of material benefit in others.

Fox, Harned and Peluse recently related their experience with irrigation by posterior suction. They contend that this treatment is of definite value in subacute and early chronic posterior sinusitis. The

principle of displacement described by Proetz is adhered to with the minor variation that irrigation with gentle suction is carried out. Proetz has labeled this "washing through." In the process continuous suction is applied at one nostril while a treatment solution made to pass through the other.

Some workers still employ the Dowling treatment, which utilizes cotton tampons saturated in a 10 per cent solution of argyrol and applied to the mucous membrane of the nose. According to Dowling, the method is suitable in acute and chronic sinus disease. "Silver colloids, applied by means of tampons, induce a watery secretion from the mucous membrane. The induced flooding of the tissues withdraws pus and bacteria and practically depletes the tissues of watery elements. . . . That actual drainage of the sinuses is accomplished is well demonstrated in occasional acute cases in which the maxillary sinuses are sufficiently filled with pus to overcome the light reflexes incident to transillumination for subsequent to treatment these sinuses will actually show a positive degree of illumination."

Various physical agents have been employed in nasal sinusitis, some with benefit, others with no appreciable favorable effect. Infra-red radiation to the face following the application of astringents to the nasal mucosa is a well regarded therapeutic aid described by numerous writers. Infra-red is most useful in acute sinusitis and in acute exacerbations of the chronic state. Ultraviolet irradiation is of little or no value in sinusitis unless the applicator conveys the rays to the mucosa. General ultraviolet irradiation to alter the body metabolism is beneficial in climates where it is not practical to utilize the natural sun's rays.

Short wave diathermy has been claimed by many followers as the treatment *par excellence* for sinus disease. Recent clinical studies and a wide experience with diathermy have led me to arrive at the following conclusions:

1. Short wave diathermy is not in itself sufficiently effective in acute sinusitis to be

employed to the exclusion of other recognized therapeutic procedures.

2. It is not a curative method of treatment of chronic sinusitis, when used either alone or in combination with other non-surgical measures.

3. It is an effective aid to indicated accepted procedures in acute sinusitis, hastening the abatement of symptoms and shortening the course of the disease.

The rationale of roentgen therapy of sinusitis was established by Butler and Wooley. The beneficial effects of X-radiation are attributed to the radiosensitivity of lymphoid structures of the hypertrophied membrane and the lymphocytes which, under small doses, are broken down, thus liberating bacteriolysins. These activate the macrophages to greater bacterial activity. Concomitantly the edema of the ostia is reduced, permitting freer ventilation and drainage. While several other reports on x-ray therapy of sinusitis are contained in the literature, only a few can be cited here. Rathbone obtained excellent results in children with x-ray treatment of both acute and chronic sinusitis. Hodges on the other hand reported good results in early polyposis, and poor results in old cases. Basing their results on 700 cases treated, Butler and Wooley found that chronic infection associated with hypertrophic membrane responds best.

ALLERGY AND SINUSITIS

Vaughn claims that many cases of so-called sinusitis are in reality nasal allergy. "When the complaint is of sinus trouble one should learn whether symptoms are intermittent or seasonal, whether x-rays have shown evidence of sinus infection, whether local treatment has given relief, whether there is associated sneezing or rhinorrhea, and whether there is history of other allergic symptoms leading one to suspect that the 'sinus trouble' is due in whole or in part to allergy."

Even when sinusitis is known to have an underlying allergic basis, it is often difficult to determine the particular kind of treatment to be applied. A strictly

allergic approach only occasionally affords effective relief of symptoms. When the symptoms are severe, topical treatment is indicated and should be instituted until a more opportune time for allergic diagnosis and management. Feinberg emphasizes that nasal pathologic processes in an allergic patient should not be neglected. He avers, however, that surgery, for example, often fails to cure the underlying allergic condition in the majority of patients. He remarks further that it is necessary to assume both a tolerant and a conservative attitude to this entire question.

The patient with nasal sinusitis who is resistant to orthodox measures and who develops frequent recurrence of symptoms should be subjected to a complete allergic workup. If a single offender is found to be the direct cause or only a contributory factor, much may be accomplished by an avoidance regime. In such instances, too, specific immunization has given good results. When, however, the offending allergens are multiple, injection therapy is far from satisfactory.

Our present knowledge of allergic therapy would lead us to believe that most patients are cured or improved when an accurate diagnosis has been made and proper treatment instituted. This is not the case, however, as failures are more frequent than cures. The complicating factors of nasal sinusitis are too well known to need more than mention. There are reasons why allergic therapy fails, but but it is not always possible to explain them. Failure of specific immunization or other allergic regime necessitates the application of non-specific measures.

In this category may well be included drugs, hormones, topical remedies, electrotherapy, and surgery. Irrigation of a sinus with an allergic basis must be considered as a nonspecific method. The same holds true of any other minor or major surgical procedure.

It is generally agreed that when an intranasal examination reveals a pale, boggy and swelled mucous membrane, a similar condition exists also in the sinuses. This may account for the frequent failures

of intranasal treatment. While the nasal symptoms are relieved by such care and probably to some extent also the sinus symptoms, enough of the pathologic process in the sinuses persists to prevent a curative result.

Too often surgery is instituted before a thorough study of the patient is made, and it is overlooked that hyperplastic changes in the membranes of the nose and sinuses call especially for endocrine and allergic analysis. Lillie has aptly brought this out and emphasized: "If these causative factors of polypoid and hyperplastic changes can be controlled the suppurative process may respond readily to adequate surgical intervention."

The suggestion that potassium may play a role in allergic sinusitis is not without clinical foundation. Bloom observed favorable effects in a small series of cases, particularly those of a polypoid nature. Bloom and Grauman obtained good results in thirteen of twenty patients with chronic sinusitis. They comment: "Should this hypothesis, that allergy is predominantly a disturbance of electrolyte metabolism be established, it would then seem reasonable in view of our increasing knowledge of the relationship between electrolytes and the endocrines, that an endocrine basis for allergy might be determined. Somewhere in this complex relationship between proteins, electrolytes and endocrines there must also be considered a role played by the vegetative nervous system."

VITAMINS AND DIET

That foods have an influence in the causation of nasal and sinus symptoms is now accepted fact. Aside from the allergists, the rhinologists has come to believe that diet is an important part of the treatment of allergic sinusitis. Cohen found in a series of 175 cases, that foods were the predominating factor in the causation of abnormal conditions in the nose and throat that one must not stop with tests for reactions to inhalants, excitants, grasses and pollens. "It seems hard to believe," states this writer, "that foods play such an important part in cases of allergy in which the patient shows nasal manifest-

tations, yet in my series of cases practically all the patients were relieved of their symptoms by eliminating from the diet the foods giving a positive reaction."

Vitamin deficiency plays an important role in the development of infections of the upper respiratory tract. While this has been overestimated in some quarters, the present trend is to prescribe mixed vitamins in all sinus infections. The fallaciousness of this rule need not be discussed. When vitamins are prescribed it should be on the basis of careful determination in history taking or by the visual photometer test. While the use of vitamins generally is still in the experimental stage, studies seem to indicate that A and C are the most intimately related to the development and maintenance of resistance to infection.

IRRIGATION OF THE SINUSES

Irrigation of the nasal sinuses is still regarded as an essential procedure to evacuate pus and promote drainage. Irrigation of the frontal sinus is not frequently performed, but when indicated accomplishes as much as does irrigation of the maxillary antrum. Van Alyea has made a comprehensive anatomic study of the frontal sinus and has found that this structure is quite variable, a fact which he believes accounts for the variable forms of treatment which are employed. He contends that most rhinologists would advocate catheterization and irrigation as an adjunct to other methods of therapy, if a safe, dependable technic for the procedure could be designed applicable to all cases. Van Alyea claims that catheterization of the frontal sinus through the natural opening is possible in most cases. "Patients with frontal sinusitis treated by the irrigation method alone show improvement and many times a complete cure. An acute attack is often relieved by one irrigation, although the case may be of such a nature as to require several such treatments. Patients with chronic cases may be treated successfully by the irrigation method, either alone or as an adjunct to operative procedures. Infected cells, which cause symptoms similar to those of frontal sinusitis, may be entered and irrigated with favourable results."

