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THE MISCELLANY

Managing Editor: Dr. P. A. S. RAGHAVAN

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THE MISCELLANY

(JOURNAL OF THE SOUTH INDIAN BRANCH OF THE INDIAN MEDICAL ASSOCIATION)

Managing Editor:

Dr. P. A. S. RAGHAVAN, Z.M.R.E. (Vienna) TEPPAKULAM, TRICHINOPOLY.

Members are requested to inform the undersigned any change of address if and when it occurs.

MANAGING EDITOR,
'The Miscellany,' Teppakulam, Trichinopoly.

ENHANCED SUBSIDY TO RURAL MEDICAL PRACTITIONERS.

Govt. Order No. 2984, P.H., dated 3rd September, 1947.

In G. O. No. 1535, P. H., dated the 5th May 1947, the Government sanctioned the enhancement of the rates of subsidy paid to medical practitioners working in rural dispensaries from Rs. 500 per annum to Rs. 600 per annum in the case of licentiates and from Rs. 600 per annum to Rs. 720 per annum in the case of medical graduates, and ordered that the enhanced rates will take effect to, in respect of the other staff under the district boards concerned. The following doubts about the implications of the Government order have been raised:—

(i) whether the revised rates are applicable to rural medical practitioners, who are working in rural dispensaries subsidized by Government; if so, whether the medical practitioners in such dispensaries in *all the districts* will be eligible to draw the enhanced rates or whether the payment will be confined only to those, who are employed in districts where revised scales of pay in respect of the staff under the local boards have been introduced; and

(ii) whether rural medical practitioners with L. I. M. qualification will be eligible for the increased rates of subsidy.

No. 2984, P.H., 3rd September, 1947.

The Government hereby make it clear that the enhanced rates of subsidy sanctioned in the Government Order cited will apply to medical practitioners employed in rural dispensaries subsidized by Government in *all the districts*. In respect of them, the enhanced rates will take effect from the 1st January 1947. In the case of those employed in rural dispensaries maintained entirely by local bodies, the enhanced rates will be paid only from the date from which the revised scales of pay are given effect to, in respect of the other staff under the district boards concerned. Licentiates, whether in indigenous systems of medicine or in the modern system of medicine, employed in rural dispensaries, will draw the enhanced rate of Rs. 600 per annum.

(By order of His Excellency the Governor)

C. O. Coorey,
Joint Secretary to Government.

Announcement

THE TUBERCULOSIS ASSOCIATION OF MADRAS.

Tuberculosis Workers' Conference—1948.

It has been decided to have the next Tuberculosis Workers' Conference at Madras during the third week of January 1948. Usually these conferences are held at New Delhi every year and this year's conference is being held at Madras at my invitation. The conference is expected to last for three days and the exact dates and the details of the programme will be forwarded in due course.

It is my endeavour to try my very best to make the stay of the delegates as comfortable as possible. I am arranging for the Boarding and Lodging for the delegates and also to reserve accommodation in rail, planes etc. for their return journey.

I am to inform you that the charges for Boarding and Lodging will be as follows:—

Indian Vegetarian with accommodation	Rs. 8 to Rs. 10 per day per head.
Boarding and Lodging in European Hotels (Such as Connemera, Spencer's, Bosotto's)	Rs. 14 to Rs. 20 per day per head.

Govt. Tuberculosis Hospital,
Royapettah, Madras,
27th October, 1947.

K. VASUDEVA RAO,
Honorary Secretary.

Acknowledgements

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The ANTISEPTIC Madras, October 1947.
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(FOR CIRCULATION AMONGST MEMBERS ONLY)

THE MISCELLANY

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FACTORS INFLUENCING THE SPREAD OF TUBERCULOSIS AND MEASURES TO BE TAKEN TO COMBAT THE SAME

BY

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Suptd. Govt. Tuberculosis Hospital, Madras
and Hony. Secretary Tuberculosis Association of Madras

Tuberculosis is rampant throughout our Presidency and Madras appears to be very badly hit. The problem that is facing us to-day is of such enormous dimensions, any attempt made to combat the disease would be touching the fringe of the problem. The position of our Presidency with regard to Tuberculosis to-day is indeed very appalling. Practically one in every seven deaths that take place in our Presidency is due to Tuberculosis. In the City of Madras alone there have been about 1,000 to 1,200 deaths from Tuberculosis every year. For every death that takes place from Tuberculosis there are at least 10 more people who are suffering from active Tuberculosis and who are infectious; thus making a total of 12,000 open cases in our City of Madras. The position of moffussil towns like Chingleput is no better. Possibly this is worse due to various causes such as dusty atmosphere, poorer standards of living and lack of sufficient knowledge and also lack of treatment. Our brethren who live in villages were better off a few years back but with the increased means of communications and closer contact between the village people, and the city people, the disease appears to have no more respect for them. The incidence among the villagers is as great as it is among the town people. This disease knows no divisions of colour or race nor of caste. It affects all human beings alike and its incidence is greater in places where standards of living are low, the economic condition of the people are poor and where there is not sufficient anti-tuberculosis propaganda made. The problem of this disease is now engaging the attention of practically the whole of India and an organised scheme is being laid down.

Unfortunately for us, the problem appears to be one which is not so easily solved, yet the organisation of a systamatized anti-tuberculosis campaign will go a long way in directing our attention and encouraging any attempt that may be made to combat this disease.

I intend dealing in this article a few facts which are responsible for the spread of this disease and a plan for prevention.

The first and foremost cause for the spread of this disease has been the low nutritive value of our food. The whole prevention of Tuberculosis centres in nutrition and it is expressed by certain clinicians that Tuberculosis is a deficiency disease just like beri-beri or any other deficiency disease. The ordinary food that is taken by a South Indian consists of Rice at both meals with a little of buttermilk and possibly a curry. The nutritive value that is contained in this ordinary diet is indeed very small. Attempts have been made at the Research Institute at Coonoor to classify the value of the different diets and it has been worked out that the diet of the South Indian is the worst as far as nutritive value is concerned. A Punjabi Diet is the best in its nutritive value and even superior to some of the diets of the western countries. Food which contains very little of nutritive element if taken, stunts the growth of the population and produces a set of unhealthy people. Poor health as a result of this poor nutritive diet always exposes the South Indian to greater risks and he easily falls prey to the diseases like Tuberculosis, because Tuberculosis can spread in an individual whose general health is poor. The loss of general health always follows ingestion of poor nourishing diet.

In addition to the poor nourishing food of a South Indian, the economic condition also is exceedingly poor. It has been estimated that the average income of an ordinary South Indian is less than three annas a day and you can well imagine what means of comfort he can command both for himself and for his family members with three annas a day.

The third factor that influences the spread of this disease is the standard of public health. It should be remembered that Tuberculosis affects individuals who are poor in their general health. Insanitary surroundings, ill-ventilated houses and dusty atmosphere have a tendency to decrease the general resistance of the individuals which in its turn paves the way to Tuberculosis. Public Health has a great deal to do in preventing this disease. Occurrence of periodical epidemics of infections diseases like Measles, Influenza and Small-pox always lead in their way to increased incidence of Tuberculosis. It should be the prime object of public health authorities to improve the public health of a place if any tangible good has to be done towards the reduction of this disease.

In addition to the above general factors, there are certain other local conditions that are always conducive to the spread of this disease. The first and foremost of this local condition is one of segregation of a Tuberculous patient. It is well to remember that Tuberculosis is infectious, that it spreads from one Tuberculous individual to another. If there are no cases of tuberculosis there can be no spread of Tuberculosis at all. The sputum that is brought by a Tuberculous patient is the source of further infection and if a person who is suffering from Tuberculosis is not segregated he is a source of infection through his sputum. The infection is greater when the individuals that come in contact with him are younger. Within three years of life the chances of catching the infection are very great, but as age advances the natural resistance of the individual does play a part and the infection does not become so acute as in infancy, nor does it lead to such high mortality as in infants.

Certain other social factors are also conducive to the spread of this disease. The persistence of early marriages among us in spite of a certain amount of legislation is still a great factor in its spread. Early marriages often lead to early motherhood which in turn exposes the mother to further infection either due to the ill-nourished condition of the mother, or due to the chances of sepsis occuring. Purdah system still persists in certain places.

In certain communities partaking of eatables and food from the same plate is still in vogue. If any Tuberculosis patient happens to be a member of that party woe unto the people who join them.

Conditions like kissing and fondling of children still continues, not knowing the dangers that they expose their children by these methods. In addition to these things, there is a collossal amount of ignorance of the elementary principles of this disease which in its turn leads to neglect to take the necessary precautions which will always lead to the spread of this disease.

There is a collossal amount of ignorance even among the educated people. It is by means of a systamatised intensive and at the same time continuous propaganda that the dangers of these factors which influence the disease should be brought to the mind of the masses and masses be educated in the prevention of this disease.

To prevent this disease it is necessary that the following precautions should be taken:

The precautions can be divided into personal and public. The precautions to be taken by the public includes the aid of the state, as well. The measures to be taken in this connection are:

The economic condition of the people must be improved; the standard of living should be raised. The nourishment must be of a better standard and of a more nutritive value. Researches should be made so as to give us a cheap diet but at the same time rich, as for as nutritive value is concerned, cheap in money but rich in nourishment. We have very many articles of diet which are richer than rice such as Ragi, Wheat etc. but unfortunately we do not use them as sufficiently as they deserve. Demands must be made by the State to impart the results of these researches to the masses so that they may understand the value of food, what food should be taken, what should be avoided etc.

The public health of the country must be improved. The sanitation must be improved. Model houses or tenements must be built for poor people to live in, with little or no rent and precautions must be taken to diminish the occurrence of epidemics as much as possible. Any condition that lowers the general condition must be got over. Legislation must be passed for sale of wholesome food and also to control the contamination that may take place in the food stuffs. Articles of food like, milk, buttermilk etc. which become easily infected should be scrupulously watched. Persons who have any infectious disease should not be allowed to handle food-stuffs. Legislation should be passed to make Tuberculosis a specially notifiable disease so that necessary precautions may be taken whenever a case occurs.

In addition to these measures, continous propaganda must be made by means of lantern lectures, cinema demonstrations, health-week celebrations and by distribution of leaflets wherein the various aspects of Tuberculosis are clearly explained and their methods of prevention are also made known. It may be necessary and I would consider it also imperative that compulsory teaching of hygiene must be introduced in the curricula of studies in schools and colleges so that when the students come out of their schools and colleges they may have a working knowledge of the elementary principles of hygiene and public health.

The personal factors in the prevention of this disease are that every individual

must realize that he owes a duty to his neighbour and to the public. Every attempt must be made by the individual to minimize the risk of further infection.

The following instructions can be followed in preventing further spread by the individual:

Segregation as soon as an individual is diagnosed to be suffering from Tuberculosis. It is best in the interests of himself and in the interest of his neighbours and his relations to get himself admitted into an institution which is specially suited for its treatment. By this admission into an institution he derives two benefits:— One he gets his condition attended to and cured and secondly, he saves his friends and relations the danger of tubercular infection.

When segregation is not possible by being admitted into a hospital, the following precautions must be observed:

He should sleep alone in a separate room with all the doors and windows open. If no room is available he must choose a verandah which serves the purpose admirably well. Secondly he must take care of the sputum he brings out. He must see that there is no chance of the sputum either drying up and getting into air as small particles or flies sitting on it and carrying the infection to other members of the family by contaminating their food and drink. He should take care to see that articles and vessels which are used by him are kept separate and that they are not mixed with other articles of the family. His clothes and beds should be separate and he should not fondle children or even kiss or allowed to be kissed by others. The principles of hygiene must be observed as far as possible. Living in crowded houses should be put a stop to as far as possible. The houses chosen for living must admit large quantity of fresh air and sunlight. The floor should be free from damp. Social conditions which increase the spread of the disease must be prevented by personal influence.

Early marriages should be put a stop to.

Care must be taken of Coffee Hotels and other clubs where a large number of people meet. The authorities of these institutions must be enforced to clean the vessels thoroughly by putting the vessels etc., for at least three or four minutes in boiling water before they are given to others for use.

It is necessary that in addition to these precautions, the individual must try to protect himself when an open case of Tuberculosis occurs in his family. He must undergo a thorough overhauling periodically by a medical man. He ought not to be satisfied unless a clean cheque is given to him. The importance of this examination is greater if there is an open case of Tuberculosis in his house. When there is an open case of Tuberculosis all the members of the family who come in contact with the individual must be examined, if necessary, periodically, especially if the contact happens to be children. By means of this contact examination, latent foci of infection in people who look apparently healthy may be diagnosed. Early detection by means of contact examination which is carried on systematically should, to a large extent, remove the spread of this disease as well as mitigate the danger of infection. Remember that Tuberculosis is a curable disease and earlier it is detected, greater are the chances of complete cure and shorter the period of treatment. It is not enough if a cursory examination of the individual is made. It is necessary that a thorough overhauling must be done.

In addition to these precautions that have to be taken by the public and by the individual, there are certain other essential machinery that is necessary for the purpose of early detection and

treatment of these cases. This is what is called the curative side of the disease. Large number of dispensaries should be opened in many centres manned by skilful and experienced medical officers. Attempts should be made to diagnose the disease in its very early stage at these dispensaries and the proper treatment given to them. Hospitals and sanatoria must be opened in large numbers so that sufficient beds may be available for all cases which have been diagnosed to be suffering from Tuberculosis at the dispensary. Mere act of diagnosing the case does not satisfy the patient. He would not be satisfied unless he is taken into an institution and cured of the disease. Hence it is essential that a large number of beds should be made available for the treatment of this disease.

It may not be possible at present to possess a sanatorium or hospital for every town though it may be ideal, but I would suggest that a group of districts which are neighbours e.g. Chingleput, South Arcot and North Arcot may join their forces and establish a sanatorium exclusively intended for the benefit of the patients from these districts. In the same way, sanatoria may be established for groups of districts until the financial position is improved and each district can have its own sanatorium.

It is necessary that after a patient has been discharged from the sanatorium or hospital, he should still live a life of protection to a certain extent because he should be watched for sometime so that the chances of any relapse may be avoided. He will not be in a fit condition to compete for work with a healthy individual who is not an ex-patient. The strain of this competition may break his health. Hence it is necessary that the ex-patients who are discharged from the hospitals and sanatoria should be encouraged to live in colonies or settlements where the competition is among themselves. They may be allowed to live there with their wives and children and certain occupations may be taught which may bring a source of revenue to the colonies. Occupations like gardening, basket-making, poultry-farming and others could easily be instituted in these colonies and the produce of these colonies must be brought by the hospital and the sanatoria. If ex-patients are allowed to live in these colonies for a period of 5 to 10 years, this would stabilize a large portion of their strength and if they come into the general world later, they would not run the risk of relapse.

SOME OBSTETRIC PROBLEMS

BY

CAPT. C. S. S. SARMA L.M.S.,

D.M.O., South Arcot Dt. Cuddalore N. T.

General Bhatia, Col. Karamchandani, Members of the Association Ladies and Gentlemen!

I feel, I should thank your branch of the Indian Medical Association, for giving me this opportunity, to address you on "Some of the problems, of a small District Head Quarters Hospital, with particular reference to Obstetrics," which is the subject I have chosen for this evening's discussion.

The subject, may not be of general interest, to *everybody* but the *persons*, who are seized with the problems, have to solve them for those, interested, willy-nilly. Time was, when just 30 years ago, seven days, after passing out of a medical college and posted as a temporary Assistant Surgeon, awaiting an order to join the temporary I.M.S., and proceed overseas, *I had to deliver* a persistent occipito-posterior presentation, in a moffussil municipal hospital, with the compounder reading to me out of the book, and the bottle and rag anaesthesia! When that case, *my first forceps*, and the patient, the Hospital sweeper's wife, got discharged with a living babe, and I was told, it was the *first case* for sometime, in that Hospital when the *mother and/or babe* went out alive, no one was more surprised than I! To this day, with all the intensive focussing of attention on maternity problems, we find ourselves forced, to do high-forceps applications, embroyotomy for doubtful babies, Caesarean sections and Caesarean Hysterectomies, and the cure and control of the disease known as "Low Forceps and the failed forceps case", the very same, and some more problems have remained. An experience spread-over, nearly thirty years, in twelve districts, roughly divided into 4 years of military duty, including two Cantonment Hospitals for British Women, and periods of 12 years in moffussil and 12 years in District Headquarters Stations, and dividing my "devastations," half in the Andhra Districts and half in Tamil parts, all these years, have only gone to prove to me that the *obstetric problems* are still *there* in their *grim, unsolved, menacing, entirety*! Our "consciousness" of them, has increased together with, perhaps, a little more ability to deal with them, but the resources and plans and personel have not been proportionately augmented. With your indulgence, I shall endeavour to show you, what these problems are, say in a 100 to 150 beded, modern Hospital at a District Headquarters, South or North, East or West, and leave the more intriguing and perhaps, more intellectually stimulating part of finding their solutions very, or even, questioning there existence, to the members assembled here, who with their much more varied experience, are in pre-eminent position, to suggest the appropriate number of rounds, referees and rules of boxing in the high level debate to follow!

You will pardon me, if I have to be somewhat 'sketchy', and what is really an unfortunate and a pet failing with minor minds, I happen to be a little *dogmatic*. You will bear with me, if my conclusions are erroneous, but I am avid for corrections, and you will find me astonishingly, refreshingly and chivalrously, owning up my mistakes, you have only to point them out!

The problems, then easily bifurcate, themselves into two distinct groups,

the *administrative* and *professional*. The first and foremost, is the question of Staff, especially, Women Medical and non-medical staff. We get Staff Nurses "with maternity training, but we can hardly keep them restricted to do maternity work and maternity work only. In a District Headquarters, as in a small community, the legend gets abroad, that a particular sister, a particularly kind sister, a Matron in name as well in reality, I presume, with a 'Flair' for organising a maternity ward, has great luck with infants and she attracts by some art or legerdemain, the pregnant female by the dozen, to the labour ward and *charms them* to bring living babies into the world, and the women go away 'pleased' for their all too brief 'one week's stay in the Obstetric wards'- a ward which is in reality 'the first and foremost of the *Neo-India's*.

Neo-National or I beg your pardon, Neo, Bi, Tri, or mutbi-national "Baby-Industry"—in fact as well as in name! *I dare not describe her opposite number*! Probably, she has solid reasons for the tenets she holds, and practices. She has a negative chemo-taxis to the pregnant female. She thinks perhaps this country, this land of chronic pregnancy is over populated, and delayed birth-control, is preferable to no birth control. And as with mosquitoes, the adult catches are as good as larvoecidal remedies. The number of admissions diminish, as well as perhaps, the number of 'ration cards' under her regime. This remark applies *when and if we have* Nurses to solely attend to the labour wards! Very often the paucity of nurses do not permit us this luxury. The Women Medical Officer has to carry on with midwives and these Women Medical Officers, have exacting collateral duties, at the out and inpatients, they attend courts and are so frequently changed and shifted and so infrequently relieved by substitutes, when they become casualities, that if any department suffers on account of understaffing, it is the Obstetric. A couple of midwives, responsible for 800 to 1000 deliveries a year, with some pupil midwives 2 to 8 or (10 during the past month or two) (when the training system was introduced by the late ministry) supervised by a shifting Staff Nurse; is a hard problem, when it comes to arranging "Duties." The Government Women Medical Officers; during their busy out-patient hours, conduct a kind of ante-natal clinic at the expense of the time of the weary waiting women outpatients. It could not be of any real value, if there is no follow-up machinery, and if no P. V. registers are maintained. This ante-natal clinic is, however, the municipality's prime function. And yet in a municipality, in my place, which conducts six such centres for "child-welfare" and as many ante-natal clinics in various parts of the town with a Woman Licenciate, as a superintendent and as many as six midwives, not one of these centres, is located in the Headquarters Hospital. These centres distribute "*advice*", but no milk, no medical comforts, no medicines, no dressings! They spot various remediable maladies, Surgical, Medical, Ear, Nose and Throat, Skin, Veneral, Nutritional, Occupational, but beyond the laconic "Go to Hospital" nothing much appears to be achieved or attempted. No ambulance, (petrol, gas, bullock or rickshaw and God forbid and pardon me, no jeep! ever) collects them. No centre midwife marches them into the Hospital, except heroic and last-ditch stragglers, who reach the Hospital, in the eleventh hour, and who arrive there with the dice heavily loaded. Anaemia with 20 to 30% hæmoglobin, frank anasarca with threatened or actual congestive cardiac failure, and as already mentioned with tainted skin, veneral poison, high grade nutritional imbalance, crowd and get admitted and a battle Royal brews with the lords of creation on one side v.s. the lords of destruction,

and it starts right in the Hospital Labour Front, I mean the *Labour Ward Front.*

To this, one adds the problem of "*Finance and Liason*" the Municipal Chairmen are in the Hospital Advisory Committees, the Municipal Health Officers, run these centres and there are Medical Officers of the Municipal Dispensaries, all of them could and should cater to the needs of the expectant mother and build up the ante-natal care, run the maternity homes, and provide domicilliary treatment and other amenities, to its low income level groups, referred to by the centres or by the general practitioners. Alternatively the small Dt. Headquarters Hospital should meet them half way. It is at this stage the major issue of co-ordination or amalgamation, between the Health and Medical Department, enters the arena of discussion, and that makes it to say the least, infinitely *interesting;* and the solution *infinitely*, will-o-the-wispy, far away and frightening!

I shall not pursue the administrative problems further, for I will be encroaching on the time and patience, you have so far shown to me and are, yet to bestow, on the purely professional problems, which we can remedy by the exercise of a sharp intelligence-as the Surgeon said to the young aspirant when he wanted to do his first huge cancer of breast! "Have a sharp knife and plenty of determination" Now to an exercise of sharp intelligence and plenty of determination!

Following directly from the set up described above, the first problem that one meets is the "Anaemia of Pregnancy". These anæmias have arrested world-attention, and I believe there is a world shortage of hæmoglobin, *paripassu* with a world shortage of food. This lack of Hæmoglobin, is not all due to Hitler nor to the political situation in the North or South of this country. We see it much in evidence, in the world of pregnancy and childbed, and to an unwelcome degree in the maternity wards of the small District Headquarters Hospital. Whatever their classification, they yield to lots and lots of vitamins, yeast, concentrated protein foods, liver extracts, exhibition of plasma, but the main problem is, they do not yield to any and or all of these *in the 38th week of gestation*, at which awful "*zero*" *hour* the small District Headquarters Hospital, picks them, up from the outpatient, like the Parson's baby! There are only 5 or 6 places, where transfusion facilities exist, plasma cannot be bought or loaned, sold or cajoled in this country, not many personel exist who are trained in transfusion technique and blood donors and blood banks, are few and far between, and mainly grow for some mysterious reason round about flourishing jails like the Central Jail, Trichy. Meanwhile the Superintendent making the round of the Obstetric ward, sees these women, big with child, all *down and out*; *stricken* with anaemia and hears their still voice whispering into his unconscious. "I, as Superintendent of this Hospital have to execute these mothers much as the Superintendent of the Central Jail! Judge Nature has tried and pronounced her sentence of death. These condemned say, in effect (1) "I come, I deliver and I die, (2) "I come, deliver, I go home and die," (3) I come, deliver and go home, but ah, me, never again to work! (4) I come, I go and I come back again but with pregnancy and T. P., with pregnancy and Heart, with pregnancy and V. D. but I shall not leave this Hospital but leave behind a couple of orphans" It is too sad for words. And, believe me, this is no exaggeration. The relations remove them against advice to keep them in Hospital, *sign*, they do so at their own risk and they are dead invariably in transit or shortly after!

I shall now pass on to the second of the problems-the problem of *Caesarean section.* I had intended to talk only about this at this first, but I preferred, now to stating the *context in general*, at this preliminary meeting and discussing the subject of Caesarean in extenso later. I can, therefore, only touch, cursorily, on this important subject. Rightly or wrongly, I fain would believe rightly, we are doing more of these sections in small District Headquarters and as my colleagues inform me, in big District Headquarters as well, and the indications are in each instance, unexceptionable, we have done I6 within a year! A skiagram of the pelvis, calibrated, if possible and a good pictare, is an un-obtainable, luxury in the small District Headquarters Hospital. A portable plant, with an intenerating Radiologist, "who has a train to catch" and excuse me! is the utmost that one can expect. Doubtful cases with dystocia, and the short statured baby-mother and,elderely prime with relative disproportion, constitute the main indications. High-up-heads, threatening Bandl's ring and rupture, from another set of indications. The elderly primipara, with her "never dilated", and "dilatable" or "dilating carvix", is another and a floating persistent brow with tonically contracted uterus, yet another. The "bad-obstetric-history-case", women who lose "child-after-child by three day long labour ordeals" with sure as fate embryotomy and who seek admission and clamour and implore for a live baby, form a class by themselves. There is no problem in doing these sections as an operation, successfully. The *problems* arise, when the guardians have to rush many times, and to many places, to obtain the necessary consent to operate, especially the consent of the husband who very often has his own and the casting vote and generally is out of reach and time presses. The problem arises also when a Caesarean section offers, the only hope for a live child, but a heavy maternal risk. The *problem* arises when a skilled anaesthetist only can save the situation and he, as often as not, is unobtainable just at present at the small District Headquarters Hospital. Even the bright strategy, of cutting the Gordian knot, by a Caesarean section, is tempered by the awful turn of events, by which we had to do a Caesaren Hysterectonmy for a case, who quietly ruptured her uterus, while undergoing trial labour and (to avert the tragedy of dead children with forceps in the past) some untreated, snail track ulceration in the past and/or weak seer which gave way! She went away the very picture of desolation, to her home and husband and frustration to the attending doctor and the Ars Obstetrica!

This takes me on to "*the use and abuse forceps*" including the Willet's forceps, which perhaps is less used than abused! The "failed forceps," a very dreaded situation for the novice, out in the villages, is also another *puccacity* problem. The back-ground to the "forceps application" with or without, "accouchement force" (*i.e.*) dilatation of the Cervix, manual or otherwise, is furnished by the concept of what is a *Normal Labour*, and *who* and by *what* standardisation and *when*, the medical and non-medical staff concerned, decree their fiat "*She will deliver normally*"? The crux of the problem is-*when* the case departs from normality and *who* signals this up to *who* in the obstetric team consisting of (1) pupil midwife (2) Staff midwife (3) Staff Nurse (4) duty Medical Officer (5) or duty Women Medical Officer (6) the Gazetted Director or Directress of the Obstetric unit (7) Assistant Superintendent (8) and Superintendent cum, and so on and and so forth: in a "*crescendo of competitive co-operation*" for a living *child* and/or a living *mother*? There is regrettable short circuiting, no clarity of procedures, no factual collection of data, on the obstetric case sheet and the problem is faced, when it is up against

one and the team hurries or not to its work of solution. To quote Omar "The ball (here the foetal head") no question asks! of. "Ayes" and "Noes". "And hither or thither as John or Joan pulls," it does *not* go and no one knows what will happen except, he or she, who the forceps pull and those who hold the legs, he or she knows. He or she knows the pain of the pull, for 2 days! The team has plenty of catchwords like these "Nothing, doing unless the cervix dilates," "Next to a full bladder, and rectum, there is no obstruction to a normal labour in a normal pelvis in a normal woman", "what this patient, wants is food by day and sleep by night", "meddlesome midwifery is malpractice:" These are all healthy maxims, spouted vociferously but alas! the days of too many P.V's' are now replaced by "*No. P. Vs.*" the days of anxious watch and ward by the patients beside, charting the "pain" and feeling the pulse and the uterus, are replaced by "Sedation", "reliance on the clock", and "maximum of interference with minimum of warrant, with the scared pupil midwife alone standing on the "floating deck, whence all but she has fled" and/or the learned team happily "alert" on their several beds in their several "duty rooms", awaiting the normal case to thus *announce* its unintended adventure to the contrary.

