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# THE MISCELLANY

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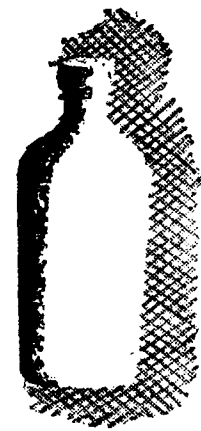
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# THE MISCELLANY

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## EPISTAXIS AND ITS MANAGEMENT

BY

MAJOR P. G. K. MENON,

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and E. N. T. Specialist, Headquarters Hospital, Mangalore.*

Bleeding from the Nostril is a malady which any private practitioner is called upon to tackle. The condition is really distressing to the patient and worrying to the doctor and my idea in this short article is to bring home to the practitioner some of the main principles involved in the arrest of haemorrhage.

The vascular supply of the nose consists of (1) The Septal post nasal artery from the Sphenopalatine. (2) The anterior and posterior Ethmoidal arteries. (3) The great palatine artery. (4) The Septal branch of the Superior labial artery. (5) The pharyngeal artery supplying the sphenoid (not shown in the diagram.)

The final distribution of these vessels is formed in the mucoperiosteum in three layers of capillary net work. They are:—

- (a) One, deep in the periosteum.
- (b) Second, surrounding the glands.
- (c) Third, just beneath the epithelium.

The purpose of this great vascular supply for the nasal fossae is evidently to carry on two important functions of the nose, namely to supply heat and

moisture by which air is raised to the temperature of the blood before it gets to the Pharynx. The nose supplies this way about 700 to 1000 c.c. of water in 24 hours. The thin lining of the lung alveoli is thus kept without damage by supplying enough moisture through the bronchi. The heating of the air in the nose is so efficient that the air at the back of the nose is kept constant at 36°C. The heat lost by this way by the human body is about 70 calories per day; that is about 2.5% of the total heat lost by the body. It is evident therefore that indiscriminate burning of the nasal tissues, which are doing such important physiological functions should be condemned.

From the list of the vascular supply of the nose it could be seen that it is either from the external Carotid or internal Carotid system. While there is free anastomosis between the Sphenopalatine and Ethmoidal arteries in the lateral walls and on the septum, the former on the whole supplies the lower and posterior parts of the cavity, the latter the upper and more anterior parts. In cases of head injury there is often a fracture through the Ethmoid or through the fronto Ethmoidal Suture and this may involve the anterior

Ethmoidal artery or one of its branches. These vessels lie in the bony canals where they are subject to mural laceration or erosion where consequently they are unable to contract and retract. Thus although they are quite small the haemorrhage to which they may give rise to is quite considerable. The middle Concha is a convenient landmark where one may determine the ultimate source of the bleeding and it is quite possible during an Epistaxis to get some idea as to whether the bleeding occurs above or below this structure. If the haemorrhage is from the Olfactory cleft it is almost certain that the bleeding is from the Ethmoidal Arteries. No amount of packing is of any avail if it is from the Ethmoidal where one has to expose these vessels as we do in external Ethmoidectomy. This can be done without much effort by local infiltration of novacaine and lifting up the periosteum of the orbit from its medial wall to a depth of about  $1\frac{1}{2}$ " from the nasal bridge. Retraction of the orbital contents defines the vessels which could be safely sealed with Diathermy.

#### Causes for Epistaxis.

The varieties of causes for Epistaxis should be borne in mind when one is called upon to tackle individual case. Here are two rare causes for Epistaxis.

1. Years back I had an uncontrollable bleeding in an influential patient after cauterisation of the turbinates. The patient had repeated haemorrhages which were stopped by repeated packings, use of haemostatics and finally blood transfusion. It was only after his death two months later that I knew that he was a patient suffering from a very serious haemorrhagic disease.

2. Another case is that of one who was planning to settle down in the hills and he came to me for consultation for repeated Epistaxis. I sealed the bleeding point with an Electric Cautery on two different occasions but when he

went up the hills his bleeding reappeared.

The local causes for Epistaxis to be borne in mind apart from injuries and fractures of skull are:—

1. Ulcerations and Perforations.
2. Atrophic Rhinitis—very common in South India.
3. Adenoid growths in children.
4. New growths, bleeding polyposis, Nasopharyngeal fibroma.
5. Syphilis and Leprosy—Due to ulcerations which they produce.
6. Foreign bodies—very common in children. The only history which the mother gives is that of bleeding through the nostrils.
7. Hay Fever—where we may get blood-tinged discharge.

The general causes are:—

1. High tension in systemic arteries—should always be controlled not to be left to bleed as a safety valve mechanism. If the blood pressure has to be reduced it should be done by blood letting under B.P. estimations.
2. High Venous pressure—Mitral Stenosis, Emphesema.
3. Toxic blood states—Pernicious Anaemia, Purpura—I had occasion to see a series of cases of Epistaxis in suspected cases of Typhus with hyperpyrexia in 1936.
4. Rarified air flying and mountain climbing—a typical case has already been referred to above.
5. Vicarious menstruation.

Whatever may be the underlying cause of Epistaxis if the bleeding does not stop spontaneously, as it does happen in many cases, it has to be deliberately controlled. If the bleeding persists it may lead to severe anaemia.

The principle of the natural control of haemorrhage should if possible be

resorted to and the results in the majority of cases are really astonishing. For this (a) the pressure within the bleeding vessel should be kept low (b) the site of the bleeding should be completely at rest. This is effected by propping the patient up with a comfortable inclination to one side, putting a dental prop between the teeth, forbidding him to breathe through the nose, or swallow, and giving him a substantial dose of Morphia. By mouth breathing and complete cessation of swallowing can the bleeding area be given the necessary haemostatic rest.

Epistaxis from the little area can be controlled by the thumb. The patient lying down flat with wet clothes over the nose does not encourage arrest of bleeding but it allows blood to drip into the pharynx leading to continuous swallowing and subsequent vomiting and restlessness.

Packing too if the bleeding comes deep in the nose is a little troublesome procedure. It should be remembered that the packing is sometimes crowded into the anterior part of the nose in front of a Septal Spur or deflection by which the blood soaks through the pack and drips into the Pharynx.

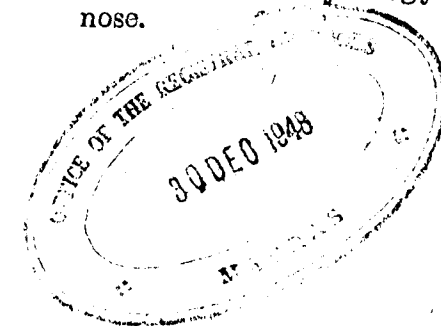
Even skilful plugging controls the bleeding only temporarily and may not prevent recurrence after the pack is removed in patients with pathological changes in the vessel walls. All the surgical measures used to control haemorrhage such as ligature and pressure aim only at temporary arrest of bleed-

ing. Permanent arrest is a vital process the stages of which are interrupted by sepsis as is seen in secondary haemorrhage. \* That plugging the nose is productive of septic changes is recognised by our insistence that no pack should be left in the nose for more than 24 hours. Moreover the distant complications of packs in the post nasal space are Otitis media and Nasopharyngeal abscess; which again leading sometimes to Osteomyelitis of the basisphenoid and meningitis and Cranial nerve palsies. In patients with arterial disease where the muscular and elastic coats are converted into fibrous tissue which prevents contraction and retraction of the vessel wall, it is the thrombosis within the vessel on which we rely for complete cessation of haemorrhage.

The blood lost should be replaced. The erroneous impression that transfusion by raising the blood pressure will cause the bleeding to start again is not borne out by experience by drip methods. Indeed it may be necessary to raise blood pressure to save life. The restlessness and anxiety of a patient who had bled a lot could be relieved by blood transfusion and Morphia.

#### References:

1. St. Clair Thomson & Negus—Text book of Nose and Throat.
2. Proceeding of the Royal Society of Medicine—Dec. 1946.
3. A. W. Proetz—Physiology of the nose.



\* The above is the subject matter of a lecture delivered under the auspicious of the Indian Medical Association, South Kanara Branch on 24th July 1948.

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## THE COMMON COLD

BY

A PUBLIC HEALTH BACTERIOLOGIST

Dr. Hobart A. Reinmann of the Philadelphia medical faculty was invited to analyse the value of the treatments for the common cold and its related infections, for the benefit of the medical profession. In an authoritative paper, published in the Journal of the American Medical Association, Dr. Reinmann's analysis is set forth at very great length. A brief account of his finding is given below setting forth all the important points

Except in the case of *true* influenza, there is virtually nothing we can do to prevent attacks. Colds and their sister infections are *Virus* infections. Both penicillin and the sulfa drugs though ineffective against virus diseases, continue to be wasted in huge amounts. If taken too freely over long periods both drugs may cause nasty and even dangerous symptoms and may give rise to resistant types of bacteria.

The use of cathartics, which is a favourite line of treatment with some, is unnecessary and exhausting and may prove harmful. Diaphoretics, hot drinks and hot baths give a certain amount of comfort and can do no harm.

Drugs such as aspirin, phenacetin, quinine, aminopyrine, etc., form the main ingredients of '*nostrums*' sold to prevent and cure colds. They have no possible effect on the infectious process. Medical opinion now holds that a moderate degree of fever is very helpful in resisting and overcoming infections. Coughs are irritating and the patients pester their doctors to prescribe cough mixtures or they buy a brand sold in the market. Coughing serves a useful purpose and should not be checked unless it is unduly harassing. Many of the cough remedies contain

codeine, heroin, alcohol or similar narcotics to soothe irritation. These should be prescribed and controlled by the physician. The vapour of benzoin, camphor or menthol that is often prescribed for inhalation when well-diluted in steam can do no harm and may give some little local comfort. Gargles, sprays and swabs are often prescribed for accessible inflamed areas and the medicaments employed are silver nitrate, phenol, iodine etc. These cannot destroy the bacteria or virus without hurting or even destroying the mucous membranes on which the infection rests. Medicated sprays and irrigations may spread the infection they are intended to check or destroy! Sinuses may get affected by forcible spraying. The continual use of medicated oil preparations used as sprays or nasal-drops is known to produce a form of pneumonia. Patients with high blood pressure should be particularly careful in the use of these sprays.

All sorts of diets and vitamin preparations are prescribed to cure colds or prevent them. There is no evidence to show that the addition of vitamins or special diets will prevent colds. These will only add to the patients' misery by eliminating foods he likes or insisting upon foods he hates.

Another fad is prophylactic and curative vaccine for colds. Fairly effective vaccines have been developed for two types of Influenza but most infections of the respiratory tract are of virus origin. Hence any vaccine claiming to cure these diseases is an obvious fraud.

A few commonsense procedures will lessen discomfort and minimize the dangers of complications. Amongst these is medicines' age-old standby—

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THE COMMON COLD

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REST. If fever is present, go to bed. Excellent physical condition, peace of mind, wholesome and adequate diet and pleasant weather furnish resistance to colds. Infections of the respiratory tract often occur and frequently recur for no obvious reasons in otherwise robust people.

In a great deal of sinus trouble, and a vast number of recurrent head colds (these are not really infections) which are allergic in origin but are sufficiently annoying and troublesome. Benadryl and PBZ (the two new anti-histamine drugs) have been cautiously and judiciously used with benefit in many cases. These however, are of little value in infectious conditions.

**Colds can be prevented.**

*Hygeria*, published also by the American Medical Association has an important article in its April (1948) number, on the successful prevention of common colds. Years of research and a series of surprising accidents have led to the new technique of "prevention of colds." In 1939, some engineers of the Research Corporation were designing an air-conditioning system for a Bank in New York. In order to remove excess moisture from the air, one of them passed the air through a receptacle containing tri-ethylene-glycol which has great affinity for water. A year later the President of the Bank was surprised to find that the Bank staff was remarkably free from attacks of cold, during the year which was quite an unusual phenomenon. So he enquired of the Research Corporation as to what they put into the bank's air-conditioning system that has stopped them from having frequent attacks of cold, and has almost entirely eliminated absences due to colds. Four British doctors had previously tried, with some success, to sterilize the dank air in the air raid shelters of London, by spraying them with Hexylresorcinol dissolved in propylene glycol (an ally of tri-ethylene-glycol). Dr. Robertson

of the Chicago University, utilising the London Doctors' recipe, cut down the Hexylgermicide gradually to a small proportion; finally he used propylene glycol alone as a spray and found that Staphylococci, pneumococci, streptococci and a large number of other air-borne organisms were effectively killed by this spray.

Here was the answer to the Bank mystery. Dr. Theodore Puck of the Commission on air-borne infections proved that the real germicidal agent in the glycol sprays was the glycol vapour and not the droplets of glycol. The great affinity which these molecules of vapour had for water made them penetrate the moist bacteria and establish a heavy glycol concentration inside the bacterial cell. A single drop of tri-ethylene glycol vapourized, will kill the bacterial life present in a ten by ten feet room in less time than it takes to read about it. Dr. Truman S. Pottir clinched the issue by a crucial experiment. He placed ten guinea pigs in a chamber and sprayed them with a strong emulsion of live tubercle bacilli. Every one of the ten died. Then he sprayed the chamber with glycol vapour and repeated the above experiment with a new colony of guinea pigs. Not one of them died, or showed any trace of the infection.

Dr. Robertson working with mice next showed that glycol vapour was deadly not only to bacteria but also to the influenza virus as well. He exposed hundreds of mice to a spray of this virus and all died within ten days. The same kind of mice exposed to a similar spray of the virus, in cages which were previously treated with glycol vapour came through the ordeal without a single mishap.

In 1943, Drs. Bigg, Jennings and Olson installed glycol vapourizers in the naval training station barracks at the Great Lakes. Subsequently vapourizers were installed in the children's homes in New Jersey, and in some large

operation is out of the question, because that is the view he has been brought up to hold. He has never thought of any alternative, much less tried one. Over a certain age a patient is too old to be operated upon for hernia—that is an accepted axiom. But does the surgeon take the same view when the life of the patient has become burdensome from prostatic enlargement? No! In such cases old age is taken for granted, it is not even considered as a drawback. Prostatectomy was opposed, and for the same reason, when first introduced. Only when surgeons tried it and found it was worth while, was it accepted. But the two operations can hardly be compared in severity, in discomfort, in risk, or in the general upset of the patient.

**Operative Procedure.** The operative problem is to close the ring and canal firmly, permanently, and rapidly, for the limited number of years left to the patient; that is all that is required. This can best be done by sewing up the ring, empty sac, and cord in one, with silver wire gauge no. 26.

A good anaesthetist is essential. He should see the patient beforehand and make up his mind as to the best method of rendering him unconscious for the ten minutes or quarter of an hour that is required for the operation; longer should not be necessary.

The patient is placed in the semi-Trendelenburg position, which ensures that the abdominal contents fall away from the ring. An incision is made exposing the ring. The external oblique muscle is split and separated from the internal oblique and transversalis muscles, which are as a rule matted together. They need not be separated. The bulky cord with the sac is levered from its bed and freed from the edges of the ring. The sac is opened and its contents dealt with. The omentum is often adherent and has been the cause of the difficulty in controlling the hernia. As much of the omentum as can be conveniently drawn down is brought into view, ligated, and removed. This decreases the intra-abdominal pressure when the parts are consolidating later.

No time is spent freeing or removing the sac, which is left *in situ*. A needle threaded with silk is passed through the cord in front of the vas, near the ring, and tied off. This closes the sac. A needle mounted with the silver wire then takes a bite of the muscles to the inner side of the ring, passes through the cord and then through Poupart's ligament, and is twisted up; it then travels down the canal taking successive bites of muscles, cord, and Poupart's ligament to finish at the lower end of the canal. On drawing this tight the edges of the canal are

approximated, and cord and sac are bound firmly to the muscles and ligament. The whole will become one fibrous mass. Interrupted sutures may be used if preferred. The external oblique is sewn over the line of the wire sutures with silk or any long thread. The wound is then closed, and a sealed dressing applied, with a bandage which affords support and ensures comfort to the patient.

The operator should know exactly what he wants to do, and do it. It cannot be repeated too often that the operation can be performed efficiently in from ten to fifteen minutes.

The after-treatment is most important. Lung complications are the only risk to these elderly patients; they can be avoided with certainty if the patient does not stay in bed. He is up next day and sits in a chair. He takes it easy—that is all; if he wants to walk about he is welcome to do so. The only likely sequel is atrophy of the testis from interference with its blood supply. This is no hardship at the age at which the operation is usually performed.

The results are excellent. Many patients have said they have regained the comfort of living which they had not known for years. The procedure is to be thoroughly recommended as one which will bring untold relief to a long-suffering class of patient.

T. N. S. R.

**Simple oscular test for death!—Dr. E. H. Coleman of Wolver-Hampton writes in the B. M. J.**

"If the fall of the eye be gently pressed between the thumb and forefinger and the pupil becomes irregular and loses its circularity, it is a sure sign of death. I read this in an old book on Forensic medicine—my father also told me he had often found it of use and I have frequently employed it."

T. N. S. R.

**Simple test for Sulfanamides in Urine—Journal of Urology.**

Put a drop of patients' urine on a piece of newspaper (or any wood—pulp paper and not fretex paper). Add a drop of a 5 per cent hydrochloric acid. A yellow colour appears immediately which on deepening turns to an orange colour, if a sulfadrag

has been taken. This colour response occurs within an hour after the first dose of a sulfadrag and remains positive for nearly 3 days after the last dose. As little as 0.01 per cent of the drug gives this "Lignin test".

T. N. S. R.

**Calcium Gluconate for the Relief of Pleural Pain—The Practitioner—August '48.**

As a result of their experiences in thirty patients I. L. Bennet, Jun. and W. Lathem (American Journal of the Medical Sciences, April 1948, 215, 431) recommend the intravenous administration of calcium gluconate for the relief of pleural pain. All thirty patients had "acute pleuritic pain due to either pneumonia or pulmonary infarction." The calcium gluconate was given intravenously in the form of 10 to 20 c.c.m. of a 10 per cent solution. Two to four minutes were taken for each injection. Only two side-effects were noted: a sense of warmth and flushing, and occasional mild nausea. The drug was not given to patients receiving digitalis. Relief of pain was obtained in twenty-seven of the patients, although in only four of these was the relief permanent. Relief was evident within 60 seconds of the beginning of the injection, and this was accompanied by easing of the tenderness and hyperalgesia of the chest wall and upper abdominal muscles. When the pain recurred, it usually did so in 30 to 60 minutes. In ten patients a second injection of the drug gave further relief. "The practical value of the use of calcium gluconate (it is claimed) lies in its simplicity." Most of the patients in this series subsequently obtained more lasting relief from procaine block of the intercostal nerves or by ethyl chloride spray. Incidentally, it is suggested that these results with calcium gluconate support the theory that the pain associated with pleurisy is due to painful spasm of the intercostal muscles.