There is no doubt that irrigation of the antrum is a valuable procedure which should be utilized when indicated. Whether the natural ostium or the inferior meatal approach is utilized will depend on numerous factors which need not be considered here. The fallacy of repeated irrigation of a sinus has not been sufficiently emphasized, with the result that some rhinologists persist in the use of the method without regard for possible consequences. Lillie has pointed out that the continuous use of aqueous nasal irrigation produces a deleterious effect. He argues that the only apparent reason for the use of such a method of treatment is its timehonoured tradition. "As my experience increases," he writes, "I feel more convinced of it. Certain patients apparently are not affected in the same manner, but the majority do better if the method is not used."

In a series of two hundred sinus cases which came under my care during the past three years, irrigation of the maxillary sinus was performed in only twenty instances, and then for not more than one to three times. Other measures were then substituted which served far better than if irrigations had been persisted in. In eight cases which previously had been repeatedly irrigated without cessation of the discharge, change to other forms of treatment promptly checked the progress of the suppurative process followed by a favorable response. It is not unlikely that the excessive mucopurulent discharge in these eight cases resulted from water-logging of the membranes, a factor brought out in Lillie's discussion of this subject.

RATIONAL SINUS THERAPY

As has already been stated the rhinologist should not adopt a dogmatic attitude in treating sinusitis. Nor can he successfully employ the same treatment for every type of the disease. The symptoms in acute sinusitis frequently call for measures wholly different from those applicable to chronic sinusitis. This holds true also for acute exacerbations of the chronic condition.

In acute sinusitis constitutional treatment is important. In fact during the

first few days local measures are best avoided. The toxic state of the individual calls for bed rest, increased elimination, alkalization, large fluid intake, foreign protein therapy, and mild anodynes or sedatives. After the acute stage, topical remedies should be applied if a spontaneous cure has not taken place.

While the procedures to be employed will depend on the particular sinus or sinuses involved, generalization of a plan of treatment for all sinuses may be adopted. The principles of improved ventilation and drainage are applied with full consideration for ciliary activity, and for these purposes utilization of astringent isotonic solutions serve most satisfactorily. In some instances the Proetz method may be all that is required. Every effort should be made to maintain good nasal ventilation following which drainage usually can be promoted by mild negative pressure.

If the suppurative process continues and treatment needs to be augmented, infra-red radiation, or short wave diathermy may serve as effective aids.

In some cases suction-irrigation is a valuable adjuvant. This has already been pointed out. Proper technic is important. The best results are obtained after thorough shrinkage of the nasal membranes. In the more severe forms of antrum disease, a single irrigation of the antrum sometimes is essential for prompt action, after which any one or combinations of the procedures mentioned will usually help to clear up the affection.

For some patients a change of environment and climate is conducive to cure. The erroneous idea that favorable climatic conditions in themselves will cure the average case of chronic sinusitis needs to be corrected. A uniformly warm climate is appreciated thoroughly by most sinus patients. The symptoms gradually become less severe in character requiring less drastic treatment for favorable results.

It is difficult to designate which climate is appropriate for a particular case. The semitropics give prompt and frequently

permanent relief to some patients. The high altitude and dry air of Arizona likewise have afforded dramatic results to others.

When a complicating allergy exists, or when the allergy is of primary importance and the infection is superimposed, general suggestions for treatment should not be followed as usually they are of little avail. Treatment must then be individualized. For this class of patients a change of climate and environment on a trial basis is good advice. It often changes the picture completely. Experience has demonstrated, however, that favorable response is not consistently obtained.

There are a large number of miscellaneous procedures which have not been mentioned in this resume and which occasionally will be found to possess merit. The rhinologist employs them and justly so on the basis of his experience. The indiscriminate use of any one procedure is irrational and highly objectionable. The therapeutic endeavor should be along scientific lines having in mind not only the rhinologic disease but also the patient's general physical condition. Over-emphasis of local treatment without regard for the systemic side has been the cause of failure in large numbers of cases.

SURGICAL CONSIDERATIONS.

It is not the purpose of this paper to exclude surgery in the management of sinus disease when it is definitely indicated. The controversial aspects of the problem render a differentiation of conservative and radical surgery difficult. There can be little argument against the necessity of radical extirpation of a polypoid mass in a sinus, and while an extensive operation is involved, the procedure should be considered a conservative one for that type of case. Preference between intranasal and external sinus operations cannot be dismissed without some comment. Here again, the intranasal operation is classified as conservative and the external procedure as radical. I have seen some intranasal procedures which were far more radical than any external sinus operation. It is obvious from all

this that our classification of sinus operations requires revision.

The subject of sinus surgery is appropriately included in every program of management of nasal sinus disease. The borderline case is the one which frequently brings about differences of opinion among consultants. While no hard and fast rules can be laid down, it seems reasonable to advocate a thorough trial of non-surgical methods when the situation is not critical and when no hazard will be added by the time element required.

When the need for surgery is absolute, no other procedure should even be considered solely on the ground that it is non-operative in nature.

CONCLUSIONS.

The introduction of several new non-surgical procedures and their successful utilization in the treatment of nasal sinusitis have changed our views concerning sinus therapy. As the relationship of allergy to sinus disease is being more thoroughly appreciated, the trend toward conservative management is constantly increasing. Surgery in nasal sinus disease is an issue only in borderline cases. The scientific utilization of non-surgical procedures seems proper so long as the situation is not critical and no hazard is added by the time element required. When, however, the indications are absolute, surgery cannot be avoided, and no effort should be made to replace it by inadequate therapeutic substitutes.

SUMMARY.

1. Recent advances in the management of nasal accessory sinus disease emphasize an increasing appreciation of non-surgical procedures.

2. Of the surgical procedures which, under certain circumstances, must be regarded as conservative, the intranasal window resection may be cited as a specific example.

3. The more important aspects of the newer non-operative procedures in sinus treatment are briefly discussed.

4. Outstanding among the advances in causal relationship and in therapy of nasal sinusitis is allergy.

5. The importance of endocrine and allergic analysis has not been sufficiently stressed.

6. Vitamins and diet in general and their relation to sinus disease must be duly considered.

7. The continuous use of aqueous nasal irrigation produces a deleterious effect by water-logging of the membranes which results in a constant, excessive, mucopurulent discharge.

8. While a generalized plan of treatment for any of the sinuses is suggested, it is realized that individualization is the secret of success especially in resistant cases.

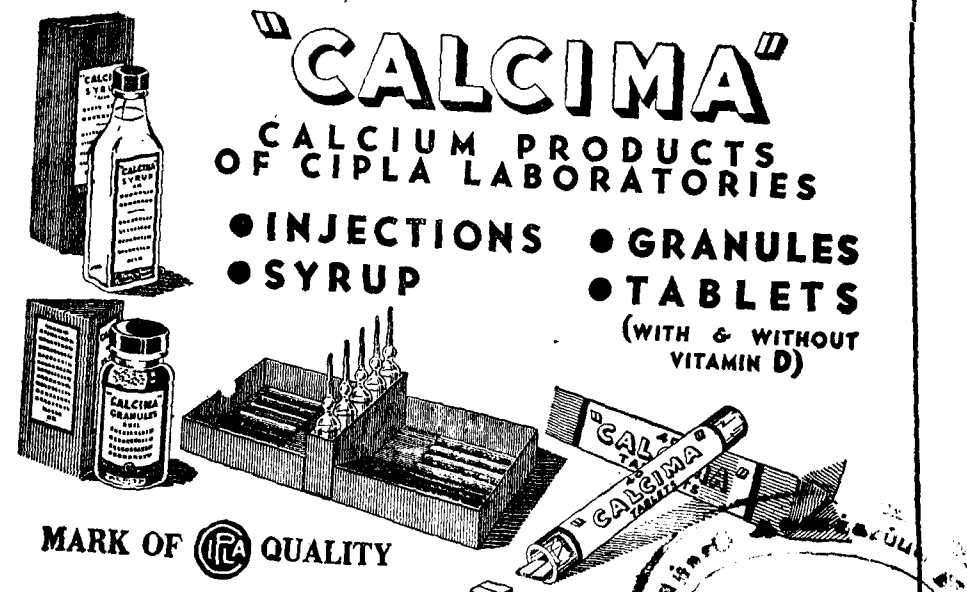
9. It is difficult to differentiate conservative and radical surgical procedures, a problem which arises only in borderline cases.

10. A thorough trial of non-surgical methods is rational and justifiable when the situation is not critical and when no hazard will be added by the time element required.

(The Eye, Ear, Nose and Throat Monthly, February 1940).

NOTICE.

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

POMEGRANATE FRUIT.

By

DR. B. S. ACHARYA, B.A., L.M. & S., F.I.M.