The case ends in the application of forceps and immediately *the problem of having applied* it starts, and culminates in P. P. H. Purspural Sepsis and Penicillin! In some hospitals, the Women Doctors themselves manage their show, and sternly cry off, any poaching on their preserves, by the mere male elements on the staff. In other Hospitals they are so hardworked and weary, by night and day duties, of a general nature, that except during their tour of daily duties, the odd forceps, by which I mean, *the emergency forceps*; falls to the lot of the duty doctor, who may be male, female, L.F., reserve, refresher, house-surgeon, student, post graduate etc., So long these are "*knowledgeable*" and keen and do their job, well and good. But the problem of continuity of "treatment and standardisation", so well appreciated a procedure in other spheres, of team work arises. The 'forceps' case of course, remains a little longer than the other cases in the wards but "that little" is only for less than it ought to be. The perversity of the patient apart, exigencies of space and demand for admissions require her discharge *too early*. At this point an important event, namely an examination of the genital tract for traumatisms, infections, sub-involutions, discharges, ulcerative inflammations, leaks, are all missed, for "no examination is made as a routine, nor record kept, nor a follow up ordered or made." Often the '*forceps*' cases, are an import from a neighbouring area and are exported with despatch of an elsewhere urgently wanted railway waggon! Thus are the prolapses, fistulae, back aches and cystoceles and rectoceles promoted, and this obstetric scrap and lumber arrive back again to the big District Head-quarters Hospital in fact, a perfect Laurel and Hardy arrangement, the small Hospital producing, *them and the large hospital collecting them.* No post-natal worker sees them, for the good and sufficient reason that no Ante-natal worker has known them.

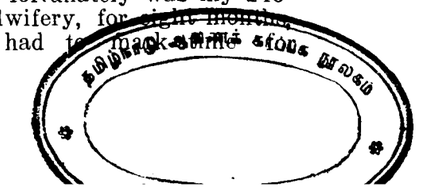
I come to the last of the problems I have listed. The problem of the "Eclamptic." There was a happy type design "maternity" block in general use at all older District Headquarters Hospitals which possessed a small 4 bedded Eclampsia ward, and which in most places did not include, as do modern constructions, a separate "clean" and "septic" labour room and/or ward. For some reason or other the Eclamptic comes, after severe handling outside and goes straight into the eclampsia ward, where also septic cases are admitted or where the septic cases, are

being conducted on a table nearby and septic cases are cluttered about the verandah. After her delivery the eclamptic finds herself generally with other "septic" cases. The integrity of the "*small exclusive "Eclamptic" ward,*" with its freedom from glare, noise, too much human bustle and traffic is hard to maintain, in places which have not di-chotomised into "Clean" and "Septic" and added an extra small ward exclusively for the eclamptic. This is not an "insuperable" problem but when so many things hang on a slender thread, this easily becomes one of life and death, as to *where* the eclamptic delivered and *where* her bed was put and *why* and *how* long she lay near a *morbid* case!

I have stated these various problems, which I am daily meeting and gaily solving without mischief, malice or premeditation, my only desire is to elicit your understanding and sympathy. I should also like to summarize, and close this "loud confessional" with a recapitulation, of how best we are trying to solve them, and how best our friends may help us to solve them, and our stern critics, may spare their breaths, to cool the post-war porrids-if and when it comes in "glittering array, and with full Bhore Committee panoply of blood banks, X-ray outfits, Laboratory Technicians, and its cohortes of trained anaesthetists, municipal, ante-natal, and post-natal, clinics, domicillary treatment by nurses, Medical Officers and free ambulance services, so on and so forth, until imagination reels! It will be a millenium for the cause not only of obstetrics but to the general good of the small District Headquarters Hospital in all its working.

For the present, the general practitioner is invited to be come more "*anaemia-conscious*;" "pregnancy-anaemia-conscious" and blood and/or plasma-transfusion conscious! These services can well be in the hands of the generation of private practitioners and/or Honorary Medical services and others, many of whom may have picked the necessary technique in their recent military experience or the junior general practitioner starting this direly needed speciality. Training of *pupil midwives,* now done in the intervals of duties by the hard worked members of the Nursing and Medical Staff, often unacquainted with the language of the area, and never paid for, should have a realistic background. The pupil midwives, may be supplied with watches as well as sarees, with shoes as well as sewing materials and provided with the semblance of a small school room, with charts and models, blackboard and a house or hostel within the Hospital, where they can live a *pupil's* life, instead or being factotums, carrying out menial tasks, and maid-servants-duties for 18 months for mediaeval midwives and angry apoplectic matrons! They should maintain and be taught to maintain "Pain" charts, and the staff nurses posted to maternity wards, should specialize in that work and remain in rotation in that section just as the theatre sister and it is she, who should conduct the *normal labour*, with the midwife under her and assisting her and the pupil midwives all round her, and not as it now happens with the fossilized staff midwives, independent of her; with vested interest, mamools, or a superannuating menopausal menace, hag-riding them and frightening, the young things, into scared unintelligent automatons.

It is no "pleasure" to give the "inside story" or anything especially, in the world of Obstetrics and Gynecology, except before men and women capable of apreciating, the affair and competent and eager to apply the remedy. With the full hope and trust that such is the august occasion at this moment, I proceed. General Giffard, I.M.S., the great founder of the Giffard School of Midwifery in Madras, who fortunately was my Professor of Midwifery, for eight months he having had to [illegible]



another Surgeon-General, who was a bit slow in retiring or taking even earned leave, used to tell us, much influenced by what he then saw in French medical practice, especially that of Pinard, during his study tour of the Continent in 1916-17, that if the foetal head is never out of your observation, you can always catch and shake it! After it has sunk into the inlet of the pelvis, you can palpate it between the tip of the coccyx and the pubic arch and until it turns round the corner, the famous curve of Carus. He advised us to feel it, whether each successive pain brings it within your palpation or it gets stuck in midcavity and hours pass and it is not palpable between the coccyx and the fourchette. He used to assert that next to a full bladder and rectum, cord round the neck, arrests this further progress. It is a call for action, for inaction leads to secondary uterine inertia or tonic contraction and its further complications. The remedy is simple, turn the patient for a moment on her side and feel at the tip of the coccyx you will feel the head jammed below the coccyx. If the patient is in the Lithotomy position, strong pains are needed to turn the corner, make the perineum stretch and dilate the anal ring and appear at the outlet but the *hold up* occurs before this is realized. As this is not realized soon and as no P.V's can be or are made, even aseptically, under the new teaching and traditions, a vigorous labour is permitted to come to a stand-still and much avoidable foetal mortality produced. It is at this stage, that a few doses of quinine, a little pitutrin, a P.V., a low forceps application, spell the difference between a living babe and non-traumatized mother or the reverse. And I seem to hear, even now the stentorian voice of the old General, stout, severe, with the upturned moustache a-la-Kaiser-Wilhelm, with a blue tongue and alas, a nuthmeg liver crying "Thou shalt make born living children," but if thou canst not, thou shalt at least discharge" "living mothers" and perforate between forceps blades, God above and faith within, but "thou shalt not traumatise the genital canal for dragging a corpse or near corpse through it."

The Willet's forceps can and should be used more often in all its indications. The elderly primpara's non dilating cervix has succumed to its blandishments, in my experience. But a perfectly well adjusted pulley and a comfortable, modern-designed maternity cot, are required for its correct performance. I make a very strong plea for a post-natal ward; "discharge and home" is not the formula for many half way house cases who are between cure and invalidism. Especially the stormy convalescent "post forceps,-post eclamptia,-post-penicillin" type of cases. The medical wards wont accommodate them, it may be also dangerous to send them there. A ward of 4 beds scrupulously kept for these post-natal wrecks, should be provided. And we can salvage many a potential V.V.F. and procidentia, backaches and discharges galore, not to mention, insidiously developing true heart, liver, blood and kidney disease after a confinment. Incisions into the cervix and episiotomy have been and should be practised more and they save the horrors of central-third-degree-tears, which unlike "mercy," curseth him or her that "gives" and thrice accurseth her and the other him, that has the charge of her later, as husband, doctor, specialist and what not. And these "repairs" are not always the success they are claimed to be on the patient's discharge, either they are too much of a success when they tear out again or cause numerous abortions, too little, when the status quo is again pitifully evident.

I have also, as for as possible, tried to collect the mothers who have lost their babes in a separate group, so that

the unfortunate girl, may not suppress her shame and sorrow and silent inferiority complex along with her swelling breasts and sigh at the smiling twins at the next bed. Puerpural Toxic Psychotic states may be perhaps promoted by undue introspection and frustration. If she sees herself amidst a few other baby-less mothers like herself she may brood less. "Better luck next time" may be a hopeful slogan and in practice, that better luck is just only 300 days off in this country from the moment she goes home!

Whether the municipal workers, in ante or post natal field, in their child-welfare and maternity clinics, help the small District Headquarters Hospitals, by first having a joint Central Office and a centre in the Headquarters Hospital may be a wishful thinking, but liberal supplies of vitamin tablets, protective foods, like dried milk and baby foods, to mothers and babes of all ages and stages, should be distributed by some body or other, why not the small District Hospital!

I have to close this very rambling and perhaps ruminating address, with a fervent vote of thanks on my individual behalf, for your patience and indulgence, in sitting through it and hearing its elaboration. It is no pleasure to say all this in public, even the protected, privileged, close knit, medicomasonic public, of the Indian Medical Association, made momentous and memorable by the immediate presence and patronage of Col. Bhatia, and ably sustained and supported by Lt. Col. Karamchandani your local chief, who is just awaiting to apply his magic wand to the newest of the Hospitals to come into the South, with the longest of second stage pains on record, probably next only to the Erskine at Madura, which took only the short span of time between War I and War II, a difference of 25 years between the gathering of the waters and cutting the cord by Gubernatorial scissors! I say it is no pleasure, but a definite pain goes off my chest. I should call it, negatively speaking a potential pleasure. To see some achievement, somewhere, somebody up and doing, with a heart for any fate. This is diluted by the feeling, that probably the easing of my chest condition might have transferred the pain to your ears, for which of course, there is no other remedy except to hear the subsequent speakers, preceded by my apology for this very long hold up.

I thank you all once again and I hope on a future occasion, when sooner or later, in service or retirment, I visit this place, and pottor about the new Hospital, here I shall seek in the Maternity plant and works, for "New-India or Bharat" and we will all be proud and happy at the finding, that, *that* new Creature, will be one that will make, two blades of grass grow where there was one before, and not two thorns where there was none-one an atom bomb and the other bug or Bactericlogical bomb!

There is only one more item left, and that is a composite problem one which has at once an administrative and professional application. It is the problem of *courtesy continuous, consecutive, and constructive*! It should be "*continuous*" from day to day to the woman in labour, her attendants and visitors, ignorant or lettered; well to do or poor; Of whatever caste, creed, colour, and political label. It should be *consecutive*, from the Superintendent to the sweeper, and *competitive* from the sweeper again to the Superintendent. It should be "constructive". The weary, huddled mother, must go back to her home and environment, not with a feeling of flight or escapism, not with a feeling of release from a smaller to a higher prison, with this *Neo-Indian-Creature of dimorphic destiny*; in her arms but with a feeling

(*concluded on page 19*)

THE GENERAL MEDICAL PRACTITIONER AS A SURGEON

BY

DR. N. S. NARASIMHA IYER, F.R.C.S., Madras (*Concluded*)

Talipis cases should be treated a week after brith, by correction of the deformity with adhesive plaster. , As regards harelip, it is better that the children are operated when they are 3 months old, if the baby is gaining in weight and has no respiratory infection. Cleft palate cases should be operated at about the end of the second year, so that their speech may not be permanently affected. Meningoceles are operated at a much earlier age than it used to be, so that there may be no excoriation or abrasions over the meningocele. Hypospadias can best be dealt with at the age of 6 or 7. Ectopia Vesicæ require the implantation of the ureters into the sigmoid colon and is best done after 5 or 6 years of age. When a practitioner is consulted about anterior poliomyelitis it is important to realise that Prostigmine, warm baths, hand massage are the most important of all. Splinting of the paralysed muscles with no weight bearing are the correct methods of treatment. This is a disease where the maximum degree of recovery takes place within the first two years. After two years the use of a special apparatus becomes necessary, if residual paralysis is present. After the age of 6, joints are to be stabilised by surgical procedures. At present most members of the profession disregard this disease and do not give correct advice.

Very often it is asked whether temporary teeth can be removed. Removal of these teeth is not advisable. But if a temporary tooth fails to shed in time, it may interfere with the proper alignment of the teeth, and hence can be pulled out.

Delay in the walking of the baby is one of the common conditions for which the practitioner's advice is sought. People give different aids to help walking as push-carts, etc. If mental deficiency and spastic dipleqia are excluded, rickets is the commonest cause of delay in walking. These children should not be allowed weight bearing as this tends to produce deformities. Deformities may be prevented by irons and boots. When deformities like knock-knee and bow legs develop, they should be treated by operation, when the active rickетting stage has passed off.

SECTION 3. Recent wounds are treated by proper cleansing of the skin outside the wound and excision of the lacerated margins of the wound and devitalised tissue and primary suture. If this is done within the first 8 hours most wounds will heal by first intention and there is a 90% chance of wounds not becoming infected. This principle has been tested widely in the World War II and has been found to be successful. If the first few hours are neglected the wounds become infected. So prevention of sepsis in wounds which will occur at all times and everywhere falls essentially to the surgery of the general practitioner.

Tetanus has been entirely prevented during the World War II by the prophylactic use of two injections one immediately and one a weak later of Tetanus Toxoid administered to every soldier. A few doses of anti-tetanic serum can be stored by the Practitioner at room temperature with the negligible risk of slight dimunition of potency and its prophylactic value is immense. It will prevent Tetanus, the mortality rate of which is in the neighbourhood of 60%. We are indebted to Lord Lister for the great principle of prevention of wound sepsis. But we owe an equal debt to the Practitioners who will execute this principle of prevention of wound infections.

It is the practioner who is going to see a burn's case at the 1st instance. In addition to giving Morphine to prevent shock, Sepsis can be prevented by smearing an ointment of Sulphanilamide 5 in a Boric Acid ointment base. The patient can be covered with a clean newly washed cloth. Elaborate dressings are not necessary. Plasma transfusion is not available to any Practitioner except in Cities and it is very difficult to decide whether the patient should be transferred to a city for transfusion. Shocked cases tolerate transit very badly.

Volkmann's Ischaemic Contracture is a condition which is seen commonly. When once contracture has set in, treatment is not of any value. So prevention should be our aim. This can only be prevented by the Practitioner who has to be wide awake in cases of injuries of the elbow and injuries of the limb where an artery may be damaged. The first sign is pallor accompanied by pain of the fingers. This is due to arterial spasm. Later only, do we get œdema and duskiness which is due to obstruction to venous flow. All constrictive bandages should be removed and the pulsation of the vessels noted. If there is no pulse the artery should be exposed, by operation within 6 hours. After 6 hours no interference is of any value. As only the wearer knows where the shoe pinches, so also in a patient who complains of pain and tightness of plaster, the plaster should be completely split and opened out and the limb examined even at the middle of the night. This sort of constriction is very common with the indigenous method of splinting with split bamboos.

Myositis Ossificans is a condition which can be prevented in 90% of cases. It results often over joints which are subject to vigorous passive movement and stretching exercises. It occurs in supracondylar fractures, dislocations and in any type of injury occurring in the region of the elbow joint. It may occur in any joint and is commonly due to gonorrhœa in the case of the knee which may be subjected to passive stretching. The scope of prevention of this condition will be entirely due to the influence and advise of the practitioners in villages where the indigenous bone setter commonly practices vigorous massage and passive exercises.

SECTION 4. Prevention of certain conditions on a nation wide scale, as Carious tooth during childhood and pregnancy, Scurvy in babyhood, deficiency states due to avitaminosis as Keratomalacia, Osteomalacia, Xerophthalmia, Rickets, anæmias etc. falls entirely to the lot of the Practitioner. While it is commonly realised that all open cases of pulmonary tuberculosis should be segregated and the sputum disinfected it is not sufficiently realised that being in contact with cases of open tuberculosis is the common cause of both pulmonary and surgical tuberculosis. It is the mobilisation of the profession and the active propagarda of this information that will enable the state and public to make arrangements for the proper care of these cases.

Every sinus of a tuberculous nature be it from skin, gland or bone contains active Tubercule bacilli, the dressings should be burnt and relatives instructed to handle these cases with proper care and for disinfection.

Duodenal and Gastric ulcer is common in our Province. A large amount of surgery is done on these cases. It should be understood that duodenal obstruction is benefitted by gastro-jegumostomy; Gastric ulcer requires gastrectomy. Many cases of duodenal ulcer are benefitted and can be cured by medical treatment. The medical treatment consists at present in neutralising free Hydrochloric acid in the gastric juice; this free HCl prevents the heaf ling of the ulcer. In the majority of cases the antacid properties of many drugs as Sodii Bicarb, Calcium and

Magnesium Carbonate, and Tribasic phosphates, Aluminium hydroxide are transient and act for a short time only. The transient effect of these drugs is due to rapid emptying of stomach. Even hourly milk feeds are not enough. The satisfactory way of neutralising free HCl is to give milk by drip feed through a Ryle's tube passed into the stomach through the nose. 5 pints of milk for 24 hours is effective. This treatment has to be continued for 4 to 5 weeks.

If this treatment is not practicable, 1/2 oz. of Olive oil and 1/2 oz. trimagnesium silicate in 8 oz. milk is given every 2 hours between main feeds. The food may consist of anything but should avoid roughage, and avoid all irritants as mustrad, spices, vinegar and alcohol, olive oil reduces the output of HCl and delays emptying.

Belladona controls hypermobility in 30 minim doses or 1/100 gr. atropine and produces prolongation of emptying time and thus it is valuable in producing relaxation and easing of pain. Atropine and Hyoscyamine are equally effective in blocking vagal impulses. They have no action on diminishing gastric secretion.

Anxiety and worry are inimical to healing. Phenolbarbitone Gr. 1 tid is useful, if it fails, Douthwrite recommends Cannabis Indica Gr. 4 four times daily. It will allow of continuous drip feeding in patients who would otherwise be intolerant to it. The drug need not be prolonged for longer than two weeks,

Smoking should be prohibited; mustard, vinegar, curry and strong alcoholic drinks, pepper and ginger should not be allowed. Sepsis of the sinuses of the nose and tonsils should be excluded. Conservative treatment of oral sepsis 'if present' is done. Ankylastome infection is dealt with. Few patients undergo medical treatment as detailed above. Operation is indicated urgently in perforations; when the patients have heamatemesis it is better to operate, and obstructions at the duodenum require operation. Operations for non-obstructing duodenal ulcers are not uniformly satisfactory. A certain percentage about 15/ come back with a gastro jujunal ulcer. Medical treatment and dietetic control and suitable occupations are required in the after care of all the operated gastric cases.

Varicose Veins and Ulcers: Recruitment from our province for labour and for soldiers has revealed that varicose vein is a common condition in these parts. Varicose veins produce œdema of legs, tiring out and weekness of the legs, dermatitis, ulceration of leg, attacks of inflammation and sometimes hæmorrhage. Varicose veins are very successfully treated by injections of 2 c.c. of quinine (a solution which is made up of 4.2 gm. quinine urethane of uncthiam in 30 c.c. of water) once a week by the empty vein technique. Crepe bandage is also of help in preventing dermatitis and ulcerations. Operation is necessary only when there is impulse transmitted along the internal shaphenous vein and when there are pouchings which cannot be dealt with by injections alone.

Amoebic Infection: Amoebic dysentery is very common. Clinically it can be diagnosed when the motions contain altered blood with mucous and the reaction is acid. The motions are not large and may occasionally be even well formed. A fresh specimen of stools should be used for microscopic examination. Microscopic examination shows a mononulear reaction with active entamoeba hystilytica. Many negative results are due to examination of stale motions. The proper treatment of amoebiasis prevents many surgical complications as, amoebic hepatitis and tropical liver abscess, amoebic ulceration of the colon, amoebeoma of the caecum which mimics tuberculosis of the caecum and appendicitis and

may produce Intussusception. Amoebic ulcers of the abdominal wall after intestinal operation and amoebic ulceration of the anal margin are also seen. They can be seen with the naked eye and can also be comfirmed by microscopic examination of the discharge. Perforation and gangrene of the colon have been seen in cases of amoebiasis.

Bacillary dysentery produces many complicatious as ulcerative colitis, chronic peritonitis, peritoneal adhesions, cirrhosis of the liver, arthritis and fascitis. Many cases of non specific ulceration of the colon have to be operated upon. The operations may vary in severity, from anillostomy, partial resection of the intestine with mesentary or a hemicolectomy. So the proper treatment of bacillary dysentery with Sulphaguanidine or sulfasuidine 2 grams every 4 hours till the motions are formed, is an important factor in treatment.

Stricture of urethra is one of the commonest conditions met with in general practice. Many hospitals in England maintain a stricture clinic on Saturday afternoons for dilatation service for workmen who may be able to attend the clinic on their way home from work, with a Sunday for rest.

This is a preventable condition but if a stricture occurs it should be kept dilated once a week for 6 weeks, once in a fortnight for another 6 months and once a month for a year, and once in 6 months after that. If this is done many of the complications are prevented. These complications are extravasation of urine, retention, of urine, periurethral abscess, multiple urinary fistulae, cystitis and infection of kindneys which account for a high mortality and morbidity and which require big operative procedures.

SECTION: 6. Closed injuries of the limb as a result of fall of heavy beams and masonry may produce a large haematoma as a result of arterial or venous injury and may also damage the circulation of the limb. If the hæmorrhage is large there is shock. As it is a closed injury operation has to be delayed. The limb should not be kept warm, but is kept open at room temperature so that blood is not drawn to supply the unimportant skin. Most cases which end in gangrene later on due to arteriosclerosis or diabetes or thrombo-angitis obliterans have definitely shown signs of insufficient circulation of the limb for a long time previously. Such signs are migratory phlebitis, cold feet, disinclination to walk and take exercise, a tendency for sedentary habit, leaving off pastimes namely cycling, playing tennis or any game, changes in the nails as hyperkeratosis or brittleness, onychia, corns and perforating ulcer. Circulation to the limb can be improved by gentle exercise. Diabetes should be treated by diet and Insulin therepy. No drugs administered orally is of any value. There is no substitute for Insulin therepy at present.

Infections of hand: A great deal of propaganda has been done on the treatment of infections of the hand by the medium of cinematograph films and monographs. The economic difficulty which an infection of hand causes is enormous immediately and later. If there is lymphangitis no operation should be done. Penicillin and Sulpa drugs are indicated. Infections of hand always require a general anaesthetic and a correct placing of the incision. Early movements must be encouraged and practised in the presence of the doctor.

Penicillin has been of great value in acute infections such as Erysipelas, Carbuncle, Cellulitis, Cancrum Oris, Caver noussinus thrombosis, acute Osteomyelitis, sinus infection, acute Otitis media, Gonorrohea, Syphilis and Gas gangrene. Gas gangrene can be prevented by the use of Penicillin and also cured by it. Many Practitioners are aware that an acute infection of the lower jaw occures after an extraction of teeth. Use of Sulphanilamide for

three days before dental extraction is now recognised to be of great value in the prevention of Osteomyelitis.

Some abscess, as Ludwigs Angina and peri urethral abscess should be treated by the Practitioner himself. If the case is advised to go to a distant hospital the patient may develop oedema of the larynx before he reaches the place and die, or he may develop extravasation of urine and become very ill. Ischiorectal abscess and anal abscess should be properly opened under general anaesthesia. The subsequent dressings and watching till it is completely healed are very important to prevent the formation of a fistula in ano, which is frequently met with in practice.

Internal piles of the 1st and 2nd degree are treated by injection of 5% carbolic acid in almond oil into the sub mucous tissue around the pile mass into the correct place through a speculam. Piles cases have a tendency to recur if the patient's bowel habits are not corrected and if there is a tendency to strain. Operation is always required in cases of prolapsed piles which cannot be treated by injection treatment. A general examination of the patient for enlargement of the liver and spleen, organic disease of the heart and blood pressure should always be done. Proctocaine injection will relieve the pain of a fissure in ano.

It is better to learn the art of shaving off corns and to lift the margin of an ingrowing toe nail to save our own reputation.

Many doctors will be consulted about stiff joints. The indigenous bone setter and masseur employs massage and passive movements. It is better to know some rules for guidance when a joint can be moved and when it should not be. Great harm will be done if a tuberculous joint is manipulated. It is a safe working rule that no manipulation should be done if the joint is warm. A joint, the external skin of which is cold, can be manipulated.

In every district in the province there are indigenous bone setters, with no knowledge of anatomy, with no idea of pathology and with no help of anaesthetics. These men have the cleverness to impose themselves on the minds of the public. It is time that the practitioner realised that they should adopt an active policy of treating these cases. No indigenous practitioner can treat a real dislocation. If the dislocation reaches the hands of even the most capable Surgeon late, he will feel helpless that he will not be able to restore normality. Dislocations are common in the shoulder, elbow, hip, metacarno-phalangeal and metatarsophalangeal joints. If the case is recent, under an anaesthatic the reduction is easy. The after effects of an unreduced dislocation at the elbow, cause a great deal of economic disability.

As soon as a fracture occurs there is not much pain on account of the immediate shock. Local swelling is not immediately present. Reduction of the fracture at this stage can be done with a perfectly good result and the fracture must be immobilised by plaster cast or cramer wire splint in the case of upper extremity and in the case of lower extremity by skin traction in a Thomas' splint. It is only when the fracture is not treated there in a large amount of hæmorrhage and oedema. There is muscle spasm, which prevents proper reduction even under an anaesthetic.

If this time-factor is more than 24 hours proper reduction becomes difficult. Radiographic examination is useful when available. If these practitioners who treat fractures more commonly take into their confidence the other practioners of the locality then every practitioner will gain confidence eventually, resulting in great benefit to the general public. The result in a case where First Aid has been given is decidedly better than in a case where the limbs are left dangling without support. Because muscle spasm is the chief obstacle to perfect reduction. The training in First Aid treatment given to Scouts, Policemen, Teachers and Sanitary Inspectors are not availed of in any organisation. "Splint as they lie" was the advice preached to all Air Raid Staff during this World war. The American College of Surgeons have organised on a nation wide scale in America the proper First Aid for fractures. It was easy to equip every practitioner with 3 or 4 Thomas Splints as a large number are now available in the market. This simple equipment and treatment with its aid will lead to improved results.

Neglated cases of fractures require elaborate surgical procedures which are all available.

Compound Factures: should not be reduced unless the skin has been disinfected and the wound excised. The protruding fragment should not be reduced unless it is properly cleaned. The limb should be splinted. Antitetanus serum, Penicillin, and Sulphanilamide should be given to get healing of the wound and to prevent sepsis, tetanus and gas gangrene. The limb should be watched for efficiency of circulation and gangrene. Cases difficult for handling are better sent to an Institution.

(*Continued from page 13*)

alike, to going from a friend's to a dear relative's home, or vice versa, from a dear relatives to a friend's home. The house shortage and economical position is bringing the better class of people into the labour ward, and it is well to bear in mind that whether they complain or not, they see things for themselves and will be sensitive about many things.

I hear some one say, there is again a World shortage of this commodity "**courtesy**!" Courtesy is controlled nay rationed, especially in the small district Headquarters Hospital and even in smaller units! If so, I humbly thank you, once again for just a little of it and crave your permission to sit down

BLOOD SUBSTITUTES *(Concluded)*

BY

DR. V. IRAVATHAM, D.L.Sc., D.T.M., TRICHINOPOLY.

Plasma, regardless of the method of preservation, possesses certain definite practical advantages over other blood substitutes. Plasma may be defined as that fluid portion obtained from whole blood containg an anticoagulant such as sodium citrate, after removal of the red and white corpuscles by centrifuging of sedimentation. It contains all of the proteins, *i.e.*, albumin, globulines, and fibrinogen, which normally occur in the fluid portion of the circulating blood. Serum differs from plasma in that it is obtained from coagulated blood, and therefore does not contain fibrinogen. At the present time, medical thought is somewhat divided with respect to the relative efficacy of serum and plasma, but a recent review form the literature would indicate that the reactions from serum significantly exceed those following the administration of plasma. However, from a practical standpoint, serum is easier to prepare than plasma, since it can be rendered sterile by candle filtration, whereas plasma cannot.

It has been shown that, because of the high osmotic pressure exerted by the plasma proteins, plasma does not diffuse from the circulation as readily as do crystalloid solutions; consequently, plasma is far more effective in restoring and maintaining the circulating blood volume.

An advantage of plasma over the blood substitutes is that it may be quickly and simply administrated, under adverse conditions if necessary, as no complicated apparatus or assistance is required. Plasma is safe, as large amount of citrated plasma have been rapidly and repeatedly administrated without causing untoward reactions. It should be remembered that regardless of what fluid is given parenterally, there will always be a certain incidence of reactions from one cause or another. This is an involved subject and will not be entered into here (since it has been admirably discussed by other workers.) It appears fair to say, however, that the general incidence of reactions for all forms of plasma administered under all conditions is in the neighbourhood of 5 per cent; for special series and for certain desiccated forms the reaction rate has run consistently in the neighbourhood of 1 per cent; this is a record which would be difficult to excel with any infusion medium.