**Guest Passenger Injuries—The Practitioner—August '48.**

This is the name given by C. L. Straith (Journal of the American Medical Association, May 22, 1948, 137, 348) to the injuries sustained in motor car accidents by

passengers sitting in the front seat beside the driver. According to this observer, this is the most dangerous seat in a motor car, and occupants of this "death seat" are said to be injured in the proportion of 3 to 1, compared with drivers. An analysis of 372 persons injured in 289 cars carrying passengers showed that 248 (69 per cent) of these were riding in the front seat. More than one-half of these suffered head injuries. These head injuries are divided into three main groups:—In the first group are those cases in which the passenger is thrown into the windscreen, resulting in severe injuries from the broken jagged glass. The second group consists of those in which the passenger is thrown into the windscreen and the head is deflected downward on to the dashboard. This results in both cutting and crush injuries, and in children teeth are often dislodged. The third group consists principally of infants and children, and here the head is driven against the dashboard, with resulting crush and tear injuries.

To reduce the incidence of such injuries it is recommended that all knobs, cranks, drop-down ashtrays, sharp ledges, and the like should be removed from the dashboard, and that rubber crash padding should be incorporated in the dashboard in front of the "guest passenger". In addition, it is urged that particular care should be taken with infants and children. They should be held firmly if riding in the front seat and should not be allowed to stand.

**Prescriptions for the Treatment of External Ear Diseases—E. E. N. T. August 1948.**

Because of its exposed position the external ear may be the seat of a variety of pathologic conditions. Being covered with skin, the external ear is especially predisposed to dermatologic affections. In this connection, seborrheic dermatitis (dandruff) is a common affliction. In the treatment of seborrheic dermatitis of the ear, it should be remembered that it will recur if the scalp is infected and allowed to remain so. Salicylic acid is an essential ingredient of all ointments employed in seborrheic lesions. It is sometimes necessary to combine antipruritic substances

with the ointment. A useful prescription is the following:

Menthol crystals, 2 grains (0.13 gm.)  
Powdered camphor, 10 grains (0.65 gm.)  
Salicylic acid, 5 grains (0.325 gm.)  
Precipitated sulphur, 1 drachm (4.00 gm.)  
White petrolatum to make 1 ounce (30.00 gm.)  
Mix and make an ointment.  
Sig: Apply to the ear twice daily.

As salicylic acid is keratolytic, once it has served its purpose, it should be discontinued and another type of ointment employed. After scaling has subsided either the above prescription minus salicylic acid may be used for the following ointment:

Cade oil, 20 minims (1.325 cc.)  
Precipitated sulphur, 1 drachm (4.00 gm.)  
White petrolatum to make 1 ounce (30.00 gm.)  
Mix and make an ointment.  
Sig: Apply to the ear twice daily.

The dermatologic lesions are sometimes irritated by the ointment used initially. In such an event, it may be essential to substitute a bland non-irritant ointment such as:

Boroglyceride, 1 drachm (4.00 gm.)  
Lanolin, 1 drachm (4.00 gm.)  
White petrolatum to make 1 ounce (30.00 gm.)  
Mix and make an ointment.  
Sig: Apply locally to the ear.

The scalp must be treated simultaneously during seborrheic dermatitis of the ear or the ear lesions will recur promptly when treatment is stopped. For treatment of the scalp the following prescription has been found satisfactory:

Salicylic acid, 10-15 grains (0.65-1.00 gm.)  
10% ammoniated mercury ointment, 1-1/2 ounces (46.00 gm.)  
Olive oil or cottonseed oil to make 8 ounces (240.00 gm.)  
Mix.  
Sig: Apply to the scalp.

The above preparation is applied to the scalp at night and allowed to remain

overnight, the head being wrapped in a towel. The following morning it is shampooed away with an antiseptic soap. It may be necessary to apply the scalp ointment repeatedly, but treatments should be kept at least 3 days apart.

Care should be exercised in choosing local applications in the treatment of eczematous lesions, for sometimes a drug intended to clear up a local lesion may through its irritant properties inadvertently perpetuate it. The clinical picture of exudative or serous eczema is characterized by a persistent inflammatory reaction in the skin which is frequently associated with papule formation or vesiculation and in addition presents the exudation of serum from the affected site. Some drugs employed locally in too great concentration for too long a period of time incite eczematoid lesions. Should secondary infection occur, the lesions are known as infections eczematoid dermatitis.

A typical preparation for use in the treatment of exudative eczema is:

Cade oil, 1-2 drachms (4.00-8.00 gm.)  
Zinc oxide ointment to make 1 ounce (30.00 gm.)  
Mix and make an ointment.  
Sig: Apply to the ear twice daily.

In nonexudative or hyperkeratotic eczema the skin is thickened and the top layer is built up to give more or less scaly dry lesions which are subject to fissuring. In treatment, an initial goal is to reduce the thickness of the overlying skin by means of one of the keratolytics. The following preparation has been suggested:

Salicylic acid, 5 grains (0.325 gm.)  
Cold cream to make 1 ounce (30.00 gm.)  
Mix and make an ointment.  
Sig: Apply locally.

In mycotic external otitis the causative organisms are molds. Molds grow in the upper layers of epithelium and their multiplication produces itching and discomfort in the ear. In general the fungi known to produce otomycosis response well to metacresyl acetate to which a small amount of thymol has been added. Metacresyl acetate is introduced into the external auditory canal on a cotton wick and is allowed to remain 24 hours. At the end of

this time the cotton wick is removed. The epithelium of the canal wall will be white from contact with the drug; the epithelial debris can be wiped away easily. The wick is reinserted and moistened with metacresyl acetate. The patient is then instructed to keep it moist with the following agent:

Oil of cloves, 3 minims (0.2 cc.)  
Cresatin, 2 drachms (8.0 cc.)  
Olive oil to make 1/2 ounce (15.0 cc.)  
Mix.

Sig: Apply to the cotton wick in the ear.

This treatment is carried on for three or four days in succession and then a bland agent is substituted:

Cade oil, 15 minims (1.0 cc.)  
Olive oil to make 1 ounce (30.0 cc.)  
Mix.

Sig: Apply to ear several times daily.

On the other hand, this is a more enduring application:

Cade oil, 15 minims (1.0 cc.)  
Lassar's paste to make 1 ounce (30.0 cc.)  
Mix and make an ointment.

Dermatitis venenata is produced as an acute, sometimes fulminating, skin reaction when susceptible persons come in contact with such plants as poisoning or poison oak. This condition is characterized by an inflammatory reaction in the skin with the formation of multiple vesicles and bullae which tend to rupture and become confluent. A satisfactory solution which may be applied as a wet dressing includes:

Copper sulphate, 10-20 grains (0.75-1.325 gm.)  
Camphor water, 16 ounces (500.00 cc.)  
Distilled water, 32 ounces (1000.00 cc.)  
Mix and make a solution.  
Sig: Use as a wet dressing.

Ammoniated mercury is an old favourite in the treatment of contagious impetigo of the ear and pyogenic dermatitis. However, the following has been found to be a very satisfactory substitute:

Sulfanilamide, 2 drachms (8.0 gm.)  
Sulfathiazole, 3 drachms (12.0 gm.)  
Aquaphor, 1-1/2 ounces (45.0 gm.)

Petrolatum to make 3 ounces (100.0 gm.)  
Mix and make an ointment.

Sig: Apply locally.

In sunburn about the ears, for its cooling effect the following has been found soothing:

Powdered camphor, 10 grains (0.65 gm.)  
Menthol crystals 5 grains (0.325 gm.)  
Calamine powder, 1-1/2 drachms (6.0 cc.)  
Liquid petrolatum to make 3 ounces (100.00 cc.)

Mix.

Sig: Apply locally.

Finally, a few words about dermatitis medicamentosa, that form of skin irritation due to the local action of drugs used therapeutically. The terms dermatitis medicamentosa and allergic dermatitis appear to overlap and are separated from each other on the basis of hypersusceptibility in the former case and specific hypersensitiveness in the latter. It is well known, for instance that blonds are more susceptible to the effects of drugs applied to the skin than brunettes. At times even the mildest substances may cause local reactions in the skin. On the other hand, overtreatment may be the cause of unduly persistent local inflammation of the skin.

\* \* \* \* \*

**Hyperhidrosis**—C.H. Whittle.—*The Practitioner*—August 1948.

Excessive local sweating is relatively common and is important, partly because of the inconvenience caused by the moisture itself and partly by reason of other conditions to which it may lead. There are certain general diseases which can be responsible, such as thyrotoxicosis, rickets, obesity, and chronic toxic conditions, such as alcoholism. But sweating with fear, apprehension or excitement is more common, and in practice emotional stress or tension plays a far more important part. An overactive sweating reflex can be made permanently worse by certain local conditions, such as flat feet, and temporarily so by prolonged standing, overwalking, overworking, and by the drinking of hot fluids such as hot tea and hot soups. All these are more likely to be effective in hot weather. The parts most usually involved and for which advice is sought

are the hands, feet and axillæ, the latter especially in women, when the clothes are often stained or even in time destroyed. The palms and soles are affected almost equally in the sexes.

The sweat alone may dissolve out irritant dyes and other chemicals from clothing, e.g. paraphenylene-diamine from dark brown dyes, or chrome products from the leather of shoes, wrist-watch straps or hatbands, which irritate the skin and set up contact dermatitis in the areas so exposed. But the frequent or constant presence of moisture may also encourage the growth of micro-organisms. In the axillæ and on the feet the sweat and sebum may be attacked by these and broken down into organic acids and other products offensive to the nose and destructive to the clothing. On the feet, especially in the toe clefts, pathogenic fungi such as the epidermophyton may find a foothold and produce the characteristic sodden appearance of "toe-rot" common in young people; whilst on the hands, monilia may flourish and give rise in the nail-folds to paronychia, and on the webs to erosio interdigitalis blastomycetica; or the firs of infective warts may start a crop of these disfiguring lesions. Warts are undoubtedly more common and more numerous in hyperhidrotic subjects, both on the hands and on the soles of the feet (planter warts). Even septic organisms may find an entry into the inflamed, macerated and cracked skin of the toes and occasionally cause acute lymphangitis in the foot. In the groins excessive sweating also favours in growth of fungi, commonly the epidermophyton causing the scaly erythema called Dhobie's itch (tinea cruris).

**Treatment.** The radical cure for excessive local sweating is a matter of some difficulty and there is unfortunately no effective measure which can guarantee permanent freedom. But in most cases much can be done to restore the part to a more normal condition. It is unlikely, for instance, that anyone who is subject to moist hands just before an examination or an interview, or an appearance in public, can be completely relieved of his disability even by a prolonged course

of psychotherapy: but at least the affected area of skin can be helped out by local hygiene. Hygiene is particularly important in preventing some of the grosser complications; and care of the feet by simple cleansing, frequent changing of socks and footwear, and the wearing of open shoes or sandals in hot weather will do much to alleviate the worst features. The wearing of sandals should no longer be stigmatized as a mark of the æsthete or crank, but should be prescribed as a routine for the hyperhidrotic subject. Flat feet should receive the attention of the orthopedist, and light clothing and avoidance of over-clothing should be encouraged. By the same token, dress preservers for women's armpits, often cause more trouble than they relieve.

Such drugs as are available have proved disappointing in most dermatologists' hands; but a surgeon of my acquaintance can get through a morning's operating in comfort if he has first applied "odorono" (sodium hexa-metaphosphate) to his over heated brow, and this saves considerable man—or woman-power, by dispensing with the gentle ministrations of the nurse usually detailed for that purpose. Such astringents as 5 per cent. formalin mopped on to the soles of the feet daily may help to shut down sweating for a time. Bland powders such as boracic, talc, or talc and salicylic acid will absorb sweat and offer a large evaporating surface which tends to keep the parts cool and dry.

X-rays have long been found of value in the treatment of local sweating but occasionally they fail; perhaps, as might be expected, more particularly in those cases in which the emotional factors are paramount. Anyhow, large doses should be avoided and treatment should be in the hands of an expert.

The physician who sets out to treat hyperhidrosis must, as always, treat the patient. He must look for errors in general health, faulty habits, overwork, inadequate sleep, lack of holidays, and emotional strains and stresses, and, in so far as he can, correct them; for local measures applied without attention to the general condition are apt to fail in their purpose.

## THE PROVINCIAL MEDICAL CONFERENCE IN MADRAS

### A RETROSPECT

BY A MOFFUSIL DELEGATE

The South Indian Provincial Branch of the Indian Medical Association held its 3rd Annual Conference in the city of Madras on the 22nd, 23rd, and 24th October 1948, in the Madras Medical College premises. The Conference commenced at 11 A. M. on Friday the 22nd inst. in the main hall which was tastefully decorated and was filled to capacity. Prominent among those present being The Hon'ble Sri A. B. Shetty, Minister for Public Health, who inaugurated the Conference, the Hon'ble Dr. S. Gurubatham, Minister for Prohibition, who inaugurated the Licentiate Conference earlier in the day, Dr. P. A. S. Raghavan of Trichinopoly, who presided over the I. M. A. Conference, Dr. K. C. Nambiar, chairman of the Reception Committee, Dr. T. S. Tirumurthy, the outgoing President of the South Indian Provincial Branch, Lt. Col. T. S. Shastri, the architect of the I. M. A. in the South, Dr. U. Krishna Rau, the Mayor of Madras, Sir A. L. Mudaliar, the Vice-Chancellor of the Madras University, Dr. R. M. Mathews, the Director of Public Health, Dr. P. Gurumurthy of Rajamundry, Dr. P. V. Cherian, many of the Professors and staff of the Medical Colleges, practitioners of the city, many delegates from the districts and a good contingent of medical students.

The function commenced with prayers after which the Hon. Sri Shetty delivered his inaugural address outlining the duties of doctors and the function of the State. Dr. K. C. Nambiar then read his welcome address. Dr. P. A. S. Raghavan, who was formally proposed to preside by Dr. T. S. Tirumurthy and seconded by Dr. K. Rama Rao, then delivered his Presi-

dential Address, printed copies of which were distributed to all those present. He first started reading his address rather slowly, but later on, probably finding that another function was awaiting, he started reading faster and to gain time even skipped over some paragraphs. Still it was felt rather too long and a little boring though now and then there were witty references. The Presidential Address which was brilliant on the whole concluded at about 12-30 P.M. after which elections to the Subjects Committee were gone through.

The gathering then adjourned to the exhibition grounds and gathered in the central thatched pavillion. Dr. R. Sankaran, the Secretary in charge of the exhibition, requested Dr. U. Krishna Rao, the Mayor of Madras, to declare the exhibition open which he did after a speech. It was felt that it would have been better if the exhibition had been declared open in the main hall itself after the preliminary session of the Conference, as that would have saved time and trouble. In the alternative it would have been better if the opening session and the other scientific sessions had been held in the pavillion itself in the exhibition grounds as was done at Coimbatore and Madura. That would have saved the delegates the trouble of going up two stories, sit for long hours in a warm hall where all the ceiling fans were not moving, and the din of the nearby road was drowning part of the speeches and the discussions. Moreover it would have given more opportunities for doctors to visit the exhibition stalls if the Conference was held in the exhibition grounds itself instead of at a distant height.

The exhibition arrangements were good and the plan was well laid. The central pavillion, though constructed of thatch, was very pretty and comodious. The stalls were all around and having been constructed at a fair distance from the centre gave ample space for free movement. The exhibition was in the usual style i.e. like a number of medical show-rooms. The additional features were the stalls for blood-bank, for B.C.G. vaccine section etc.

The scientific sessions were of a high order as papers were read by top ranking people of the profession. Many felt that so many papers should not have been crowded into each session, but more time given for discussion. The attendance during the scientific sessions should have been better, for the hall used to get filled up mostly with students when a popular professor was speaking and then rapidly get emptied, except for the few sitting in the front rows.

There was a feeling that members from the moffusil were not looked after and treated with courtesy and care. The mess for the moffusil delegates was arranged in a choultry far from the Conference place and the attention at the mess was scanty and left much to be desired. The lunch interval was so short that unless one rushed in his own conveyance, he would miss the lectures. The mess arrangements should have been made in the premises of the Medical College itself.

The Mayor's 'Tea Party' and the Association dinner, both on the 23rd October, were grand affairs, the former being graced by the Hon. Sri A. B. Shetty and the latter by the Hon. Dr. T. S. S. Rajan, the Food Minister. Both the functions were held in the exhibition pavillion and covers were laid for more than 500 guests. After the Tea Party, Dr. U. Krishna Rau extended a hearty welcome to all those present and hoped they would carry

pleasant memories of their stay in Madras. Dr. P. A. S. Raghavan, the President in a neat speech thanked the Mayor for giving an opportunity of meeting so many colleagues and hoped that Dr. U. Krishna Rau gave them the Tea in his capacity as the Mayor of the premier city of Madras, thereby associating the public, with the medical profession. The President also mentioned that in Trichinopoly in 1945, the President and the members of the I. M. A. were accorded a Civic Reception and that at Bombay the previous year the Mayor of Bombay met them a party at the Taj.

Dr. T.S.S. Rajan after the dinner, in proposing the toast of the I.M.A. said that it would have been more appropriate if a non-medical man proposed it. It was also anomolus that he should propose the toast of the I. M. A., virtually the toast of Dr. Raghavan, the President who was a cousin of his. He deprecated the inferiority complex of the Licentiates and it was probably to change that mentality that Dr. Raghavan was elected as the President of the I. M. A. He deplored the lack of enthusiasm of doctors to take up social activities or nonremunerative professional activities. Replying to the toast Dr. Raghavan explained that the Licentiates as a class never had the inferiority complex but those in service felt inferior in being placed at the lowest rung of the ladder with no chance of ascending higher. Moreover inferiority complex was inherent in paid service, the one in the lower grade feeling inferior to the one in the upper grade and this existed in all the cadres. He felt he was elected president not because he was a Licentiate but because of his service to the I. M. A. He thanked the Minister for the advice he had given about doctors taking interest in social activities and assured him that the profession would acquit themselves creditably when occasion arose. Dr. K. C. Nambiar proposed the toast of the Guests and Dr. Surya-

narayana of Madura responded to the same. The gathering broke up at a late hour.

On 23rd morning the President and a number of doctors were taken to Asoka Vihar in the Peoples Park and to the newly started Tuberculosis Hospital in Perambur, which is being run by the Municipal Corporation. A few delegates went round the Anotomy, Physiology and Pathology museums. In the evening there was a variety entertainment in the main hall which was well attended and much appreciated. Dances by the two daughters of of Lt. Col. D. S. Iyer were the highlights of the show.

The last function of the Conference was the open session held in the afternoon of the 24th. From the rather poor attendance at this, it is evident that members are not taking much interest in the Medico-Political activities of the Association. Most of the resolutions which were of a non-con-

trovertial nature were put from the chair and carried nem con. The resolution on the admission of at least some students who were qualified to join the Medical College, but could not get admission on account of communal reasons, should be admitted if they gave an undertaking to serve for 5 years in the rural areas, was hotly debated and ultimately thrown out. Another resolution that Government should post service doctors to Local Board and rural dispensaries instead of closing them for want of medical personnel or hand them over to L. I. Ms. or Ayurvedics also evoked hot discussion but was ultimately passed. The President allowed a discussion on Nationalisation of Medicine in which many members took part and the subject was talked out.

The President then presented certificates to the various exhibitors. After passing resolutions giving thanks to various persons and organisations concerned with the Conference, the Conference concluded.

## Announcement

[The proceedings of the Council of the South Indian Provincial Branch held on 22-10-48 is published elsewhere in this issue. The Addresses and Scientific papers read at the Conference will be published in the Conference Number of the 'Miscellany' in December '48—*Managing Editor*.]