With reference to the letter of Dr. V. Gopalakrishnamurti, in your issue for May 1940 on page 295, regarding the successful use made by him of the rind of the pomegranate fruit in cases of dysentery, and calling for information about the composition and properties of the drug, I am herewith forwarding a note containing the available previous literature on the plant and request you to publish the same in your valuable columns.

PUNICA GRANATUM (Linn) N. O.
Myrtaceae.

Synonyms:—

Sanskrit...	Dadima
Mahrathi	Dalimba
Concani	Do.
Telugu	Danimma
Tamil	Mathalai
Hindustani	Anaur, Gulnar.

Habitat:—Northern Africa and Western Asia as far as the Western Himalayas. Naturalised and cultivated in most tropical and subtropical countries. Royle states that it may be seen growing wild in the Himalayas.

Description:—Large shrub; 15-20 ft; Leaves opposite, oblong-lanceolate, foliage dark green like olive or myrtle. calyx 5 cleft; petals five; fruit size of orange, peculiar, composed of two whorls of carpels, one placed above the other, the lower consisting of 3 or 4 and the upper 5 to 10 carpels. Hard brown yellowish rind containing a reddish seedy juicy pulp. Flowers nearly sessile, scarlet. All flowers produced at the extremities of the young branches, formed the same year. Longevity of the tree remarkable.

The rind of the fruit, the flowers and other parts of the plant are used in medicine. All parts of the plant are rich in

tannin and act as astringents and are employed successfully in diarrhoeas and other similar diseases and as local application for relaxed sore throat and cancer of the uterus (Ainslie).

I. GRANATI RADICIS CORTEX.

Pomegranate root-bark, was official both in British and Indian Pharmacopoeas, (now deleted from B. P.)

It contains in addition to a large quantity of tannin 20%, a number of alkaloids, at least 4 in number, varying from 0.5 to 0.7%. They are:—

1. Pelletierine (Punicine).
2. Iso-pelletierine (Iso-punicine).
3. Methyl-pelletierine (Methyl-punicine).
4. Pseudo-pelletierine (Pseudo-punicine).

Of these the first two constitute the pelletierine of medicine, the other two alkaloids methyl and pseudo varieties are inactive.

Action and uses:—

Locally astringent. Internally used for the destruction of the tapeworm. But as it possesses no purgative property, an aperient is required to ensure the expulsion of the worm. Large doses of the bark or the alkaloids may cause headache, vertigo, dimness of vision, nausea, vomiting, and muscular weakness.

Preparations:—

Decoctum Granati Radicis. (Decoction of pomegranate root-bark).

Take of fresh pomegranate root-bark sliced two ounces: water two pints. Boil down to a pint and strain, making the strained product up to a pint, if necessary, by pouring water over the contents of the strainer.

Dose:—

As an anthelmintic two fluid ounces taken fasting, and the same quantity repeated every half hour until six doses have been taken, to be followed by an aperient.

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Fluid extractum Granati (U. S. P.)

Dose:—1-2 fluid drams.

Also in German Pharmacopoea as Extractum Granati Fluidum.

PELLETIERINE ($C_9 H_{15} N. O.$)

Dose:—2 to 6 grains.

It is a mixture of alkaloids obtained from Pomegranate stem and root bark, a colourless oily volatile liquid with aromatic odour, becoming brown on exposure to the air, capable of uniting with acids forming stable salts.

PELLETIERINE SULPHATE

(Punicine sulphate) French Codex.

It is a mixture of the sulphates of pelletierine and iso-pelletierine.

It a brown syrupy liquid freely soluble in water, sometimes as a crystalline mass.

Dose:—5 to 8 grains, taken fasting followed by a full dose of compound tincture of jalap.

PELLETIERINE TANNATE. (B. P.) and U. S. P.

It a mixture in varying proportions of the tannates of the alkaloids obtained from the bark of the root and stem of Punica Granatum.

A greyish powder slightly soluble in water 1 in 700 but soluble 1 in 80 of alcohol 90%.

Dose:—2 to 8 grains as a taenifuge followed in two hours by an ounce of castor oil, effectual causing neither colic nor headache.

II. GRANATI CORTEX.

The dried rind or pericarp of the fruit was officinal in Pharmacopoea of India.

Preparation:—

Decoctum Granati Corticis (Decoction of Pomegranate rind).

Take of dried pomegranate rind, bruised 2 ounces: water one pint. Boil for

15 minutes in a covered vessel, then strain and pour as much water over the contents of the strainer as will make the strained product measure one pint.

Dose:—from one to one and a half fluid ounces.

A good astringent for gargles also useful in diarrhoeas and advanced stages of dysentery and other cases requiring the use of astringents.

According to Kirkpatrick the rind of the fruit is a valuable tonic and astringent and as decoction with cloves is the best known remedy for the chronic forms of dysentery under which the poor native of India so often suffer.

Combined with opium it proves most useful in the diarrhoea of the natives of India.

The juice of the ripe fruit contained in the red succulent pulp which covers the seeds, is slightly acid, extremely pleasant to taste, not unlike orange, very refreshing and well calculated to quench thirst in fevers.

According to V. G. Desai, the juice of the entire fruit is Rochaka (appetiser) Blood purifier and astringent used in debilitated conditions of the bowels, diarrhoeas and dysenteries and Sangrahani. Fresh fruit is preferable to dried ones and where fresh ones are not available dried whole fruits should be used. The dried bark of the fruits is not useful.

According to Bhavaparakash Nighantu, there are 3 varieties of the Dadima fruit described as sweet, acid-sweet and purely acid in taste. The sweet variety is Tri-doshaghna (destroys three doshas), allays thirst and burning in fever, good for the heart, throat and mouth diseases, productive of Shukra, Medha, and strength.

The acid sweet variety is deepana and Ruchya (produces taste and increases appetite and productive of slight pitta).

The acid variety produces Pitta, removes Amavata and Kapha.

The rind is Krimighna, Grahi (astringent) and removes dysentery.

MEDICINAL QUALITIES OF 'CHATIM' BARK.

A Substitute for Quinine.

BY

DR. B. S. ACHARYA, B.A., L.M. & S., F.I.M.

As a result of researches carried on by various leading Ayurvedic Institutions in India, the bark of the Chatim tree (Latin: Alstonia Scholaris, Sanskrit: Saptaparna) has been, it is claimed, found to be more efficacious than quinine in the matter of treatment of malaria. It contains an active bitter constituent called 'Ditain', which in equal doses has the same medical effect on malaria as quinine sulphate, without any disagreeable symptom of the latter, such as deafness, sleeplessness, excitement. In the Manila Hospital, malaria cases were treated with the Chatim bark and the result has been, it is stated, so satisfactory that it may safely be predicted that it would completely replace quinine."

The drug was officinal in the India Pharmacopoeia and later in the British Pharmacopoeia. Its properties were mentioned as being astringent, tonic, anthelmintic and antiperiodic.

There are also other efficient remedies mentioned in the literature on Indian Medicinal Plants for not only 'intermittent fevers' but for many other diseases also. For testing the usefulness of such remedies and verification of their properties, a band of medical practitioners who are interested, may easily carry out such clinical experiments and communicate the results through the columns of the Medical Practitioner.

SOME NEW DATA ON THE DISTRIBUTION OF POLIOMYELITIS VIRUS.

Although poliomyelitis does not stand high numerically in the list of human diseases from the standpoint of either the average numbers of cases reported annually

or as a cause of death, it is one of the dreaded epidemic infections. It is feared largely because of the crippling which is frequently a distressing sequel and because of the feeling of insecurity that arises from the lack of a specific preventive measure. A safe and effective specific prophylactic procedure may ultimately be evolved, but so far this is a hoped-for prospect rather than an accomplished fact.

Recent investigations on the distribution of poliomyelitis virus may have a possible bearing on the mode of spread of the disease, concerning which able investigators differ. Members of the Department of Medicine of Yale University have recently demonstrated, for the first time, the presence of poliomyelitis virus in sewage. Samples were collected from several localities in the city of Charleston, S. C., during the epidemic there in the summer of 1939. Inocula prepared from a sample taken from a pumping station at which sewage was received from a hospital where poliomyelitis patients were isolated caused experimental poliomyelitis in two monkeys, demonstrated by clinical symptoms and histologically in both animals and also in one animal by successful passage of the virus.

In another recent article, the recovery of poliomyelitis virus from the stools of healthy contacts was reported. At least three such instances had been reported previously in the literature, and also the detection of a healthy carrier without history of contact with poliomyelitis cases. The facts developed from the study of this institutional outbreak, in which the virus of poliomyelitis was recovered from the stools of 3 out of 12 apparently healthy children in contact with cases and in a healthy adult nurse intimately associated with cases, support the theory that the infection is transferred by direct personal contact and offer corroborative evidence that the virus of poliomyelitis is probably spread throughout the general population by healthy carriers.