Another therapeutically important fact is that plasma, in contradistinction of whole blood, does not further increase the hæmoconcentration which invariably accompanies shock and severe burns.

(These considerations led to the selection of plasma, and its procurement and storage in large quantities for the use of the armed forces; and the part which this has played in the saving of lives on the U.S.S. Kearney at Pearl Harbour, and elsewhere throughout the world has long since passed into legend.)

One of the greatest indications for the administration of plasma, in military and to no less a degree in civil practice, is shock. Shock may be of many types which depend upon the precipitating factors. While there is considerable division of opinion with regard to the mechanism of shock, there seems to be general agreement with the teachings of Moon and others that the loss of plasma through the capillary walls into the extravascular tissue spaces with a decrease in blood volume is constant. The decrease in blood volume results in the fall in blood pressure which is characteristic of shock. However, Moon and his associates have demonstrated in a series of patients suffering from shock due to various causes that hæmoconcentration precedes the fall in blood pressure and gives warning of a circulatory collapse. The essential aim in the treatment of shock, regardless of whether the condition is hematogenic, neurogenic, or vasogenic in origin, is the restoration of blood volume.

Another condition of major clinical importance in which plasma is indicated is a severe burn. (Five thousand deaths occur in the United States each year as the result of burns and many of these deaths might have been prevented by the early and adequate administration of plasma.) Severe burns are a common cause of shock particularly on the battlefield and in the heavy industries. The physiological changes which occur in both situations are similar.

Plasma is also of value in the emergency treatment of acute hæmorrhage, since no time is lost because of the necessity of grouping and cross matching. The underlying physiological principles which have already been outlined in connection with shock and severe burns apply also to acute hæmorrhage, but there are in addition certain other physiological changes involved.

One of the most important questions in connection with administration of plasma is that of how much should be administered in a given case. No definite dosage schedule can be outlined as many factors, such as the age and weight of the patient, the blood protein level, and the condition under treatment, must be taken into consideration. The important thing is to give the plasma as promptly as possible, and in sufficiently large amounts to reverse the abnormal physiological changes which have occured. We have never seen a report of too much plasma being administered but we know of many instances in which too little has been given.

CASE REPORTS

A CASE OF BRONCHIAL ADENO-CARCINOMA.

DR. V. P. NAIDU, M.B.B.S., Asst. to DR. A. SRINIVASAN, M.R.C.P., (Lond.)
Hon. Physician, General Hospital, Madras.

History: Sathyanadan. Age 25 years. Hindu. Male was admitted into the Government General Hospital, Madras, on 10th July, 1947 with the history of cough and spitting of foul-smelling blood since 2 days. According to the patient's history he had a similar attack about 3 months back. It started first with fever and cough. Two or three days later he started spitting blood which was not foul-smelling then and this lasted for about 4 days, after which the fever and cough subsided. Till now he has been free from such attacks. Patient is not a smoker or addicted to spirits and there is no history of pulmonary tuberculosis in the family.

Physical Examination:—On examination, patient was found to be a fairly healthy looking individual of about 25 years, not apparently anaemic or jaundiced. (confirmed later by Biochemical and blood examination) Not cachetic, tongue was moist and clean; teeth clean; throat and conjunctive not congested. No clubbing of fingers or evidence of septic foci could be detected.

Heart:—Boundaries and sounds were normal except for a split second sound in the pulmonary area. No adventitious sounds were present.

Lungs:—Both sides of the chest moved equally with respiration. Neither any localised swelling nor enlarged superficial veins could be seen on the chest wall.

In the left infra-axillary region, percussion revealed a dullness and on auscultation-breath sounds were found to be slightly diminished and the breathing was cavernous in type over this area with a few moist sounds. The vocal fremitus was not altered. On the right side of the chest breath sounds were relatively harsh, but were vecicular in type and there was no adventitious sound present.

Abdomen:—Liver and spleen not palpable-no enlarged glands felt.

Investigations:—Blood pressure 110/70.

X-ray chest: *Left Lung*:—A triangular area of opacity with apex towards the hilum and the base towards the periphery

extending from the level of the 4th to the 7th rib. There was no evidence of any mediastinal displacement.

Urine:—Specific gravity 1020—acidic—no albumin or sugar or deposits.

Motion:—Formed, normal colour, no ova or R.B.C. seen on microscopic examination.

Sputum:—Negative for acid-fast bacilli.

Blood:—Hb: 70% R.B.C., 4.65 million/c.mm. W. B. C. 9,600/C.mm. Differential count:— Polymorphs: 62%
Lymphocytes 33%
Monocytes 3%
Eosinophils 2%

Blood picture: Normocytic—No Malarial parasites.

Other tests:—

(1) Erythrocyte sedimentation rate: 15 minutes—3 m.m.
45 minutes—20 m.m.
(2) Bleeding time: 1 Minute 10 seconds.
(3) Coagulation time: 2 minutes 55 seconds.
(4) Thrombocytes: 1,50,000/c.mm.
(5) Blood W.R. and Kahn—Negative.

Discussion of differential diagnosis.

The possibilities were:—

(1) Pulmonary tuberculosis
(2) Bronchiectasis
(3) Pulmonary infarction
(4) Malignant disease of the bronchus
(5) Blood dyscrasias.

Repeated examination of sputum failed to reveal the presence of Koch's bacillus and there were no physical signs nor history suggestive of pulmonary toberculosis. General health of the patient was quite good. Recurrent attacks of acute onset of hæmoptysis, absence of foul-smelling sputum or clubbing of fingers, cyanosis and absence of physical signs could rule out bronchiectasis. From the history and physical findings, it was very difficult to rule out pulmonary infarction. But the absence of pleural involvement, in the light of the fact that the opacity was situated in the periphery of the lung was a point against it. Also there was no evidence of a causative lesson as sub-acute bacterial endocardities, as evidenced by absence of pyrexia, leucocytosis, heart signs and other embolic phenomena. Normal coagulation and bleeding time with a positive X-ray picture and history ruled out blood dyscrasias. The one thing left over being malignant disease of the bronchus, excepting the age of the patient, all points were in favour of the condition. Hence the sputum was sent for pathological examination and paraffin section, and the pathologist confirmed the presence of malignant cells in the sputum, "arranged in acinar form, suggestive of adenocarcinoma." A bronchoscopic examination could not be done in this case as it would not have been of any use as the growth was in the periphery.

Treatment and progress:—Treatment was first on symptomatic lines in the nature of hæmostatic agents as intravenous congo, red and coagulum 'ciba' etc.

Later it was proposed to collapse the left lung with a view to find out the exact site and nature of the tumour. Artificial pneumothorax was done thrice and during the second and third time, there was a good collapse of the healthy part of the lung, showing out prominently the region of the tumour.

Patient is now awaiting irridiation therapy which obviously is the only available form of treatment.

Remarks:—Though according to textbooks malignant tumours are rare before the age of forty or forty-five, here is an instance of one occurring in a man of twenty five. That was one reason, why in differential diagnosis, malignant disease was thought of last. Also, absence of cachexia and anæmia were points against carcinoma. Hence even when we thought of tumour, we thought, it might be a simple adenoma of the bronchus. But the pathologist confirmed the presence of malignant cells in the sputum.

I wish to thank the Surgeon-General to the Govt. of Madras, and the Superintendent, General Hospital for permitting me to publish this Case, and finally my thanks are due to Dr. A. Srinivasan, M.R.C.P., (Lond.), for his permission and help in publishing the case report.

STANDARD SOUTH INDIAN DIETS

BY

Dr. R. SAMBASIVAM, M.B.B.S., *Trichinopoly.*

Vegetables—Though most Indian vegetables do contain a small percentage of proteins, carbo-hydrate and mineral matter, the main interest in their study centres upon their Iron value and vitamin value.

Iron—In a well balanced diet, the minimum daily requirement of 20 mgms. of Iron (this requirement is the same for both adults and children) should be well exceeded in the total iron intake from all foods, in order to ensure the minimum absorption as required above, for much of the iron in the food stuffs is not 'available' for biological absorption and hence exerted by the human body without being assimilated. So, unless a decent margin well above the 20 mgms. per day is ensured in our daily table, the body may not get its minimum daily requirement of Iron.

From this consideration, we shall review the Iron content of most commonly used vegetables. The figures are expressed as so many mgms. per 100 gms. of the stuff. An Iron content of over 20 mgms. exists in tender Amaranth (Keerai) Manathakali, tender Neem Leaves, Sundaikkai, Asafoetida, Kandan Thippili, and dried Yeast powder. Between 10 and 20 mgms. of Iron content exists in Coriander Leaves, Ponnanganni Keerai, Gingelly Seeds, Mustard Seeds, Arisi Thippili, Coriander Seeds, Omum, Pepper, Tamarind and Turmeric. For the purpose of the study of Iron content, we may include in this category of 10 to 20 mgms. content a few other items also, namely Jaggery and Kali-Paku.

Vitamins in Vegetables—In order to understand the figures for Vitamin values in vegetables which we usually express in terms of international units, we should have some standard by which we can compare these figures and arrive at a mental assessment of the values.

Vitamin 'A' Value in vegetables—The usual standard for comparison of Vitamin A value in food stuffs is Cod Liver Oil. The Vitamin A value of Cod Liver Oil is round about 100,000 international units for 100 gms. of the oil. Keeping the standard before our mind we can easily understand the figures for Vitamin A which we may give for most commonly used food stuffs including vegetables. So far as vegetables are concerned, the published figures for Vitamin A value refer to Carotene value, that is, Pro-Vitamin A value which we may take as almost equivalent to vitamin A value. Taking this standard for Cod Liver Oil as 100,000 units of A per 100 gms. the Vitamin A values of some of the commonly used vegetables are really interesting and remarkable. The figures are 12,000 for Coriander Leaves and 15000 for Coriander Seeds, 12,000 for Curry Leaves (Karuveppilai), 11,000 for Drumstick Leaves, and 200 for Drumsticks, 9,000 for Agathi Keerai, 7,000 for tender Amaranth (Keerai), 4,500 for tender Neem Leaves, 3,000 for Carrots, 3,000 for Spinch (Pasalai), 2,000 for Cabbage, 2,000 for Lettuce, 1,000 for Sundaikkai, 700 for Green Pepper, 500 for Green and Dry Chillies, 400 for Yams (Senai), 330 for cluster Beans (Kothavarangai), 300 for Tomatoes, 250 for Mustard, 200 for Bitter Gourd, 200 for French Beans, 150 for Green Mango, 150 for Peas, 100 for Tamarind Pulp, 84 for Pumpkin, 67 for Ginger, 60 for Snake Gourd, 60 for Lady's-fingers, 50 for Green Plantain, 50 for Ridge Gourd, 50 for Turmeric, 40 for Cauli Flower, 40 for Potatoes, 25 for Small Onions and nil or negligible values for most of other common vegetables.

Vitamin 'B' Values in Vegetables—In order to understand figures for Vitamin B value in food stuffs including vegetables, we should have a standard. The Vitamin B content in Yeast in terms of international units per 100 gms. is expressed as 2,000 units. This may be taken as the standard by which to judge the relative figures for most vegetables. The Vitamin B values for some common vegetables are 300 for Ground Nuts, 200 for Pumpkin, 120 for Peas, 100 for Cauli Flower, 90 for Lettuce, 70 for Drumstick Leaves, 70 for Spinach (Pasalai), 60 for Carrots, 60 for Radish, 50 for Cabbage, 40 for Onions, 30

for Cucumber, 25 for French Beans, 22 for Ridge Gourd, 20 for Potatoes, 20 for Yams (Senai), 20 for Ash Gourd, 20 for Bitter Gourd, 20 for Lady's fingers, 20 for Tomatoes, 15 for Brinjals, 15 for Green Plantains, 15 for Coconuts, 10 for Amaranth Leaves (Keerai) and nil or negligible values for most other vegetables.

Vitamins 'C' Values in Vegetables—Lime and Orange may be taken as the standard for comparison for the purpose of this article. The average Vitamin C value for Lime or Orange expressed in terms of mgms. per 100 gms. is 60 mgms. of Vitamin C which is the content in every 100 gms. of Lime or Orange. Then taking 60 as the standard, we find the Vitamin C values for the common vegetables as 600 for Nellikkai (Amla), 220 for Drumstick Leaves, and 120 for Drumsticks, 173 for Amaranth (Keerai), 135 for Coriander Leaves, 124 for Cabbage, 100 for Green and Dry Chillies, 88 for Bitter Gourd, 85 for Knol-Khol, 66 for Cauli Flower, 50 for Cluster Beans (Kothavarangai). 48 for Spinach (Pasalai), 30 for Tomatoes, 24 for Sweet Potatoes, 24 for Greeen Plantains, 23 for Brinjals, 17 for Potatoes, 17 for Radish, 16 for Lady's fingers, 15 for Lettuce, 14 for French Beans, 13 for Garlic, 11 for Manathakkali, 11 for Onions, 9 for Peas, 7 for Cucumber, 3 for Carrot, 3 for Green Mangoes, 3 for Tamarind and nil or negligible for other vegetables. (*To be continued*)

ASSOCIATION NOTES

TRICHINOPOLY BRANCH

President ... Dr. P. A. S. Raghavan
Vice-President ... Dr. R. Sambasivam
Secretary ... Dr. V. Enok
Treasurer ... Dr. K. Rangasamy Iyer

A clinical meeting of the above association was held at 5-30 p.m. on 31-8-'47 at the Trichy Xrays Ltd., Trichinopoly when Dr. C. S. Rao, M.B.B.S., D P.H., Blood Transfusion Officer, King Institute, Guindy delivered a lecture on Blood Transfusion in General Practice.

Dr. P. A. S. Raghavan, the President presided.

About 30 doctors were present.

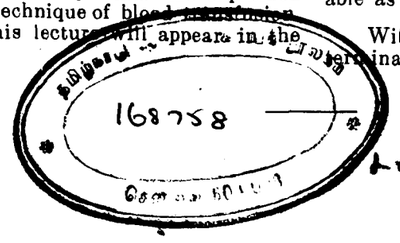
Dr. C. R. Tirvengadam, M.B B.S., Asst. District Medical Officer, was 'At Home'.

Dr. C. S. Rao, explained in detail that various indications for Blood Transfusion both whole blood and plasma. He explained in detail the technique of blood transfusion. (Details of this lecture will appear in the '*Miscellany*'.)

There was an interesting discussion after the lecture, in which many members took part.

The President, in his concluding remarks, informed the members that blood banks have been established in the Head Quarters Hospital of the following districts:— Trichinopoly, Madura, Calicut, Cochin, Cocanada and Vizag, the General Hospital, Madras and the King Institute, Guindy and that donors will be paid Rs. 5/- each. He appealed to the Government to increase the rate. He also informed the members that blood for transfusion was available for practitioners in these banks at the rate of Rs. 20/- for a bottle of 200 c.c. of whole blood and Rs. 50/- for a bottle of 300 c.c. of plasma. He exhorted Doctors to recommend their patients particularly those suffering from high blood pressure to donate blood to these banks and he hoped that blood letting will become as fashionable as nerve cutting is in America.

With a vote of thanks the meeting terminated.



ODDS & ENDS

Gluttony is as bad as drunkenness. Many people dig their graves with their teeth.

***

Raising opsonic index can be explained as buttering the bacilli so that the leucocytes may swallow them.

***

The first Flying Doctor Service in Australia began in April 1938. Its sturdy little "Tiger" has covered 125220 miles, brought medical treatment to 7850 patients and carried 50 stretcher cases. Working with the Flying Doctor are 4 hospitals, in sparsely settled country north of the Great Australia.

***

Oh, Doctor, my baby has swallowed the film of my camera. Don't worry. Nothing will develop.

***

He was found dead in the kitchen with the gas turned on. He was a single man who had worked hard and had lately been a little worried about making do with his rations. Autopsy revealed a cerebral haemorrhage but his old aunt, who was his nearest relative, said she was quite satisfied with the corners verdict, "death from national causes." The Lancet.

***

Dear Doctor: Charley Jones told me of some pile tablets which he got from you last spring. He said the tablets were to inhale in the rectum. Please send me a box. (A.M.A.J.L.)

***

Unbreakable spectacles incorporating all types of high precision plastic lenses have gone into large scale production in Britain. They are light in weight, have low heat capacity and absorb less light than glass and therefore give a clearer vision.

***

The following change of address has been notified to us:—

Dr. A. Janakiraman, L.M.P., from Tiruvennainallur to Markanam.

Dr. K. Pitchu Iyer, L.M.P., from Cheyyar to Vellore.

Dr. P. R. L. Iyer, L. M. P., from Manjeri to Mannarghat.

Dr. T. D. Ramaseshan, L. M. P., from Ramnad to Sankarankoil.

Dr. N. Krishna Rao, L.M.P. from Pudukottah to Perungalur.

Edited and Published by Dr. P. A. S. Raghavan, Z. M. R. E. (Vienna,) Teppakulam, Trichinopoly, and Printed at St. Joseph's Industrial School Press, Trichy—Q. H. No. Ty. 1—1947

CONFERENCE NUMBER

सर्वेजनाः सुखिनो भवन्तु

THE MISCELLANY

Managing Editor: Dr. P. A. S. RAGHAVAN

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
OF INDIAN MEDICAL ASSOCIATION

IV NOVEMBER 1947 No. 5

GENERAL PROGRAMME OF THE 'MEDICAL FESTIVAL' IN BOMBAY

1947

22nd December 1947		
9 a.m.—	1 p.m.	Meeting of Provincial Secretaries and Working Committee of I.M.A.
2-30 p.m.—	5-30 p.m.	Meeting of Working Committee I.M.A.
5-30 p.m.—	7-30 p.m.	Meeting of Working Committee I.M.A.
23rd December 1947		
9 a.m.—	1 p.m.	Meeting of Central Council of I.M.A.
2-30 p.m.—	5-30 p.m.	Meeting of Central Council of I.M.A.
5-30 p.m.—	7-30 p.m.	Meeting of Central Council of I.M.A.
24th December 1947		
9 a.m.—	12 noon	Inauguration of All-India Medical Conference.
12 noon—	1 p.m.	Election of Subjects Committee, I.M.A.
3 p.m.—	4-30 p.m.	Opening of Exhibition.
4-30 p.m.—	5-30 p.m.	Tea in Exhibition Grounds.
5-30 p.m.—	7-30 p.m.	Subjects Committee I.M.A. Conference.
9 p.m.—	11 p.m.	Subjects Committee I.M.A. Conference.
25th December 1947		
9 a.m.—	10-30 a.m.	Inauguration of Radiological Conference.
10-30 a.m.—	1 p.m.	Open Session I.M.A.
4-30 p.m.—	6 p.m.	Inauguration of Obst. & Gynae. Congress.
6-30 p.m.—	8 p.m.	I.M.A. Open Session.
9-30 p.m.—	11-30 p.m.	Entertainment by medical students.
26th December 1947		
9 a.m.—	10-30 a.m.	Inauguration of Surgeons Conference.
10-45 a.m.—	1-15 p.m.	Inauguration of Physicians Conference.
2-30 p.m.—	4-30 p.m.	Inauguration of Licentiates Conference. I.M.A. Open Session. Conference.
5-15 p.m.—	7-15 p.m.	Open Session of I.M.A. Conference.
9 p.m.		Boat Trip.
27th December 1947		
9 a.m.—	12 noon	Functional Uterine Bleeding (Discussion).
12 noon—	1-30 p.m.	Inauguration of Venereologists' Conference.
2-30 p.m.—	6 p.m.	Scientific Session of all conferences.
8-30 p.m.		Subscription Dinner (if possible).
28th December 1947		
9 a.m.—	12 noon	Antibiotics (Discussion).
2 p.m.—	6 p.m.	Scientific Session of all Conferences.
9 p.m.—	11-30 p.m.	Entertainment.
29th December 1947		
9 a.m.—	12 noon	Apendicitis (Discussion).
2 p.m.—	5 p.m.	Scientific Session of all Conferences.
6 p.m.—	7 p.m.	Concluding session, all conferences participating.
30th December 1947		
8 a.m.		Trip to Elephanta and Canary caves.

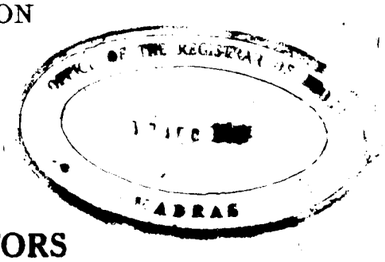
All the conferences will be held in the compound of J. J. Group of Hospitals and the Grant Medical College, Byculla, Bombay.

A new feature will be a 'Clinical Exhibition' depicting the historical, etiological, diagnostic, therapeutic and other features of the Medical and allied Sciences.

Members requiring reservation from Madras to Bombay are requested to remit the Railway Fare Rs. 53—15—0 (II Class), Rs. 31—3—0 (Int. Class) and Rs. 17—0—0 (III Class) to Dr. D. V. Venkappa, 3, Deenadayalu Street, T. Nagar, Madras, and to intimate before the 15th Dec. by what train and date they require accommodation.

INDIAN MEDICAL ASSOCIATION

SOUTH INDIAN PROVINCIAL BRANCH



Appeal

RELIEF TO RUFUGEE DOCTORS

DEAR DOCTOR,

Probably you are not aware that among the refugees from Pakistan there are over 1000 doctors who have been uprooted and are now stranded in India. Many have lost their all (both material and domestic) and have to start lives afresh irrespective of age. We in the South, who are lucky to have peaceful and normal life must rise to the occasion and help our brothren in their distress. An appeal has been issued by the Indian Medical Association under the signatures of Dr. B C. Roy, Dr. Jivaraj N. Mehta, Capt. P. B. Mukerjee, Dr. S. N. Kaul, Col. Amirchand and many others, requesting doctors to contribute to the relief fund. May we request you to contribute liberally to the fund but we hope it will not be less than Rs. 10/- and send the amount to Dr. P. A. S. Raghavan, Trichinopoly ear-marked "Refugee Doctors Relief Fund" or to the Surgeon-General with the Government of Madras, with an intimation to Dr. P. A. S. Raghavan.

May we appeal to you to rise to the occasion and give a lead to the other provinces.

A. B. SHETTY, Minister, Public Health
S. L. BHATIA, Surgeon-General
A. L. MUDALIAR, Vice-Chancellor, Madras University
T. S. TIRUMURTHY, President, I.M.A., S.I.P.B.
P. A. S. RAGHAVAN, Secretary, I.M.A., S.I.P.B.

ODDS & ENDS

Chancroid ulcers heal quickly with local application of Sulphadiazine.

∴ ∴ ∴

Streptomycim seems to be an effective drug in the treatment of Gonorrhoea About 90 percent responded to 0·2 gm. and 100 percent to 0·3 gm. or more.

∴ ∴ ∴

Dr. C. L. Deming of Yale reports that massive doses of the female harmon estrogen help four out of five cases of cancer of the prostate and often prolon life. At the Chicago University, three researchers found ethyl carbamate i also effective, but it has to be cautiously given.

∴ ∴ ∴

It is stated a new antibiotic, called tometin, has been isolated from th tomato plant. It seems to have marked activity against germs of both the gran positive and gram negative groups. In laboratory tests, it has also shown th ability to destroy the fungi that cause athletic foot and ringworm.

∴ ∴ ∴

Sexual profligacy may be a prophylactic against senile prostatic en largement.

∴ ∴ ∴

An official committee in Pakistan has recommended the raising of medica schools into colleges and immediate abolition of all class distinctions in th medical service.

∴ ∴ ∴

The Madras University Senate has resolved to institute a B. D. S. Degre (Bachelor of Dental Surgery) and has asked the Academic Council to frame th necessary regulations.

A resolution to institute a Diploma Course in Maternity and Child Wel fare has been referred to the Board of Studies in Medicine.

∴ ∴ ∴

The All-India Ophthalmic Conference to be held in Delhi is postpone to 9-11th February 1948.

∴ ∴ ∴

It was a practical class for prohibition propaganda. The teacher had o the table two glass tumblers one with plain water, and the other with alcohol He took a live worm and put it in the tumbler with water. The worm wa wriggling through the water. He then took the worm and put it in the alcohol It died immediately. "What does it show?" asked the teacher triumphantly "Alcohol can kill the worms in our tummy" piped in a tiny one at the en of the class.

(FOR CIRCULATION AMONGST MEMBERS ONLY)

THE MISCELLANY

JOURNAL OF THE SOUTH INDIAN BRANCH
OF
THE INDIAN MEDICAL ASSOCIATION

VOL. XIV] NOVEMBER 1947 [NO. 5

Proceedings of the Annual meeting of the Council of the South Indian Provincial Branch, Indian Medical Association held at 2 p.m. on Saturday the 18th October, 1947, in the premises of Coimbatore Poly Clinic, Coimbatore.

Members present:—

Dr. T. S. Tirumurthy	*(President)*	Madras.
Dr. K. Balakrishnan	*Member*	Madura.
Dr. V. Enok	,,	Trichinopoly.
Dr. P. A. S. Raghavan	*Secretary*	Trichinopoly.
Dr. C. V. Ramaraj	*Member*	Coimbatore.
Dr. R. Sankaran	,,	Madras.
Dr. B. S. Viswanathan	,,	Coimbatore.
Dr. D. V. Venkappa	,,	Madras.
Dr. Mrs. K.I. Vythilingam	,,	Vellore.

1. **Report of the Secretary.** The report of the activities of the Branch (given here with) was presented by the Secretary.

Approving the report unanimously, it was resolved to place on record the invaluable services rendered to the South Indian Provincial Branch by the Secretary, Dr. P.A.S. Raghavan.

2. **Accounts of the Council upto 30-9-'47.** The audited statement of accounts upto the end of 30—9—'47 was passed.

3. **Election of office-bearers.** Dr. T.S. Tirumurthy was re-elected as President of the South Indian Provincial Branch having been nominated by a majority of branches.

Dr. P.A.S. Raghavan proposed, and Dr. D.V. Venkappa seconded that Dr. Mrs. K.I. Vythilingam, M.D., of Vellore be elected as Vice-President, and this was unanimously approved.

It was unanimously resolved to place on record the invaluable services endeared to the South Indian Provincial Branch by Dr. G. Joseph Gnanadickam the Vice-President during the last 2 years.

Election of Secretary was postponed to a later date.

4. **Amendments** to the rules of the South Indian Provincial Branch. A Sub-Committee consisting of the President, Vice-President, Secretary, Dr.B.S. Viswanathan, Dr. S. Chandrasekaran, Dr. R. Sankaran, Dr. D. V. Venkappa, and Dr. G. Joseph Gnanadickam with power to co-opt. 2 more by the President, was formed to re-draft the rules of the Branch and place it before the next Council meeting after circulation to the Branches.

5. **Working Committee of I.M.A.** Dr. T.S. Tirumurthy (Madras), and Dr. P.A.S. Raghavan (Trichinopoly) were elected members to represent the South Indian Provincial Branch on the Working Committee of the Central Council.

Coimbatore,
18—10—'47

T.S. TIRUMURTHY,
President.

The South Indian Provincial Branch of The Indian Medical Association.

RESUME

The South Indian Provincial Branch was formed in 1940 by the federation of the five district branches of the I. M. A. *i.e.* Madras, Trichinopoly, Madura, Ramnad and Tinnevelly, representing about 500 members. After some activity, the Provincial Branch became dormant since 1942, due to the war and also partly due to the ban of the Govt. of Madras on their officers from being the members of the I.M.A. The Provincial Branch revived its activity since the end of 1944 and Dr. P.A.S. Raghavan was elected Secretary on 5-5-45. It has now 17 branches with over 1210 members. There are branches of the I.M.A. in all the districts of the Presidency, except in the Andhra Desa where there is a separate Provincial Branch, and in the states of Mysore and Pudukottah. Attempts are under way to make the Medical Associations in the states of Travancore and Cochin and the State Medical Association of Mysore join the I.M.A., and it is hoped they would join soon.

Minutes of the last annual meeting held on 29—12—'46 and the meeting held at Perunturai on 4—5—'47 have been circulated to the members.

ACTIVITIES

Conferences. After the South Indian Provincial Branch became active in 1944, the 1st South Indian Provincial Conference was organised at Trichinopoly in October 1945 under the Presidency of Dr. Jivaraj N. Mehta, M.D., M.R.C.P. The Trichinopoly Branch under the Chairmanship of Dr. T.S.S. Rajan acted as the Reception Committee. Emboldened by the success of the Conference, the South Indian Provincial Branch invited the All India Medical Conference to South India and it was held in December 1946 at Madura. Most of the members of the profession in South India joined the Reception Committee as members. The Madura Branch, with Dr. P. N. Rama Subramanyan as the Chairman, and Dr. A.K. Rajagopal as General Secretary, acted as the Executive Committee. The Conference was acclaimed a great success. In view of the holding of the All India Medical Conference in South India, the 2nd Provincial Conference was not held in 1946.

