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EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

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CONTENTS.

ing the ideal type of case only, but now-a-days the indications are far more liberal.

1. Most suitable cases are those with unilateral progressive disease with or even without cavities.

2. Cases with bilateral disease.

Where there is a minimal lesion in the other lung it should be taken now-a-days as an additional indication for starting A. P. on the more affected side. There is every chance of the fresh lesion completely healing up when the general condition improves with A. P. If not, A. P. can be started later on this side also. When the disease in both the lungs is fairly extensive and progressive especially when the midzone and the bases are also affected, one is most likely to be disappointed with the result. But even in such cases, it should not be withheld for it does at least relieve the symptoms and give comfort to the patient. In these cases, in spite of a bad prognosis the social aspects of the disease have also to be taken into consideration. A person living in the midst of a large family and coming in contact with many young people ought to be given A. P. irrespective of other indications, for it will minimise largely the number of tubercular bacilli in the sputum. But in definitely hopeless cases of extreme wasting attendant with oedema of feet, etc., it will be of no use and if attempted will only bring discredit to the method of treatment.

3. In stationary disease with cavity, either unilateral or bilateral the prognosis is certainly improved with A. P. Further if these patients are wage-earners they may be sent back to work and earn their livelihood much earlier with A. P. than without it.

4. A. P. is the surest and the most effective method to be applied for recurrent haemoptysis or for any uncontrolled profuse pulmonary haemorrhage.

Laryngeal or intestinal tuberculosis is no contra-indication but is an additional indication for instituting A. P. immediately. They are mostly secondary to the pulmonary condition and when the primary condition improves with A. P., these secondary lesions also usually clear up.

Pregnancy and Diabetes are also similarly no contra-indications and A. P. should not be delayed on that account.

In cases of Pleurisy with effusion the more recent view is to aspirate the fluid and replace it with air and if the condition of the lung demands it, it can be kept up as a regular artificial pneumothorax.

The technique is quite simple although some experience is necessary to decide the amount of air to be introduced and the interval between the refills.

In the early days, experiments were tried with various gases as Nitrogen, Oxygen, Carbon Dioxide, etc., and there are some recent reports of using some precentage of Chlorine gas. But they show decidedly no advantages over the ordinary atmospheric air.

There are, of course, some complications frequently met with during the treatment and these have to be treated properly. Chief among them are tears of the lung and effusion.

One must certainly know exactly when and how to stop A. P. A. P. is to be stopped under two circumstances: One is, when the object for which it was introduced is accomplished and the other is, as soon as it is realised that the object could not be accomplished. This is a very significant statement. There is what is called Selective Collapse and the other called Contra-Selective Collapse. By the term Selective Collapse is meant effective collapse of the diseased portion, while the rest of the lung which is healthy is not so much collapsed and can take part in its normal function. In fact, this is the ideal attempted by collapse therapy. By Contra-Selective Collapse is meant, collapse of the healthy parts of the lung while the diseased part is ineffectively collapsed. This is a dangerous condition and A. P. should be abandoned, as soon as it is discovered; for a Contra-Selective Collapse has been found to be worse than no collapse at all. Almost certainly the disease spreads to the other lung if it is persisted, besides giving rise to other complications.

That which mainly interferes with the production of an effective Selective Pneumo-thorax is the presence of adhesions between the two pleural layers. If it is a complete pleural symphysis, it is impossible to start any A. P. In several cases the adhesions, which are mainly over the diseased area, prevent that part from falling in and this contributes to the state called Contra-Selective Collapse. If these adhesions are fairly extensive, one cannot do much except to abandon the treatment. But in those cases, where these adhesions are scattered here and there keeping only certain parts of the diseased area stretched with air all around, it is possible to sever these adhesions and thus convert what was a Contra-Selective Collapse into a Selective one. Adhesions are got rid of nowadays by the Cautery, with the help of thoracoscope. Briefly the technique is as follows. Study the approximate position and nature of the adhesion by fluoroscopy and then under local anaesthesia, a puncture is made in one of the most suitable inter-costal spaces by a trocar and canula. The trocar is withdrawn and the thoracoscope is introduced in its place. Through this the adhesions are visualised and a second similar puncture is made at a selected suitable space to admit an electric cautery. Under direct vision, the adhesions are severed by means of either galvanic or diathermic cautery depending on the nature of the adhesions. This is a fairly easy procedure in experienced hands and the main risks are injury to the lung and the blood vessels and these ought to be avoided.

The proper time for cauterisation is between 2 and 3 months after the pneumothorax treatment is started. This period is necessary for the adhesions to stretch sufficiently. Sometimes this operation may have to be done in more than one sitting. In case even this fails and the pneumo-thorax remains a Contra-Selective one, the lung must be allowed to re-expand and other measures have to be thought of.

Among the cases where collapse therapy is indicated, in about 30% A.P. cannot be induced at all. Among the rest, in about an equal number A.P. may have to be abandoned for various reasons like Contra-Selective collapse or tuberculous or mixed empyema. They are all potential cases for major surgical measures like Thoracoplasty.

Before describing the operation, Thoracoplasty I shall say a few words about another important procedure called extra-pleural pneumo-thorax. Though suggested several years ago, this, as well as many other surgical measures were taken up systematically only in recent years. In this connection, I am reminded of a remark by one of my professors, which at first sounded rather funny, but is full of meaning. He said that the discovery of the tubercle bacillus was largely responsible to the apparent neglect of surgery in the treatment of pulmonary tuberculosis. This is fairly true. For a number of years after the discovery of the causative organism of tuberculosis by Robert Koch in 1882, the eyes of the profession were all turned to Berlin for the cure of the disease. It was expected by scientist that some vaccine or serum will be found out of it which will revolutionise all treatment but there came the disappointment. Of course, there is a vaccine (Tuberculin) but it failed to produce the desired effect. Undaunted by this failure, research is still being carried on to find out a successful product by the splitting up of the different constituents of the bacillus. Naturally therefore the impetus turned towards again improving or modifying surgical measures of treatment the extra-pleural pneumo-thorax which was once attempted and given up, but it has now taken up with improved technique. Here collapse is effected by compressing the lung by putting in air outside the parietal pleura. I shall describe briefly the operation: The patient is prepared as for any major operation under local anaesthesia, a large curved incision is made along the course of the 4th rib, and about 4 to 5 inches of the same resected. Then with the finger introduced under the bed of the rib, the parietal pleura is slowly separated from the chest wall. All stripping is

Abstracts.

VENEREAL DISEASE.

By

R. C. L. BATCHELOR, M.B., F.R.C.S (ED.), D.P.H.

Clinical Medical Officer, Venereal Disease Scheme, Edinburgh Corporation, Surgeon, Department of Venereal Diseases, Royal Infirmary, Edinburgh.

The treatment of venereal disease still suffers from the "snap" diagnosis and therefore it is less inexcusably platitudinous to introduce this subject by stipulating that accurate diagnosis is an essential preliminary to appropriate and successful treatment. There are still too many cases of abrasions on the genitals which, without a dark-field investigation, are dismissed as non-syphilitic, because the history or clinical appearances are not typical. Conversely, any breach of the surface on the genitals may be pronounced syphilitic without dark-field confirmation, and a course of anti-syphilitic treatment given. If the lesion were really syphilitic, one course of treatment might be insufficient to attain cure, and if the lesion were not syphilitic, then anti-syphilitic treatment would be inappropriate, and its administration in a case of chancroid (instead of sulphapyridine) might allow painful destructive ulceration to progress or permit the formation of a suppurative bubo.

It is good working rule to regard any lesion on the genitals as potentially syphilitic, but the acceptance or exclusion of this diagnosis should not rest on the history or clinical evidence alone, but should in every case be determined by the repeated dark-field examination of serum for *Spirochaeta pallida* and, if this be negative, by follow-up serological tests, involving first the bi-weekly and then weekly observation of the Wassermann and Kahn tests over a period of fourteen weeks from the date of exposure to infection. Such a prolongation of observation allows for a long incubation period of, say, ten weeks, and thereafter an interval of four weeks to ensure enough antibody production for the fact of the syphilitic infection to be revealed in positivity of the Kahn or Wassermann. The cardinal and still too prevalent mistakes are, first, failure to diagnose syphilis when present; secondly, diagnosing syphilis when not present and, thirdly, inadequate treatment.

Continuity in anti-syphilitic treatment should be secured through effective liaison between civil and military health authorities. Gaps in continuity may occur when treatment started in civil life is interrupted by the patient's being called up for military service, or again when treatment started in one of the services is allowed to lapse on the patient's leaving the service to resume civil employment. In all such cases the transfer from one health authority to another should be facilitated by the issue of suitable transfer documents (for example, Forms V. 15 or V. 44) to the patient, and intimation of the impending transfer by a letter to the competent authority.

EARLY SYPHILIS.

So far as the treatment of early syphilis is concerned, the chief difficulty lies not so much in overcoming the disease as in maintaining tolerance to the drugs used. If a case of primary syphilis, whether sero-positive or sero-negative, receives four "unit" courses of *neoarsphenamine* ("914") and *bismuth*, each "unit" course comprising some 6 gm. of "914" and 3 gm. of bismuth, then the expectation of complete and lasting cure approximates to 100 per cent. A similarly hopeful prognosis, only slightly less favourable, holds for early secondary syphilis, and the cure rate in late secondary syphilis, which requires five "unit" courses, is a percentage high up in the nineties. But the examination of any large collection of case records will soon reveal that the majority of patients, even of those who do not default, fall considerably short of receiving 24 gm. of "914" in their total amount of treatment. The fact is that a dose of 0·6 gm. "914" every week for a ten weeks' course and such a course repeated after rest intervals of four weeks for four or five spells—this intensive schedule must be regarded as an ideal to be aimed at rather than as a regular plan to be applied uniformly.

PROBLEMS OF INTOLERANCE.

Various manifestations and varying degrees of intolerance are of frequent occurrence: the symptoms are usually slight, such as nausea, anorexia, headache, epigastric discomfort, pains in the shoulders, gingivitis, but nevertheless usually occasion some modification of the treatment, especially a reduction of dose. The more severe manifestations of intolerance, such as jaundice, dermatitis, and purpura, are by no means uncommon. The problem at present therefore is not so much to find some other drug or drugs more effective in combating syphilis as to find means of securing tolerance to the drugs now available. This raises the whole question of factors governing tolerance and the conditions conducing to an upsetting of the balance.

If there is any mystery surrounding the ability to keep a patient fit and active while he is receiving large quantities of organic arsenic and heavy metal, or, looking at it in another way, the inability of some patients to absorb and assimilate these substances without becoming more or less seriously upset and deranged, this mystery is merely deepened by the use of the word idiosyncrasy. This epithet, besides making obscurity still more obscure, is defeatist in intention, the implication being, "I don't know, and leave it at that." But modern research is steadily lifting the veil, as one by one the factors influencing intolerance are being elucidated. Concurrently with this line of investigation runs the persistent search for an organic arsenical of lowered toxicity and heightened, or at least unimpaired, potency.

Nevertheless, no matter how biochemical or pharmacological research develops, it seems unlikely that the personal factor will ever be completely eliminated, at any rate as long as treatment is given by injection. Some operators will continue to have a lower incidence of intolerance than others. If syringes are dismantled and washed completely after each injection, thereby removing from behind the piston traces of previous solutions that steadily oxidize and become more toxic; if slight perivenous infiltrations of "914" (which sensitize the skin) are scrupulously avoided by meticulous technique; if the time taken for each intravenous injection is not less than three minutes; if the patient already is or is rendered unexcitable and quickly co-operative; if such ideal conditions always obtain, then many, possibly most, toxic side-effects would be eliminated. But such procedure would not remove all of the untoward reactions, because of the possible existence of such other factors as foci of toxic absorption or the existence of vitamin deficiency.

Vitamin therapy.—Recent work by Horne and Scarborough (1940) has demonstrated that those patients who develop such manifestations of intolerance to the arsenobenzols as purpura, dermatitis, and jaundice have diminished capillary resistance resulting in increased fragility and permeability. It has also been shown (Scarborough and Stewart, 1938) that the capillary resistance, and therefore presumably the tolerance of organic arsenicals, may be increased by the administration of certain substances (*e.g.*, hesperidine and citrin) derived from orange and lemon juices. These substances, flavanone in nature, are effective even when ascorbic acid fails to produce any beneficial effect. It would appear therefore that a definite clinical entity, namely low capillary resistance, may be substituted for the vague label "idiosyncrasy" as an explanation of many toxic reactions produced by the organic arsenicals. From the point of view of practical policy it would seem to be most desirable to direct patients' attention to the value of orange juice in keeping them well and

able to stand intensive treatment. Glucose "orangeade"—glucose to fortify the liver and orange juice to strengthen the capillaries—is rightly regarded as probably the finest prophylactic of toxic side-effects.

Many of those who are guilty of sexual indulgence have other proclivities, especially addiction to alcohol. Alcoholism in turn leads to neglect to take suitable food and to dietetic deficiency. *Vitamin B* is often especially depleted. In addition, the cells of the liver are poisoned and the stomach and duodenum are irritated and their function deranged. Alcoholics as a rule do not stand the arsenobenzols well, but aneurin given parenterally and orally will help to prevent toxic neuritis, whether this be due to the alcohol or the arsenic.

Deficiency of *Vitamin E* has been suggested (Bicknell, 1940) as the reason why some syphilitics develop tabes dorsalis, and the administration of this vitamin in the form of green leaves and wheat-germ oil has been recommended in prophylaxis and treatment. The relationship between the impoverished diet and the attack on the nervous system may be coincidence, but I am at present treating a tabo-paretic, whose wife expatiates most emphatically on his life long aversion to green vegetables and eggs. It is possible that war-time stringency, if reflected in increasing scarcity and rising prices of fresh citrus fruits and green vegetables, may result in an increased incidence of dietetic deficiency and through this to diminished tolerance of arsenical and bismuth therapy.

DRUG TREATMENT IN WAR TIME.

The drug treatment of syphilis can be readily adopted to meet the needs of war-time conditions. In treating early syphilis occurring in Services personnel the salient requirements are the economizing of time and the minimizing of interference with military duties. These desiderata are achieved by the adoption of the system of dual therapy in which arsenic and bismuth are given concurrently once per week, in course of ten weeks separated by rest intervals of four weeks. For a man, the standard weekly dose of "914" is 0·6 gm. and of bismuth 0·3 gm., and during the first fortnight this is best given in half doses twice in the week. After the first fortnight (during which any disabling genital lesions are healed), treatment can be effectively continued by one weekly injection visit and should therefore be compatible with active military duties. For the arsenical part of the treatment *arsphenamine diglucoside* (stabilarsan) is a particularly convenient preparation because it is already in solution in the ampoule, is suitable either for intravenous or intramuscular administration, and is well tolerated and attended by few serious toxic effects. If for any reason intramuscular injections are undesirable, for example, in motor-cycling or mounted troops, or mounted police, then the new orally administered bismuth preparation, *sobisminol mass*, is a possible alternative. It is probably just about equal in effectiveness to the ordinary bismuth suspensions given by intramuscular injection, but its use must be watched carefully as gastric distribution and gingivitis may easily occur. Syphilitic patients in whom the trivalent arsenicals cause intolerance, for example, dermatitis, can sometimes be given pentavalent arsenic in the form of *tryparsamide*, and when a tendency to intolerance is accompanied by difficult veins, another pentavalent arsenical, *acetylarsan* given intramuscularly, is worth a trial.

NEUROSYPHILIS.

Artificial Pyrexia.—When syphilis has attacked the central nervous system, and especially in those later cases which have resulted in paresis, tabo-paresis or tabes, it is likely that the best results are obtained by a combination of fever therapy with the prolonged, regular, and persistent administration of course after course of intravenous tryparsamide and intramuscular bismuth. With the younger patients especially (age 35 to 40 under), this procedure should be continued for four or five years or longer according to the time taken to secure reversal of the serological and cerebrospinal fluid tests. Thereafter the patient should be kept under regular observation, with testing of the blood and cerebrospinal fluid, and the clinical improvement should be maintained by yearly or six-monthly injection courses or by repetition of the fever therapy. Pyrexia is best induced by malaria inoculation or by electrical or physical methods, such as for example, inductothermy or the Kettering hypertherm *Neocryl* is acclaimed by some clinicians as an efficient substitute for tryparsamide and less likely to damage the optic nerve, but it must be regarded as being still in the experimental stage.

Relapse is very real danger in these cases of neurosyphilis and they should not be allowed to drift away from medical observation. The "follow up" of these patients needs to be as well organized and maintained as it is with cancer cases. Early paretics drift into and out of institutions or change their addresses and are only too easily lost sight of. In this connexion the services of a competent nurse-almoner are invaluable in any large venereal disease organization.

Fever therapy by means of the inductotherm is of value as an alternative treatment when arsenical drugs are not tolerated as, for example, in such cases as interstitial keratitis occurring in a congenital syphilitic.

GONORRHŒA.

The general adoption of *sulphapyridine* (M & B 693) in this country has so simplified and shortened the treatment of gonorrhoea that this most prevalent venereal disease should be prevented from causing the amazing wastage of man-power and woman-power for which it was responsible during the last great Europe war and afterwards. But the very simplicity and rapid efficacy of sulphapyridine involve the risk that gonorrhoea may be regarded too lightly and dismissed on the disappearance of symptoms like a nasal catarrh which has reacted to aspirin. There is a strong suspicion that many sulphapyridine treated gonorrhoeal patients are being let loose on society without having undergone a sufficient test of cure. So far as clinic-treated cases are concerned, investigation at once transforms the suspicion into a certainty, and this disclosure serves to intensify the doubt whether the majority of privately treated cases receive satisfactory testing over an adequate period of three months from the disappearance of symptoms and signs. In male patients, repeated examinations of the prostatic and seminal vesicular secretions are essential, and smears must be made of any slight morning "drop." In female patients, complete examination necessitates the use of a speculum in order to obtain specimens from the canal of the cervix uteri. Urethral smears must be obtained under the best conditions, that is, after the urine has been held, preferably overnight. In short, success in treatment depends upon the continuous bacteriological observation of the discharge from all areas likely to be infected, and prolongation of such observation for three months after apparent cure.

Other measures.—An appreciable proportion of gonorrhoeal infections do not respond satisfactorily to chemotherapy. The percentage of drug-resistant cases is about 6 per cent. with sulphapyridine and 32 per cent. with sulphanilamide (Batchelor, Lee and Thomson, 1940). In such cases recourse must be had to the old regime of irrigations supplemented by vaccine therapy. Toxic effects with the sulphonamides, for example, anorexia and nausea, may be lessened by the concomitant administration of *alkalis* and of 5 to 10 mgm. of *nicotinic acid* with each dose of the sulphonamide. When sulphanilamide is used, sulphur-containing food (*e.g.*, eggs, onions and pulses) and drugs (*e.g*, Epsom salts and liquorice powder) should be avoided, but this restriction does not seem to be necessary with sulphapyridine.

The metastatic complications of gonorrhoea are now less frequently encountered, but it is well to remember that recent gonorrhoeal arthritis responds well to fever therapy, either inducto-pyrexia or hyperthermy (Kettering apparatus).

LEUCORRHŒA.

Recent work by Liston and Cruickshank (1940) has thrown fresh light on the

causes of leucorrhoea in pregnancy and has demonstrated that only a very small proportion (2 per cent.) of such cases are suffering from gonorrhoea. These workers found that in 40 per cent. of these cases the protozoal parasite *Trichomonas vaginalis*, was the cause of the leucorrhoea, and in 25 per cent. the parasite of vaginal thrush was implicated. Formerly these cases were suspected of being gonorrhoeal, even if the gonococcus could not be demonstrated. The greater accuracy of diagnosis now attainable facilitates the applications of the most suitable treatment for example, stovarsol in trichomonas infestation and gentian violet paint or dilute iodine for thrust.

Trichomonas vaginalis infestation in male subjects has been investigated by Liston and Lees (1940). Among the conclusions reached by these authors was that approximately 16 per cent. of males suffering from non-gonococcal urethritis are cases of *Trichomonas vaginalis* infestation. In regard to treatment it was observed that irrigation was not curative and might do harm, but that strong alkalinization of the urine relieved symptoms and might produce clinical cure. In the Edinburgh clinic *stovarsol* jelly (10 per cent.) with 1-10,000 merfenil has proved a useful application for the infested urethra.

MERCURIAL OINTMENT.

The success as fungicides (in such conditions as epidermophytosis) of jelly-like ointment bases incorporating such mercurials as phenyl mercuric acetate (*e.g.*, "mersagel") seems to suggest that the old-time calomel cream might with advantage be replaced as a prophylactic by some mercurial-carrying jelly which, by achieving more intimate and continuous contact with the skin of the genitals, would afford a greater measure of protection from invasion by spirochætes or gonococci.

CONCLUSION.

In conclusion, it is still as true to-day as formerly that success in the treatment of venereal infections rests upon immediate and accurate bacteriological examination, and the consequent application of the most suitable therapy at the earliest possible opportunity. This primary need may be particularized and emphasized by observing that recent gonorrhoeal and syphilitic infections can and should nearly always be cured, and that such sequelæ of mishandled or neglected early infections as stricture of the urethra and tabes dorsalis or general paresis are often irremediable.

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NOTICE.

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A PLEA FOR EARLY DIAGNOSIS IN GLAUCOMA.

BY

D. T. ATKINSON, M.D., F.A.C.S., F.I.G.S.

San Antonio, Texas.

Glaucoma, because of its comparative frequency and because of the necessity for its early diagnosis, is probably, from the standpoint of both the family physician and the ophthalmologist, the most important of all eye disorders. It has well been termed the tragic eye disease due to the accepted fact that only a small percentage of glaucomatous eyes have been saved.

Now why does such an unfortunate condition of affairs exist, and why are so many glaucomatous eyes lost that might have been preserved? I recall regretfully that during my early practice I was numbered among the many of that period who saw glaucomatous cases drift into advanced stages because of diagnoses made too late to serve any useful purpose.

The history of a large percentage of glaucomatous cases I now see recalls to my mind those early experiences. Examinations in some of these later cases have been made in a perfunctory manner, and an eye wash may have been prescribed. Such a collyrium has sometimes contained atropine, which drug when used for any length of time in glaucomatous eyes usually spells destruction of vision.

For thirty five years I have been seeing these misdiagnosed cases come into my office all too frequently, and during this period I have made many attempts to convince the family physician and the ophthalmologist that the burden of the responsibility is pretty well divided between them. I have attempted to stress the thought, in numerous essays as well as in my book on ophthalmology, that our only hope for glaucoma cases lies in early diagnosis and that in this we are often lax.

As I have already suggested, we, ophthalmologists come in for our share of censure in overlooking early glaucoma cases. This, according to my own observation, has not been due so much to a lack of acquaintance with the early manifestations of the disease but, because of the haste occasioned by frequent overpressure of office practices, to the habit of making casual eye examinations. I have noticed that omissions leading to the overlooking of glaucomatous symptoms occur in about the following order:

(1st) A patient's history of having had numerous recent changes of glasses without obtaining relief therefrom has not been given the importance which it deserves. There is, I believe, no other eye condition in which refractions are as unsatisfactory as they are in chronic simple glaucoma cases. The variation in the increase in intraocular tension and the effect of such variations upon the crystalline lens are no doubt largely responsible for this. But whatever the reason, we should remember that all patients in whom refractive errors are unstable should at least awaken in the ophthalmologist the suspicion of their being early glaucoma cases.

(2nd) The decreased vision resulting from lens opacities may lead us into the error of overlooking the fact that increased intraocular tension will of itself often create a change in the capsular epithelium of the lens so as to be almost identical in appearance to uncomplicated incipient cataract. Unless the examiner is very cautious, this change may thereby give rise to a mistaken diagnosis of incipient cataract in glaucoma cases.

(3rd) The failure of the ophthalmologist to remember that everyone has his individual intraocular tension or a tension which is normal for him. This is a fact so often overlooked that many persons have lost their vision as a result of an elevation in their individual intraocular tension, which tension so disastrous to them is not higher than the tension in average eyes. On the other hand, we often see cases in

which an increase of tension is found which apparently has been in existence for a long period without setting up a glaucomatous picture in the eyes examined, and in such instances such a tension may be considered normal for those individuals. It is only by watching the tension curve in some suspected eyes that we may pretty definitely decide whether or not a given eye is glaucomatous. If, for instance, we observe a tension in the late forenoon reaching a point as high as was the early morning tension, together with a lack of the downward curve in tension which we know occurs in the average normal eye in the early afternoon, we should immediately be on the alert. Such a curve, we should remember, may suggest early glaucoma, even if the tension be not higher than the tension of the average individual.

(4th) Mistaking a glaucomatous cupping of the optic nerve for a physiological cupping. It must be admitted that the differential diagnosis between the two often presents difficulties. Frequently the depth of the disc is not markedly interfered with in early compensated glaucoma so that the classical overhanging of the vessels across the border of the ledges of the cup, so characteristic of classical glaucoma, is not seen. But as a rule the disc in glaucoma cases is changed in color and assumes a whitish yellow center which coloration gradually pales toward the periphery. In addition to this, the diagnosis may be suggested by the appearance in the cup of the tips of the lamina cribosa showing like small yellow dots.

(5th) A very disastrous omission in glaucoma cases consists in the habit of putting off the taking of visual fields until a later or more convenient time. An appointment may have been made and not kept by the patient and the whole matter forgotten, or because of lack of time the fields were taken incompletely or hastily. Often the peripheral form fields only are checked, thus overlooking the great aids in diagnosis provided by the presence or absence of Ronnes', Bjerum's and Seidel's scotomas. Probably the color fields are involved in early glaucoma more often than are the form fields, yet I have learned by interrogating many ophthalmologists that omitting to take color fields is very general, and in this I must personally plead occasional lapses. But it is an omission nevertheless which may lead us into failure to diagnose early simple glaucoma.

As I have already suggested, and with no reflection upon either the ophthalmologist or general physician, most cases of glaucoma are diagnosed too late to save useful vision. In addition to the causes I have enumerated, this unfortunate situation may be due to several other reasons. Too frequently glaucomatous patients do not have access to an ophthalmologist and neglect to consult their family physicians regarding their eye symptoms. In acute glaucoma too often the family physician is seen between the attacks only and at such a time a glaucoma may easily be mistaken for one of the numerous eye disorders whose management rightfully falls into the domain of the general practitioner. If under these circumstances, for instance, glaucoma should not be recognized and a simple collyrium prescribed, similar attacks may occur several times before further examination is sought by the patient.

It is generally conceded that the largest percentage of glaucoma cases are seen first by the general practitioner, and while I am not advocating that he assumes the function of the ophthalmologist, I do wish to impress upon him the fact that by observing carefully certain simple external manifestations, which are obvious even without the use of the ophthalmoscope, perimeter, or tonometer, he may make correct diagnoses in the majority of glaucoma cases.

Thus far I have attempted to stress the great importance of the diagnosis of glaucoma, but before proceeding further let us consider first the real nature of the condition we are attempted to diagnose. It is known by all that glaucoma is the result of increased tension in the affected eye. But why does this tension exist? Simply because an obstruction of the normal outflow of fluids from the anterior portion of the eye has overfilled the eye.

This being the case, why should such an obstruction occur; and when present, how does it bring about the early symptoms we see?

For many years it has been generally thought that the increased intraocular tension of glaucoma results from certain abnormal conditions causing the spaces of Fontana as well as Schlemm's canal to be interfered with, thus causing more or less obstruction to the egress of intraocular fluid. There are many theories relative to how this is brought about, but one of the most plausible explanations, it appears to me, lies in Schicks' contention that intraocular pressure may be increased by a migration of dislodged pigment from the iris or the choroid into the spaces of Fontana, thereby blocking them and interfering with normal drainage. This observation is in singular accord with that of McKenzie to the effect that dark-eyed persons with an abundance of pigment in the iris are more liable to glaucoma than are light-eyed persons. This idea is also strengthened by the known fact that there is likely to be more displaced pigment in persons of mature years than in the young, and that glaucoma is found much more frequently in the old people than in juveniles.

In medical literature there are numerous classifications of glaucoma, many of which are confusing while others are more or less contradictory. The classification of glaucoma is somewhat simplified, it seems to me, by the following arrangement: First is primary glaucoma, which occurs in two forms—chronic congestive glaucoma and chronic non-congestive or simple glaucoma; and, second, there is acute inflammatory glaucoma. In addition to these are the less common conditions—secondary glaucoma and infantile glaucoma.

Chronic congestive glaucoma represents a type of increased intraocular tension which may be active for many months before vision is affected. In this form of the disease the tension is increased but is very variable. The pupil in these cases is usually dilated and responds poorly or not at all to light. Often instead of the normal black color there is a greenish hue to the pupil. The cornea may be anesthetic and it is rather changed in appearance. It may be only slightly duller than normal or it may be so cloudy as to resemble ground glass.

Chronic non-inflammatory or simple glaucoma is apt to occur as an accompaniment of old age at a time in which many degenerating bodily changes are taking place. The attacks may follow fatigue, worry, sleeplessness, and the like. They are usually intermittent and the patient is likely to attribute their noticeable manifestations to a "run down" condition. Following the attacks a common occurrence is persistent headache and the phenomenon of rainbow tints around artificial lights. As each attack subsides, the eye apparently returns to normal and the matter may be forgotten or ignored for many months.

In these prodromal cases scotomas are apt to develop and a narrowing of the peripheral field occurs. The patient may not be conscious of these field changes until suddenly he may notice that he sees only part of an object looked at.

Acute inflammatory glaucoma may have all the symptoms of simple glaucoma just enumerated. They may create little concern at first until suddenly they all become increased. Then comes severe pain in the eye accompanied by appreciable loss of vision. This occurs oftenest in the night and is accompanied by profuse lacrimation. The discomfort may continue for a few days only and then may be followed by apparent recovery, or the primal attack may continue unabated until the eye is lost.

On close inspection it will be seen that in both acute and chronic glaucoma cases the iris is pushed forward as direct result of increased pressure within the eyeball. This anterior bulging of the iris is often so pronounced that the anterior surface of the iris almost approximates the posterior wall of the cornea. Undoubtedly the increased tension contributes to this clinical picture. It is also generally thought that during an inflammation of

MADRAS MEDICAL COUNCIL.

REVIEW OF PROCEEDINGS.

MARCH 1941 SESSION.

BY

DR. V. RAMA KAMATH,

Member, Madras Medical Council.

The Madras Medical Council met on 31st March 1941 at 11 A.M. in the Office of the Surgeon-General with the Government. Col. (now Major-General) H. Stott, who succeeded Major-General N. M. Wilson, presided.

Before the proceedings commenced, I, in my capacity as the retiring Vice-President of the Council, spoke a few words welcoming the new President and the President made a suitable reply.

ELECTION OF THE VICE-PRESIDENT.

The readers of The Medical Practitioner might remember that soon after I was unanimously elected as the Vice-President of the Council last October, a commendable suggestion was made in the columns of The Medical Practitioner to bring into existence a convention that the Vice-President should be unanimously elected by the Council conferring this honour by rotation to a member of the Council, who is a medical licentiate, a graduate and one possessing the British qualifications (preferably an European) to demonstrate that the medical profession does not recognise divisions in the profession in spite of their existence. Though my term of office as Vice-President did not actually last for one year, as the rules demand that the Vice-President should be elected by ballot at the first meeting of the Council in each calandar year, my term of office had to cease. I did not seek re-election in spite of my being requested to do so by some members of the Council, as I wished to carry out the principle of the convention referred to above. The convention did take effect though unfortunately the election could not be unanimous. Dr. C. R. Krishnasami being elected as the Vice-President for the calendar year. I attempted not to have a contest but failed and consequently did not take part in the election.

PURPOSELESS OBJECTIONS.

Drs. P. Gurumurti and V. Govinda Nair raised series of objections in regard to the correctness of the report of the proceedings of the meeting of the Council held at the last October session. The objections from the former were gone through in detail and fell through, the latter did not press his objections. The Council ordinarily meets only twice in a year at a tremendous cost towards the travelling allowance to be paid to moffusil members which is certainly disproportionate to the meagre income of the Council earned by way of registration fee. At times the decisions of the Council which should take speedy action are delayed for want of confirmation of the minutes. To avoid such delay, the Council at my instance unanimously agreed some time ago to circulate the report of the proceedings of the meeting within a week, after the date of the meeting, the members agreeing to communicate to the Registrar within a week after they received the draft of the proceedings, any error in the minutes. This was a formal arrangement not against the rules which say that:

(1) The minutes of each meeting shall be printed, marked "confidential" until confirmed, and a copy sent to each member within thirty days of the meeting.

(2) The minutes shall be taken as confirmed if no objection as to their correctness is received by the Registrar from any member within thirty days of the receipt by such member of a copy of the minutes under by-law 24. If any such objection is received, confirmation of the minutes shall await the next meeting of the Council.

The formal convention agreed to by the Council went on smoothly till the October

1940 Session and it is hoped would be adhered to by the new Council as it facilitates quicker action without any prejudice to the privilege enjoyed by the individual members relating to their right to correct the minutes if incorrectly reported.

DISCIPLINARY CASES.

Dr. R. K. Narasimhachari, L. M. P. of Paramakudi: Hand-bills printed in Tamil were received by the Registrar to the effect that in the dispensary run by Dr. R. K. Narasimhachari all kinds of diseases including deliveries would be attended to and that the doctor in charge had authority to issue certificates. The medical practitioner having failed to appear before the Council at the October 1940 Session was summoned to appear at the March 1941 Session. He was severely warned.