(The Journal of Medicine, March 1940).

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[No. 3

NEW YEAR PRAYERS.

Last year late in December when we sent our New Year greetings to the members of the medical profession, World War though declared three months earlier than December, did not begin the actual destruction work. In this country and elsewhere in the British Dominions hopes prevailed at the time that Hitler dared not attack the French Magnot Line and the defence behind the Line was impregnable. Six months later, i.e., in June last, it was realised that the calm was only the precursor of storms of destruction. Gloom and despair prevailed in last August and now in the month of December there are distinct signs of victory for Great Britain and her allies in spite of the fact that German indiscriminate destructive air raids continue in the British Isles and the danger of invasion of the Island is lurking in everybody's mind. The valiant British though not quite prepared to meet the blood-thirsty Hitler who has been preparing for war for over ten years, seem to be very well prepared now to meet any exigency at home or abroad. We have had occasions to talk about air raids in England with many British residents of Madras and we amazingly admired at the cool and tranquil way they received the alarming news of destruction in the Island of their birth. Even in the months of last June and August they expressed that the reverses were of temporary nature and were cock-sure of the final victory for the Allies. The

British nation is famous for its dogged pertinacity. They have faith in themselves and in their power. Whatever might be the causes of war, the British and Indian interests are so intermingled at present that they cannot part and every attempt should be made by all concerned that the British and the Indians may work for common good and in equal partnership. This neglected country has now splendid opportunities of making itself self-sufficient not only to protect itself against invasion by land, sea or air, but also in the manufacture of chemicals and other scientific products required for the upkeep of health and happiness of the people. This can only be done by active co-operation in war efforts. Unfortunately the Indian National Congress have devised a treatment for political ills, which consists of principles of incompatibility. The Congress condemns Nazism but at the same time calls on people not to contribute towards the sinews of war. This is Mahatma Gandhi's cult. He is loved and respected not only in India but throughout the continent. So his cult cannot be brushed aside. He has started a war of principles, which though harmless to the extent it does not kill the combatants, is likely to create an atmosphere of hatred amongst those who cannot be expected to conceive Gandhiji's cult. Demonstrations are in evidence of a cult which is quite the reverse of that of the Mahatma and it was even displayed at an University education centre during the recent visit of His Excellency

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the Governor of Madras and the immediate Head of the University whom His Excellency honoured could not control the youths. It is most unfortunate that the medical students who are trained for diagnosing and curing all ills are reported to have a large share in the demonstrations. We learn that the present Government are of opinion that the educational centres throughout the world have been mainly responsible for the spread of revolutionary ideals, be it Nazism, Bolshivism, Fascism or any ism and that it should be the concern of the Government to put down the isms which in the opinion of the Government are harmful to the society. Therefore, the Government have made up their mind to put down any agitation engineered in educational institutions.

We are quite conscious that due to some rabid politicians the youths are surcharged with false notions of self-determination. But the remedy is not repressive discipline but reformation tendered with real affection and pity. Even the wildest animals are tamed by kindness and not by terror. Of all the professions, the medical profession, can analyse the mind most scientifically and devise suitable methods to free the mind from obsessions. The members of the profession possess the necessary imagination that the mind gets diseased due to ailments in the body, of physical or of psychological origin. Gifted with such imaginative faculty, the members of the medical profession can easily forgive the wrongdoers. So it is our earnest appeal to the members of the medical profession official and non-official, to make a capital of the inherent virtues of the profession and be active in preventing and curing the diseases of distrust, indiscipline and their sequelae. They can do so without spending money and be useful in their own way to help

war efforts without any fuss of satyagraha or the consequent repression. Everybody is conscious of the power of healing art. Let the members of the profession display it during these days of grave anxiety. Moral and spiritual force is certainly far superior to any physical force. Let the medical profession studiously have recourse to this weapon throughout this year. To such of those able-bodied amongst them we appeal to volunteer to do active war service and bring honour and credit to Indian medical profession.

The situation in the whole world is such that human reasoning and wishes are of little or no avail, and just at this juncture we cannot think of anybody except God and we have been praying Him to extricate the world from human aggression and we appeal to one and all members of the medical profession to join us in our prayers to rid the world of Hitlerism.

REORGANISATION OF MEDICAL SERVICES.

STIPENDIARY MEDICAL SERVICE.

The Congress Government in their Order No. 3600 P. H. dated 23-12-'37 laid down that all paid appointments excepting those mentioned below should be gradually thrown open to the honoraries:—

(i) Superintendents of Government Hospitals in the Madras City.

(ii) District Medical Officers and Superintendents of Government District Headquarters Hospitals.

(iii) Chief Medical Officers in charge of Government Hospitals with a bed strength of 30 and above.

(iv) Resident Medical Officers who will also be assistants to Superintendents of Hospitals.

(v) Appointments in the King Institute, Guindy and Pasteur Institute, Coonoor.

The present Government though they have been so far giving effect to the above order, seem to have felt that it was desirable to pay the honoraries some compensation and the Surgeon-General did foreshadow the future policy of the Government as adumbrated unanimously by three local medical associations, whom the Government recently consulted. If this policy is followed vigorously, there will not be any need for fresh recruitment. But the intriguing official influence over the University has been such, that unless progressive liberal-minded members of the independent members of the medical profession get into the University Senate and control the University Medical Education, there will not be any encouragement for the younger generation belonging to the non-official medical profession to aspire for higher medical qualification such as M. D. and M. S., so as to enable them to serve in the hospitals attached to the teaching institutions. The readers might remember our comments in these columns last year, when the Principal, Madras Medical College objected that a honorary physician possessing the M.D. qualification and a honorary surgeon who is a Fellow of the Royal College of Surgeons, England, should not give clinics to the students, as both of them did not put in 4 years after they got the higher qualifications which entitled them to teach. The regulation of the University demanding higher qualifications such as M. D. and M. S. came into force only in 1937 when perhaps those that were responsible to promulgate this regulation found, that there were enough officials in the Medical Department to satisfy the needs of the regulation and who were likely to be disturbed from the positions they occupied, of which positions they took advantage to enable them to possess

the higher qualifications demanded by the University in 1937. A glance at this regulation would satisfy an impartial reader that those who were the authors of this regulation were scrupulously careful that the regulation was consistent with the qualifications then possessed by those who occupied the professorial chairs. For example, the University demanded M.D. for the Professor of Ophthalmology amongst other qualifications such as D.O.M.S. The Professor of Ophthalmology at the time was an M.D. (Leeds) which is not a special higher qualification in Ophthalmology. As mentioned above in 1939 when the Government selected a young M.D. to serve as an honorary Physician, Government General Hospital replacing another old honorary possessing the same qualification, the Principal, Madras Medical College wrote a letter to the Madras University requesting that the rules regarding the qualifications of Lecturers in Clinical subjects be prescribed by the Syndicate, and the syndicate resolved that the qualifications and attainments of Clinical Lecturers should be the same as those governing the Professors or Lecturers in clinical subjects. That this special resolution of the Syndicate was a pistol aimed at the honoraries is evident from the fact that the University has been tolerating Professors and Lecturers in paid service who did not possess the qualifications prescribed by that body and granted special exemption which was not applied for in the case of honoraries even when suggested. As in politics there are found leaders in the Indian medical profession who lead others for the benefit of the individuals and not for the common good of the entire profession and so long the medical profession is controlled by officials, in the medical profession, leaders cannot be found outside the official hier-

archy. In such an atmosphere the G.O. No. 3600 P.H. dated 23-12-'37 will serve only as an eyewash and even the present idea of paying the honoraries compensation for holding duty posts which is a tithe of the pay of the paid officers would within a short period of experiment prove a failure and likely to bring discredit to the Honorary System of Medical Service. So, till the profession is able to get rid of the selfish sycophants who are able to make things appear quite the reverse of what they really are and have been able to use their followers in their art of jugglery, it is much safer for the members of the independent profession to rely on non-Indian Head of the Medical Department. The scientific medical profession as it is practised to-day in India came from the West and the Indian members of the medical profession whether they be officials or non-officials will do well to depend upon the Western methods for the evolution of the medical profession as enunciated by the official Head of the Medical Department till India gets political independence as in this case there will be less personal bias and more justice. The Honoraries will do well not to accept duty post on a pittance but continue to work as honoraries without remuneration excepting conveyance allowance and do only professional work and not administrative work in the institutions they serve. At the same time, we earnestly appeal to the Government to give up the idea of entrusting duty posts to Honoraries which we do in the interests of honoraries as well as stipendiaries. Let the Government spend at least 10 years to create an atmosphere of trust in the honorary service and during this period never entrust administrative responsibilities to the honoraries. In the meanwhile the Government should see that they have

sufficient number of medical officers to teach non-clinical subjects such as Physiology, Anatomy, Bio-Chemistry, Pathology, Bacteriology etc. It is also desirable that the Government should establish separate cadres for teaching and non-teaching medical institutions as they have done for the teaching of Anatomy and Physiology, so that there may be facilities to find proper and sufficient number of persons when vacancies arise in the respective cadres.