As per resolution No. 6 passed at the last meeting of the Council at Perundurai on 4—5—'47 the Secretary met the members of the Coimbatore Branch and they agreed to organise the Second Provincial Medical Conference and it is being held now.

The Coimbatore Branch with Dr. C.S. Ramaswamy Iyer as Chairman and Dr. C.V.Ramaraj as General Secretary, is the Reception Committee of the 2nd Provincial Medical Conference. The members of the profession and the I.M.A. branches are greatly indebted to Dr. C. S. Ramaswamy Iyer and the members of the Coimbatore Branch of the I.M.A. for the great amount of time, labour and money spent by them to make the conference a success in all respects.

In pursuance of resolution No. 11 passed at the Perundurai meeting on 4—5—'47, a deputation waited on the Minister for Public Health with the Govt. of Madras, and discussed the various points mentioned in the memorandum submitted to him, (Memorandum published in 'Miscellany' July 1947) The Minister promised to consider them favourably and pass orders.

As the recent G. O. No. 2711 P. H. dated 4—8—'47 (published in the Miscellany August 1947) was vague and indicated no unification of the Civil Medical Cadre, the President and the Secretary of the South Indian Provincial Branch of the I.M.A., with the Secretary, Provincial Branch of the All India Medical Licentiates Association Dr. D.V. Venkappa, and a member of its committee of action, Dr. R. Sankaran met the Minister on 29-9-'47 when the Surgeon-General and the Joint Secretary, Public Health Department were also present. It was brought to the notice of the Govt. that not only was the G.O. vague but it perpetuated the class distinctions in a different garb and brought down the status of the Graduates instead of elevating that of the Licentiates. The Govt. have promised to reconsider the G.O. and suitably amend it.

BRANCHES

Two branches, Tinnevelly and Salem, which had become defunct some years back, were revived, each now having a membership of 58 and 50 respectively.

As many doctors in Negapatam and Nannilam Taluks could not conveniently join the Tanjore Branch, a branch at Negapatam was organised with about 22 members. The doctors in and around Cannanore have expressed a desire to form a branch at Cannanore and it is hoped that a branch will be formed there soon.

Some branches have been very active both in the matter of holding meetings and in the matter of attending to routine matters. But some branches are lethargic both in their activities and in the matter of attending to correspondence. If at least one member in each branch association takes active interest, the branch association will function satisfactorily.

The branch associations are requested not to forward directly to Govt. any resolutions or representations on matters concerning the whole province, as it is not only against rules, but will serve no purpose, particularly when different branches give different views on the same matter.

WORKING COMMITTEE

According to the new rules, the Provincial Branches are empowered to elect their representatives to the working Committee of the Central Council. At the last annual meeting the Council elected 2 representatives because we have over a thousand members, but it is a pity that for the three meetings of the Working Committee held during the year only one representative *i.e.* our President could attend only one meeting and for another, a substitute representative was sent. In the interest of the association, only those who are willing and capable of serving the association should offer themselves for election to the Committees.

FINANCE

When the South Indian Provincial Branch was formed, it was resolved that constituent branches should pay Rs./5- each per annum for the maintenance of the Provincial Branch. It was found that no work, not even the routine official work could be carried on with this meagre finance. So the centre was approached and the I.M.A. passed a resolution allowing the Provincial Branches Re. 1/- per member out of the Central Fund Contribution of Rs./3- that each member pays.

Now with the increase of Central Fund Contribution to Rs./6- per member, the Provincial quota has also been increased to Rs./2- per member, and hence our finances are bound to be very satisfactory hereafter. Since the branches were sending the Central Fund Contribution direct to the Central Office, it was difficult to maintain correct accounts here. Moreover, the

Provincial quota was not being sent regularly from the Central Office due to various difficulties. Strong representations were made to the Central Association that it should receive the Central Fund Contribution only through the Provincial Branch and that the Provincial Branch should be allowed to take its quota and send the balance to the Central Association. This has been accepted, as the rules also permit it. The Central Association has circularised all the branches that correspondence, representations and remittances to it should be made only through the Provincial Branch.

At the beginning of the present official year, we had a cash balance of Rs. 1764—1—10 and had to receive from the Central Association Rs. 763—8—0 upto end of September 1946 and Rs. 1063—8—0, till end of December 1946 as the provincial quota. As the provincial quota was not forthcoming from the Central Association, due to the disturbed state of affairs in Calcutta, this Provincial office after informing the Central Association, started appropriating the whole of the Central Fund Contribution from the branches towards its due from the Central Association, and the accounts are now quit. Hereafter the C.F. Contribution will be forwarded to the Central Association after deducting the provincial quota. The audited statement of accounts is appended herewith.

As Hony. Secretary I wish to bring to your notice the invaluable help I received from the President and the Vice-President, but for whose advice and drive I could not have done the little work I was able to do for the Provincial branch during the past.

P. A. S. RAGHAVAN,
Hony. Secretary,
18—10—'47

SALES TAX AND MEDICAL PRACTITIONERS

TO

THE MEMBERS OF THE INDIAN MEDICAL ASSOCIATION

It was reported that medical men in Madura were asked to submit their accounts for the assessment of Sales Tax. Dr. T. S. Tirumurthy, the President Dr. D V. Venkappa of Madras and the undersigned interviewed the Minister and impressed upon him that Medical men should not be taxed Sales Tax. The Minister referred the matter to the Revenue Department. Dr. D. V. Venkappa, Dr. R. Sankaran of Madras with Dr. A. K. Rajagopalan of Madura interviewed the Deputy Commissioner of Commercial Taxes (Central) on the 21st of November 1947 and discussed the whole matter with him and it is expected that orders will be passed soon exempting Medical Practitioners from the Sales Tax.

It has to be impressed on the Practitioners that if they dispense prescriptions of other doctors for payment, or dispense to their own patients and receive payment for the same as a separate item, they are liable to pay Sales Tax. As payment is made to doctors by patients for general treatment which includes consultation, operation, injection and supply of medicines, etc., the bill must be made in a consolidated form as **"For Treatment"**. Rs.....

It is hoped that members will note the above and do the needful.

P. A. S. RAGHAVAN,
Honorary Secretary,
South Indian Provincial Branch, I. M. A.

THE SECOND SOUTH INDIAN MEDICAL CONFERENCE

The Second South Indian Medical Conference was held in Coimbatore at the Coimbatore Poly Clinic (Dr. C. S. Ramasamy Iyer's New Hospital) Trichy Road, Coimbatore on the 17th, 18th and 19th October, 1947. About 300 doctors from all over South India attended the Conference.

The distinguished guests, the delegates and visitors were received by the members of the Reception Committee and led in a procession to the Conference Pandal to the accompaniment of Nadhaswaram, preceded by a caprisoned elephant. The proceedings commenced with the hoisting of the National Flag by Dr. C. Nanjappa, a member of the Reception Committee and the Chairman of the Coimbatore Municipality. After taking the Salute, the gathering, which included the elite of the city, adjourned to Tea given by Coimbatore branch of I. M. A.

The Conference commenced at 5 P.M. with a welcome address by Dr. C.S. Ramaswamy Iyer, the Chairman of the Reception Committee. This was followed by the inaugural address by Sir C.V. Raman F.R.S., M.A., P.H.D. Dr. B. K. Narayana Rao, M.B., M.R.C.S., D.O. Retd. Surgeon-General with the Govt. of Mysore, then delivered the Presidential address. This was followed by an address delivered by Sri C.S. Rathnasabhapathy Mudaliar of Coimbatore, declaring the Exhibition open, Dr. Friedman M.D., spoke on 'Nuclear Energy in Medicine.'

Two little daughters of Dr. T. K. Narayanan, a member of the Reception Committee, entertained the gathering with exquisite dancing. On behalf of Dr. C. S. Ramaswami Iyer, Sir C.V. Raman, presented the two girls with two silver cups and spoke in appreciative terms of the high proficiency of their dancing. This was followed by a Techni-color film on 'Folvite.

The day's proceedings came to a close with a dinner given by Ciba (India) Ltd.

The Scientific sessions commenced on the morning of the 18th at 8 A.M. with an opening address of Col. S.L. Bhatia C.I.E., M.C., V.H.S., F.R.C.P., M.A., M.D., F,R.S., I.M.S., Surgeon-General with the Govt. of Madras.

The following programme was then gone through.

2nd day. 18—10—'47.

Surgery:—President, Dr. N.S. Narasimha Iyer, F.R.C.S. Madras, Talk on 'Peptic Ulcer'

'Vesico Vaginal Fistulae and their Treatment' by Dr. P. Vadamalayan, M.B.B.S., Madura.

'Early Ambulation in Surgery' by Dr. T. V. Sundaram, D.M.S., Trichinopoly. Tea by Meclec Ltd.

Medicine:—President: Capt. S. Thambiah, M.C., M.R.C.P., F.D.S., Talk on 'Prognosis in Hypertension.'

'Rheumatic Fever' by Dr. S. K. Sundaram, M.D., Madras.

'Recent Prostatic Surgery' by Dr. N. S. Narasimha Iyer, F.R.C.S., Madras. Dinner by variety Hall Talkies Ltd., Coimbatore.

'Riboflavin Deficiency' A film show by Messrs. Eli Lilly & Co. Bombay.

Entertainment: Hindi Drama.

3rd day 19—10—'47

Visit to Perur Temple.

'Problem of Venereal Diseases in South India and its Medical and Hygenic aspects' by Dr. R. V. Rajam M.S., M.R.C.P., Madras. Lunch by International Pharmaceticals Ltd.

'Otosclerosis' its Diagnosis and treatment by Dr. V. S. Subramanyam, M B.B.S., F.A.S.

2 to 4 P. M. Open Conference.

Tea by Ratilal A. Shaw, Coimbatore.

Cinema show on Caudal Anesthesia. 'Problem of Tuberculosis in South India and a five year plan to prevent it' by Dr. K. Vasudeva Rao, M.D., M.R.C.P., T.D.D.

'Amoebic Syndrome' by Dr. S. Rajaram, M.B.B.S. Salem.

'Rabies' with Magic lantern show by Dr. Veeraraghavan M.B.B.S. Coonoor. Dinner by Coimbatore, Branch of I. M. A.

Visit to Central Studies.

Dr. B. K. Narayana Rao had to leave during the evening session of the Conference earlier, he requested Dr. D.V. Venkappa to preside over the Conference. In bringing the Conference to a close, Dr. D. V. Venkappa thanked the various lecturers, the members of the Reception Committee and the exhibitors for participating in the Conference.

The open sessions of the Conference was held at 2. P.M. on 19—10—47 under the Presidentship of Dr. T. S. Tirumurthy, the Provincial President when a number of resolutions were passed. (Resolutions published elsewhere)

After the proceedings of the open Conference ended, Dr. T. S. Tirumurthy complimented Dr. C.S. Ramaswamy Iyer and Dr. C. V. Ramaraj, and the members of the Reception Committee for having accepted to hold the conference in Coimbatore and for making such elaborate arrangements for its success. Dr. B. K. Narayana Rao, the President of the Conference congratulated the organisers on the grand arrangements made and the attention to details which contributed to the success of the Conference. On behalf of the visiting doctors he thanked the doctors of Coimbatore for the comforts provided to them.

Dr. C. S. Ramaswamy Ayer and Dr. C. V. Ramaraj thanked the visitors for attending the Conference in such large numbers, the various hosts, and the firms for participating in the exhibition. The Conference terminated after Dinner.

(Address of the Chairman, Reception Committee, the inaugural address of Sir C. V. Raman, the Presidential address of Dr. B. K. Narayana Rao, and the address of Col. S. L. Bhatia opening the Scientific Session are published elsewhere.)

The Managing editor would be grateful for information as to the names of doctors elected to the Municipal Councils in the last election, for publication in the *Miscellany*.

Resolutions passed at the Open Conference held on Sunday the 19th October, 1947 at the Coimbatore Poly Clinic, Coimbatore.

1. This Conference places on record its grateful thanks to the Government of India and its sincere appreciation, on the appointment of Dr. B. C. Roy, an eminent member of the profession and past President of the Indian Medical Council, as the Governor of United Provinces.

Moved from the chair and carried unanimously.

2. This Conference places on record its heart-felt thanks to the Government of India, and congratulates Dr. Jivaraj N. Mehta a renowned member of the I.M.A. its past President and the President of the 1st South Indian Provincial Conference, on his appointment of Director-General of Medical Services in India.

Moved from the chair and carried unanimously.

3. This Conference congratulates the various doctors who have been elected as Chairman of the different Municipalities in the Province, such as Dr. C. Nanjappa, Chairman of the Coimbatore Municipality, Dr. Meghanathan, Chairman of the Coonoor Municipality, Dr. P. S. Srinivasan of Conjeevaram Municipality, Dr. A. R. Menon of Palghat Municipality and others.

Moved from the chair and carried unanimously.

4. This Conference requests the Government of Madras to treat Lady Assistant Surgeons on a par with men Asst. Surgeons in the matter of promotion as Civil Surgeons, as there is no justification for any differentiation. Moved by Dr. Mrs. K. I. Vythilingam (Vellore) and seconded by Dr. B. S. Viswanathan (Perundurai)

5. This Conference requests the Government of Madras to give effect to the Bhore Committee recommendations suggesting the admission of atleast 30 students into Medical Colleges on merit.

Proposed by Dr. B K. Narayana Rao (Bangalore) and seconded by Dr. T. S. Balasubramaniya Iyer(Trichinopoly) carried by a large majority.

6. This Conference requests the Government of Madras to alter the G. O. No. 2711 P. H. dated 4-8-'47 regarding the unification of the services in such a way as to remove the Grades I and II and place all medical officers on a Gazetted rank.

Proposed by Dr. P. A. S. Raghavan (Trichinopoly) and seconded by Dr. D. V. Venkappa (Madras) Carried unanimously.

7. This Conference requests the Government of Madras to immediately provincialise the Local Board Medical Services in the same manner as the health services are at present. Proposed by Dr. R. Sankaran (Madras) and seconded by Dr. P. A. S. Raghavan (Trichinopoly) carried unanimously.

8. This Conference requests the Government of Madras to improve the conditions of Rural Medical Service as suggested by resolution No. 17 dated 27-10-1945 at the 1st Provincial Conference held in Trichinopoly.

Proposed by Dr. M. R. Bhat (Trichinopoly) and seconded by Dr. P. A. S. Raghavan, (Trichinopoly.)

9. This Conference views with disfavour the unethical way of advertising of medical and pharmaceutical products

(*Concluded on page 11*)

THE INDIAN MEDICAL ASSOCIATION
THE SECOND SOUTH INDIAN PROVINCIAL CONFERENCE,
COIMBATORE—1947

WELCOME ADDRESS
By Dr. C. S. RAMASWAMY IYER.

Mr. President, Sir. C. V. Raman, Col. S. L. Bhatia, Sri. C. S. Ratnasabapathy Mudaliar, Members of the Medical Profession, Ladies and Gentlemen.

I am specially privileged and honoured to have been given the pleasure, of welcoming this distinguished gathering to Coimbatore, and my new hospital, which has been chosen as the venue for your deliberations, is greatly blessed, by the presence of so many of you here.

After the mammoth gathering of the Annual Conference, of the All India Medical Association, at Madura last December, we are now assembled at this Provincial Medical Conference. In the meantime, our country has wrested the long fought for, and cherished Laurels of Freedom, without arms or ammunitions. What pleases us most is, that the "Great Architect of Freedom" is still with us, to guide our nation through the many rugged patches on the path to peace and prosperity.

How paradoxical it is, that a nation, which won freedom so peacefully, is now engaged, in a strife of fanatical communal orgy of violence and bloodshed! As a consequence, the nation which has been credited with the capacity to rise to unprecedented cultural eminence, is being laughed at by the world owing to this sudden degradation to the jungle of primitive lawlessness. Both the repercussions of this unexpectedly sudden freedom from a foreign yoke and wanton outburst of aboriginal passions are acting as effective barriers. Added to this, the spectre of famine is already casting its dark shadows over our country. No wonder that in this background of depressing events, ill health thrives as though to bless the Doctors to prosper and multiply.

This cheerless prelude to a welcome address is only to wake up all of us to unite together to meet the combined unexpected tragedies. The first real step in an attempt to meet this mighty national problem and its dire consequences, if allowed to drag on unsolved, is the elaborate and painstaking findings of the Bhore Committee. I make no apologies for mentioning about this blue print, the first of its kind in India which exhaustively deals with all relevant matters pertaining to our profession and their relation to the rest of the national problems. It is elaborate enough to suggest an almost suicidal ideal for our profession, "to exterminate ourselves."

One essential to put our ideals into practice as part of a National Programme is to prepare the receptacle for the soil i.e. to educate the masses on fundamentals of hygiene, prevention of disease and the various methods of practically and successfully combating diseases with the means at their disposal; it means our preachings and practices should be reduced to such an elementary state as to be capable of being appreciated and practised even by the basic national unit, the village tiller of the soil. Herein comes the bogey of the different systems of Medicine. The adherents of these systems produce still more cleavages, which prevent unity of action in planning and promoting a national health programme. Anything

that is not in the national garb of the regional language, is alien to the villager. We are all aware of the heated controversies about Allopathy and Ayurveda. The adherent of one system cries down the other. In the majority of instances it is the exponent, usually the unskilled one of either system, that is being ridiculed and cited as example for the failure of the science itself.

Therefore, I feel bound to give a simpler outlook for this undesirable and unhealthy cleavage. All that the adherent of our ancient system asks is "What is new in your western medicine, which was not in our ancient one"? I say the answer is simple. It is only to remind the adherent of the ancient system that we practise Ayurveda reorientated and woven in a different language. Tell him that that Allopathy is nothing, but the son, who left long ago his parental home due to neglect and unsuitable environments and travelled all over the world, studied different languages, discarded his national garb and become selfreliant, and more progressive and practical, but, due to still existing, uncongenial conditions, in the parent home, is still considered an inordinately expensive and luxurious liver. Is it not proper and dignified that the father should welcome his refined and educated son as his own? That is how the adherents of our ancient system should interpret Allopathy. Unfortunately the son due to long absence from home influences had forgotten his native tongue and homely accent and the father is unable to recognise and understand him and is even scared of him. But it is now the duty of the loving son to greet his father in his native tongue and accent and bring about the happy reunion; the father embraces the son and the son the father. The parental affection naturally dictates to him to say "Son! you are better equipped than I. Live long and prosper! Bless you." It is this reunion or amalgamation of these systems that we should look forward to. This anecdotal son should talk in his national language.

By amalgamation I do not for a moment suggest a disproportionate synthesis or these systems for fear that a freak of a hybrid may be brought forth. This may look almost impossible, unless it is tried honestly and worked out sympathetically. Will it be too fantastic or unpractical if I suggest that technical and scientific studies should be imparted in the national language? For international purposes the English language cannot be discarded. A national language should never reduce itself to a verbatim translation of some other language, for example, the translation into Tamil for the "Flying Fortress" by our broadcasting centres as "Parakkira Kottai."

Having assured ourselves of a proper reception at the hands of the public, it is our duty to go forward and plan systematically and methodically to tackle the many problems that confront us from time to time. In the fight against Microbes and Diseases, a vigorous campaign of relentless nature, unified purpose and uniform technique will not be considered too ill-conceived or inopportune. While it sometime happens that different techniques may lead to the same results, the nature of the technique and its manœuvrability are very often difficult and different. The unit of the Medical Army for such a compaign should be uniform. For this purpose the first and foremost should be the prescription of an uniform syllabus for medical studies in all the Medical Colleges in India. Otherwise controversial, commercial algebraic values will be attached to the various provincial degrees and diplomas.

Next to the technique, the choiee of the individual soldier has given rise to intriguing situations. While communalism should have been a thing of the dead past, it is still being perpetuated by communal reservations for admission

into schools and colleges and for appointments to services and for promotions transfers and preferments in them. This has only a reinforcing effect on the persistance of a depressed class of human beings in the social order. This amounts to the "sucking up of the cylinder on the sand driving it deeper into its depth." The Bhore Committee's recommendations are often quoted when it serves the purpose of Government but when the recommendation to concede premium to merit is sought to be implemented, it is discredited unreasonably.

A most heartening and really significant event in our profession is the appointment of Dr. Jivraj N. Mehta as the Director General of Medical Services in the Indian Union, a fitting honour to a prominent member of our profession and our leader who has come out the better and the stronger through more than one incarceration in jails. But will I be reading your hearts when I say that he should be designated the Director General of Public Health including medicine and not merely the Director General of the Medical Services. The services contain only a minority of the members of our profession. Could we have a better person both as man and doctor, strong but humble as our Commander-in-Chief? We feel proud of the high honour conferred on Dr. B. C. Roy by the central government by nominating him as the Governor of U. P. We are glad to felicitate him in anticipation of his taking charge of the appointment.

Now the great army of medical crusaders is ready to march and the order for the day for each division or unit of the crusaders should be issued from the Head Quarters. With this object in view it is our imperative duty to see that the fault of the exponent is not put at the door of the science. It is our sacred responsibility to equip ourselves with the best and latest in science, which means periodic and prompt intellectual rejuvenation. While all of us have individual duties to perform with individual freedom, we should not forget the strength and the benefit which will accrue out of our collective responsibility. Therefore, I appeal to you for ever-increasing and ever-lasting unity and harmony amongst us. Let us rise together. While ours is a technical mission, none the less it has for the proper fulfilment of its innate purpose to accommodate to non-technical factors. If our profession has been rectified it is not in a little measure indebted to these well meaning allies of ours, the exponents of other systems of medicine. Accommodate with generosity, but without being intimidated; and let us display tolerance and forbearance in our actions.

Last but not least we should be aware that a spirit of commercialism is being introduced into our noble profession. Are we then surprised that on occasions, all of you know when, we are assessed as a bania class? With a righteous indignation a will to erase this insult is the inherent right and mission of every member of our order. But the devil at the bottom of the mischief is the unsatisfied hunger and unsatiated desire for a life of luxury. No wonder the "Science of life" has become the "Science to live" somehow. It is this state of affairs that should receive the attention of the elders that guide the destinies of the profession. While workers in every other field are fighting for increased wages, increased privileges and greater comforts and the Government appoints Judicial Tribunals for assessing the claims of these workers, we who are also workers in the most essential service to the Society are ignored or neglected, nay, even forgotten, because the honour of our profession expects us to keep the Oath of Hippocratis, which enjoins us not to bargain on human lives and sufferings. Let us all sit and deliberate and resolve to impress on the Powers-that-be that the time is well up.

that we are awake and shall not rest till we achieve our goal for prosperity and plenty and peace.

Friends! I may have given you a cartoonish disproportionate picture of our problems. But during the proceedings of this gathering I hope, with all your energy, experience and determination you will evolve a good classical portrait out of this cartoon and forgive the cartoonist. On behalf of this Association and on my own behalf as the builder of this private hospital and clinic, let me once again welcome all of you. Little did I realise the magnitude of my task, when I light heartedly accepted the request to be the Chairman of the Reception Committee. But the enthusiastic co-operation of my good colleagues has given me courage and confidence to shoulder this onerous responsibility. Our gratitude will be sincere and our happiness real if at the end of this session you have all felt "none too uncomfortable."

(*Continued from page 7*)

in the lay press, requests the govern ment to take necessary action to prevent such advertisements and requests the lay press to co-operate in this matter.

Proposed by Dr. R. Kalamegham (Trichinopoly) and seconded by Dr. B.S. Viswanathan (Perundurai).

10. This Conference notes with alarm the increasing incidence of Venereal Diseases particularly Syphilis and the grave menance to the Public Health and is of opinion that immediate measures should be instituted by Government to set up a Provincial Venereal Diseases Control organisation to plan and carry out control measures such as:—

1. Setting up of free diagnostic and treatment centres in all District and Taluk Hospitals.
2. Intensive and continuous propaganda.
3. Mobilization of the services of practitioners in the fight against the disease by providing them with facilities for free diagnosis and treatment.

Moved from the chair and passed unanimously.

MEDICAL ADVENTURES

Under this heading, it is proposed, whenever space permits, to publish interesting episodes in one's life as a doctor. We request our readers to give us their experiences, which might be entertaining or useful to others. They will be published with or without the author's name, according to their wish.

INAUGURAL ADDRESS

OF

SIR C. V. RAMAN, F.R.S., M.A., Nobel Laureate.

Dr. Ramaswami Aiyar. Dr. Narayana Rao, Ladies and Gentlemen,

Allow me to express to the organisers of this Conference of which you are the spokesmen this evening, my thanks for having given me the privilege of associating myself with this function. Your Provincial Secretary Dr. Raghavan did not warn me when he persuaded me to accept this invitation that I would have to write out an address in advance with the result that later when he wanted me to expound my wisdom on paper I frankly declined to do so (laughter). I have given myself the chance of facing this distinguished audience and just saying what comes to my lips on the occasion. In all such gatherings which it has been my privilege to address in various parts of India, I have felt that nothing is worth saying which is not inspired by the gathering in front of me, by the place I speak from and most of all by that indefinable thing called the 'spirit of the gathering' which breathes through it. Allow me to say, ladies and gentlemen, this is great honour to me to particiate in a function which is to be presided over by my esteemed friend Dr. B. K. Narayana Rao.

Which of us can place his heart and say that he never needed the services of a doctor? Speaking for myself I can without a trace of shame confess that but for the services of doctors I should have, as the Irishman said, been dead many times over. (laughter) I am sure of one thing that but for the devoted knowledge brought to bear by the opthalmologist I should long ago have been blind and even this pair of spectacles would have been of no use whatever.

I am not a stranger to Coimbatore. I remember coming here and speaking on many occasions on many topics. But the last three or four years seemed to have produced an almost miraculous development in the activities of Coimbatore. Coming here to-day I have been vastly impressed by this great gathering. I had just been through this institute (polyclinic). I looked round. I looked at this pandal which looks almost like a bridal pandal, and then I had the pleasure of listening to the outspoken address by Dr. Ramaswami Aiyar. I think I would be failing in my duty if I did not as a man of science pay a tribute to his up-to-dateness. Some day I had hoped that I should be able to fit up my future laboratory with flourescent lighting. He has stolen a march on me. I congratulate not him but Coimbatore on having somebody who could breathe the spirit of the times. Body and soul I have devoted myself to the cause of science. I am an internationalist. I still wear a turban just to show what I am not (laughter). In the field of knowledge, in the field of science, all humanity is one. Not that men of science are always honest men or that they are always very wise or that they are free from the many failings of the ordinary human beings. I know for example two professors in the Berlin University who carried out their difference on a question of physics to the point of belabouring each other with umbrellas (laughter.) The achievements of science are comm n property to all. You cannot by any manner of means hide the light of learning under a bushel. You make a discovery and even if you want to keep it a secret it leaks out and it becomes the property of the whole world.

Of all the sciences pure and applied and misapplied, there is one thing, rather there are two, that stand out because the common man can understand them. One is agriculture and the other is medicine. By agriculture I mean not only the growing of plants or fruits or trees but also the growing of cows, i. e. veterinary science is included in agriculture. You cannot have agriculture with the animals left out. The whole world lives together and forms the wonderful thing called agriculture.

Today, however I want to talk to you about medicine. There you have the supreme union of all the sciences devoted to a purpose which by its very nature calls forth the instinctive homage of all humanity. A little while ago I was saying that there is no man yet born of a woman who is not in need of a doctor. That would have been sufficient reason but there is more than that. There have been many professions in this world. One of the oldest professions in this world is the profession of a doctor. The profession of medicine has always had from the earliest times the very highest of traditions. The name of an ancient Greek, Hippocrætis comes to our mind. He set up the highest ideals for the medical profession. Similarly, the name of Archimedes in the field of mathematics and physics and Aristotle in the field of biological studies stand out. They will never die because they represent the flowering of the human spirit in a time and in a way that has never been surpassed in the history of humanity. I just mentioned to you that this profession of medicine has rightly followed the highest traditions inherited from the ancient past. I could have quoted precepts and examples from the history of our own people but I do not wish to do so because I have something very much more interesting and important to talk to you about.