Dr. T. C. Sankara Ayyar: The Assistant Sessions Judge, Tinnevelly in a letter dated 10th October 1941, addressed to the President of the Council, complained that Dr. T. C. Sankara Ayyar who treated a patient for the grievous injuries received by him from an assailant who was the accused in a Sessions case, would not promptly issue a medical certificate as demanded by the police and did so only after the police promised his fee. The Assistant Sessions Judge was of opinion that the conduct of the practitioner was not satisfactory. The Assistant Sessions Judge in his letter complained against another practitioner in whose nursing home, the patient was admitted for treatment. But as the latter was not a registered practitioner as per the Madras Medical Registration Act being a L. I. M., the Council could not take cognizance of his conduct and consequently I refrain from making any reference to the part played by the L. I. M. in the case. When the Registrar informally consulted me in my capacity as Vice-President, I gave my opinion that the Council could only take cognizance of infamous conduct in a professional act and that I was doubtful whether the charge made by the Assistant Sessions Judge came under the above category. The matter was referred to the Council by the President for an expression of opinion. After some discussion the Council approved the resolution moved by Dr. P. Gurumurti that the matter did not come within the purview of the Madras Medical Registration Act.

Dr. S. Sanjeeva Shenoy: The readers might remember the case against this practitioner as reported in The Medical Practitioner (Review of the proceedings of the Council at the last October 1940 Session). The practitioner having infringed the Excise rules was directed by the Council to submit quarterly to the President of the Council two certificates in regard to his conduct, one from the District Medical Officer, North Arcot, the other from a registered practitioner. Dr. Sanjeeva Shenoy produced the certificate from the private practitioner and pleaded his inability to get the D. M. O's certificate, which he said was due to some domestic inconvenience preventing him to leave his residence. The Council did not accept the excuse put forth by the practitioner and reproved him severely for not obeying the Council's directions and warned him that in case he did not submit the certificate to the President on the 7th April 1941 and on 7th July 1941 and thereafter quarterly for a period of one year, the Council would be compelled to proceed against him.

Dr. U. D. Gopala Rao versus Lt. Col. S. C. Alagappan: While reviewing the proceedings of the Council of the April 1940 Session, it was said that at the direction of the Council, the complaint filed by Dr. U. D. Gopala Rao against Lt. Col. S. C. Alagappan was referred to the special committee of the Council. Dr. Rao's complaint was that Lt. Col. Alagappan did not summon him while giving a second opinion on a certificate granted by him to a Government servant and that Lt. Col. Alagappan made some remarks to the patient which were likely to affect his prestige as a private practitioner. The special committee was of opinion that Dr. Rao did not prove his case. Against the order of the Committee Dr. Gopala Rao appealed to the Government pointing out several irregularities in the procedure adopted by the Special Committee. But the Government regretted that they were advised that no appeal could be made to Government by practitioners in disciplinary cases except by those who are affected by the decisions of the Council under Section 16 of the Madras Medical Registration Act.

When the above matter was reported to the Council at the March Session, the following resolution moved by me was unanimously approved by the Council:

While recording the Government Order (No. Ns. 5468, P. H., dated the 20th November 1940), the Council feels the necessity of having a provision in the Madras Medical Registration Act, 1914, for appeals by an aggrieved complainant against the decision of the Council in disciplinary cases.

Dr. D. S. Asirvatham's appeal to the Government: The readers might remember that while reviewing the proceedings of the Council (April 1940 Session) it was mentioned that the Special Committee of the Council to whom the case against Dr. Asirvatham was referred decided that the name of the practitioner should be permanently removed from the Medical Register as he was found guilty on the charge that he was advertising himself by means of printed hand-bills. The medical practitioner appealed to Government against the order of the Committee of the Medical Council, under section 18 of the Act. The following is a copy of the order passed by Government with reference to the appeal:

"In his proceedings No. C. 4/9-3/40, dated the 8th May 1940, the Registrar, Madras Medical Council, on behalf of the Council, framed a charge against Sri D. S. Asirvatham Nadar, L. M. P., Registered Medical Practitioner, Vaniyambadi, to the effect that on or about the 3rd June 1939, the practitioner issued hand-bills intended to advertise himself for professional advantage and thereby contravened the provisions of paragraph 6 of the Warning Notice issued by the Madras Medical Council. In its proceedings, dated the 17th June 1940, the Special Committee appointed by the Council under section 17 (1) of the Madras Medical Registration Act, 1914, to deal with the case, found the medical practitioner guilty of the charge and directed the Registrar to erase his name from the Madras Medical Register. Sri D. S. Asirvatham Nadar has appealed to the Government against the decision of the Committee.

The Government have carefully considered the appeal and the remarks of the President of the Madras Medical Council thereon. The only evidence in support of the charge against the appellant was the copy of the hand-bill sent by Mr. M. Abdulla, L. C. P. S., L. M. S. (Hyderabad), Vaniyambadi, who in his letter, dated the 31st January 1940, stated that hand-bills were 'printed and distributed in the town.' There is no direct evidence in support of the charge. There is no finding by the Committee as to what facts were proved. In the circumstances and for the reasons stated above, the Government are pleased to allow the appeal and to set aside the Proceedings of the Committee, dated the 17th June 1940, referred to in paragraph 1 above. It is open to the Committee to pass a fresh order after recording the necessary evidence, its findings and the reasons for the findings."

Comments: The Medical Council or the Committee appointed by the Council under Section 17 (1) is a Court and the procedure to be adopted by this Court is unique in itself and not in par with the Civil and Criminal Courts of Justice. This procedure was prescribed by the Government and has the force of law and cannot be deviated by any authority. In civil suits especially those under the jurisdiction of the Courts of Small Causes, *ex-parte* hearing of suits is quite common and such a procedure has been provided for relating to disciplinary cases by the Council or by its Committee. This rule is numbered 11 (2) and the last sentence in the rules runs as follows:

"If the medical practitioner refuses or without reasonable cause neglects to appear to answer the charge either personally or by his Pleader, he shall be taken to admit the truth of the articles of charge."

The Government seem to have relied entirely on the statements, made by the appellant in para 11 of his appeal and decided the appeal on the assumption that there was no direct evidence in support of the charge. Direct evidence in disciplinary cases can be gathered only at the time when the Council or the Committee sit as a Court. Till then the two bodies are to decide whether there is a *bona-fide* case against the practitioner complained against, and it can be said without any reasonable doubt that there was a *bona-fide* case before the Council.

In Criminal Courts the accused is always in the Court unless he is let on bail and has the permission of the Court to be absent from the Court when his pleader has to be in the Court and both in Civil and Criminal courts the plaintiff or the complainant as the case may be or their pleaders are always present, at the time of the hearing. In disciplinary cases before the Medical Council provision has been made for the hearing of the case without the complainant or the practitioner complained against. In the former case the Registrar has to take the role of the complainant and the practitioner *must*

appear in person or by his pleader and in the absence of both, the Council or the Committee 'shall' take it that the practitioner complained against admits the truth of the article of charge. In this particular case though the practitioner did not admit the truth of the article of charge, during the preliminary stage of enquiry he must have appeared before the Committee on the day of the hearing of his case himself or by his pleader, as required in the rules for procedure, or he must have given reasonable causes for not being present, even through his pleader. It is true he alleges in his appeal to the Government that he was not well at the time and that he wrote to the Registrar to that effect but he did not take the trouble of sending even a medical certificate in proof of his allegation nor did he send the letter by registered post alleged to have been addressed to the Registrar, and the Registrar. did not as a matter of fact receive any such letter at all, I wonder if the Government are aware that the practitioner is an Honorary Magistrate appointed by the Government, of which fact the Council came to know from the records before it. A person in the position of a magistrate should know the position of the accused. I am sure that the Registrar sent to this practitioner the articles of the charge by registered post and the practitioner ought to have sent his letter relating to his illness by registered post. The discretion to believe or not to believe those appearing before a Court or have to appear is entirely vested in the trying Court which is in possession of all records. When the practitioner complained against did not appear before the Committee nor adduce causes without reasonable doubts in regard to his absence the Committee had no option but to rely on the procedure laid down by the Government in such cases and did what it should have done under rule 11 (2) and had to take it for granted that the practitioner admitted the truth of the articles of charges.

The practitioner has made serious allegations against the Registrar, the President and others using the words 'conspiracy' and such objectionable terms throughout his writings including the appeal before the Government. In appellate Courts when such uncalled for and defamatory allegations are made in the records before them, the Court makes suitable remarks relating to such allegations and if the allegations are against lower court, this court or the Appellate Court charge those who made such allegations for contempt of Court.

The order of Government is silent relating to these *allegations which are certainly defamatory*. The absence of such a reference in the order of the Government allowing the appeal will have most undesirable effect on the medical profession and also on the public and lower the prestige of the Council. The appellant practitioner will certainly make much of his success in this case and of the allegations made by him against the Council and its President.

The Council will be justified in having recourse to a retrial of the case, as suggested by the Government in their order and it is indeed disappointing that the Government allowed the appeal and did not remand the case for a re-trial as is usually done by all British Courts of Justice when the Courts find the necessity for a re-trial whether it be for miscarriage of justice or any error in the evidence before the Court, originating either from the parties concerned or in the process of administering justice by the lower Court".

The Council referred this case to a Committee consisting of Drs. P. Gurumurti, V. Krishna Menon and C. R. Krishnasami.

REGISTRATION.

The Medical Council of India which is without a medical register of its own feels the difficulty for not being able to establish an uniformity in the matter of registration of medical practitioners in India, the Provincial Medical Councils being autonomous in the matter of registering practitioners. So to effect such uniformity the Medical Council of India had suggested to the Central Government the necessity of having legislation, so that the Provincial Councils might be deprived of their autonomy and made to register practitioners possessing foreign qualifications which are recognised by the Medical Council of India. This subject was referred to the Madras Medical Council by the Local Government and the following resolution moved by Dr. M. Krishna Rao was passed by the Council.

That with reference to this subject, the Provincial Medical Council will refrain, as far as possible, from recommending for recognition under the Provincial Medical Act, qualifications granted by institutions of other countries.

In regard to the registration of D. P. H. and H. Y. qualification granted by the Faculty of Tropical Medicine and Hygiene, Bengal, the Council decided to postpone the consideration of this subject till the Bengal Government passes orders on this subject which has been referred to them by the Bengal Medical Council.

Irregularities in the Madras Medical Register: The readers might remember that for some years before 1930, there was systematic fraud going on in the matter of registration of the practitioners with the result that early in 1930 or 1931, a defalcation of the funds of the Council to the extent of Rs. 5,000, was detected. During this period and till the date of detection of the fraud and embezzlement of the funds of the Council, lot of devices were played by those concerned in the fraud. Some amongst them were, giving one registration number to more than one practitioner. These devices have caused irregularities in the Medical Register. To correct such irregularities, the Council appointed a Committee, consisting of Drs. Rao Bahadur S. Rama Krishnan, C. R. Krishnaswami and V. Rama Kamath.

GOVERNMENT ORDERS ON THE RESOLUTIONS OF THE COUNCIL.

At the meeting of the Council held on 15th April 1940, I moved five resolutions relating to the rights and privileges of the registered practitioners. All of whom were unanimously passed by the Council, and these resolutions were submitted to the Government for necessary action.

Resolution No. 1: *The Madras Medical Council is of opinion that it is derogatory and against the spirit of the Madras Medical Registration Act to use such expressions as "L. M. Ps need not apply" "above the rank of an L. M P." and similar expressions by the Government departments and local bodies while advertising for posts, as such and similar expressions convey an inferiority complex.*

Government Order: *The Surgeon-General is authorized to issue instructions to Presidents, District Boards and Executive Authorities of Municipal Councils as proposed.*

Resolution No. 2: *In order to maintain a uniform standard relating to the Code of Medical Ethics, the Madras Medical Council requests the Government and local bodies to report to the Surgeon-General through the proper channels all* bona fide *cases of infamous conduct in a professional respect brought to their notice against official medical officers or non-official practitioners under their control such as subsidized practitioners, etc., before any action is taken against them and that the Surgeon-General be requested to bring such cases as he thinks fit before the Madras Council.*

Government Order: *The rules under section 24 (1) (iii) of the Madras Medical Registration Act, 1914, require that complaints of infamous conduct in a professional respect should be made in writing to the Registrar of the Medical Council and not to the Surgeon-General. In any case employers cannot refrain from taking action against their medical employees while a report is being made to the Medical Council. Action by the Medical Council can only supplement and not be a substitute for departmental action.*

Comments: *Resolution No. 2 is not the same which I intended to move. The purpose of my original resolution was that all cases of infamous conduct in a professional respect relating to Medical Officers under the Government or Local Bodies should be brought to the notice of the Madras Medical Council. The purpose of my resolution was to avoid miscarriage of justice when vague complaints are made against the Medical Officers especially under Local Bodies, such as, the Subsidized Rural Medical Practitioners, against whom departmental action is taken by the Heads of the Local Bodies who not being professional men, usually miscarry justice. In some cases especially in the Government Department very serious misconduct is either condoned or treated lightly. At the same time a private practitioner cannot escape disciplinary action by the Medical Council in case of infamous conduct in a professional respect when complained against. My intention was to give the benefit of a fair trial in these cases to the aggrieved parties whether they be medical men or the members of the public. For example, some years ago, a Subsidized Rural Medical Practitioner in Coimbatore District who was sent away from service by the President, District Board, for an alleged misconduct on the report of the D. M. O. and who brought this misconduct to the notice of the Madras Medical Council also, was found innocent by the Council and was reinstated. While, recently another Rural Medical Practitioner who was removed from service by the President, District Board, Madura, for an alleged misconduct in a professional respect and whom the D. M. O. found the practitioner innocent was not given the benefit of a trial by the Madras Medical Council, though the practitioner requested the Government to report the case to the Council. The future of this young practitioner is consequently jeopardised. So to bring about uniform standard of punishment for infamous conduct in a professional respect, I thought the best thing to do was to request the Government and the Local Bodies to report such cases to the Medical Council also. It was not my intention to deprive either the Government or Local Bodies of their rights of departmental action against their Medical Officers.*

But unfortunately one of the members of the old Council amended the resolution to such an extent as not to make the Government realise the purpose of my original resolution. I intend reviving the subject once again.

Resolution No. 3: *Government are requested to direct Local Bodies not to deny the rights and privileges conferred on subsidized practitioners, who are on the Madras Medical Register, by virtue of their registration.*

Government Order: *It is open to the Medical Council to report to the Surgeon-General specific cases in which rights and privileges conferred by registration have been curtailed in the case of subsidized practitioners.*

Comments: *It would have been more to the point if the Government had ordered that the aggrieved Subsidized Practitioners might report to the Surgeon-General instead of through the Medical Council, as the aggrieved parties are the Subsidized Practitioners. The Subsidized Practitioners should thank the Government for this small mercy and should take advantage of the spirit of the Government Order on the subject, and report to the Surgeon-General as and when their rights and privileges are infringed by those in authority over them.*

Resolution No. 4: *Resolved to inform the Madras Public Service Commission through the Government that it is derogatory and against the spirit of the Madras Medical Registration Act to make invidious distinctions between official and non-official registered practitioners in regard to physical fitness certificates demanded by the Commission from candidates applying for posts under the Government and that all registered practitioners who possess L. O. diploma granted by the Madras Government Ophthalmic Hospital or who possess the London D. O. M. S. diploma or any equivalent eye qualification should be considered as eye-specialists for the purpose of medical certificates without making any reference to the Surgeon-General with the Government of Madras.*

Government Orders: *The Government have decided that certificates of physical fitness in the case of candidates for employment in certain branches of the public service should be given by Medical Officers in Government Service. The suggestion in regard to officers competent to grant certificates regarding eyesight will be considered separately.*

In continuation of G.O. No. 5250, P.H., dated 7th November '40, the Registrar, Madras Medical Council, is informed that the Government have decided not to alter the existing orders under which applicants for employment in Government service having defective vision should produce special certificates regarding eye-sight from eye-specialists in the employ of Government.

Comments: *The orders of the Government deny to Registered Practitioners the privileges conferred on them by Registration. The Government Order relating to Eye certificates, adds special injury to the general insult. If the rights and privileges of Medical Registration are denied to the independent medical practitioners, there is little or no purpose for the Medical Council to continue as such and for the representatives of the medical profession to serve as members of the Medical Council. I did throw a hint to my comrades who fought the last elections with me in a team, and also to my non-official colleagues in the Council to this effect, but had no response. The members of the independent medical profession should now do the needful in the matter.*

Resolution No. 5: *The Madras Medical Council notes with regret that in spite of a special Government Order that when a Government Medical Officer is requested to give a second opinion on the certificate granted by a private practitioner, the former should request the practitioner who granted the original certificate to be present at the time the patient is being examined by the Government Medical Officer. Instances are being reported when Medical Officers in the position of Presidency Surgeons having set at nought the Government Order on the subject. Therefore the Surgeon-General with the Government of Madras is requested to take notice of the conduct of the officers concerned so that the Government Order on the subject is strictly adhered to.*

Government Order: *It is open to the Medical Council to bring to the notice of the Surgeon-General instances where the instructions issued by the Government in the matter of obtaining second medical opinion, have been ignored or violated, together with the details connected with such instances.*

Comments:—*There was no need to communicate this resolution to the Government, for the resolution concerns only the Surgeon-General.*

Fortunately for the Medical Profession there are at present 9 private practitioners in the Council of 16 and they should be certainly able to put in an united front to guard and protect the interests of the profession and in case the Government are not pleased to carry out the reasonable requests and recommendations of the Medical Council, they should conjointly and seriously decide to take such effective measures to force the Government to treat the Officials and Non-Officials in the medical profession alike relating to the rights and privileges conferred on the members of the profession by Medical Registration Act. Unfortunately there is no provision in the Medical Registration Act for recording the speeches made by the members of the Medical Council during its Session. Consequently, either the Government or the members of the Medical Profession have no means to know what is going on in the Council. It is therefore necessary that when important questions relating to the medical profession are discussed by the Council *verbatim* reports of the speeches made by the members, should be submitted to the Government along with the resolutions, so that the Government may be apprised of the feelings of the profession, relating to their Orders which affects the status and prosperity of independent medical practitioners.

D. M. & S. Diploma: *The following is the Government Order relating to the D. M. & S. Diploma:*

In G. O. No. 986, P. H., dated 8th May 1933, the Government extended the course of studies of pupils for the diploma of L. M. P. from four to five years with effect from the academic year 1933—34. The Surgeon-General proposes that the diploma granted to the pupils who have undergone this extended course should be described as a Diploma in Medicine and Surgery (D. M. & S.). The Government approve the proposal.

As soon as the above G. O. was received by the office of the Council, I, in my capacity as the Vice-President sent a note to the Registrar, requesting him to circulate the same to the members of the Council. This was done. The following is my note:

There was an all round desire in the medical profession to put an end to castes in the profession and to have one uniform standard of medical education. Accordingly, the Government were pleased to abolish the medical schools in 1938 and amend the Madras Medical Registration Act with a view to bring about fusion and harmony in the profession and the present Council represents the profession as a whole and not the three groups in which they were divided by the old Act. The new qualification described as Diploma in Medicine and Surgery, though well meaning and instituted by the Government with the best of intentions will certainly give rise to a cleavage in a class of practitioners whose number is the largest in the profession both in this Province and elsewhere and the new Diploma will set at nought the very purpose of the newly amended Medical Act and with it cause resentment in the profession, especially amongst the Medical Licentiate section of it. The Council must be aware of the history of medical education in this country where the scientific medical profession of the type which is under the purview of the medical Act, was first introduced for the purpose of medical service. The profession has been therefore depending for its growth and evolution on authorities outside the profession and not in the profession itself as is the case in other civilized countries. The Medical School Education was first brought into existence during the days of the East India Company and the Schools first trained a class of medical men called the Dressers known later as Hospital Assistants and the Diploma was described by the Government as Hospital Assistant Diploma and when the school admitted private pupils and when their number was much more than the number required for Military or Civil Service, the Government described the Diploma as Licensed Medical Practitioner, 30 years ago. Preceding the changes in the nomenclature of the Diploma, the course of studies in the medical schools underwent changes in quality and quantity and the duration of the course of studies which was only for a period of 1½ years during the days of the East India Company gradually increased to 3 and then to 4 years in 1903. The first batch of students who underwent the four years' course came out of the Medical Schools in 1907 with the Diploma described as Hospital Assistant. Perhaps three years later, the Government changed the name of this Diploma to Licenced Medical Practitioner (with the abreviation L.M.P.) which they did on their own initiative and gave retrospective effect to their order relating to the L.M.P. qualification permitting all who passed out from the Medical Schools (during the days of East India Company and later) before the date of their order the use of L. M. P. Diploma. So, it is but fair and quite consistent with the principle and the spirit of the newly mended Medical Act that the Council should suggest to the Government the desirability of giving their Order relating to the New Diploma retrospective effect when it is known that the school standard of the medical education has been abolished in this Province once for all and in the course of some years the practitioners known as Medical Licentiates and with them those possessing the new Diploma D.M. & S., will be extinct.

It was expected that while recording the G. O. on the D. M. & S. Diploma and the Government Orders on my five resolutions referred to above, the Council

would express its opinion on the Government Orders; unfortunately this was not done. To add to the misfortune of the profession, 31st March was a busy day to the Surgeon-General. The Council adjourned for lunch at 2 P. M. to meet again at 2-30 P. M. that day. It was not possible for me to be on my seat at 2-30 P.M., and when I reached the Council room at or about 3 P. M. when both the above subjects and many more were disposed off. Yet I made an honest attempt to send a personal telephonic message to the President at about 2-20 P. M. when I was told that the President in his capacity as Surgeon-General was busy with a committee meeting. Soon after I was on my seat in the Council room, I requested the President to permit me to have my say at least on the Government Order, relating to D. M. & S. Diploma, but failed. While I appreciate the zeal of those who represented the Madras Branch of the All India Medical Licentiates' Association in waiting on the Surgeon-General, to request him to recommend to the Government to give the Government Order retrospective effect, so that all the L. M. Ps may have the benefit of the new Diploma, I endorse every word appearing in News and Comments column of the Medical Practitioner, April 1941 Issue under the caption "D. M. & S. Diploma" I have not lost hopes, the present Government seem to be very vigilant relating to public opinion; in this matter it is the opinion of the profession which should move the Government. Nothing has been heard so far as to how the members of the medical profession received the disappointing news, relating to the reply of the Surgeon-General to the deputationists representing the Madras Branch of the All India Medical Licentiates' Association.

Amendments to the Indian Medical Degrees Act, 1916: As the Indian Medical Degrees Act of 1916 was defective in that, it could not take action on the quacks who befraud the public by using such qualifications after their names, as M. B. (H)., M. D. (H)., the Madras Medical Council represented to the Government some time ago to amend the Act suitably. About two years ago, the Council appointed a Committee, consisting of Drs. Rao Bahadur, T. S. Tirumurti, Rao Bahadur. M. R. Gurusami Mudaliyar and V. Rama Kamath to draft amendments to the Act. This was done, and the Council submitted the draft amendments to the Government. The Government instead of adopting the amendments of the Council, framed amendments *denovo* which were less drastic than those proposed by the Council. The Government amendments have since been incorporated in the original Act and now assumed the force of law as the Madras Act to amend the Indian Medical Degrees Act of 1916. The amendments are only two and they appear in the Correspondence columns.

The new Section 6-A is likely to apply to those who own foreign qualifications such as M. D. (Berlin), M. D. (Vienna), etc., which are not so far recognised by the Governments in British India, and the display of such foreign medical qualifications may be objectionable. So to consider this doubt a committee consisting of Drs. P. Gurumurti, V. Krishna Menon and C. R. Krishnaswami was appointed.

Annual Maintenance Grant for the Medical Council: An annual grant of Rs. 1,000/- was given to the Madras Medical Council by the Government whenever the Council could not balance its budget and the Council had been uniformly drawing this grant till 1939 when the Government withdrew the grant. In 1940 when the Government was requested to reconsider their decision, they informed the Council that they were not prepared to reconsider the question and the Council was asked to raise the fee for registration from Rs. 15/- to Rs. 20/-. The Council which considered the suggestion of the Government twice, could not make up its mind to raise the registration fee. The tie between the Council and the Government was loosened by the late President, Major-General, N. M. Wilson and the Council was given the grant for 1940. In view of the increasing demands on the finances of the Council, it was decided at the last meeting to appoint a Committee to consider ways and means to increase the revenue of the Council and the members of the Committee, Doctors, Rao Bahadur S. Ramakrishnan, C. R. Krishnaswami and V. Rama Kamath are reported to be considering this matter.

Location of the Office of the Council: Soon after the Madras Medical Council came into existence in 1915, the Council appointed a part time Registrar and located the office of the Council in his residence paying him the actual rent. This arrangement went on till about the year 1926, when the office was run in the residence of the clerk of the Registrar. During the same period, the actual work of the Council had to be transacted in three different buildings separated from each other at least by 3 miles. The President of the Council held his office at the southern-most end of Mount Road, the Registrar had his office till 1926 in a central locality in Egmore, while the meetings of the Council were held in the Madras Medical College. From 1926 to 1930, the Registrar's office was shifted from Egmore to Royapettah and the Registrar lived in San Thome, and his clerk in the Registrar's office. These arrangements might look wonderful and as funny, yet they existed till the year 1930. Thanks to Major-General Sprawson who was the President of the Council in 1930. I represented to him soon after my entry into the Council in 1929, that the Council office should be located in the office of the Surgeon-General where all the activities of the Council could be conducted with advantage. Though he could not see eye to eye with me in many matters of the Council, during the period of his Presidentship, he agreed to my suggestion and the affairs of the Council have been running smoothly till March 1941, when a new Government appointment, the Principal Nurse was created by the Government. To accommodate this woman-officer, a notice was served by the Surgeon-General of course, through his Personal Assistant, that the Registrar with his office should quit the office of the Surgeon-General within perhaps a week or fortnight from the date of the notice. This notice again might look very strange when it is known that the Surgeon-General is the nominated President of the Council. Thanks to Major-General Stott, for it is said that he had permitted as a temporary measure, the Council to run its office in the office of the Registrar of the Midwives and Nurses' Council. This tempts me to make a suggestion to combine both Registrars into one. This would also relieve the present financial burden of the Madras Medical Council. So long the Surgeon-General is the President which he will be for 3 years more, the office of the Council should be in the office of the Surgeon-General or else there is likely to be dislocation of work. Moreover the Council cannot afford to pay rent to a private building. Next best thing to do will be to shift the office to the Secretariat Buildings as is the case with the majority of other Provincial Medical Councils in India.

RESOLUTIONS BY THE MEMBERS.

Dr. T. S. Shetty moved: Resolved that the non-official members of the Medical Council be paid Rs. 15 as sitting fee and the mofussil members including the Government officials be paid actual second class fare to and fro, when they attend the Council and an allowance of Rs. 5 (in addition to the sitting fees) per day of the meeting.

The following amendment to the proposition was moved by Dr. M. V. Krishna Rao and seconded by Dr. M. J. Samuel:

That after the expression 'attend the Council' the following be added :-

That an allowance of Rs. 4 for every hundred miles travelled by rail and eight annas per mile by road,

After some discussion the consideration of this subject was postponed till the next meeting of this Council.

Dr. V. Krishna Menon wanted to move the following resolution, but it had no support from any other member of the Council and the President asked the mover whether he wished to move the resolution and the resolution was withdrawn.

Resolved to request the Government that the members of the Madras Medical Council shall be given the privilege of using the suffix 'M.M.C.' (Member, Medical Council) during the period they are in office, either elected or nominated.

Dr. V. Krishna Menon moved another resolution which was passed.

Resolved to authorise the Registrar, Madras Medical Council to get 'The Medical Registration Manual' corrected up to the 31st March 1941 and to get the same reprinted.

Dr. P. Gurumurti gave notice to move the following resolution:

1. The Council resolves to request Government to amend sub-section (3) of section 14 empowering the Council to levy Rs. 5. for registration of persons under the Madras Medical Registration Act who are already registered under any other Provincial Act.

2. This Council is of opinion that in view of the arguments advanced by Dr. P. Gurumurti in his letter, dated the 16th October 1930, addressed to the President of the Council, no legal opinion need be obtained in the matter (vide resolution No. 29, dated the 7th October 1940) as section 16 (2) empowers the Council to restore a person 'so removed' *i.e.*, altogether or for a specified period.

3. This Council resolves to request the Government to substitute the following for rule 19 of the rules for the election (other than the first election) of members to the Madras Medical Council.

4. This Council resolves to request the Government to delete the words fourteen clear days . . . votes occurring in rules 10 (3) and substitute in its place on or before the 4th day appointed for scrutiny.

5. This Council resolves to rescind resolution No. 4 passed at the meeting of the Council held on 7th October 1940 regarding Dr. R. K Narasimhachari of Paramagudi and 'to take that the medical practitioner in question has admitted the truth of the articles of charge and proceed to hear and decide upon the said charges in his absence.'

6. This Council resolves to delete by-law No. 33 (a), 40, and 'and 40' in by-law 41.

Resolutions No. 1 and 5 were withdrawn by the move on the suggestion of the President resolutions (3), (4) and (6) were referred to the Committee consisting of Drs. P. Gurumurti, V. Krishna Menon and C. R. Krishnaswami. Resolution No. (2) was passed by the Council.

Dr. V. Rama Kamath moved:

1. As the Medical Council is the proper statutory authority for the recognition of medical qualifications, the Council requests the Government and the Madras and Andhra Universities that any medical diploma or degree which the Government or the University contemplate to institute, the Medical Council should be consulted by the Government or the University, respectively before the diploma or the degree are finally approved.

Dr. K. Narayanamurti seconded. After some discussion, the motion was put to vote and lost. A poll was demanded with the following result:

For:—Dr. V. Rama Kamath and Dr. K. Narayanamurti.

Against:—Dr. S. Ramakrishnan, Dr. P. V. Cherian, Dr. V. Govindan Nair, Dr. P. Gurumurti, Dr. V. Krishna Menon and Lt.-Col. G. R. McRobert.

Neutral:—Dr. C. R. Krishnaswami, Dr. M. V. Krishna Rao, Dr. M. J. Samuel and Dr. T. Shenappa Shetty.

2. The Madras Medical Council desires to point out to the Government that it is detrimental to the interest of the Medical Profession and the public to fix the maximum age-limit of 35 years for candidates appearing for the T. D. D. diploma, newly instituted by the Madras Government that the maximum age restriction may be done away with.

Seconded by Dr. V. Krishna Menon, this motion was passed by the Council.

The second resolution in effect is a corollary to the first and I am grateful to Dr. V. Krishna Menon who seconded the 2nd resolution without hesitation and rightly appreciate the co-operation of such of the members who were either against or neutral in regard to the first resolution. I congratulate myself—as there is nobody else to do it—on my success, in spite of apparent opposition to the resolution No. 1. The T. D. D. course introduced for the first time in India is the outcome of the personal indefatigable efforts of Major-General Wilson, the late Surgeon-General. In his anxiety to get through his pet scheme of campaign against tuberculosis, he got the sanction of the Local Government to institute this Diploma which like other Government Diplomas were created without any reference to the Statutory Medical Council which is the only body to recognise any diploma for the purpose of registration. In all civilized countries, medical education is controlled by the medical profession which founded different bodies for different purposes. independent of the Government, including the university medical education.

In India, especially in Madras, the Surgeon-General is the origin founder in fact the creator of all Government Diplomas and the Government Medical Officers entirely control the University Degrees and nothing is known to the medical profession, what is going on in between the Surgeon-General and the officers of the Madras Medical Department till the persons possessing the Diplomas or Degrees are seen. It is no exaggeration to say that the Diplomas and Degrees are created for special appointments under the Government and not for the benefit of the profession. It is also a fact that independent medical practitioners do not care to qualify themselves for higher degrees of the Madras University. For they are not recognised for the diplomas or degrees they may possess as it is the office of a medical man in the Government Service that has the recognition by the Government and also by the public. For what can a private practitioner do if he is a M. D. in Midwifery, M. D. in Pathology or in Radiology or M. S. in Ophthalmology and possess any other new degrees instituted by the Madras University unless he has a Government Hospital to display his talent? I need hardly say anything about the new degrees such as M.Sc. or B.Sc., etc. in non-clinical subjects which has no value outside Government institutions.

No Medical Faculty of whatever denomination would have thought it necessary to fix age limit for any degree or diploma. In the British Isles and elsewhere, medical practitioners over the age of even 50 are candidates for the M.D. or M.S. degrees or F.R.C.P. and F.R.C.S. Diplomas. Thanks to the Madras University it has not fixed age limit for its higher degrees. Perhaps there was no necessity for it, because none outside the city of Madras amongst Government officials can aspire for these special Degrees and the Government have fixed 55 years as the age limit for service and all below forty cannot come near the City Citadel of the State Hospitals till those who began their official life as M.B.B.S. in Madras attain the age of 55. My intention in giving notice to the resolutions under reference was to popularise the Government Diplomas and University Degrees so that the medical profession and with it the public might have the benefit of higher medical qualifications. With the exception of Drs. P. Gurumurti and V. Krishna Menon, I should say I have the moral support of other non-official members who were neutral to the extent of their not being against the resolution and I fervently hope my neutral colleagues will be the future supporters of this and similar reforms and those against will judge the reforms on broad principles of common good to the entire profession without minding its source or authorship. As India cannot afford to have an organised medical profession for obvious reasons, those who are in the Medical Council especially the new democratised Madras Medical Council, would take into consideration the interests of the members of the medical profession who returned them to the Council and not the person or persons who sponsor the reforms. It is possible for them to achieve what the organised profession does in other countries.

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RECRUITMENT TO WAR MEDICAL SERVICE.