## MALABAR BRANCH

*President:* Dr. N. Achuthan  
*Vice-President:* Dr. P. B. Menon  
*Secretary:* Dr. C. V. Narayana Iyer  
*Asst. Secretary:* Dr. A. P. Kunhuramanunni  
*Treasurer:* Dr. N. Govindan

The annual meeting of the Malabar Branch of the Indian Medical Association was held on Thursday 28-10-48 at the Beach Hotel, Calicut with Dr. N. Achuthan in the Chair. Dr. R. G. Cochrane, Hon. Director of Leprosy Campaign, addressed the members on several aspects of Leprosy including the social side and about latest Medicines. Dr. C. V. Narayana Iyer read the annual report. The following office bearers for 48-49 were elected. President-Dr. N. Achuthan, M.B.B.S., Vice-president-Dr. P. B. Menon, L.R.C.P. & S. Secretary-Dr. C. V. Narayana Iyer, L.M.P. Asst. Secretary-Dr. A. P. Kunhuramanunni, L.M.P. Committee Members-Dr. R. Hermon, Dr. A. G.

Nair, Dr. K. R. G. Kurup, Dr. A. B. Das, Dr. Mrs. V. Krishnan, and Dr. P. V. Karunakaran Nair of Tellicherry. Auditors-Dr. U. Thiruvikraman and Dr. M.K. Koya. Treasurer-Dr. N. Govindan. For the central council Dr. C. V. Narayana Iyer & Dr. M. Sundaram were elected and for the Provincial council Dr. A. B. Das, Dr. M. Krishnan & Dr. C. K. Karunakaran were elected. The meeting was followed by a Dinner and Dr. Narayana Iyer proposed the Toast of the Association and Dr. Achuthan proposed the Toast of Dr. Cochrane. A Condolence resolution on the demise of Dr. M. V. Sharma was passed all standing.

## NAGAPATTINAM BRANCH

*President:* Civil Surgeon  
*Vice-President:* Dr. J. Y. Arthur  
*Hony. Secretary:* Capt. S. S. Chari  
*Jt. Secretary & Treasurer:* Dr. T. S. Varadhachari

The monthly meeting of the association was held on 25-9-48. Dr. J. Y. Arthur, Vice-President of the association presided. After Tea, for which Dr. D. Narayana Iyer stood as host, the meeting commenced with reading the minutes of the last meeting.

It was resolved that the following will represent the branch as delegates in the Provincial Conference, Madras. Capt. S. S. Chari the Secretary and Dr. Mayuranathan.

Resolved unanimously that trainage to and fro be met from the association funds for representatives for the Provincial Council meetings.

Resolved to hold the 1st Annual Celebration in the 1st week of November 1948 and that a committee consisting of Dr. Chary, Dr. Miss Narayanaswamy, Dr. Mayuranathan, Dr. Rama Rao, and Dr. Arthur to make necessary arrangements.

In case a Civil Surgeon is not posted by the 15th October 48 the Secretary is authorised to invite the D.M.O. to preside over the annual meeting.

Dr. S. Ganapathy gave an interesting talk of experience in Burma.

After vote of thanks by the Secretary the meeting came to a close.

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The annual general body meeting of the above association was held on Thursday the 14th October 1948 under the Presidency of Dr. J. Y. Arthur B.A., L.M.S., Vice-President of the Association. 14 members were present.

After the adoption of the annual report and the audit report of the association, the following office-bearers were elected for the year 1948-49.

*President:*  
 Civil Surgeon, Govt. Hospital,  
 Negapatam.  
*Vice-President:*  
 Dr. J. Y. Arthur, B.A., L.M.S. „  
*Secretary:*  
 Capt. S. S. Chariar, L.M.P. „

*Jt. Secy. & Treasurer:*

Dr. T. S. Varadachari, L.M.P.,  
 Negapatam.

*Auditor:*

Dr. D. Narayana Iyer, L.M.P.

*Committee members:*

Dr. Rama Rao, L.M.S., Velipalayam.  
 Dr. Ganapathy, L.M.P. „  
 Dr. V. D. Rajan, L.M.P., Negapatam.  
 Dr. Miss T. K. Narayanaswamy „  
 Dr. S. K. Pillai, Govt. Hosptl. „

*Representative to Central Council:*

Dr. N. R. Thangavelu, Nagore.

*Representative Provincial Council:*

Dr. M. R. Mayuranathan

## NILGIRIS BRANCH

*President:* Col. A. J. D'Souza  
*Secretary:* Dr. I. G. K. Menon  
*Jt. Secretary:* Capt. C. N. Narayanan

The first annual meeting of the Nilgiris District Branch of the Indian Medical Association was held at 5 p.m. on Wednesday 15 September 1948 at the New Taj Mahal Hotel, Ootacamund. Col. S. L. Bhatia, C.I.E., M.C., M.A., M.D. (Cantab.), F.R.C.P. (Lond.), F.R.S. (E), Surgeon-General with the Government of Madras presided and Dr. Lind of the World Health Organization addressed the meeting on "B. C. G. Vaccine". Col. A. J. D'Souza, M.C., I.M.S. (Retd.), President of the branch, opened the meeting with a warm welcome to Col. S. L. Bhatia and Dr. Lind. He thanked the members of the Association for their support in making the Association a success and referred appreciatively to the services rendered by the Secretary, Dr. I. G. K. Menon, who was shortly to go overseas on a Government of India Travel Fellowship. He wished him all success.

Col. Bhatia in his opening speech said that he was very happy in being able

to meet the members of the Association including some old friends that evening. He was sure that the Association would be a success, now that it has passed its first year. He explained how the Government of India, through the efforts of the Health Minister, Raj Kumari Amrit Kaur managed to get the services of Dr. Lind and Dr. Gellner for the purpose of starting a B. C. G. Vaccine unit here. It was a happy augury of international relationship that Dr. Lind from Denmark should be addressing this meeting at Ootacamund. He regretted that Dr. Gellner could not attend the function due to pressure of work. The Secretary then Read the Annual Report of the working of the Association. He took the opportunity of thanking personally Col. D'Souza and other members for their help as well as for their good wishes.

Dr. P. Lind, of the State Serum Institute, Copenhagen, who has been deputed by the World Health Organization to

start the manufacture of the vaccine at King Institute, Guindy, then addressed the meeting on "B. C. G. Vaccine." He started by referring to Calmette's research work over years leading up to its preparation and the early trials in France, Germany, Denmark etc. The details of tuberculin testing in individuals, the selection of cases for vaccination, the nature of its action, the technique followed and the reactions seen were all dealt with comprehensively by him. It was a very instructive address and he also showed the various materials like purified tuberculin ointment and dilutions for testing, B. C. G. culture and the finished vaccine. This was followed by an interesting discussion in which several members took part and Dr. Lind answered them on the points raised. The fairly high incidence of tuberculosis in the Nilgiris was also discussed. Col. Bhatia in his concluding remarks dealt with the problems of tuberculosis control in India. He referred to the findings of the Prophit Survey

on tuberculosis in England and stressed the importance of similar surveys in various parts of our country. The results of the first survey now being carried out at Madanapally by Dr. Gellner would prove important and interesting. India owes thanks to the World Health Organization for its help in starting the work on B. C. G. Vaccine here. The various measures already taken by the Government of Madras to increase the number of sanatoria in the Presidency were explained by him and he felt that Madras led the rest of India in such Public Health activities. He thanked Dr. Lind for his excellent address on the subject.

Col. D'Souza, M.C., I.M.S. (Retd.), then thanked Col. S. L. Bhatia for kindly presiding over the function and Dr. Lind for the trouble he has taken in coming from Madras for the occasion and for his very complete and instructive exposition on a subject which was of the greatest importance to our country now,

#### SOUTH ARCOT BRANCH

*President:* Dr. S. Chandrasekaran  
*Vice-President:* Dr. S. Sankararaman  
*Secretaries:* Dr. C. Seshachalam  
 Dr. R. Narasimhan  
*Treasurer:* Dr. S. Mahandranath Singh

The Annual Meeting of the South Arcot District Branch of the Indian Medical Association was held on 26-9-1948 in the premises of the Municipal High School Cuddalore N. T. Dr. B. Govindaraj Shenai, M.B.B.S., L.O., Dt. Medical Officer, South Arcot, presided.

The programme consisted of a full day's session commencing at 10 A.M. Dr. R. Mahadevan M.S., F.R.C.S. (E) F.R.C.S. (Ed.) delivered a lecture on "TREATMENT OF WOUNDS".

The members adjourned to lunch at 12 noon at 2-30 P.M. Dr. K. S. Sanjeevi, M.D., delivered a lecture on "RECENT ADVANCES IN MEDICINE".

At 4 P.M. the General Body met and passed the accounts of the closing year and elected the Office-bearers for the year 1948-49. The list of Office-bearers is attached herewith.

After Tea, Dr. B. M. Sundaravathanan, B.A., M.B.B.S., L.R.C.P. and F.R.C.S. delivered a lecture on "ABDOMINAL EMERGENCIES".

The members enjoyed a delightful dinner at 8 P.M. After the Secretaries thanking the members for their co-operation and contribution towards making the function a success, the meeting came to a close.

#### TRICHINOPOLY BRANCH

*President:* Dr. T. N. Subramanyam  
*Vice-President:* Dr. G. Joseph Gnanadickam  
*Secretary:* Dr. P. V. Sundaram  
*Treasurer:* Dr. C. R. Chary

A monthly meeting of the association was held on 11th September 1948 in the premises of the Bishop Heber High School, Trichinopoly. About 50 members were present.

In the absence of the President and the Vice-President, Lt. Col. R. K. Chettur, Dist. Medical Officer, Trichinopoly was proposed to the Chair.

Dr. V. Enok, M.B.B.S., was 'At Home' to the members.

Dr. P. A. S. Raghavan wished to place on record the invaluable services rendered by the late Dr. O. R. Balu to this association especially in the matter of raising the finances of the association by over Rs. 5000/- He was a popular and leading member of the medical profession.

The following resolution was moved from the Chair. "This association

records with deep regret the untimely demise of a popular practitioner and a member of this association." The resolution was passed with all members standing in silence for 2 minutes as a mark of respect for the deceased.

Then the lecturer, Dr. R. Kesavan Nair, F.R.C.S. Surgeon, Govt. Hospital, Trivandrum was introduced to members as an eminent surgeon who was known to be carrying on work of a high order in the Trivandrum Hospital. Dr. Kesavan Nair delivered an excellent lecture dealing with problems of cancer laying particular emphasis on the importance of early diagnosis. This was followed by a discussion.

The meeting came to a close by about 7-30 P.M. with a vote of thanks to the lecturer, the host and the authorities of the Bishop Heber High School.

#### CHANGE OF ADDRESS

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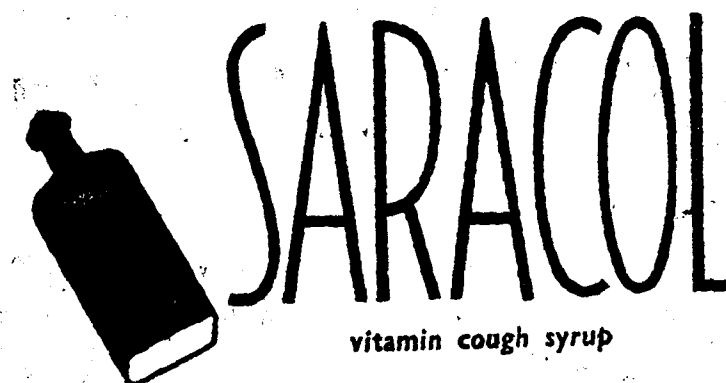
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Advice to the Lean:—"Don't eat fast."

To the Stout:—"Don't eat-fast."

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Why are doctors always bad characters?

Because the *worse* the people are the more they are with them.

∴ ∴ ∴

"You were admitted for heart palpitation. What did they do?"

"They sent me an elderly nurse."

"So, that slowed down your heart, I see."

∴ ∴ ∴

"Doctor, why does a small cavity feel so large in the tongue?"

"Just the natural tendency of your tongue to exaggerate, I suppose."

∴ ∴ ∴

Nurse: I see you have been admitted for observation.

Patient: Yes, to observe the pretty nurses here.

∴ ∴ ∴

Having attended first-aid lectures, the wife imagined she knew quite a lot and so when her hubby felt seedy next day, she proudly produced a thermometer and proceeded to take his temperature. The result of her reading so startled her, that she immediately phoned up the doctor—"My husband's temperature is 122, please come at once." Back came the reply "Ring up 99, the Fire Brigade."

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CONFERENCE NUMBER

## THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH  
OF INDIAN MEDICAL ASSOCIATION

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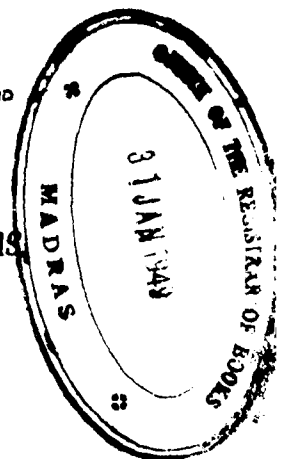
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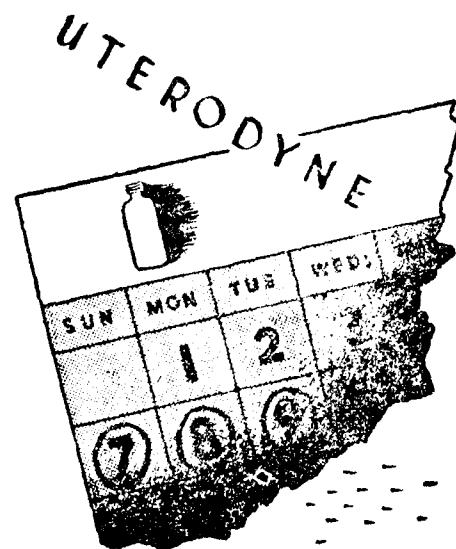
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# THE MISCELLANY

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OF

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## The Third South Indian Provincial Medical Conference I.M.A.

### INAUGURAL ADDRESS

BY

Hon'ble MR. A. B. SHETTY, Minister for Public Health.

I am grateful to your Association for the privilege accorded to me to participate in your conference. This gives me an opportunity to come into personal contact with many of the leading men of the medical profession in this province. I have always had a great liking for doctors and their work. Many of you doctors seem to be quite charming fellows in your own way. The idealism of the man who devotes himself to the practice of medicine as a noble calling and not a trade is indeed admirable. Medicine demands for its service and elicits in its practice qualities of the highest character. It requires the scientific mind, zeal for continuous learning and capacity for fine judgement to do high class work. Success in the profession depends on many things. You must have an acute appreciation of human nature and particularly of the psychology of the sick people. It is essential for you to have a knowledge of the way in which physical illness is influenced by the mind and the various other factors in the patient's environment. The patient as seen at the hospital or the consulting room with his medical complaints does not give you the entire picture. The social and environmental factors that have a bearing on his health and his emotional reaction to them have to be taken into consideration. Social medicine is largely the study of the environmental and social background in which the disease has developed. A considerable percentage of all prolonged illness is said to be psychological in character. Psychiatry has received a great impetus during the recent war. It is not easy to remove or mitigate the influences of adverse social as well as physical factors. Even the best medical and social services cannot offset the effects of poverty, bad housing, occupational maladjustment and unhappy family relationships. Yet it is helpful to study the patient and his environment as a whole and to understand the inter-relationship of disease and social relationship. A lot of doctoring consists of dealing with peoples worries, fears and obsessions. The establishment of a proper physician-patient relationship is necessary for this purpose. The physician must gain the confidence and co-operation of the patient and also his family. The management of

a patient is no longer a one-man affair. The general practitioner has to indent on the service of specialists and other ancillary personnel in his work. It is a collaborative effort by a team whose experience, skill and assistance have to be made use of in all difficult cases.

The doctor of the future will be called upon not only to diagnose and cure disease but to deal with all the health needs of human beings. The public still think of the doctor as some one to consult in times of sickness only. The present system of calling in a doctor when a person is ill and paying him for attending on the patient has been condemned on the ground that it is likely to create in doctors a vested interest in disease. The more rational thing to do is to employ doctors as whole-time servants of the state and make them responsible for the health of the people living in their area.

Astrologers, magicians and quacks of all descriptions abound in this country and they vie with each other in advising people about healing disease and averting misfortunes of all sorts. The credulity of the human mind is exploited by them. People do not pause to consider whether the cures sometimes effected by them are due to the medicine prescribed, to its psychological effect or to spontaneous recovery. The experienced doctor knows that there are certain diseases which get cured with or without medicine and others which can neither be prevented nor cured. People have a child-like faith in the medicine bottle and a pathetic craze for injections. In the attempt to satisfy this craving an indiscriminate use of drugs and injections is made without due regard to their utility in the conditions under treatment. All sorts of novelties introduced into the market from time to time are prescribed. Col. Sir Chopra has drawn attention to the tendency among medical men in this country to overdose patients with drugs and injections of doubtful efficacy and to the large amount of money wasted on expensive proprietary medicines and patent foods when simpler and much less costly remedies of equal value are available.

It is a curious phenomenon that while the scientific knowledge of drugs and their action, the discovery of new drugs and the application of this knowledge in therapeutics has made remarkable progress, there exists side by side with it a widespread popular belief in the efficacy of all manner of useless and even dangerous substances. If such drugs could all be swept to the bottom of the sea, it would, as observed by Olevér Wendell Holmes, be all the better for mankind and all the worse for the fishes. The patent medicine industry spends enormous sums on advertisements. Free samples are sent to members of the medical profession. The preparations are so elegant and the presentation is so cleverly done that we succumb all too easily to the temptation. It is the duty of medical men to give proper guidance to the people in such matters. It is said the claims of all food and drug advertisers are examined by the various councils of the American Medical Association and the journals published by the Association do not publish advertisements or even the names of preparations which have not been tested and found to be genuine and useful. The protection of the public against adulterated and dangerous or useless drugs and foods would be a public health service of great value.

Medicine and surgery have made greater advance during the last 40 years than in all the preceding centuries. To-day medical science has placed in your possession well-attested remedies for the radical treatment of several diseases. You have a host of scientific aids to help you in correct diagnosis. It is said that the British and American Armed forces have never been so well looked after and medicine has never made such a contribution to victory as during the last war. Typhoid, typhus and tetanus were practically eliminated from the fighting areas. Vast numbers of the badly wounded were made fit for civilian life and often sent to fight again by employing new treatments and improved surgical techniques with the aid of chemotherapy, blood transfusion and &c. Plastic surgery has achieved wonderful results in correcting deformities, getting crippled persons on to their feet, removing disfigurements and restoring beauty. The use of mepacrine, paludrine and D.D.T. has been of great help in combating malaria. The mental disorders caused in soldiers by fear, fatigue and injuries have been treated with considerable success by medical psychologists. The health record in the British as well as the American Armed forces was so good in World War No. II that it must be considered as an outstanding achievement. Even apart from the results seen during war time, the labours of health and medical workers in Britain and America have great achievements to their credit. A review of the last 100 years shows that they have brought about a gradual decline in the major epidemic diseases. Motherhood has become safer, childhood healthier, mortality rates have been reduced and people live longer and healthier lives. The health and medical services in our country cannot boast of any such accomplishment. We have to grapple with the problems created by poverty and ignorance. There is so much of sickness in the country that we cannot hope to provide for the medical care of more than a small fraction of the people who require hospital treatment. A reduction in the demand for curative treatment can only be secured by neutralising the adverse effects of the social, economic and environmental factors which are the main causes of the low level of health in our country.