The subject of medicine represents the union of all sciences and one has only to study the history of science to realise how much not only humanity in general but also science in particular owes to the followers of this noble profession. I should like to say this further that to my mind at any rate the supreme importance of the medical profession arises in the fact that the medical profession deals first and foremost with that thing which interests us all and that is ourselves. The subject matter of medicine is this: Shall I say this piece of earth that we call the human body? Shall I say this manifestation of the divine spirit, this manifestation of the noblest ideals that is enshrined in this human body? We human beings are necessarily most interested in ourselves. Why it is that the medical profession occupies such a unique position is because it concerns ourselves.

India is inflicted with no less than 400 million examples of this species. The worst enemies of man are not men and women. They are little tiny things, invisible particles, virus, bacteria and so on. They are really the inheritors of this raj. The principal possessors of this earth are the rats (laughter). We are here by sufferance and sufferance only. The principal aim of the medical men as I see is very necessarily to guard man against himself, and then save him from every zoological species. In this process of the medical profession the doctor has to come into contact with what I may call humanity in the raw, meet people at a time when their tempers are raw with suffering. What is the result? The doctor has, above all things, even more than his knowledge of medicine, to acquire one supreme possession and that is his knowledge of human frailties, in short human psychology.

No phenomenon impresses me more than the fact that to-day the medical profession in south India has made an honoured place for itself and has won for itself the appreciation of the general public and has shown also that it can rise beyond the narrow interests of the profession and take a leading part in all humanitarian activities and what is more, to use its influence which it obtains, to save the life of man. That is an extremely gratifying feature and my presence at a medical conference is largely to enable me to give expression to my experience acquired in my visits to various parts of India that the medical profession has risen rapidly in the esteem of the general public and what is more the greater part it is playing in the general life of the community.

A profound knowledge of man comes from the practice of the medical profession. The very science of the medical profession is based on that knowledge. The human body is an exceedingly complex and difficult organisation. There is no doubt at all that the human personality and the activities of the body are very intimately connected with each other. I had this brought home to me in a vivid way by personal experience. There was a time when I was suffering from a severe trouble in the stomach. I went to a learned doctor and he diagnosed it as 'stockbroker's disease'. (laughter). He told me that stockbroker's disease is simply the disease brought about by the acute anxiety of the mind. I told him he was perfectly right. Then I realised that the way to health is not to worry about things. Many of us fail to realise that the surest way to be happy is firstly to try to find happiness in the common things of life. Secondly, to keep yourselves busy and interest yourselves in something, whatever it may be. These two prescriptions plus the well-known adage 'eat an apple' if everyone followed there is no need for doctors at all (laughter). This fact has to be recognised, that this body of ours is not a mere machine but a complex mechanism controlled by the spirit and the mind. The whole thing has to be tuned up and kept running. The capacity to realise this and to use knowledge to purpose, that is the secret and success of medical science. It is this understanding that has created modern medicine. No wonder therefore because such deep and penetrating knowledge of what human life is that makes the medical profession one of the most remarkable callings that one can imagine.

But there is something more. Medicine like agriculture is the meeting ground of all sciences. That is recognised in our curricula. There is general indication that medicine essentially represents the union of a great many branches of human knowledge. If you study the history of science you find that medical men have throughout played a most remarkable part in the history of science and not merely in the history of medicine but in the history of a score of sciences it is the medical men who have understood the whole and then understood the significance of the parts. Specialisation in science prevents your understanding of the relative importance of different things. Medical science by the very fact that it has to do with an integrated human body and that man is compelled to see the relations of the parts to the whole has made the practioner of that profession the initiator of great and significant new ways and the pioneer in many branches of knowledge.

But having said so much in favour of medicine I must also not forget to say that medicine is also indebted to science. Medicine exists and survives because of what for example physics has done for medicine. The fact is this: medicine has repaid the debt it owes to science. Take for example the discovery of X-rays. As a man of science I understand the fundamental relationship between medical science on the one hand and the other science of which I have the honour to be a representative.

There is one other aspect of the matter about which I should be untrue to myself if I did not say a word or two. And that is to my mind, even for more important and far more interesting than what I am talking about just now. That is the miracle of the human body. The human body is one of the most amazing pieces of machinery which nature creates. Take the embryonic child. It is almost impossible to understand the beauty of it. We often wonder when we look at the modern radio, televison, etc. Of all the miracles of modern science there is no miracle which can distinctly approach the human body in its marvellous performance. Take the human eye. It is one of the most amazing things. A lot of work has been done on the sensitivity of the human eye. Again, take the sense of hearing. The quantity of energy which goes into a whisper, the amount of sound which you can actually listen to is something incredible. No monometer, no instrument however delicate could ever show the changes of pressure which the human ear discovers in a sound. Again, a tremendous amount of work has been done in modern times to follow, the nervous impulses. We have in our human body a great many other powers of perception, which so far have defied scientific research. They offer even to-day a practically virgin field of inquiry. We can distinguish thousands of smells from each other and what is more we can characterise them. The nature of the smells whether it is physical or chemical is a matter worthy of investigation.

For 50 years we know what we have gone through. We have developed certain complexes. We have not outgrown these things. It is the height of folly, the acme of stupidity to shut our eyes to the results of modern science in every field of inquiry. On the other hand, so far from its being a sign of patriotism or virtue to exalt what has been done before, it is the surest way of perpetuating our inferiority. Mankind goes on. Discoveries of science often come from purely altruistic people. The real object of science, of all true sciences is just the pursuit of science for its own sake, just the desire to understand the world about us. The things of science are not given to this or that nation. We want to rise as a nation. We want to live happier and better lives. We want to hold our own against the impact of western civilisation upon us. We can do so if we put aside all these hangovers. We must take our stand on realism. We must recognise everything that is new. I would ruthlessly reject anything merely because it comes from the west. But the very last thing you have to reject is science and results of scientific inquiry. You have to adopt and use them. You have to admire your past. But let us not be foolish enough to think that the past embodies all wisdom. There is no future for us in India as a nation, as a people, as individuals unless and until we are prepared to exert ourselves. We must develop a highly critical attitude. Authoritianism should have no place in the field of science. The only kind of independence I can think of is intellectual independence. When we have achieved this every other kind of independence will acquire its real meaning. There must be an intimate relationship between the progress of medical science and the progress of fundamental sciences in our country. Despite what has been done in our centres of learning science in South India is extremely backward. The amount of attention being paid to what I may call the real study of science intended to breed in our younger generation a real knowledge of science

is inadequate. We are far behind some of the North Indian Universities. South India is not in the picture at all. It is a most distressing state of affairs. The decision to locate the national physical laboratory in Delhi is not a wise decision. Delhi is not a suitable place at all. The blame for the backwardness of South India in the field of science is on ourselves. We have not realised the importance of our talents. We export them. We do not want to keep them. To-day perhaps the greatest name in the field of theoretical astronomy is Chandrasekar who is now at Chicago. He had to go to Chicago because we did not find any use for him. The same could be said of every branch of science. It is the intellectual leaders that are the priceless possession of our land. We have to realise the supreme importance of developing intellectual activity on the highest plane. We have to realise that all science is one. Talent, ability, character, energy, perseverance are the qnalities that should be supported and encouraged.

We must organise ourselves. A repressive complex stands in the way of great men emerging. We ought to trust ourselves to judge our own people and give them opportunities to build centres of research. I do not yet see any sign of the realisation of the tremendous importance of medical research. We should not think it is the duty of the Central Government to develop scientific research. It is the duty of the provincial governments to take the initiative in the matter and create such opportunities for us that the Central Government would no longer be able to ignore, even if they wanted to, the claims of South India. I have great pleasure in declaring this Conference open. (Loud applause).

THE NEW MAYOR OF MADRAS

The *Miscellany* offers its heartiest congratulations to Dr. U. Krishna Rau, M.B.B.S., Editor, *Antiseptic*, Madras, on his election as the Mayor of Madras.

Distinguished son of a distinguished father, Dr. Krishna Rau eminently deserves the honour conferred on him. His predecessors. great ambitions were to make the city bigger, more beautiful and all that. Dr. Krishna Rau's is greater than all those—he is anxious to make Madras a cleaner and healthier city. We wish the new Mayor every success in his endeavour.

THE INDIAN MEDICAL ASSOCIATION
THE SECOND SOUTH INIAN PROVINCIAL CONFERENCE, COIMBATORE.

PRESIDENTIAL ADDRESS

BY

DR. B. K. NARAYAN RAO, M.R.C.P., D.O., Bangalore.

Ladies and Gentlemen,

I am very thankful for the honour you have done me in asking me to take part in the study and discussions of the many problems that face us in the new India of to-day. It is this opportunity that I greatly value.

I am sure you would all wish that at the outset we should express our gratitude to Providence and its instrument, the Mahatma, for making this ancient land once again free from the crippling hold of foreign domination in all departments of human life, including Medical Social Service. To say so is, however, not to withhold the measure of appreciation that is due to the Indian Medical Service, which has now ceased to be. It rendered valuable service to the people, especially, in its earliest stages by organising efficient departments of medicine and sanitation. It introduced good discipline into public health administration, and it built up centres of Medical Education and Research. A few of its members by their brilliant research made appreciable contributions to the world's store of knowledge and have put humanity in their debt.

With the advent of independence, the responsibility of both the Government and the Medical profession in India, for providing a comprehensive Health Service to the people on an adequate scale, has become great and urgent. Fortunately, the Health Survey and Development Committee appointed by the previous Government of India has done a great service by its careful and well informed study of the problems involved and its practical recommendations to solve them. Though, with the change that has since come in the political picture which was then not foreseen, some of the Committee's recommendations have necessarily to be modified, yet, the general lines of advance and the main steps in that direction suggested by the committee constitute a valuable guidance both to Government and to the Medical profession. The old and somewhat limited aim of merely how to save life and reduce pain has rightly been altered to one of how to ensure a vigorous, active and fruitful life for the people, of securing "positive health" as they term it. The importance of prevention of all preventible ills by attention to environment, in addition to the study of personal habits of life, has been given due emphasis.

Nowadays, while many young doctors seem to think that early specialisation is a short cut to financial and other kinds of professional success, the conception of the Bhore Committee of a 'basic doctor' possessing an adequate knowledge of both preventive and curative aspects of individual illhealth and an intelligent and balanced understanding of community health, comes as a refreshing and much needed corrective. Even in advanced Great Britain and U. S. A., responsible authorities have discouraged the temptation to too early specialisation as tending to narrow down a medical man's out-

look and reduce the quality of his service. As a practical measure, it may be suggested that our Universities and other examining bodies might insist on some evidence of general prefessional work on the part of a candidate before granting him a postgraduate specialist diploma, such as, D.O.M.S., D.M.R.E., T.D.D. etc.

To further improve the quality of medical service to the community more encouragement should be shown in admissions to Medical Colleges to graduates, who come with a record of cultural studies and have undergone a greater discipline in scientific thinking and working. The field of selection may in some cases even be extended to graduates in Mathematics, Economics, Psychology and similar Social Sciences, if they have previously taken a short coaching in the subjects of Physics, Chemistry etc. I feel that they would not compare unfavourably with ordinary I. Sc's who now constitute the bulk of our entrants to medical courses.

In addition to preliminary academic qualification indicating a minimum of cultural and disciplinary background, other factors, such as, physical fitness, personality and alertness in mental working have to be assessed and taken into consideration in selecting applicants for the medical course, and this can be done by a personal interview before final selection.

To make the comparatively high expenditure on Medical Education yield the maximum return in quality and usefulness to the country, considerable modifications and readjustments in the curricula of Medical studies seem necessary. Till now we have followed the British pattern blindly in almost every detail. While we have done well in sticking to the general principles underlying this pattern, we have neglected to modify its details to suit our requirements. Over emphasis has been laid on the study of some subjects to the detriment of others of great local importance, such as, Tropical Diseases (so called), Preventive: Medicine, Ophthalmology Infective Diseases and Psychiatry.

It is fortunate that in recent years, Public Health has been considered to be of sufficient importance to have a Ministry for itself in most of the provinces and in some states. Individual health is not merely freedom from sickness or disability but the capacity to live a vigorous, active and useful life. Similarly, community health connotes an environment of living and working, not merely free from danger but also conducive to longevity, efficiency and happiness. To secure these ends, nutritional sufficiency, occupational safety and well employed leisure are necessary and it is desirable that the Ministry of Health should deal not only with all problems of curative and preventive medicine but also should have influence on the administration of Horticulture, Public Parks and Gardens, Physical Culture, Sports, Cinemas and Theatres, and other institutions, providing for relaxational employment of leisure. The Ministry should also have a potent voice in the planning and working of agricultural development and live-stock control.

It is obviously of the utmost importance that the Public Health Ministry should be given the responsibility of supervision and control over the manufacture of foods and drugs. Complete state ownership of these industries may not be possible at present, even if desirable, but the state should aquire some share in the management of such concerns and exercise a vigilant watch to secure the purity of products, as they affect the health of the consumers.

To improve Health Services in quality and make them less costly in rural areas, it is necessary that scientific, diagnostic and therepeutic facilities, like

Pathological laboratories, X-ray and Dental units, should be brought within easy reach of practitioners in rural areas. To bring into existence such small units in adequate numbers, Government and Local bodies might establish them at their own cost or better still, might encourage qualified suitable doctors to establish them by securing for them facilities for the import of necessary apparatus and by granting them subsidies for a few years in the initial stages. Another important line of work for the Ministry of Health is the adoption of measures to promote the manufacture of such apparatus within the country. There is a vast scope for development in this field.

Co-operative Societies for medical help may be established in rural areas and suitable arrangements may be made with practitioners for affording medical service to members and their families. Supplies of drugs and even facilities for inpatient treatment and maternity service may be arranged for through these co-operative institutions. This will lesson the cost of treatment to patients and will secure better service to them, while it will ensure steady work and income to the doctors employed.

It is said that for a satisfactory all-round Public Health Service, which should preferably be nationalised, there should be on an average at least one qualified doctor to 2000 of the population. The figures that obtain in Britain and U.S.A. are one for 1000 and 750 respectively. Madras province has one doctor for about 6000 of population and India one for 6300.

These figures do not include a number of trained practitioners of Ayurvedic and Unani systems and of a large number of practitioners with no regular organised training in either system. Russia effected a phenomenal increase in the number of well trained doctors to the required level within a comparatively short period and this seems to have made some authorities think that similar advance could be made by us. But considering that medical training was but a part of the various socialistic activities of the Communist Republic and that we are not likely to be in a hurry to copy her in many other activities, the hope that we could produce medical men at that rate in the very near future appears somewhat too optimistic and nationalising the doctors' work too seems only a remote possibility. The crying need for more doctors apart from state employees will therefore continue to exist for at least some decades, providing ample opportunities for talent outside of State employment.

Some provinces have abolished medical schools and others have been advised to do so. This measure, though desired by all, seems to have occasioned some differences of opinion on the score of balance of practical advantage in the immediate future, especially, in some parts of India and in some States. The preference for the continuance of schools as schools in certain areas is mainly due to financial difficulty and is understandable, when we remember that in the opinion of the Bhore Committee, a sufficiency of graduates for nationalisation of Health services can only be had at the end of about 20-years, even with the conversion of all the Medical schools into colleges, besides the establishment of new colleges and increasing admissions to existing colleges. Madras has been happily the first to set a good example by abolishing schools and increasing colleges.

Licentiates have by all accounts proved their worth all along as good and capable doctors. They were recruited in large numbers for war work and they rendered very satisfactory service. Therefore, their segregation into a separate category in our registers is no longer tenable. All the qualified medical men and women, licentiates or graduates,

should be brought on one common register, as in other advanced countries. For special posts and services in Government, definite qualifications may be prescribed and whoever possesses them may be considered as eligible. Further, licentiates may be enabled to take a degree with reasonable ease and more facilities created for their doing so. The bogey of so called recognition by other countries need not worry us.

To make medical help more fruitful, there should be a plentiful supply of auxiliary service personnel, such as, nurses, laboratory technicians, radiographers, pharmacists, sanitary inspectors, malaria workers and several others. There is a deplorable paucity of such help at present. Many schools should be opened for training technicians on the model of a two year course that obtained in France and Germany before the war.

Various legislative measures are necessary in the interest of conservation of health of the people. One of them is to make the assumption of bogus medical qualifications which mislead the public, a penal offence. To avoid confusion it would be a good thing to insist on every practitioner to indicate by some distinctive appellation (like the time honoured terms, Hakim or Vaidya) the system of treatment which he follows.

As the menace of patent medicines of doubtful value has become great and their advertisements are met with everywhere, it is of great importance to protect the unwary public from fraud. In some countries the ingredients of patent medicines have to be published on the containers, including even the quantities of important constituent drugs. Legislation to ensure similar action regarding indigenous or imported patent medicines is necessary. It should have Ayurvedic and Unani patent medicines in its purview.

Nosturms loudly claiming to be certain cures for such chronic undermining diseases as tuberculosis and cancer mislead the sufferers into delay and consequent advance to incurable stages. Stringent rules are necessary to control the advertisement of such concoctions.

With closer co-operation between the Public Health authority and the local practitioners the beneficial intentions of the Public Health Act can be realised to the great advantage of the people. The Health Officer of an area, instead of being a mere glorified sanitary inspector as is unfortunately often the case at present, can be as he deserves to be by his qualifications and scope of work, a helpful colleague and consultant of all the doctors in the area in reducing preventable morbidity and suffering. Medical Inspection of schools and scholars, maternity and infant welfare, occupational diseases, epidemics, all these are items in which a close co-operation is necessary. Want of such co-operation at present to the desired extent, and the sense of urgency to fill that want have been, I believe, strong reasons for the new idea of a "Basic Doctor," trained in everything and useful for all kinds of work.

In our country, 85 of the population live in villages often with poor communications, and with few amenities of civilised life. One of the effective measures to overcome the natural reluctance of well qualified medical men to settle in village areas, is the introduction of electricity and telephone services. These will infinitely enlarge in numerous ways the amenities of life to all the people and to the general improvement of their health also. There will be less of the feeling among doctors of banishment from civilised life and if there are arrangements for ambulances to bring consultants from bigger centres and to take patients to bigger institutions whenever necessary, rural medical work would be regarded by them as more fruitful and life there quite worth

while. Establishment of such a network of ambulance units might be undertaken by Local Bodies, assisted by the Red Cross Association.

One word to my fellow doctors. It is said that the Indian Medical Profession has not contributed any large share to the world's pool of knowledge of modern scientific medicine. This is unfortunately true to some extent, though there have been brilliant individuals, who have done meritorious work. Outstanding knowledge in regard to malaria, dysentery, plague, cholera, some eye diseases and maternity diseases has been contributed in India by Indian nationals. With the new freedom for advance and a new Government determined to foster the nation's progress along paths of science and social reconstruction, Indian Universities and other centres of education and research are expected to organise scientific work to unravel problems of medicine and so help to raise the status of the Indian Medical Profession in the world's estimation. For this the establishment of numerous medical libraries is essential. Even more important, a general atmosphere of sound scientific attitude in making correct observation and right conclusions on the part of all practitioners is necessary in treating patients or in doing community health work. There is no lack of talent in our country; with opportunity and application, I am sure much advance can be made and will surely be made hereafter.

In conclusion, may I say, Ladies and Gentlemen, that medicine, in spite of the advances in scientific knowledge, still remains partly an art. I believe this will remain so as long as the human mind remains individualistic and elusive in its workings. We have to do our work not merely on the physical but also on the psychological plans. To achieve the best possible results in such a calling, grace and sympathy and the attitude of genuine friendliness are the most potent factors. In the present day, when that most ugly and violent social phenomenon, aptly termed a "strike" is being resorted to by workers for society at every turn, our profession of service will, I earnestly hope, never yield to the temptation of its wiles and will, on the other hand cultivate a constant sense of its own humanitarian mission. It will be an evil day for all, when our profession ceases to look upon itself as a high and beneficient ministry and allows itself to degenerate into a mere trade union. A great and noble tradition beckons to us from the history of our own land, no less than from that of Europe, a tradition of brotherly service to fellow beings. May it be given to us all never to prove ourselves unworthy of it!

ACKNOWLEDGMENTS.

We acknowledge with thanks receipt of the following :—

1. The Antiseptic, Madras, November '47.
2. Indian Medical Journal, Madras. November, '47
3. The People's Health, Madras, November '47.
4. Wealth and Welfare, Madras.
5. Calcutta Medical Journal, Calcutta, November. '47.
6. The Oriental Watchman and Herald of Health, Poona.
7. Sunday Times, Madras.
8. My Magazine, Madras,
9. Voice of Assisi, Trichinopoly.
10. The Madras Homeopathi Journal, November, '47.

Diner: I say, there is a fly in the *Rasam*.

Server: It can't be a fly sir. It may be the vitamin bee, which they say we must have in our food.

THE SECOND SOUTH INDIAN MEDICAL CONFERENCE

(INDIAN MEDICAL ASSOCIATION)

Speech delivered by Col. S. L. Bhatia, C.I.E., M.C., V.H.S., M.A., M.D. (Cantab) F.R.C.P. (Lond.) F.R.S.(E.) Surgeon-General with the Government of Madras at the opening function of the Scientific session of the Conference held at Coimbatore on 18—10—1947 at 9 a. m.

MR. SIR C. V. Raman, Ladies and Gentlemen,

I deem it a great honour to have been invited to open today the Scientific session of the Seconnd South Indian Provincial Conference. I appreciate it very sincerely and am deeply grateful for it.

This is the first Conference, we are having, since the day India attained its cherished goal of Independence (cheers). For that reason this occasion has a special significance. This is the time for us to proclaim our renewed faith in our profession and to make great resolutions,—resolutions for the improvement of the health of our country, a task which is mainly ours, and a privilege for which medical men should be proud. At this juncture when our country has started on a new Era, there are certain matters which deserve special consideration on the part of the medical profession.

In the first place, there is much greater need today for mutual contact between the members of the profession than ever before. This will afford opportunities for the exchange of views and for the discussion of our difficulties, so that we may make combined offorts to deal with the situation that faces us.

It is also necessary, that we should make greater contact with the medical profession of foreign countries. This will promote international understanding and goodwill. I need hardly remind you, that medicine in its aims and outlook is international and knows no boundaries of caste, creed or colour. It is my firm belief, that in the existing troubled state of affairs in our country and elsewhere, medicine can be and is a great instrument for creating an atmosphere of goodwill. we medical men by virtue of our calling, are "Patriots of Humanity." In our relations with foreign lands, each one of us should be an ambassador of our own country, and this should help to promote peace, goodwill and concord.

Yesterday we learnt, that Dr. P. B. Mukherjee, the President of our Association, had gone to Paris to attend the meeting of the World Medical Association which was held in the month of September 1947. This organisation was brought into being last year. Perhaps you may be interested to know what it stands for.

The objects of this Association as set out in the provisional Articles and Byelaws are :—

(a) To provide closer ties amongst the Doctors of the world by personal contact, and all other means available in order to assist all peoples of the world to attain the highest possible level of health.

(b) To study the professional problems which confront the medical profession in the different countries.

(c) To organise and exchange information on matters of interest to the medical profession.

(d) To establish relations with and to present the views of the medical professions to the world Health organisation, the U.N.E.S.C.O. and other appropriate bodies.

Some may say where is the necessity for a World Medical Association, when there is a World Health Organisation? These two bodies in fact are in the same relationship to each other, as the Indian Medical Association is to the Medical Department of the Government here. The World Medical Association is an organisation of medical men. It will be the highest professional authority on medical matters and its prime aim will be to advise and formulate proposals for the improvement of the health of the peoples throughout the world. The World Health Organisation on the other hand is the official organisation concerned with the administration of world health matters. I do believe, that both these organisation are complementary to each other, and that they are both very essential.

Associations like the World Medical Association and the Indian Medical Association can assist the Government in a very satisfactory way in its task of administration and in implementing the various plans for the improvement of the health of the country. It is for this reason, that in the new Era in which we find ourselves, there should be greater contact between the Government and the independent medical profession than before. I would like to take this opportunity to say, that those of us who are in Government service are really servants of the people, whose needs and welfare are our primary objects. All medical men in Government or in any other public service should carry out their duties in a spirit of service to their country and to the people. I am glad to say, that the members of the medical services in this Presidency are performing their noble task in a spirit of service.

The next most important matter for consideration is the need for promoting medical research. Yesterday our distinguished Scientist, Sir C. V. Raman, for whom we have the highest respect (cheers), told us that we should not accept all the new knowledge that the West offers us, without further scrutiny on our part. I am in entire agreement with him.

To assess new knowledge from abroad and to make our own contribution to it, it is necessary that we should have a large body of first class research workers.

During the war, I had the privilege of visiting America as the medical member of the Indian Scientific Mission. I had the opportunity of studying closely the arrangements there in regard to medical research and medical education. I found that to some extent the conditions in these respects in the U. S. A. and India were analogous. America is a relatively young country and India too has come into contact with the West in comparatively recent times.

In every country which is opened to Westren civilization there are three successive stages in its relation to Medicine:—

(a) *First stage.* Trained Physicians have to be imported or the sons of the soil have to be sent abroad to study Medicine.

(b) *Second stage.* The medical training can be undertaken at home, Medical Colleges and other training institutions are established in the country. The number of Physicians is thus increased. Many of them keep in touch with scientific progress abroad, make this knowledge their own, and pass it on to their stundents. But the attention is concentrated largely on turning out more and more Doctors and not much attention is paid to research work.

(c) *Third stage.* The Medical Colleges and Schools flourish and in them medical research is encouraged and actively pursued.

America has advanced on these lines. The same three stages can be discerned in the medical history of our own country. It was with the establishment of Johns Hopkins Medical School at Baltimore in 1893, and of the Rockefeller Institute of Medical Research in New York in 1901, that medical research inU. S. A. received a great impetus. Since then rapid advancement has taken place. The names of certain pioneers are intimately associated with this movement, namely those of Osler, Welch, Kelly and Halsted at Johns Hopkins and of Simon Flexner, a pupil of Welch, with the Rockefeller Institute. They paved the way for the development of scientific Medicine in America.

Medical research in America is becoming increasingly broad and intense. It is establishing greater cooperation than ever with other fundamental sciences, viz. Physics, Chemistry and Mathematics. One finds a large number of Physicists and Chemists actively engaged in Medical research and making important contributions to medical science. We also find research in clinical science going ahead.

It is not possible to speak of medical research without thinking of medical education. Medical research and medical education are intimately connected with each other. They are indivisible. No medical education can be complete and effective, unless it is conducted in an atmosphere of research. It is only under such conditions, that more research workers can be

produced. This fundamental truth has been appreciated in America and every attempt is made in the Medical Colleges to promote research.

Now coming to our own country, I feel that the fundamental problem that faces us is the improvement of medical education, so that medical research is intimately associated with it. So far medical research here has been largely confined to a number of Institutes, namely, the King Institute, Guindy and the Pasteur Institute of Southern India, Coonoor, in Bombay, the Haffkine Institute; in Kasauli, the Central Research Institute and in Calcutta, the Tropical School of Medicine, and so on. Some excellent research work has been done here. Some of the fundamental investigations in Malaria, Cholera, Plague and other diseases have been carried out in this country. Time has now come, when these institutes should be intimately connected with the Universities. In the Medical Colleges active steps should be taken for the promotion of medical research. You are no doubt familiar with the Goodenough Committee's Report, which was published sometime ago. According to it, teaching hospitals and postgraduate Institutes have three important functi ns in relation to medical research :—

(a) to discover and train future research workers;

(b) To encourage and facilitate original investigations by members of their teaching staff;

(c) To have special research units and workers.

All necessary facilities should be provided in Medical Colleges in India to discharge these functions. There should be suitable provision of funds for this purpose. Philanthropists like Nuffield and Rockfeller, should come forward in India to provide necessary funds for the development of research.

The Medical Colleges and Universities are logical centres for medical research. It is here, that pure or basic research really flourishes. It is here, that the investigator has the benefit of associations with others working on similar problems. There is also the stimulus constantly derived from teaching and from contacts with young enquiring minds, as well as the advantage of consultations with teachers and investigators in allied and basic science.

Research units should be established in teaching institutions and research scholarhips should be given on a larger scale than hitherto for this purpose.

Further, to develop medical research it is necessary, that there should be close liaison between the Department of Health, Education, Agriculture and Engineering. An increasing number of Physicists, Chemists, Zoologists, Botanists, and Engineers should be encouraged to undertake research on medical problems. As we were reminded yesterday by Sir C. V. Raman all these subjects are closely connected with each other. Research should be undertaken in the form of team work.