The brief telegraphic summary of the proceedings of a two-day Conference that met at Simla on 21st and 22nd instant, appearing in the newspapers confirms the apprehensions expressed in the columns of The Medical Practitioner last April. The Conference which must have cost the Central Government some money towards the travelling allowance, did not achieve a bit more than the communiques which the Defence Department published through the Provincial Governments, relating to conditions, rates of pay and additional concessions for the Emergency War Service. The telegraphic summary has been published in the Correspondence Columns and we wish the readers to go through it. The Conference has only decided to give greater publicity to the communiques already published and even before the conference concluded its proceedings the Defence Department had published very attractive pictorial advertisements in the newspapers which in our opinion is not likely to have greater effect than that of the communiques already published. In regard to Licentiates it would have been wiser if the advertisement was silent about them, The rates of pay offered to the other members of the medical profession and those offered to Licentiates in such a pictorial show will make the distinction as odious as the display of the advertisement is prominent and add to the disappointment, that the telegraphic summary of the proceedings for the Simla Conference had not a word about the Licentiates. In the display, mention has been made that the rank of Sub-Assistant Surgeon is abolished and the Licentiates are to be designated as Assistant Surgeons. A recent Communique from the Defence Department that the professional equipment of the present day Licentiates is much higher than that of the old Hospital Assistant, did naturally raise a hope in this class of practitioners, that the authorities who were kind enough to recognise higher professional knowledge in the Licentiate than that of the old Hospital Assistant brought into existence during the days of the East India Company, would offer them proportionately higher pay and other emoluments than those that exist now. The advertisement would naturally retard the recruitment of Licentiates. If no mention was made about the pay of the Licentiates, the effect of the advertisement would have been better. We do not make this statement on mere imagination. We had occasion to meet about 8 or 9 Licentiates quite recently, who having applied for War Service and who were summoned by the Surgeon-General with the Government of Madras, to meet him for the execution of bonds and all of them expressed to us that they joined Emergency Service with the hope that they would be raised to the rank of Subedars at least and that a recent announcement that the rank of Sub-

Assistant Surgeon was abolished encouraged them to enter War Service, but the advertisement which was published in the newspapers on the 22nd July, had shattered their hopes.

The Heads of the Medical Departments either in the Provinces or at the seat of the Government of India, have been so fixed up with their Departments, that they hardly come in contact with the general profession and consequently they cannot be expected to feel the pulse of the profession themselves. We have been trying our best to create a happy contact between the Head of the Medical Department in this Province and the members of the profession, especially the rank and file and did succeed to a great extent. But unfortunately the term of office of these officers is so short, that what is aimed and expected, could not be achieved. If the Heads of the Medical Department and officers similarly placed in position next to them, have been minding about the welfare of the members of the medical profession outside the official circle even to a much smaller extent than they are doing in regard to their Departmental Medical Officers, there would have been no difficulty to find enough and more recruits for War Service and there would have been no need for Conferences, much less for the advertisements. The last thing that the authorities have placed before the Indian Doctors are the proceedings of the Simla Conference. Though the events connected with the Conference, give an impression that the Conference and its findings, relate to the recruitment of Emergency I. M S. and have nothing to do with the Medical Licentiates, judging from the proceedings of an informal conference, summoned recently by the Surgeon-General with the Government of Madras and the advertisement appearing in the newspapers on 22nd instant, the very day the Simla Conference concluded its proceedings, we are led to surmise that the Provincial Selection Boards referred to in the proceedings of the Conference, were meant for the recruitment of Indian Doctors, both for I. M. S. and I. M. D. The personnel of only the Central Advisory Body has been fixed, consisting of the Director-General, Indian Medical Service, the Secretary of the Defence Department, the Secretary belonging to Education, Health and Lands Departments and two private medical practitioners. But nothing is mentioned about the personnel of the Provincial Selection Boards which for the major provinces are to consist of five members, three officials and two non officials, and in minor provinces to consist of two official and one non-official member. It is not known whether the two non-official members in the major provinces, and one non-official member in the minor provinces, are to be private medical practitioners Judging from the personnel of the Central Advisory Board we may not be wrong in guessing that the non-official members in the Provincial Boards are likely to be private medical practitioners In Madras it is just possible that the Selection Board will consist of the Surgeon-General and the Principals of two medical colleges in the city or two Superintendents of the two teaching hospitals, depending upon the convenience of the latter officers. The two non-official members, if they were to be private medical practitioners and if the Selection Board, were to select the Medical licentiates also as presumed by us, one such member should be a graduate who is a popular figure amongst medical men, both in the city as well as in the moffusil and the other should be a licentiate well known both to the licentiates and graduates. If a good choice is made

of the non-official members without placating any interest and minding only the recruitment to War Service, the popularity and status of these two members are sure to attract candidates for the purpose for which the Selection Board is to be constituted. The selection of a graduate or a licentiate who has War Service to his credit, would be ideal as these members will be able to tell the candidates their actual experience in the last war. The pay given to raw medical men in the commissioned rank is certainly decent and young unmarried practitioners who have little or no responsibility should not hesitate to volunteer. Apart from War risks they will be very much benefitted in regard to their professional knowledge and cultivate a spirit of adventure and enterprise. The Selection Board should be competent to allot rank to the candidates selected by them as the principle involved that senior practitioners should be given a rank depending not only on seniority but merit and experience has been conceded by all concerned including the Simla Conference. Regarding age limit we could suggest that it should depend upon the health and constitution of individual candidates. There are practitioners including those who retired from Government Service who look younger than their age and quite fit for hard work. We had opportunity of meeting at least one such practitioner, practically a widower and who has ample means to live without outside help and who expressed to us that he was anxious to have a taste of War Service also. There will be surely many more of the spirit which we admired in the practitioner referred to by us.

We wish to point out that the available resources relating to the supply of medical men have neither been tactfully tapped nor husbanded so far. There are many medical posts in the military department which could be offered to private practitioners possessing the required qualifications. We would mention in this category, I.M.S. in charge of Medical Stores in different provinces, the military officers doing duty in Station Hospitals or Camps and such and similar posts unconnected with active war service. All these posts may be occupied by private practitioners or retired Government medical officers. To the extent these posts are filled by non-military medical men to the same extent trained military medical officers will be available to do active War Service.

It will not be out of place for us to refer to the intention of the Madras Government to force unwilling Civil Assistant Surgeons and Sub-Assistant Surgeons within the age of 40 in the case of former and within the age of 50 in the case of the latter class to take up War Service. They seem to rely on their order passed in 1937 relating to Public Service, wherein military duty outside the Madras Presidency is one of the conditions of service in the case of Civil Assistant Surgeons. It is said that there is a similar clause in another order passed in 1934. It is very doubtful if the Government could force War Service on such of the Assistant Surgeons who joined service before 1934. Even in case the Government could do so, it is not desirable to create a scare of compulsion. After all the number of Civil Assistant Surgeons below the age of 40 will be very insignificant. The Government would do well not to force their order on unwilling Asst. Surgeons or Sub-Asst. Surgeons. Peaceful persuasion will be more conducive in War Efforts than Military *Zulum*. To have power is one thing; to use it discreetly is another thing. Much more good work could be done by showing the rod of power and authority than by using it indiscreetly. It is really a strange coincidence that when the Government circular regarding compulsory war service was in circulation in Madras, Mr. Menzies, the Prime Minister of Australia made an appeal to the doctors in Australia to the effect :

"All male doctors born between July 1906 and 1921 who are unmarried or widowers without children will now register for home military service." Mr. Menzies issued another appeal to the resident hospital doctors to volunteer wherever possible in view of the difficulty of getting enough doctors for the Navy, Army and Air Force.

We wish the picture of the Government policy in Madras and elsewhere in India be something similar to that displayed by a Dominion Minister. The Selection Board to be instituted in Madras and other Provinces should not technically confine their activities to the term implied. It should be a propaganda board as well and such of its members who could afford to go out of the City should do so and implement in them the acuteness of vision of the eagle's eyes to enable them to get practitioners of the right type for the Selection Board to choose. Matters relating to recruitment of doctors are not really as bad as they are made to appear. They require tactful and judicious handling and the rule of the red tape should be loosened sufficiently for the speedy action demanded by the situation.

SUBSIDIZED RURAL MEDICAL RELIEF SCHEME.

The Provincial Subsidized Rural Medical Practitioners' Association or its Provincial Committee consisting of representatives of the District Branches of the Association has been meeting regularly year after year from the year 1937 when the activities of the Association were revived and has been submitting to the Government the resolutions passed at the annual conferences. The Association soon after it met at Samalkot in April 1939 could not submit the resolutions passed by the Conference as the Association has been awaiting the orders of the Government on the memorandum submitted to the Government by the Working Committee of the Association on 20th February 1939. Consequently after a delay of exactly one year, the President of the Association submitted the memorandum to the Government on the resolutions passed at Samalkot on 23rd April 1941, through the Surgeon-General, and another memorandum was submitted the same day to the Surgeon-General himself as the subject of the latter memorandum came under the direct authority of the Surgeon General. The Government were pleased to pass two orders relating to the memorandum submitted to them, both of which appear in the Correspondence Columns. We understand that the reply from the Surgeon-General has not been yet received. It is probable that the Surgeon-General might have referred to the Government some of the subjects appearing in the memorandum submitted to him. The Association will do well to send a reminder to the Surgeon-General.

Renewal of Agreements Cancelled : The orders of the Government must have been received by the rural practitioners with mixed feelings. They are bound to express their gratitude to the Government who conceded to the request of the Association, that the periodical renewal of agreements between the Government District Board and the practitioner was not necessary. We congratulate the present Government on their having realised for the first time in the annals of the history of rural medical relief scheme, that the subsidized practitioner was expected to settle in the village of his choice permanently so long as he did not violate the terms of the agreement.

Transfers & Conversions to Continue : The next important suggestion made by the Association to the Government for prohibiting transfers, conversion of dispensary of one system to that of another and the conversion of subsidized dispensary into a regular local fund dispensary, has not been accepted by the Government

in spite of the fact that the principle involved in this suggestion was similar to that adumbrated by the Government in the previous suggestion. As the Association found that in some cases due entirely to political reasons, subsidized allopathic dispensaries run to the satisfaction of the public by popular practitioners were converted into ayurvedic dispensaries for the purpose of getting rid of practitioners who were not wanted by the Presidents, District Boards or their henchmen. The dishonest purposes at times involved in such transfers were brought to the Government in the memorandum, but in vain.

Enquiry under Clause 13 of Agreement Unsatisfactory: It is most disappointing that the Government could not find their way to agree to the suggestion of the Association, that any enquiry held under clause (13) of the agreement should be conducted by an agency which was above the reach of political influence. The Association quoted specific instances of miscarriage of justice. There have been instances where the future career of a few practitioners was ruined for want of impartial enquiry, relating to their conduct. In fact, in majority of cases, the District Board President was the prosecutor as well as the judge. There is a very far fetched consolation in the decision of the Government on this subject. They have for the first time formulated a procedure as to how the enquiry is to be conducted. It has been made compulsory that the District Medical Officer should be referred to at two different stages of an enquiry, first at the preliminary stage, next at the final stage. We wonder if the Government are aware that the affairs of a rural practitioner are usually the last item in the programme of the daily routine in any office and his lot is usually decided by a clerk or a superintendent or at times both combined and the concerned officers find time only to put a '*dobhi mark*' (if we could borrow the expression of an old Surgeon-General) on the concerned file. Our efforts to bring the Surgeon-General in direct contact with the rural practitioners did have tangible results and the old days of pilgrimage which the rural practitioners made to the residence of concerned clerks used to be scarce or far between. The Government must know at least one instance, where a subsidized practitioner in a district was depicted as a worst criminal and was made a prey to the tutored charges made against him by his own subordinates, an attender and a midwife and it so happened, that just at this juncture, the Collector of the particular District who became the ex-officio President of the Board, conducted the enquiry and the practitioner was exonerated. To the misfortune of the same practitioner the District Board President came back and the practitioner was pursued again and the poor fellow preferred leaving the District for good. Medical men however eminent, cannot claim to have legal knowledge of the type which a Collector or Deputy Collector has by virtue of his office, and the Association thought and rightly so that the Inspector of Municipal Councils and Local Boards who was usually a senior Collector or his Deputy not below the rank of Deputy Collector and who could afford to be above factions in the District, would be the proper officer to sit in judgment in the enquiry to be conducted under Clause 13 of the agreement as any adverse decision against the practitioner would actually cost his future career as a medical man.

Inadequate supply of medicines to Dispensaries: The request of the Association that the present supply of medicines is inadequate in dispensaries where the daily attendance is above 30 and in many others over 50 a day. is said to be under the consideration of the Government and it is hoped that though the request is over 2 years old, the Government will be pleased to pass favourable orders in the interests of efficiency and popularity of the subsidized dispensaries.

Equipment to Dispensaries: The subsidized rural medical relief scheme came into existence in 1925 and the same year the Government ordered the local bodies to supply all the dispensaries uniformly with a set of instruments for minor general surgery including the dental instruments, and a large number of dispensaries

till this day have not been equipped to the requirements of Government Order. Year after year, the Government were apprised about this difficulty and Government did instruct these bodies, but to no purpose. This request was repeated at Samalkot and the Government have been pleased to instruct the Surgeon-General not to recommend the opening of new subsidized dispensaries in any district, where the existing dispensaries have not been equipped as per Government Order on this subject passed as early as 1925. We trust this order will have some effect at least. Knowing as we do the state of affairs in the local bodies, it may be too much to expect that even the recent Order on the subject will have the desired effect.

Special Allowance for Festival Duties: The subsidized practitioners have been getting a daily allowance of Rs. 5 for doing festival duty. Such of the practitioners who have undergone Public Health training, and who are given an additional monthly subsidy of Rs. 15 desired to know if they could claim Rs. 5 as daily allowance as compensation for loss of private practice. The Government have not only been not pleased to grant this reasonable and modest request but have curtailed the allowance granted so far to the practitioners not entrusted with public health work, ordering that the latter should get only Rs. 3 instead of Rs. 5, the old allowance. We can conceive that the Government will not be so harsh. It is just possible that 3 is a printer's devil for 5. The Association will do well to write to the Government and ascertain whether Rs. 3 has been printed in the Order by mistake.

Belated Investigation: It was brought to the notice of the Association at Samalkot that the Coimbatore and Tanjore District Boards overlooked the claims of two subsidized practitioners, one in each district while filling vacancies which then occurred in the respective Boards in the regular L. F. dispensaries. The Government have requested the Surgeon-General to investigate whether any action is necessary. It is too late to expect any fruitful result from this belated investigation.

Other Requests: The Association asked for enhancement of subsidy to Rs 600 per annum and desired that the practitioners should have holidays for 30 days in addition to public holidays. Both the requests have been turned down and also a third one which was to the effect that the subsidized practitioners should be treated as Government servants in the State medical institutions. A para has been added in the last refusal order suggesting to local bodies that the subsidized practitioners may be extended the same concessions in regard to medical treatment in the local fund medical institutions as those allowed to regular local fund medical officers. We wonder if there is any decent institution at present under the Local Boards where the rural practitioner humble as he is would like to get relief!

Advice: In spite of unsatisfactory replies from the Government to some of the suggestions made to them by the Association, we should say that on the whole the tone of the Government order is such as to stimulate and encourage the Association to organise much more strongly. We advise the existing members of the Association to bestir themselves and persuade their non-member comrades to join the Association without hesitation making them realise that each one of them is for all and the whole Association is for one. If this is achieved in right earnest. time will not be long when the Government will realise that the Association is one of the limbs of the Government Departments and the Government will naturally consult the Association in all affairs concerning the Rural Medical Relief Scheme, in which case there will not be any need for troubling the Government with memoranda year after year and much less to comment on Government Orders.

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.

HELP VICTORY EFFORTS.

We have been receiving communications both from the graduates and the licentiates seeking our advice in regard to their entry into War Service. The graduates are from the Andhra Districts. They ask why the Government of India are silent in regard to the resolution passed by the Medical Council of India granting retrospective recognition to the Andhra Medical Degree? The licentiates feel and naturally so that even after the recognition by the Defence Department, that they, the present day licentiates are very much advanced in their general and professional knowledge, the medical profession as a whole will be lowered in status and prestige if the licentiates in the Military Service are not paid a salary befitting the dignity of the medical profession. When we have been musing being puzzled as to what sort of replies we could send to both the class of practitioners, we saw a gleam in the horizon when we were going to the press indicating the hopeful news from a reliable and as authoritative a source that an order of the Government of India relating to the recognition of Andhra Medical Degree was on its way and that the Licentiates would also have as good news which was likely to encourage them to volunteer for Emergency War Service.

Everyone in the medical profession is painfully aware of the grim irony that, India does not have one qualified practitioner to a population of 10,000 in urban areas and that in rural areas, the proportion seems to be not even one doctor for every 24,000 of the population. Yet unemployment and with it cut throat rivalry is rampant in the medical profession to a degrading level. Now there is an opportunity, which if met by the Defence Department in a spirit of good will may be made use of with advantage by both the medical profession and the Defence Department. The authorities should realise that the War Service concessions for the future entrants into the Civil and Military Departments may be realised by only a very small number who may return from war. Therefore the only way to stimulate War Recruitment, is to offer more pay to the licentiates befitting their present knowledge and meet generally the demands put forth by the Indian Medical Profession outside the licentiate fold. The news we have in our possession should make all sections in the profession to be less hesitant to volunteer for War Service.

In the circumstances referred to above we hasten to suggest to the members of the profession especially those whose conditions and responsibilities in life are such, that service in War is much more honourable and as useful to their future career in life than a life of unemployment and lethargy. We trust that the medical profession will rise to the occasion suitably and add to the psychological effects of the emblem **V** which stands for Victory.

Correspondence, Reports, Etc.

RECRUITMENT TO I. M. S.

Simla Conference Proposals

The informal two-day Conference on recruitment to the Indian Medical Service under the chairmanship of Sir Girja Shankar Bajpai, which concluded to-day, considered the terms and conditions of recruitment to the service and came to a number of conclusions which are briefly summarised in a communique as follows,

Greater publicity should be given to (a) the existing terms and conditions for emergency commissioned officers of the Indian Medical Service, to bring out the fact that they involve no discrimination between European and Indian entrants in regard to rank, emoluments, promotion or other conditions of service; and (b) the fact that for the period of the war, no new permanent appointments will be made to the Indian Medical Service.

The procedure for recruitment should be decentralised and adequate machinery for the purpose should be set up in the provinces. It was accepted that in the major provinces the Selection Board should consist of five members, two of whom would be non-officials, while in the minor provinces the Board would consist of three members, one of whom would be a non-official.

A Central Advisory Body should be set up which would review the progress of the arrangements now proposed for improving recruitment and make recommendations when necessary. This Central Advisory Committee should consist of five members. three of whom would be ex-officio, viz., Director-General, Indian Medical Service, and the Secretaries of the Defence and Education, Health and Lands Departments, and two private medical practitioners.

Further proposals to make the conditions of service more attractive, especially for medical practitioners of some years' standing, were put forward and will be examined by Government.

The Conference finally recommended that a percentage of permanent commissions in the Indian Medical Service after the war should be reserved for emergency commissioned officers who have rendered approved service. Some of the non-official members of the Conference suggested that the civil side of the I. M. S. should cease to exist, but it was pointed out that this question impinged on the constitutional field and the suggestion could not, therefore, be considered during the war.

The Hindu, 23—7—1941.

AMENDMENTS.

Indian Medical Degrees Act, 1916.

By the first amendment for the words of 'such titles' appearing in the preamble, the words 'of such titles and of titles implying qualifications in other systems of medicine' have been substituted. And after section 6 of the original Act an additional section as 6-A has been added which runs as follows:

After section 6 of the said Act, of the following section shall be inserted, namely:—

"6—A.(1) No person shall add to his name any title, description, letters or abbreviations which imply that he holds a degree, diploma, licence or certificate as his qualification to practise any system of medicine unless:—

(*a*) he actually holds such degree, diploma, licence or certificate; and

(*b*) such degree, diploma, licence or certificate

(i) is recognised by any law for the time being in force in British India or in any part thereof; or

(ii) has been conferred, granted ar issued by an authority referred to in section 3; or

(iii) has been recognised by the General Council of Medical Education of the United Kingdom; or

(iv) in cases not falling under sub-clause (ii) or sub-clause (iii) has been conferred, granted, or issued by an authority empowered, or recognized as competent, by the Provincial Government to confer, grant or issue such degree, diploma. licence or certificate.

(2) Whoever contravenes the provisions of sub-section (1) shall, notwithstanding anything contained in section 6, be punished in the case of a first conviction, with fine which may extend to two hundred and fifty rupees and in the case of a subsequent conviction, with fine which may extend to five hundred rupees."

GOVERNMENT OF MADRAS.

EDUCATION AND PUBLIC HEALTH DEPARTMENT.

(PUBLIC HEALTH)

G. O. No. 2405, 9th June 1941.

Medical institutions—Rural (subsidized)—Provincial Subsidized Rural Medical Practitioners' Association—Conference at Samalkot—Suggestions—Orders passed.

READ—the following papers:—

The Government have considered the suggestions made by the Provincial Subsidized Rural Medical Practitioners' Association at its conference held at Samalkot in 1939. They proceed to pass the following orders:—

(1) *Suggestion 1.—That renewal of the agreements of rural medical practitioners at periodical intervals should be discontinued.*— In view of the provisions contained in clause (13) of the agreement prescribed for rural medical practitioners, the Government do not consider that it is necessary to renew their agreements at periodical intervals. The following shall be substituted for the second part of the preamble in the form of agreement in Appendix I to G. O. No. 3510, P. H., dated 4th October 1938:—

"Whereas the board with a view to bringing medical relief within the easy reach of the rural population has requested the practitioner to proceed to the village of and there to practise as a medical practitioner from the date of his arrival there till the termination of this agreement, upon the terms and conditions hereinafter contained, which the practitioner has agreed to do upon the terms and conditions hereinafter contained: Now it is hereby agreed and declared by and between the parties hereto as follows":—

(2) *Suggestion 2.—That transfer of rural medical practitioners from one dispensary to another without their mutual consent and the conversion of rural dispensaries into regular local fund dispensaries or rural dispensaries of other systems of medicine should be prohibited.*—The Government decline to accept the suggestion.

(3) *Suggestion 3.—That the Inspector of Mnnicipal Councils and Local Boards or his deputy not below the rank of a Deputy Collector should conduct the enquiry provided for in clause (13) of the agreement.*—The existing clause (13) in the form of agreement does not provide for a formal enquiry in respect of any charge framed against a rural medical practitioner. The Government however consider that provision should be made in the agreement for such an enquiry which should be conducted by the president of the local board concerned. At the enquiry the rural medical practitioner who is charged should be heard in person, if he so desires. Clause (13) of the form of agreement shall be amended as follows:—

For the portion commencing from "In the event, however, of an alleged breach by the practitioner" and ending with "and communicate the decision of the Board to the District Medical Officer or the Principal, as the case may be," the following shall be substituted:—

"In the event, however, of an alleged breach by the practitioner of any agreement on his part or of any alleged unsatisfactory work or gross misconduct on his part, the President shall first obtain the views of the District Medical Officer or the Principal as the case may be, and then frame definite charges in writing and obtain the explanation of the practitioner in writing. The practitioner shall be required to state whether he desires to be heard in person. If he so desires or if the President so directs, an oral inquiry shall be held. At that inquiry oral evidence shall be heard as to such of the allegations as are not admitted, and the medical practitioner charged shall be entitled to cross-examine the witnesses, or give evidence in

person and to have such witnesses called as he may wish, provided that the person conducting the inquiry may, for special and sufficient reasons to be recorded in writing, refuse to call a witness. If the practitioner concerned has absconded or where it is for other reasons impracticable to communicate with him or if there is a difficulty in observing exactly the requirements of this clause, all or any of the provisions thereof may, in exceptional cases for special and sufficient reasons to be recorded in writing be waived by the President. The proceedings shall contain a sufficient record of the evidence. The President shall then consult the District Medical Officer or the Principal, as the case may be, who will give his definite findings on each charge and the grounds therefor. The President shall thereupon place the matter before the Board with the views of the District Medical Officer or the Principal as the case may be, and communicate the decision of the Board to the District Medical Officer and the Principal as the case may be."

(4) *Suggestion 4.—That supply of medicines should be increased.*—This suggestion is under consideration and orders will be issued separately.

(5) *Suggestion 5.—That rural dispensaries should be adequately equipped in accordance with the instructions issued in G. O. No. 761, P. H., dated 7th April, 1925.*—Necessary instructions will be issued to the Presidents of District Boards concerned in the matter.

(6) *Suggestion 6.—Failure by the Coimbatore and Tanjore District Boards to appoint rural medical practitioners as Sub-Assistant Surgeons in regular local fund dispensaries.*—The Surgeon-General is requested to investigate into the matter and state whether any action is necessary.

(7) *Suggestion 7.—That the annual subsidy to rural medical practitioners should be increased to Rs. 600 per annum.*—The Government decline to accept the suggestion.

(8) *Suggestion 8.—That holidays should be excluded from the maximum leave admissible to rural medical practitioners*—In G. O. No. 5768, P. H., dated 17th December 1940, the Government have permitted rural medical practitioners, with the previous sanction of the President, to avail themselves of leave of absence for 30 days in a year including public holidays. They do not consider it necessary to accept the present suggestion.

(9) *Suggestion 9.—That rural medical practitioners should be treated as Government servants for the purpose of their treatment in the state medical institutions.*—The Government are unable to accept the suggestion. Local boards may, however, extend to the rural medical practitioners under their control, the concessions in regard to medical treatment allowed to medical officers in regular local fund medical institutions.

(10) *Suggestion 10.—Rural medical practitioners deputed for festival duty should be paid allowance.*—Rural medical practitioners who are entrusted with public health work and given an allowance of Rs. 15 per mensem need not be given any additional allowance if they are deputed for festival duty. In the case of other rural medical practitioners, who are deputed for festival duty occasionally, a sum of Rs. 3 per day may be granted by local boards to compensate for their loss of private practice.

(By order of His Excellency the Governor)

V. V. SUBRAHMANYAM,
Deputy Secretary to Government.

Order—No. 2406, P.H , dated 9th June 1941.

It has been brought to the notice of Government that subsidized rural dispensaries in certain districts have not been supplied with the equipment necessary for the proper working of the institutions. A list of the dispensaries inadequately equipped is given in the appendix to this order. The President, District Board, is requested to rectify the defects at an early date and report the fact to the Surgeon-General / Principal, Indian Medical School through the District Medical Officer concerned.

2. Presidents of District Boards are informed that their proposals to open new subsidized dispensaries or to grant subsidies to any of the existing dispensaries will not be considered until all the existing dispensaries are properly equipped.

3. The Surgeon-General and the Principal, Indian Medical School are informed that they should recommend to Government in future the applications of only such local bodies as satisfy the condition laid down in paragraph 2 above.

(By order of His Excellency the Governor)

V. V. SUBRAHMANYAM,
Deputy Secretary to Government.

P. S. R. M Ps' Association.

CIRCULAR.

Some members of the Association brought to the notice of the undersigned that the District Board Presidents of their respective districts, were forcing them to return the deal wood boxes etc. used by the medical stores for supplying drugs etc. to the rural dispensaries. The matter was brought to the notice of the Surgeon-General. The Surgeon-General in his proceedings No. P. M. O. 173 A. /41 dated 10th July 1941 had decided that the packing materials are the property of the rural practitioners so long they continue as such and utilise them or their sale proceeds for the running of the subsidized dispensaries.

V. RAMA KAMATH,
Rresident.

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Dr. V. Rama Kamath,
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ASSOCIATE EDITORS } Capt. E. S. Gopalan, M.B., M.S.; A.I.R.O., (Madras)
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CONTENTS.

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Original Articles

SOME THERAPEUTIC INDICATIONS FOR X-RADIATION*

By

DR. P. RAMA RAO,

Director, Radiological Institute and Cancer Hospital, Madras.

I shall in this address attempt to define our bearings in the new developments the methods of irradiation have brought us during the past ten years avoiding as far as possible controversial questions concerning a complex problem. I shall be permitted to present the subject under four sections—therapy of inflammatory diseases, diseases of the lympho-haemopoetic system, benign and malignant conditions.

The treatment of acute and chronic inflammation by Roentgen rays dates back about 35 years; one can even say 40 years, as Freund of Vienna applied radiation therapeutically as early as 1897; but at that time much of our present knowledge of the action of x-rays on different kind of cells did not exist. I shall not go into a historic resume, but shall content with a concise description of the rationale of this type of therapy as has developed recently. How can one account for the fact that a single exposure to a small or moderate dose of rays is usually sufficient to influence favourably an acute inflammatory lesion, and the favourable effect is perceptible in a few hours after the exposure? To pathologists it has long been known that one of the prominent features of many forms of inflammation and especially of acute inflammation, is leukocytic infiltration, the degree of which varies according to the kind of bacteria responsible for the inflammation and perhaps also according to the number and virulence of the bacteria present In a large number of cases in which inflammation is caused by pyogenic bacteria, notably by staphylococci (furuncle, carbuncle, abscess, acute adenitis), the favourable effect of radiation can be observed within from 2 to 24 hours. If the lesion has been irradiated during the early part of its course, the pain subsides, and disappears, although there may be an increase in the pain for an hour or two before it begins to diminish. The swelling abates and the lesion gradually undergoes what is known as resolution. When the lesion is exposed a second time, the resolving effect is less striking. When the lesion is irradiated after suppuration has started, the suppurative process is hastened and it may be necessary to provide drainage much earlier than for similar lesions which have not

* Lecture delivered at a meeting of the Madras Branch of the Indian Medical Association on 30—7—'41.

been exposed to x-rays. These changes may be said to manifest themselves in about 75% of lesions irradiated. In the other 25% such modifications may not be evident, specially when the inflammatory process is due to infection from streptococci. What is the explanation?

Animal experiments have long since established the fact that the lymphocytes in lymph nodes, spleen, circulating blood, intestinal follicles, thymus gland and other structures in which lymphoid cells are to be found, are the most radiosensitive of all the different kinds of cells in the body. The polymorphoneuclear leukocytes and the eosinophiles are less sensitive, but only slightly less. All three varieties of leukocytes are much more sensitive to radiation than any other type of cell except the variety of epithelial cell which secretes mucus and which is found chiefly in the salivary glands, stomach and instestines and bronchii. The mucus-secreting epithelial cells are slightly less sensitive than lymphocytes and more sensitive than polymorpho-neuclear leukocytes and eosonophiles, but seldom play an essential part in inflammatory lesions while the three leukocytes do. When structures containing these cells are irradiated, certain proportion of them subsequently undergo degeneration and many are destroyed; the degree of these changes depend on the dose of the rays. In lymphoid structures the lymphocytes destroyed by rays are replaced by connective tissue, locally; but, in the circulation the contents of these lymphoid or polymorphoneuclear cells (antibodies, ferments) are liberated in the blood stream, and exert their effects in the same or in some other region—sort of autovaccination effect. Leucocytic infiltration varies with different kinds of inflammations; with staphylococcal infections it is more, while with streptococcal infections even in virulent forms, leukocytic infiltrations may often be slight. When the infection is diffuse rather than localised and is caused by virulent bacteria, the leukocytes may not have time to infiltrate the tissues but may elaborate antibodies in the blood stream. When in acute inflammation, a proportion of these infiltrating lymphocytes polymorphos and eosinophiles are destroyed by rays, the contents of these cells including the antibodies and protective substances which have already formed are liberated.

In chronic inflammations (cervical lymphadenitis etc.) a prominent feature is proliferation of connective tissue, leucocytic infiltration playing a less prominent part. These are also characterised by varying degrees of central necrosis, caseous degeneration, calcification, or hyaline or amyloid change. Cells which have already undergone necrosis cannot be influenced by rays as these cells are already dead; likewise caseous and calcified tissues being end products of cellular degeneration. Connective tissue is more resistant to radiation and that is why in chronic inflammations response to radiation is slow and several doses are necessary, repeated at intervals. Tubercular adenitis, tubercular peritonitis, chronic arthritis, bronchiectasis, chronic-unresolved pneumonias, may be few of the conditions where radiation will be useful. In chronic pelvic inflammatory diseases, which flare up in a more or less pronounced manner in the premenstrual period, and in cases of menorrhagia consequent thereto, sterilisation doses to the ovaries and stopping of menstruation has helped to heal up the pelvic peritonitis. In abscess of sweat glands, a large dose, epilation dose (80% S. E. D.) should be given. Inflammation of the mammary gland 40% S. E. D. stops lactation. Lactation is not disturbed in subsequent pregnancies. Roentgen therapy of inflammatory conditions is no panacea. One should not rely exclusively on its effect and thus omit an indicated surgical measure. For this reason, nobody has tried to irradiate a case of appendicitis instead of operating on it, and nobody irradiates a carbuncle when operation is indicated; but on the other hand Roentgen therapy should be given in all those cases in which surgical procedure is not indicated. Suppurative or post-operative parotitis reacts well to x-radiation. The adenoid tissues is very radiosensitive and x-rays are very efficacious in cases of

hypertrophy. There is no danger of injury to normal tissues and of interference with growth.

Irradiation remains the chief resource in the treatment of Hodgkins disease. Surgery, is worth considering in the earliest stages limited to accessible lymph nodes, but even in such cases treatment by radiation to include the contiguous lymph-node areas seems imperative. From a clinical standpoint, the fever, the rashes, the esonophiles, the local and general distribution and modes of extention of infilterations, the frequent traces of allergic phenomena, the common polymor phoneuclear leukocytosis, all point to an inflammatory rather than a truly tumour process. Yet, until something better is found we must do our best with the proven palliative remedy radiation. The method adopted is to irradiate the whole of the lymphatic groups in the body—not the obviously apparent ones alone. Lower voltage such as 140 K. V. is used in the first instance except in deeply situated lesions when 180 K. V. is used. ¼ to ½ S. E D. is given to each area and repeated at such intervals as indicated by the reactions that follow. Lower voltage is preferred, to begin with, as it permits the use of higher tension, such as 170 and 200 K. V. when there is a recurrence. The cells develop a degree of radioresistance to the same voltage and hence the need for application of higher tension. Lymphosarcomas are sensitive and respond well.