The Jail medical service may be separated from the medical department and the entire control be handed over to the Inspector-General of Prisons who is a medical man.

There are three mental hospitals belonging to the Government which should be entrusted to mental specialist. There are only two such recognised specialists in the Government Mental Hospital, Madras and the Superintendent of this hospital is directly under the Surgeon-General. The other two hospitals in Calicut and Vizagapatam are under the immediate control of the respective District Medical Officers who are not mental specialists. One of the specialists from the Madras Mental Hospital may be put in charge of the Calicut Mental Hospital. The present Medical Officer in charge of Vizagapatam Mental hospital has sufficient experience, having worked in Mental Hospitals for a number of years, may be made independent of the District Medical Officer. Soon after the war comes to an end, the Government should invite applications from senior medical officers of over 15 years service to be trained in the foreign mental institutions. It is also conducive to have a special cadre for Mental Hospitals.

Unlike in other Presidency towns like Bombay, Calcutta, in Madras there is a dearth of recognised specialists with the required qualifications amongst the members of the independent medical profession to take the place of paid specialists. So, it is necessary that the Government should depute capable men or women already in service who have put in over 15 years service to foreign countries to specialise in subjects such as Dermatology, Venereology, Orthopedics, Pediatrics, Ophthalmology, E. N. T. surgery, etc. There should be at least three specialist officers in each of the subjects mentioned above to meet the exigencies in service.

The pay and the emoluments of full time medical officers under the Government should be in par with those of the officers serving in other departments. The head of the medical administration of a district should be paid the same pay as that paid to the Indian head of a department in a district. The Assistant Surgeons should enjoy the same pay given to an officer next in rank to the District Officer in other Departments. The subordinate medical service should be abolished soon after the present incumbents retire and competent medical men from amongst the Subsidized Rural Medical Practitioners may be posted to hold the appointments so far occupied by the Sub-Assistant Surgeons on a monthly honorarium of Rs. 50. Such a step will make the subsidized rural medical service more attractive and efficient. We have discussed in these columns last four months, in detail, how in course of time honorary medical officers should take the place of stipendiaries for doing professional work. If, as we have suggested above, the Government will be pleased to increase the pay of the Medical Officers now in service they should be debarred

from even consultation practice. In case any member of the public wishes to consult the full time paid officer of the Government such consultation should be done in the hospital where the medical officer works and the fee charged either for consultation or for professional work should be credited to the Government. Very few at present amongst the paid officers of the Government respect the conditions laid down for consulting practice and instances are not wanting where at least a few medical officers holding high posts in the hospitals give advice to the members of the public without the intervention of a private medical practitioner and we hear stories of the friend and relations of patients consulting particular medical officers during the course of treatment of particular patients in a hospital, who consulted the officers for seeking admission so that the admitted patients may have personal care and attention. So, even the morale of the medical officers will improve in case the consulting practice is prohibited for full time medical officers.

If medical science is far ahead in other civilised countries and not so much advanced in India, it is due to the fact that the destinies of the profession are controlled by the profession and not by the Government and it should therefore be the aim of the Government in India to encourage the medical profession to evolve depending upon the mental resources of those who practise the healing art, the Government giving such help and encouragement as is needed and demanded not in individual interests, but for the benefit of the profession as a whole. There have been signs these few months at least when the Head of the Madras Medical Department has been, of his own accord trying to decentralise his powers to his imme-

diary district subordinates and appointing committees to help him in his administrative duties which require active co-operation of those on the spot. It is also to be said to the credit of the present Surgeon-General that during his regime, the Government of this Province consulted for the first time in the annals of the history of honorary medical service local medical associations instead of appointing Government committees to consider the necessity of amending or modifying the honorary scheme and if the profession at large attempted to come in contact with him, he would have been glad to consider any suggestion on behalf of the entire profession in the Presidency. We suggested ways and means to achieve this and all concerned were as callous as they have been in the past.

Before closing, we wish to reiterate our request to the Government that in the interests of the medical profession, the public and discipline in the hospitals and more than anything else in the interest of economy it is essential that the doors of the hospitals should be closed against those who can afford treatment outside the hospital. The Government of a minor Province of Orissa have been bold to have recourse to this step. Suitable almoners should be appointed for admitting patients into the hospitals who should not be medical men. Unless this is done the morale of the medical service will always be at discount.

News and Comments.

Stanley Medical College—General Wilson's Concern: On 29.11.40, General Wilson, Surgeon-General with the Government of Madras presided over the annual prize distribution of the Stanley Medical College and Mrs. Wilson distributed the prizes. Dr. G. R. Dinker Rau, Principal of the College began the function by the reading of the progress report of the College. He said it was the second academic year of the Institution since its conversion into a College in 1938. Dr. Rau paid a tribute to the good work turned out by his predecessor, Dr. T. S. Tirumurti who had been striving hard to get recognition of the College by the University, and that a Commission appointed by that body would visit the College next February. He requested the P. W. department to complete the buildings and equipment of the College by the end of this year so that the visiting Commission might see things "as they are and not as they are likely to be." Dr. Dinker Rau made an appeal to the All India Medical Council, on behalf of the licentiates with a five-year course of study. Their curriculum was modelled almost entirely on that of the Madras University, and it was recognised that the instructions given in that Institution was the best compared with all the other Schools in India. He hoped that the All-India Council would sympathetically consider the application of the students for the recognition of their Diploma. Dr. Rau appealed to the Surgeon-General to take up the matter with the All India Medical Council. The entire address delivered by Major-General Wilson has been published in the correspondence columns and we wish the readers to peruse the same, so that they could know the deep and abiding concern of General Wilson about the future of the Stanley Medical College which it was rumoured was likely to be closed. The

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mischievous authors of the rumour will have now to hide their faces.

It was indeed a sad disappointment that a large number of prize winners including the best outgoing student who was the recipient of the Government Gold Medal were conspicuous by their absence. Such an indifference on the part of the outgoing students on the eve of their entering the profession is likely to create a bad impression and it is hoped that the staff of the College will prevent a recurrence and bring credit to all concerned in the celebration of such and similar functions. We do realise that it has been a very hard task to the outgoing Principal and will be so to his successor to transform an atmosphere of artificiality to one of reality whether it be relating to discipline, love or affection between the teachers and the taught.

National Health Association: The annual meeting of the National Health Association of Southern India was held in the Banqueting Hall, Government House, Madras on 5.12.40. Hon. Lady Hope, the Patron of the Association presided. Major General N. M. Wilson, Surgeon-General with the Government of Madras, the Chairman of the Executive Committee of the Association, welcomed the Hon. Lady Hope and thanked her for consenting to be the Patron of the Association. In the course of his speech he referred to the good work turned out by the Association relating to the principles of hygiene and good health. Mr. R. Suryanarayana Rao, Hon. Secretary circulated the annual report which was taken as read. We were rather surprised to read in the body of the report the following lines:—

"In removing age-long prejudices by propaganda associations like ours will be more useful than the machinery of the State however necessary and useful State action may be. The State should welcome these unofficial efforts and assist them to play their important and essential part. It is to be regretted that such co-operation is not always welcomed. A scheme sent by the Association to promote closer association and co-operation to enable the enforcement of the Public Health Act was not accepted and even a small grant which the Association had been receiving has for some reason also been withheld. It is not known if the

Government feel that their officers alone are competent to undertake health propaganda and others are considered as interlopers. However, the Association is determined to play its part, in however a small measure, consistent with its limited resources, relying on public support and hoping the Government will soon realise that in our Association they have an ally whose assistance they should welcome and in affording support to it they are to some extent lessening their responsibility."