The medical outlook is changing and broadening. The increasing emphasis on the preventive aspects of medicine, the developing conception of social medicine, the greater attention paid to psychological factors in medicine and the emergence of the idea of 'positive health' are but symbols of this changing outlook. The major causes of preventable disease in our country are bad housing, insanitary surroundings, lack of safe water supply, malnutrition and ignorance. Most of our troubles may in the last analysis be traced to the economically backward condition of the majority of the people in this country. The masses are chronically under-nourished. They live huddled together in overcrowded dwellings. Their habits are unhealthy. What these poor debilitated people primarily need is a reasonable house and good feeding rather than a bottle of medicine. Till we are able to provide for them these essential and minimum needs of life, our towns and villages will continue to be factories for supplying cases to our hospitals and dispensaries. We must attack the problem of ill-health at the root instead of trying to cure and patch up after the damage has been done.

In the development of preventive medicine in the west, the first phase was the improvement of the environment with a view to provide the basic conditions of healthy living. The second phase was immunisation by the use of sera and vaccines to give protection against certain infectious diseases. What may be regarded as the third stage has come now. It seeks to prevent deviations from health from whatever cause and keep human beings at their best. The term 'constructive medicine' as against remedial or preventive medicine has come into vogue. This type of medicine has for its objective the active construction of greater health. The Peckham Health Centre in England has done pioneering work in this new field. No individual is wholly 'normal', much less can anyone be said to be in the fullest possible health. 90 per cent of the people who came in first to this centre were found at the first overhaul to have some physiological defect or aberration. They were people who were going about their daily work either unaware of anything being wrong or they didn't mind it. "Many conditions easily curable in their initial stages are, by delay in obtaining treatment, converted into chronic and incurable diseases." The Peckham Centre experiment has demonstrated the importance of the earliest possible detection of slight departures from normal health and of the prompt initiation of measures for their arrest. Periodic health examination is necessary for this purpose. Such examination makes it possible to detect illness at an incipient stage and prevent it from establishing itself and becoming intractable at a later stage. It also gives an opportunity to teach the patient how he should live and how he should regulate his diet, work, and rest. Medical men as well as the lay public have been slow to recognise in practice the need for a periodic health overhaul like the one they have at the Peckham Health Centre. The attention of doctors has hitherto been directed much more to the diagnosis and treatment of established disease rather than to the detection and correction of early and slight departures from health. Periodic health examination done in a thorough way will come to be regarded as the number one task in the future strategy of personal preventive medicine.

Chronic diseases are often due to neglect or ineffective treatment in early stages. They are the cause of a tremendous amount of illness and invalidity. The chronically sick occupy a large proportion of the beds in our hospitals. They are a drain on the resources of the family and of the state. We have yet to provide homes for the convalescent and hospitals for incurables. Many poor patients are discharged from our hospitals even though they may still require medical care. When they return home and resume work a relapse takes place and the illness assumes a worse form. Patients who recover from serious illness or from infectious fevers are often in a run-down condition. They are hardly in a fit state to resume their normal occupation. It is a sad mistake to ignore the need for after-care work for such discharged patients. In the case of T. B. patients for instance, it often happens that patients restored to health by proper treatment are compelled by force of circumstances to return to the same work and the same conditions which led to their breakdown in health. Rehabilitation has long been neglected. In war time it became a military necessity and it was demonstrated that the physical and emotional rehabilitation of persons disabled by disease, accident or maladjustment is possible. The provision of

a useful satisfying occupation suitable to disabled conditions is a psychological factor of great value in regaining and maintaining health. The development of rehabilitation will, therefore, become an essential part of preventive medicine in future.

Medical science has still many worlds to conquer. The outstanding problems which contemporary medicine has to tackle are the insidious, degenerative diseases which are common in the later years of life. These have been called Fifth Column diseases because they arise from within and remain hidden until they have done irreparable damage. Cancer and the group of cardio-vascular-renal diseases have become the major killing affections. They take a heavy toll of the age-groups beyond 45 or 50. Medicine will have to find ways and means of stemming the ravages of these progressive disorders, which make old age a tragedy. Treatment of cancer by the best available methods of modern medicine has made little progress in our country. The study of the diseases of old age will have to receive greater attention and become a speciality of medicine in future as pediatrics is today.

By eliminating preventible illness and arresting the progress of other diseases in their early stages we can reduce the burden of national sickness. The problem we have to tackle in regard to medical relief is how to improve the quality as well as the distribution of medical care in the Province. It is the people in cities that benefit most by medical progress. The people in rural areas are medically underprivileged. Medical practice of a high standard requires facilities for diagnosis and therapy which are available only in urban areas. Good doctors are therefore, unwilling to settle down in rural areas which are unattractive also on account of low income and the lack of amenities of civilised life. The paucity of scientific medical aid in rural areas is not a feature peculiar to this country. Even in Britain and America they are said to be experiencing a similar difficulty.

Medical science has revealed many of the causes of disease and it has opened the way for a more rational therapy. Medicine is now in a phase of rapid advance. Unless medical practitioners remain students throughout life, eager to learn and improve their art, their practice will fall behind the times and they will become back numbers. Many of the medical men in mofussil places stagnate and get into a groove. They must read books and journals, visit hospitals where they can observe the latest technique and seek opportunities to come into contact with the best men of the profession. Those who have an aptitude for higher studies should undergo post-graduate training and specialise in some branch of medicine or other. Occasionally they must go abroad to get into touch with the new developments in medicine and surgery. In a free India, medical men will have to play a large part in the work of preserving and improving national health. Administrative measures of vast magnitude will be required to raise the level of public health in this country. A National Health Service like the one just established in Britain providing comprehensive medical care for all members of the community will no doubt be the goal towards which we should strive to go. The cost of such an undertaking will be prohibitive for us at the present time; but when we can afford it, it will be an investment which is sure to yield high dividends in health, happiness and efficiency in work. I trust at this Conference you will discuss several problems of interest and importance to you and I hope you will go back with new ideas, and fresh zeal to the sphere of your work.

# The 3rd South Indian Provincial Medical Conference I.M.A.

## WELCOME ADDRESS

BY

DR. K. C. NAMBIAR, F.R.C.S., Madras

With the attainment of Freedom and establishment of a National Government in our country, this National Medical Association has opened before itself a newer and wider vista. Unrecognised by the Government at all times, banned and incarcerated during certain periods of emergency within the last few decades of British Rule, this institution has grown slowly and steadily to this size and extent, that no other medical association in this country could possess the privileges of speaking on behalf of the profession and advising the Government in matters relating to the profession. The vestiges of the British Medical Association and the South Indian Medical Union are still in existence in the city of Madras. The former is purely a clinical organisation and the latter played its most useful part as a Clinical and Political Body for decades past on behalf of the Independent Medical Profession. There is hardly any necessity for maintaining these institutions at the moment; and I take this opportunity to beg and appeal to the authorities concerned to join ranks and amalgamate the above mentioned organisations with the main body of the Indian Medical Association at the earliest possible opportunity, so that we all can live in one house, think with one mind and speak with one voice. There may be a need for retaining certain sectional organisations such as the Licentiates' Association, Provincial Service Association or Honorary Medical Officers' Association with a view to study and represent their special problems to the Government, but members of every such organisation must automatically be a member of the Indian Medical Association prior to the dates of such membership.

I speak with a certain amount of prophetic vision when I say that I see reasonable opportunities for Madras becoming a Medical Mecca of the East sooner or later. This is the second time I am stating this on a public platform. I am deeply convinced of this possibility, at the present state of medical advancement in this province and the geographical position of the city in relation to the numerous Island Chains of the Pacific and the intimate cultural relationship to us of the millions inhabiting these Islands conjointly produce this laudable object, provided we are able to keep abreast of modern scientific advancements and render help and opportunities to our neighbours in the matter of attaining such knowledge. In other words, the teaching Institutions in the City must attract, provide for and cater to them in the matter of Post-graduate Medical Education. There is one drawback and a great one too. Great schemes and Reports of Committees are breaking on the rock of finances and some of them shelved into the backwaters for some time or for ever. A poor Province made poorer by depletion of important revenues cannot at the present

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moment look beyond its food and clothing. With poor finances, but with purer spirit though depleted of all *spirits* we have to march along slowly, but surely till our objective is reached and I hope everyone of us shall nurture this ambition in our minds.

Of late, we have been listening to certain resolutions and agitation that medical relief in our country may be based upon the Socialised system of Medicine, as is obtained in Russia. I have not yet been able to reconcile myself to this view. On a question of morals, is it incumbent on any Government to render medical relief to the people at the expense of the Government? Food and Clothing we acquire by private enterprise, which certainly takes precedence of medical relief. When food and clothing are socialised as in Russia, ipso facto, medical relief will also be socialised. The duty of the Government will lie to the extent of producing opportunities for medical relief and not by directly paying the doctor's fees on behalf of the people. So the production of doctors and sufficient number of doctors will be the duty of the Government as individuals cannot produce teaching Hospitals and Colleges for producing doctors for their own use. Similarly, prevention of diseases is the direct concern of the Government and the expenses thereof must be met by the Public Exchequer, and the individuals have no more responsibility than to co-operate with the Government in this matter. The responsibility of the Government does not stop with the production of sufficient number of doctors, but extends to the question of making them available to the people in the villages as well. There have been various systems of medical aid to the public, starting from the socialised system prevailing in Russia, passing through the Government sponsored Health Insurance Scheme as obtained in England, the system of Private Enterprise with state-aided hospitals as in India and finally coming to our ancient system of Ayurveda, where medical aid to the public as well as the production of medical men were entirely matters of private enterprise, without any state-aided hospitals.

Many a platform has been crying hoarse about the paucity of doctors in India. And many a doctor is still starving at the place of his practice, unable to keep the wolf from the door. We have about ten thousand doctors for this province of 50 million people, a ratio of one in 5 thousands, as contrasted to 1/8000 for the whole of India and 1/1500 in British Isles and 1/1000 in the city of Madras. This gives a clear insight into the unfair distribution of doctors in various places. Ten thousand doctors for twenty thousand villages works up to a figure of one doctor for every two villages. But in certain districts, we do not find one doctor for ten villages. This is indeed a deplorable state. The relief that can be obtained by adopting the suggestion of the Bhore Committee by appointing the paid medical men to places and villages of no practice can only touch the fringe of the problem, as the total number of paid doctors today is clearly less than 5% of the existing medical men. If 50% of admissions to medical colleges are reserved for those who undertake to serve in the villages for a period of 5 years after graduation, at the end of ten years, we will have a thousand doctors working in the villages; and I have no doubt that there will be a magnificent response from the candidates seeking admission to the courses of medical studies.

One word about the paucity of doctors. If the word doctor denotes anybody who administers any system of medicine for the alleviation of human sufferings, we can count upon the minimum of four doctors to every village. This is a proportion unprecedented in any other country at any other time. No statistician can forget the fact that more than 90% of the villagers are still seeking medical aid through the various indigenous systems. If we include all such practitioners in the enumeration of statistics, the proportion of doctors to the populace becomes formidably high, and this will also explain the poverty of doctors. All the same the proportion of qualified doctors of the Modern Scientific System is low indeed. Attempts have been made of late to start more medical colleges in our province. Two of them were actually born but passed away shortly after, creating a world record of cent per cent Infant Mortality. Abolition of Medical Schools has to some extent affected adversely the annual turnover of medical men. At the time hopes were entertained that this deficit would soon be made up by the opening of some more medical colleges. All such hopes have been in vain. The increase in the population and their increasing demand for the Modern Scientific System cannot be met except by increasing the number of Medical Colleges in the Province.

It has often been argued by scientists that the Government are unwise in encouraging the indigenous systems of medicine which are not scientific. I fully agree that the Indigenous systems are not strictly scientific as they are not based on basic sciences like Physics, Chemistry, Anatomy, Physiology and the like, but on the hypothesis of unknown theoretical Humours called Vatha-Pittha-Kapha. But it must be remembered that a popular Government can rule only as per the popular will. When 90% of the people that voted for the Government knows only and had the benefit only, of the indigenous system and knows nothing of the scientific system, they can only plead on behalf of the indigenous system. So the fault lies neither with the Government nor the people but with the scientific system for not having penetrated the masses. The costly education and the costly upkeep of the modern doctor makes it impossible for him to penetrate the masses. The poverty of our country makes it impossible for the Government to force the modern doctor into the villages on payment basis. What then is the position of the Government? Aren't they responsible for the health of the villagers? Is not a quack better than no doctor, at least on psychological grounds? Government can have no other course but to encourage them and accept them till such time as we can find sufficient number of Modern Medical men. Viewing the circumstances mentioned above penetration of the masses through the scientific system can be attained only through a lower order of trainees that can be recruited in larger numbers for the special purposes of the villages. I would straightaway be condemned, and probably outraged by the profession, if I should suggest the reintroduction of classes among the doctors that have been removed with years of struggle. But, such lower grade trainees need not be designated as doctors. If a first-aider, a trained nurse and a midwife could be posted to every village, which is definitely within the finances of our province, we could congratulate ourselves that the scientific system has penetrated the masses.

The problem of the ever-increasing population of our country is a matter on which much thought has to be bestowed. Very little has been done in the study of this subject by the Government, the people or the profession. Anyone of us who can look back three decades ago will find, that he belonged to a family of five or six, which today has multiplied into several tens of them. Any one of us who was born in a village with a dozen houses scattered here and there with plenty of cultivable areas, now find such places full of houses and devoid of lands. This is a position that has definitely to be reckoned with. It has now been accepted by science that the birth-rate among the poorer classes is greater. The poorer, the greater the fecundity. And it is poorer countries and poorer people that should control and regulate their birth-rates. The statistics that we possess of birth and death rates are unreliable. Deaths are always known and therefore reported, while very few births are being reported, especially in outlying villages. The tendency of the people to live in large joint family houses has given way to the habit of a house for every single family. This has taken away a very large portion of our cultivable lands. The natural ways of destruction of the human race are being well fought against. War, Pestilence and Famine were the natural weapons of God invented for the checking of the overgrowth of population. But man has invented their effective antidotes. Wars have been stopped by the good offices of the United Nations, except in stray cases of Police Action, as in Hyderabad. Ravages of pestilence are successfully combated, prevented and wiped out, by the departments of Health. Famine has no more place in our country with a large number of the Honorable Ministers of Food, successfully manoeuvring with alternate and timely control and decontrol of foodstuffs. Research workers are working and discovering vitamins that increase the fecundity rate. Man has advanced so far that Poor God finds it difficult to maintain a balance between births and deaths. So it is for a man again to devise ways and means of balancing the birth-rates, lest this country of ours will be forced into a crisis of inconceivable sufferings sooner or later. It is time that our Government, our people and the profession turn their eyes towards this serious and sickening problem.

### 'MISCELLANY'

As all the Scientific papers read at the Third Provincial Medical Conference have not yet been received the present Conference Number will contain the various general addresses. Scientific Papers will be published later on.

*Managing Editor.*

# The 3rd South Indian Provincial Medical Conference Madras

## PRESIDENTIAL ADDRESS

BY

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FRIENDS,

Let me thank you most sincerely for the great honour you have conferred on me by electing me as the President of the South Indian Provincial Branch of the Indian Medical Association and thus enabled me to preside over this, the 3rd Provincial Medical Conference. Being conscious of my shortcomings, I feel all the more gratified that you have bestowed this honour on me in recognition of the little service that I have been able to render to the Indian Medical Association during the 4 years that I have been its Provincial Secretary. I feel I have a right to accept this honour, as your offer indicates that service, however little, should be recognised and rewarded. I feel proud that it has been given to me to serve the Association and help to place the South Indian Provincial Branch on the medical map of India and to get it recognised as representing the medical profession in the Province.

### INDIAN MEDICAL ASSOCIATION

The Provincial Branch has progressed by leaps and bounds during the last three years, the local branches having increased from 5 to 19, and the membership having risen from about 500 to over 1500. I am also glad to announce that the Travancore, Cochin and Mysore State Medical Associations, with nearly 1500 members, have decided to join the Indian Medical Association. Credit for this achievement should go to Dr. T. S. Tirumurthy, our outgoing President, for the spade work he did in Travancore, to Lt.-Col. T. S. Shastri, the indefatigable worker and association-man, for the hard work he put in in these States, and to Lt.-Col. Amir Chand, who gave the finishing touch to their labours by his recent tour of these States.

The strength that this Association has attained upto now is not enough. All qualified medical persons should be on the rolls of the I.M.A. and carry out the decisions arrived at by the Association, as is the case with the B.M.A. in England and A. M. A. in America; it is only then that the public and the Government will give due weight to our deliberations and decisions. For in unity is not only our strength but at times even our very existence. As it is, even Insurance Companies have snapped their fingers at the various resolutions passed at our conferences, and we have helplessly to hang our heads and keep mum. It is this want of unity in the profession and consequent lack of strength in the Association that account for most of the resolutions passed at our meetings and conferences remaining as dead letters. It is also because of this that the Government recognise our existence only

haltingly, consulting us on some matters now and then and heeding to our suggestions only when it suits them. We must become the absolute representatives of the profession, so that the Government might consult this Association on all matters of Public Health and Medical Relief and Medical Education concerning the Province as a whole.

### THE LICENTIATES

I crave your indulgence to deal about the Licentiates at the very outset. I am basically a Licentiate, and though, as Secretary of the I.M.A. for the past few years, I have been the servant of the Profession as a whole, my sympathies have naturally been more with this handicapped last limb of the Profession. Hence I hope you will bear with me while I say a few things about them.

We are extremely grateful to the Government of Madras for the minor reform they introduced at our suggestion, namely, giving gazetted rank to the Sub-Assistant Surgeons recently renamed Assistant Surgeon Grade II. Though this reform is only a small step in the direction of the unification of the Civil Medical Cadre and is not all that the Associations wanted and great strides have yet to be taken to bring about real unification, still this is a unique reform which no other Province or State had thought of, and it may be long before it is followed by others. Thus Madras has again led the country in medical reform, and I hope the Government will accept all our suggestions and thus give a lead not only to India but also to many other countries.

We are also grateful to the Government of Madras for heeding to our suggestion about exempting Doctors' consulting rooms, dispensaries, nursing homes and hospitals from the operation of the Shop Assistants Act as contemplated in the original Bill. We are also thankful for exempting Doctors' dispensaries from the operation of the Sales Tax. In this connection, may I mention that it is unethical for doctors to run dispensaries even for their patients and much more so for others, patients. Though at this stage of development, it may be a necessary evil, it should be liquidated as soon as public dispensaries are available in the remotest parts of the country.