Acute leukaemias are not subjected to radiation. I had two cases which did not react well and ended fatally. Chronic-leukaemias (splenic, lymphatic, myelogenous) do very well. We have controlled six cases for three years now 1/3 S. E. D. is given daily over the spleen, long bones or lymph glands until the W.B.C. comes down to 20,000 and until one notes absence of immature cells (Myeloblasts). In polycythaemia Vera irradiation of long bones will often cause reduction in the number of red cells. Agranulocytosis with its high mortality rate, has been favourably affected by radiation—destruction of leukocytes with production of neucleic acid products which in turn stimulate leukocyte production—but, doses should be small. Irradiation of the spleen is also known to increase the coagulability of the blood and hence adopted, in uterine haemorrhages of puberty and haemorrhages after surgical wounds of the nasopharynx. In cases of thyroid toxicosis, whatever the stage of the disease, x-rays are an exceedingly reliable therapeutic measure to adopt. Considerable amelioration of symptoms follow the exposures and in about 40 per cent of cases a difinite cure is obtained. Surgery removes the secreting tissues, while radiation lessens secretions. Various complications such as development of adhesions and injuries to skin and larynx and occurrence of myxoedema are avoided by proper technique. Tracheo-malacial changes and compression symptoms are clear indications for immediate surgery. Radiation is discontinued when Basal Metabolism rate drops to + 10 per cent.

Despite the rapid recent advances in our knowledge of the physiology and anatomy of the sexual cycle and despite the availability of pituitary-like and ovarian substances for the treatment of menstrual disorders, there has not been the expected improvement in results following the employment of these substances in the treatment of menstrual disorders. There remain and are likely to remain a number of patients who will require radical therapy by various destructive methods among which radium and x-ray will be of importance. We have treated over 300 cases of metropathias, fibrosis uteri, fibroids and climacteric haemorrhages with deep x-rays and had most gratifying results. All had cessation of menstruation in one or two months following irradiation; the period of amenorrhoea varied from 6 months to one year in younger women; one lady started menstruating normally after the period of amenorrhoea, conceived and delivered a normal baby; the course of pregnancy and confinement were uneventful. Two ladies had to be submitted to hysterectomy on account of very severe haemorrhage. In older women, 40 and above, permanent amenorrhoea results.

The action of rays is of a two-fold nature. There is a direct effect on the endometrium, blood vessels and myometrium —an endarteritis obliterans; action on the ovaries resulting in diminution of hormonal secretions a destruction of graffian follicles. Blood supply and nutrition to the uterine muscle and the fibroid is impeded and they shrink. Ovaries actively recover from effects of radiation, so, no serious endocrine disturbance results.

Radium is used by some gynaecologists for these uterine haemorrhages, but I should prefer x–rays; in cases of submucus fibroids and chronic or glandular endometritis when haemorrhage is profuse the good effects of a dilatation and currettage and insertion of radium are almost always immediate because of the local caustic effects of the radium. This procedure will also help to eliminate possibility of carcinoma of the body of the uterus by pathological examination of the currettage. Effects of radium is more local. No appreciable radiation reaches the ovaries unless about 1800 mgm. hours are given. This is too large a dose for benign uterine haemorrhages. In younger ladies one should certainly prefer x-rays as, if pregnancy occurs later the uninjured uterine cavity will be more likely to retain the ovum. Cases have been reported when 'Caesarian' had to be performed on account of the cicatrical stenosis of cervix due to radium. In abnormal haemorrhages of puberty, mostly due to endocrine disturbance mere organotherapy does not always produce the desired result. We do not irradiate the ovaries, but the pituitary gland. In using x-rays to the pituitary gland we know we get the desired effect, but it is difficult to explain how! Some say x-rays are always destructive; others in small doses have stimulative effect; still another opinion is that there is immediate depression followed by greater activity after recovery. We know that the pituitary is the master gland of all endocrines and the ovary is completely under its dominance. I have not used radiation exclusively in such cases; combined with x-ray, organotherapy has given better results, than organotherapy alone.

A large variety of dermatoses respond well to x-rays such as tineas, psychoses, acne, eczema, naevus and haemangiomas, warts, keloids etc. I have treated 6 cases of prostalic hypertrophy in the aged with exceedingly good results. These patients were either not willing to submit themselves for an operation or such a procedure was contraindicated on account of the general condition. Catheterisation has to be resorted to when there is inflammatory radio-reaction and swelling of the gland. The result was seen in 2 or 3 months after the course of treatment. Schneider (whose article was reprinted in the British Medical Journal of August 14th, 1937) claims the preservation of sexual function in Radiotherapy.

The biological effects of radium and x-rays were discovered by production of accidental injuries. Marie Courie's hands never recovered from their damaged condition, the result of contact with radium she was isolating, though it was Becquerel's historic burn that drew direct attention to the destructive capacity of this agent. Lesions from x-rays of the early workers and patients are well-known. The therapeutic value of rays came later. Study of biological effects on various cells followed; then use of filters to protect the skin from serious injury and the foundation that divided small doses cause less caustic effect on the skin than a single large dose. Regaud called attention to rhythmic appearance of mitosis in tissues and pointed out that in the testicle a continuous feeble dose of radium might cause complete sterilisation of a tissue by killing the mitotic cells only. This introduced the principle of avoiding damage to the healthy tissues but at the same time destroying the neoplasm. Under Regaud's direction, Coutard developed a practical technique for the treatment of human cancer and laid the foundation for the modern effective use of radiation—the theory of periodicity and that the rapidly growing tumours should be treated more intensively than the slow-growing, that mitotic cells are more sensitive than resting cells and in slow growing tumour the period of radiation must be extended

to include 2 or 3 of these slow mitotic cycles. Coutard advocates slow radiation extending over several weeks until a definite radio-epithilite or radio-epidermite reaction is produced. In actual mucus membrane or skin burn due to radiation should be the guide as to whether adequate dose is delivered. But to-day, with higher voltage and heavier filter one can deliver the same dose without these severe skin or mucous membrane reactions. Moreover this radio epidermite reaction so changes the structure of the skin, its vascular supply etc., that a later trauma heals very slowly and the tissues become defenseless. Coutard's opinion is that the daily radiation should be extended over several weeks until the desired reaction is obtained; but the modern conception appears to be, however, not to extend the treatment period beyond 4 weeks (destructive phase), as during the inflammatory reactions (healing phase) that appear after 4 weeks' radiation, the residual tumour cells get usually mature and are radioresistant. So give as large a dose as possible in the first 4 weeks, then radiate again if necessary after 4 to 6 weeks or so of the healing phase. Continuing the radiation beyond the first four weeks also retards the healing phase or reactions. Some tissues such as lymphoid tissues, ovarian, follicle,epidermis,basal epithelium are sensitive to radiation and malignant lesions arising therefrom may be made to disappear by radiation. While connective tissue, muscle, bone, nerve tissues and cylindric and endothelial cells are more resistant and need greater amount of radiation. To destroy a neoplasm, it is necessary to give such a dose of radiation as to wholly or partly destroy the matrix from which it arises. A sensitive neoplasm may disappear without much injury to matrix. A resistant neoplasm arising a resistant matrix, is difficult to destroy. The more undifferentiated the cells the more sensitive they are to radiation. The more differentiated the cells the greater is the resistance to radiation.

MALARIAL SPLENALGIA

BY

DR. V. RAMA KAMATH.

A boy aged 12 was brought to me on 16th July 1941, with a history of fever for 3 days, along with another child aged 2 years, the youngest brother of the former who had coryza attendant with bronchitis. Both were treated for Influenza the chief ingredient in the prescriptions for both being Soda Salicylate. On the 2nd day of the treatment the grandmother came running to me saying that the boy aged 12 was very bad, complaining of agonising pain on the left side of the chest and was profusely perspiring. She added that about a year ago the boy was given a blow by his school mate on the very spot from where the pain had started and ever since, now and again the boy had been complaing of pain in the very place. She felt highly suspicious that there must be a serious damage internally at the seat of the pain and urged that a X-ray photo should be taken immediately. It was about 1 p.m. when she came to my residence that day and I, not being inclined to go out, advised the grandmother that she might call any other practitioner and I would give the copy of my prescription for his guidance. The lady would not listen and when I gave an excuse that I was not feeling quite fit to drive my car, she ran up and brought a taxi. Being the medical attendant of the particular house for over 25 years, I could not refuse to see the boy in spite of my infirmity. When I reached the patient's residence he was quiet, but his skin was cold and clammy, pulse quite good 78 per minute, respiration normal, temperature 99 in the mouth. There was no swelling at the seat of the pain nor were there indications of injury or inflammation. Direct deep pressure on the part did not elicit any pain. The boy was of a highly nervous disposition. Nothing extraordinary struck me and I prescribed a carminative mixture, with a good dose of Potassium Bromide. The following morning the boy's father gave an alarming report of the condition of the patient the previous night. He said that his son had not a wink of sleep and the fits of pain which came once in an hour or so were continuous and the boy lost his consciousness during the fit and the father forced me to get a X-ray photo. I was immediately rather puzzled not knowing what to do and simply to gain time, if not for anything else, asked the father to get me a sample of the patient's urine. The urine was examined. It was of usual colour and consistency and did not help me a bit. I remembered about referred pains in appendicitis, and in gall-bladder troubles and made up my mind to make a thorough and detailed examination of the abdomen which I did at the second visit. When I was doing this and feeling unable to detect anything abnormal anywhere, I suddenly remembered the boy's father having suffered from Malaria a couple of years ago and also of the fact that there was an old well in the house. I also recollected my having treated all sorts of complications and sequelae due to malarial infection when Malaria as an epidemic was doing a great havoc in Madras especially in Vepery, Choolai and Purasawalkam divisions of the City Corporation in the years 1912 to 1914. I then concentrated my attention on the spleen. The tympanitic sound on the Trube's space, extended beyond its area and deep percussion only elicited dulness 2 fingers internal to the mid-axillary line. To the same extent the area of increased dulness could not be detected at the lower border of the spleen area on deep percussion. But on deep palpitation the lower border of the spleen could be felt about a finger below the costal arch. Then the idea struck me that the pain complained of by the patient on the left side of the abdomen and chest might be due to splenalgia due to malarial infection.

When I was examining the boy he got constant fits of pain and I had to stop examining him several times. It took me about an hour to finish my examination.

In the meanwhile I could see that the patient was in real agony and required immediate relief. I prescribed :—

Quinine Hydrochloride..		grs.	xx
Acid citric	...	grs.	xxx
Ammonium Chloride	...	grs.	xxx
Pot. Bromide	...	dr.	i
Caf. citras	...	grs.	vi
Tinct. Card. Co.	...	drs.	i
Syr. Lemonis	...	drs.	vi
Aqua Chloroform	...	ounces	iii

Half an ounce every 4 hours.

The bowels were made to move by administering ½ gr. dose of colomel after each dose of mixture followed by Seidlitz powder the following morning. The first dose of mixture was given at 10 a.m. and the patient had to be waked up at 2 p.m. to be given the second dose and he made an uneventful recovery.

The points to be noted in this case are :—

1. During these days patients or their relatives force their medical attendants to have recourse to X-ray or other auxiliary aids for diagnosing diseases and at times suggest even treatment either not indicated or at a time when the medical attendants do not consider it necessary. Practitioners of some standing should resist such tendencies more in the interest of the patients, as such yielding on their part makes the treatment more costly in addition to the delay in adopting therapeutic measures indicated in these cases. The X-ray diagnosis of diseases should be reserved for confirming diagnosis provisionally made after careful examination of the patients, obtaining first the history of the case, followed by the observation of the clinical signs and symptoms. Rushing to X-ray and other methods of diagnosis in themselves would make practitioners mere machines and will eventually retard the intelligent evolution of the virtues of serene judgment to be arrived at after the usual methods of physical examination of patients. In this particular case X-ray examination would not have helped me to arrive at a correct diagnosis and my mind would have been distracted to such an extent as not to stimulate in me a keen sense of observation dependent on history and the physical examination.

2. At times some points in the history of the case serve as a straw for a drowning man. The fact that there was an old well in the house of the patient coupled with the history that his father had a typical attack of Malaria made me to dig for the spleen, the enlargement of which I would not have perhaps made out but for my knowing that the patient's father suffered from Malaria.

3. The mutual advantage and benefit for the patient and the doctor in arriving at correct and quicker diagnosis are not realised these days of cut-throat competition in medical practice. In this particular case my indifferent state of health came in my way, and I should say I was guilty of culpable neglect of my responsibilities when I advised the grandmother of the patient to seek the help of another medical attendant, when she entreated me to leave my bed on the day she came running to me to request me to see the patient at a time when the patient's condition alarmed all in the household. She would not leave my house and wanted only me at any cost knowing full well that a new medical attendant was not likely to arrive at a speedy diagnosis for want of knowledge of proper history of the case.

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.

THE TECHNIQUE FOR SUCCESSFUL INTRAVENOUS INJECTIONS.

BY

DR. K. V. KRISHNA, M.B., B.S.

I was prompted to contribute this article not because the practitioners do not know the technique but oftentimes for some reason or other many of us fail to remember some of the trifling details. Recently I have had occasions to witness the unnecessary suffering to which the patients were subjected during the course of intravenous injections.

Intravenous injection is oftentimes a simple operation, but at times it worries many a doctor, young or old and causes much suffering to the patient.

A practitioner gave about six pricks before he could tap a vein of a European male. Every time he failed and gave a prick he put on a sweet smile and his patient in turn smiled rather reluctantly just to please the doctor.

Another doctor injected N. A. B. into what he must have thought a deeply placed median basilic vein. The patient suffered from great pain for many days and developed ankylosis of the elbow and later disuse atrophy of the limb.

Sometimes junior nurses who are allowed in some hospitals to give intravenous injections or raw blood, do the work in a very light-hearted fashion and seem to think that their poor patients are so many dummies.

The agonising pain which the irritating solutions cause when they do not get right into the vein should make the operator remember the saying of Sage Confucius, "*Do not do to others what you do not like others do to you.*"

After the writer had adopted the technique described below he did not have any mishap or failure worth mentioning in the several thousands of intravenous injections he gave except when the needle was blunt and the light poor.

THE TECHNIQUE.

Besides the need to sterilize the syringe etc., and the site of injection, the following details have to be very carefully observed if constant success is aimed at in intravenous injections. This is especially necessary if the doctor is a private practitioner, for every mistake he commits reflects on his reputation. Further he will save much personal suffering to the patient and mental agony to himself. Hence no apology is required for the elaborate description of the technique.

See that you have:

1. A sharp needle.
2. A patent needle.
3. A full vein.
4. A steady vein.
5. A bright light from the left side.
6. The patient in a comfortable position, at least, with the forearm steady resting on something firm. This is very necessary in case of children and nervous persons.
7. A sure method of tapping the vein.

Some explanation of the above items will be necessary:

1. Irresponsible assistants cannot be trusted. Satisfy yourself that the needle is sharp.

2. It is annoying to put the needle into the vein and find that no blood enters the syringe. When you pull out the needle you may find a haematoma under the skin or blood may flow out. So test the patency of the needle each time before use.

3. A vein that is clearly seen is not necessarily a full vein. Feel the fullness with the finger when in doubt. It was

by not noting this, that six pricks had to be given to the European patient above referred to who had green visible veins. In veins that are prominent but not full the needle very often slips up between the layers of the vein wall or alongside of it for quite a distance sometimes. So in all doubtful cases:

(*a*) Make the patient open and close the hand several times. If necessary, let him hang down the hand also for a while.

(*b*) Use a soft rubber tubing or some such thing as a tourniquet. In difficult cases and in children, better go round the arm gently two or three times, then once firmly. This extra time to produce a full vein is worth spending.

4. In old thin subjects the radial and the common ulnar veins look temptingly prominent. Avoid these; for in them, as the needle touches the veins, the veins move away and cannot easily be tapped unless the needle has an extra sharp point.

The median cephalic or the median basilic does not move.

5. When the solution to be injected is dark, there should be bright light from the left side. In any case this is a very helpful necessity.

6. A nervous patient or a child may suddenly pull away or shake the arm a little while the solution is being injected into the vein. The consequent escape of the solution gives pain. The doctor will have to share the blame for not seeing that the arm is kept steady and for not warning the patient or the attendant.

7. A sure method of tapping the vein.

The common practice with most practitioners is to insert the needle into the vein at an angle of about 40 degrees to the anterior surface of the elbow, so that the needle enters from before backwards. To do this the position of the vein must be visible or prominent. The vein being about one-third or one-half c. m. wide, a slight error of any sort may cause the missing of the vein or transfixing of the same. In nervous patients and in children one has to be quick and very often mistakes are made.

There is a different method of giving intravenous injections. Though many do not use this method, there may be some at least that adopt it. After all the preliminary precautions and steps have been taken and when the vein is full, insert the needle under the skin to one side of the vein about $\frac{1}{2}$ to $\frac{3}{4}$ c. m. away from it. Now approach the vein at an angle of 45 degrees. Feel the yielding side of the distended vein with the point of the needle. When sure, let the needle enter the vein. Blood freely enters the syringe. The advantage of this method is apparent. It is the first prick into the skin that is painful and makes the patient to shake or pull away the arm. In the usual method of intravenous injections with the first prick the wall of the vein also has to be entered; whereas in the method under description after making the skin prick you can take your own time to make sure of the position of the vein. There can be no missing of the vein by hurriedly trying to inject a nervous patient or a troublesome child. You can also give the patient some time to settle down if he is nervous. There is no fear of a haematoma as a result of the patient pulling away the arm after the vein has been entered.

When, on several occasions, some have failed to give an intravenous injection by the usual method, this method easily succeeded on the very patient. The method is specially useful when a vein is deep down in a thick, fat subject. Here it is only by palpation that we can feel the distended vein. The chance of transfixing the vein is again much less; for the moment the needle enters the vein and blood is seen in the syringe, the point of the needle can be made to come to the middle of the lumen of the vein and the needle parallel to its walls if the angle of approach be slightly lessened.

The best way to test the case with which this method can be practised is to keep a thin rubber tube under a cloth and try to enter it with a needle in the way described above.

Some difficulties that may be met with while giving an intravenous injection and how to remedy them:

1. Blood enters the syringe, but on beginning to inject the solution there is a small swelling at the site of injection. Why? The needle entered the vein and then blood appeared but the end of the needle soon pierced the opposite wall and the escaping solution is causing the swelling in the tissues. If you are not sure how much to pull back the needle, boldly draw it out and make another prick into another vein.

2. When the end of the needle is bevelled and the opening is long and oval, blood appears in the syringe even when half the opening enters the vein. On attempting to inject the solution some escapes through the other half of the opening that has not entered the vein. Even here if you are not bold to push in, better to draw out and try another vein.

3. What to do when the fluid that spills into the tissues causes pain?

If you have no solution to neutralize it as Sodium theosulphite for N. A. B., wait for a few minutes to see if the pain decidedly subsides or not. If it does not, spray Ethyl Chloride and give a cut over the swelling. The patient will feel happy and will thank you for it. A small sterile dressing to be opened after two days is all that is required. Never send a patient home hoping that the pain will subside. No fomentation or ice pack or morphia injection will equal a timely incision. One must see a patient suffer to appreciate this advice.

4. An air bubble is found in the syringe.

By tilting the syringe up the air bubbles may be made to go to the back of the syringe. Air bubbles of the size of even ½ c. c. are said to have no deliterious effect on the patient but by the above manipulation they need not be let into the vein.

SUMMARY

1. Every effort must be made to have no failure in giving intravenous injection.
2. Have a sharp, patent needle.
3. Make the vein full and distended. Some bold patients can grip their free hand.
4. Prick the skin ½ to ¾ c. m. away to one side of the vein and approach it at an angle of 45 degrees.
5. With the point of the needle feel the wall of the vein and see that it is yielding.
6. Gently but quickly prick the vein and as soon as blood is seen, make the point of the needle occupy the middle of the lumen of the vein, by reducing the angle of approach. This precaution will obviate transfixion of the vein.
7. When the solution does not flow in freely, when there is the slightest doubt that the point of the needle is not in the lumen of the vein, pull out the needle and try another vein. Half a dozen pricks to find a vein are better than spilling the the solution into the tissues.
8. Never send a patient home if he has pain after an intravenous injection due to escape of solution into the tissues. Relieve it either with a neutralizing solution or by an incision.

Abstracts.

ALLERGY AS A CAUSE OF CORNEAL DISEASES AND ULCERS

BY

SAMUEL MORSE, M. D.

New York. N. Y.

For many years it has been recognized that superficial and deep keratitis or ulcerations of the cornea should be treated as local conditions. The exceptions to this are the well-known constitutional types of corneal disease produced by syphilis, tuberculosis and metabolic disorders. Corneal ulcers should be divided into two classes: those of endogenous, and those of exogenous origin. In the former group are classified the constitutional types mentioned above; in the latter, those due to local causes, such as trauma, infection and local inflammatory reactions.

Another standard classification of corneal disease is: (1) ulcerative and (2) non-ulcerative, or the so-called deep interstitial type which is usually of endogenous origin. If not infected or followed by necrosis, the lesions clear up under appropriate treatment, without scarring. The ulcerative type can of course be a complication of the non-ulcerative type.

In the formation of corneal ulcers or keratitic inflammations of a sub-acute or chronic nature, tbere are usually signs of vascularity of the cornea, extending from the sclero-corneal margin to the center; nature's attempt to establish collateral nutrition to the cornea.

Another older classification of ulcers divides them into the following groups: (1) catarrhal ulcers; (2) phlycentular; (3) trachomatous, with or without pannus; (4) dendritic; (5) serpent ulcer; (6) disciform ulcer; (7) Mooren's ulcer; (8) kerato-malacia; (9) keratitis neuro paralytica (dystrophic keratitis), and (10) parenchymatous keratitis (which is usually syphilitic). Some of these names are applied to ulcerative diseases of the cornea on a morphological rather than on a pathological basis.

It has been found in private practice and in clinical work, that a great many of these deep ulcers and those of heterogenous shapes are chronic and relapse without apparent causation. In many of these cases, classical local therapy will benefit the lesion. When the ulcers heal, and then, somewhat later there is a relapse, allergy, particularly food allergy, should be suspected as the cause. I have for a long time past suspected an allergic etiology for recurring and relapsing types of keratitis or ulcers, when syphilis, tuberculosis, focal infections, etc., have been excluded. In fact, this has been my experience in at least two cases of suspected tuberculous lesions, which rapidly responded to tuberculin, only to relapse. Ultimately, I found that a food allergy was responsible for the ocular condition.

As a rule, the symptoms in allergic corneal disease vary from slight photophobia to ciliary injection, with edema of the bulbar conjunctiva and iritic pains. Upon careful investigation, there is usually no history or evidence of trauma, local discharge or focal infection. Wassermann and tuberculin tests are negative. Several of these patients have been cured for long periods of time, following the elimination of the dietary or allergic cause.

Phlycentular keratitis, which years ago was thought to be due to dietary indiscretions, and in recent years was believed to have a tuberculous origin, has frequently turned out to be an allergic corneal manifestation. In some of these chronic relapsing cases, (pollen types), desensitizing injections alone often effect a cure. In other cases with irregular relapse of the

disease, a cure will occasionally result by avoidance of the offending foods. It is therefore proper, in these relapsing cases, to consider allergy as an etiologic factor. After a routine investigation of all possible causes of ulcer, an allergic study should be made. During the course of an acute attack, the customary elimination diet, somewhat modified, is given (see below). Occasionally the attack will subside without local eye treatment.

Reudemann, who has thoroughly covered the subject, has shown that ocular conditions such as recurring chalazia or styes, chronic conjunctivitis and vernal catarrh, may likewise be caused by allergy. Reudemann states: "Except in a very few instances, involvement of the cornea is usually due to some general allergic condition and not to any local, so-called 'contact dermatitis.' However, our most outstanding case of corneal involvement was in a girl who had a serious corneal desquamation in each eye. It was found that she was extremely sensitive to orris root and only to orris root. Elimination of this substance from her daily routine produced complete relief and she has not had a recurrence of the process."

I have recently seen two cases of this kind. Both were treated by local methods for a long time. These patients continued to have recurrences. One patient, a physician who had chronic conjunctivitis for a year, was found to be sensitive (mostly in the right eye) to feathers. When his pillows were replaced by kapok or silk floss, the eye condition cleared up. Another patient who daily came in contact with sheep's wool, was found sensitive to wool.

Such cases must also be thought of, because they can easily be mistaken for simple chronic conjunctivitis. The patient will go from one physician to another seeking relief from treatment and refraction without benefit. Therefore, the history and the chronicity of the disease with recurrent attacks, are very important considerations in disease in and around the eye, especially when there are no symptoms except lacrymation, probably due to corneal irritation.

In every case of kerato conjunctivitis and phlycentular keratitis, a careful study of allergy should be made, as well as eliminating the presence of a tuberculous process. In 1929 I published an article on "Ocular Tuberculosis," dealing with tuberculous conditions of the cornea.

An interesting case was seen recently with a definite history of tuberculosis. The patient gave a positive tuberculin test; he improved on a dozen or more injections of increasing doses of tuberculin, administered according to a method which has proved very successful in my hands, but several weeks later there was another relapse. The corneal lesions relapsed again subsequently while the patient was under treatment. The complication in this case was food allergy and nasal pathology, which had to be corrected.

Unless the underlying cause of the food sensitivity is found and eliminated, such relapses will occur repeatedly, causing a permanent scarring of the cornea. Reudemann in his article further states, "It is my belief that in no instance should the patient be given tuberculin or any other therapy for tuberculosis, unless the possibility of food allergy has been carefully checked." I subscribe to this method, because it may save the patient a great many injections and unnecessary treatment. If allergy has been eliminated as a cause, and the corneal disease does not clear up, then it is best to institute tuberculin therapy, when indicated.

Every patient with recurrent or persistent conjunctivitis or keratitis should not be labeled allergic. Whenever there is a history of repeated attacks or relapses under competent treatment by an ophthalmologist, or when there is not sufficient reason to explain said relapses; then it is important to study the allergic and clinical history.

It has long been known that the aetiology of vernal conjunctivitis or spring catarrh is on an allergic basis. It has been exceedingly difficult to determine or demonstrate the pollen which causes vernal conjunctivitis, except by all skin diagnostic tests. Many investigators have found that very large doses of pollen must be given in order to make any impression in the relief or cure of vernal catarrh. Locally, the best treatment for this disease has been cold applications, and radium in the more severe cases. I have found radium very satisfactory. If handled properly, in accordance with the most recently recommended technique, which is quite simple, this therapy is a great aid in the cure of vernal catarrh.

Reudemann states that "he has seen a great many conditions in the eye, which he has found to be allergic; even changes in the lens." A very interesting observation is the fact that stubborn vitreous opacities, for which no cause or cure has been discovered (except that they have always been thought of as focal infections) have been found to be due to food sensitivity. In such cases the floating vitreous opacities do not disappear, but they do not increase in number." Other therapy, iodides and non-specific proteins, are of great value when there is an allergic history. When some form of iodide is administered, there is an improvement in, or a disappearance of the opacities." I have seen one such striking case which I followed over a period of five years. The patient had vitreous opacities probably caused by chronic colitis with clinical signs of food allergy. An elimination diet and saturated solution of potassium iodide cleared up the symptoms.

There are other types of lesions in the eye, such as toxic neuritis or neuroretinitis, which may be due to allergic sensitivity. In adults with allergic corneal disease or ulcers, such foods as milk, cod liver oil, chicken and eggs have frequently been the offenders, even where they were prescribed for ocular conditions, in dietary regime.

If allergic keratitis is prolonged and recurrences take place, interstitial vascularity occurs, resulting in permanent scarring with definite loss of vision. There may be a secondary iritis in conjunction with the keratitis. The pupil must be kept dilated with atropine, sopolamine, duboisine, or some other substance to which the patient is not sensitive (locally). It is important that this warning be given here because of the marked local sensitivity these patients may have to certain alkaloids. Atropine is a very common offender, and the patient, under no circumstances, should use atropine if sensitivity exists. It will add to his discomfort and increase the local irritation, thus complicating the case. This is also important in the use of other substances around the eye in people who have a definite sensitivity to other substances, cosmetics, etc.

When an etiologic diagnosis has been made, and one has eliminated all other causes except allergy, it is really not necessary to give the patient any local treatment to the eye, unless there is an iritis present. Then hot bathing and atropine 1% may be given, if the patient is not sensitive to it. Wherever there is the slightest corneal desquamation due to sensitivity or necrosis, it is always best to cover the eye with a dressing patch with some slight pressure, until the lesion is filled in with new epithelium. It is best for the patient to wear dark glasses to cover the other eye, even though not affected. Once it is determined that the condition is allergic, it is inadvisable to use any astringents or antiseptics on the conjunctiva or eyeball. Mild drops or ointments may be used.

I have successfully arrested the progress of a case of allergic keratitis by the use of radium to the cornea for scars. The radium lessened the scarring and had a curative effect on the inflamed process as well.

Reudemannn states that he has studied more than a hundred patients who had definite positive reactions to one or more substances. He found that those who had myopia had a tendency to be less progressive, and in some cases the myopia was arrested. This has not been sufficiently verified. With the elimination of foods to which the patient is sensitive, it is

necessary to build these patients up with large doses of Vitamin A. B. and D, particularly B (Thiamin Chloride), unless there is an allergy to these vitamins. (Natural vitamins as cod liver oil.)

The elimination diet is successful only if the patient is made to understand that he must adhere strictly to the original diet, adding a new food every four days. He must note if the particular food added causes any relapse in the eye. A careful observer will see in a very short time whether his patient is co-operative. If the patient does not co-operate, the complete diagnostic food tests must be made by scratch and intradermal methods.

ELIMINATION DIET

MENU	*SUBSTITUTES*
Breakfast	
Grapefruit juice	Lemonade, pineapple, pear, and other fruits later.
Boiled rice	Rice flakes, corn meal mush, corn flakes and other cereals.
Rice muffin	Corn oil and well washed butter.
Grapefruit marmalade.	Lemon jelly, pear butter, pineapple jam, sugar.
Noon Meal	
Lettuce	Carrots, spinach, beets.
Cotton seed oil mayonnaise	Corn oil mayonnaise.
Pear	Grapefruit, lemon, pineapple, peach, apricot (fruit and vegetable salad).
Lamb broth	Add rice or other vegetables when they do not cause symptoms.
Lamb chops	Roasted chicken, oysters, scallops. beef soybeans, lima beans, peas.
Lamb	Bacon, lamb liver fried in bacon. Later other meats.
Spinach (cooked)	Carrots. beets artichoke. squash potato.
Cotton seed oil	Butter.
Rice muffin	*See* breakfast.
Rice pudding	Tapioca, cornstarch pudding
Tea	Lemonade, grapefruit juice.
Evening Meal	
Similar to noon meal.	

If, at the end of several months treatment, the condition is not definitely arrested (no relapses), it is wise to restudy the whole case as to causation, making another Wassermann test, tuberculin test and having X-rays of the sinuses taken. It is possible then to find what may not have been thought of previously, namely, a bacterial allergy or nasal disease.

If opthalmologists and allergists will bear in mind the fact that all chronic corneal inflammations or ulcers of the cornea, are either originally traumatic (exogenous) or constitutional (endogenous), and treat them as such, they will not fall into the error of treating an allergic keratitis with antiseptics, cauterization of the cornea, etc. This of course, is the indicated treatment in ulcerative infected types of keratitis. Furthermore, one must remember that an allergic keratitis or ulcer can become secondarily infected and spread. A dendritic or spreading type of ulcer may become a serpent ulcer with hypopyon. This is especially so where the co-operation of the patient is very poor, and where the eyes are rubbed or subjected to dust, dirt and bacterial contamination. Similarly a patient may have food allergy and develop a corneal ulcer from a secondary infection. This ulcer will not heal in spite of careful allergic elimination, and so it becomes a chronic recurrent ulcer or vicious cycle. In other words, trauma to a poorly resistant cornea may be the exciting cause of persistent ulcerations in a patient with allergic tendencies.

Daily examination of all ulcers should be made by the usual accepted methods, such as direct light illumination, indirect illumination, illumination by transmitted light, oblique illumination with fluorescin in the eyes, with the aid of white or ultra violet light. In early cases of unexplained conjunctivitis without discharge, the cornea should be carefully studied with a slit lamp, with and without the use of fluorescin. If evidences of edema of the cornea and other inflammatory evidences are found in the eye and properly treated, the case may be arrested before a real manifest lesion develops. Since there are so many cases of non-traumatic corneal ulcers, luetic and non luetic, which have permanent loss of vision due to scarring and clouding of the cornea, the simplest corneal invasion can be dangerous to the

eyesight of the individual. In taking such case histories, the question of allergy should immediately be discussed with the patient. This can be done in a simple manner such as asking the patient whether he has previously had eczema, hives, gastric intestinal disease, hay fever, vaso motor rhinitis, migraine, etc., which are suggestive. If the history is suspicious, careful note should be made of same, and the information can be used as a reminder, to investigate further when necessary.

* * * * *

The author quotes a few cases to demonstrate that corneal diseases and ulcers could be cured by the elimination of the dietary or allergic causes.

SUMMARY.

The types of corneal ulcer or keratitis falling into the category of allergic origin, or the non-infective, non-traumatic ulcers which begin as keratitis, or ulcers without primary infections beginning in the conjunctiva, or without trauma. They may begin as a phlycentular keratoconjunctivitis, and they may resemble dendritic keratitis. It is my opinion, that in all probability, disciform keratitis may be allergic in origin, although I have not personally seen such a case. Of course, in all such cases as mentioned above, focal infections had been ruled out or eliminated. One of the patients had all dead teeth extracted prior to coming under my care.