Now, having considered the question of medical research, the object of which is to increase the knowledge of Medicine, to which India has already made its own contributions, thequestion arises, how best to utilise this knowledge for the benefit of the common man. This is ultimately the object of Medicine. In order that the results of Medical research be applied for the benefit of the people, a close coordination between the organisation for medical research and organisation for public instruction is necessary. So far as curative medicine is concerned, we all know, that no great difficulty is experienced in adopting new remedial measures. But in adopting new methods discovered by research for the prevention of disease, there is need for both enlightened public opinion and enlightened medical profession. The amount of new knowledge of preventive Medicine is increasing so rapidly, that its application is not keeping pace with it. It has been said, that if all knowledge which we possess in regard to the prevention of disease were applied for the benefit of the people, the death rate would be halved and the average span of life would be doubled. It is therefore important to undertake as extensive programme of Health education of the people. This is very important.

It is also necessary to organise postgraduate and refresher courses for the Medical Practitioners and Medical Officers of Government and others on a bigger scale than ever to enable them to get acquainted with the latest achievements of medical research, so that they could apply and disseminate new knowledge in the course of their daily work.

Improved health means improved working and earning capacity of the people, as well as a happier outlook on life. By the adoption of the suggestion I have made, I hope we may look forward to a healthier, more prosperous and happier India.

In providing medical relief we need to pay special attention to the rural parts of the country. In the urban areas also there is need, but the need of the villages is greater, for the health conditions in the villages are far worse and the existing facilities of medical relief there very inadequate. To carry medical relief to the rural areas we require improved communications and the necessary trained personnel consisting of Doctors, Nurses, etc.

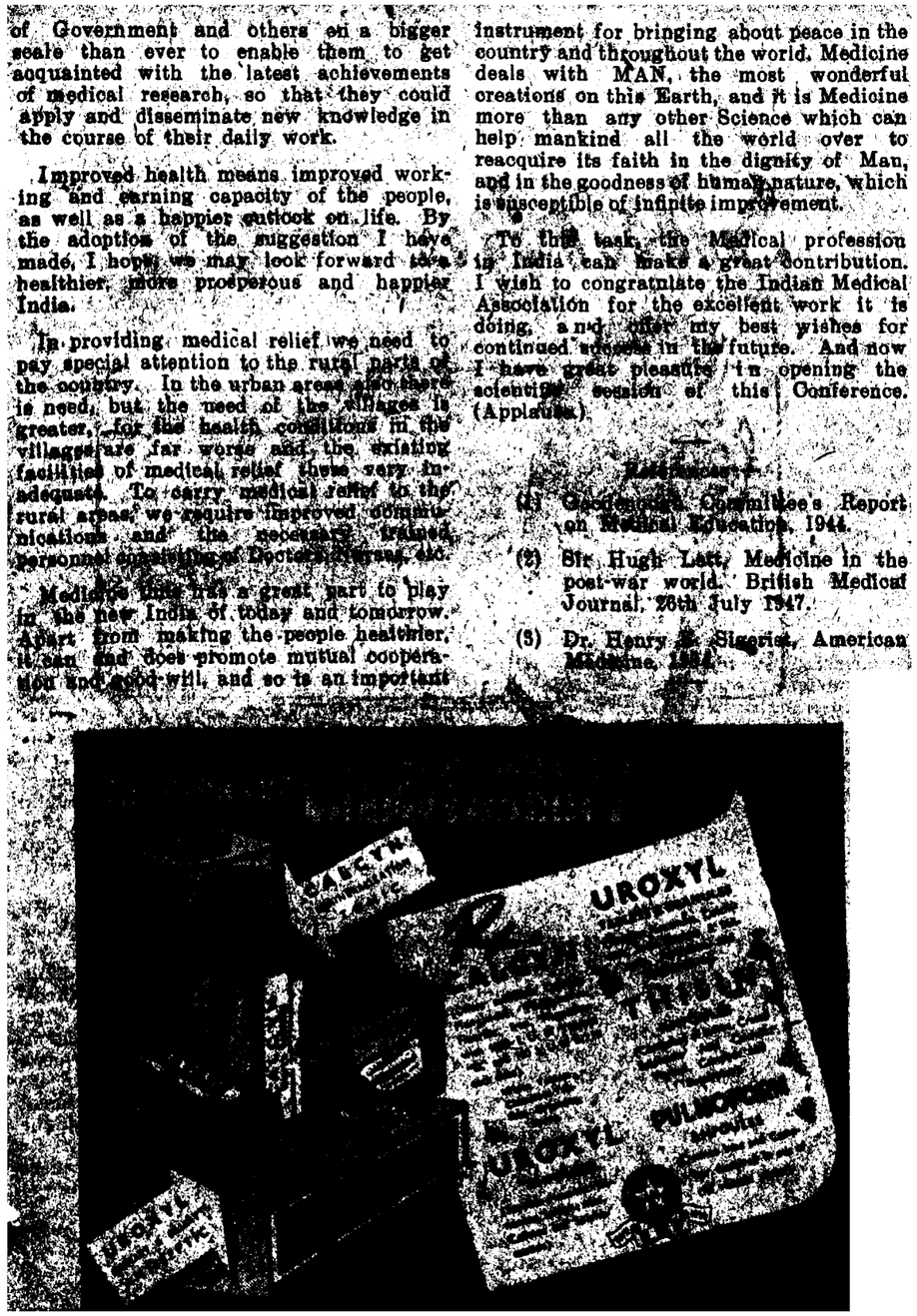
Medicine thus has a great part to play in the new India of today and tomorrow. Apart from making the people healthier, it can and does promote mutual cooperation and good will, and so is an important instrument for bringing about peace in the country and throughout the world. Medicine deals with MAN, the most wonderful creations on this Earth, and it is Medicine more than any other Science which can help mankind all the world over to reacquire its faith in the dignity of Man, and in the goodness of human nature, which is susceptible of infinite improvement.

To this task, the Medical profession in India can make a great contribution. I wish to congratulate the Indian Medical Association for the excellent work it is doing, and offer my best wishes for continued success in the future. And now I have great pleasure in opening the scientific session of this Conference. (Applause).

(1) Goodenough Committee's Report on Medical Education, 1944.

(2) Sir Hugh Lett, Medicine in the post-war world. British Medical Journal, 26th July 1947.

(3) Dr. Henry E. Sigerist, American Medicine, 1934.



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Announcement

Miscellany will accept publication of short announcements by doctors of their needs, or of any sale of their appliances or medicines. This free service is for doctors only, and for goods pertaining to medical work and which are their personal property and which they want to dispose off. This concession cannot be availed of by firms or doctors dealing in patent medicines etc.

The Managing Editor reserves the right to refuse publication of any such announcement without giving reason.

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The following change of address has been notified to us:—

Dr. C. Jagadesan, L.M.P., from Arni to Conjeevaram.
Dr. K. Venkataraman, L.M.P., from Rajasinganallur to Tondi, Ramnad Dist.
Dr. K. S. Venkatachalam Iyer, M.R.C.S., Etc., Dist. Medical Officer, (Retd.) from Ramnad to Kollangode.

The Trichinopoly and Salem branches of the I. M. A. have passed resolutions protesting against the inclusion of practitioner's dispensaries, clinics, consulting rooms etc., under the category of "shops" for the purposes of the Madras Shop Assistants bill, and have requested the Government to exempt these from the provisions of the Act.

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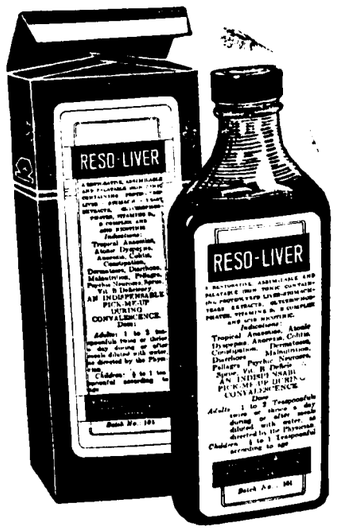

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सर्वेजनाः सुखिनो भवन्तु

Managing Editor: Dr. P. A. S. RAGHAVAN

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
OF INDIAN MEDICAL ASSOCIATION

NOTICE

UNIVERSITY OF MADRAS

The University is arranging through the Council of Post-Graduate Medical Education post-graduate lectures in the subjects of (i) Medicine (ii) Surgery (iii) Midwifery (iv) Opthalmology and (v) Oto-Laryngology, intended more particularly for the benefit of those preparing for higher Degrees and Diplomas. The course will be conducted in the Madras Medical College and the associated City Hospitals, during the months January to March 1948. Any registered Medical Practitioner can attend the course by paying the prescribed fee of Rs. 50/- for each subject or Rs. 100/- for the full course. (Applications in the prescribed form, which can be had from the Registrar, with fee should be sent so as to reach him not later than the 3rd January, 1948.)

●

Tuberculosis Workers' Conference,

January, 1948

I have great pleasure in informing you that ensuing Tuberculosis Workers' Conference will be held in Madras on the 20th, 21st, 22nd and 23rd January 1948 (both days inclusive), at the Banquetting Hall, Government House, Mount Road, Madras.

K. VASUDEVA RAO.

●

We regret to announce the demise of

Dr. P. A. VENUGOPAL, L.M.P., BANGALORE.

(FOR CIRCULATION AMONGST MEMBERS ONLY)

THE MISCELLANY

JOURNAL OF THE SOUTH INDIAN BRANCH
OF
THE INDIAN MEDICAL ASSOCIATION

VOL. XIV] DECEMBER 1947 [No. 6

THE PROBLEM OF VENEREAL DISEASES IN SOUTH INDIA IN ITS MEDICAL AND HYGIENIC ASPECTS*

BY

Dr. R. V. RAJAM, M.S., M.R.C.P., Madras.

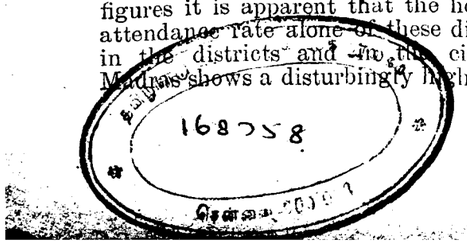
I have chosen to address you on the problem of venereal diseases in South India in its medical and hygienic aspects for the principal reason that the medical profession should have some idea of the enormity and the urgency of tackling the problem in this presidency. Though primarily a clinician who has been practising this speciality for the past two decades, it has been my privilege or lot to study the subject in its wider public health aspects. The ignorance, apathy and disgust of the general public about these diseases is only equalled by the laissez-faire, indifferent and individualistic attitude of the average medical man. The exact prevalence of these diseases among the population is not known and can never be accurately known because of the moral and social stigma attached to it. It is my opinion that venereal diseases constitute a major and menacing public health problem in this Province. To illustrate the serious nature of the problem I shall take the two principal major diseases, Syphilis and Gonorrhoea for discussion.

According to the Annual Report of the working of the Civil Hospitals and Dispensaries in this Presidency during the year 1945, 2,93,835 patients with syphilis and gonorrhoea had attended one or the other government, state-aided, municipal and local-boards medical institutions in this Presidency. Of this, 165,888 were cases of syphilis and 127, 947 were cases of gonorrhoea. Syphilis is one half times more prevalent than gonorrhoea and generally considered a better indicator of the venereal diseases status of a country or population. Further the number of syphilis patients which are given in the report probably represents only obvious cases of early syphilis, late cutaneous syphilis and congenital syphilis and does not include all aspects of the disease. It is well known that syphilis causes serious disorders of the nervous and cordio-vascular systems years after the original infection. From the 1945 annual report, it is gathered that 541,474 patients with diseases of the nervous system and 99,236 patients with diseases of the circulatory system, had been treated in the institutions of this Presidency. In at least 50% of the former and 15% of the latter, it is my cautious estimate that syphilis is the aetiological culprit. So taking all aspects of syphilis, the annual hospital incidence of syphilis comes to nearly ½ million cases. From a comparison with two other chronic communicable diseases, Tuberculosis and Leprosy, it would appear from the hospital returns, that syphilis is five times more prevalent than Tuberculosis and 6½ times more frequent than Leprosy.

It is my statistical surmise that for every twenty persons suffering from either syphilis or gonorrhoea, only one person seeks treatment in a hospital and the rest either get no treatment or are treated by quacks, or private medical practitioners. Hence an approximation to the real prevalence rate of the two principal diseases, among the general population may easily be twenty times the hospital rate. This would mean that 5,876,700 people of either sex have had or are suffering from one or other of the two diseases. From the figures worked out in the Venereal Clinic at Madras, it would appear that five out of every eight patients seeking treatment for either syphilis or gonorrhoea are in an infectious state. Applying this ratio to the probable prevalence rate among the population, nearly 3½ million persons of either sex are harbouring the diseases in a communicable state and are a source of danger to the uninfected population. To the physical havoc wrought by these diseases and by the conditions in which they breed must be added the social wreckage of twisted moral and ethical values, of warped and irreparable damaged lives. Syphilis is a great destroyer of child life, both antenatal and neo-natal. During the past half a decade the admissions for congenital syphilis in the Venereal Clinic at Madras alone, have shown a fourfold increase. From the hospital returns for the year 1945, the district-war distribution of these diseases is worked out in the accompanying table, giving the total number of syphilis and gonorrohoea, syphilis alone, gonorrohea alone and also the estimated population of the districts with the hospital rate per 100,000 of the population. The last column in the table is an estimate of the prevalence of these diseases among the population. From these figures it is apparent that the hospital attendance rate alone of these diseases in the districts and in the city of Madras shows a disturbingly high rate; with Guntur and East Godavari leading in the north, Madras in the centre, Madura and Ramnad in the south. In the decade between 1935 and 1945, there has been an increase in the incidence of syphilis alone among the urban population of the Madras City, Guntur, East Godavari, Madura, Ramnad and Malabar as may be gathered from the accompanying table.

War has been the traditional vanguard of the venereal disease epidemics all over the world and this province could not have escaped its consequences. The increase in the syphilis rate has been particularly marked during and since the war years (40 45) the indigenous spirochetes having been reinforced with Burmese, West African and European strains. There has been a decrease in the hospital rate of gonorrhoea in the city of Madras as well as in many of the districts and this decline may be due to the widespread use of Sulphonamide drugs by the population not only for gonorrhoea but also for other conditions As the result of such widespread use it is possible that the more susceptible strains of gonococci have been weeded out of the population and only the more resistant types persist. The increasing number of Sulphonamide resistant cases of gonorrhoea which one sees in clinical practice lends support to this view.

With the abolition of commercialised prostitution by the enforcement of the Suppression of the Immoral Traffic Act in many of the urban areas of this Presidency, sexual promiscuity and prostitution have become individualised widely dessiminated and have assumed Bizarre, Clandestine, Causal, and Perverted forms. The old professional prostitute is no longer in the picture her place having been taken by an increasing army of amateurs. A very disturbing feature in many of the towns and cities is the prevalence of what is known as "Wife Prostitution." It



would appear from my investigations that venereal diseases are more frequently dessiminated by such casual clandestine sex behaviour.

A communicable disease can be controlled in four ways:—

1. Immunization.
2. Isolation.
3. Sterilization of the infected individual.
4. Education of the public with respect to prevention.

In the case of venereal diseases, immunization does not exist. Isolation and quarentine of the infected individuals is a practical impossibility. The education of the public in respect of prevention has only a limited value for civilian populations. For disciplined communities, like the army, the applications of preventive measures has had a measure of success as may be gathered from the reports in the Armies during World War I and II. There remains therefore for the control of venereal diseases the fundamental public health principle of sterilization of the infected individual. In recognition of this important principle most of the European countries have instituted various public health measures for its control. It is recognised that the treatment of the infected persons by modern scientific methods and with the help of potent remedies is the strongest weapon we have at our disposal. And in the case of venereal diseases treatment is prevention, as it will reduce to the lowest possible proportion the number of infection carriers in the community. Let us take a look, for information and guidance, what other countries have done with regard to the control of these diseases.

All the progressive nations of the World, which really mean the European nations, have recognised that the health of the men, women and children should be the prime responsibility of the State. The first of the diseases to be socialised is veneral diseases and the credit for tackling the problem of control goes to the Scandinavian countries. It is a fasinating story of a century of ceaseless unremitting effort on the part of these countries. The steady decline of venereal diseases during the inter-war period (1919-39) in these countries is now recognised as one of the classical public health achievements in the field of venereal diseases control and unsurpassed by any other country. The public health measures for the control of these diseases were based on the principle that the diseases are communicable and should be dealt with as such. The measures adopted by them are as follows:—

1. Compulsory notification of cases.
2. Free and compulsory treatment at state expense.
3. Penalising the knowing transmission of the infection.
4. Tracing of contacts and bringing them under treatment.

The decline rate in syphilis alone in these three countries between 1919–1935 was something spectacular. In Denmark, the rate of 527 cases of syphilis per 100,000 of the population in 1919 declined to 21·3 per 100,000 in 1935. In Norway the decline was from 316 to 15 and in Sweden from 119 to 9·4 during the same period. These countries were enabled to achieve such results because they contain a small homogeneous, cohesive, highly literate population with great respect for law, and greater respect for modern medicine and almost completely free from the social inhibitions attached to these diseases in other countries. In Great Britain in 1917, an act called the Venereal Diseases Order was passed by the Parliament

of the first two diagnostic tests mentioned above. In every district head-quarters venereal diseases clinic, provision should be made for the performance of a single, least expensive, easily carried out serological test for syphilis, like the Kahn Test. The present system of sending bloods for examination to distant laboratories like Guindy and Coonoor is time consuming, expensive and unsatisfactory. Laboratory technicians should be trained to staff the district laboratories and they will work under the supervision of the medical officer in-charge of the clinic. The basic requirements of a good venereal diseases clinic are:

1. A full time salaried medical officer with enthusiasm and trained in the diagnosis and treatment of venereal diseases.
2. A sufficiency of other personnel including nurses, nursing orderlies, social worker and clerk-typist.
3. Out-patient accommodation ensuring privacy and separation of the sexes in the examination and treatment.

   Limited in-patient accommodations for the ill patients in the district head-quarters and the larger Taluq hospitals.
4. Morning and evening sessions in the V.D. out-patients to enable the working class people to take advantage of the facilities without interference to their means of livelihood.
5. A liberal supply of special drugs used in the treatment of these diseases.

From the point of view of control of infectiousness, within the shortest possible time the introduction of Penicillin in the therapy of syphilis and gonorrhoea is a tremendous advance on the older drugs. But Penicillin at present is unsuitable for the mass treatment of syphilis as it is costly and requires hospitalization and the third hourly frequency of injections round the clock. The per capita of treating syphilis with Penicillin alone comes to about Rs. 45/- without taking into consideration the cost of hospitalization. In the case of the older drugs, arsenic and bismuth, 20 injections of each administered over a period of 3 to 4 months will effectively control the infectiousness in the vast majority cases of syphilis. The per capita cost of these drugs, 20 doses of arsencial and 20 of bismuth comes to only about Rs. 7/- which is only 1/5 as costly as an adequate dose of Penicillin. Therefore in the free treatment of syphilis in public clinics, these drugs alone will have to be used in the ambulatory treatment of syphilis. In the treatment of gonorrhoea, Penicillin should be the drug of choice. The recommended dosage of 200,000 to 300,000 units is not more costly than Sulphonamides, it is more potent and the treatment is compressed within few hours.

Prophylaxis

At each of the treatment centres, facilities for personal prophylaxis should also be made available. In addition the larger municipalities and congested industrial areas, in pilgrim centres, there should be a few more such prophylactic ablution centres. In the Army as well as in civilian population of the western countries, there is a strong reason to believe that the condom or rubber sheath has been the most valuable single venereal disease preventive measure, so much so that girls out for a good time as well as the confirmed prostitutes carry these articles in their vanity bags. But chemical prophylaxis is a more certain preventive against infection. The Americans have evolved what is known as a Unitary Chemical Prophylactic, effective against all the venereal diseases. It is an ointment containing 15% Sulphathiozole and 30% Calomel in a vaseline

light mineral oil and alcohol base. It was extensively used during World War II, easily self administered and found to be very effective. Such an ointment can easily be made at any hospital or by a Pharmacist and should be freely available at the public clinics as well as for private patients at a cheap price.

For the control of any communicable diseases like venereal diseases, next to affording facilities for treatment educational propaganda among the public is of the utmost importance. Provision of free facilities for treatment is likely to be of little use unless organised and continuous propaganda at the same time helps to educate the people on the nature and danger of venereal disease. So far as I am aware, the propaganda is almost non-existent. Unlike Tuberculosis and Leprosy, individuals and voluntary associations fight shy of interesting themselves in venereal diseases. Hence it devolves on the State to devise measures for the education of the public. The various modern devices such as films, radio, magic lantern slides, lectures, newspapers, posters, pamphlets, handbills, and touring exhibitions should be employed in a continuous and systematic manner to impress upon the adults of both sexes, the nature of venereal diseases, their mode of spread, their prevention, the dangers of neglect when once the disease is acquired. The great success which England and Wales achieved in bringing 80% of patients suffering from venereal diseases under treatment is largely due to the educational propaganda conducted through out the country. In our country it is not only the illiterate public that has to be educated but also the medical profession which brings me to the third item in the fight against these diseases, i.e., *the role of the private medical practitioners* in the control of venereal diseases. In all the cities and municipal town in our province, nearly 95% of the doctors practising the modern scientific system of medicine are concentrated. It is my impression that a fairly large but unknown number of patients with early venereal diseases are treated by the private practitioners in the towns and cities. The standards of diagnosis and treatment in private practice are neither fair to the patient nor a credit to the profession. Faulty diagnosis, misuse of drugs, sub-curative treatment and the absence of the epidemiological approach to these diseases are some of the disconcerting features in the treatment of these diseases under private auspices. There are several causes for the unsatisfactory state of affairs one being the ignorance of many practitioners of the elementary methods of recognising venereal diseases, particularly syphilis. A lack of understanding of the proper use of and interpretation of serological tests and the absence of appreciation of syphilis and gonorrhea as infectious diseases requiring certain optimum standards of treatment to render them non-infectious. The ignorance, carelessness of the treated patients and the expense of treatment. I am optimistic enough to hope that the co-operation and the services of the private medical profession can be mobilized in the fight against these diseases, provided certain conditions for their co-operation are brought into being; free diagnostic facilities, and free supply of drugs should be made available to the practitioners at state expense. Such of those practitioners who are willing to come under this scheme may be given short refresher courses in a state clinic in the diagnosis and treatment of these diseases. Free consultative service should be available to the practitioners at the public or State clinics. The practitioners in their turn will be expected to treat poor patients free and charge a nominal fee for those who can afford to pay. Under such a scheme, the reporting of cases by number if not by name should be

obligatory. If and when the financial resources of the State permit I envisage a desirable state of affairs in which the treatment and diagnosis of venereal diseases will be completely socialised as in Western Countries. The recommendations of the Bhore Committee which are merely quoted now like 'Shakesphere and Milton' will be implemented in its entirety. In other progressive countries, the treatment of venereal diseases by unqualified persons is punishable by law. It will be premature to suggest the enactment of any such law in our province, till the state has provided abundant facilities for treatment and has educated the public sufficiently intensely to take advantage of the facilities so provided. In the near future a provincial venereal diseases organization may have to set up as part of the provincial health department under the administrative control of the head of the Public Health services. A full time venereal diseases control officer should be in-charge of this organization and he should combine in himself public health experience, and wide clinical knowledge of venereal diseases. It should be the function of this officer to plan the campaign against these diseases in its public health and medical aspects. He should have a number of trained assistants, both medical and non-medical, for dealing with the various aspects of control as the following:—

1. Propaganda.
2. Treatment control.
3. Supply of special drugs.
4. Social work including contact tracing.
5. Maintenance of accurate statistics.

In conclusion let me thank the organisers of this conference for affording me this opportunity to address you of the medical fraternity who have a great part to play in the fight against this social menace.

---

*(Address delivered at the 2nd South Indian Medical Conference of I.M.A., in Coimbatore on 19-10 '47)

The following resolution was also passed at the conference:—

This Conference notes with alarm the increasing incidence of venereal diseases, particularly Syphilis, and the grave menace to the Public Health, and is of opinion that immediate measures should be instituted by Government to set up a Provincial Venereal Diseases Control organisation to plan and carry out control measures such as:—

1. Setting up of free diagnostic and treatment centres in all District and Taluq hospitals,
2. Intensive and continous propaganda,
3. Mobilisation of the services of practitioners in the fight against the diseases by providing them with facilities for free diagnosis and treatment.

Table showing the hospital incidence of syphilis and gonorrhoea in the Presidency for the year 1945

Serial number	NAME OE THE DISTRICTS	Total number of cases both syphilis and Gonorrhoea	Total number of cases of syphilis including acquired and congenital	Total number of gonoccocal injections alone	Estimated population of the district	Hospital rate of both diseases per 100,000	Hospital rate of syphilis per 100,000	Hospital rate of gonorrhoea per 100,000
1	Vizag ...	5467	3638	1829	4000,520	137	91	46
2	East Godavari ...	21533	12915	8638	2177,476	990	593	397
3	West Godavari ...	9012	4790	4222	1537,320	585	311	274
4	Kistna ...	7761	4203	3588	1528,094	507	275	232
5	Guntur ...	70123	46122	24001	2831,032	2944	1937	1007
6	Nellore ..	6208	2988	3220	1672,710	370	178	192
7	Kurnool ...	5892	3685	2207	1198,471	492	307	185
8	Bellary ...	4517	2552	1965	1085,711	415	235	180
9	Ananthapur ...	7244	3288	3956	1223,819	592	269	323
10	Cuddapah ...	5428	3279	2149	1102,893	492	197	195
11	North Arcot ...	4175	4248	9927	2713,137	523	157	366
12	Chittoor ...	5944	2833	3111	1712,849	347	165	182
13	Madras City ...	16637	10148	6489	836631	1988	1212	776
14	Chingleput ...	3495	1362	2133	1896,512	184	73	111
15	South Arcot ...	8530	4479	4051	2672,991	319	168	151
16	Salem ...	6550	3820	2730	3064,539	214	125	89
17	Coimbatore ...	9165	4349	4810	2970,323	309	146	163
18	Trichinopoly ...	5756	2837	2919	2303,138	250	123	127
19	Tanjore ...	12751	6311	6440	2638,032	483	239	244
20	Madura ..	25330	15122	10208	2569,213	986	588	398
21	Ramnad ...	16767	8005	8762	2038,894	822	393	429
22	Malabar ...	14244	8685	5659	4100,323	347	212	135
23	Tinnevelly ...	8044	4304	3740	2329,212	345	185	160
24	Nilgiris ...	772	498	274	228782	337	218	119
25	South Canara ...	2470	1427	1043	1589,147	155	90	65
	Total ...	293835	165888	127947	5157,1739	605	343	262

Probable Prevalence rate of syphilis and gonorrhoea among the population

...	5876700	3317760	2558940	12100	6860	5240

Hospital for syphilis per 100,000 of the population

S. No.	District	Year 1935	Year 1945
1	Guntur	964	1937
2	East Godavari	482	593
3	Madras City	940	1212
4	Madura	212	588
5	Ramnad	141	393
6	Malabar	103	212

PROGNOSIS IN HYPERTENSION

BY

Rao Bahadur Capt. S. THAMBIAH, M.C., M.R.C.P., D.T.M. & H.,
Retd. Professor of Medicine, Madras Medical College.

Prognosis is the art or act of foretelling from the symptoms and signs, (Pro: before, gignoskein: to know) the probable course a disease will run. To be trustworthy, it must be based on wide experience and careful evaluation of facts made out on careful examination. Complications, untoward symptoms and predisposing causes should be given appropriate consideration. Prognosis should not be volunteered. Many a physician of eminence has wrecked his reputation on prognosis. When the prognosis is grave or tending to be so, a responsible person of the family should be kept informed so that the doctor safeguards his own reputation.

Some generalisations may be made at the outset. Essential hypertension fairly often runs a benign course in women. When it appears early in life round about the thirties and before forty, the outlook is grave. Persons who have valid excuse for raised Blood-Pressure have better prognosis than those who have none, for the object of treatment is to modify, reduce or give up strain and stresses of life. If strenuous hours of work can be curtailed, the person can be given a better prognosis. Much depends on the patient trying to confirm to the regime outlined by the medical attendant. He should be taught a 'new way of life' by cutting out "fears and apprehension" and securing greater rest and tranquility. *Blood Pressure*, estimations may give valuable guide to prognosis. Persistently raised systolic and diastolic pressure carries a prognosis in direct proportion to the reading. Diastolic pressure is a better guide, as emotion and posture do not influence it. A diastolic pressure of 130 will indicate that essential hypertension has entered the malignant phase, and the arterio-sclerosis is in an *active* stage. Rising diastolic pressure with a falling systolic gives a bad prognosis and the patient dies within 6 months.