### Indian Medical Council

The Medical Council Act which was passed in the year 1935 under the guidance of the alien Government was left incomplete merely to satisfy the fiat of the British Medical Council which was influencing the then Government. In no country in the World, is there a Medical Council without a Register, except in India. The primary duty of a Medical Council is to maintain a register of all persons qualified to practise medicine, and to see that a certain minimum standard of medical education is imparted. Merely because the British Medical Council would not recognise a large body of medical men numbering nearly 50,000, the Licentiates educated by the Government itself under a 4 years' course, and because the same body would not recognise Graduates of certain Universities like the Andhra and the Mysore, on the ground that these universities did not possess adequate buildings and equipment or were not manned

by professors qualified in England, the primary need, namely, a medical register was omitted. The entire medical profession and the two All-India Medical Associations have been crying themselves hoarse to secure a Medical Register in which all qualified practitioners must find a place. The Indian Medical Council which would not recognise the Licentiates even temporarily for the duration of the War, though such recognition was recommended by the then Government, is now prepared to recognise the Licentiates and have a register and to include the Licentiates also in it. It is gratifying to note that the recent Conference of the Health Ministers held in Delhi has recommended the creation of a Register in which the Licentiates also should find a place, and it is to be hoped that this great reform will be effected without delay.

### Inequalities in Service

Another injustice which our Central Government have perpetrated is to debar Licentiates from getting even temporary commissions in the Army. While even simple S.S.L.Cs can obtain commissions in other departments of the Army, the possession of an additional Licentiate qualification seems to be a bar to obtain a commission in the medical section! These Licentiates were quite fit for emergency kings commissions during the Great War where their services were utilised and appreciated in the various theatres of War, in Europe and in other overseas countries. Many of them have had to sacrifice their practice which they had built up after years of hard work, in volunteering their service to the country at the time of its greatest need. They did so not only to help their countrymen in the fighting lines but also in the hope that after the war their status and position would be safeguarded by the Government. But the Government are now throwing them overboard. Our Provincial Government have gone a step further and declared they are not prepared to take them straightway even as Assistant Surgeons Grade I.

### Unification of Services

It is regrettable that in spite of repeated pleadings and entreaties, our Provincial Government have not seriously tackled the problem of the unification of the medical services. In place of the I.M.S. which was abolished on the 15th of August 1947, we have another cadre created to keep up the number of compartments. The two Associations have been demanding a unified Civil Medical Service to which both Graduates and Licentiates should be recruited alike and treated alike. Instead of this, the Government have created a new cadre which, though it has the dignity of a gazetted rank, still perpetuates the distinction under a more glorified name.

The Government have not seriously tackled the problem of provincialisation of the Municipal, Local Board, and Rural Medical Services. The problem is not taken up under the plea of want of finance and their inability to force these bodies to fall in line with the Government scales of pay, etc. When the Government have enough powers to compel these bodies to conform to Government standards of pay and conditions of service for most of their staff, where is the difficulty in applying the same rule to the medical personnel? Once the standards are the same, provincialisation

becomes easy, for the Government have merely to collect the remuneration and pay it to the medical staff themselves, as is done in the case of the Health, the Engineering and the superior executive staff. This will obviate dual control of the medical personnel and remove them from the baneful influence of party politics and allow them to attend to their work unhampered. Many of the evils of compartmentalism in education and services are to be laid at the doors of our former rulers, the British, who had their own peculiar ways, not only for us but also for themselves. Different grades of medical education are a peculiar feature of the English, while in all other parts of the World, there is only one medical course leading to the M.D., England alone has various degrees and diplomas. This, and with it the different cadres of service to suit their convenience, they imported into India. Now that we are a Free Nation, we have to reshape our education and our services to the present-day needs.

### Primary Health Units

Our Provincial Government are planning to implement the Bhole Committee's recommendations in a small measure by starting 30 Basic Health Units in villages. It is problematic whether they would get graduates to man these Units as suggested by that Committee. With the poor pay offered and the want of amenities in villages, young graduates may be reluctant to accept these jobs. Moreover, they cannot hope to have private practice. If there is dearth of graduates to take up these jobs, Licentiates should be appointed as Basic Doctors, if necessary, after a short training. The youngest Licentiate is at least 10 years old in practice, and there will be no more Licentiates after a few years, for the licentiate course was abolished in our Province 10 years back. Till such time that graduates are available for village work Licentiates must be appointed and these doctors must be paid more than doctors in towns and cities. And this arrangement can at best hold for only a decade or two.

Even for places where a graduate is willing to go, but where there is already a licentiate practising within a range of 5 miles as a private practitioner or a subsidised one, he should be given the first preference to be in charge of the Basic Unit. When medical relief was not available in rural areas, these practitioners were induced to settle down in villages, very often with a subsidy just to keep body and soul together. After years of solitude, sweat, tears and toil, they have built up their practice, and if now a Primary Unit is started in or about their place, these practitioners will have to go to the wall.

### INDIGENOUS SYSTEMS

The Medical and Health policy of our Provincial Government has not been definitely stated. The rationale of the conversion of the Indian Medical School into a College seems to be only to satisfy the clamour of false nationalism. As in all other sciences, like Chemistry, Physics, Mathematics, etc., there cannot be an Indian medicine as well as a modern medicine. Even in agriculture and industry, we want modern agencies and appliances, such as Electricity, tractors and mills; but when it comes to

the question of life and death, it is folly to contend that the indigenous system of medicine which flourished centuries back and have not progressed but have been lying dormant are still the best. If we deceive ourselves into thinking that all modern discoveries were known to our ancients, we shall be living in a fools' paradise. We do not waste our time and energy to find out how our ancients made Akasavimanam, but only try and develop the modern aeroplane. All of us cannot afford to sit in darkened caves and develop the faculty of Gnana Drishti, but must use the modern Radio and Television. What is good in the ancient system of medicine should be absorbed into the modern system, after due test and trial, and not merely because our fathers and forefathers used it. This cannot be achieved by increasing hybrid schools and colleges which cannot stand the test of modern science. There must be research in indigenous systems of medicine by scientific methods and those aspects found useful should be incorporated into modern medicine for the benefit not only of this country but also of the whole world. Our esteemed countryman and able administrator, Sir C.P. Ramaswami Iyer, recently said that during an epidemic of malaria in the Travancore State, indigenous medicines were found as useful as modern medicines. It is a pity that when he was at the helm of a progressive State, he did not think it worthwhile that such a finding, which would have been a great boon to a poor country like India, should be made known to many in this country. His other argument that the indigenous systems are great because a few judges and high-placed men preferred it, cannot hold water. The merits of a system cannot be judged by the idiosyncrasis of a few faddists, but must be decided by research and statistics.

The argument that the majority of our people who live in villages prefer indigenous medicine is not true to fact. They have no facilities to avail themselves of modern methods of treatment, to compare and prefer the one to the other. But where facilities for obtaining both modern and indigenous treatment are available side by side, the greatest rush is at the institutions giving modern treatment, even though people have to wait for hours and can be seen by the doctor for only a minute or two, as so often happens in dispensaries, where one medical man has to dispose of 3 to 4 hundred patients in 3 or 4 hours. The majority of our population who scarcely have one square meal a day do not have any treatment at all when they fall ill. Nature itself cures many ailments. The next largest number are treated with crude remedies by some old lady in the house or in the next house. A large number of others are treated by the village quack who is innocent of any system of medicine. It is only a microscopic minority that is treated by practitioners of indigenous systems who have had some sort of training. But, even assuming that the majority prefer the indigenous systems and hence these should be encouraged, what is their future? Can they stand competition with the modern system which is rapidly pervading the whole World? What measures are there in the indigenous system for preventing epidemics like small-pox, cholera, plague, typhoid, etc.

The Bhoze Committee has stressed that there are no preventive measures in the indigenous system as in the modern system. The World Health and World Medical Organisations with which India is connected will not recognise these systems. Even

for travelling abroad, we require certificates of Physical fitness and vaccination against various diseases, and how can practitioners of the indigenous systems who do not believe in and cannot give vaccinations, issue certificates?

If the Government propose to foster the indigenous system for the sake of sentiment and the modern system for real service, could any Government afford to sponsor two systems? The only course under the existing circumstances of the country would be to synthesise these two systems. This cannot be achieved by creating more hybrid schools and colleges where a smattering of both systems is taught. There should be purely Ayurvedic, or Unani, or Siddha colleges, which should be in the nature of Research Institutes. There should also be "Chairs" for indigenous systems in the Medical Colleges which should function as Research Institutes. I am glad to find that my friend, Ayurveda Visarada V. B. Nataraja Sastri, presiding over the recent Provincial Ayurvedic Conference at Kumbakonam, advocated purely Ayurvedic colleges instead of these combined institutions. The results of these institutes should be scientifically tested and statistics gathered. It will be no good saying that the indigenous systems are God-given and cannot be tested by the mere human beings. With the rapidly changing times, and with the newspapers and the Radio bringing news from all corners of the World to our very door in towns and villages, even the common man will not take everything for granted but would require only the best.

Even in China, which is considered a backward country according to modern standards, the indigenous systems are to be banned. Japan and Russia have ignored these systems. In this connection it is heartening to note the statement of our Minister for Public Health who recently affirmed on the floor of the Legislature that if there had been any specifics in the indigenous methods for diseases like Leprosy etc., the incidence of these diseases would have been much less than what it is now. It is true there are some excellent remedies in the indigenous systems, but they have to be discovered by modern methods and adapted to the present-day needs. For instance, Chaulmagra for Leprosy, Kurchi for amoebic dysentery, Ephedra for Bronchial Asthma, etc. are indigenous drugs adapted in modern medicine.

### MEDICAL RELIEF

With the advent of Independence to our Country, we seem to be suddenly confronted with colossal problems of finding food and clothing and shelter for the millions. These problems have been there for years but were brought to the surface by two global wars, and the responsibility of tackling these became ours on taking over the reins of Government. Solving these problems will solve many other problems including problems of Health. Staggering as these are, they have become more acute by the influx of millions of refugees into the Indian Union from Pakistan, Kashmir and Hyderabad. It may take years for problems of food, clothing and shelter to be solved; but the conditions of health cannot wait till then, and hence these problems will have to be tackled immediately. The previous Government, probably realising that it would have to quit the country soon, and probably to atone for its past sins and to be able to face world opinion, pondered over the deteriorating health conditions

and appointed a Committee, the Health Survey & Development Committee, popularly known as the Bhore Committee, to tour the country, survey the health problems and report to the Government as to what could be done to relieve the sick and the suffering of the land. Being composed of eminent Indians, the Committee viewed the whole situation from a national and international point of view, and suggested sweeping reforms from top to bottom. But even the short-range or immediate 5-years programme suggested by the Committee, which is very meagre in itself, looks financially impossible of achievement, owing to other urgent commitments. Considering that the Health of the Nation is the Wealth of the Country, this programme should be given the highest priority. Any expenditure of this item is investment in gilt-edged security which yields high dividends immediately. The legacy of red-tapism which we have inherited from the previous foreign bureaucracy should be liquidated and quick action taken as during war-time. Till now man-power had no value, as the cost of living was low. With cheap labour and unemployed millions, human life seemed to have had no value in the country; and even if lakhs died of epidemics every year, it did not matter. With the increased cost of living and the rapid industrialisation of the country, the value of life has increased tremendously, and we cannot afford to be indifferent to loss of life due to epidemics and diseases which can and ought to be prevented. The Bhore Committee report states that it is estimated that in undivided India, over a 100 million people or nearly a quarter of the population were suffering from Malaria, and Madras Province may proudly claim a fifth as its share. Taking for granted that a man, treated or untreated, loses on the average about 10 days in the year, we lose 200 million days in a year. It is estimated that the *per capita* income now is Re. 1/- a day and assuming that half the sufferers are unemployed, we still lose a 100 million or 10 crores of rupees. We do not realise this loss as it is spread among the dumb millions. Though it may not be quite possible to prevent this colossal waste except by changing the whole landscape of the country by removing water-logged areas immediately, yet a great saving can be effected by distributing widely and freely potent anti-malarial drugs like quinine, mapacrine and paludrine. That a stitch in time saves nine is never more true than here.

Even though the provision of adequate medical relief for the whole country seems so difficult, a beginning might be made by the following method. The last 1941 census showed that we were 48.5 million strong in this presidency; and assuming that we have not multiplied since as rapidly as usual owing to war and food scarcity, we shall estimate the present population as 50 million. Out of this, about 10 million are catered for by the various city, town, taluk and local dispensaries and private practitioners in the Province. To provide medical relief, for the remaining 40 million at the rate of one Medical Unit for 50,000 of the population, we require 800 Primary Units. Assuming that the incidence would be halved by the suggestion made in the next para on preventive measures and we cater to the needs of only half the population we require 400 Units. Providing each Unit with a man and a woman medical officer may cost Rs. 5,000 per annum; a compounder, a male nurse, a mid-wife and a woman attender, Rs. 3,000/-; medical and other expenses, 5,000/-; temporary

buildings and equipment, Rs. 12000/-; total, Rs. 25,000 per annum for a Unit, and for 400 Units, Rs. 1 crore. It is not very difficult to find the personal and the finance for this scheme. Even with the existing number of doctors, it is not difficult to secure the 800 doctors from the Ex-army medical officers, practitioners in rural areas, and even from the local board hands, who can be replaced from town and city doctors, whose places can be easily filled by Hony. Doctors. If need be, retired medical officers may be requested to give part of their time as Hony. Physicians and Surgeons to relieve doctors in the head-quarters. The problem may be a little more difficult with regard to women doctors, but still the attempt should be made. If there is still difficulty, I would commend, the East Punjab Premier, Dr. Gopichand Bhargava's suggestion of conscription of the paid staff for village work.

Out of the population of 50 million, I do not think more than 3 or 4 million were addicted to drink; but to wean them from the vice, our Government have sacrificed an income of 17 crores per year. Though the Government are losing this amount, still the money is with the masses and will go to better their position and increase their purchasing power. So the Government should increase the general Sales Tax from 1¼% to 2% and reserve the ¾% for medical relief alone, and the amount will roughly meet the medical needs. If this is not adequate I would suggest that Death Duty which is bound to come to our country, should be ear-marked for this work. The rich dying must help the poor living.

### PREVENTIVE MEASURES

If a large number of our people have to be given immediate medical relief, and if the countryside should improve in health, very many young men and women and the indigenous and unqualified practitioners, particularly from the village side, should be given a short course of training, say for 2 years, in Public Health, First Aid, Home nursing and treating minor ailments such as Malaria, Filariasis, Diarrhoea, Dysentery, etc. For such a course the Tamil book *The Village Doctor* written by Dr. T. S. S. Rajan when he was in Jail in 1940, could form an excellent text-book. The booklets in various languages written by Dr. U. Rama Rao on First Aid will also be found useful. They can also be taught to give inoculations against small-pox, typhoid, cholera, plague etc. They can be trained to detect serious illnesses, which they must refer to the nearest Health Unit or nearest qualified doctor. Improving the health conditions of the population and protecting them against epidemics will obviate the occurrence of many diseases. First Aid and Home Nursing will prevent many catastrophes. This alone will be much more useful than starting a number of medical Schools and Colleges.

These trainees however, should not be designated Doctors, lest they should think that they had the licence to use all kinds of medicines including poisonous and dangerous drugs and even for doing surgery. This idea is on the lines of the recent suggestion of our Health Minister that vaccinators and Sanitary Inspectors should be trained to do not only preventive work but also curative, such as giving First Aid, etc., and that they should be put in one category and called "Health Assistants." A similar

suggestion has also been made at the Conference of Health Ministers recently held in Delhi, where it was resolved to recommend to the Provinces to start such a service, which in their view would bring down the incidence of disease by about 50 per cent. In addition to this, the suggestion of the Hon. Dr. T. S. S. Rajan when he was Health Minister in 1938, that health training and health education should form part of the syllabus of training teachers in all the grades, should be given effect to immediately. These teachers should not merely teach the pupils healthy ways of living but should demonstrate them by practical methods and inculcate healthy habits at the very beginning of life. So our Provincial Government should give serious consideration to this aspect of medical relief and take necessary action soon.

### STATE INSURANCE

In most of the civilised countries of the World, the State provides Health Insurance, from the womb to the grave, by providing maternity insurance, infant insurance, education insurance, sickness and accident insurance, unemployment insurance, and old age pension. The previous alien Government never cared for Insurance at any age, not even in the most valuable and productive stage. Thanks to world opinion and thanks to the fact that India was inevitably getting into the international sphere, and of course to the fact that labour was getting organised, a halting measure in the form of Workmen's Compensation Act was passed in the year 1923.

Our leaders soon after assuming the reins of government took up the question of Health Insurance seriously. They have introduced Central legislation in the form of Workmen's State Insurance Act in 1948, which for the present tackles the industrial labour alone and will cover  $2\frac{1}{2}$  million of the population. We are glad to note that the suggestion of the Working Committee of the Indian Medical Association to include the members of the family of the workmen under the purview of the Act has been accepted by the Government. Even so, this reform touches only the fringe of the population, as the majority of our people live in villages and do only agricultural or domestic labour.

### STATE MEDICAL RELIEF

To cater for the whole population, medicine may have to be nationalised, as in England and in Russia. From the point of view of medical men, there are few points in favour of, and many points against, such a scheme. In England, the majority of the organised profession were against such a scheme, and at one stage it looked as though there would be a deadlock between the B. M. A. and the Government. It was, however, realised that the scheme was inevitable, and hence the profession has acquiesced in it and is now co-operating with the Government to make the venture profitable both for the public and the profession. Just as nationalisation of Industries, Transport services, etc., is coming to our country also, nationalisation of medicine may become inevitable, and so we should prepare to safeguard our interests and play our part usefully. Health Insurance of the whole population might look too mighty a problem to be solved now or in the immediate future, but if tackled in the proper way, it should not be so difficult of solution. The Health Insurance Act compels Industrialists to

provide certain amenities for the health and the well-being of their employees by providing them with decent quarters, modern hospitals to treat the sick and the injured, and pay compensation for loss of earning or death due to accident. Though the State has to contribute a moiety under the scheme, the main burden is on the employer. To that extent, the State is saved the expense of providing hospitals to this class of the population, which is mainly concentrated in urban areas. Thus, in cities and towns, the State has to provide medical relief only for the non-industrial population. Hence the Government must divert their attention to the smaller towns and villages. The suggestion made on the floor of the provincial legislature by some enthusiastic city-dwellers that two more big hospitals should be started in Madras to cope with the increased population is a case of the remedy being worse than the disease, as it deals with the effect, not the cause and will attract more people to the city. It is true that the population of cities and towns is increasing at a rapid rate, and the only way to tackle this problem is to wean the population from coming to cities, by providing all amenities such as colleges and courts in smaller towns and making these towns more healthy and beautiful. Our esteemed countryman, Sri C. Rajagopalachariar, who is at the helm of the State as the Governor-General of India, stressed this point in his recent reply to the civic address in Madras, and it is the soundest advice for decentralisation. He pointed out that people flock to towns and cities for the amenities these places provide, and to prevent this he suggested that these amenities should be made available in smaller towns and villages. For us medical men, the amenities are not theatres and cinema houses or parks and pleasure-houses, but laboratories, X-Ray institutes, well-equipped hospitals, and the services of the specialists. Until every district and taluk headquarters hospital is provided with these facilities, which should be freely available to all practitioners, private institutes must be encouraged and subsidised. At least one specialist in each subject should be posted to each headquarters hospital, so that the practitioner and the public could avail themselves of their services without having to rush to the metropolis.