Then again, the ulcers do not respond to the usual type of treatment, except that they have shown a tendency to improve on cauterization with iodine and pressure bandage. Sometimes atropine is an aid where there is a marked iritis. Drugs of this nature should not be continued for any length of time, unless the patient is scratch tested on the skin for possible local allergy to this drug. In fact, if relapse occurs under treatment of every sort, it is advisable to consider food allergy and go into its study as thoroughly as possible. Any drug which has been used for a long time during the management of keratitis or corneal ulcers should be eliminated for several days to see whether the condition improves without the use of that drug. It is best to test the patient's reaction to it on the skin by the scratch test. Of course, there may be an insidious type of conjunctival infection which might be a primary cause, or a secondary infection during the course of the keratitis allergica. In any event, it is good practice to take a culture of the conjunctival secretion, if any, or of the cornea itself. As for example, in pneumococcic infection, appropriate therapy should be used in addition to eliminating the food factor as a cause.

It is very important to have intelligent co-operation of the patient in regard to the use of the elimination diet. The patient is to add a new article of food to his diet every four days, keeping a record of the foods rejected. In one case recently observed (a compensation case), a man received an injury to his eye, after which repeated attacks of catarrhal ulcers resulted. I am quite sure that they were due to some food allergy, or sensitivity to rye, as in rye whiskey (which was being taken liberally by the patient). Therefore, any prolonged or relapsing condition of the cornea, which has shown no tendency to remain permanently cured, should immediatety suggest an allergic study of the case.

CONCLUSION

Evidence of sinusitis, especially of the ethmoids con be a cause of systemic or focal infection involving the ocular tissues or causing so-called bacterial allergy. It is well known that when a bacterial allergy is removed by surgery (removing the focus), or by desensitizing the patient with injections (vaccines or non-specific therapy), allergic sensitivities to foods which previously existed may suddenly disappear and become no factor in the causation of the allergic symptoms in question. Therefore, in multidietetic allergies it is advisable to eliminate the focal infections before going on to the elaborate method of diagnosis and treatment by allergic methods.

—*The Eye, Ear, Nose and Throat Monthy, May 41.*

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HELPING WAR EFFORTS.

The World War as the term implies is of such stupendous magnitude that every citizen, man or woman has to think of war first and always while awake and even during sleep. The Government must have all the help from the people now and in case they themselves do not ask for help from quarters or from people where such help is available, it is the duty of such people, wherever they are, to come forward and offer help. Medical men and women are the people who can help War Efforts, whether such help is requisitioned or not by the Government. War news is fairly settling itself and sooner or later, India is likely to be a target of the Axis and its allies. There seems to be no dearth of soldiers or sepoys but the dearth of medical men for War Service is keenly felt and as we expressed in these columns last month, efforts in this direction are not tactfully handled. There are three sources which, if tapped with a sincerity of purpose, are sure to supply all the needs both of the Military Service as well as of the Civil. The civil population is as much in danger as those on the fields of war during these days when science is misused for the destruction of people. Consequently the needs of civil population cannot be neglected while satisfying the needs of military medical service. There are three sources from where the required help could be had and they are in the order of their number and availability: (1) the Private Practitioners, (2) the Civil Government Medical Officers, and (3) retired Government Medical Officers. The Government should take all these three classes of medical men into their confidence without minding false ideas of authority, prestige and most of all racial distinctions. At the same time medical men of all denominations on their part should mind only the health and welfare of the people even with a certain amount of risk to their lives and prosperity. Then only the future of India will be certainly brighter and the healing profession will earn the everlasting gratitude of the people wherever they are and the response of such gratitude will go a good way in earning freedom for India though indirectly.

In a life and death struggle, economy is out of question much less racial distinctions. Even in the British Isles, loud complaints are made against the Government that large amounts of money are wasted in the name of war in providing posts for people who had no profession of their own. Such an allegation cannot be made against medical men either in Great Britain or India, and the Government should be generous to a fault in their efforts to organise medical relief not only on the battle fields but also in civil areas which at any moment may be turned into battle-fields. It should also be realised that services of assistants are always more than those of officers in all offices and still more so in hospitals and other medical institutions. The fact that Medical Licentiates in India have been able to stand the competition of other medical men possessing the Indian University qualifications and even foreign qualifications, and some of them at least have been able to be at the top in private practice, should also be remembered by all concerned in war efforts. There cannot be any doubt that the Indian Army is in need of more I. M. D. officers than I. M. S. officers. It is also a fact that there is a dearth of the former much more than that

of the latter. Yet there are no signs of any serious efforts from any quarters as to how to encourage recruitment for the I.M.D. The largest number who are recruited as commissioned officers are the medical graduates of Indian Universities who during peace times ordinarily aspire for the posts of Civil Assistant Surgeons whose starting pay was Rs. 200 a month, a few years ago and now only Rs. 160. They are given a start of Rs. 450 as commissioned officers whereas the medical licentiates are to get Rs. 75 a month. The mere abolition of the designation of Sub-Assistant Surgeons and styling them as Assistant Surgeons though a reform in the right direction, is not likely to have the desired effect in regard to recruitment of doctors for the I.M.D. Now that the Defence Department has recognised the merit of the Licentiates, the next reasonable step should be to give the labourer his legitimate hire and in our opinion this hire cannot be less than what is paid to Military Assistant Surgeons belonging to the Anglo-Indian community.

The machinery of helping war efforts relating to recruitment of doctors would be satisfactorily worked if the Provincial Selection Boards take the role of an organised medical association such as the British Medical Association and is entrusted during the period of war to look after medical relief both Civil and Military as it will be difficult to differentiate one from the other at present in regard to the needs. For, to the extent the military department gets a supply of doctors to the same extent the civil population will be deprived of them. If the Provincial Selection Board takes up the conjoined responsibility of looking after recruitment to military service and medical relief to civil population, the entire medical profession of the province will depend upon the Board for employment of whatever nature and this body will be in an advantageous position of coming in contact with a large number of medical practitioners for distributing work suitable to each individual practitioner at the same time, the members of the profession of all ages and all grades including the retired medical officers will hope to find employment to their taste and capacity. Of course, the Board should mind the need of war first. We learn that the Provincial Recruiting Board which was entrusted by the recent Delhi Conference has nothing to do with the recruitment of the I.M.D. officers and the Surgeon-General with the Government of Madras has brought into existence a separate body consisting of five members, three of whom, the Principal, Stanley Medical College, Superintendent, Stanley Hospital and the Personal Assistant to the Surgeon-General are official members and two private practitioners selected by the Surgeon-General. This Committee is to be a sort of Advisory Committee to help the Surgeon-General in recruiting officers for the I.M.D. We have no idea whether the constitution of this Committee was the initiative of Surgeon-General himself or emanated from the Defence Department. Whatever be the origin of this separate Committee, we should say that the idea of having two separate independent Committees instead of one Provincial Committee whose role was described above, is not commendable. It is a pity those in authority have not as yet seriously realised that War is a corrective and if no sincere advantage is taken to correct past mistakes, the horrors of War are likely to continue longer than ordinarily expected.

There are many posts in the Government Military and Civil Departments which could be more economically distributed temporarily without affecting efficiency amongst senior private practitioners and retired Government Medical Officers. In the Civil Medical Department responsible posts in the grade of Civil Surgeon especially in the teaching institutions may be offered to retired medical officers of tried merit instead of appointing juniors in the Civil list who are at the bottom of the list as is being done by the Government. The Government might have done this with the best of intentions. But interested people complain that favouritism had its play in some of these appointments. Supersession of seniors in the Civil list has caused resentment and discontent in the service. Government would do well to recall retired officers who have been holding teaching posts. Supersessions in the teaching institutions has been a chronic malady in the Medical Department. The old policy of drift due to want of vision of the future needs of these institutions on the part of those in authority, is mainly responsible for such supersessions. This standing grievance in the Department may be obviated to a certain extent during the period of War by recalling retired officers for filling vacancies in the Medical Colleges the juniors being advantageously spared for war service. Such a course will enable the juniors to earn seniority with proportionately less service. Even in case of appointments of Civil Surgeons to serve as D.M.Os, the Government will be well advised not to select officers of less than 20 years service. In case Assistant Surgeons having 20 years of service could not be found in the list, experienced medical men having the necessary qualifications commanding respect and popularity may be selected from amongst the private practitioners of a district. The same policy may be adopted for teaching appointments. The retired medical officers should be entertained if only suitable private practitioners are not available. We wonder if the Government have realised that their present policy of filling temporary vacancies in the Assistant Surgeon grade by raw graduates is responsible to a great extent in retarding recruitment for War Service. The temporary posts must have been offered to private practitioners above the age of 50 belonging to the respective districts or stations where the practitioners have been practising preferring the practitioners who were holding honorary appointments in the past or are working as such at present. Posting of raw Medical Graduates with little or no experience to the moffusil hospitals even as assistants to the District Medical Officers cannot be conducive to the welfare of the public, we may even say is hazardous. Orientation of a policy of trusting private practitioners to occupy paid posts at least during the period of war will have a marvellous effect on war efforts.

It is rumoured that the present Personal Assistant to the Surgeon-General is likely to be posted as a Superintendent in a City hospital in the near future. Unfortunately for the department, this post has been going a begging these few years. There was at one time a stupendously surprising and as awkward a suggestion that an Assistant Surgeon was competent to hold this responsible post. Perhaps as a compromise the Congress Government permitted the then Surgeon-General to have an officer as his Personal Assistant whose grade was between an Assistant-Surgeon and a permanent Civil Surgeon and this arrangement continues. A post which was once occupied by an I.M.S. officer and later by a senior Civil-Surgeon in the selection grade is now occupied by a Civil-Surgeon on probation or perhaps one who has just finished probation. It is really a strange irony that it has not been possible for the Government to realise the responsibility attached to the office of the Surgeon-General who has to work with one Personal Assistant where the neighbouring Head of the Public Health Department has nearly half a dozen Assistants to help him. Apart from the volume of work, the Medical Department spends nearly a crore of rupees a year, whereas the Public Health Department spends perhaps a third of this amount. In addition to the ligitimate duties of office, the Surgeon-General has under his control over twenty activities of a demi-official nature. So advantage may be taken about the present situation and the Surgeon-General may be given the assistance of a retired Civil Surgeon, capable of doing hard work, who, in addition, is in a position to command respect and prestige next only to the Surgeon-General. It is possible for the Government to find one such from amongst the retired officers. The Surgeon-General should have an assistant whom he can trust and if such an officer has to his credit the faith and trust of the medical profession and the public, he will be an acquisition especially during the period of War when the Head of the Medical Department has to play a most responsible and important part in the discharge of his duties.

News and Comments.

Lt. Col. C. M. Ganapathy :—Exigencies of war snatched away from Madras Lt. Col. C. M. Ganapathy, one of the most popular Directors of Public Health, Madras ever had. Col. Ganapathy was appointed as the Director of Public Health of the Madras Presidency in 1934 and worked in this province to the entire satisfaction of the Government and the public till 13-8-'41, when he left Madras to join the Army Medical Service. In the ordinary course of events he was to retire early in September this year. The sudden withdrawal of Col. Ganapathy from his Civil appointment would serve to point out the rigour of military service apart from exigencies of every service. We met Col. Ganapathy soon after we heard the news of his being called away for war service to bid him good-bye both on our behalf and on behalf of the medical profession and unlike other officers who were similarly ordered for military duty, Col. Ganapathy took the event of his sudden transfer as a pleasant domestic event inspite of his reaching the end of his military service in the immediate future. Those who have only heard and read about war, Col. Ganapathy's sense of duty even on the eve of his retirement would not only admire, but would wish others in his position and much younger in age should follow his temperament. It is indeed a strange coincidence and we wish it would be as happy that Col. Ganapathy began his professional career by joining the Indian Medical Service in 1914 during the last Great war, which ended in Victory for Great Britain and rejoins the Army in 1941, in the midst of the World War at a time when the hope of victory is on the lips of everybody.

Col. Ganapathy was born on December 14th in the year 1886 and after finishing his professional educational career in Edinburgh and qualifying for the M.B. Ch.B. degree and the D.P.H. diploma of the Cambridge University joined the I.M.S. in 1914 and was in active War Service till 1918. He served in Iraq from 1920—21 during the rebellion in that country and later, was transferred to Razmak Field Force in N. W. Frontier where he served from 1923—24. In 1924, he was appointed as Assistant to the Director-General, Indian Medical Service which appointment he held for three years till 1927, when he became the Health Officer, Simla, where he served till 1928. In 1929, he was made the Director of Public Health, Central Provinces which office he held till 1932. The following year found Col. Ganapathy In New Delhi where he held the combined office as Assistant Director of Public Health Delhi Province and Health Officer, New Delhi. Later, after serving as Deputy Director-General for a short period, Col. Ganapathy came to Madras in 1934 as the Director of Public Health which office he held till 13th August. Col. Ganapathy's official career for seven years was full of activities relating to preventive medicine and but for the red tape and the slow running Government machinery which at times could be stopped even by a small loose screw somewhere, the Madras Presidency would have enjoyed much more benefits during Col. Ganapathy's regime. Expansion of maternity and child welfare work whith

may be called the mainspring of preventive medicine was the pet hobby of Col. Ganapathy. He felt the need of an institution like the clinical hospital in curative medicine to teach students practically preventive medicine. For this purpose he advised the Government to run a Health Unit at Poonamallee to demonstrate to the public the benefits of preventive medicine and advantage was taken of this Unit to give practical training to subsidized rural medical practitioners who were quite handy for the purpose. It is a pity the Government have decided to close the Poonamallee Health Unit instead of expanding it for the benefit of training the B. Sc. and L. P. H. students. Vital statistics is in a hopeless condition in India. This is a useful machinery to gauge the cause and effects of public health activities. The credit of centralising the work of vital statistics of a province in India for the first time ever since Public Health Department had a separate existence, should go to Col. Ganapathy. It is said that other provinces are trying to follow Col. Ganapathy's lead in this direction and the services of a clerk trained for this work in the office of the D. P. H. Madras has been requisitioned by the D.P.H., Bengal. Want of wholesome water-supply is a cause of ill health and epidemics in Indian villages and Col. Ganapathy had launched a scheme covering 5 years to improve the water supply in the villages. Col. Ganapathy tried his level best to introduce compulsory medical inspection of schools and colleges but unfortunately had not the support of the Government. He was responsible to introduce legislation relating to re-vaccination. Apart from introducing fresh public health activities of a general nature in his department, Col. Ganapathy had a driving love and insight for research. Plague, malaria, hook-worm disease and filaria may be mentioned among the diseases against which Col. Ganapathy directed research with tangible success. Fairs and festivals which are the breeding places of epidemics in this country did not escape the notice of Col. Ganapathy and it has to be said to his credit that during his regime epidemics at the fairs and festivals were not known. The crowning activity in which Col. Ganapathy interested himself is the Public Health Act and it is the ill luck of this province that a Public Health Officer of a large vision should be snatched away before he could put the Act in working order. It cannot be said that this Presidency was entirely free from epidemics like cholera, small pox etc., during the regime of Col. Ganapathy but it is a known fact that wherever it be, in the City of Madras or outside in the mofussil epidemics of the intensity and magnitude, which prevailed before 1934, did not give rise to wide spread havoc as in the past. During recent years plague in the Nilgiris District, cholera in Guntur District, and epidemic meningitis in the Madras city were nipped in bud soon after they made their appearance.

The Head of a department who has laudable work to his credit has to depend upon to a great extent on the willing co-operation of his assistants. The amiable and as affable temperament of Col. Ganapathy was responsible for his being able to command from his assistants reciprocal love and regard for him and every one in the office of the D. P. H. from the menial to the highest official next to Col. Ganapathy carried out his orders most pleasantly. The popularity of Col. Ganapathy was not of a lip deep variety as he knew his assistants not only by their work but also by name.

In whatever capacity Col. Ganapathy served, his services were recognised by the Government. In the earlier part of his official life when he was on military duty he got awards such as M. C. and his name was mentioned in the despatches during the last war and during the rebellion in N. W. Frontier. Recently he was the recipient of the title C. I F. in recognition of the good work turned out by him as a sanitarian of high order. We send our hearty good wishes to Col. Ganapathy wherever he be serving his country and King on the battle field. In the ordinary course of events, he ought to have enjoyed well-earned rest during the days of his retirement after a strenuous

career. The military demands might compel Col. Ganapathy not to retire though he finishes the term of his service next month. Col. Ganapathy from what we know of him, would willingly serve in the Military Department with creditable zeal as long as his services are required.

The Tuberculosis Association of India: The Tuberculosis Association of India though yet an infant regarding the period of its existence, its robust activities seem to be going far ahead and it cannot be an exaggeration when it is said that any such association throughout the world could not have to its credit a work of the magnitude which the Tuberculosis Association of India has been able to place before the public within a short period of 2 years. Since the Association came into existence two new sanatoria have been opened at Amritsar and Quetta, eight are under construction at Baroda, Anantagiril (Dec), Indore, Nagercoil, Bombay, Bangalore, Kapurthula and Kasauli and the buildings of eleven more are under consideration. Out-patient clinics are also constructed at Budge-budge, New Delhi, Boloan and twenty five more are planned in different parts of India. In addition to the sanatoria and clinics, the construction of five tuberculosis hospitals is also under consideration. The sanatorium which is completing its construction at Kasauli and the Clinic already opened at New Delhi deserve special mention. These two institutions were planned, constructed and equipped in an ideal way so as to serve as models for the benefit of the vast sub-continent of India.

Within a brief period of two years, the Association has been able to establish Provincial Affiliated Branches in all the eleven provinces in India and in addition three inter-provincial branches. The Indian States were not wanting in their responsibility to check Tuberculosis menace and there are at present twelve State Tuberculosis Associations

Publicity and propaganda have been a prominent feature of the activities of the Association. Three broad-cast talks, were given in the course of the last year. The first was by Her Excellency, Marchioness Linlithgow, the President of the Association, her subject being "Tuberculosis—A Menace to India." This was followed by a talk given by Lt-General Sir G. G. Jolly, Chairman of the Execution Committee of the Association. His subject was "Organised Front Against the Menace." Later Dr. C. Frimodt-Moller broad-casted a talk on "Individual Defence Against the Menace."

In addition to the issuing of pamphlets, leaflets, posters and charts, the Association has been publishing 'Tuberculosis News' through the medium of 'Indian Medical Gazette', 'The Medical Practitioner', 'Bengal Tuberculosis Journal', and 'Red Cross Journal'. For the benefit of general practitioners, the Association has been arranging post-graduate courses in the important cities, such as Madras, Bombay and Calcutta. The Madras Government had instituted a special diploma, 'T.D.D.' on the lines obtaining in Great Britain, the theoretical three months course being conducted in the Madras Medical College and the six months practical at the Arogyavaram Sanatorium. It is hoped that the Madras Government would make it possible in the near future to have the entire course in Madras bringing the Tuberculosis Sanatorium at Tambaram to the level of that at Arogyavaram.

A notable activity of the Association is the Conference of Tuberculosis Workers in India. At this Conference both the general and scientific aspects of the prevention as well as the cure of Tuberculosis are discussed by experts on these subjects and the proceedings are published for the benefit of those interested in Anti-Tuberculosis Campaign.

The report of the activities of the Association and the reports of the Affiliated Associations appended to that of the Central Association show a very good record of work in all directions. All this was possible due to the personal interest taken by Her Excellency the Marchioness of Linlithgow.

The working principle of the Central Association has not been dissimilar to that of the Central Government of India, the Affiliated branches enjoying autonomy more or less of the type enjoyed by the provinces. The affairs of the medical profession in India are quite unique in themselves. The scientific medical profession as such was started in India as a department of Government and it is but natural that the driving force of the activities of the medical profession starts from Government Medical Departments and any scheme relating to the exercise of the medical profession has to emanate from the Government Departments. It cannot be otherwise relating to the campaign against Tuberculosis. It has also to be said that the public in India are callous relating to its own welfare and has been depending entirely on the Government. Yet it is seen in the report that a pretty large number of philanthropists did come forward with large donations to help the Tuberculosis Association and have been co-ordinating with it in its activities. This was possible as the head of the Anti-Tuberculosis Campaign is Her Excellency Marchioness of Linlithgow. It is the good luck of India that Her Excellency conceived the idea of starting a powerful Association choosing her colleagues who could command authority and influence. It is also a fortunate circumstance that Lady Linlithgow had the perception that next to the Government it is the missionaries who have been responsible to give the public in this country especially rural areas, the benefits of scientific medicine and it was most appropriate that Her Excellency has chosen a medical missionary who has been mainly responsible to establish in Southern India, the biggest and at the same time, the best equipped Sanatorium in India. The Medical Commissioner in the person of Dr. C. Frimodt-Moller is an asset to the Central Association not only in his capacity as a specialist of vast experience in Tuberculosis but also as one well versed in the knowledge of Indian conditions. It is rightly hoped that Dr. Moller would be able to drive in the spirit of true missionary spirit in the activities of the Association and the authoritative influence commanded by the other office-bearers of the Association combined with the spirit of missionary service would speedily check the menace of Tuberculosis, a disease which has been doing destructive work in India of the nature not dissimilar to that of Hitlerism and it is the hope of the medical profession and the public in India that Her Excellency Marchioness of Linlithgow would be able to arrange the future activities of the Association on a footing worthy of the new order of things that are now envisaged by those in authority and power in both the Hemispheres giving the medical profession a rank and place obtaining in the other free countries.

Surgeon-General's War Efforts:— Every Department of the Government has seriously to shoulder the responsibility of winning war. The responsibility of recruiting doctors for military has naturally fallen on the Medical Departments and the Heads of the Medical Departments in the provinces are very busy in finding ways and means to stimulate recruitment of doctors. The Surgeon-General with the Government of Madras has been very active in this direction and is making use of his gift of tongue and pen in appealing to the official and non-official section of the Medical Profession in this province. He is very mindful of the work from the very bottom and for this purpose addressed the students of the Madras Medical College on 4-8-41. The Government Medical Officers in the City were also invited by the Principal, Madras Medical College to attend the meeting at the College and a few selected private practitioners were the additional invitees. The Surgeon-General said that not less than 1,000 doctors graduates and licentiates were required for war service before the end of the year and no fewer than 200 graduates from the Madras Presidency had already received the commissions, a number larger than that of any other Province in India. Proceeding, the Surgeon-General said that while helping the war efforts, the members of the medical profession would be bringing succour and assistance to the sick and wounded and at the same time gain lot of

skill and experience. He mentioned that those in military service would have the best hygienic surroundings with plenty of good food and in addition would have regular daily physical exercise and a well disciplined life which wouid be an asset to the future well-being of the doctors. Even materially those who entered military service would be benefitted as they would have a chance of being entertained permanently either in the Civil or Military Medical Departmeat, recruitment for which had been stopped during the period of war. He pointed out to the young doctors now serving as House-Surgeons and House-Physicians that there was no comparison to the monthly allowance of Rs. 25/- which they were now getting to Rs. 450/- which was the starting pay for commissioned medical officers. The Surgeon-General added that those who were not in official service would be given gratuities after the termination of military service and that the question of granting certain additional concessions to those taking up commissions, had been discussed by the recent Conference at Delhi and would be shortly announced. In the meanwhile, he said that those who wished to join military service should do so immediately as seniority counted much in service. The Surgeon-General warned such of those who aspired for the rank of Major and that all those who possessed higher medical or surgical qualifications such as M.D., M.R.C.P., or M.S., F.R.C.S. etc. should not expect to be raised to the rank of Majors. Turning to the final year medical students, the Surgeon-General told them that the Madras University was likely to hold final examinations three months earlier for the benefit of such of those who would promise to join military service soon after passing. This news was received by the students with applause for obvious reasons.

Excepting the last item of concessions allowed to the final year medical students, there was nothing new in what came out from the mouth of the Surgeon-General but the way he reiterated what appeared as his departmental proceedings and Government Communiques, was very much impressing and appealing too. Some of the Assistant Surgeons who possessed the higher medical and surgical qualifications are said to be very much disappointed as almost all of them are said to have given a conditional undertaking that they would volunteer for war service in case they got the Major rank. They seem to think that the rank of Major depended entirely on the period of service and such of them who had put in service in the Civil Department of a period which entitled a Lieutenant to be a Major should be the only consideration that should weigh with the Defence Department. They say all Majors in the I. M. S. are not specialists. Yet for the purpose of pay and other emoluments, all Majors are treated alike, excepting perhaps that the specialists among Majors are paid an additional allowance.

The medical licentiates had only a passing reference in the address; perhaps the Surgeon-General intends addressing them elsewhere at their native place of training. We should say that for reasons mentioned elsewhere in these columns, the number of licentiates required for war service must be much more than that of the graduates. As such, the licentiates have to be stimulated and encouraged more than anybody else in the medical profession. But they are unfortunately treated as brooms which while under use, are considered the best material, but soon after, thrown away as they are cheap and could be had for little or no price. Recently the Defence Department has been magnanimous to give the brooms a rank befitting their usefulness, but this department has not thought it necessary that the labourer should be paid a hire worthy of his work. It is said that some announcement relating to the pay and prospects of licentiates in military service is coming soon. Time and opportunity should be the main factor during war emergency. It is so, everywhere and concerning everybody else excepting the licentiates. Apart from the Defence and Civil Departments of the Government, even the leaders in the non-official medical profession seem to have given little or no thought about the usefulness of licentiates for war service. They are treated as untouchables even relating to the work of recruitment and a separate Advisory Committee is said to have been constituted specially for this class of medical men. It is such distinctions that have been the causes of discord in society and on a larger scale in the countries of the world, which are now shedding blood and unless the angles of vision change for all purposes for correcting past ills, there will be little or no hope for the early dawn of peace. Indians are a set of spiritualistic people, they have less faith in materialism and could adjust themselves for all conditions. Licentiates of the type now existing in India do not exist anywhere else in the continent. They have been managing to survive so long, inspite of inequities and they will still strive and manage to hold their own inspite of such inequities.

Eye Treatment in Ancient India:— The School of Indian Medicine is an institution which has the largest number of platforms and as many Associations. One of them the Apprentice Physicians' Association requested Capt. V. D. Nimbkar, ex-Honorary Surgeon, Government Ophthalmic Hospital, Madras, to address them on the inauguration day of the Association. The report of the meeting appeared in a local lay daily under the caption, "Eye Treatment In Ancient India". It was also said in the report that the Principal of the School of Indian Medicine distributed the diplomas to the out-going students.

Capt. Nimbkar's subject of address was, "Ancient Operation of Couching Cataracts". The head line under which the report of the meeting appeared in our contemporary was as misleading as the function itself. The purpose of the meeting was not dissimilar to a convocation of an university. The apprentice-physicians lent the name of their association and the Principal of the School, found an opportunity to distribute the diplomas and the convocation address was delivered by Capt. Nimbkar and he chose a subject 'couching of cataracts' in ancient India, an operation usually performed by quacks and charlatans in villages and which is condemned by eminent ophthalmologists, including the late Col. Elliot who was for several years the Superintendent of the Government Ophthalmic Hospital, Madras and who was considered as one of the foremost ophthalmologists of his age. Col. Elliot is the author of a book entitled "The Indian Operation of Couching for Cataract" incorporating in the book the Hunterian Lectures delivered by him before the Royal College of Surgeons of England on February 19 and 21, 1917. The history of this operation dates 270 years before the birth of Christ as mentioned by Celsus, a contemporary of Christ himself. We gathered this information from Elliot's book. The author acknowledges that the original inventor of the operation must be an Orient. Capt. Nimbkar made a reference to the prehistoric times when the operation was performed as did Col. Elliot in his book. The present day ophthalmologists are likely to be surprised to read the assertive statement made by Capt. Nimbkar (as reported in the newspaper) that, "the success of couching was almost as good as extraction with the necessary requisites for the operation." We wonder if Capt. Nimbkar has a record of cases operated by him or by any qualified ophthalmologist known to him which encouraged him to say that the ancient couching operation for cataract was as good as extraction. We have been receiving during recent years reports on the working of the Government Ophthalmic Hospital and none of these reports make mention of the operation of couching of cataracts. The lecturer went a step further and hoped that the couching operation should be given a trial in the hospital connected with the School of Indian Medicine. The hopeful suggestion of the lecturer did not fall on deaf ears. Dr. M. A. Nair who holds dual honorary responsibilities as an Ophthalmic Surgeon of the Hospital connected with the School of Indian Medicine and the same position in the Stanley Hospital and who was also present at the meeting stated, that 'the suggestion of the lecturer would be given a trial in the hospital of the school'. Though it was not mentioned

"by whom" the sequence of the sense in the report makes us presume by Dr. M. A. Nair himself.

The publication of lectures on medical subjects in lay newspapers is universally condemned by the medical profession as unethical and the medical councils take disciplinary action against the registered practitioners for publishing the lectures of which they are the authors. The purpose of enforcing high ethical sense in the members of the medical profession, seems to be more in the interests of the public than of the medical profession; as it is considered that undue publicity of events relating to established facts or doubtful results of research are likely to mislead the public as in the case of Capt. Nimbkar's address, to the outgoing students of the School of Indian Medicine. An idea amounting to a complex seems to prevail in the School of Indian Medicine that everything in medicine which connotes its relation to ancient times should be encouraged willy-nilly. In such an atmosphere professional or public interests demand that controversial subjects should be scrupulously avoided inspite of anybody's love and regard for things ancient. The School of Indian Medicine is an institution primarily meant for the teaching of Ayurveda, Siddha and Unani systems and the students are only expected to know the rudiments of surgery as practised by the modern scientific practitioners. So, they are not expected to pick grain from chaff. If we remember right, Capt. Nimbkar is the author of a statement in the press that the students passing out of the School of Indian Medicine, should be only styled as physicians. We refer to his statement subject to correction. It is a pity he did not realise the risks of an address and that on a surgical special subject.

They say that the main field of practice of the licenciates in Indian Medicine, is the rural area. It is in the rural area the "Cataract Couchers" usually Mohammadans migrate from the Northern India. The Coucher looks 'ancient' from head to foot, so also his ways and habits, and therefore the villagers flock to them. The dangers of couching operation have been so exhaustively described and illustrated by the late Col. Elliot in his book that those who have read this book would stagger at the idea of couching operation as done by the couchers. Perhaps the technique of the operation of couching if followed by qualified ophthalmic surgeons, is not likely to make as many people blind and miserable as in the hands of village couchers described by Elliot in his book. But what is the need of a convocation address on a surgical operation which is not practised and even condemned? Capt. Nimbkar would have done better service to his speciality if he advocated the couching operation for cataract before an audience consisting of specialists like himself placing before them the record of cases of operations performed by him with greater ease and success than the operations now performed for the extraction of cataracts. Half knowledge is indeed more dangerous than no knowledge, especially in an atmosphere where things ancient and not science reign supreme!

Admission to Medical Colleges:— The order of the Government in cancelling the selections once made by the selection-committee consisting of three Principals of three Government Medical Colleges, two in Madras and one at Vizagapatam and the subsequent shuffling procedure adopted in re-selecting the candidates for admission into the Medical Colleges prove that even the Government at times have to be a creature of circumstances and be responsible for the acts of omission and commission brought about by their officers placed in high positions, which acts bring the Government to disrepute. It is not the purpose of these comments to justify or decry the communal rules or orders which the Government have been promulgating either for entry into Government Service or for admission into Government teaching institutions, which again, are events of circumstances. It is said that soon after the abolition of Selection Committees by the Congress Party Government which Committees were brought into existence by the Justice Party Government, representations were made to the Government

that the abolition of Selection Committees for selecting candidates for admission into various Government Colleges, had been followed by a noticeable increase in the admission of Brahmin candidates and reduction of non-Brahmin Candidates. The Government after calling for statistics and scrutinising the same, came to the conclusion that there was no foundation for the allegation that undue preference had been shown to the Brahmin Community. Basing upon the scrutiny made by them, the present Government issued an order G. O.-No. 1435 P. H. dated 1st August 1940, the relevant paras in the order run thus:

"Government think that colleges which provide training to fit students to enter a profession and earn their own living without special reference to Government service, should not be treated, for purposes of admission in the same way as Government service, and that admission to such colleges should be in proportion to the extent to which the communities wish to take advantage of the facilities offered.

The Government are against fixing a rigid communal proportion for admission into Government Arts and Professional Colleges. They had however already issued a Press Communique, dated 29th March 1938, which is as follows:—

'The Principals of Government Colleges are requested, while making selection for admission to all classes in their colleges, to exercise the greatest care in seeing that due representation is given to non-Brahmins, to all minority communities, to Mohammadans, to scheduled classes and to women. The fact that candidates from backward communities do not possess equally high marks as candidates from forward communities should not stand in the way of deserving applicants from such communities being given the consideration. In the case, for example, of the scheduled class and of Muslim women, very few of whom ever reach the collegiate standard, special consideration should be shown. In cases of doubt, the Principals of Colleges may, if they consider it necessary, refer the cases to the Director of Public Instruction for decision.'

The Government wish again to draw the attention of all Principals of Government Colleges to this communique.

The Government do not consider that there is any ground for suspecting that the Principals of Colleges will not give effect to the Government's policy of fairness and justice to all communities or for fettering the discretion of the Principals of Colleges in the matter of admission, by associating non-official committees with them. Such committees led to much canvassing in the past and were abolished on account of the dissatisfaction which they had caused. The Government are therefore against their revival."

The Government affirm that they are against fixing a rigid communal proportion for admission into Government Arts and Professional Colleges. The communique referred to in the order applies only to the Arts Colleges and not at all to the Professional Colleges. It cannot be doubted that the order dated 1st August 1940 was not communicated to the Principals of the Medical Colleges, who formed the committee and that these Principals did not comprehend the spirit and the principle laid down in the Government Order. All the same, we should say that the reference made in the G. O. relating to the Government Communique dated 29th March was indeed most unfortunate. If the Selection Committee had any doubt about the intention of the Government either before they met or at the time of selection, they ought not to have proceeded with the selection and must have referred their doubts to the Government.