By *special tests*, accurate information may be obtained with regards to the pressure whether labile or fixed. The former will indicate spasm in the systemic circulation and the patient will have a better prognosis as structural damage has not set in and rest, sedatives and restricted diet will keep the condition down without allowing rapid progression. *Sodium Amytal*. 0·2 gram every hour for 3 doses. Blood pressure recorded every ½ hour for 5 hours. When the blood pressure is labile a great fall in the systolic pressure is to be expected. The fall in diastolic pressure is not so marked. If the diastolic pressure does not go below 100 of Hg. surgeons reject the case as unsuitable for sympa-thectomy.

Tetræthyl ammonium bromide, 0·5 gram in 5 c.c. of water to be administered intravenously. Records made in the same way as for Sodium amytal. Blood pressure should be recorded both by auscultatory and tactile method.

Cardio-Vascular System. It has been shown that 60% of hyperpietics die of heart complications. Heart slowly wears out in essential hypertension. The compensatory left venticular hypertophy gives place to myocardial degeneration. Orthodiagraphic measurement will show 2-2·5 millimetre increase annually. Cardiac dilatation

arises from increased mechanical load and deficient supply of oxygen to the muscle fibres. Then again Coronary Scelrosis interferes with the blood supply to the heart muscle and brings about myocardial degeneration resulting in cardiac failure. In other words, left ventricular muscle nutrition suffers and dilatation appears This nutritional interference may be sudden from a myocardial infarction, or gradual and brought about by progressive narrowing of many of the smaller coronary branches. History and electrocardiogram will give the clue to diagnosis of the myocardial failure. Anginal pain, radiation of pain, fall in blood pressure with pallor and evidence of shock along with Q1, T1, and Q3, T3 type of electro-cardiogram will indicate myocardial infarction. Fever and leucocytosis will give more confirmation. In fact, myocardial infarction is a frequent complication of hypertension and should always be kept in mind. Electro cardiogram may show increasing left axis deviation i.e. a tall R in Lead I and a deep S in Lead III and this may give place to a condition known as left venticular *stress* indicated by a continuous sweep of the T wave from the end of the descending R wave. When this occurs, left venticular failure is bound to take place within three to six months.

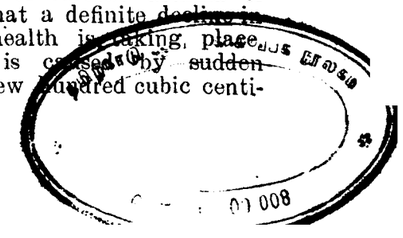
From a prognostic point of view, X-ray examination may not provide much useful guide. Prominence of the ascending and descending part of the aorta and a large aortic kunckle will lead us to conclude that the hypertension is in an advanced stage due to atheroma of the aorta.

Evidence of a change in *Vascular structure* and active arterio-sclerotic disease is looked for in the presence of haemorrhages which, apart from frank haemorrhage such as epistaxis, hæmoptysis, haematemesis melaena, menorrhagia, include retinal haemorrhages and microscopia haematuria. Other evidence of active arterio-sclerosis is to be found in E.C.G. evidence of myocardial damage, venous and arterial thrombosis and in the presence of renal damage such as allows of the diagnosis of malignant hypertension.

A phase of active and progressive disease will be recognised by increasing hypertension, the appearance of new symptoms of headache or giddiness especially by the appearance of microscopic haematuria, retinal haemorrhages and perhaps papilloedema.

Renal condition. From the point of view of prognosis investigation of renal function gives little aid, yet unilateral and remediable renal condition may be dealt with by surgery and the hypertension brought to normal levels as removal of the diseased kidney in unilateral hydronephrosis, pyelonephritis and tumor, or the relief of urinary obstruction due to prostate or stricture or the treatment of renal pelvic infection. In the routine examination the centrifuged deposit should be examined for casts and pus-cells. Renal insufficiency as shown by albumin cylindruria, haematuria, nitrogen and phenosulpheno phathalein retention may point to the condition passing into malignant essential hypertension. Retinal examination may reveal papilloedema and retinal haemorrhages. The diastollic pressure may have passed well beyond 130 mm. of Hg. The out-look is ominous. Most patients do not survive beyond six months. Some may linger on for a year. When a patient round about the thirties develop hypertension and reveal particulars as passing into the malignant state, prognosis is extremely grave.

Respiratory symptoms. Dyspnoea is worth inquiring into a certain amount of pulmonary congestion is often present. The appearance of cardiac asthma is an indication that a definite decline in the state of health is taking place. The condition is caused by sudden *trapping* of a few hundred cubic centi-



metres of blood in the already congested lungs. The left ventricle is unable to drain the lungs of an equal quantity of blood pumped in by the right ventricle. The left ventricle cannot keep up with the right ventricule. The left ventricle which is normally much stronger than the right does not possess enough reserve power. This excess blood thus trapped in the lungs reduces efficiency by reducing the vital capacity and pulmonary elasticity. This picture will become further added to by the spasm of the bronchi and the turgessence of the bronchial mucosa giving rise to the well-known asthmatic wheeses and groans. When this stage is reached and the cardiac asthma frequent, the span of life may have at least a year to go.

Periodic breathing of the Cheyne-Stokes type (apnoea alteratively with hyper-pnoea) is also a hearlding sign of the downward progress of the case. If the physician has not seen him get into this type of breathing, he may note a rapid and noisy breathing while examining his *fundus oculi* with an ophthalmoscope. During the procedure the patient unconsciously holds his breath (apnoea) and then passes into the rapid and noisy breathing.

Early stages of left venticular failure may be indicated by an unusual dyspnoea on ordinary effort which was easily performed before. He may go to bed at the usual retiring hour or take a nap after lunch hour in an arm-chair, but suddenly wakes up urgently breathless, frightened, unable to be down or secure relief. He feels there is not enough air in the room and staggers towards an open window. This is a gentle ominous sign and may pass on to pulmonary oedema recognised by incessant short cough, a copious, frothy, sometimes blood-tinged fluid, gushing from the mouth and nose. When the latter condition is seen, the end cannot be longer than hours to two or three days.

Feeling the Pulse. This is an art which is going out of fashion. The recognition of a *pulsus alternans* either by the finger or by a Sphygmomanometer and stethoscope carries a grave prognosis. Hypertensive patients have more frequent extrasystoles than persons with any other condition. They do not generally carry any significance unless as heralding the approach of funicular fibrillation in an advanced mitral case. When a hyperpietic with extrasystoles (premature systoles) is carefully examined the pulse may be found to alternate in volume and pressure for a few beats succeeding the extrasystole. Considerable practice is necessary for detection.

1. **Retinal examination.** This should always be done as a routine. Papilloedema and retinal haemorrhage are definite signs of malignant hypertension, and the outlook is often grave. Perhaps retinal haemorrhages are seen much earlier than the appearance of epistaxis and subconjunctival haemorrhage as evidence of vascular damage through artieriosclerotic changes in long standing hyperpietics.

Cerebral changes. Though the old adage "the pump, the pipe or the filter may fail" still holds good, only a very few people, say 20 die of haemorrhage or thrombosis. The sudden appearance and disappearance of focal cerebral symptoms aphasia paraesthesia, monoplegia, hemiplegia or syncope, or the development of more generalised cerebral symptoms as intolerable headache, vomiting, drowsiness, coma or convulsions is much in favour of vascular spasm (the first stage in the progress of essential hypertension is spasm of the systemic circuit) as shown first by PAL in 1905 and latter by Oppenheimer and Fishberg in 1928. These manifestations are found early and should not produce anxiety. Sudden stroke occurs while the blood pressure is high and cerebral vessels are badly damaged. The patient very rarely survives a haemorrhagic stroke, as an initial small haemorrhage opens up more and more of cerebral tissue which eventually ends up as a severe bleeding. Thrombosis is commoner and survival is only to be carried away by haemorrhage. Again cerebral thrombosis is commonest in patients with extensive arterial damage and low pulse pressure on account of the circulation, rate becoming sub-normal. One finds repeated small cerebral thromboses, scattered indifferently, giving rise to mental changes in the form of deterioration in judgment and business acumen. He may be a source of annoyance to the members of his family and household servants. All these are premonitary signs of the end which may take place as a final haemorrhage.

In conclusion, some cardinal facts should be borne in mind. Younger patients between 30 and 40 carry a bad prognosis. Hyperpietics after 40 but before 60 run a benign course and may live a good many years if the physician can direct him properly and reduce his hours of work and worry. These men are ambitious undertake too much and there is a back-ground of fear, apprehension and worry. Rest and leisure and relaxation should play a larger part, than drugs. Sedation has a place, and all substances advertised, used, and much relied on are at best placebos. The patient should be taught a way of life to suit his case. Early cases, those in the state of spasm, giving rise to hypertension, may be given the choice of surgery. The Adson and the Smithwick operations are the ones of choice. Hyperpietics are still left with the conservative methods of treatment which is only palliative. Heart requires constant attention. Nearly 50% of all organic diseases of heart arise or can be traced to high blood pressure. Out of these a good fifty percent die of coronary artery complication. Renal extracts are still in the realm of experiment. The physician should "think pessimistically and act optimistically."

"We are such stuff, as dreams are made of, and our little life is rounded with a sleep." *Shakespear's Tempest.*

(Address delivered at the 2nd South Indian Medical Conference of I. M. A. in Coimbatore on 19-10-'47.)

DOCTORS IN PROHIBITION AREAS.

I am informed by the Government that Doctors in Prohibition Areas cannot stock medicated wines. They can prescribe medicated wines upto one quart per patient and this will be supplied by chemists who hold "Form 2" license under the Prohibition Act. Doctors can also prescribe Brandy upto 2 ounces per patient. If Doctors want to stock Brandy for their own dispensing, they have to take out license in "Form 3" under the Prohibition Act, to be issued by the Collector of the District.

P. A. S. RAGHAVAN,
Hony. Secretary,
S. I. P. Branch.

STANDARD SOUTH INDIAN DIET

BY

Dr. R. SAMBASIVAN, M.B.B.S., Trichinopoly.

(Continued)

General Remarks on Vegetables—From the foregoing review of figures and with the economic background and our present and future difficult times, certain general conclusions may be arrived at for our immediate guidance. Coriander Leaves and Curry Leaves (Karuveppilai) bear a small cost in relation to their immense value. For example, a daily Chutney item of Coriander Leaves and Curry Leaves will assure us a Potency in Vitamin A which will be equivalent to nearly half the Potency of Cod Liver Oil. Sentiment, tradition, and all religions, have put these two greens in the approved list. Then again, Drumstick Leaves costing an anna or two can suffice for a family as accessory to a meal in place of costlier vegetables. Further, cheapness is not its only virtue. It carries a Potency of Vitamin A perhaps a fourth of that of Cod Liver Oil in the quantity which is usually consumed with a meal. Another uncared for but valuable stuff is Manathakali (both leaves and green fruits) which carry an Iron content of 20 mgms. per cent and Vitamin C content of 11 mgms. per cent. Custom and tradition have endowed it with highly medicinal qualities though it is not in popular favour in most households. Then again, when we consider tender Neem leaves we find of course that it is not a vegetable. But there is a legend which has survived through past generations in the remotest villages that weekly or daily use of it conduces to longevity. More commonly, it is supposed to destroy worms and parasites in the bowels. One should create a taste for it first as we do for so many odd things on earth. An ounce of tender Neem leaves may be ground into a paste and mixed with a little curd and taken the first thing in the morning every Sunday as a religious duty. Further, it has been stated that it keeps the liver going fit and fine. Then, look at the poor man's Onions. It carries in its modest way all the three Vitamins. Two annas worth of raw onions chopped and mixed with curd and salt will suffice a whole family along with the meal. It carries almost a equal status with Potatoes: only its price is considerably less. On about the same par as Onion comes the poor man's Sweet Potato. It contains Vitamin A and C a little better than Onions and Potatoes. Then, Yam (Senai) is not a cheap vegetable but middle-priced and its excellence consists in carrying all the three Vitamins, particularly Vitamin A in decent quantity. The common Brinjal carries all the three Vitamins in moderate quantity. Cluster Beans (Kothavarangai) carry a very decent quantity of Vitamin A & C and its price is lower than most others in the same series. It will be interesting to note here that tender Jack and Jack Fruit Seeds do not carry any Vitamins. Ladies Fingers carry all the three Vitamins in moderate quantity and they are fairly cheap in the season. Green Mango is noted mainly for its Vitamin A and its Iron and a small quantity of Vitamin C. It is cheap enough and can be pickled and preserved all the year round. Nellikkai (Amla) has beaten all records in its content of Vitamin C. It carries 600 mgms. per cent which is ten times greater than that of the best orange. Further, it can be dried and kept all the year round without serious loss in its Potency. It has been a renowned item in ancient Hindu Medicine and is a primary constituent of the popular Chyavanaprash Legiyam. It will be interesting to note here that Plantain Flower or Plantain Stem (Thandu) do not carry any Vitamins. On the other hand, Green Plantain carries all the three Vitamins. Sundaikkai carries a very high Vitamin A content and is cheap and can be dried and preserved all the year round. It is one of the despised items in Hindu Society and much so without justification. Then, Tomatoes carry all the three Viatmins with a relatively high content in A and Tomato is lesser priced than most others. Green Chillies and dry Chillies carry a relatively high Content of Vitamin A & C, and so we need not be afraid of using them. The bigger hill varieties of Chilly are certainly less pungent, but as valuable as the country varieties. Corainder Seed has a high Vitamin A content and should go as a matter of routine in the daily table. Further, it has a fairly high Iron content. The much despised but the inevitable Tamarind carries a high Iron content and a decent content of Vitamin A and a small content of Vitamin C. It is certainly the poor man's friend and its nutritional value is of no mean order, and along with Tamarind should go Turmeric into the daily table.

(To be Continued)

ABSTRACTS FROM CURRENT MEDICAL LITERATURE

CONJUNCTIVITIS IN GENERAL PRACTICE.—*The Lancet*—May 1947—Doctors in general practice are usually reluctant to treat an inflamed eye, preferring to send the patient to an ophthalmic surgeon without committing themselves. Since the penalty of a mistaken diagnosis may be loss of sight, this attitude is understandable, but expert help is not always to hand and the practitioner must then rely on his own knowledge. Most forms of conjunctivitis can be diagnosed on a few simple observations and one question, and every medical man should surely be familiar with these. Having ventured thus far it will be interesting for him and in the interests of his patient if he can decide on the particular form of conjunctivitis present and its origin. This is achieved by a methodical examination of the lids and conjunctiva, which requires no special apparatus but only neat fingers and good daylight.

Blepharitis and conjunctivitis may go hand in hand, and no examination of the conjunctiva should be undertaken until the lids have been carefully inspected. Scales on the roots of the lashes should be looked for, and these may be hard and crusty, leaving an ulcer at the base of a cilium when removed. This is typical of staphylococcal blepharitis; but soft greasy scales, which can be picked off easily leaving no ulceration, are seen in seborrhoea of the lids. In such a case examination of the scalp will usually reveal the origin of the eyelid infection—a scurfy scalp leads to scurfy lids. Staphylococcal erosions of the outer canthus also occur, especially in winter and spring, and cause infection of the conjunctival sac; a touch of silver nitrate to the erosion will usually put this right. A study of the Meibomian glands can likewise be included in the examination of the eyelids. A glass rod is held inside the lid and contents of the glands are expressed by pressing with the finger against this rod. Normally Meibomian secretion is a thin transparent oil, but it becomes thick and yellow when infection is present. Residual swelling from recurrent styes indicates a staphylococcal infection of the eyelid which may be the cause of a conjunctivitis, and before leaving the lids pressure should be exerted with the thumb over the lacrimal sac. Regurgitation of mucopus or mucus will indicate a stricture of the nasolacrimal duct, or occasionally the typical yellow granules of a streptothrix infection of the canaliculi and sac may be found.

Much can be learnt about the conjunctiva by a general inspection of the eye before questions are asked or special techniques employed. A truism which might well be hung in every doctor's consulting-room is *Conjunctivitis causes a Sticky Eye.* If the lids are gummed on waking conjunctivitis is present. If not, the cause of the trouble lies elsewhere. The sensitive patient will remove the more obvious signs of stickiness before presenting himself, but the lashes will give the show away. Normally they stand out singly and symmetrically from the lid margin, but where any discharge is present they are matted together in twos and threes, lying flat against the skin of the cheek. If any doubt remains, the question "Do your lids stick on waking?" will clinch the diagnosis. The situation and type of conjunctival hyperæmia is next noted. The greatest

redness will be found in the fornices and canthi, fading towards the cornea. In infective conjunctivitis the colour is a brilliant red, while in allergic conditions it is paler—sometimes almost milky in appearance owing to the intense oedema occuring in this condition. Two negative points should be remembered conjunctivitis is *not* painful and does *not* produce blepharospasm. The conjunctiva contains many mucus cells which in the hyperæmic state will be working overtime. This mucus combined with white cells and epithelial debris constitutes the mucopurulent discharge seen in bacterial conjunctivitis. Where the swelling is great and the discharge scanty, it is probably that a virus infection is present, and the frothy white foam sometimes seen between the lids is due to overactivity of the meibomian glands. Flakes of tenuous mucopus occupying the lower fornix, with the rest of the eye white and normal, suggest a self-inflicted condition, but this is rarely seen except in the Services or among those detained at His Majesty's pleasure. Absence of lacrimal fluid in elderly women sometimes causes a chronically dry eye which becomes sore and sticky because there is nothing to wash away the normal mucus secretion. Such women usually have dry mouths and stiff joints from absence of saliva and synovial fluid. The eye condition is called kerato-conjunctivitis sicca and the whole syndrome, Sjogren's syndrome.

It is important not to confuse the lymphoid follicles normally found in the conjunctival fornices of young people with the follicles of trachoma. Trachomatous follicles are large, flat, and easily expressed, while those of folliculosis are small, hard, impossible to express, and unaccompanied by any inflammation or signs of reaction in the cornea. Trachoma normally starts in the tarsal conjunctiva of the upper lid, and any follicles in this position should arouse grave suspicion; folliculosis avoids the tarsal conjunctiva and involves the extreme limits of the fornices. Conjunctival ulceration is uncommon, but when it occurs the diagnosis is not usually difficult. The single indurated ulcer is usually tuberculous, and enlarged lymph-glands should be sought. Multiple shallow ulcers may be ocular pemphigus; or, if they are yellow, agglutination tests should be done for oculoglandular tularæmia. A thick conjunctival membrane is sometimes found in diphtheria while a fine transparent membrane may be found in spring catarrh and some other allergic conditions. Scarring beneath the upper lid denotes old trachoma, beneath the lower lid pemphigus, while diffuse scarring may denote healed diphtheritic lesions. Phlyctenules in the conjunctiva have come to be regarded as an allergic reaction to a bacterial antigen—most commonly tuberculoprotein, though they can be produced by introducing various different foreign proteins into the conjunctival sac; they respond well to general treatment.

Only one germ is known to penetrate the healthy cornea—the gonococcus. The meningococcus may do so too, but gonococcal and meningococcal conjunctivitis are exceedingly rare. Otherwise, conjunctivitis does not tend to spread to the cornea, but the cornea should nevertheless be carefully examined. Marginal infiltrates may be found in staphylococcal infections, but they do not usually from ulcers and they respond to simple forms of treatment; a central subepithelial opacity may be seen in the form of epidemic kerato-conjunctivitis imported from America during the war years. If the cornea is involved the patient will complain of some pain and photophobia, and specialist advice is then urgently needed. It is easy to leave the examination of the external eye forgetting to palpate for enlarged lymph-glands. Glands in the preauricular and submaxillary group may be grossly enlarged in tuberculous conjunctivitis or the oculoglandular syndrome of Parinaud, but single slightly enlarged preauricular lymph-nodes are common in keratoconjunctivitis. Ordinary bacterial muco—purulent conjunctivitis rarely produces enlarged glands.

It is usually best to send the patient with any but the simplest sore eye to an expert, but the practitioner will not go far wrong if he remembers that conjunctivitis should only be diagnosed if there is a sticky eye, without pain or blepharospasm of misty vision. This disease is usually self-limiting, but the patient will appreciate some boracic ointment between the lids at night so that they will open more easily in the morning.

Acute Intestinal Amoebiasis.—*K. R. Hill—Lancet, June 1947*—Stool of acute amoebic dysentery is of blood stained or liquid faeces in which are scattered small pieces of blood clots and mucus. The blood is often dark, (occasionally chocolate coloured) and mucus tinged dirty brown quite unlike the white mucus of Bacillary Dysentery. The stool is foul smelling and acid in reaction to Litmus.

MICROSCOPICAL EXAM.-Selected portions of stool in saline:—For vegetative amoeba, iodine stained preparation or concentration methods are unnecessary. A selected piece of mucus free from excess faecal matter should be examined. To a loopful of warm physiological saline on the slide a loopful of mucus is added and emulsified and a cover slip applied.

EXUDATE in acute stages contain many R.B.Cs, pus cells macrophages and often necrotic epithelial cells, but compared with bacillary dysentery the mucus is non cellular.

AMOEBA IN SALINE PREPARATION.—E. Hystolytica must be distinguished from non-pathogenic amoeba of E. Coli etc. Criteria for diagnosing amoeba are one or both of the following:—1. The amoeba are progressively motile (they move from place to place). 2. The amoeba have ingested R. B. Cs. The E. Hystolytica is unique in this respect (20-30 m.). The pseudopodia of E. Hytolytica are fingerlike projections which are pushed out "explosively" the whole body of the amoeba (both ecto and endoplasm) may flow into the pseudopodium and it is this which gives amoeba its progression, which is ribbon like, and which has been described as a "slug moving at express speed." Sometimes E. Hystolytica may be non-progressive but if one waits, the explosive projection will be seen. It pushes out only one pseudopodium at a time. In E. Hystolytica the ectoplasm is structureless and is different from the finely granular endoplasm. The nucleus of E. H. is invisible or is only poorly seen, as that of a fine thread-like nuclear membarne studded with fine chromatin dots with a central single dot Karyosome. E. Hystolytica is the only amoeba which injests R. B. Cs. though macrophages show injested R. B. Cs., they in addition show bacteria, food particles and leucocytes.

ROUNDED OFF AMOEBA.—If stool has been cold or the patient has a condition well named "Walking Diarrhoea," rounded off forms showing degeneration with little or no activity, irregular in shape or normal and having sluggish pseudopodia are seen. If the heated loop is held under the slide, the amoeba is coaxed into activity showing explosive protrusion. If this device fails examination must be repeated.

ADJUNCTS TO DIAGNOSIS.—Aqaeows smears are made similar to saline preparations.

All vegetative forms of amoeba are destroyed within 5 to 15 minutes. E. H. as well as E-Coli rupture explosively, but there is never complete emptying of the endoplasm.

WET FILM STAIN.—This consists of two solutions.

Brilliant cresyl blue	0·2·G.	A
Soda Citrate.	0·1·G.	A
Soda Chloride.	6·55G.	A
Hyd. perchlor (Satur sol.)	0·1 c.cm.	A
Water.	100 c.c.	A
Eosin	0·1 G.	B
Water.	100 c.c.	B

A loopful of each solution is mixed and emulsified with a selected piece of mucus and a cover slip applied. The amoeba are picked out as blue-green objects under the low power objective. Motility is unimpaired.

Chronic Intestinal Amoebiasis.

NAKED EYE EXAM. OF STOOL.—More often the stool is formed and of normal appearance. Superificial shreds of mucus or blood may be detected. If the stool is loose it is of 'pea-soup' variety or light chocolate coloured. It has a foul smell.

MICROSCOPICAL EXAM.—The same procedure as for acute amoebic dysentery with the addition of an iodine preparation is recommended.

Iodine	1 G.
Pot. Iodide	2 G.
Water	100 c.c.

EXUDATE.—The commonest findings are scanty R.B.Cs., and a few leucocytes. The appearance may vary from no exudate at all to those described under active infection.

CYSTS IN SALINE PREPARATION.—Cysts of E.H. are perfectly round of 5 to 20 U. Nucleus of E.H. is invisible in unstained preparation whereas nucleus of E. Coli is easily seen. About 90% of E.H. show highly refractile chromidial bars which are usually broad and blunt. Besides E.H. cysts, there may be other cyst-like structures which can be identified and eliminated by the use of aqueous preparations as these cyst-like structures will appear dull and dead compared with the glistening protozoan.

CYSTS IN IODINE PREPARATION.—The same procedure as for saline is adopted. E.H. (1 to 4 nuclei) cystoplasm is stained finely granular whereas that of other cysts is coarsely granular. The Glycogen mass is always a faint brown indefinite patch tending to disappear as the cyst attains maturity. The diagnosis of E. H. is often not easy and is made by carefully deliberating and summating all positive findings.

1. Cysts with a nucleus and central Karysome. Differentiation is made on the visibility of nuclear detail and the presence of chromidial bars in the saline preparation and on cytoplasmic granularity and nuclear membrane structure.

2. Cysts with 2 nuclei showing large Glycogen mass pressing and flattening the nucleus to the sides are characteristic of E. Coli.

3. Cysts with 4 nuclei show one, two or three centrally placed Karyosome and the remainder eccentric. The Karyosome of E. Hystolytica is always central and never eccentric.

Cysts of Giardia Lambelia in iodine preparations very faithfully reproduce text book descriptions.

Adjuncts to Diagnosis in ambulatory cases—The night before examination two hours after last meal 1 gr. of Emetine Hcl. is given I.M. Next morning a saline purge 1 2 oz. Mag. Sulph. is given. The first, second and third stools are examined. In place of Emetine Hcl. E.B.I. grs. 3 may be given by mouth.

Sigmoidoscopy.—Which necessitates admission to hospital for two or three days is done and smears examined for amoeba.

P. V. S.

ASSOCIATION NOTES

CHINGLEPUT BRANCH

President :—Dr. B. G. Shenai.
Vice-President :—Dr. P. S. Srinivasan.
Secy. and Treasurer :—Dr. R. Varadarajan.

A Meeting of the General Body of the Chingleput District Branch of the Indian Medical Association was held on Saturday the 22nd November 1947 at 2 45 P.M. at the Municipal Council Hall, Chingleput, Dr. B. G. Shenai, M.B.B.S., L.O., President of the Association presiding.

There were 31 members present.

A. Minutes of the previous meeting were read and adopted.

B. The Statement of accounts from 1-1-47 to 30-9-47, presented by the Secretary, were read and passed.

The Association recorded its thanks to Mr. M. Ramamurthy, Accountant, District Medical Office, Chingleput, for the valuable free service rendered in auditing the accounts of the association.

C. **Election of Office Bearers.**

The following office bearers were elected unanimously for the year 1947-48.

(*a*) *President :*—Dr. B. G. Shenai, M.B.B.S., L.O., District Medical Officer, Chingleput.

(*b*) *Vice-President :*—Dr. P. S. Sreenivasan, L.M.P., Medical Practitioner, Conjeevaram.

(*c*) *Secretary and Treasurer :*—

Dr. R. Varadarajan, L.M.P., L.P.H., Chingleput.

(*d*) *Members of the Executive Committee :*—

1. Dr. A. Sundaraja Rao, L.M.P., Honorary Asst. Medical Officer, Govt. Hospital, Chingleput.

2. Dr. P. K. Varughese, L.M. & S. Medical Practitioner, Tambaram.

3. Dr. K. Vittal Doss Pai, M.B., B.S., Rural Medical Practitioner, Pallavaram.

4. Dr. T. K. Thayumanava Mudaliar, L.M.P., Medical Practitioner, Conjeevaram.

D. Representative to the Central Council.

Dr. P. S. Sreenivasan, L.M.P., Conjeevaram.

E. Representatives to the Provincial Council.

1. Dr. A. Chandramowli, L.M.S. (late), L.M.S., B.S.Sc., L.O., Medical Practitioner, Conjeevaram.

2. Dr. A. Sundaraja Rao, L.M.P., Chingleput.

3. Dr. D. Rajamanickkam, L.M.P. Medical Practitioner, Conjeevaram.

F. Read Circular No. Nil dated 14-11-47 of the Hony. Secretary. South Indian Provincial Branch enclosing copy of the draft rules suggested by the special Sub-Committee appointed for the purpose and advising the Associations to place the same bofore the General Body.

"The General Body of this association approves the draft rules suggested by the Sub-Committee."