The Non-co-operation on the part of the Government Officials belonging to the Public Department was evident even at the meeting in the Banqueting Hall. The infection must have affected the Health Department of the City Corporation whose officers were also conspicuous by their absence though its chief Executive officer, the Commissioner played his part well at the meeting by explaining to the gathering what had been done by the Corporation regarding the health and welfare of the people committed to his care. All the speakers that took part at the meeting including Hon. Lady Hope stressed the need of propaganda and publicity through non-official agency to popularise health laws and deprecated the use of Health Act to educate the people in the principles of health and the prevention of diseases. We trust, the Patron of the Association and the Chairman, Executive Committee, will use their influence and make the Government realise that it is economically a sound proposition to get work done relating to Preventive Medicine by voluntary agencies and procure for the Association the necessary sinews of war to fight disease and ignorance without the need of coercive measures. We congratulate the Honorary Secretary for the good work turned out by him which though a thankless task, will have its own rewards. We also admire the undaunted courage of the Secretary to push on the useful work of the Association in spite of the disappointing attitude of the Government. Though belonging to an institution bearing a humble name, the Servants of India Society, the Hon. Secretary deserves to be called a soldier.

Outgoing Medicos: The students of the Madras Medical College and those of the Stanley Medical College have been for several years holding special functions

to bid farewell to the outgoing students. This is a gala day with all fun and frolic. Of late, there is a tendency for associating the names of the teachers in the fun and cracking of practical jokes about them. This is not good taste and should be avoided. We hope, it will be possible for the young medicos to realise that temperaments of individuals differ and on a merry day it should be concern of all to avoid studiously any injury to anybody's feelings, especially of the teachers. We are told that at the last farewell function at the Madras Medical College, the outgoing student who answered the farewell address was rather pessimistic about the future of the medical profession and in his despondent mood said something unguardedly about the honorary medical officers, which amounted to a libel. At a function recently celebrated at the Stanley Medical College by the Stanley Medical College Association, the otherwise most pleasant function was marred by the misdirected zeal of an outgoing licentiate who, while responding to the farewell address, went out of his way and talked about matters which have no bearing on the function. We learn that the Principal of the College who presided over the gathering interfered at the right moment and drew the attention of this young medico that what he was saying was most objectionable and as unjustifiable. If what happened at the Madras Medical College was taken due notice of by the Principal of the College as publicly as the libellous statement was made by the outgoing graduate, the scene at the Stanley Medical College staged by an outgoing licentiate might have perhaps been prevented. These misguided incidents remind us of a story of a father who had a pet son. The father was so fond of his son that he did not take notice of his son raising his arm to beat anybody he saw. It so happened one day that the pet son raised his hand on his own father and thrashed him well. All evil tendencies in the growing youth should be nipped in bud, not necessarily by harsh provocative measures but in a way most suitable to the medical educational institutions.

We commend the new item in the programme introduced by the Stanley Medical College students, of the association of

one of the old students of the school now a college and requesting him to address the outgoing students. This year the choice fell on Dr. P. Rama Rau, a pupil of the old school who has made a mark as a Radiologist of international reputation and of whom not only the licentiates, but also the whole medical profession should be proud of. The Association of the outgoing licentiates with such a successful practitioner will certainly serve as a good fillip on the eve of their entering the medical profession. Dr. Rama Rau traced the history of the scientific medical profession and incidentally referred to the recent advances in Radiology and spoke words of encouragement to those who were just entering the profession.

All India Ophthalmological Conference:—That even the specialists in the medical profession are in need of publicity through the lay newspapers and not through professional periodicals can be observed from the reports published in the local dailies relating to the Conference of Ophthalmologists who met in Bangalore on 21st and 22nd December. We were attracted more by the message to the Conference from His Highness, the Maharaja of Mysore and the speech of his versatile Dewan Sir Mirza M. Ismail than by the short reports of the address of the President of the Conference, both of which contained thoughtful ideas and material to wake up not only the ophthalmologists but other specialists, all of whom would do well to realise that their interests more than the interests of the general practitioners will be safer even without the need of annual All-India Conferences, if they organise humbler gatherings of local medical men in the locality they serve and educate themselves while practising their speciality through the help and co-operation of the general practitioners. If those who are interested in the treatment of the diseases of the eyes wish to meet in a central place to exchange their views on professional matters, there is no need of publicity in newspapers of such meetings much less the need of opening and closing ceremonies. If the specialists are anxious that their special knowledge should be made use of by general practitioners, the specialists can do this work extensively by

publishing the results of individual research or collective experience in the existing medical journals or through special publications made available to the members of the medical profession. There is now a living example in the Punjab of a world-renowned Eye-specialist who never took part in All-India Conference in his life time but has been doing most useful work by concentrating his skill and energy in his own place, most silently, yet leading thousands and thousands to 'brighter worlds' so aptly referred to by the Dewan of Mysore while opening the Ophthalmological Conference. We wish the ophthalmic and other specialists realise that mere cutting of the eyes or part of the eyes or bodies or portions of bodies dexterously cannot make specialists much less the attendance at Annual Conferences. Every specialist even the general surgeons should first spend a greater portion of his life as an all round physician before he takes up any speciality. The theory referred to by the President of the Ophthalmological Conference that cataract was due to vitamin deficiency and the treatment recommended for its prevention was brewer's yeast and lemon juice should convince the ophthalmic specialist that days are dawning when the specialists cannot claim an existence of their own and the real work in preventing blindness or any other ailment lies with the research physicians. Sir Mirza M. Ismail truly said that "dangers surrounded the eyes from the cradle to the grave". The President of the Conference complains of poverty and superstitions amongst the masses and suggests that the State should employ itinerant ophthalmic surgeons. We wonder whether the Dewan of Mysore was present at the Conference after he inaugurated the same. Surely the Senior Surgeon to the Government of Mysore, Dr. Narayan Rau must have been there, being the Chairman of the Reception Committee. He is himself a renowned Eye Surgeon. To us who have been reading and hearing that itinerant medical relief was a failure, the suggestion of the President does not appeal nor will the Dewan of Mysore who has realised that dangers surrounded the eyes from the cradle to the grave,

appreciate the suggestion of itinerant eye surgeons. The only remedy seems to us to prevent blindness is a liberal and charitable disposition on the part of ophthalmic surgeons who are lucky to be in charge of State or Private ophthalmic hospitals and who should unreservedly give ample opportunities to do operative work to those working under them and other medical men who go to these institutions for special training. We suggest to the Ophthalmic Surgeons and other specialists that they will serve themselves and others in the profession more satisfactorily if they co-operate with the Indian Medical Association and arrange their meetings at the annual conferences which are held under the auspices of that Association.

Blind Man's Buff: A leading Daily in the city contains an Editorial under the caption "Doctors in Conference" published in its columns on 28-12-40 relating to two conferences, one of the practitioners belonging to the indigenous systems of medicine and the other of the practitioners belonging to the allopathic system now styled as the scientific system. At the very outset, the Editor commits an error that India has only ninety thousand qualified practitioners—a figure which he must have extracted from the address of the Chairman of the Reception Committee of the Conference of allopaths and which figure, we have very good reasons to believe, cannot be correct for the calculations made use of by the Editor who makes no difference between the allopaths and the practitioners of the indigenous systems. For, in the Madras Presidency itself there are nearly 7,000 registered practitioners of the allopathic system and over 20,000 practitioners registered by the Central Board of Indian Medicine brought into existence by a Government Order and not by a statute and all told, this Presidency has over 27,000 practitioners whose qualifications are recognised by the Government. We wonder if the Editor is aware that any person who is certified by a Revenue Official to be practising indigenous system of medicine can get his entry into the Register of the Central Board of Indian Medicine. The Bombay and the U. P.

Congress Governments went a step further and did bring into existence a statutory body to recognise the practitioners belonging to the indigenous systems who for the purpose of being registered need not undergo any training in any recognised schools of Indian Medicine. If these circumstances are taken into consideration, India has this day roughly over 2,75,000 qualified practitioners. Depending upon the figure of 90,000 practitioners, the Editor suggests to fill up the 'hiatus' by more practitioners belonging to the indigenous system not knowing the fact that though the indigenous systems are not unscientific, the practitioners belonging to these systems are to be registered only on the certificate of the Revenue Official who has only to say that either the applicant for registration or his grandfathers are practising the indigenous systems.