The fact that the Selection Committee communicated the result of selections to the candidates soon after the committee dispersed, indicates that none in the committee had any doubts about the Government's intention, as indicated in the G. O. Inspite of all this that the Government thought it fit to undo the work of the Selection Committee, was most disappointing especially at a time when the Government were not constituted out of any political party. It is not our intention to make much of an event at a time when the Government have to concentrate their attention on nothing excepting war. But we feel we should draw the attention of the Government to the danger, if the Government balance leans more than necessary towards circumstances instead of justice and fair play which are the best materials not only to win war but to prevent war in future. It is desirable that the Government should hold an enquiry as to how the results of selection of candidates, in all their details, were made available for attacking directly the Selection Committee and indirectly the Government. Apart from Communal

consideration, there are many other flaws relating to the admission of candidates into the Medical Colleges and we will revert to this subject once again.

Science Exhibition:—The Madras Science Club, a social body consisting of members from the staff of the teaching institutions in the city both Arts and Professional and the staff of the King Institute arranged an exhibition of various departments of science, Physics, Chemistry, Zoology, Botany, Geology, Medicine (including clinical and non-clinical subjects) and Veterinary Science at the Madras Medical College. The idea of having this exhibition was conceived by the Executive Committee of the Science Club for the purpose of of helping the Governor's War Fund. His Excellency, Sir Arthur Hope, opened the Exhibition on 14th August and the Exhibition was kept open from 15th to 17th August from 9 A. M. to 6 P. M. for the benefit of the public. Admission was by tickets, the price of each being As. 8/- for adults and As. 4/- for *bona-fide* Students. Sections were under the direct charge of students, male and female representing the institutions which sent the exhibits. It was indeed a happy sight to see the several students vieing with each other to make their demonstrations interesting and attractive and it was a pleasant surprise that apart from the scientific interest displayed by the students at sections under their charge they amply displayed the business side of art and profession.

His Excellency Sir Arthur Hope said, while opening the Exhibition that the Exhibition served two purposes. One was that it would help the War Fund, the second was that it would popularise science. Medicine is an all pervading science and it was most appropriate that the venue of the Exhibition was the Madras Medical College. It seems to us that even the different institutions of Arts and Science have also realised the blending of all sciences in medicine as could be judged from the fact that the Vice-Principal of the Madras Medical College is the elected President of the Madras Science Club.

War seems to be a blessing in disguise. India has now splendid opportunities of developing in all direction on account of war and these developments are possible and will be sustaining if scientific outlook in the people is stimulated and encouraged. We trust the Executive of the Science Club will have the wider interests of their country at their hearts. We suggest to the Science Club that the Exhibition which began as a war effort should be repeated year after year so as to make it a real effort to make this Presidency if not the whole country develop on scientific lines, so that the future exhibitions may rightly be called welfare and prosperity efforts for the good of the country. We congratulate all the office-bearers including the students who took lively interest to make the Exhibition a success and trust the enthusiasm and zeal shown by them will be an earnest for their future work on the lines suggested by us.

Subsidized Rural Medical Relief Scheme: Last month when we commented on the Government Order No 2405 P. H. dated 9-6-'41, relating to the resolutions passed by the Provincial Subsidized Rural Medical Practitioners' Association at Samalkot in 1939, we said that the daily allowance of Rs. 3, to be granted to the subsidized practitioners for doing festival duty as appearing in the G. O. must be likely a printer's mistake as the practitioners were given this allowance in the past for loss of private practice while doing festival duty. As suggested by us in the comments, the President of the Association made a reference to the Government and the Government in their memorandum No. 31574—1—D. I. P. H. dated 25—8—41 have mentioned that the figure Rs. 3 appearing in the G. O. is not a printer's mistake and the reduction from Rs. 5 to Rs. 3, of the daily allowance was arrived at by the Government after due consideration. The memorandum is appearing in the correspondence columns of this issue. By a resolution passed at the Samalkot Conference, the Subsidized Practitioners requested the Government that such of them who had undergone public health training and who were

given a monthly subsidy of Rs. 15 for doing public health work should also be given a daily allowance of Rs. 5, for doing festival duty, which allowance the practitioners have been getting in lieu of loss of private practice ever since Subsidized Rural Medical Relief came into existence. The Government have been unduly harsh in reducing the festival duty allowance by Rs. 2, in case of the practitioners who had not undergone public health training and did not get additional snbsidy of Rs. 15, for doing public health work. This action on the part ot the Government will surely be resented and cause discontent in the practitioners, especially in those that do not get the additional monthly subsidy of Rs. 15, for during public health work. Legally the subsidized practitioners are bound by the terms of agreement and one party in the agreement cannot in ordinary circumstances change the terms without the consent of the other party or parties. But the Government in case of subsidized practitioners who are one of the party to the agreement, usually change the terms of the agreement without consulting the other party. We have been always admiring the sense of British Justice and appealing to it whenever we saw things against this justice. We should say events like this though concerning a humble class of practitioners is likely to shake the faith in British Justice as the principle involved cannot be over-looked. It is the duty of the Government to protect the interests of humbler folk. The people in a higher strata of life have means and methods to press their demands on the Government effectively. The amount involved is so small and negligible that the violation of justice and fair play will be felt the more. A certain group amongst the subsidised practitioners put forth a demand and this demand was not granted by the Government. On the other hand, a different group of subsidized practitioners are virtually punished by depriving them of their legitimate dues which they were getting all these years. We appeal to the Government to maintain *statu quo ante*.

Private Practice by Government Medical Officers: We have been receiving complaints from private practitioners both in the moffusil and the city of Madras that a large number of Government Medical Officers of all grades are having general practice, coming in direct contact with the patients. When the Congress Government promulgated the rule in 1939, restricting private practice to state-paid officers only to consulting practice, imposing 5% of the amount earned by them by private practice, to be paid to the Government, the Government thought that the later imposition would serve as a check. We said at the time amongst other things, that the Government Medical Officers should have consulting practice within the doors of the institutions where they are employed and a reasonable proportion of the fees earned by them should go to the Government treasury or else the G. O. would be obeyed more in breach and that it would not be possible to detect the violation of the Government Order. Next to the Surgeon-General, the immediate superiors over the medical officers working in hospitals, are the Superintendents of the hospitals and when at least some of them are said to be utilising the hospitals as non-paying nursing homes what check will there be over the officers immediately below the Superintendents? The Government cannot but be aware to what loss they are put to if patients that could pay hospital charges both for stoppages as well as for operations, are put into the category of non-paying patients. This loss apart if those who openly violate the Government Order happen to be teachers of the future members of the medical profession, the moral and ethical effects that would insidiously degenerate the medical profession may be very well imagined than described. Matters are tending to a stage that the eminence of medical men is counted by the money he is able to earn, not by his professional attainments and acumen. The Government machinery is so arranged that detection of crimes in the exercise of the medical profession in the hospitals, is more difficult than the finding out of some of the most uncommon diseases. It cannot be said that all are corrupt in State Medical Institutions, but it can be safely asserted that even a few of the most honest

and vigilant Superintendents of the hospitals have not been able to punish the corrupt officers working under them though as a matter of fact, they, the Superintendents themselves knew who the culprits were. We once heard some established *mamools* in at least a few of Government institutions. These *mamools* are not dissimilar to those that prevailed at the Negapatam and other Port Health Offices whereever since these offices were established the Government Port Health Officers earned money by thousands openly, till at last very recently the Government found out such *mamools* as crimes and punished three officers who were on the scene last. We are referring to Negapatam Port Office just to convince the readers that some of the unethical practices have become so common, that they are not considered infamous in a professional respect.

The state of affairs reported to us seem to have reached a climax as to make us presume if the Government have relaxed the order relating to restriction of private practice to their medical officers as to nullify the policy contemplated in the original order relating to this subject passed a couple of years ago. To clear our doubts, we have referred this matter to the Surgeon-General and soon after we get a reply, we shall publish the same for the information of our readers. In the meanwhile, may we suggest to the Government to test the veracity of the reports received by us, referred to above. They have the necessary machinery for this purpose and we were once told by a responsible officer of the Govern nent that the machinery was made available to find out the nature of work turned out by their officers working in the hospitals as honoraries. It was also said that depending upon the reports gathered with the help of this machinery, Government made up their mind to pay the honorary labourer his hire. In case of full paid me lical officers of the Government, it is desirable in the interests of scientific medicine and its advancement whether the love of money in them is to be encouraged when they are paid for the work done by them in the hospitals and whether extra work turned out by them to earn more money was not likely to interfere with their legitimate work directly or indirectly. The Government might even increase their salaries if they are of opinion that the Government labourers are not now paid adequately. It may be questioned how and why the interests of scientific medicine suffer if state paid practitioners are allowed unrestricted private practice. Medicine is an ever advancing science and if high paid Government Medical Officers exhaust their energies in earning money trading on their official position as specialists, they will have little or no time to think of science nor do they find a need for it for their positions are such that what they do is considered to be the best available science.

Medical Certificates : The non-recognition of medical certificates issued by registered private medical practitioners as against the recognition of the certificates of State paid registered practitioners is a standing grievance which makes the private practitioners feel seriously whether there is any advantage to be in the Provincial Medical Register, established by a statute, the Medical Registration Act. The Act provides special privileges for the registered practitioners and has equally provided a statutory body, the Medical Council which has ample powers to erase the name of any practitioner from the Register and deprive them of the privileges conferred on him by virtue of registration. In spite of this, the Government have been making invidious distinctions between the registered practitioners under their employ and practitioners who earn their own bread. The reason seems to be that the Government could command disciplinary administrative action against their corrupt officers. The result of such a policy has been quite the reverse of what Government expected. The special monopoly enjoyed by the State-paid practitioners has given room for corruption which the Government have to condone for want of legal proof and the chances of selling medical certificates for fabulous prices are more in the case of State-paid practitioners than in case of

private practitioners whose certificates have little or no value in the market.

At least from the year 1929, 15 years after the Medical Registration Act came in the Statute Book of the Madras Government, attempts have been made by a few non-official members of the Medical Council to stop the monopoly enjoyed by the Government Medical Officers and a stage has been reached, when it has been possible to make the Head of the Medical Department, who is the ex-officio President of the Madras Medical Council, to realise that it is against the spirit of Medical Act not to recognise certificates issued by private practitioners practicably for all purposes, excepting those concerning the Government themselves. The Surgeon-General during recent years has been pleased to inform the executive heads of local bodies at least, that the non-recognition of medical certificates granted by registered practitioners is against the spirit of the Madras Medical Registration Act. So far so good. The majority of private practitioners have not as yet realised that 'vested interest' is not an incurable malady and that persistent agitation conducted in these columns did serve to point out to the authorities to a certain extent at least that the 'vested interest' relating to medical certificates is a disease likely to bring the noble profession to disrepute. The chief cause of the spreading of the infection of the disease is the monopoly enjoyed by the State-paid practitioners some of whom are the teachers in medical teaching institutions. It cannot be said that the Government are not aware of the existence of black sheep in the Medical Department and we cannot deny that there may be many more in the private medical profession as the number of private practitioners is several times more than that of medical officers. The Government are in a false sense of security that they could control their subordinates by administrative disciplinary action. Such a control cannot reach the officers on the higher rung of service whom the Government cannot easily reach, due to defective autonomy the Government have been enjoying. Regarding those in the next lower rung, the Government must have felt the difficulty of bringing them to book even though the Head of the Department had personal knowledge of the corruption. The rules to guide the conduct of public servants are at times so impregnable that a dishonourable servant instead of being punished gets the certificate of unimpeachable honesty. Even otherwise corruption relating to medical certificates cannot be punished by the Government to the extent the Medical Council can do. For even the highest punishment of dismissal from service cannot prevent a registered practitioner to enjoy the privileges of Registration, unless his name is finally removed from the Medical Register. This can be done only by the Medical Council which is presided over by the Surgeon-General. Even if the Medical Council errs on the side of leniency in grave cases, relating to certificates, the Medical Act has provision for Government intervention. The Medical Council has now a working majority of non-officials and in case the members of the independent medical profession care to read the proceedings of the Madras Medical Council as reviewed occasionally in these columns, and find out what their representatives are doing to guard their interests, they could find an effective remedy against 'vested interest'. Of course, the disease has taken very deep roots, the more so there is a need for organised and presistent agitation.

Late Capt. P. Ramachandra Rao : With deep sorrow we announce the death of Capt. P. Ramachandra Rao, M. B., Ph. D. (London), Professor of Pathology, Madras Medical College on 25-8-41 at his residence in Madras. He was suffering from typhoid fever for about a month and it was said till a few days before his death he was progressing satisfactorily when he suddenly developed hyperpyrexia and inspite of best available medical aid he succumbed. Capt. Rao was born in a village called Pavanje in South Kanara and after qualifying himself for the M. B., B. S., degree of the Madras University entered Madras Provincial Medical Service as an Assistant Surgeon. He served for a short

time in the mofussil hospitals and later served as an Assistant to the Professor of Pathology, Vizagapatam now Andhra Medical College. He had a special aptitude for study and research. He availed himself of study leave and went to London and qualified for the Ph. D. degree in Pathology. He returned in 1936 when he was appointed as Professor of Pathology in the Andhra Medical College. When there was a vacancy of the same professorial post in the Madras Medical College in 1940, Capt. Rao was transferred to Madras. Capt. Ramachandra Rao was very popular with the students as well as with his colleagues and he would be very much missed by both. His friends, students and colleagues felt grievously disappointed not being able to pay their last respects as the death took place, it was said, at about 9 p. m. on 25th August and the body was cremated that very night. On the 27th, a condolence meeting was held at the Madras Medical College presided over by the Principal, Rao Bahadur Dr. A. H. Mudaliar. Dr. Mudaliar eulogised the services rendered by Capt. Rao as a Professor, Warden of the Medical College Hostel, Member of College Library and as one of the officers of the University Corps. Col. McRobert paid his tribute of praise to the departed Professor who, Col. McRobert said, materially raised the efficiency of the Pathology Department. The Medical College was closed on the 27th August as a mark of respect to the late Professor.

The passing away of Capt. Rao in the prime of life is indeed a most irrepairable loss to his wife and children to all of whom we send through these columns our sympathies. May Capt. Ramachandra Rao's soul rest in peace!

Correspondence, Reports, Etc.

GOVERNMENT OF MADRAS.

EDUCATION & P. H. DEPARTMENT.

Memorandum No. 31574-1-DI-P. H.

Dated 25th August 1941.

SUBJECT :—Medical institutions—Rural Medical practitioners deputed for festival duty—payment of allowance.

REFERENCE :—*From* Sri V. Ramakamath, No. R. M. P/G/332 dated 13th August 1941.

It has been decided by the Government after a careful examination of the question that Rural Medical Practitioners other than those who are entrusted with public health work may be paid an allowance of Rs. 3, when deputed for festival duty. The figure '3' appearing in the last sentence of paragraph 10 of G. O. No. 2405 Public Health dated 9th June 1941 is, therefore, not a printer's mistake for '5'. Steps will be taken to alter the figure in clause (9) of the form of agreement.

V. V. SUBRAHMANYAM,
Deputy Secretary to Government.

The Indian Medical Association

GUNTUR DISTRICT BRANCH.

The General Body meeting of the above Association was held at the Government Head Quarters Hospital on 19-7-41 with Dr. K. S. Subramanyam, District Medical Officer and the President of the Association in the Chair.

DR. N. PADMANABHA RAO, addressed the meeting on congenital syphilis. After some discussion the President wound up the proceedings by suggesting that in public interest it was desirable that the King Institute should do the blood tests for syphilis free of charge.

DR. D. RAGHAVA RAO, gave a discourse on Honorary Medical Service and pressed the need for filling the vacancies of Civil Assistant Surgeons by appointing Honorary Medical Officers for the same.

DR. G. V. HANUMANTHA RAO, the Secretary while reviewing the activities of the Association in regard to the campaign now led by the alumni of the School of Indian Medicine said that the students in the School had not adequate training in Indian Medicine much less in modern medicine and the introduction of the later subject in the curriculum of studies served only as a stunt to deceive the public. Proceeding, he said that there was a great danger to public welfare on account of the Government establishing the so called Central Board of Indian Medicine for the registration of practitioners of Indian Medicine, and which Board was registering anybody and everybody certified by the subordinates of the Revenue Department of the Government, to be practising Indian Medicine. He informed the audience that the alumni of the School and even the Principal had been trying to create a false impression for the purpose of propaganda that the existence of the School of Indian Medicine was necessary for establishing synthesis of ancient and modern medicine while actually they are bringing the scientific medicine to disrepute. Dr. Rao said that it was not correct to say that the majority of the members of Legislative Assembly were in favour of transforming the School into a College when as a matter of fact 4/5th of the members of the Assembly were against such transformation. The Secretary stressed the urgent necessity for not allowing the practitioners of Indian Medicine as Registered practitioners and the purpose of recognition of ancient medicine could be served by their votaries being allowed to style themselves as Registered Hakim, Vaidyan, etc. In conclusion he asked the members of the Association to pass a resolution to the effect that while reiterating all the resolutions passed by the Association relating to the School of Indian Medicine and approving the explanatory notes communicated to the Government by the Honorary Secretary of the Association, the Association requested the Government to give full consideration to them before passing final orders on the subject.

On 23rd August 1941, the Association met at Narsaraopet, Capt. J. H. Rao occupied the chair. The meeting passed the following resolutions unanimously:—

1. The Association was of opinion that Fellows and Associates of Indian Medicine should be appointed as teachers in the School of Indian

Medicine and not the Licentiates who were intended to practise in rural areas.

2. The Association strongly condemned the contention of the Principal of the School of Indian Medicine that the study of fundamentals only was enough to the essentials of modern medicine.

3. The Association pointed to the Government the urgent necessity of scrutinising the medical register brought into existence by the Board of Indian Medicine for the purpose eliminating from it clerks, teachers, etc., who got themselves registered to serve as a means to earn more money than their legitimate profession could guarantee.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the month of June 1941.

RECEIPTS.	Rs.	A.	P.	CHARGES.				Rs.	A.	P.
Cash balance on 1-6-'41 ...	665	8	0	Postage ...				6	2	3
Interest received on Post Office S. B. Balance for 1940-41 ...	2	13	0	Amount credited to the Medical Practitioner ...				14	4	0
Subscription from members ...	29	4	0		Rs.	A.	P.			
Entrance fee from a new member.	0	4	0	Pay to Clerk for the month of April 1941 ...	15	0	0			
Subscription from members for the Provincial Conference ...	8	0	0	For 17 days in May 1941 ...	8	8	0			
Payments received for Group Photo ...	15	5	0					23	8	0
Postage received towards Group Photo ...	0	7	0	Printing Charges for 10 receipt books ...				3	12	0
				Printing Charges for 13 Photo Mount Headings ...				1	0	0
				Contribution to Anantapur District Branch ...				1	0	0
				Cash Balance :						
				With Savings Bank ...	668	10	7			
				With Office ...	3	4	2			
								671	14	9
Total ...	721	9	0	Total ...				721	9	0

July 1941.

RECEIPTS.	Rs.	A.	P.	CHARGES.				Rs.	A.	P.
Cash balance on 1-7-'41 ...	671	14	9	Postage ...				1	0	3
				Cash Balance :						
				With the Savings Bank ...	668	10	7			
				With Office ...	2	3	11			
								670	14	6
Total ...	671	14	9	Total ...				671	14	9

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

Reviews.

ADMINISTRATION REPORT

OF THE

KING EDWARD VII MEMORIAL HOSPITAL

AND THE

SETH GORDHANDAS SUNDERDAS MEDICAL COLLEGE, BOMBAY.

For The Year 1939-1940.

As usual the report of the Dean of the above two institutions is replete with information useful from the administrative point of view as well as professional. The report deals first with the administration of King Edward Memorial Hospital and next with the administration of Seth Gordhandas Sunderdas Medical College. As envisaged in the previous report, the Hospital building was extended and it could now accommodate 426 patients as against 370 in the previous years. Yet the demand for beds still continues. Apart from the increase of bed strength, the hospital had been extended for other purposes such as extension of electro-cardiograph room, stores, clinical pathology laboratory, and quarters for ministerial staff. The Dean has been provided with quarters within the hospital compound, so also the Assistant Dean and Assistant Medical Officers so that the hospital may command their services at any moment. Out-patient Department had its share of extension so also the kitchens. In fact, the increase of beds in the hospitals necessitated all-round extension. In addition two general wards for medical and surgical patients, the hospital had all other special departments excepting one relating to Psychiatry; and accommodation has now been provided for the admission of mental patients for observation. The students attending the King Edward Memorial Hospital are indeed very lucky not having to run from one institution to another for the purpose of study and practical work.

The statistical information relating to the treatment of diseases of all varieties in the general and special wards, has been appended to the report in a methodical manner. As is the case with such institutions in India, the admissions both in the out-patient and in-patient departments have been steadily on the increase.

The affairs and activities of the Seth Gordhandas Sunderdas Medical College and of the King Edward Memorial Hospital are so much intermingled, being under the administrative control of one officer, that it may be safely said that both these bodies have one soul. Consequently what one sees in the K. E. M. Hospital is the counter-part or co-ordinating link of the S. G. S. Medical College. Medical science rests on the foundation of research and such research can reach the general practitioner only through publication, both of which have been undertaken by honorary staff of the two institutions. In addition to the Research Fund belonging to the hospital itself, members of the honorary staff of the hospital have been taking keen interest in research, availing themselves of the help from the Bombay University, Indian Research Fund Association and Sir Dorabji Tata Trust in collaboration with the Baby and Health Week Association.

The Dean has taken upon himself the responsibility of a guardian of all students under his charge. There is nothing special to be commented upon relating to teaching and the results of examinations which is the stereotyped routine appearing in all such institutions. What should strike those interested in the future of the medical profession is something else which is usually not found in the administration reports. The students under the care of the Dean undergo systematic medical examination and cases requiring medical care are referred to the honorary staff of the

K. E. M. Hospital. A record is kept which shows how many students are married, how many not married. This is not all, even the betrothal record is maintained.

The college has been keeping pace with other side-activities of far reaching and immediate importance. From the year 1939 " Refresher Course " for three weeks have been organised in collaboration with the Grant Medical College. The courses seem to be very popular. War efforts have not escaped the notice of the Dean. A. R. P. classes are systematically held in the S. G. S. College for the training of the students and lay public. The Dean seems to believe that all work and no play will make the subordinate and ministerial staff dull. To prevent this, well-planned social activities find a routine place in the administration and the nursing staff especially, have regular social trips and picnics under the direct supervision of the Dean. The menial staff who are always in want, have been provided with a Co-operative Bank and they are saved from the clutches of greedy unscrupulous money lenders especially the Pathans who have been migrating steadily from Northern India.

The fact that Dr. Jivraj N. Mehta is not only an educationist of high order but also a patriot of no mean order, is exemplified in the actual working of the hospital and the College under his charge. Dr. Mehta may look at times as a bigotted Indian on account of his strong convictions which made him more than once a guest of His Majesty, the King, the guest-house being the jail. He talks and writes what he feels and the rigour of his convictions could be seen prominently in his actions. He may have faults, which man has not? The two institutions, the College of the Hospital attached to it are the monuments of Dr. Mehta's convictions. Though an ardent and uncompromising lover of things Indian, Dr. Mehta had realised that the modern scientific methods of teaching and practising of medicine should be copied wholesale from the West, which he has been doing fearless of consequences at times, costing him dearly the displeasure of a few colleagues of his, whose intriguing influence he could defeat with marvellous courage. We wish we had a few more Mehtas with all their faults, in charge of Medical Teaching Institutions in India.

ANNUAL REPORT

OF

THE UNION MISSION TUBERCULOSIS SANATORIUM,

AROGYAVARAM,

Near Madanapalle, South India.

1939—40.

The report has been so well arranged that it is useful and pleasant reading to the members of the medical profession as well as to the lay public interested in the prevention and cure of the fell disease, Tuberculosis. The Sanatorium is now under the direct charge of Dr. P. V. Benjamin who has spent almost all his life in this institution. The services of the permanent Medical Superintendent, Dr. C. Frimodt-Moller being lent for the last two years to the Tuberculosis Association of India of which he is the Medical Commissioner.

The number of beds available in the Sanatorium which was 109 in the year 1915 when the sanatorium was opened, is now 249. There are 9 General Wards with a total of 134 beds, 7 wards contain 18 beds each, of which 5 are for men and 2 for women. To each of these sections is attached a smaller ward of 4 beds intended for Anglo-Indian men and women respectively. There are two semi-general wards each with 4 beds, one for men and the other for women. There is also a temporary ward of the same type with 5 beds. In addition to the above, there are 102 special wards containing one or two beds.

The statistics relating to the admission is so methodically arranged that in addition to the enumeration of sects and communities, occupation, age, territorial distribution are mentioned in the report. Amongst those admitted, males seem to be in predominance, and the Hindus form the bulk of the population of the sanatorium. It is mentioned in the report that amongst those admitted students are the highest in number. Next to them come the cultivators, clerks and teachers. The age between 21 and 25 is mentioned in the report as the period when the disease attacks people in large numbers, the next periods being 26-30 then 16-20. The greater the age, the less the chances of infection. Though childhood is said to be another period when the chances of infection are said to be great, the number of children admitted into the sanatorium is very low.

The medical statistics is so arranged that it will be of great educative value to the members of the medical profession. So is the statistics relating to different methods of treatment, medical and surgical, adopted in the sanatorium. The institution has been a training centre for the members of the medical profession coming from all parts of India and since two years the Government of Madras who have instituted the special T. D. D. Diploma, have made the sanatorium as the training centre for practical and clinical work relating to this course which runs for nine months, 3 months being spent in the Madras Medical College and six months in the sanatorium. This apart, the sanatorium has been supplying from amongst its staff, medical men to be in charge of sanatoria that are being started recently at the instance of the Tuberculosis Association of India. In fact the Arogyavaram Sanatorium has now turned out to be a model institution to be copied by all in this country, who are interested in leading a campaign against tuberculosis. The institution is also providing from amongst its staff, personnel for advisory and survey work conducted by the Central Tuberculosis Association of India and its Provincial and State Affiliated branches.

On 19—6—1940, the sanatorium celebrated its Silver Jubilee under the presidentship of Rev. B. Rottschafer and Mr. now Sir G. T. Boag, Chief Advisor to the Government of Madras opened on that day the Recreation Hall dedicated to the memory of Dr. and Mrs. C. Frimodt-Moller both of whom spent their lives at the sanatorium and were able to bring it to the prominance which it now commands. Dr. (Miss) Ida S. Scudder unveiled a tablet on the same day in the Patients' Library and Reading Room, associating the name of Miss Gartrude Dodd with that part of the building dedicated to Dr. and Mrs. Moller.

The Arogyavaram Sanatorium had been turning out excellent work in all directions in the cure and prevention of Tuberculosis and deserves praise and encouragement from all quarters.

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The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,

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CONTENTS.

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Original Articles

WHOOPING-COUGH

By

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

Hon. Physician, Government General Hospital, Madras.

The fact that whooping cough though a most distressing and equally a fatal disease, has not been sufficiently recognised as such by the public in this Presidency if not in this country and that at present sporadic cases are seen in the city of Madras as well as in the mofussil, prompted me to take up the subject of whooping cough. India though a hot-bed of all known diseases and many more peculiar to its position in the tropics, has not as yet attained the importance in the field of study and research relating to medicine though it is said and acknowledged that in ancient days she gave materials to the rest of the world for the treatment of diseases. Up to date well-equipped hospitals, at least those attached to the medical teaching institutions, have been springing up in India but to the same extent facilities for study and research, are still wanting and the postmortem study is exclusively in most cases devoted to help the Police in the investigation of causes of death in criminal cases. The peculiar conditions prevailing in India which prevent hospital authorities to investigate causes of death and the pathological conditions which led to it, have been hampering seriously the study of such of the diseases which could not be properly and correctly diagnosed during life in spite of all available facilities for the purpose. Whooping-cough is a disease rarely seen in the hospitals in India though seasonal epidemics of this disease have been prevalent in India, which must be the cause for a large number of deaths of infants and children and which must be also a predisposing cause for the prevalence of tuberculosis in this country. It is indeed more distressing than the agony of infants and children that whooping cough has not attracted the serious attention of the public and of those in charge of the welfare of the public.

With the above introduction I shall attempt to give a clinical picture of whooping-cough, mentioning briefly the aetiology, bacteriology and pathology, complications and sequelae, prognosis, diagnosis and treatment. I cannot claim any originality while I discuss the several items pertaining to this disease. I will only put forth a few personal observations attempting to impress on the readers that though no specific has yet been found

out for whooping-cough, the practitioners can to a great extent relieve the distress of the little ones and at the same time prevent the complications and sequelae of the disease. When it is known that the most probable sequela of whooping-cough is tuberculosis of lungs, one can imagine the valuable service the practitioners may render in preventing the the spread of tuberculosis.

DEFINITION: Every practitioner knows that whooping-cough is a specific infectious disease which has derived its name from its peculiar symptoms, attacks of spasmodic cough followed by crowing inspirations popularly known as whoops.

AETIOLOGY. The cause of whooping-cough is now established to be the infection due to the bacillus of Bordet and Gengou, a Gram-negative organism. Though we have to depend entirely on observations and conclusions arrived at by foreign physicians relating to the history of this disease in all its details, yet we may be able to point out certain variations in such history depending upon Indian conditions, All agree that this is a disease most common in children especially those within two years of age and that one attack generally establishes immunity to ensure freedom from a second attack. The present tendency is towards the idea that no age is exempt from infection and that infants are prone to catch the infection as frequently and as easily as more grown-up children but the symptoms may not manifest as a typical case of whooping-cough. The seat of infection may be the brain or the gastro-intestinal tract as was demonstrated in autopsies of infants. Rare cases of whooping-cough may be seen in adults in this country as in other parts of the world and it is presumed that majority of adult population must have earned immunity after an attack of the disease in earlier life. Regarding sex, books say from satistics collected by their authors that the female children suffer more than the male and that mortality is also higher in the children of fair sex. With reference to climate, it is said to prevail mostly in the spring in cold climates but the experience in India especially in the Madras Presidency indicates its prevalence as an epidemic at the change of seasons and in the city of Madras attacks seem to be more during summer when the vitality of infants and children is at low ebb as could be evidenced by the fact of the prevalence and consequent deaths in children from summer diarrhoea. The incubation period is said to be from one to three weeks. Though the period of infectivity may be different in different children. It is found out that a patient suffering from whooping-cough is not infective after six weeks from the time of the appearance of first whoop. This has been definitely proved by experiments conducted in English schools during the epidemics of whooping-cough. After six weeks, susceptible children might, it is said, safely move with those who had the attack and in whom paroxysms of cough may continue.

PATHOLOGY: Though the characteristic whoop in children is the deciding factor in diagnosis, the practitioners must have come across persistent cough in children without the whoop and with no lung signs. In these cases bacteriological examination must be the only aid to diagnosis. For this purpose potato-lactic-acid-blood-agar medium is put in Petri dishes and exposed to an infected patient during a fit of coughing and colonies of the organism may be seen in the dishes. This test is used in England and other countries and is considered to be the most reliable method not only for diagnosis but also to determine the period of infectiveness in individual cases.

In the early stages of whooping-cough, the number of white cells is increased, the increase is due to lymphocytes which may number 15,000 to 30,000 per c.mm. This blood picture with the presence of cough gives good grounds for the diagnosis of whooping-cough. There are no chances in India of witnessing autopsies relating to deaths from whooping-cough excepting accidentally. Most salient, morbid anatomical characters reported in books are repeated here to refresh the minds of readers so as to make them realise

how neglected cases of whooping-cough lead on to disastrous results accounting for sudden tragic end of the lives of children: "The anatomical changes produced by whooping-cough as opposed to its complications are not as a rule striking. The body of a child dead of uncomplicated whooping-cough shows some reddening of the trachea and larger bronchi. If death has taken place early in the illness, suitably-stained sections of the trachea show Hæmophilus pertussis lying closely packed under the lining membrane. Later in the illness the lungs are studded with recently-formed emphysematous bullae. The rupture of such a bulla into the mediastinal fold of the pleura on occasions, gives rise to gross surgical emphysema extending up under the skin of the neck and face. Such an occurrence, though by no means always fatal, leads to post-mortem manifestations as typical as those it gives rise to in life. Less frequently an emphysematous bulla bursts into the pleural cavity leading to pneumothorax with collapse of the affected lung. In fatal cases in young children and babies, multiple small haemorrhages are sometimes found scattered over the meninges and in the substance of the brain and spinal cord."

CLINICAL SIGNS AND SYMPTOMS: Every practitioner is quite familiar how whooping-cough starts insidiously with signs and symptoms of ordinary cold and how after a week or so cough takes the place of the running from the nose. Later, cough takes a prominent place and at this stage there may or may not be any signs in the lung and if there were to be any, they may be a few rales here and there. The throat at this stage and later till the end of the attack looks red and the enlarged tonsils get worse. The appearance of the characteristic whoop is the marking point of the malady. It starts with any reflex—it may be an emotion, a laugh or a cry. It may start with the mere sight of food or during the act of swallowing. The fit of cough is so severe at times that the onlooker feels that the life of the child will come to an end for want of breath. Face grows first red and then blue, froth dribbling all the while from the mouth. The child tries to catch anything it can get at. The neck with veins distended, looks swollen, eyes suffused. At last the typical whoop comes on when the fit of coughing may stop or one or two more paroxysms may follow. A lump of thick tenacious mucus may be brought out at the end of a whoop or emptying of stomach may follow the terminal whoop. The patient then looks pale and exhausted, may then get into a tiresome sleep on the mother's lap or arms or if a troddler, he or she may sit for a while rubbing the watering eyes or wiping the frothy mouth and soon after mixes with his or her playmates. Suffering varies with individual patients. The paroxysms may be far between or very frequent occurring even every half hour. Attacks are worse at nights perhaps due to closed rooms.