Just as the Workmen's State Insurance Act compels the employers to provide for the treatment of their staff, schools and colleges should be compelled to employ full-time doctors on their staff, at the rate of one doctor for a thousand students. Such doctors should teach the students hygiene and physiology in the class room, examine them regularly once a quarter and keep a record of the health of each student. Early diagnosis of the diseases can be made by this method and referred to hospitals for necessary treatment, and the improvement shown should be recorded. In residential schools and colleges and in separate hostels, in addition to the whole-time medical officers, there must be well-equipped dispensaries and small hospitals to treat the students. This will also relieve the pressure on the Government to a certain extent.

In many not be possible for the Government to extend full benefits of a Health Scheme to the rural population in the near future. But a great deal can be done by tapping private resources for endowing hospitals and maternity homes. This will not be very difficult as the tradition is there saying that giving medical

relief is one of the highest forms of service. Moreover, our Panchayat system was so well organised and the individual was so well attuned to his surroundings that everybody felt it his duty to help the needy and the suffering in his locality. The custom still persists in many villages, where the labourer's weal or woe is shared by his master, the land-lord who is bound to make a contribution on the occasion of every event in the labourer's family. With this back-ground, it will not be difficult for our Government to tap public charity and evolve a scheme of Health Insurance for the whole country by tapping the generosity of the haves for the benefit of the havenots.

Inadequate and underpaid as the medical men are, still many practitioners are willing and eager to give a part of their time for the service of the State in an honorary capacity. Their services should be utilised to the fullest extent.

### MEDICAL EDUCATION

The Bhore Committee has recommended the Degree as the minimum qualification, and the entire medical profession has been clamouring to have one standard of medical education. This has been accepted by the Indian Medical Council and it has also been taken for granted by the committee appointed by our Ministry last year to consider problems of medical education; and in anticipation of this, the previous Congress Ministry in this and many other provinces had abolished the medical schools. It is now whispered that our provincial Government is contemplating to revive the medical school education. We hear that the Central Provinces Government are contemplating to go a step further and have a school course of only three years, the products of which will not be eligible for any registration but still will be called doctors. The plea put forward is that the country, particularly the poor in rural areas, needs cheap doctors and the Government must mass-produce them. Human life is as valuable in a village as not more so than in a town, and it is an insult to the rural population to say that they require cheap doctors. We who live in urban areas are almost like parasites living on the villager, and to say that we in towns and cities should have all the good things in the world and those in the villages should be satisfied with cheap and nasty things is the height of ingratitude. And, after all, cheapness in medical relief, as in all things, is costly in the long run, it costs loss of life itself.

There should be only one standard of medical education, which should extend to at least five years. Many more colleges should be started in the Province, and the Government should not waste money on brick and mortar or on massive structures but must reduce construction of buildings to the minimum. Buildings should be designed and built to last only for 20 to 25 years, for with rapid progress and change of ideas, what is good and useful now may become out-dated and out-moded after a few years. If there is any difficulty in obtaining recognition from Universities for want of massive buildings and structures, the Government might run their own colleges and grant diplomas as was done in the case of schools and as is still done by private bodies in England. These diploma-holders should have equal opportunities with University graduates both for practice and service under Government and other public and private bodies. If medical education cannot be entirely free as in Russia, at least

it must be cheap and within the reach of the average man. Even then, at least 30% must get medical education free, in order to enable brilliant but poor students to get medical education. In return for it, they must agree to serve for not less than 5 years in rural areas. The cynic may say that very often persons who pass high examinations are failures in life, and so holding academic qualifications is no criteria for admission into medical colleges. Until other standards of testing merit are found, success at examinations should continue to be the test of merit, whether merit and success in life always go together or not. In order to help inherited inclinations and save investments made, children of medical men should be given preference in cases of equal merit. In this connection we are sorry to note that our Government have abandoned admission on merit altogether and also postponed the opening of the medical colleges in Madura and Guntur, which would have given us at least 150 doctors per year though only after 5 years.

### POST GRADUATE COURSES

Our country is very backward in this matter. Post-graduate courses are given in different countries in various ways. In England, post-graduate courses are full and intensive, varying from one to three years, and ending with the grant of a diploma after examination, and these are open to University graduates and diploma-holders alike.

For post-graduate training, I would prefer the Vienna method, where a medical man can specialise in any subject he chooses for as long as he wants. This can be done in well-equipped city hospitals where there are specialists. The services of these specialists should be paid for decently by those who want to specialise. The rate of fees for these specialists or their assistants can be fixed per hour, and the amount divided among the students undergoing the training. This will compensate for the loss of private practice, which will have to be enforced sooner or later. Competition to train up more specialists, will induce the professors to put in their best to attract more trainees. Persons possessing post-graduate or specialist training may be granted diplomas to indicate in what subjects they have specialised. This need not necessarily be after a stiff examination. There are many anomalies in these examinations. The Indian Universities in general, and the Madras University in particular, try to find out what the student does not know rather than what he knows. In 1938, while I was in England, a colleague appeared both for D.O.M.S. (London) and D.O. (Oxford), and though the D.O. examination was considered the stiffer of the two, he passed the D.O., but failed in the D.O.M.S. The agency for arranging these trainings can be either the Government or a private body like the Indian Medical Association. In Vienna, the American Medical Association does this work, and the Universities and Government permit their staff to undertake this work. I hope the Indian Medical Association will take up this work.

### REFRESHER COURSES

In England refresher courses consist of lectures at University centres, and are optional. For refresher courses in our country, I would suggest the American method

of making every Headquarters Hospital a centre for refresher courses arranged at convenient periods of the year in two or three batches. Eminent medical men, preferably from teaching institutions, must be deputed to these centres to deliver lectures or rather hold classes for about a week in each subject, giving the practitioner a general idea of the latest developments. These medical officers should be treated as on official duty and be paid their travelling and other expenses. This will facilitate practitioners to attend these classes without much sacrifice of their time and money. Medical men and women, whether they are in service or in private practice, must be compelled to attend these refresher courses, at least once in 5 years. Registration of medical men should be valid for 5 or 6 years only, after which re-registration must be sought. Persons who have not undergone the refresher course should not be registered. This will not only raise the standard of work, but will also enable the keeping of correct and up to date registers.

### MEDICAL RESEARCH

It is a matter for regret that India has contributed but little to world knowledge by medical research. It might be true that till now the alien Government did not give scope for Indians to do research, and what little could be done in spite of this handicap was labelled with the name of the English I.M.S. head of the department. Now that we are free, research must go on unimpeded. For this research scholars must be paid amply so that they should have no worries about finding food for their families, and they should be provided with ample facilities to carry on their work. It is true that we have a few world-famous Institutes in India, such as the School of Tropical Medicine, the Haffkine Institute, the Guindy Institute, and the Pasteur Institute, but they are far too few for such a large country as ours. Every college must have its own research department, besides many more Central Institutes. Government alone cannot afford to start and run research institutes. Philanthropic millionaires must come forward for this work. Industrialists, particularly in the medical field, must include research departments in their factories. Some of the latest medical discoveries of the present day such as the Salvarson, the Sulphanamides, Liver Extracts, Mercurial diuretics, were discovered by such industrial research institutes. Then it will not be difficult for us to produce a medical Ramanujam or a surgical Sir. C. V. Raman. It is only then that India can find an honoured place on the medical map of the World.

I would here like to place on record the irreparable loss that the country has sustained in the ultimately demise of Yellapragada Subbarao in far off America. He was an Alumni of the Madras Medical College, and after taking his Ph. D., in London, was doing research work in America, and just as he was getting to be recognised as one of the outstanding world figures in Bio Chemical Research, the cruel hand of death had snatched him away. It seems to be an irony of fate that some of our brilliant men should be taken away quite early in their lives and just as they begin to show that they world leaders. I am sure the conference will pass suitable resolutions on the subject and the profession will do the needful to perpetuate his memory.

### MEDICAL INDUSTRIES

Another great handicap is that we have no allied industry in this country worth the name. This defect came to the surface during the World War, when we had merely to look to the sky and pray that our medical supply ships should escape the enemy submarines and magnetic mines and reach our shores safe and deliver the goods. It is true that there are a few manufacturing firms but they are far too few to meet the needs of the Country. Many more concerns should be established all over the country to meet the needs of the profession and add another stone to the edifice of economic independence. In this respect, Madras seems to be not quite fit for this kind of industry, for while other provinces have progressed at least to some extent, Madras is no-where in the picture, probably because we are more politically minded than industrially, and are experts only in quill-driving. However, with the annihilation of distance by rail and plane and the unity of India assured, it does not matter where these industries are started; it is only the concern of our local industrialists not to lag behind.

### MEDICAL ADMINISTRATION

We are glad that the medical portfolio is in charge of the Hon'ble Mr. A. B. Shetty who is gentleness and peace personified. My only complaint against him is that he is too good and too kind-hearted. I have a suspicion that he is a vegetarian, otherwise he would have demanded his pound of flesh from the Finance Department at the time of the last budget, instead of being satisfied with what was rationed to him, a mere Two crores and odd. The smaller local bodies are expected to spend 12½ per cent of their income on health and medical departments, and the major municipalities should set apart 30 per cent for this work. Normally, Governments are expected to spend a minimum of 15 per cent and up to 50 per cent of their revenues on the prevention and cure of diseases. But this year, the medical department got only about 4 per cent of the revenue for this work. Dr. R. M. Mathews our Director of Public Health finds that the present allotment for preventive medicine works at 1 anna 3 pies per head, just about the cost of one Iddili and Chutney. I take it, one anna will go to cover the remuneration of the staff and so only the pungent chutney is left behind to deal with the prevention of diseases. One redeeming future about the Hon'ble Minister is that he has an open mind and invites advice from the organised profession. The South Indian Provincial Branch along with the Andhra Provincial Branch is constituting a Standing Committee to represent the I. M. A. in this Presidency, and I am sure the Hon'ble Minister will consult this Committee on the various problems which he will have to tackle in the near future.

As Surgeon-General of the Province, we have in Col. S. L. Bhatia, a highly cultured and sympathetic officer who is a gentleman to the core. We expect he will advice the Government correctly and then carry out the policies chalked out by the Ministry without fear or favour and administer the Province for the good of the profession as well as the people.

# The Third South Indian Provincial Medical Conference

## OPENING OF THE EXHIBITION

SPEECH BY

DR. U. KRISHNA RAU, M.B., B.S.

I am extremely grateful to the Reception Committee for the signal honour they have conferred upon me in asking me to declare this Exhibition open. It would have been more fitting and appropriate if the choice had fallen on one who is in power and authority, for it not only would have afforded him the opportunity to know firsthand how much lee-way India has yet to make if she is to be on a par with other nations in regard to her essential requirements of drugs and medicines, but it would have also induced him to persuade his colleagues in the Government to turn their immediate attention to this all-important matter and to do everything in their power to advance the cause of the Indian Pharmaceutical and Chemical Industries. But probably the Reception Committee thought that a member of the profession would be in a better position to speak from his own personal experience of the many shortcomings and difficulties under which the profession has to labour as a result of the callous indifference shown in the past by our administrators in this most vital matter. But even here there are many who are much more competent and capable than myself, who can catalogue the various acts of omission and commission in the past and make suggestions to remedy the present state of things and to bring about rapid improvement. If, in spite of this, the choice has fallen on me, I take it to be the result of the love the Committee has for me. I therefore, value the honour all the more and I give you this assurance that I will do everything that is possible for me to do to help advance the cause we all have so much at heart.

If we study the history of industrial development in various countries, we would find that exhibitions of the kind that has been organised here have played no mean part in bringing about rapid improvement. They widen our outlook; they increase our knowledge; they open our eyes to the possibilities of large scale development; and, above all, they create in us the spirit that is needed to bring about an improvement in the position, by utilising the facilities that are available in that direction. But for exhibitions, the knowledge that they had inculcated, the possibilities that they had shown, it is very doubtful if the industrial history of the world would be what it is today. While other nations in the West had considerably profited by these, our country has unfortunately remained stagnant due to causes which are fairly wellknown and into which it is unnecessary for me now to enter.

We became aware of our helpless position during World War I when our main sources of supply were cut off, and our unfortunate country was placed in a most awkward predicament. It is very doubtful if the ravages of the influenza epidemic

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towards the close of the twenties of this century would have been so great but for this stoppage and for our absolute dependence on allied nations for even our most elementary requirements of drugs. Some show of an attempt was made to encourage indigenous industries and make the country self-sufficient in the matter of her requirements. But immediately peace was established all these measures were dropped like hot potatoes and many of the Chemical and Pharmaceutical industries that were started in this country during the war period subsequently languished for want of nourishment and faded out of the picture altogether. This naturally had its own reactions in the country, and nobody was willing to come forward to start chemical and pharmaceutical industries in the face of the step-motherly attitude shown towards them by the Government, and when World War II broke out the country found itself again in the same pitiable position. And the then Government realised the folly of its predecessors and came forward to encourage indigenous industries, with the definite and positive assurance that such help would be continued even after the emergency which had forced their hands had ceased to exist. And if today the country is better off to a certain extent than before it is not a little due to the adoption of this policy. The country would be much better off, the chemical and pharmaceutical industries would have stood still higher up in the rank, had not the Government stuck to the letter of their promise but adopted the spirit of it. But, no, it is too much to expect of an alien government which always had an eye on the industries in its own country.

Fortunately for the country this state of things has ceased to exist; the shackles that had bound us hand and foot together have broken down; we have attained absolute freedom to shape our policies on lines we consider best in national interests. But this freedom, this independence from foreign exploitation and control, has added considerably to our duties and responsibilities. It is no longer a question of assembling once in a year, criticising the administration for its various acts of wilful omission and commission and dispersing with the self-satisfaction of having done our duty. We have to sit together, discuss the needs of the profession and the country, evolve suitable plans, put forward practicable and concrete proposals and plead with those at the helm of affairs with all our strength to implement them without delay. And all proposals so evolved and formulated are bound to receive the sympathetic and favourable consideration of our Ministers both at the Centre and in the Provinces. Therefore the responsibility for making the Government see eye to eye with us and implement the proposals we put forward have now devolved on us. Let us therefore, rise to the fullest heights the noblest of the professions demands of us and prove ourselves worthy of our ancient and glorious heritage.

The first and foremost requisite for the development of an industry in any country is the adoption of a sound plan based on national interests and the following of a liberal and broad based policy of protection where new and nascent industries have to face the serious competition of powerful rivals who are far advanced in the field and who have the strong backing of their respective governments. You will remember that as a result of the Report of the Industrial Commission which carried on an elaborate investigation all over the country in the thirties, it was laid down as

the policy of the Government that protection should be afforded to industries for which raw materials are available in the country. Considering the outlook of the then administration and the position that existed in the country previous to that such a declaration might then have been welcomed by many as a great step forward. Has any such halting policy been adopted in any other country which was bent on industrialisation? Never. Let us take the case of England itself. Not one cotton plant is grown in England. It has to depend for all its cotton requirements on other countries. If the policy that was laid down for India had been followed in England we could not have heard of the cotton industry in Manchester. Not only did England not follow the policy that was laid down for India, but she even went out of the way to put down the cotton industry in India which commanded then the greatest admiration of the whole world. The policy laid down in the thirties still holds the field for all practical purposes in spite of new declarations and it should be given up once for all and for ever. Every industry which is in national interest should be encouraged and protection afforded to it to safeguard it from powerful rivals, whether the requisite raw materials for its development are available or not in the country. And in making trade treaties with other countries, national interests should weigh supreme and nothing should be done which would affect existing or new or nascent industries. The Pharmaceutical and Chemical Industries come under this category, and with the painful experience which unfortunately was our lot during the two World Wars and with another War threatening the world—God forbid it!—it should be the main concern of the Government to see that not only that nothing is done to affect the prospect of the growth of these industries in the country but also every help and protection is afforded to them so that in a short period India can not only be self-supporting but also able to hold her own against powerful rivals.

Such a bold and forward policy laid down, the next important step is the establishment of Pharmaceutical and Chemical Industries under the protective wing and the financial backing of the Government, wherever necessary, making full use of the services of Pharmacists now available and who are likely to graduate from the colleges in the near future. It is a pity that even the services of the few now available have not been made proper use of. At the same time it is no good disguising the fact that the Pharmacy graduates who have come out or are likely to come out of colleges under the present scheme of things are not sufficiently equipped with enough practical knowledge, that they labour under a serious handicap. It is the bounden duty of the Government to arrange for the practical training of these Pharmacy graduates in Government Stores or other well-equipped factories. May be there are not enough men who can give them that practical training for the production of drugs on a large scale that the trade requires. In that case it will be worth while securing the services of competent men from abroad on contract basis so that they can not only give practical training to the Pharmacy graduates but also prepare a large number of them to undertake that work in the future. We, of the profession can do a lot in this field. It must be possible for many of us to start Pharmacies or a co-operative basis in our respective areas, and availing ourselves of the knowledge

which advances in research have made and are making available to us, produce drugs at a comparatively less cost and make them available to the public at fair and reasonable prices. Drugs should be standardised to ensure their purity and efficacy, and spurious drugs must be altogether eliminated from the market. Many such spurious drugs and so-called patent medicines as the sure panacea for this or that disease have been largely propagated by wide publicity that many have begun self-drugging on the strength of the statements made in advertisements with results only too well known. To eliminate these altogether, strict control over advertisements is to a certain extent needed and necessary. The Drugs Control Act and the Rules made under it by the Provinces are no doubt good in their own way, but it cannot be said with any measure of certainty that they are scrupulously followed. I shall take, for instance, Rule 71 of Madras Drugs Rules. It lays down that no licence shall be granted for the manufacture of drugs unless the licensing authority is satisfied that the manufacture will be conducted under the active direction and personal supervision of a competent technical staff consisting at least of one person who is a graduate in Pharmacy or Pharmaceutical Chemistry, or a graduate in Science who has studied chemistry and has had practical experience in the manufacture of drugs, or a person whose general training, knowledge of chemistry and practical experience extending over not less than three years in the manufacture of drugs are, in the opinion of the licensing authority, adequate. It is quite possible that some manufacturing concerns which had carried on without expert assistance and supervision before the introduction of these Rules might have arranged with a qualified person to lend his name to satisfy the Rules and secure the licence. There should be no room for such loopholes, and constant inspection by officers will be necessary to see that the Rules are strictly followed. It is also necessary to test occasionally whether the drugs manufactured and retained for sale continue to maintain their potency and efficacy. Only when there are a sufficient number of touring officers can this be done effectively. Also it is necessary to ensure that indigenous drugs are properly and effectively controlled. It is quite possible to escape from the clutches of the Rules by using allopathic drugs and adding some indigenous drug and then calling it indigenous drug to escape attention and scrutiny. Such possible and probable malpractices must be put a stop to.

These and many other points are bound to receive your earnest attention at the Conference and I trust you will consider them in all their bearings and carry through necessary resolutions. I thank you once again for the great honour you have done me and have now great pleasure in declaring the Exhibition open.

JAI HIND

## INAUGURAL ADDRESS AT THE SCIENTIFIC SESSION

BY

Surgeon General Col. S. L. BHATIA

LADIES AND GENTLEMEN,

I consider it a great honour to have been invited to open the Scientific Session of this Conference today. I greatly appreciate this honour and am truly grateful for it.