Neither the Editor nor the distinguished practitioner of allopathy, Dr. Guruswami Mudaliar whom the Editor has quoted, is fair and charitable while giving expression to a general statement that it was "the fashion among allopaths of dismissing the followers of all systems other than their own, as quacks." It was to get rid of such delusions the allopathic system is now called the 'scientific system' and the practitioners belonging to the latter system have been recognising every drug or preparation of known potentialities which were proved by science. What the practitioners of the scientific system complain and rightly so, not so much in their interest but in the interest of public safety that quacks should not be let loose in the name of ayurvedic, siddha and unani systems as is being done by politicians forming the Government who mind popularity and with it votes and not scientific development of medicine. Is it not an open secret that when the Congress Government was on the saddle in this Province and advocating reforms with a galloping speed, the member in charge of medical portfolio revolted against

the happenings in the Government School of Indian Medicine but was made to swallow science for the sake of political peace? The fact that the elected President of the Conference of All India Medical Practitioners, belonging to the scientific system advocates research of ayurvedic and unani drugs and preparations ought to have guided the Editor before he condemned the allopaths.

The Editor advocates a high uniform standard of medical education for the allopaths and applauds the Madras Government for abolishing the L. M. P. Diploma. At the same time he calls upon the Government to encourage the products of an institution of the hybrid system which institution stands condemned by many votaries of the very indigenous systems. When the L. M. Ps cannot cope up to master one system of medicine within four years, it is strange that the Editor could not conceive the impossibility of the L. I. Ms. to master ayurvedic, unani and siddha systems within four years and that by those whose general education is below the S. S. L. C. complete standard. The L. I. M. course is a real danger to the growth of even the indigenous systems much more to the development of scientific system of medicine. The safe and the only course would be to abolish the L. I. M. course as such and have a school of Indian Medicine just on the lines of School of Tropical Medicine to impart knowledge of indigenous systems to the medical men passing out of the colleges belonging to scientific system.

Madras Post-Graduate course: We are requested to announce that a post-graduate course will be held for two months from 16th January to 15th March 1941 at the Medical College, Madras. The course is open to all Registered Medical Practitioners. Not more than 20 candidates will be admitted and a fee of Rs. 100 will be charged for the course. Further particulars can be had from the Principal, Medical College, Madras.

Correspondence, Reports, Etc.

MAJOR-GENERAL WILSON AND
STANLEY MEDICAL COLLEGE.

DR. DINKER RAU,
LADIES AND GENTLEMEN,

It gave me genuine pleasure when asked by the Principal of this College to preside this afternoon at the Annual Prize Giving and it gave my wife much pleasure to be asked to present the prizes. As Dr. Dinker Rau has told you this will be the last occasion that we will have the pleasure of attending this function.

I would like first to congratulate all those who have won prizes and particularly would I like to congratulate Dr. A. Basaviah, who has carried off the Blue Ribbon of this College, by winning the Government Gold Medal.

I have read with great interest the annual report of the College and congratulate the Principal, the staff, and students upon the great part they are playing in building up a tradition for this New Medical College in spite of many difficulties most of which are connected with finance, but it is pleasing to know that the Madras Government are meeting as far as possible the many demands made on them to bring the College to a high standard of efficiency, and I can visualise that in the near future the Stanley Medical College will rank in importance as a Medical Teaching Centre with the other two fine medical colleges of this Presidency, but it is up to you all to help to your utmost in every possible way to make your College second to none.

Col. McRobert and the members of the Surgeon-General's Committee have given us valuable help in their examination of the main requirements of the Stanley Medical College for purposes of recognition by the University of Madras, and the Indian Medical Council and I am glad to state that the Public Works Department are co-operating in every way to complete the structures as soon as possible to meet with the approval of the next Inspection

Committee. Dr. Dinker Rau mentioned the need for a common reading room and recreation room for the men and women sections and says he hopes that the Surgeon-General will get the necessary sanction for it at an early date.

If only sanction were needed the badly needed recreation rooms would be started already, but as I have just told you, Government are meeting all your legitimate demands as far and as quickly as finance allows and I give you my word that this all important point of a recreation room will be considered as seriously as the other buildings which are now in the process of completion.

I fully realise how difficult it has been for the College to make headway in athletic activities; it is very necessary that a Sports Director should be attached to the College, this has been strongly represented to Government and I have every hope in the very near future that the Madras Government will sanction this post. I have always maintained, and I am never tired of telling medical men that it is more important for a doctor to keep himself fit than for men and women in other professions; if a doctor keeps fit and looks fit, his fitness radiates and inspires confidence in his patients. In the near future, I will look forward to hearing of inter-medical college sports, this college vying with the Madras Medical College and Andhra Medical College in all spheres of sport and in this way building up a sportman's comradeship.

I congratulate the men and women students of this college and their officers on the magnificent example they have set to other medical colleges in the manner in which they have joined up in the St. John Ambulance and Nursing Divisions of this Presidency. The Stanley Division was conspicuous at the last parade of the St. John Ambulance Brigade by their smartness and complete mastery of their subject and I sincerely hope that they will continue in this very fine work. Now that we may be in danger of air

attacks the men and women of this college who are in the St. John Ambulance Brigade could play a very important part in the A. R. P. organisation and I can truthfully say that we rely on them in implicit faith knowing that in actual danger they would prove themselves as efficient as on parade, and this brings me to a very grave and very important point.....

In our Presidency we have the finest example that has ever been set by man—the example of His Excellency, our Governor, in his individual work in the war effort. This Presidency leads all India in its generosity and keen appreciation of the vital issues at stake, but I am distressed to state that the recruitment of doctors has not so far kept up to this high level and I feel personally ashamed that this should be so, because of all the Departments the Medical Department should be foremost in its willingness to offer service. Apart from the honour of serving one's country, in its need, a doctor has marvellous opportunities for his skill, and gains experience which subsequently benefits his whole career if he is a keen doctor. Let it not be said when the History of Madras War Effort is written, Madras lead the whole of India in every way with the deplorable exception of its medical department—I will not believe that this is what will be written, but at present there is not that enthusiasm amongst medical men that one is proud to note in other ways.

There are three cardinal qualities that a doctor should strive to represent—Firstly, Devotion to duty—often self-imposed in a doctor's life—Secondly, Loyalty to the highest traditions of his Profession—cooperating with his fellow doctors, for as you all must realise, loyalty is one of the foundation stones of "Medical Ethics," without which the structure could not be called The Noble Profession. Thirdly, Sympathy—sympathy with his patients be they rich or poor and this "Sympathy" does not mean a weak admission of all a patient complains, but readiness to help in alleviating pain and distress and encouraging the patient to be brave.

In concluding these few words, I would like to pay a tribute to Doctor Tirumurti for the work he has done over a difficult period to bring the transformation from School to College to such an excellent conclusion. It behoves all who are now connected with the College to carry on the good work. I thank the staff and students of the Stanley Medical College for their loyalty and support to me during my Surgeon-Generalship. I will always be glad to have news of you all and wish you and the College the very best of good fortune.

THE MADRAS PROVINCIAL
SUBSIDIZED RURAL MEDICAL
PRACTITIONERS' ASSOCIATION.URGENT AND IMPORTANT NOTICE
FOR THE CONSIDERATION OF
SUBSIDIZED PRACTITIONERS.

The President, Madras Provincial Subsidized Rural Medical Practitioners' Association is reliably informed that the Government intend to strengthen the status of the Subsidized Rural Medical Practitioners by entertaining them in regular government service with a right for private practice. They will be also asked whether they will accept war service in time of emergency up to the age of 40.

It is desirable in the interests of all concerned that this subject should be discussed in detail at a meeting of the Provincial Committee of the Association, so that an unanimous reply be submitted to the Surgeon-General individually through the respective District Medical Officers. The Subsidized Medical Practitioners are therefore requested to send their views to the district representatives of the Association on or before 5th January 1941, so as to enable the district representatives to place their views before the meeting of the Provincial Committee which will be summoned to meet in Madras on or before 12th January 1941.

V. RAMA KAMATH,

30-12-'40.

President.

ANNUAL CONFERENCE POSTPONED.

As announced in the October issue of The Medical Practitioner, the Annual Conference of the Association could not be held during the Christmas holidays due to the very poor response to the circular No. R. M. P. M. 365/456 dated 29-11-40 wherein each member was requested to let the Central Office know whether he would attend the Conference or not. There was also a request from the Vizagapatam District Branch to postpone the Conference as the Secretary-Treasurer informed the Central Office that almost all the members of that Branch were the members of the Reception Committee of the All India Medical Conference which was to meet on 27th December and continue the sessions till 30th. In the meanwhile, there came a suggestion from the Secretary-Treasurer of the Malabar District Branch under whose auspices the Conference was to be held at Koduvayur to postpone the Conference. All the above information was placed before the Working Committee of which three members approved the idea of postponing the Conference and to hold it during the Easter holidays. This idea has the approval of the undersigned. Two members of the Committee, Drs. Kunjunni Nair and Prasada Rao have not as yet communicated their views to the Central Office. As the Christmas holidays will be over by 3rd proximo and as it is impossible to hold the Conference even if the two silent members wish to have the Conference as already announced, the undersigned has therefore been forced to announce taking the view of the majority of the members of the Committee, that the Conference is postponed and will be held during Easter holidays.