The duration of illness also varies, the average is from four to six weeks and there are cases where the paroxysms of coughing continued six to eight months. There is another factor to be remembered in the course of illness. If during the course the patient has an attack of pneumonia or any infective fever such as measles or small-pox, the paroxysms may disappear till the course of the intercurrent disease and appears in greater severity later. There are also cases when the whoop disappeared altogether and later, after six months or even after a longer period if the patient suffered from pneumonia, otitis media, etc, the whoop appeared again. Many a time the symptoms of whooping-cough are not characteristic at all. In infants under one year the whoop is not so prominent a symptom as vomiting is. Very young babies manifest brain symptoms instead of those of the lungs. Fever is not a constant factor. At the beginning of the infection older children may have a temperature not above 100°. But in the case of infants there may be marked rise ushering brain symptoms. In order children who have low fever and in whom lung signs cannot be detected at the beginning of the illness when the characteristic whoop has not begun, one may notice higher respiration count disproportionate to fever and pulse. This phenomenon should put a practitioner on guard during

the prevalence of whooping-cough in a house or a locality. Such cases will invariably turn out to be typical cases of whooping-cough. Even in advanced typical cases there may be no lung signs excepting a few rales or rhonci. Towards the end of the illness unless the case was very mild patches of emphysema of varying dimensions may be detected even after months when the patient is free from whoop. Usually the mediastinal glands are enlarged and on percussion the lung area covering the mediastinal glands is dull. The enlarged glands may be made out by X-ray. Bronchitis and pneumonia are the usual attendant complications. At times there is rupture of small blood vessels in the eyes or in the skin of the face.

COMPLICATIONS AND SEQUELAE: The most common complications are bronchitis and pneumonia and emphysema. Generally bronchitis leads on to pneumonia in infants and proves fatal. Still more serious complication is the flaring up of an underlying tuberculous infection. The starting point of the spread of infection are the mediastinal glands from where the morbid process may involve the lungs or manifest itself as generalised tuberculosis.

Convulsions and more serious complications relating to nervous system are common in infants. In fact these complications may be the only manifestations of the disease masking the actual lung symptoms, the real illness being diagnosed in the post-mortem room by local and bacteriological examinations.

In infants under one year complications relating to gastro-intestinal system are of common occurrence and it is said that the bacillus Haemophilus pertussis could be detected in large numbers in the stomach and intestines. Gastro-enteritis is usually a fatal complication.

PROGNOSIS: Uncomplicated cases of whooping-cough in a healthy child above one year do not generally forbode any risk of life. Under one year the disease is often fatal the danger being due to complications mentioned above.

DIAGNOSIS: A typical case of whooping-cough especially if the patient is a child, is not likely to be confused with any other illness. In suspicious cases during the early stages of the disease, the characteristic blood picture outlined above and the bacteriological test, will help materially in arriving at diagnosis. Yet in less characteristic cases difficulty in diagnosis may arise.

In young babies much difficulty will be felt to arrive at correct diagnosis if the lung symptoms are being masked, giving place to brain or gastro-intestinal symptoms. Culture tests may dispel doubts in these cases, if facilities of laboratories are available.

TREATMENT: As in all infectious diseases, the treatment of whooping-cough has to be preventive as well as curative. Prevention of whooping-cough is still a problem. Isolation is as ineffective as the protection by prophylactic vaccines or convalescent serum. This is not only my experience but the experience of eminent physicians including authors amongst them. Two types of vaccines are in use. One is an emulsion of bacteria killed by heat; the other is a product obtained from grinding up living bacteria. Some advocate large doses which do not produce local or general reaction. The dose being 20 to 30 thousand million bacteria weekly. Others report favourable results in much smaller doses. Even taking for granted that the vaccine confers immunity, it should be given sufficiently early, *i.e.*, 2 to 6 weeks before a contact is exposed to infection as antibodies can develop only two to six weeks after the administration of vaccine. The nature of infection in whooping-cough is such that it is hardly possible that a contact, is not infested within 2 to 6 weeks and even if this is possible, opinion is almost unanimous that those protected by the vaccine do get the attack though it is said, the attacks are milder. Detoxicated vaccine is of some value in lessening the severity of the attacks. The result of immunisation by convalescent serum is reported to be quite useless.

As yet no specific has been found for whooping-cough. Once the disease has developed vaccine or convalescent serum is not of any avail. So the treatment has to be symptomatic depending entirely on indications at different stages of the disease and its complications. Open air treatment in sanitary surroundings, is best suited. In India especially in this presidency there is no risk of children catching cold in open air. The patients are comfortable in the open air and do not as a rule get frequent fits of cough. It is desirable that during the febrile stage the patients should have complete rest on bed and even during a febrile stage exertion should be avoided. Food should be very nutritious, given in small quantities at frequent intervals so that a loaded stomach might not cause more distress during paroxysms of cough. As the upper respiratory tract is more or less in an inflammatory condition, warm food is indicated. In addition to easily digestible and nutritive diet, the patients must be given vitamins A, B, C & D and an elegant preparation of calcium. Reinforcing the system with vitamins and calcium is likely to prevent graver complications. In the early catarrhal stage with slight fever an alkaline mixture with suitable dose of Tinct. Camphor Co. is all that is necessary, the bowels being kept open if necessary with a mild laxative. The best drug for this purpose is calomel in divided doses. It is in the paroxysmal stage that the patients require relief and it is the treatment at the stage that baffles the therapeutic knowledge of every practitioner. In books authors make mention of drugs whose usefulness vary with each author. The only two drugs that find a place in almost every book, are belladonna and camphorated tincture of opium. The rational indications that are to be considered are:—(1) to make the mucus in the bronchioles, less tenacious and viscid (2) to relieve the spasm in the bronchioles, and (3) to depress the cough reflex. These indications are met with in a prescription as the following; the doses in the prescription are for a child 2 years old:

Soda Benzoas	grs. 30
Ammon. Chloride	grs. 15
Ext. Glycyrrhiza Liq.	drs. 2
Tinct. Camphor Co.	mms 48
Tinct. Belladonna.	mms 15
Aqua ad	ounces 2.

2 teaspoons every 4 hours.

Soda Benzoas is a drug highly talked of by Burne and Yeo to be very effective in liquifying ropy mucus in the lungs and they rely on this one drug only in cases of pneumonia in children and say that it does the work of an emetic in bringing out the phlegm without actually producing emesis. Ammon. Chloride has more or less the same effect though not to the same extent and in addition, is a stimulating expectorant acting on the mucous surface of the bronchioles. Both these drugs in combination are likely to help the child in bringing out viscid mucus in the act of coughing. Tinct Camphor Co. is a very mild preparation of opium that can be safely prescribed for children. It would materially deaden the nerve ends of the bronchioles and control reflex cough. It will control secretions but not check them altogether as the stronger preparations of opium do. Indirectly it would serve as an antispas nodic also. Belladonna is a sovereign remedy for relieving spasm and lessen the secretions and children bear this drug wonderfuliy well. Glycyrrhiza is a demulcent and of sweet taste and therefore will be an elegant adjunct. Some authors advocate the use of belladonna in physiological dose in the early stage of the disease to relieve catarrhal symptoms. The use of big dose of belladonna in the early stages of the disease is to be deprecated. It is not desirable to check secretions in the early stages as secretions and even fever are nature's attempts to 1st out toxic material from the system and if belladonna is pushed on unnecessarily, the toxins are likely to accumulate and concentrate in the system. Moreover the suffering of running from the nose is nothing compared with the agony of the later paroxysm. At this stage bacteria and their products are coughed out and there are secretions in the lungs more than necessary. But the spasms prevent the egress of the secretions. Non-specific drugs in diseases are always lesser of the two evils —the drug and the disease

—and so the drug is to be used at a stage when the evils of disease are more than compensated for by the drug. The secretions in the lungs should not be checked more than necessary and this should be very well remembered in the treatment of whooping cough. The tendency to use stronger preparations of opium such as morphia should not be encouraged. A host of drugs and preparations are mentioned as sedatives, of which bromides of potassium and ammonium may be drugs of choice to be given as and when necessary either in the first or second stage. These are harmless sedatives having no action on secretions. Chloral hydrus ranks next. Bromoform is mentioned by some but bromide of potassium or ammonium can do the work of bromoform with much less risk or no risk. When cough persists from pulmonary complications hot lin-seed poultices every 4 hours are very useful, with a little mustard added to it. Its place may be taken by Antiphlogistine in case of patients whose parents can afford its cost. William Squire and Osler speak very high of quinine in all stages of whooping-cough: One gr. dose for every age twice or three times a day, is recommended by them. If the child cannot stand the taste, it may be given by rectum. Ether in olive oil per rectum is mentioned in recent books to relieve the paroxysms. Its action as a sedative is doubtful but it is a valuable stimulant. Most of the remedies vaunted for cure of whooping-cough owe their repute to their having been administered in the later stages after the sixth or eighth week of illness when other preparations are said to have failed and the disease is nearly over.

Venkatachalam and Ratnagiriswamy in a contribution to the Indian Medical Gazette, a reprint of which appeared in The Medical Practitioner some months ago, discussed that whooping-cough is primarily a disease only of children in whom reproductive organs did not function as in adults and presumed that artificial stimulation of Anterior Pituitrin which develops and controls the activity of gonads was likely to relieve the symptoms of the disease. They have quoted statistics in support of their theory. They treated cases of whooping-cough with success using a preparation of pregnancy urine akin in action to Antutrin. S. of Messrs. Parke, Davis & Co: and also with latter preparation. But none else so far in the medical profession seem to have come forward in support of this theory. This research has been referred to for the purpose of stimulating thought.

The third stage of whooping-cough is one of convalescence. Much harm is done by sending children out for play or change of air before convalescence is secure. Change of air has a remarkable effect in restoring appetite and removing spasm when the disease is quite over. The danger of tuberculosis infection should always be borne in mind at every stage of the disease especially during convalescence. Although the treatment of whooping-cough is entirely palliative, a lot of good can be done to the suffering patients to prevent severe attacks of the disease and disastrous complications and after effects. There is much scope for the application of these principles. Optimism always pays. It should be so also in medicine.

REFERENCES. Osler's Text Book of Medicine.
Hare's Practical Therapeutics.
The British Encyclopaedia of Medical Practice.

NOTICE.

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DAGENAN (M. & B. 693) IN THE TREATMENT OF CHILDREN'S PNEUMONIA.

BY

DR. V. RAMA KAMATH.

Dagenan (M. & B. 693) chemically known as Sulphapyridine has come into world-wide use to an extent that medical practitioners do not generally think of anything else except this preparation the moment they diagnose the ailment from which their patients suffer to be pneumonia. My experience about this preparation is very limited and that gained in private houses of patients. My faith in chemotherapy depended mainly on books and journals. Practitioners like myself usually get baffled, if they do not get results during the course of treatment of diseases with the help of new preparations whose success is highly talked about. M. & B. 693 is one such preparation for the treatment of pneumonia lobar, lobulur or midway between the two as diagnosed by ordinary clinical methods.

My experience relating to Dagenan limited and depending entirely on clinical circumscription, has been that this preparation has marvellous effect only on lobar pneumonia and primary brancho-pneumonia in both of which micrococcus lanceolatus and diplococcus pneumoniæ of Fraenkel are the predominant organisms. But in secondary broncho-pneumonia which occurs as a sequence of infectious fevers such as measles, whooping-cough, small-pox, diphtheria, influenza, typhoid fever etc. and in secondary pneumonia which manifests itself as the so called aspiration or deglutition pneumonia whenever the sensitiveness of larynx is benumbed as in coma due to any cause or apoplexy, Dagenan is of little or no avail and the maximum good it can do perhaps, is to lessen the severity of the streptococcal infection but not cure the disease.

Microbes that are present in the sputum of patients suffering from secondary broncho-pneumonia, do not usually belong to any known species. The presence and multiplication of streptococci and staphylococci generally seen in the sputum of secondary broncho-pneumonia is analogous to the presence and breeding of organisms in a stagnant pool of water. A running stream is usually purer unless it is contaminated with micro-organisms accidentally. It is the stagnation of blood in the lungs in the course of infectious fevers and contamination of the lungs due to food particles or infection from the mouth, pharynx or larynx in aspiration and deglutition pneumonia that give rise to secondary pneumonia. So the indication for treatment in secondary pneumonia is to prevent stasis of blood in the lungs and prevent contamination of the lungs during aspiration and deglutition in patients suffering from coma, apoplexy, etc. It must be remembered that preparations belonging to sulphanilamide group are toxic and that they affect the constitution adversely, deteriorating the quality of blood and also the digestive and urinary systems at times to a dangerous extent. So while attempting to kill the organisms or lessen their growth and virulance, we should bear in mind that the preparations given for the latter purpose do not kill the patients or retard the chances of their living. This aspect of the action of sulphanilamides should be specially borne in mind while treating children suffering from pneumonia.

From the statistics appearing in books very few of them written in India either by private practitioners or by Government Medical Officers, it is seen that lobar pneumonia as such rarely attacks children under two years, "to the sixth year the predisposition is marked, it diminishes to the sixteenth year but then for each subsequent decade it increases." Whereas primary broncho-pneumonia is most common in children under two years and it starts as abruptly as the lobar does in adults in

apparently healthy robust children and it is said terminates in a crisis as does lobar pneumonia. It is only in pucca lobar pneumonia and in the broncho primary pneumonia in children that M & B 693 proved very successful in my hands so much so that at times the parents even suspected whether the cases were pneumonia at all as invariably the temperature touched normal within 24 hours after the administration of Dagenan and the children had little or no cough and other attendant symptoms of pneumonia which the parents were accustomed to watch most anxiously before chemotherapy revolutionalised the treatment of pneumonia. To the same extent I should say pushing indiscreetly sulphapyridine in children suffering from secondary broncho-pneumonia must have increased the mortality rate. In secondary broncho-pneumonia all attempts should be directed in maintaining the resisting capacity of patients not by drugs only but by suitable diet and regimen. For reasons mentioned above, the rational treatment to be followed in the treatment of secondary pneumonia is to prevent stasis of blood in the lungs and maintain the resisting capacity of the system. I am not in a position to condemn the use of sulphapyridine in these cases but the few cases of secondary pneumonia I treated after the reputation of sulphapyridine came to stay. as in measles, whooping cough and typhoid fever got over without the administration of sulphapyridine. I have been using this preparation with very good results only in cases when pneumonia starts as such in children and not at all in secondary broncho-pneumonia.

The chief purpose of my writing this article is to report my experience relating to a few cases of pneumonia in children under two years of age which came under my treatment in the course of last two years. Three of these were typical for the purpose of demonstrating what I have in my mind.

The *first patient* in the series was a male child in Triplicane aged one year and four months. The child was brought to me on 8-3-40 with a history that he had a severe attack of catarrh, attendant with high fever and cough and was treated as an out-patient for six days by a local practitioner for bronchitis. The patient looked very ill perspiring profusely in the forehead resting his head on the mother's chest ; breathing was shallow and the alae nasi were moving up and down. But for this and an occasional hum there was no other sign of distress. If there was not good light in the room where I saw the child, I would have missed to see the movements of the alae nasi. There was no rattling in the throat. Temperature noted in the rectum at about 10 a.m. was 102°, pulse 140, respiration 60 per minute ; tongue moist but furred and the child was cutting teeth ; coughed once or twice within a period of about one hour when the patient was in my room. On percussion a pretty big patch of consolidation could be made out below the lower angle of right scapula. Auscultation revealed moist rales throughout the left lung but not so many in the right. The child was put on one-third tablet of 0·50 gm. Dagenan every 4 hours. An alkaline expectorant mixture containing Pot. Citras and Ammon. Carb. with brandy was prescribed. Usual advice relating to diet and regimen was also given.

The next day I was shocked to see the child brought to me and when I rebuked the mother that she did lessen chances of the child's recovery as the child was suffering from a grave disease, pneumonia, she retorted and said how could her child suffer from pneumonia when the child had no fever. She said that her husband recorded the temperature twice in the rectum that morning before they left home and that the temperature was only a point above normal. She added that she was taking the child to their doctor in Triplicane almost every day before the child was brought to me and that doctor did not find fault with her. Thinking that there was not much use in discussing with the mother, I told her to send her husband to me the following morning and in case the child was brought to me again I would stop treatment and she might as well take the child to any other practitioner. As advised the father came to me the next day and I explained to him about the seriousness of the case and that the child should have absolute rest in bed. He said that I did not give him this advice and as they used to take the child to the other doctor who had been treating the patient almost every day, his wife brought the child a second time to me specially so because that I diagnosed the case as pneumonia and the other doctor said it was bronchitis. His wife wanted to be sure of the diagnosis.

For two days after the administration of Dagenan the temperature kept on to normal in the morning and a little less than 99° in the evening. On the 3rd day of treatment it shot up to 103°F and kept steady. By this time the lungs cleared up to a great extent. I consulted Dr. K. Narayana Murthi, Hon. Physician, Government General Hospital. He examined the blood and said that there was a tendency for leukopenia. Immediately the chemotherapy was stopped. There were no other signs and symptoms to indicate intolerance to sulphapyridine. By this time the lungs were almost clear excepting for slight dulness in the area of consolidation. I had to leave Madras entrusting the case to a junior practitioner close by to the patient's residence. I returned to Madras after a week and saw the child running a remittant temperature ranging from 101 to 103°F. An idea was put into my head by the father of the child that the case might be typhoid fever. The father got the idea from the attending physician who was introduced to me by Dr. K. Narayana Murthi. I did not slight the idea and got the blood examined for Widal's test which was negative. The blood picture was normal. The temperature was gradually coming down and on 11-4-'40 a month and three days after I first saw the child the morning temperature reached normal the evening reading being 100° and a week later the evening temperature was also normal. During the stage of remittent fever the child was put on Vitamin A. & D. and Vitamin C. In addition the child was also given an alkaline diaphoretic mixture with urotropine and brandy and another containing quinine hydroch and calcium hypophos.

Alkaline Mixture.

Pot. citras	grs.	20
Ammon carb	grs.	6
Urotropine	grs.	10
Syr. Aurantii	drs.	4
Aqua ad	ounces	2

2 teaspoons 4 times a day (8 A.M. 12 noon 4 P.M. & bed time).

Quinine Mixture.

Quinine Hydro Ch.	grs.	4
Calcii Hypophos	grs.	4
Tinct. Aurantii	mms.	20
Glycerin	drs.	2
Aqua Chloroform ad.	ounce	1

N.B.—*No acid should be added to the mixture to dissolve quinine. The quinine should be dissolved in boiling water about 2 to 3 drs. and added to the mixture. Aurantii is a flavouring agent. Glycerin is a mild laxative and in addition reduces the bitter taste of quinine.*

Of course, glucose was continued all through the course and there was no need for any advice regarding its administration as glucose and ovaltine are now household necessities during any illness and the house people make mention of them before the doctor prescribes any diet to his patients.

The *second case* in the series was a male child 11 months old, in Purasawalkam. I was sent for to see the child on the very day in the evening when the child got suddenly ill with high temperature 104·2°F in the rectum. There was slight running from the nose. Breathing rather distressed, respiration 54, pulse 130, per minute. Percussion could detect a small patch of relative dulness at the base of the right lung where the breathing was tubular. The breathing in the rest of the area in the right lung was defective, compared with that in the left lung where the breathing throughout was relatively harsher. No adventitious sounds could be found in the lungs. I had a doctor friend in my car Dr. K. V. Krishna, a senior practitioner from Malaya. I requested him to have a look of the patient. He examined the patient and agreed with my observations. We decided to have recourse to chemotherapy and the

one of choice was M & B 693. My friend strongly advocated the use of Antiphlogistine in addition and I agreed. ¼ of a tablet 0·50 gm. was prescribed every 4 hours with an alkaline mixture containing only Pot. Citras. The patient was first seen on 12-11-'40 and on 15-11-'40 temperature touched 99° in the morning and 101° in the evening. On 17-11-'40 morning and evening temperature was normal. Patient began coughing after temperature touched normal. Dagenan was stopped. On 18-11-'40 the temperature shot up to 102° and nasal catarrh which was absent since the 11th reappeared and persisted till recovery. The dull area at the base could not be detected after 21-11-'40.

On 22-11-40 I saw the gum in the upper jaw in the area of the incisors red and swollen. Thinking that the persistent temperature might be due to teething I scraped the gum with the finger nail taking all aseptic precautions and brought out both the incisors. This had a temporary effect on the temperature. The temperature came down to normal the following day but went up again after 2 days. But there was a gradual fall since then. Both morning and evening the temperature was normal from 11-12-40. The child was given vitamin A & D and vitamin C as in the case of patient referred to above. The patient was also given Potassium Bromide now and again when there was nervous irritation due to teething.

The *third patient* in the series was a female child 9 months old. She was brought to me on 9 8-41 and it was a strange coincidence that Dr. K. V. Krishna was with me that day. The grandmother who brought the child gave a history that the child had cold and cough for about a week and suddenly got high fever the previous night. The child was examined by me and Dr. Krishna. Temperature in the arm pit was 101·4° at 9 a. m. Profuse running from the nose. Both lungs showed signs of bronchitis. A small area of consolidation could be made out in the left lung below the angle of scapula. The child did not look very ill and was having moist cough. Dagenan was prescribed, ¼ tablet of 0·50 gm. given every 4 hours with an alkaline expectorant mixture. My friend Dr. Krishna forgot about his favourite application, Antiphlogistine in this case. The temperature was normal on 13-8-40 but evening temperature that day was 101° F. On 15-8-41 temperature shot up to 103° F and continued to be of a remittent type ever since. Lung signs and symptoms showed marked improvement from the very commencement of treatment. Though fever was persisting, the lungs were getting clear. Dagenan was not stopped in this case though the frequency of doses was reduced. As soon as the temperature rose up, Dagenan was given every four hours and stopped altogether after 2 days as it had no effect on fever. On 1-9-41 I put the child on the alkaline and quinine mixtures both containing ingredients as in the case of first patient in the series.

Two days after the administration of the above 2 mixtures the temperature was admirably controlled and the temperature has been keeping normal from 5-9-41.

CONCLUSION.

1. Sulphapyridine must be the preparation of choice in the treatment of lobar and primary broncho-pneumonia. The knowledge gathered by me from books during my student days that lobar pneumonia and primary broncho-pneumonia in children are due mainly to the infection of micrococci lanceolatus and diplococci pneumoniae of Fraenkel, the marvellous effect of M & B 693 on temperature and condition of lungs noticed in children's pneumonia which is usually primary, due to infection of the cocci mentioned above, indicate that chemotherapy in pneumonia is most effective in cases of pneumonia due to micrococci lanceolatus and diplococci pneumoniæ of Fraenkel.

2. The persistent remittent temperature noticed in the three children after the cessation of fever and lungs symptoms indicates that Dagenan has no effect on streptococci and other organisms which get themselves mixed in pneumonia infection, at least to the extent it has on the micrococcus lanceolatus and diplococcus pneumoniae of Fraenkel and that the persisting temperature might be due to secondary infection or other internal constitutional causes. I may add that Dagenan is likely to lead to disastrous results if pushed in secondary broncho-pneumonia.

3. There is no necessity of giving large doses of M & B 693 as is usually mentioned by some. This preparation is a double edged weapon to be used with care and caution.

4. Any amount of care and caution on the part of practitioners will not be too much while treating children under two years of age. This is a period of dentition in children when their nerves are very delicate and any illness is likely to be exaggerated during the period. So in addition to chemotherapy, other useful measures should be adopted to help the resisting capacity of children during the attacks of pneumonia. Deficiency in Vitamin A & D and even B and C should be thought of and met with during the course of treatment of pneumonia in children.

5. Quinine in small and judicious doses is a wonderful drug especially in diseases due to any infection. It helps phagocytosis.

6. Last but not of least importance is the necessity of practitioners realising that they should not hesitate to give instructions to their patients in detail even to a fault. At times practitioners feel delicate to insist on rest during illness as many a time the patients misunderstand the advice, thinking that the doctors give this advice to increase their visits. Seniors especially those in the position of consultants should lead a way in this direction. We know as a matter of fact that there were a few cases of death in this city where a few eminent medical men themselves fell a prey to diseases like typhoid fever for want of rest in early stage.

Abstracts.

SYMPTOMS OF ALCOHOLISM.*

PHILIP PIKER, M.D., CINCINNATI, OHIO.

On consideration of what material to include under the title "Symptoms of Alcoholism," it seemed to me that a detailed, formal description of four or five well known alcoholic syndromes might constitute a waste of your time and attention. The various shades of classical acute intoxication, from conviviality to coma, are unfortunately all too familiar. The more spectacular physical, emotional, vegetative, ideational, and sensory symptoms of delirium tremens present few diagnostic difficulties. We know, or should know, the organically degenerative and emotionally disintegrative results that are possible with chronic alcoholic excesses. Korsakow's psychosis has become sufficiently identifiable psychiatrically to permit diagnosis even without the erstwhile complementary neuritis—and, indeed, at times without the formerly necessary proof of alcoholism. And it would seem that clinicians generally are becoming sufficiently well acquainted with pathologic intoxication to realize that the alcoholic factor in this condition represents merely an indicator of defect, and that the illness itself is made up primarily of the patient's sensitivities and intolerances.

Perhaps, however, a brief recounting of the more characteristic gross psychiatric changes of some of these syndromes would be in order at this point. The acute alcoholic may be gay, excited, belligerent, maudlin, or depressed; and his judgment will be defective, as may be his orientation and his mental acuity generally. Increasing degrees of intoxication will find his threshold of response and ideation becoming higher, until stupor and then coma supervene.

In delirium tremens, the premonitory development of insomnia, anorexia, apprehensiveness and restlessness are characteristic. With the disease in full bloom these symptoms become exaggerated, and vivid hallucinatory and delusional experiences are added. The hallucinations may involve any of the senses, but are for the most part visual in nature. Extremes in emotional displacement occur, with intense fear the most constant affective development. To be kept in mind here, as with all deliria, is the frequently fluctuant character of the psychosis; and a few hours of normalcy is not to be accepted as evidence of complete recovery, lest disaster follow relaxed vigilance over these patients.

Korsakow's psychosis is essentially an organic syndrome which results from pathology not necessarily associated with alcoholism. As with organic brain changes generally, memory and judgment defect are particularly prominent. The memory is most unreliable for recent events; and associated with this defect is the practically diagnostic symptom of confabulation. The syndrome may develop gradually as the result of many years of drinking, or may appear suddenly during or immediately following alcoholic deliria. In the latter event, recovery at times occurs in from a few days to a few weeks. It is to be kept in mind that Korsakow's syndrome may be ameliorated in some instances, by abstinence and adequate nutritional support, even after existing for as long as six months to a year.

Some clinicians think of pathologic intoxication in terms of particularly violent, bizarre, or overwhelming reaction to alcohol, regardless of the amount ingested; while others prefer to limit this diagnosis to similar reactions which have been induced by minimal quantities. In either event the reactions are of extraordinary intensity, tend to recur in certain individuals with each alcoholic indulgence, and include violent excitements, spectacular deliria, twilight states, convulsions, coma, and mixed states.

* Read at a meeting of the Academy of Medicine of Cincinnati—May 20, 1941.

There is not sufficient time to discuss such conditions as acute and chronic alcoholic hallucinations, alcoholic paranoid states, pseudo-paresis, polioencephalitis superior of Wernicke, pellagra secondary to alcoholism, and leukencephalitis of the corpus callosum. In addition to all the sequelae of alcoholism mentioned, and frequently developing coincidentally with or as a precursor to them, is the simple alcoholic deterioration which spares few drinkers of long duration. This deterioration involves impoverishment of the intelligence, emotional disintegration, and personality disorganization generally.

Having thus cursorily dismissed symptom complexes with which you all are familiar, I hope you will permit me to indulge in a more or less rambling discourse on some of the more interesting or striking symptoms associated with alcoholism, and some of which are not usually considered in this connection. The phrase "associated with alcoholism" is used because the existence of direct casual relationship between alcohol and some of the phenomena that develop incident to its excessive use has been seriously questioned in recent years, and with considerable justification. Nevertheless, at the very least, we must grant alcohol the position of a predisposing or contributing role in the production of of such symptoms.

Some of the eye findings are worthy of special mention. The acute alcoholic pupil is exceedingly unpredictable, varying from wide dilation to almost pinpoint constriction in the same individual. In chronic drinkers one may find pupillary irregularity, inequality, and alterations in reaction. Nystagmus is a frequent development during a debauch, and probably occurs to some degree in every case of acute intoxication. The most violent horizontal nystagmus I have ever seen occurred in a patient with delirium tremens, and lasted about two days. Toxic amblyopia may be the result, at least in part, of excessive drinking; and the incidental diminution of visual acuity, impairment of color sense and development of scotomata suggest a possible organic basis for some of the hallucinatory experiences in alcoholic deliria. It is generally known that the application of pressure to the eyeballs of patients suffering with delirium tremens may evoke subjective visual phenomena. Because of these visual distortions, it has occurred to us to speculate regarding the possibility of vitamin A deficiency as a factor in the production of some of the symptoms in alcoholic deliria.

The respiratory apparatus may present changes which merit acquaintanceship. In the nose, irritative nasal catarrh may simulate the rhinitis of an acute upper respiratory infection. Chronic post-nasal catarrh occurs in chronic drinkers. Epistaxis in an alcoholic should suggest hepatic cirrhosis. Chronic pharyngitis is not uncommon. The larynx is the site of several possible complications of alcoholism. Simple acute laryngitis, the whisky voice of hypertrophic laryngitis, unilateral abductor paralysis, and tremor of the vocal cords are not rare. Contact ulcer of the larynx, hyperesthesia and paresthesia, and laryngeal vertigo have been described. In the lungs of alcoholics, pneumonia is apt to be apical and quite serious. Pulmonary edema should be kept in mind in acute alcoholic coma and in alcoholic convulsions.

The digestive tract contributes its share of derangements, some of which are acute and chronic gastritis, duodenitis, and impaired efficiency of the digestive juices. The beefy, red tongue of debauch and the smooth tongue of nutritional defect are well known. Achlorhydria is an incident of so-called alcoholic pellagra. A less well known complication is paralysis of the oesophagus, thought to be peripherally neuritic pathologically. The occurrence of the enlarged, tender liver of hepatitis is rather frequent during prolonged debauch. Cirrhosis occurs sufficiently frequently in chronic alcoholics to merit an assumption of some casual relationship, though the correlation of the various possible contributing factors have not yet been precisely worked out. It is felt by some that chronic alcoholism, through cholecystitis

secondary to intestinal catarrh, may predispose to the formation of gallstones.

Impaired hearing, tinnitus, or typical Meniere's syndrome is attributed to alcoholism at times, and may be helped by abstinence. Here again one may conjecture regarding the possible physical basis for some of the auditory phenomena of the psychotic episodes of alcoholism.

The kidneys seem to tolerate alcoholic excesses rather well. The acute alcoholism may result in acidification of the urine, albuminuria, and acetonuria, these findings are not usual, and are rarely significant of serious renal change. Indeed they may well represent additional evidence that alterations in carbohydrate and fat metabolism merit more consideration in attempts to understand the physiology and pathology of alcoholism than has thus far been accorded such alterations. Nonspecific urethritis with urethral discharge occasionally occurs with acute alcoholism, and may be directly due to it. The alcohol is not to be considered an aphrodisiac technically, its loosening effect on emotional blocks makes for practical erotic stimulation in many individuals. On the other hand, with the full weight of its depressant influence at work, impotence frequently results. It has been contended, though not scientifically established, that conception occurring while either parent is intoxicated may result in defective children. Acute alcoholism during pregnancy has been blamed for abortions, though this contention is viewed with skepticism in many quarters.

The effect of alcohol on the circulatory apparatus has been the subject of study and discussion in some quarters in recent years. I might mention here the fall in blood pressure that occurs in acute alcoholic coma, and point out that a marked drop is to be viewed with clinical alarm. Elevation of the systolic pressure, is a usual occurrence in delirium tremens. Tachycardia is common in the various acute alcoholic episodes, and tends to persist beyond the other symptoms. Peripheral vascular collapse in alcoholic coma, and particularly in delirium tremens, is a most ominous development, as is a persistent climb in temperature in delirium tremens. The vasodilation that results from alcohol ingestion, and which is apt to be particularly noticeable in the face, leads to flushing in acute alcoholism and permanently dilated vessels in the chronic alcoholic. Acne rosacea, teleangectasis, and petechial hemorrhage frequently make up the badge of the persistent drinker.

Some of the more dramatic or serious outgrowths of excessive drinking deserve emphasis. Acute alcoholism rarely is considered a serious illness, even by most physicians. Death, however, may result from what apparently is ordinary drunkenness, and should be kept in mind particularly when the patient's temperature drops markedly. In addition, subdural hemorrhage should be considered whenever a patient remains in what seems to be an alcoholic coma longer than four or five hours. Though no definite connection between alcoholism and spontaneous subdural bleeding has been established, statistics indicate an appreciably greater incidence of this disorder in alcoholics than in the population generally. Furthermore, one can never be certain that an inebriate has not fallen and suffered head injury.

Epileptiform convulsions occur in about 10 per cent of chronic alcoholics, usually during a debauch. I have seen approximately fifty such episodes, with each patient recovering. Despite the fact that this suggests that "whisky fits" are not necessarily of ominous portent, convulsions are never to be regarded lightly. Lennox's electroencephalographic findings of the epileptic brain waves in 10 per cent of the general population coincide with incidence of convulsions in alcoholics so closely as to suggest that here, as in pathologic intoxication, the alcohol merely acts to bring out latent defect.