You have a very interesting programme before you which covers a vast range of subjects. There is the symposium on the important subject of chest pain; there are papers on sterility both in the male and female; treatment of cardio-vascular syphilis; industrial medicine, electro-encephalography as well as a symposium on disorders of micturition, in which lectures on their surgical gynaecological, venereal, medical and radiological aspects are to be given. In the final session you have discourses on Anterior Poliomyelitis, extravacation of urine, management of common nasal complaints and anti-histamine drugs in general practice. Distinguished members of our profession are participating in all these symposia and discussions and we all look forward to a most interesting and instructive scientific session.

May I take this opportunity to remind you, that India has already made great contributions to the Science of Medicine. This is an achievement of which we may well be proud. Confining ourselves to recent times, I need only refer to the work on Malaria, Cholera, Plague, the Dysenteries, Leprosy, Leishmaniasis, Indigenous drugs, etc. Madras itself has played a noble part in the advancement of medical knowledge, especially certain Tropical diseases.

I am sure it is the desire of all of us, that, taking our inspiration from our past traditions, we should continue to play our part nobly, in extending the boundaries of medical knowledge. I therefore wish to make a strong appeal for the vigorous prosecution of medical research in India.

There is no doubt that there is an urgent need for the improvement and development of Medical Research in our country. So far, with some notable exceptions, it has been confined largely in a number of research institutes, which speaking generally have remained more or less aloof from the teaching hospitals and Medical Colleges. It is in the Medical Colleges that Medical Research needs to be specially organised and encouraged.

Amongst the recommendations for the organisation of Medical Research in India, the Bhore Committee suggested the establishment of an All-India Medical Institute with the following objects:—

1. "To bring together in one place educational facilities of the highest order for the training of all the more important types of health personnel and to emphasise close inter relations existing between the different branches of professional education in the field of health.
2. To promote research of the highest type in all the branches of study for which the institute will be responsible.
3. To co-ordinate training and research.
4. To provide post-graduate training of an advanced character in an atmosphere which will foster the true scientific outlook and a spirit of initiative, and
5. To inspire all persons who undergo training, undergraduate or post-graduate, with the loftiest ideals of the profession to which they belong and to promote in them a community outlook and high degree of culture, in order that they may become active apostles of the progressive spirit in whatever field they may be called upon to serve, whether it be teaching, research, general health work or administration."

These proposals have been carefully considered by the Government as the result of which they were referred to a Committee, who recommended that apart from the establishment of a new All-India Medical Institute as contemplated by the Bhore Committee, certain departments of the existing Medical Colleges should be upgraded so as to make them centres of post-graduate instruction and research. We have had a visit from the members of the upgrading committee recently, whose recommendations are awaited with much interest.

Apart from the necessity of suitable buildings and equipment which are essential for the prosecution of research, there is of course, the imperative need of trained personnel, with necessary scientific outlook. I have full confidence in my country and my profession and I can say boldly that given the necessary facilities, we can do medical research of the highest order here. There is no lack either of talent or initiative. These exist in abundance.

Another essential condition of development of research in the provision of adequate funds. I trust this money will be available. Apart from Government may I appeal to the philanthropic citizens of our great country to render financial assistance on an increasing scale for the prosecution of medical research. Much has been done in this respect in the past, but much more still remains to be done.

In our future programme of research we should give a high priority to two subjects, namely, Clinical Research, and Research in Indigenous drugs. Both these subjects are sure to reward the investigator with a rich harvest of fruitful results. What is needed most is an open mind on problems which await investigation, and to try to solve them in a true scientific spirit. Science as you know is knowledge which is based on facts, which are ascertained by observation and experiment. From

these facts inferences are drawn and general laws and principles are formulated into which these facts can be fitted in. "Facts are the air of a Scientist" said Pavlov, the celebrated Russian Physiologist. "Without them you never can fly. Without them your theories are vain efforts." Science concerns itself with truth. The social importance of medical science is that it enables us to gain mastery over disease, and thus enables us to raise the standard of health of human beings. Medicine stands on a higher pedestal than pure physical science, for it is a wholesome combination of science and humanism. The medical investigator thus is doubly blessed, for it is not only the discovery of Truth which is his aim, but also that the Truth he discovers ultimately helps to remove sickness and suffering from this world, and is thus an instrument for the promotion of happiness of all mankind.

That is the high and noble aim then of all those who have assembled here this afternoon. I have much pleasure in declaring open the scientific session of the Conference, and I wish you all the very best of success in your deliberations.

### SOUVENIR OF THE THIRD SOUTH INDIAN PROVINCIAL MEDICAL CONFERENCE

This excellently got up book giving various information about medical and allied institutions in the City of Madras contains a number of photographs of persons and institutions in South India.

A few copies are still available for the members of the profession and the price of a copy is Rs. 2/- Doctors desirous of possessing one may address Dr. M. R. Bail, Hony. Treasurer, Indian Medical Association, Madras Branch, 32, Muker Nallamuthu Street, George Town, Madras.

P. A. S. RAGHAVAN

*Managing Editor.*

The Madras Medical Register for the year 1947 was published as a Supplement in the Fort St. George Gazette dated 11.5.48. The Register for 1948 is under preparation. Practitioners are requested to scrutinise the Medical Register for 1947 as appearing in the Gazette and to report to the Registrar forthwith any mistakes of omission or commission regarding, especially their names, qualifications and addresses.

V. GOVINDAN NAIR,

*Registrar, Madras Medical Council.*

November 1948]

### WELCOME ADDRESS AT THE SCIENTIFIC SESSION

BY

DR. P. T. RAGHAVACHARI, M.B.B.S.,

*Secretary, Scientific Section at the inauguration of the Scientific Session of the III S. I. P. M. Conference on Friday the 22nd October, 1948 at 2. p.m.*

Mr. President, distinguished visitors and delegates of the All-India Licentiates', and Indian Medical Associations.

On behalf of the Scientific committee and on my own behalf I hereby welcome you the distinguished guests and delegates who have gathered here and thank you for the response so generously extended to our invitation.

A scientific section constitutes a regular and an important feature of our conferences. It assumes an added importance when it is held in a city like Madras, which possesses well equipped hospitals and teaching institutions with great traditions, manned by well known specialists and eminent professors with high academical qualifications. In the organisation of this scientific section, I have drawn freely from the abundant resources of these institutions.

I am happy to say that I had the goodwill, wise guidance and whole-hearted co-operation of all those medical men and women whom I approached and I take this opportunity of thanking them publicly for the help rendered.

In drawing the programme, the scientific Committee has set the scientific programme at the level of the general practitioner, to keep the general practitioner abreast with the progress on the various branches of the medical sciences. Also opportunity has been given to the members to present scientific papers, of merit and interest to the general practitioner, during this session.

A good portion of the time allotted to the symposium has been set apart for a profitable discussion of the subjects by the members.

I earnestly request the members to make their valuable contributions to the discussions and thus make the session a great success.

In addition arrangements have been made with the kind permission of the Principal and the professor of Anatomy and Pathology of the Madras Medical College, to have their museums open during the conference sessions for the benefit of the members of the profession.

The United States Information Services have kindly agreed to show us the following highly technical films:

1. Dynamics of Respiration
2. Perineal Prostatectomy
3. Prefrontal lobotomy
- Laboratories
4. Cholelithiasis with stone in the common duct.

The Lederle people will be showing us their films on Folic Acid and the Ciba firm their films on Coramine and spinal anaesthesia.

Gentlemen, it is needless to point out that we should strive to maintain our medical knowledge at a high level by regular reading, by attending refresher courses whenever available and by attending and taking an active interest in the clinical meetings and conferences of our association. It is incumbent on us to add our knowledge and experiences to the common pool and thus contribute to the advancement of medicine and raise the status of our country in the medical world. Even a general practitioner can contribute his own share to the knowledge of the various diseases and their treatment. This is a duty we owe, gentlemen, to our profession. A good many members of our profession are still hesitating to join our ranks. I trust that they will all soon join us, when once they realize that their duties to the citizen, the profession and state could only be performed efficiently by being members of the Indian Medical Association, an association which represents all sections of the medical profession of India.

The mere acquisition of scientific knowledge is not enough to practise a scientific system of medicine. The progress of modern medicine has been so rapid that the general Practitioner requires a number of ancillary methods of diagnosis and specialist aid in order to treat the patients efficiently. In many cases patients can not afford to pay for the various investigations and technical assistance and a specialist aid. It is here, that the Government, Municipalities and local bodies should help the individual doctor by making available free of charge or at nominal charges the facilities which the individual doctor could not provide for himself. Or they should create conditions in which the individual doctor can make effective contribution to the common good. I am afraid that till such facilities are easily made available the standard of medical relief will not be of a high order.

It has been frequently said that medical relief by the practice of scientific system of medicine is costly and therefore other systems which are less costly should be utilized for the benefit of the rural population. Cheapness is desirable in medical relief as in so many other things but never at the cost of human life. I feel that with the help of the state, means may be devised to make the medical relief less costly and make it available for the poorest of the rural population.

We are fully aware of the economic and financial difficulties of the state. But our plea is that these factors should not be allowed to unduly delay the initiation of nation building activities.

Apart from this, in order to raise the standard of medical relief, the members of the medical profession, whether they belong to the Public Health service or the Government service or to the ranks of the general practitioners should all cooperate supplementing each others' work. It is only lack of appreciation of each others functions that leads to conflict and misunderstanding among the various groups of members of our profession.

The relation between both the medical profession and the state must be as cordial and as personal as can be accomplished.

The state has a right to expect the whole-hearted co-operation of the profession in keeping the nation healthy, and the profession has equally the right to expect the co-operation of the state by providing facilities for health relief, refresher courses, post-graduate education and medical research.

Has not the Father of our nation, Mahathma Gandhi laid down that the rights of man accrue by duties well performed and should not the axiom equally apply to the rights and duties of our profession?

Ever since Col. Bhatia, assumed office as the Surgeon General of the province, he has been evincing such great interest in the medical relief and public health matters, in the medical education and in the welfare of the medical profession that the Executive Committee of the Reception Committee was eager that he should inaugurate this scientific session of the III S. I. P. M. conference and take part in the activities of this section.

Col. Bhatia is a distinguished member of our profession and our association. For his public work, he has been honoured by the State by conferment of high titles. We are proud to note that for the scientific contributions he made he has been made a Fellow of the Royal Society and a fellow of Royal College of Physicians, London, the highest position that a member of our profession, from this country could aspire to. By his interest in the medical services both paid and unpaid, he has gained the gratitude and warm affection of the medical profession of this presidency.

We consider it an honour and a rare privilege to have him to inaugurate this session. We are thankful to him.

Thank you ladies and gentlemen.



### THIRD PROVINCIAL MEDICAL CONFERENCE OF THE SOUTH INDIAN PROVINCIAL BRANCH OF THE INDIAN MEDICAL ASSOCIATION

*Resolutions passed at the Open Conference on Sunday the 24th October 1948.*

1. Moved from the Chair.

This Conference places on record its deep sense of sorrow at the demise of Mahatma Ghandhi, the father of the nation, a World figure and non-violence and peace personified.

The resolution was passed all standing for 2 minutes.

2. This Conference records with regret the passing away of the following members of the Indian Medical Association and conveys to the members of the bereaved family its sorrow and sympathy.

1. Dr. M. Venkatachalam Chetty of Madras.
2. Dr. M. Devaji Rao of Madras.
3. Dr. O. R. Balu of Trichinopoly.
4. Dr. S. N. Neelakantan of Chingleput.
5. Dr. T. A. Venugopal of Bangalore.

3. This Conference places on record its deep sense of sorrow at the untimely and sad demise recently of Dr. Yellapragada Subba Rao, L.M.S., Ph.D. (Harvard) in Chicago, one of the world famous scientists, and resolves to appoint a sub-committee to take necessary steps for perpetuating his memory by founding a Bio-Chemistry Institute in the city of Madras.

The Committee consists of President, Secretary, Jt. Secretary, Drs. U. Krishna Rao, Velappan, S. Chandrasekaran, S. Balasundaram, P. Guruswamy, and Col. Shastry, as convener.

4. This Conference requests the Government that in order to employ the requisite number of doctors in the Health Units, the services of those who are within a radius of five miles be requisitioned and that for purposes of facility and convenience Licentiate be made the basic doctors by virtue of their merit and experience.

5. This Conference views with great concern the starting of a medical school in Nagpur with a shortened course of three years much against the policy of our Association of not having any further caste in the profession and its constant endeavour against lowering the standard of medical education.

6. This Conference emphatically protests against the continuance of the Indian Medical Council Act of 1933 as it excludes from its purview medical Licentiatees and strongly urges upon the Central Government to so amend the act as to include the Licentiatees and bring into existence an All-India medical register with the names published in an alphabetical order.

7. This Conference requests the Government of Madras to extend the same privileges and status existing in the Madras Medical Service to the other services such as the Local Boards, Municipalities and to see that they are paid the same salary and emoluments till the provincialisation of the services is brought into effect.

8. This Conference resolves to address the Central Government that the Asst. Surgeons, Grade I of the State Railways must be gazetted as in other Provincial Medical Services and must be treated on a par with other Asst. Officers of other departments of the Railways such as Engineering, Traffic, Mechanical etc., as the Railway Service is also a Government Service.

9. This Conference resolves to address the Central Govt. that the unification of the cadres of Asst. Surgeons Grade II (Sub Asst. Surgeon) and Asst. Surgeons Grade I must be similar to that of the Madras Govt. as per their G.O. dated 13-7-48 and their scales of pay also be raised from Rs. 100/8-140-10-170 EB-10-230 to Rs. 150-10-2-170-15/2-230 and remove the EB now interpreted in the present state of the Railway and the service of Grade II men, also should be gazetted.

10. This Conference resolves that the practice of direct recruitment of District Medical Officers to Railways must be given up forthwith and make open the avenue of promotions from among the senior subordinates and Asst. Officers to the District posts abolishing the present percentage system as all other departments and in Provincial Governments.

11. The following resolution was discussed but was not adopted. This Conference requested the Govt. of Madras to admit 30% of the candidates for admission into the Medical Colleges if they give an undertaking to work in rural areas for at least 5 years.

12. The following resolution was discussed and passed by majority.

This Conference requests the Govt. of Madras to post service men to Rural and Local Board Dispensaries instead of closing down these dispensaries, and replace these medical officers in towns and cities by Honorary Medical Officers.

## The Madras City Government Compounders' Association (Regd.) Madras

### WELCOME ADDRESS

BY

MR. M. WILLIAMS, (*Secretary*)

On the occasion of the Provincial Compounders' Conference held on the 24th October '48 at Medical College, Madras.

Mr. President, Gentlemen and Brother Delegates,

It is with a great sense of joy and pleasure I welcome you all to this historic Conference. We meet here for the first time in this metropolis which is in the vanguard of progress. It is very kind of Dr. K. Narayanamurthy, M.D., our President to have consented to preside over this conference. We are quite aware of his great interest in our welfare and his sympathy for our profession. We are greatly indebted to him for all his services. Our thanks are also due to Col. S.L. Bhatia, our Surgeon-General who has evinced great sympathy for us and who ought to have inaugurated the Conference but could not do so, and hence Lt. Col. Sangam Lal has kindly consented to inaugurate this function. This augurs well for us as this gives us an opportunity to voice our grievances through him to our Government for redressal.

We have assembled here to bring to the notice of the powers that be, our genuine grievances and to seek redress at their hands. We are a neglected section of the medical profession though our sufferings are fully appreciated by the public who come into contact with us daily. There is no gainsaying the fact that we form a branch of the noblest of professions and do yeoman service to the public in silence. It is a pity that our profession, which is next to that of a Doctor, remains unrecognised. We all know that a compounders' job is as responsible as any other profession and yet no sympathy is paid for this profession even by medical reformers. We are unable to understand the antipathy of the Government towards us.

Though we are designated as compounders, besides dispensing medicines, we are called upon to do the duties of nurses, store-keepers and clerks. This is invariably true in the case of compounders in the mofussil towns.

Our work is heavy and responsibility great, but the reward is very poor and discouraging. Further, the nature of our service is such that there is no prospect of any promotion to any higher cadre, nor is there any provision to get into other branches of the profession.

In this connection it may be pointed out that sufficient candidates are not attracted to this profession for the simple reason that the remuneration and conditions of service of a compounder are not quite attractive and encouraging. The fact that those candidates who had training under private medical practitioners for four years are eligible to become compounders will bear testimony to the above statement that the profession remains unattractive.

November 1948]

WELCOME ADDRESS

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In this connection, we may be allowed to suggest that the services of well-experienced compounders could be utilised for social services under Rural Development Schemes, as Sanitary Inspectors and Male Nurses after giving training for a short period. This will open new avenues for youngsters with good qualifications and thus relieve the present dearth for compounders.

It is needless to mention the high cost of living in a city like Madras with its attendant difficulties. So we appeal to our Government and those interested in the profession to come to our help and do the needful. We are aware of the financial commitments of our Government. Yet we, the compounders form a small important group of loyal workers and we request the Government to redress our grievances and keep us satisfied and contented.

In conclusion, I once again accord you a hearty welcome. I hope we have done our best regarding the arrangement for this Conference and I am sure our honoured guests and brother delegates will bear with me for any shortcomings.

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## PRESIDENTIAL ADDRESS

DELIVERED BY

DR. K. NARAYANAMURTHI, M.D.

on the occasion of the Provincial Compounders' Conference held on 24th instant at the  
Madras Medical College Common Hall.

FRIENDS,

You have met to-day under the auspices of the Madras City Government Compounders Association to consider the various means and methods by which you could focus the attention of the Public and the Government that the Compounders tho' they belong to the noblest profession have now come to be neglected body. Repeated representations made by the parent body of our association, the Madras City Government Compounders Association and by several other Associations that were formed in the Districts did not bring about any amelioration in the condition and emoluments of the compounders. But we have not lost hope in the Government and in the public bodies to bring about the most desirable place and status the Compounders should occupy in the Medical profession. The City Compounders Association met several times and passed resolutions, led deputations and sent several circulars, but we are sorry to-day to say that all those representations were given a deaf ear by the Government.

The compounders form an important limb in the service to mankind, but unfortunately no due recognition is given to their work. Most of the people think that dispensing medicine is mechanical which does not require skill and intelligence but we must remember that it throws a heavy responsibility on the dispenser which a slight mistake might lead to disastrous consequences. I know that you are always alert, calm and collected and undergo a lot of mental strain than of physical work. The service you do just like nursing is of greatest value to the doctor. In the mofussil I know you are all entrusted with multifarious duties and that you are over-worked and the worst can happen for what you all do is that you have no rest and no holidays. They do undesignated work like clerical, giving Chloroform, assisting in theatres during operations, serving to keep records as store-keepers and some times you are allotted the work of a nurse and attender. To such a responsible and heavy work done by you unstintingly what is the remuneration you are getting! It is inadequate, meagre and insufficient and not in comparison with any of the services in the Government. An S.S.L.C. candidate without any further technical training could raise in status of a manager in an office, but what is happening with the compounder who is also an S.S.L.C. with the additional technical qualification? It is no wonder

November 1948]

PRESIDENTIAL ADDRESS

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that Mr. Sri. S. Ramaswami, Chairman Reception Committee in his welcome address on the 6th September 1947 remarked "when once entered as a compounder one should die as a compounder", but I am not so pessimistic as that for the reason that you are in a new era of things, and new orientation should be given to the existing rank and file of the entire medical profession. In this connection may I suggest that the designation of the compounder must be altered or modified so as to give a fair name and that too a befitting name to the kind and nature of the work you are doing; and in fact, it is not simple compounding or mixing medicines you are concerned though it is by no means it is an art. The term which I suggest in the place of compounders' is a medical assistant. This designation is more noble and quite appropriate to the work you are doing. You prepare injections, you prepare medicinal enemas, and other solutions of different strengths. As a matter of fact practically every thing that is expected to be done by a B.Sc. student in pharmacy you do. If we ask the Government to raise the status of the compounders to that of the pharmacist I believe you would not mind to undergo training for a few months if necessary though you as are really do not require any training.