G. Read letter No. 286 of 47 of Dr. K. Vasudeva Rao, M.D., M.R.C.P., T.D.D., Honorary Secretary of the Tuberculosis Association of Madras regarding "Tuberculosis Workers' Conference 1948, at Madras." Recorded.

H. Read letter No. Nil dated 3rd November 1947 of the Hony. Acting General Secretary, Indian Medical Association, Calcutta, enclosing an appeal towards "Benevolent Fund" subscription for the members of the profession who are evacuees from West Punjab and East Bengal and who have been hard hit.

Read and recorded with an appeal to all the members requesting them to contribute their mite.

* * *

The Ordinary Monthly Meeting of the above Association was held on Saturday the 22nd November 1947 at 3 30 P.M. at the Municipal Council Hall, Chingleput, Dr. B. G. Shenai, M.B.B.S., L.O., Presiding.

After tea, Dr. V. S. Subramanyam, M.B.B.S., M.Sc.(M.E.D.) F.A.C.S., Ear, Nose and Throat Surgeon, Lempert Hospital Madras gave an interesting and instructive lecture on "Deafness, its different forms and their treatment." He dealt especially on "**otosclerosis**" and the mode of treatment by operation.

After the lecture there was an interesting discussion in which many members took part.

MADRAS BRANCH

Annual Report for the year 1946-'47

The Executive Committee submits the following report for the year ending 30th September, '47.

Membership.—The total number of members on the rolls at the beginning of the year was 209. One member died, seven members resigned, and ten members left Madras during the year and so the total decrease in membership is eighteen. New members enrolled during the year was 57. So the strength of the Association at the end of the year is 248.

We regret to record the untimely demise of Dr. K. Bhashyam, one of our oldest members and, a staunch Congress worker. We offer our heartfelt condolences to the bereaved family.

Meetings.—The Annual General Body Meeting was held on Wednesday, 30th October '46 at the Madras Medical College under the Chairmanship of Dr. K. C. Nambiar, Vice President of the Association, when the election of office-bearers for the year was held and new Rules and Regulations of the Branch were passed. There were four executive committee meetings during the year and twelve clinical meetings.

The Association arranged a series of lectures during July, August and September of this year on subjects of practical interest to General Practitioner. These were much appreciated by members and well attended. We gratefully thank the lecturers, who at great personal inconvenience took great pains to address our members on subjects of their speciality. The list of lectures is appended in the end.

Tea-party.—To felicitate Dr. P. V. Cherian, M.B.E., F.R.C.S., a member of the I.M.A. on his appointment as Surgeon-General with the Government of Madras, the Association got up a subscription Tea-Party on 3rd April '47 at the Madras Medical College Grounds. We thank the members for contributing and making the function a grand success.

In conclusion, the Executive Committee takes this opportunity to thank our President Rao Bahadur Capt. S. Thambiah for giving Tea to members at two clinical meetings and also the Principal of Madras Medical College for allowing the Association the use of College Premises for holding our meetings.

Meetings held during the year

	Lecturer	Subjects	Date
1.	Lt. Col. C. R. Krishnaswami, M.S.	"A few points About Fracture."	29-11-'46
2.	Sir Heneage Ogilvie, K.B.E., M.D. Ch., F.R.C.S., F.A.C.S.	"Surgical Lessons of the War."	28-12-'46
3.	Dr R. Subramanian, M.D., M.R.C.P.	"Tropical Liver Abscess."	27- 2-'47
4.	„ J. C. David, M.B, B.S., Ph.D.	"Recent Advances in Drug Therapy."	22- 3-'47
5.	„ P. Arunachalam, M.D, M.R.C.P.	"Medical Emergencies."	28- 3-'47
6	„ S. K. Sundaram, B.A., M.D.	"Some Liver Disorders."	23- 7-'47
7.	„ K. C. Nambiar, F.R.C.S.	"Fallacies in Medical Practice."	30- 7-'47
8.	„ K. Vasudeva Rao, M.D., M.R.C P., T.D D.	"Recent Advances in the Treatment of Pulmonary Tuberculosis."	6- 8-'47
9.	„ R. R. K. Thampan, F.R.C.S., M.R.C.O.G.	"Bleeding in Women After Thirty-five."	20- 8-'47
10.	„ U. Mohan Rao, M.S., F.R.C.S.	"Minor surgery of Rectum and Anal Canal."	27- 8-'44
11.	Rao Bahadur Capt. S. Thambiah, M.C., M.R., C.P., D.T.M. & H., F.D.S.	"High Blood Pressure."	3- 8-'47
12.	Dr. P. Venkatagiri, M.D., M.R.C.O.G.	"Fear Complex during Pregnancy Parturition and Puerperium.	10- 9-'47

NEGAPATAM BRANCH

President :—Dr. M. Sanjeeva Rao.
Vice-President :—Dr. J. Y. Arthur.
Secretary :—S. S. Chariar.
Jt. Secretary and Treasurer :—Dr. T. S. Varadhachary.

The monthly meeting of the above Association was held on 16-11-47 at 5 p.m. at the Govt. Hospital, Negapatam. 10 members were present. Dr. M. Sanjeeva Rao, Civil Surgeon, Negapatam presided. After the minutes of the last meeting was read and passed, it was resolved that an account be opened in the local Co-operative Bank and authorise Dr. T. S. Varadachari to operate the same.

Then Dr. V. Subramaniyam, Municipal Health Officer, Negapatam spoke on "Public Health—an appeal to the medical practitioners." He dealt with the subject of Cholera and how the medical practitioners should co-operate with the health department and asked the medical practitioners to send the initial cases to the hospital where adequate treatment can be had and prevent the spread of the disease. They can also segregate patients and disinfect at once and also notify the occurence, so that the health staff may know the place and preventive steps may be taken at once. He said that though he may not say much about the curing of the disease, if sufficient steps are taken before hand the disease can be prevented. He also added that an infectious ward had been put up adjoining the hospital with facilities for giving saline etc.

Many members took part in the discussion.

Afterwards, the maternity and child welfare subject was discussed and it was resolved to request the Municipality to open M. & C. Welfare Centres in Negapatam and Nagore.

Capt. S. S. Chariar then spoke about the necessity of starting a Health Association under the Health Committee of the Municipality and propaganda should be done on subjects of Public Health and ante-natal care.

With a vote of thanks from the chair, the meeting came to a close. Dr. J. Y. Arthur, B.A., L.M. & S., was the host at "Tea".

NORTH ARCOT BRANCH

Prsident :--Dr. Umapathy Mudaliar.
Vice-President :—Dr. E. J. Koshi.
Secretary :—Major P. S. Dorairaja.

A meeting of the above branch was held on 20-9-47. Dr. K. Narayanamurthy, M.D. Hony. Physician, Govt. General Hospital, delivered a lecture on 'Recent Advances in Therapeutics'. About 42 members from different places attended the meeting.

Dr. K. Narayanamurthy in his lecture said that the treatment of several diseases was not empirical nor palliative as it was once thought, but curative. Great advances were made in Chemotherapeutic drugs such as Penicillin, Sulphanilamides, Endocrines, Vitamins and the discovery of a number of synthetic chemical drugs, as Folic Acid, Abebrin, Paludrine, etc. Spectacular advancement was made in Blood Transfusion and administration of Hydrolysates. The importance of dietetics in the treatment of a wide variety of disorders was stressed. The importance of the doctors' help was essential as regards functional disorders in which he should make his patient adjust himself to his social and environmental conditions.

Dr. P. S. Dorairaja, the Secretary of the Association, demonstrated a case Achylasia Cardia with X-ray photos etc.

Dr. A. Umapathy Mudaliar, the D.M.O. and the President of the Association thanked the learned lecturer of the evening and pointed out that it was the duty of every doctor to do his bit, without expecting any return and that remuneration would come automatically.

With a vote of thanks the meeting terminated.

RAMNAD BRANCH

President :-- Dr. K. S. Venkatachala Iyer.
Vice-President :—Dr. T. S. Shetty.
Hony. Secretary and Treasurer :—Dr. S. Sundaresan.
Asst. Secretary :—Dr. M. Sreenivasulu.

A meeting of the branch was held at Nattarasankottai on Sunday the 20th April '47.

The members were entertained to a sumptuous lunch and tea by Dr. S. Janakiraman, Medical Officer, Nattarasankottai.

After lunch the President, Dr. K. S. Venkatachala Iyer, M.R.C.S., L.R.C.P., D.M.O., Ramnad took the chair. The minutes of the previous meeting was read and adopted.

Dr. A. Jabbar read a short and interesting paper on 'Tonsil Surgery' with demonstration of instruments and specimens and was followed by a discussion in which several members took part.

After tea and the usual of vote of thanks the meeting came to a close.

* * *

Minutes of the monthly meeting held in the S. M. S. High School, Karaikudi on Saturday 27th Sep. 47 at 4 P.M.

There were 27 members present.

The members were entertained at tea by Dr. Miss P. Rajam of Kanadukathan.

Dr. K. S. Venkatachala Iyer, D.M.O., Ramnad presided.

Dr. R. Mahadevan, M.S., F.R.C.S., Surgeon, Erskine Hospital, Madura, was introduced to the members by the President in his opening speech.

The Secretary read the minutes of the last meeting and the following two resolutions proposed by Dr. S. Sundaresan and seconded by Dr. T. V. Appaswamy, were unanimously passed, and the Secretary was authorised to communicate them to the respective parties.

1. Resolved to congratulate Dr. N. Jivaraj Mehta on his appointment as the Director-General of Indian Medical Service.

2. Resolved to request the Government of India and the Provincial Government to place the Local Fund Medical Officers in the same cadre as Government Medical Officers regarding Pay and Status etc.

Dr. R. Mahadevan gave an interesting talk on "Some Recent Trends and Future Possibilities in Surgery." He dealt at length about the latest discoveries in medicine and their uses in surgery and also about the invention of the latest instruments in plastic materials such as plastic cathetres etc. Various X-rays photos of cases of lung abscess which came under his care were exhibited by the lecturer who stressed the necessity for X-ray in all cases as far as possible. Lastly he visualised about the possibilities of surgery in the future.

The Vice-President, Dr. T. S. Shetty thanked Dr. Mahadevan and the hostess Dr. Miss P. Rajam and the School authorities.

The 17th Annual Conference was held at S. M. S. High School, Karaikudi, on Sunday, the 23rd November 1947 under the Presidentship of Dr. K. S. Venkatachala Ayyar, District Medical Officer, Ramnad.

More than 65 Doctors including those from Madura and Trichy attended the function. The minutes of the last meeting and the Annual Report were read and adopted.

The following Office-bearers were elected unanimously for the year 1947-48.

President :

Dr. K. S. Venkatachala Ayyar, M.R.C.S., L.R.C.P., D.M.O., Ramnad.

Vice-President :

Dr. T. S. Shetty, M.D., Kanadukathan.

Secy. and Treasurer :

Dr. S. Sundaresan, Kanadukathan.

Joint Secretary :

Dr. M. Srinivasulu, Pallathur.

Committee Members :

1. Dr. T. V. Appasami
2. Dr. A. Jabbar
3. Capt. S. V. Joseph
4. Dr. Miss A. Rajamirtham.

Representatives to the Provincial-Council.

1. Dr. S. Subramaniyam
2. Dr. A. Jabbar
3. Dr. T. S. Shetty

Representatives to the Central-Council :

1. Dr. T. S. Shetty
2. Dr. S. Subramaniyam, M.L.A.,

The following two resolutions were passed :—

I. Resolved to contribute Rs. 89/- to the "Indian Medical Association Benevolent Fund" from the funds of the Association.

(A sum of over 300/- was also subscribed by the members.)

II. The Association strongly protests against the inclusion of 'dispensing medicine' by Medical

Practitioners in the proposed amendment to the Madras Sales Tax Act which is under the consideration of the Government at present. This inclusion in addition to lowering the prestige and self respect of the Medical Profession, makes it highly derogatory to the honour and self respect of the profession which seems to descend by these regulations to the level of ordinary shopkeepers. This Association is of opinion that the inclusion of Medical Profession should be deleted in the proposed Act by the present Government.

The draft rules circulated by the South Indian Provincial Branch was read and adopted except (9b) deleting "one of whom shall be in Madras."

At 3-30 p.m., The Hon'ble Mr. A. B. Shetty, Minister for Public Health, Madras was presented with a Welcome Address and a Memorandum to which the Minister replied.

The Hon. Mr. A. B. Shetty, Minister for Public Health, Government of Madras, in his reply to the Welcome Address and the Memorandum submitted to him by the Ramnad District Branch of the I. M. A. on 23-11-47, said that he was glad to be amidst such a gathering of Medical Men. Being a non-medical man he looked forward to such opportunities to know their views on various matters and be advised by them. It was with the same object that he had called the Public Health Conference recently to advice him on matters of Public Health and Medical Education. The representatives and other eminent medical men were invited for the same and he would be guided the reports of the various committees set up by that conference.

Regarding the unification of the Civil Medical Services and the Provincialisation of Local Board Services, he said that the matter was under the active consideration and orders would be issued soon.

Regarding the giving of greater facilities for the training of compounders, he said that training centres had been increased from 5 to 10, each centre to train pupils.

As regards the bill for the control of private Nursing Homes, he said that the idea of the Government was to regulate the proper development of such homes and it would be in the interests of the practitioners themselves.

Regarding the inclusion of doctor's dispensaries, Clinics and Nursing Homes under the purview of the recently enacted "Shop Assistant Act," he said that the matter had been referred for legal opinion and the Government would consider that matter after receiving the same.

After Tea and group photo, the Scientific Session began under the Presidency of Dr. K. S. Venkatachala Ayyar, District Medical Officer, Ramnad.

Dr. M. G. Kini, M.S.,F.R.C.S., Superintendent, Stanley Medical College, Madras, delivered a very interesting lecture on "Injury in and around the elbow joint" followed by Dr. Joseph on "Acute affections of the eye" and a short talk on X-ray therapy, by Dr. P. A. S. Raghavan, Trichinopoly.

The Secretary proposed a vote of thanks to all and the function terminated after dinner.

SOUTH ARCOT BRANCH

President :—Capt. C. S. S. Sarma.
Vice-President :—Dr. S. Sankararaman.
Secretaries :—Dr. C. Seshachalam,
Dr. R. Narasimhan.

The annual meeting of the above Branch was held on 20 9 47 in the Municipal High School Hall, with Dr. C. S. S. Sarma in the chair. Thirty six members including Dr. P. A. S. Raghavan, the Provincial Secretary of the South Indian Provincial Branch were present.

The annual report and the account for the year 1946 47 were read by the Secretary and adopted.

The following office bearers were elected unanimously for the next year.

President :—Capt. C. S. S. Sarma.

Vice-President :—
Dr. S. Sankararaman.

Secretaries :—Dr. C. Seshachalam.
Dr. R. Narasimhan.

Committee Members :—
Dr. Mrs. Ferriero.
Dr. V. Krishnamurthy.
Dr. S. Chandrasekaran.
Capt. C. A. Rajamani.
Dr. R. S. Reddiar.

Representatives to the Central Council :—
Dr. V. Krishnamurthi.
Dr. P. Vaidyanathan.

Representatives to the Provincial Council :—
Dr. S. Seshachalam.
Dr. V. Krishnamurthy.
Dr. S. Chandrasekaran.

Representative to the British Empire Leprosy Relief Association, South Arcot Branch.
Dr. R. Narasimhan.

The following were elected as delegates for the ensuing Provincial Conference to be held at Coimbatore next month.

Dr. K. G. Sadagopan, Dr. B. Rajagopalan, Dr. A. Janakiraman.

By a majority of votes Dr. T. S. Thirumurthy was nominated as President of the South Indian Provincial Branch.

The resolutions as proposed by the Secretary, South Indian Provincial Branch, regarding the abolition of the cadre of Sub Asst. Surgeons, but creating 2 grades of Civil Asst. Surgeons, was considered and the following resolution was passed.

"The principle of the resolution as put forward by the South Indian Provincial Branch is accepted and a Committee composed of the following doctors will be formed, to frame suitable resolutions and transmit it to the Provincial Branch with a memorandum embodying the Association's view and recasting the wording if necessary".

Dr. Capt. Jayaram.
Dr. R. Narasimhan.
Dr. Capt. C. A. Rajamani.
Dr. R. S. Reddiar.
Dr. Capt. K. S. Ganesan.
Dr. Rangaswamy.
Dr. R. Subramanian.

The business part of the agenda having concluded the members were served with refreshments.

Dr. U. Mohan Rau, F.R.C.S. delivered lecture on 'Some common Surgical disorders of the Rectum and Anal Canal' and Dr. K. C. Paul, M.D. of Madras, spoke on "Diabetes".

As it was already late, by the time the second lecture was finished the President suggested that a general discussion may be waived and this was agreed to.

After the President's remarks, Dr. Chandrasekaran moved a resolution placing on record the good services of the outgoing Secretary, which was passed unanimously.

With a vote of thanks to the lecturers and members present, the meeting terminated.

After a delightful dinner the function came to a close.

SOUTH KANARA BRANCH

President :—Dr. U. P. Mallya.
Vice-President :—Major W. E. Mascarenhas.
Hony. Secy. and Treasurer :—Dr. K. R. Kini.
Jt. Hony. Secretary :—Dr. M. Umesha Rao.

The Annual General Meeting of the above branch was held on 22-11-47 at 5-30 P.M. in the Wenlock Hospital, Mangalore. There were 22 members present. Tea was served to the members present.

Dr. U. P. Mallya, the President, then occupied the Chair and the proceedings commenced.

The Annual Report and audited statements of the accounts were placed before the meeting. After discussion both were adopted.

The following bye-laws were then considered and altered.

Bye-law No. 8. As the Central Fund Contribution has been raised from Rs. 3-8-0 to Rs. 6 per member, subscription to be raised as follows: Rs. 2 per month, from Rs. 1-8-0 for resident members and Rs. 5 per half-year, from Rs. 3-4-0 for non-resident members.

Bye-law No. 13. As it was found that a Joint Secretary was necessary to help the Honorary Secretary, it was decided to elect a Joint Hony. Secretary and the bye-law was altered accordingly.

Bye-law No. 18. The duties of the Joint Hony. Secretary were fixed under this bye-law.

Bye-law No. 24. As it was found that it may be necessary to alter the bye-laws in the course of the year to conform to any alterations of the Bye-laws of the Central Association whenever necessary, this bye-law altered suitably.

The budget for the year 1947-48 was adopted.

The following office-bearers and members of the Executive Committee were elected :

President :—1. U. P. Mallya.
Vice-President :—
2. Major W. E. Mascarenhas.
Hony. Secy. and Treasurer :—
3. Dr. K. R. Kini.
Joint Hony. Secretary :—
4. Dr. M. Umesha Rao.
Members :—
5. Dr. M. Ramanna Shetty.
6. Dr. S. Gopalakrishna Rao.
7. Dr. M. Rangappa Kamath.
8. Capt. P. N. R. Shetty.
9. Dr. Miss L. Lobo.
10. Dr. K. B. Shetty.
11. Dr. K. Nagappa Alva.
12. Dr. P. Narayana Rao.

The following were elected to the Central Council :—

1. Dr. K. R. Kini and 2. Dr. K. Nemiraja Alva.

The following were elected to the Council of the South Indian Provincial Branch :—

1. Dr. M. Umesha Rao. 2. Dr. B. R. Hedge. 3. Dr. K. K. Hedge.

The following were elected as delegates to the ensuing Annual Conference :

1. Dr. U. P. Mallya. 2. Dr. K. R. Kini 3. Dr. A. F. Coelho. 4. Dr. K. Nagappa Alva and 5. Dr. M. Ramanna Shetty.

A resolution congratulating the three members Dr. K. Nemiraja Alva, K. Nagappa Alva and Dr. B. R. Hedge on being successful in the Mangalore Municipal election was passed.

A resolution congratulating Dr. U. Krishna Rao, a distinguished member of the Profession from South Kanara on being unanimously elected as Mayor of Madras was passed.

The President wound up the proceedings with a speech appealing to the members to take more active interest in clinical meetings and activities.

With a vote of thanks by the Hony. Secretary the meeting terminated.

TRICHINOPOLY BRANCH

President :—Dr. P. A. S. Raghavan.
Vice-President :—Dr. R. Sambasivam.
Secretary :—Dr. V. Enok.
Treasurer :—Dr. K. Rengaswamy Iyer.

A General Body Meeting of the above association was held at 5 30 P.M. on Friday the 10th October 47 at Bishop Heber High School, Trichinopoly.

Dr. P. A. S. Raghavan, the President presided and Dr. O. R. Balu was 'At Home.'

About 60 members were present.

The meeting commenced by the President extending welcome to distinguished visitors in the persons of Dr. A. Srinivasalu Naidu, Dr. T. S. Tirumurthy, and Dr. D. V. Venkappa, the provincial Secretary of the A. I. M. L. A. and Major C. Raman, L.R.C.P., M.R.C.S., Civil Surgeon of Negapatam, (on transfer) and to the new members of the branch numbering 15.

The President then announced that Dr. Sarvothaman who was posted for special cholera duty at Govt. Hospital, Trichinopoly would be available to help practitioners in the treatment of cholera cases. He also read out a report from the Director of King Institute, Guindy, that the delayed reaction after inoculation of cholera vaccination was in the nature of a local anaphylaxis in some individuals, and it subsided in a day or two and that for further scientific investigation, statistics of such delayed reaction might be gathered and forwarded to the Public Health Authorities.

The following business was transacted :—Put from the chair and carried unanimously :—

1. The members agree to the increase in Central Fund Contribution from Rs. 3-8-0 to Rs. 6 per annum.

2. Dr. T. S Tirumurthy was nominated for the Presidentship for the South Indian Provincial Branch.

3. Delegates: Dr. Miss A. K. Verghese, Dr. V. Iravatham, Dr. R. Kalamegham, Dr. T. S. Balasubramania Iyer, and Dr. C. R. Tiruvengadam, were elected as delegates to the forthcoming Provincial Conference at Coimbatore.

4. It was resolved to form a 'Study Circle' under the auspices of the Association.

The Study Circle to have its reading room at the Trichy X-rays Limited, West Bouleward Road, Trichy, kindly placed at disposal of the Association by Dr. P. A. S. Raghavan.

The following members, to form a committee to conduct the Study Circle were elected :—

Dr. P. A. S. Raghavan, Dr. R. Kalamegham, Dr. T. V. Srinivasan, Dr. N. C. Subramaniyam, Dr. V. Ananthagiri, Dr. G. Joseph Gnanadickam, Dr. V. Iravatham, Dr. P. V. Sundaram, Dr. Bendict Veda, Dr. V. Enok, and Dr. K. G. Menon.

Bombay inaugurated the conference and exhorted medical men to do their utmost to help their hapless country-men in the rural areas. Lt. Col. Amirchand of Punjab, the president of the conference and of the I.M.A. for the year 1948, reviewed the progress of the association in the past and outlined its work for the future. Though he did not want to touch on politics, still his lacerated heart could not retain its feelings and burst out with these words.

"In this drama, the Britisher has played his part remarkably well. He used to say that before quitting, the country will be smashed to bits and he has been true to his words. In the Punjab the riots broke out suddenly and simultaneously in Lahore, Amritsar, Multan and Rawalpindi, the four biggest districts administered by British officials. They, like Nero, fiddled while the districts they ruled over, burned. The other districts administered by Indian officials remained at that stage largely, if not entirely, peaceful. This could not have been without significance or a mere coincidence. The Britisher who had all along been known for his conscientiousness and humaneness suddenly turned callous and causal. Approached by the afflicted and terror-stricken for succour, he said "We are quitting, why come to us, why not go to Gandhi or Nehru or Patel?" I do not know if he ever said "Why not go to Jinnah?" Verily one has to fathom the depth of an Englishman. A writer is perhaps right when he says "The English have been on the whole either ruthless adventurers, or suave swindlers, or simple pioneers, or prospectors, or smart alecs, or insufferable fools".

On subsequent days the other conferences were inaugurated in twos and threes a day in the main pandal and later moved into the various lecture halls to hold their respective scientific sessions which were often held concurrently, where papers of high order in their specialities and high level discussions took place.

The Madras Presidency which has been in the vanguard of Medical education, medical relief and medical politics, dominated the Bombay arena. Not only were there over a hundred fifty doctors from this province, who attended the conference, our illustrious collegues presided over 4 out of the six specialists conferences. The leading light of our presidency, Sir. A. L. Mudaliar, presided over the Obstetrics Congress, Dr. M. G. Kini over the Surgeon's conference, Dr. R. V. Rajam, over the Venereologists and Dermatologists conference and Dr. P. V Cherian, over the Oto-Laryngologists conference, and a number of others participated in the discussions.

To single out personalities will be doing injustice to the hundreds of others who strained all their nerves to make the conference a great success, but still mention should be made of a few who were the heart and soul of the conference. There was slim cooper at every important place attending to something important. The Organising Secretary Chimanlal and his cos. Oak and Nayen were everywhere doing something or other throughout the day and the best part of the night.

Throughout the meeting of the Working Committee and the Central Council of the I. M. A. and the inauguration of the various conferences five important personalities were always present and active, they were the incoming president, Col. Amirchand and the outgoing, Capt. P. B. Mukerjee, the incoming General Secretary, Dr. P K Guha and the outgoing, but raised to the Vice Presidentship, Dr. S. C. Sen, and the architect, the friend philosopher and guide of the I. M. A. Dr. Jivaraj Mehta. It is a wonder how Dr. Jivaraj could find time with his multifarious duties as the Director of Public Health Services and Secretary to the Ministry of Health, Government of India, could find time to attend, advice and guide all the committee meetings and Inaugurations, and still fulfil a number of other engagements in Bombay, such as opening of the Hospital for Disabled and Crippled children, etc.

A great step towards the long desired amalgamation of the two great All India Medical Associations, the I. M. A., and the A. I. M. L. A., was taken by the two Associations, the former re-iterating its desire for amalgamation and the later resolving to take a referundum for this purpose. It is was also a happy augury that these two bodies and also several other Associations have decided to meet

in their next annual conference in Calcutta during the Xmas week of 1948, which is the Silver Jubilee year of the founding of the I. M. A. Another innovation and a step to have a common Lingua Franca for India, was created by Dr. M. D. Pustheke, the president of the Licenciates conference, by his delivering the presidential address in Hindi, though English translations of the same were printed and supplied to the members.

The concluding sessions of all the conferences was a joint function presided over by the Hon. Dr. M. D. D. Gilder, the Health Minister of Bombay, when in addition to the usual thanks offerings, felicitations were offered to Dr. Jivaraj Mehta for his services to Associations, the profession and the country at large and on his being appointed as the guide of the Medical and Health Services.

The week was not merely a medical austerity week, with papers and discussions on professional subjects and medico-political activities, but had its lighter side, by providing visits to the various hospitals, and places of interest. Batches of delegates went out on boat cruise in the harbour every evening and there was music and dances every night. The public of Bombay joined in the celebrations of the week in various ways, particularly the medical mercantile portion, who exhibited their wares in the forty and odd stalls at the medical exhibition, which was opened by the first citizen of Bombay, its Mayor, Sabavala, and who also invited the members of the profession for a party at the Taj Mahal Hotel on the 27th evening.

The gala week was a memorable ending for a memorable year.

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Members are requested to inform the undersigned any change of addr
if and when it occurs.

MANAGING EDITOR,
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ODDS & ENDS

A merry heart helpeth to keep the blood warm.

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According to Dr. A. C. Ivy of Illinois, tight crosets are a direct cause of stomach ulcers in women.

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Stilboestrol helps to relieve the pain and diminish the size of the Prostatic Cancer. But the new preparation known as Y 59 acts better in this condition. Lately it has been noticed that Orchidictomy completely relieves the patient of this condition altogether.

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Hypospray, by air pressure, blasts liquid injection material through the skin without causing pain or showing mark of penetration, thus eliminating the painful hypodermic injection.

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Some teaching hospitals in India are eager to get television apparatus to project operations to class rooms, where all students can have a better view in detail of the operative procedure and technique.

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The death-rate among American male doctors between 25 and 34 is only three-fifths that of other males in the same group, but between 55 and 64, they die 11 percent faster than other men.

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French doctors and midwives who have no means of transport are to have the opportunity of buying luxurious cars formerly reserved for cabinet ministers.

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Dr. S. T. Achar, Professor of Pedriatics, Madras, has been elected a Fellow of the Royal College of Physicians of Canada.

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"Is your child wearing the glasses always as I instructed?" "No, doctor she refuses to have them on. But, do you know what I do? When she is asleep, I slip in and gently fix them on her face and they are there till she wakes up" replied the mother complacently.

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