The transient tremor of delirium tremens, as well as the more persistent one seen in many chronic alcoholics, is an interesting symptom. In the acute psychosis the tremor is often sporadic,

and at times seems to coincide with the fluctuation in the degree of apprehensiveness present. In both conditions, accentuation of the tremor is apt to appear on intention. This together with the nystagmus and ataxia of acute alcoholism, suggests that the cerebellum and midbrain may be particularly susceptible to the inroads of alcohol.

In prognosticating regarding the acute psychotic episodes of alcoholism, it is well to bear in mind the possibility of chronic sequelae. We have seen an appreciable number of schizophrenic, assorted paranoid, and Korsakow's psychoses precipitated by acute alcoholic hallucinosis and delirium tremens. Indeed, some of the so-called chronic alcoholic psychoses probably are primarily schizophrenic and paranoid states, and are either uncovered by or merely coincidental with alcoholism. Likewise, periodic drinkers should be carefully scrutinized for evidence of cyclothymic disorder.

While on the subject of differential diagnosis, it is not amiss to point out that the odor of alcohol on the breath does not preclude the presence of any of the whole host of causes for coma; and that the existence of actual alcoholic intoxication may coincide with paresis, epilepsy, skull fracture, or any of the other overwhelming diseases.

Another of the more serious possible eventualities of excessive drinking is suicidal attempt. Every maudlin drunk represents suicidal possibilities to a degree at least equal to depressions of other sorts. In a survey of over 1,800 suicidal attempts in Cincinnati, I found that at least 15 per cent had been made with the patient under the influence of alcohol. Similarly, with inhibition diminished, emotions rampant, and judgment impaired, the possibility of homicide increases—especially in the excited or belligerent alcoholic.

To be emphasized here, and wherever else possible, is the increased likelihood of accident, particularly on the part of drunken drivers. It is probably no exaggeration to label this hazard of drinking as one of the most widespread and serious of the various sequelae of intoxication. Because of the interest of problem, much emphasis is being placed on the need for a precise method of diagnosing acute alcoholism. I would like to spend the few remaining moments of my time discussing one phase of the search for such a method.

Much has been stated in recent years concerning the association of a definite concentration of alcohol in the blood with the manifestation of definite clinical symptoms. Hence it may be of interest to mention briefly some of the observations which our group at the Cincinnati General Hospital, together with that of Dr. Arthur Mirsky at the May Institute of the Jewish Hospital, have made on this question.

During the course of study on the oxidation of alcohol by the eviscerated rabbit, we observed a series of interesting phenomena. The eviscerated preparation is essentially an animal from whom the gastro-intestinal tract and liver have been removed, but who otherwise appears perfectly normal—that is: the muscles and nervous system are intact. When such an animal is given an intravenous injection of alcohol, the utilization of alcohol does not occur, since that is essentially an hepatic function. Hence the blood alcohol remains at a relatively constant level for a long period of time. Of interest was the observation that when such an animal was given alcohol so that the blood alcohol content rose to 100 mgm. per cent, the animal became comatous for approximately 10 to 12 minutes, following which period a complete restitution to normal ensued. This return to normalcy occurred in spite of the fact that the concentration of alcohol in the blood was the same at the end of this period of coma as it was at the beginning of the comatous period. When the second injection of alcohol was made into such an animal, thereby raising the concentration to approximately 200 mgm. per cent, coma again ensued; and

as with the first episode, in 10 to 12 minutes after the injection the animal became perfectly normal in its reactions, despite the fact that its blood alcohol was now 200 mgm. per cent, as opposed to the 100 mgm. per cent level at which the animal originally was intoxicated.

We have, on occasion, been able to produce three or four periods of coma consequent to alcohol injection in the same animal. With each increment in blood alcohol the animal went into coma, and after a short interval of time returned to normal in spite of a fixed concentration in the blood. These observations suggested to us that there might be some compensatory mechanism at play and in order to determine whether or not our observations are a general phenomenon, we extended the studies to man. We administered alcohol to humans and observed carefully the exact point at which definite signs and symptoms of alcoholism occurred. Blood samples were drawn at this time, and at various other intervals in order to follow the curve of alcohol concentration throughout the study. When the clinical symptoms of intoxication had completely subsided, we again noted the concentration of alcohol in the blood. In this way it was possible to determine the concentration at which symptoms of alcoholism first appeared, and likewise the concentration at which the symptoms disappeared. Thus, for example, in a patient in whom symptoms first appeared at a blood level of 194 mgm. per cent, no symptoms whatsoever were apparent six hours later when the blood level was 250 mgm. per cent. Such studies were made in a number of human subjects. The only apparent significant difference between this experiment in man and those in the rabbits is one of time. Thus whereas it took 10 to 12 minutes for the rabbit to compensate for the effect of a certain concentration of alcohol in the blood, in man six to eight hours were needed to compensate in a similar manner.

These observations are not entirely new, for they are in accord with the frequently mentioned statement that the symptoms of alcoholism are more apparent when the blood alcohol level is rising than when the level is falling. Our studies suggest that some compensatory mechanism exists whereby cerebral function can reassert itself even at levels of concentration higher than that necessary to induce symptoms, but that time is required for this compensation to occur. In accord with such a concept is the observation first made by Bowman and his group, that when metrazol is administered to a patient in alcoholic coma, consciousness will be apparent in several minutes after the injection of this drug. We have studied several patients in whom alcoholic coma was induced and found, for example, that a patient who was in deep coma with a blood alcohol of 420 mgm. per cent, could be made almost completely conscious within 10 minutes after the intravenous injection of metrazol, even though the concentration of alcohol was still 420 mgm. per cent.

Time does not permit further elaboration of these observations. I merely present them in order to emphasize that there is no definite quantitative and temporal relationship between the concentration of alcohol in the blood and the specific symptomatology of alcoholism, and to suggest that the central nervous system can compensate to varying concentrations of alcohol. The only generalization that our study makes permissible is that the symptoms of alcoholism may occur at almost any blood alcohol concentration, but the quantity of alcohol at any given time does not serve a fixed specific indication that symptoms must be present.

DISCUSSION

DR. KARL G. ZWICK: Dr. Piker's report on the results of his comprehensive study of the "Symptoms of Alcoholism" compels us to revise some of our concepts of the relationship between the quantity of alcohol ingested and the character of the symptoms produced.

The popular idea of this relationship was aptly formulated by Shakespeare when in "Twelfth Night", in answer to Lady Olivia's question: "What's a drunken man like?", the Clown answers:

"Like a drown'd man, a fool and a madman:
One draught above heat makes him a fool;
The second mads him;
And a third drowns him!"

According to this concept the severity of the symptoms keeps step with the amount of alcohol imbibed.

The modern legal opinion take origin from a similar conclusion, since judicial decisions concerning the state of sobriety of an individual are based, in part at least, on the quantitative analytical determinaton of the alcohol in the blood (and urine). In McNally's "Toxicology" Muehlberger's table lists a series of six (6) stages of clinical manifestations of alcoholic intoxication corresponding to six (6) percentages of alcoholic concentration.

However, according to Dr. Piker's findings the alcoholic dosage and the resultant concentration of alcohol in the blood—as determined by chemical analysis—do not go strictly parallel with the intensity of the symptomatic manifestations of the alcoholic intoxication.

In this connection I recall that Wolff and his collaborators found that there is also no absolute parallelism between the dosage of alcohol and its pain-threshold raising effect, *i.e.*, its analgesic action.

I mention Wolff's findings, because as I see it, they support in a measure Dr. Piker's explanation that the divergence between alcoholic blood contents and alcoholic symptomatology indicates "that the central nervous system is able to adjust itself to varying concentrations of alcohol in the blood."

In view of the contingency, in a given case, of such an adjustment the juridical principle of (employing legal phraseology) "res ipsa loquitur" no longer applies. That is to say: the mere finding of a certain percentage of alcohol in the blood of an individual is per se henceforth no longer acceptable as legally valid proof, but only circumstantial evidence, that the symptom complex observed in that individual is the result of his excessive indulgence in alcohol.

I await with interest the results of the further studies of Dr. Piker. They will no doubt enlighten us about the biochemical processes which accompany or produce the adjustment of the central nervous system observed by him. His findings will, I hope, also serve to explain the development of the tolerance which results in a quasi symbiosis of the chronic alcoholic with his cacoethes bibendi. A knowledge of these two biological phenomena would or should aid the physician in the therapeusis of acute and chronic alcoholic intoxication.

Dr. F. K. HARDER: Dr. Piker has given an interesting resume of the effects of alcohol. His comments concerning the restitution of sobriety at rather high levels of concentration of alcohol in the blood are significant in view of recent interest in blood alcohol determinations in persons charged with driving while under the influence of liquor. There have even been some attempts legally to define the level at which alcohol interferes with the driving of an automobile. This is sometimes unjust because while chemical tests show the alcoholic content of a specimen of blood, urine or breath, drunkenness is a clinical condition to be diagnosed in the light of clinical and laboratory findings.

A laboratory test by itself does not establish a diagnosis. The purpose of the laboratory in relation to alcoholism may well be summarized in the words of a committee of the Academy of Medicine—'It is advisable from the medicological point of view to have specific and precise data to indicate that alcohol, as such, was present or absent in a given instance, and that it was or was not present in concentration compatible with the clinical diagnosis of alcoholic intoxication."

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ADMISSION TO MADRAS MEDICAL COLLEGES.

Last month when we commented on the episode of admission of candidates into the three Government Medical Colleges in this presidency, we said that apart from communal considerations there are other defects which though not relating to the birth of candidates in a particular community, affect adversely all candidates and indirectly the candidates belonging to the particular community, to prevent whose predominence in public offices the communal orders have been promulgated by the Government in some form or other whenever occasions demanded, the underlying principles of these orders depending upon appeasement of a particular community. We do not wish to say anything adversely against communal orders or rules lest we should increase the poison of communal hatred which has been virtually hindering progress and prosperity of this country though it might have served the purpose of the communal leaders and brought these few individuals name and fame which in their trail brought them wealth too.

From the limited knowledge of the history of medical colleges which we had to avail of, for the purpose of this subject, we are not in a position to say which Medical College, which University or which Government demanded for the first time that the candidates seeking admission into the Medical College must have passed the Intermediate Examination in Science of a University or an equivalent examination of any other recognised university in the subjects of Biology, Chemistry and Physics. It was also not possible for us to trace from the history of admissions to Medical Colleges in the Madras Presidency whether the Madras Government or the Madras University that was responsible to lay down that the general educational qualification must be the passing of the Intermediate Examination in Arts and Science and Science has been limited to Physics and Chemistry without any mention of the very important subject Biology with which subject medical students should be as much familiar as with Chemistry and Physics if not more. But actually during the process of selection Intermediates who have passed in the first class with Biology, Physics and Chemistry are preferred to those who have passed Intermediate Examination in the First Class with Mathematics, Physics and Chemistry. But these latter are preferred to the candidates who have passed in the second class in the Intermediate Examination with Biology, Physics and Chemistry and even to candidates who have passed the B.Sc. or B.A. Examination with Biology, Physics and Chemistry as optional subjects unless the graduates

have passed in the first or second class. We had casual conversation relating to this subject with two out of three Principals of the Government Medical Colleges of this province, one of whom opined that a Biology Intermediate should be preferred to Mathematics Intermediate even if the former passed in the Second Class, the other Principal was of opinion that a First Class Mathematics Intermediate was usually a much brighter boy than a Second Class Biology Intermediate. He added that the Madras University would not listen to the proposal to insist on the rule favoured and strictly given effect to by other medical colleges in India that the entrants to the medical colleges should be only Biology Intermediates. That the knowledge of Biology is more useful to a medical student than that of Mathematics and that the latter subject is more useful to an engineering student none can deny. But it is beyond reasonable conception why in this province only Mathematics Intermediates are admitted at all. It may be argued that the Arts Colleges which undertake to teach Biology are fewer in number than those teaching Mathematics. But it cannot be said that the three Medical Colleges would not get the required number of students *i.e.*, about 200 in number from out of the Colleges that teach Biology. If the student's brightness as shown by his having passed in the first class in Mathematics is to be taken into the consideration, first class Intermediates with History and Logic as optionals should also be admitted depending upon the marks scored by them in the Intermediate Examination. Nothing is impossible for bright boys of exceptional intelligence. There are instances when a graduate with a particular subject or subjects as optional gave them up and studied quite different subject or subjects for the purpose of competing for All India Services such as I.C.S., F.C.S., etc., and passed these competitive examinations with credit. In medical science it is the utility of a subject more than the intelligence of the candidate that should count in selecting candidates for admission into the medical colleges.

Academic merit should not be the only criterion relating to admissions to Medical Colleges. Amongst professional courses the longest, the most tedious is that pertaining to medical profession. An entrant to a medical college should be physically more fit than a candidate seeking admission into any other Professional or Arts Colleges. He should also be one who loves sports. This aspect of the qualification is neglected totally at the time of selection of candidates to the Madras Government Medical Colleges. Far from having a look at the candidates at the time of selection, even physical fitness certificates are not demanded at the time of selection. The authorities of the medical colleges in other provinces and especially in Bombay demand a certified copy from the Registrar of the University of the report of the last medical examination held by the University Panel of Medical Inspectors and in addition a certificate from a qualified Ophthalmic Surgeon that the candidate does not suffer from granular conjunctivitis, is also demanded. This special certificate is perhaps considered necessary as in some parts of Bombay Presidency, Trachoma seems to be a common eye disease. This is not all; another certificate is to be produced from the Principal of the College from where the candidate seeks entrance into the Medical College, to prove that the candidate was taking part in games and if he took part in inter-collegiate tournaments, the events and games in which the candidate took part has to be mentioned in the certificate. In fine, the Medical College authorities in other provinces while selecting candidates take into consideration not only the academic merit but also the physical fitness and habits of the candidates. The omission of taking notice of the physical condition of the candidates seeking admission into the Medical Colleges in Madras is conspicuously glaring indeed.

Some unnecessary information is demanded in the Madras application forms such as relating to the income of the guardian or father, knowledge of classical languages etc. The significance of such and similar queries cannot be understood when it is known that the only criterion which weighs with the committee consisting of three Principals of the three Government Medical Colleges, is the community to which the candidate belongs and his merit in the Intermediate Examination.

The present Head of the Madras Medical Department who is the Chief Adviser to the Government is an officer who had intimate connection with an Indian Medical College which enjoys the unique privilege of being the only Medical College in India which has independent existence unlike in Madras and other provinces where the Medical Colleges are under dual control of the University and the Governments. He must now be in a position to know for himself the advantages and disadvantages of dual control of medical institutions where the University has been able to dictate to him what he should do. The communal canker does not and cannot make democratic institutions really serve as such. Democracy in India is really in disguise and helps autocrats to have their sway. It cannot be otherwise in Madras and yet there are ways to make the autocratic rule more tolerant. If the Head of the Medical Department whom the present Indian democracies cannot touch, does not make up his mind to protect the interests of medical education from which the medical profession has to spring up, who else can venture to do this task? We ask him to do what is fair and just not at all in the interests of any special community but in the interests of all communities and specially in the interests of medical education and medical profession.

The Madras University may have its own rules and regulations and may also break its own rules when they cannot work out impossibilities. For example, about a couple of years ago, the University fixed qualifications for professors and their assistants in the Madras Medical Colleges without reckoning the future fixing qualifications as possessed by the professors and their assistants at the time the regulations and rules were framed. These helped to keep out some unwanted in the sphere of teaching. A time has now come when all these regulations and rules cannot be given effect to and the university is swallowing its new rules and regulations relating to appointments in Medical Colleges.

We are sure that the present Surgeon-General, an eminent medical man possessing the highest possible medical qualifications and himself an educationist, cannot deny that Biology is more useful to medical students than Mathematics or Logic. All other medical colleges in India admit only Intermediate candidates having Biology as their optional and fortunately the Madras University recognises such preference though for reasons best known to the University itself, it prefers first class Mathematics candidates to the Second Class Biology candi-

dates. We may point out that the students after passing S. S. L. C. test, choose Biology as their optional with the set purpose of choosing medicine as their future career. No other professional college prefers Biology Intermediate for admission. The S.S L.C. students who take up Mathematics as their optional do so with the fixed idea to take up the engineering profession. As a matter of fact, almost all the candidates with Mathematics as their optional, first apply for admission into the Engineering College and when the chances of success cannot be assured, apply for admission into Medical Colleges We learn it is easier to get a first class in Mathematics than in Biology. We mention about all this at length so as to make the Surgeon-General realise the actual state of affairs especially, the rude disappointment to the Biology candidates. It is astounding that first class Intermediates are preferred to the Third Class Bachelors of Science. Applying the same principle the Madras University may as well exempt the first class Intermediates from passing the B Sc. Degree and grant them the B. Sc. Degree with a third class rank. So long the B. Sc. is a higher qualification the third class rank obtained by the B.Sc. candidate should not lower the prestige of the B. Sc. Degree itself. It is one thing to say that a first class Intermediate is at times more proficient than a B. Sc. Degree holder but quite a different thing to recognise the individual merit of a lower qualification over the qualification of a higher degree. So a B Sc. Degree of whatever rank should be considered as a higher qualification than the first class Intermediate. The Madras University does not prefer a first Class M B.B.S. to a M D or M. S. for holding professorial appointments though the M.D. or M.S candidates might have just got the passing marks. The last but not of least importance is the necessity of taking into consideration the physical well-being of the candidates at the time of selection.

Before closing we wish to commend the desirability of earmarking at least 10 per cent of seats in the Medical Colleges to the children of medical men, the selection being made by the Surgeon-General himself who should take into his considera tion not only the merit of these children but also the services rendered by their parents to the public and to the profession. This suggestion is not likely to appear strange to the Surgeon-General who made it known to his audience on 4-8-1941 at the Madras Medical College when he addressed on 'War Efforts', the students, staff of the Madras Medical College and the other medical officers specially invited by the Principal for the occasion, that during the last admission to the Medical Colleges, children of medical officers who volunteered for war service during the last war had been given special preference and the same policy would be followed in future. It is really an unfortunate fact that invidious distinctions are made and shown by the authorities only in India between the official and non-official members of the medical profession and that such distinctions are made to be felt during the period of war. We have said in these columns repeatedly that such an outlook on the part of the authorities has seriously hampered the enthusiasm in the non-official practitioners who are now very slow to volunteer for war service. It is the spirit of service as such and not the spirit of departmental service and the money and advantage it may confer that should be stimulated. To stimulate such an ideal may not be so easy as it involves vested interests and many more such interests. The Surgeon-General did make it public on the eve of his taking charge from his predecessor that the Surgeon-General exists not only to take care of his officers but also of the private practitioners. It may be justifiable that during the actual period of war a certain amount of allowance should be made to the actual conditions to serve special purposes. Though we hope and pray that the present war be the last one, who knows another Hitler may not be born in the West or in the East? It is proved beyond doubt that the civil and military authorities cannot depend on their salaried medical dependents, but have always to depend on private practitioners. So the Heads of the Medical Departments, Civil and Military, should take the role as the Heads of the Medical Profession inspite of their official position. Consequently the concession shown only to the children who had served or may serve in future in the Military Medical Department, though it may look laudable and attractive at present, is likely to serve time and not the wider interests of the medical profession. This consideration apart, it is to be conceded even by the non-imaginative that generally doctors' children are supposed to have greater aptitude for the practice of medicine than those born to lay persons and therefore the former would serve the profession much more usefully than the latter. Many a time an honest, equally successful practitioner cannot afford to bequeath to his children anything excepting his good will and reputation and it will be really sad if the children of such practitioners cannot claim special considerations from the Head of the Medical Department, who being a medical man is expected to divest himself of all official and departmental considerations which come in the category of vested interests while he takes special note of not only the last suggestion on the subject of admissions to medical colleges but of all suggestions that have been expressed by us as frankly as the occasion demands. If Major-General H. Stott does what is expected of him as the Adviser to the Government, relating to this affair, he would be giving living effect to his feelings that the Surgeon-General is the virtual guardian of private practitioners also. If he takes the independent medical profession into confidence now it will pay war efforts or any efforts relating to public welfare not only now during his regime but even after he leaves this country. His successors cannot but follow his foot steps if they are truly and firmly laid in the interests of the medical profession as a whole.

WHY FORCE UNWANTED REFORM!

We learn that the Bombay College of Physicians and Surgeons, has extended the course of studies for the L. C. P. & S. Diploma from four to four and half years. A brief report of the proceedings of a protest meeting held in Bombay is published in the correspondence columns of this issue. The medical licentiates throughout India have been denouncing all these years the inferior Diploma course and stressing the need of one uniform standard of medical education as obtaining in the other parts of civilized world. This noble and admirable attitude of the medical licentiates suicidal to their own interests, ought to have been highly appreciated by all the Governments in India if they were really minding the welfare of the public and the harmonious growth of Scientific Medical Profession in India. The fact that no Government in India except the Madras Government did abolish the Medical Licentiate Diploma Course and that the Bombay Government has agreed (if our information is correct) to the proposal of the College of Physicians and Surgeons to increase the L. C. P. & S. course by six months, indicates

that all the Provincial Governments though convinced about the necessity of one uniform standard of medical education condone the existence of a lower medical diploma as a measure of economy. For, uniform standard of medical education will necessarily entail higher uniform wages to the medical men under Government employ. The existence of war may be yet another reason to perpetuate the continuity of a course of medical studies which practically satisfies the needs of the practice of medicine and surgery at a much cheaper cost than the Defence Government may have to pay, as uniform university standard of Medical Education means uniform commissioned rank in Army Medical Service. The latter service can be had from one medical man for not less than Rs. 450 a month whereas the Medical Licentiate Service from an individual can be had for Rs. 75 a month. It is said that the strings of the Bombay College of Physicians and Surgeons are in the hands of eminent non-official Indian leaders of the Bombay Medical Profession who got and are getting the highest diploma, F. C. P. & S. without examination, to attain which, the actual primary product of the College, the L. C. P. & S. Diploma holder has to undergo tedious study and as severe examinations after his qualifying for the Membership Diploma of the College. It looks as if there are few or none amongst the Bombay Medical Leaders who sympathise with the medical licentiates. This cannot surprise us as the readers of The Medical Practitioner have been told through these columns many a time that there exists an Indian Medical Fraternity only in Bombay which refuses to recognise Medical Licentiates as qualified Medical Practitioners. The existence of a statutory body, the Medical Council of India is a standing monument to test the sympathy of Indian Leaders towards the Medical Licentiates who are wanted by all for medical and surgical practice but not for recognition of such service in the shape of money much less in the shape of prestige and status. These practitioners have been serving a very useful purpose for swelling the number of members of all existing medical associations, of District, Provincial and all-India importance. Is it not a sad irony that they had tangible support from none so far excepting from a single individual brother of theirs in Madras, Dr. Rajan, the Ex-Minister who being a Licentiate himself did abolish the Licentiate Course in Madras, a reform which seems to be impossible of achievement anywhere else in India.

MUCH NEEDED COLLABORATION.

To Dr. Jivraj Mehta, Dean, K. E. M. Hospital and G. S. Medical College, Bombay, goes the credit of bringing about the much needed collaboration between the manufacturers of chemical and pharmaceutical products on one side and the representatives of universities and research institutions on the other side ; both parties till now have been struggling hard to be useful to themselves and to the public for want of a proper co-ordinating and co-operating link between them. The need for such a link was amply stressed by Dr. Mehta on 20-9-'41 when he had the unique honour of presiding over the conference of manufacturers and research workers in different spheres and fields of work. "It is indeed a matter of shame" said Dr. Mehta at the very outset of his address, "that a vast country like India with its tremendous natural resources, both in raw materials and in motive power, should have to depend on other countries for her economic and industrial life." Dr. Mehta referred to the Board of Scientific and Industrial Research and the Industrial Research Utilization Committee established by the Government of India and while welcoming both these bodies he said that the amount of five lakhs placed at the disposal of these two organisations, was extremely too poor for the purpose for which the two bodies were brought into existence. In fact, the presidential address of Dr. Mehta gave a picture of the brain necessary for research with its co-ordinatory functions to make the brain force really useful. He impressed that a research brain was of little or no avail unless it had the necessary sinews to demonstrate the activities of the brain. Dr. Mehta's address is remarkable in another way. Presidents of conferences are always chosen from amongst leaders and it has been our sad experience which we did not keep secret that usually Presidents of conferences never justified their choice as leaders for, they could not give a lead to the ideas expressed by them in their addresses. Our experience of this phenomenon is limited to all-India Medical conferences. Dr Mehta's address was a very happy exception though he belongs to the fraternity of the medical profession. The unanimous resolutions passed by the conference over which Dr. Mehta presided, appear in the Correspondence Columns of this issue. These resolutions demonstrate what true leadership is. We wish the Presidents of the future all-India Medical Conferences copy Dr. Mehta's lead. We regret that the war conditions did not permit us to publish Dr. Mehta's address and we request our readers to go through this address which appeared in almost all leading dailies throughout India.

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.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the month of August 1941.

RECEIPTS.	Rs.	A.	P.	CHARGES.		Rs.	A.	P.
Balance on 1-8-'41 ...	670	14	6	Postage ...		3	6	9
Subscription received from members ...	17	5	0	Cash Balance :				
				With the Savings Bank ...	668 10 7			
Contribution for Provincial Conference ...	3	0	0	With Office ...	19 2 2			
						687	12	9
Total ...	691	3	6	Total ...		691	3	6

V. RAMA KAMATH,
President.

R. S. KOTHANDARAMAN,
Treasurer.

Correspondence, Reports, Etc.

The Madras Provincial Subsidized Rural Medical Practitioners' Association.

Proceedings of the first meeting of the Working Committee of the Madras Provincial Subsidized Rural Medical Practitioners' Association held at the Central Office on 6th September 1941 at 12 noon.

PRESENT:

Dr. V. Rama Kamath, President.
Dr. M. Krishna Rau, General Secretary.
Dr. R S. Kothandaraman, Treasurer.
Dr. C. V. Subba Rao, Joint General Secretary North.

Dr. C. Kunjunni Nair (from 2 p.m.) Joint General Secretary South.

The President at the outset made an introductory speech pressing on the attention of the members of the Working Committee their responsibilities towards the successful working of the Association and announced the names of the office-bearers from the list of the members of the Working Committee. He said that it was likely that he might have to take complete rest from all activities in the immediate future and therefore he had selected Dr. M. R. Bhat as the Vice-President considering his intimate and continuous services to the Association as General Secretary of the Association from the date of the rejuvination of the Association in the year 1937.

The Working Committee collectively inspected the books, Daily Cash Book, Ledger including the Personal Ledgers of the members before Dr. R. S. Kothandaraman took over the charge of the office of the Treasurer.

A suggestion was made by Dr. M. Krishna Rao that in the ledger the quota due and the quota paid to the District Branches may be shown Districtwar.

N.B.—*This suggestion had to be given up as the committee decided later not to distribute district quota from this year.*

The President brought to the notice of the Committee that as a result of the referendum circulated to the members of the Association through the official organ The Medical Practitioner two members of the Association were not in favour of the amendments 4, 5 and 6 mentioned under the resolution No. 2 passed by the Annual Conference held at Madras and requested the Committee to decide whether the District Branches should be paid the quota for 1941.

After keen discussion over the matter the Committee passed the following resolutions unanimously:

1. Resolved that as there is a likelihood of calling Provincial Committee meeting in the course of the remaining portion of the year and as in the past the attendance at the meeting of P. C. was not satisfactory, some of the members of the Committee bitterly complaining their inability to spend money from their own pockets on account of the members of the respective District Branches not sharing the expenditure incurred by the Secretary-Treasurers as decided by the P. C. in the past and as there are important matters to be settled by the P. C. the Working Committee is of opinion that the resolution relating to the District quota be given effect to in the year 1941, to ensure better attendance at the future P. C. meetings.

The President brought to the notice of the Working Committee in his capacity as the Managing Editor of The Medical Practitioner that 71 defaulting members of the Association having not paid their annual subscription to the Association which included the quota to The Medical Practitioner, he has iucurred a great loss by sending them the journal in good faith in the year 1939 and 1940.

2. While sympathising with the Managing Editor for the loss sustained by him the Working Committee requested him to write off his claims against the Association in regard to irrecoverable items and that in future he was requested to send every year December issue of The Medical Practitioner by V. P. P. to recover the subscription due to the Association for the following year.

3. The Working Committee requests Dr. M. R. Bhat, the Vice President to edit the memorandum and the rules of the Association as amended at the last annual conference held at Madras at his earliest convenience in consultation with the President of the Association. The President is requested to correspond with the Government for the purpose of getting from the Government as many Government Orders as there are available relating to the Subsidized Rural Medical Relief Scheme and in case the Government Orders are made available, to append the same in the Manual containing the memorandum and rules of the Association. It was further resolved that a reasonable price be fixed by the President for the sale of this Manual, the expenditure for printing the Manual being defrayed from the funds of the Association.

4. Resolved to have Dr. V. Rama Kamath, Dr. M. Krishna Rao, R.M.P., Thambarahalli, Bellary Dist. Dr. C. Kunjunni Nair, R. M. P., Koduvayur, Malabar Dist. in the panel for the election of the President of the Association for the year 1942.

5. Resolved to sanction the expenditure of Rs. 14-0-7 incurred by the President for making a brass plate containing the name of Major General N. M. Wilson, in the portrait presented to the Stanley Medical College and the President is authorised to incur a reasonable expenditure for preparing a plate to indicate that the portrait is a gift from the Association and which plate is to be hung along with the portrait in the Stanley Medical College.

6. Resolved to sanction the necessary expenditure for making facsimile rubber stamps for the signature of Dr. R. S. Kothandaraman, Treasurer and of Dr. M. Krishna Rao, the General Secretary. The President is requested to hand over the facsimile rubber stamps of the signature of Dr. K. Govindan, to Dr. Govindan the ex-Treasurer and of Dr. M. R. Bhat, to Dr. Bhat the ex-General Secretary.

7. Resolved that Dr. R. S. Kothandaraman, the Treasurer be empowered to operate on the Savings Bank Account of the Madras Provincial Subsidized Rural Medical Practitioners' Association in the Vepery Post Office.

8. The Working Committee records with pleasure the sincere and faithful services rendered by Dr. K. Govindan as Treasurer and member of the Working Committee of the Association which office he had to resign on account of his indifferent health. The Working Committee prays for the long life and prosperity of Dr. Govindan and hopes that he will continue his services to the Association giving it the benefit of his experience as one of its oldest members.

CONFERENCE OF MANUFACTURERS AND RESEARCH WORKERS, BOMBAY, 20-9-41

RESOLUTIONS.

The need for closer co-operation and co-ordination between manufacturers on the one hand and research workers and institutions on the other, was reiterated in a resolution adopted by the Conference after speeches were over.

The Conference urged that facilities should be provided by research institutions, universities and colleges for industrial researches being carried on in their laboratories on behalf of the manufacturers of chemical and pharmaceutical products.

The Conference also requested the various universities and research institutions that post-graduate research work by their students be carried on in such a manner as to prove useful to the development of chemical industries.

With a view to bringing about a speedier development of industrial research, the conference suggested that the Government should set apart an adequate portion of the excise revenue collected from pharmaceutical products and preparations to provide for the establishment, maintenance and assistance of research and field laboratories in the various Provinces and States.

A sub-committee was also appointed to frame a detailed scheme of closer collaboration between manufacturers and research institutions.

BOMBAY L. C. P. & S. DIPLOMA.

A plea for the abolition of the College of Physicians and Surgeons of Bombay and the establishment of one uniform standard of medical examination in the country was made by Dr. U. B. Narayana Rao, presiding over a meeting held under the joint auspices of the Bombay Branch of the All-India Medical Licentiates' Association and the National Medical College Old Students' Association. Dr. Narayana Rao, also protested against the recent move of the College in Bombay in increasing the course of the student —licentiates to four and a half years, only just half a year less than that for graduates. Dr. Narayana Rao explained that the All-India Licentiates Association and the Indian Medical Association, the Ministers' Conference in 1937 and the Indian Medical Council in 1941 were in favour of a uniform standard. Dr. Rao referred to 'the unjust treatment' of the Licentiates and said that even though the course had now been extended so as to be only six months less than that for the graduates, the status of future licentiates would not be higher than those at present.

In conclusion, Dr. Narayana Rao urged the abolition of the course and said that until the schools should be converted into colleges, a state medical faculty representing all interests should be established as in other provinces. (A. P. I.)

Adenwalla Medal and Prize in Ophthalmology.

The Committee of the All-India Ophthalmological Society announces that the subject for the next award of the Adenwalla Medal and Prize in Ophthalmology will be "Changes in the cornea due to malnutrition." The prize will be awarded to the best work on the above subject and is open to all ophthalmic specialists resident in India. The essays must be submitted to the Secretary, All-India Ophthalmological Society before the 15th Nov. 1942.

Anantapur District Medical Association.

The monthly meeting of the above Association was held at Hindupur on 14th September 1941, in the Co-operative Town Bank, Ltd. Dr. S. Narayanaswamy Iyer, District Medical Officer and President of the Association, presided. After Tea, Dr. A. Parasayya Naidu, Penukonda, read a paper on *Dysmenorrhoea*. An interesting discussion followed, and the President summarised the salient points upon the subject, laying stress on the psychological factor as a frequently physiological entity. In proposing a vote of thanks, Dr. T. Narasinga Rau, Hindupur, expressed the hope that in future the Association would meet in the mofussil stations more than at present. The function concluded with a Dinner in the night.

Doctors are human!

The lay public seldom show much consideration for medical men, that is, in the exercise of their profession. Calls at all hours of the night and refusal to accept errors in diagnosis are all too common. Patients even make no allowance for the doctor's natural enthusiasm when new methods of relieving suffering comes to his notice. And yet how easy it is sometimes to pass over the old and tried prescriptions when the new discoveries are favourably reported on!

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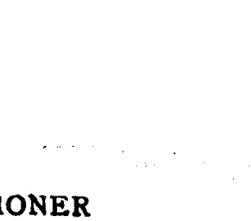

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