Out of 23 District Branches, 12 viz., Anantapur, Bellary, Coimbatore, Cuddapah, East Godavari, West Godavari, Guntur, Madura, Malabar, Ramnad, Salem and Vizagapatam have elected the Secretary-Treasurers for the year 1941.

The six District Branches viz., South Arcot, Chingleput, Chittoor, South Kanara, Kurnool and Nellore have not as yet elected the Secretary-Treasurers.

The two District Branches, North Arcot and Kistna held meetings for the election of Secretary-Treasurers but the proceedings had to be declared invalid as the majority of members said to have taken part in the meetings were either not members of the Association or were in arrears of subscription for the year 1940 and could not exercise their franchise as per rule 5 (3) of the rules of the Association.

In the two Districts of Trichinopoly and Tanjore meetings were held but the election of the Secretary-Treasurers could not be held as only two members were present at the meeting in each place. At Tanjore there were three more R. M. Ps. present at the meeting but they were not members of the Association.

It is hoped that advantage will be taken of the postponement of the Conference and the District Branches who did not elect the Secretary-Treasurers would elect them soon and report to the Central Office.

The contribution of Re. 1 towards the expenditure of the Conference as decided by the Provincial Committee, must be paid by all the members of the Association whether they attend the Conference or not. The Provincial Committee has rightly made this payment compulsory to avoid overburdening a particular District Branch by incurring expenditure for the Annual Conference, the benefits of which will be shared by all the members of the Association.

V. RAMA KAMATH,
25-12-'40. *President.*

RAMNAD DISTRICT BRANCH.

A meeting of the above Association was held at Manamadura in the O. V. C. High School on Saturday the 23rd November 1940 at 2-30 P.M. under the presidentship of Dr. Natarajan of Neikuppai.

The following resolutions were passed:—

1. Resolved to appeal to such of the R.M.Ps. who are not members to enlist themselves as members without delay and to those members who are in arrears to pay the same at an early date.

2. Resolved that each member should pay to the credit of Branch finance Rupee One a year to meet travelling allowance expenditure of Secretary-Treasurer for attending the Provincial Committee.

3. Resolved that if any member is in trouble he should report about it to the Central Office of P. S. R. M. Ps' Association, Madras through the Secretary-Treasurer for necessary action and advice.

4. Resolved to hold the meeting once in three months in different places in the District in consultation with Joint Secretary-Treasurer.

5. Resolved to represent to the District Medical Officer, that days on which the meeting of R. M. Ps' Association and District Medical Association are held should be treated as permission and not as casual leave.

6. Resolved to elect Dr. Abdul Sathar of Sarakaneil as Secretary-Treasurer and Dr. Hariharasubramanian of Tiruchuli as Joint Secretary-Treasurer for the year 1941.

7. Resolved to ask the Secretary to start with new statements of account.

VIZAGAPATAM DISTRICT BRANCH.

An ordinary meeting of the P.S.R.M.P's Association, Vizagapatam District Branch was held on 24-11-'40 at 8 A.M. in the District Board Office Meeting Hall Vizagapatam under the Presidentship of Dr. K. R. Chowdary, L.C.P.S., R.M.P. Amadalavalasa:—

The following resolutions were passed:—

1. Letter of Dr. V. Rama Kamath dated 1-9-40 was read by the Secretary to the members, Circular from the Central office. Ref: R. M. P. M. 335/417 dated 18-10-40 was also read and both were recorded. Resolved to authorise the Secretary to write to the President P. S. R. M. P's Association to send for the guidance of the branch the rules and regulations of the constitution of the P. S. R. M. P's Association.

2. Resolved to request the authorities through the President Dr. V. Rama Kamath that the days on which the R. M. Ps attend the meetings of Indian Medical Association or R. M. P. Association not to be included within the 30 days casual leave admissible in the year.

3. Resolved to discuss the contents of the circular from the Central office, Madras. Ref: R. M. P. M. dated 24-5-40 for the next meeting.

4. Resolved to request the President, District Board Vizagapatam that the drugs that are not

supplied by the Medical Store Depot, Madras may be supplied by the President District Board or the R. M. P. be allowed to buy them from a recognised firm at the cost of the District Board.

5. Resolved to bear the actual T. A. of Dr. K. R. Chowdary, R. M. P. Amadalavalasa who represented our district branch in the Provincial Committee Meeting held in Madras on 21st and 22nd September 1940.

6. Resolved that the Secretary or joint Secretary of the association should go personally to every non-member or depute the nearest R. M. P. to enlist members and the expenses thus incurred will be borne from the funds of the association.

7. Resolved to collect Rs. 2-0-0 from each R. M. P. towards the association fund as the association is poor financially.

8. The following office-bearers are elected for the year 1941:—Dr. U. Narasingarao, R. M. P., Maradam, Secretary, Treasurer, Dr. K. R. Choudhary, R. M. P., Amadalavalasa, Joint Secretary-Treasurer.

9. Resolved to authorise the Secretary to write to the President, P. S. R. M. P's Association, Madras that as the All India Medical Association is going to be held in Vizagapatam in the month of December '40 (commencing from 27th to 30th) the Annual Conference of the P. S. R. M. P's Association going to be held in Malabar District may not fall in the same month as none can attend the Annual Conference from this District Branch, each R. M. P. being a member of the Reception Committee for the 18th All India Medical Association.

THE SOUTH KANARA DISTRICT MEDICAL ASSOCIATION.

The 10th Annual General Meeting of the South Kanara District Medical Association was held on 23rd November, 1940 in the Canara High School, Mangalore. Captain W. E. Mascarenhas, President, occupied the chair. The annual report with audited statement of accounts was read and adopted. For the first time since the starting of the Association, the General Body elected the following Honorary Members all belonging to the District, who have made a mark for themselves in their career, highly respected both by the public and the profession:—

(1) Dr. U. V. Nayak, M.B. & B.S., Ph.D., (Lond.), (2) Lt. Col. V. R. Mirajkar, I.M.S., F.R.C.S., O.B.E., (3) Capt. M. G. Kini, M.Ch., F.R.C.S., (4) Dr. M. B. Prabhu, M.B. & B.S., M.M., (5) Dr. U. Rama Rao, (6) Rao Bahadur M. Keshava Pai, M.D., O.B.E., (7) Dr. V. Rama Kamath, (8) Dr. P. Venkatagiri, M.D., (9) Dr. G. R. Dinkar Rao, M.D., (10) Rao Sahib Dr. B. Colaco, (11) Dr. L. B. Fernandes, B.A., L.M. & S. and (12) Dr. S. R. Pandit.

After Tea, the toast was proposed by Dr. M. Umesha Rao, L.M. & S., T.D.D. (Wales) in a very suitable form. Dr. K. R. Kini replied to the toast. Captain W. E. Mascarenhas and Dr. C. P. Kamath were re-elected as President and Secretary respectively for the ensuing year.

After a vote of thanks proposed by the Secretary the meeting terminated.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the month of November 1940.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance on 1-11-'40 ...	406 2 2	Postage ...	12 15 9
Subscriptions from members (including V.P.P. charges) ...	45 4 0	Stationery ...	3 3 0
Subscription from members for the Provincial Conference ...	11 0 0	Pay to Clerk for the month of October 1940 ...	15 0 0
Advance from the President to meet the office expense ...	5 0 0	Amount credited to The Medical Practitioner from the subscriptions paid by members ...	18 8 0
		Contributions paid to Secy.-Treasurers of the District Branches:	
		Rs. A. P.	
		W.-Godavari ... 13 8 0	
		Coimbatore ... 1 8 0	
			15 0 0
		Refunded to the President the amount advanced by him in Sept. 1940 to meet the expenses for the Provincial and Working Committee meetings held and to pay the District Branch quota to the Secretary-Treasurers who were then present ...	115 0 0
			179 10 9
		Cash Balance:	
		Rs. A. P.	
		With Savings Bank ... 285 13 7	
		With Office ... 1 13 10	
			287 11 5
Total ...	467 6 2	Total ...	467 6 2

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

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