The other term that I venture to suggest is Hospital Assistants. The doctors need not quarrel that you have usurped their place for they are styled as medical officers and you are designated as Hospital Assistants. At this juncture I may point-out that the medical relief in rural areas has been accepted by the Government as well as the public, is an urgent necessity. I am sure the training you had and the experience you gained will stand you in good stead if you have been drafted as a hospital assistant to the rural areas and thereby provide medical relief without much cost to the Government. We know that the Kasturibai Fund has been training a set of people who are neither doctors nor pharmacists but one supposed to cater to the needs of the villagers as rural health officers. If the more experienced amongst you who are proficient in all branches of the hospital work could be given responsible places in the villages I am sure you will discharge your work for beyond the expectations of many. I venture to suggest to the Hon. Minister Dr. Gurubatham who is incharge of Firka Development to think if these people could not be employed in the rural areas and thus provide medical relief immediately.

The other terms that I would like to suggest in the place of compounders is that of "Apothecaries" which term though old is still used in Ceylon and other Western countries. The training might be a bit longer and appropriately their salaries are higher. I am sure with little more training you will be as much fitted to do the work as those of the "Apothecaries".

A doctor cannot be efficient without the help of a competent compounder and with a nurse they both form an integral part of one unit and as such the doctors of our province who assembled here in their provincial conference under the presidentship of Dr. P. A. S. Raghavan will not look upon us as people fighting for the rights of a doctor. We have absolutely no quarrel with them. Leave alone the status and designation, but all must agree that you belong to an illpaid service in our profession

you are overworked, both day and night by duties, foregoing practically all holidays, what is it that you get by the time you retire. A very meagre sum which cannot be said to keep the body and soul together particularly in these difficult days.

But I visualise a great future for you, for the reason that we require many pharmaceutical concerns so as to make Free India self sufficient in its medical products. We require many more men of your calibre to assist the pharmaceutical concerns to manufacture many products and in fact such of those big concerns as that of Parke Davis & Co., May & Baker, Lilly etc., though they have enough of medical personels with them it is the pharmacists that manufacture the products. If you have such noble ideas not only you enrich yourself, the doctors that work in your pharmaceuticals and chemical industries but also that of the country in general.

Friends, I do not like to be exhaustive in the presidential address for I know that you are shortly sitting for a subject committee meeting in which I expect that your representatives from different districts that assembled here will all give me valuable experiences and support in drafting resolutions through which we could put our grievances and forward the same to the Government. I am sure if we are all united and present a united front, the Hon. Minister of Public Health will be able to find funds to increase the salaries and other ameleorations pertaining to your profession.

I shall conclude, thanking you most sincerely for the great honour you have conferred on me by electing me as the President to preside over the deliberations of this conference.

I have a debt of gratitude to those distinguished members of the Medical Profession and other delegates and distinguished visitors who at a great inconvenience and multifarious activities responded to my invitation.

I also offer my thanks on my behalf and your behalf to Lt. Col. Shangam Lal who was good enough to inaugurate the conference.

JAI HIND



November 1948]

## GOVERNMENT OF MADRAS

### Education and Public Health Department

Memorandum No. Rt. 17 P. H. dated 29th November 1948

*Sub.:* STORES—Medicated wines and Methylated and Rectified spirits.  
Exemption from the operation of the Prohibition Act.

*Ref.:* From the Hony. Secretary, Indian Medical Association, Trichinopoly dated 9—3—1948.

From the Board of Revenue, Nos. 11096—Pro./48-XF-3, dated 5—4—1948 and 32134-Pro./48-XC-5, dated 16—10—48.

From the Surgeon-General, No. 20997-H/48, dated 24—8—1948.

The Hony. Secretary, Indian Medical Association, South Indian Provincial Branch, Tiruchirapalli, is informed that the Government have agreed to permit each Registered Medical Practitioner to keep with him a stock upto half a gallon of methylated spirit at a time for his professional use. Necessary amendment to the Madras Denatured Spirit and Methyl. Alcohol Rules, 1939, will be issued separately in the Revenue Department.

2. With regard to the request for stock by Registered Medical practitioners upto 1 lb. of Rectified spirit for their professional use, the Honorary Secretary is informed that under the Madras Rectified Spirit Rules, 1937, a medical practitioner may without a licence possess at a time two reputed quarts of rectified spirit.

3. As regards the request for the exemption of medicated wines containing less than 20 per cent of spirit from the operation of the Prohibition Act, the Honorary Secretary is informed that the Government are unable to comply with the request.

(Sd.) T. GOVINDA MENON,

Deputy Secretary to Government.

To the Honorary Secretary, Indian Medical Association, South Indian Provincial Branch, Tiruchirapalli.

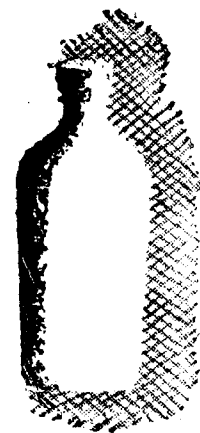
„ „ Board of Revenue, Madras.

„ „ Surgeon-General with the Government of Madras.

„ „ Revenue Department, Madras (with enclosure).

Forwarded: By order.

(Sd.) T. RAMACHANDRA RAO,  
Superintendent.



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Doctor: "So your husband talks in his sleep, does he? Oh, we'll soon remedy that."

Mrs. Brown: "Er—I suppose you couldn't do anything to make him speak more distinctly."

He was furious when the bill came from the doctor.

"Such a heavy bill for just ten days' treatment?" he shouted at the doctor.

"My dear Sir," replied the doctor calmly, "if you only knew what an unusual case yours was, and how strongly I was tempted to let it go to a post-mortem, you wouldn't complain."

"What is your trouble," asked the doctor.

"Oh! everything, can't eat, can't sleep. I'm hot and cold all over,"

The doctor examined her.

"Your heart doesn't seem to be all right. Have you had any trouble with Angina Pectoris?"

"You are almost, right doctor," replied the young fellow. "Only that isn't her name."

Nurse: "Your pulse is as steady as a clock."

Patient: "Yes, your fingers are on my watch."

Ram: My uncle had a bad accident while driving his car.

The doctor said he would have him walking in a month.

Gop: Was he able to do that?

Ram: Oh, yes, when he sent his bill, my uncle had to sell his car to pay it.

The hypochondriac was taking the life out of her doctor.

"Have you any pain anywhere today?" he asked on seeing her again.

"Yes, doctor, it hurts when I breathe. My only trouble now is with my breathing."

"All right," said the doctor, "I shall give you something that will stop that."

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तपनना: सुविनी भवन्तु

# THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH  
OF INDIAN MEDICAL ASSOCIATION

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sulphadiazine . . . 0.185 gramme  
sulphamerazine . . . 0.130 gramme

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Since the solubility in the urine of each of the constituents of 'SULPHATRIAD' is not affected by the presence of the other two, the risk of renal complications such as crystalluria during treatment with this combination of sulphonamides is greatly reduced. Such a combination may also have certain advantages from the point of view of therapeutic activity.

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Vol. XV

DECEMBER 1948

No. 6



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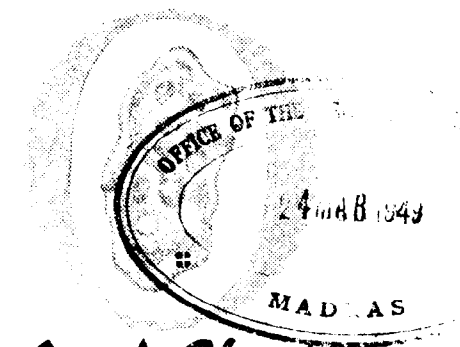
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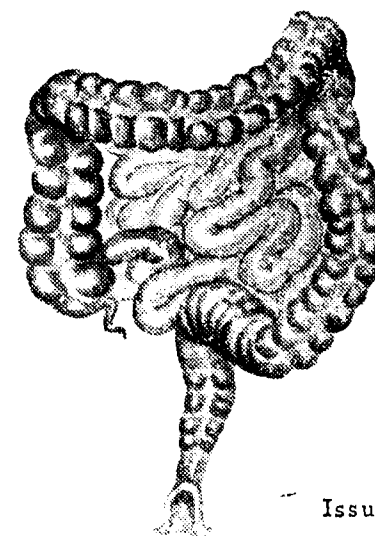
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President delivering address and  
 Hon. A. B. Shetty, Minister for Public Health  
 who inaugurated the Conference.



Mayor addressing before opening of the  
 Exhibition



A section of the audience



Mayor's Tea Party on  
 23-12-1948

Photos by Dr. Damodar Das.



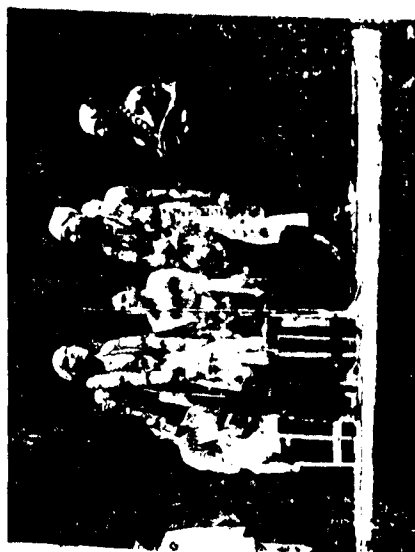
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# THE MISCELLANY

JOURNAL OF THE SOUTH INDIAN BRANCH  
OF  
THE INDIAN MEDICAL ASSOCIATION

VOL. XV]

DECEMBER 1948

[No. 6

## EXTRAVASATION OF URINE

BY

DR. D. KANAGA SABESAN, M.S., F.R.C.S.,  
*Govt. General Hospital, Madras.*

1. The escape of urine into the cellular tissues round any part of the urinary tract leads to gross pathological changes in the body—toxic absorption of infective exudates and urinary poisoning. Damage to the wall of the urinary tract may occur at any level from the top of the kidney to the urinary meatus. A break having occurred at some part of the tract, leakage of urine into the loose meshes of the cellular tissue or into the peritoneal cavity nearby progressively increases and the pressure ahead strips up the fascial planes to their utmost extent being limited only by their attachments and until the flooded area becomes tense.

2. While trauma is a common cause of extravasation (13%) from the upper urinary passages, the urinary wall is more frequently perforated by disease processes (80%). In traumatic rupture, the process may remain non-infective in the early stages but when it takes place from the yielding of a septic process, the infection already present seriously aggravates the clinical state. The inflammatory reaction, spread of infection and toxic absorption depend largely on the nature of the extravasated area, its texture, vascularity and proximity to any important viscera or septic body cavity. If one remembers that urine

represents a waste product—something that is not wanted by the body—and that it is as a whole more dilute than the blood and that certain constituents are present in it, in greater concentration than in blood, one can realise that the absorption of such a fluid even if non-infective is injurious to the system. Apart from this the absorption of bacterial toxins in cases of infected urine causes still further damage. It is only in the severity and rapidity of the pathologic processes initiated that there is any difference between cases of extravasation due to traumatic rupture and dissolution from disease; for infection either from outside or from the hollow septic cavities nearby supervene after a short period, may be only a few hours. The bacteria usually responsible for the infection are fortunately however the common pyogenic organisms viz., the strepto and staphylococci, both sulphamide and penicillin sensitive. The prognosis even though has improved to a certain extent since the advent of chemotherapy and penicillin is still sufficiently serious enough to deserve careful consideration as it requires prompt and appropriate surgical treatment. A clear knowledge of the tissue spaces into which extravasation may occur is essential for a correct appreciation of the course and extent of its

spread. It is essential to know exactly the situation of all extravasated areas and also the underlying cause viz., trauma, disease, operative injury, foreign body, virulent infection from outside etc., and also the state of the neighbouring hollow viscera distended or otherwise.

3. The adipose capsule of the kidney and the perirenal fascia limit urinary extravasations at this level to their confines; thus while it may not travel up, it can easily track down into the iliac region, in cases of rupture of the posterior surfaces of the kidney as the layers of the perirenal fascia do not blend below; (*Vide Diag. A*) anteriorly the fascia is intimately blended with the peritoneum while posteriorly it is in contact with the lumbar fascia and so in injuries implicating the anterior layer of the perirenal fascia, the peritoneum is often torn and escape of urine into the peritoneal cavity will result. When the rupture involves one of the calyces or the renal pelvis urine escapes into the perirenal fat along with extravasated blood and spreads widely in the loose cellular tissue behind the peritoneum. (*Vide Diag. B*)

4. The ureter is rarely ruptured accidentally by itself but it is frequently involved in association with injury to the kidney. Extravasation takes place into the perinephric tissue; if the urine is sweet, a small leak is of no small consequence; it is absorbed but if the urine is septic, a perinephric abscess may result. If neglected this may end in suppression of renal function this side.

5. *Bladder.* Rupture of the bladder may be intraperitoneal or extra peritoneal. Intraperitoneal tear occurs only in a distended bladder usually in the upper and posterior portions because of the peculiar distribution of the oblique and longitudinal muscle fibres of the bladder wall and also because the mucus membrane there is least supported. It may result from blows, falls, crushes or penetrating wounds. Blood and urine

escape into the peritoneal cavity; in spite of absorption of some of the urine by the peritoneum, urine accumulates inside, rises up and is likely to get infected from the bowel closely; if the urine is already infected as in the case of disruptive ulceration and perforation of the bladder wall by a calculus in a sacculi or the tip of a catheter in the hands of a novice, septic peritonitis ensues straightaway. (*Vide Diag. C*)

Extra peritoneal rupture of the bladder is however more common and often associated with fracture of the pelvic girdle; there may be associated injuries of the vagina or rectum making the fracture compound and hence urine is also likely to be infected and set up infective complications.

6. Surrounding the lower part of the bladder, its neck and the three portions of the urethra are four fascial compartments into which urine may extravasate (*Vide Diag. D*) (1) Below the peritoneal reflection behind the prostate and seminal vesicles and surrounding them and above the deeper layer of the triangular ligament is a cellular space, some of it being in front, some behind and a comparatively small amount on the lateral aspects. Localised violence to the lower part of the abdomen when the bladder is distended may lead to tear in the anterior wall below the peritoneal reflection; the urine finds its way into the Cave of Retzius, infiltrates the cellular tissue, spreads up towards the navel lifting up the peritoneum, also laterally towards the anterior superior spines and downwards as far as the bladder neck. This is the type of extravasation commonly seen in drunken persons. When the tear however is lower down and close to the bladder neck, the first area to be flooded is round about the bladder neck and then it rises up towards the abdominal wall; but a good amount of the extravasated urine passes into the pelvic cellular tissue and collects

between the bladder and the rectum in Denon Villier's space. Septic infection following child birth is sometimes followed by pelvic cellulitis. The unskilful dilatation of a urethral stricture and the production of a false passage by the passage of the point of the instrument through an opening in the floor of the urethra and perforating the posterior wall of the bladder by tunnelling under the prostate is another not uncommon cause of extravasation into this area. If this is not recognised immediately and treated by proper suprapubic drainage, extravasation and diffuse cellulitis will follow. (2) The perineum forming the outlet of the pelvis (*Vide Diag. E & F*) is bounded in front by the pubic arch and the inferior pubic ligament, behind by the coccyx and laterally by the conjoint rami of the pubis and ischium, the iscial tuberosity and the sacro tuberos ligaments. Stretching across this lozenge-shaped perineal space are the transversus perinei muscles meeting in the middle line at the perineal body; the triangular space in front contains the external urogenital organs, while the one behind houses the termination of the anal canal. The triangular ligament or urogenital diaphragm consists of two layers of fascia, the superior and inferior, which are continuous with each other at their anterior and posterior ends and forms the deep perineal pouch; in it are the membranous urethra the sphincter urethrae membranaceae, Cowper's glands in the male, the vagina in the female, the internal pudendal arteries, arteries to the bulb, a plexus of veins etc., The ducts of the bulbo urethral glands in the male pierce the inferior layer and enter the urethra one inch distally while in the female the Bartholin's glands are outside and so their ducts do not pass through it. Anteriorly at the apex, the two layers fuse to form the transverse ligament of the pubis, between this and the inferior pubic ligament the deep dorsal vein of the penis or clitoris enters the

pelvis; the base directed backwards is connected to the perineal body and is continuous with the anal fascia and behind the transversus perinei superficialis with the membranous layer of the superficial fascia. It is perforated from two to three centimeters below the symphysis pubis by the urethra, the arteries and nerves to the bulb and the ducts of the bulbo urethral glands etc., It is also perforated at the base by the scrotal vessels and nerves at the base. (3) In front of the triangular ligament is the superficial perineal pouch; Colles fascia or the membranous layer of the superficial fascia of the perineum is the continuation downwards of scarpa's fascia; it invests the penis and scrotum; it is also attached laterally to the ischio pubic rami and below to the posterior border of the urogenital diaphragm. Hence in rupture of the urethra anterior to the triangular ligament which is the commonest site of extravasation, the connective tissue of the perineum, scrotum, penis, groins and anterior abdominal wall will be the seat of urinary extravasation. As this fascia is attached posteriorly to the base of the triangular ligament, extravasation cannot spread backwards but it may extend upward along the spermatic chord on to the abdominal wall and extend down over the inguinal ligament only for an inch or so because at this level scarpa's fascia is attached to fascia lata; but it can spread upwards to any extent even as far as the axilla. (4) Lastly surrounding the penis is the fascia penis—Buck's fascia—which fuses with the suspensory ligament of the penis anteriorly and the deep layer of the superficial fascia posteriorly. Any break through of urine in the anterior part of the penis as in cases of meatal strictures, impact of foreign bodies or calculi producing destructive ulceration of the urethra in front of the angle of the penis (that is the suspensory ligament) will tend to be confined to the penile shaft in the first instance and only later break

through the elastic fibrous sheath and enter into the superficial perineal pouch.

The above review of the anatomical extent of these fascial spaces and attachments of the fascia enclosing them should be borne in mind in planning incisions for drainage or for repairing injuries in these regions.

The commonest cause for extravasation of urine is rupture of a peri-urethral absciss secondary to a gonorrheal stricture. In cases of this type it is the superficial perineal pouch that is frequently invaded; occasionally however the rupture takes place between the two layers of the triangular ligament but soon the anterior layer is broken through and the superficial perineal pouch is also invaded. I shall deal with this first as this is the one which the practitioner has ordinarily to deal with. Patients with this type of extravasation are in a very serious state. They are highly toxic and may have high temperature with rigors repeatedly, the perineum, scrotum and penis become greatly swollen brawny and discoloured; the swelling may extend into the abdominal wall; in the worst cases the appearances are those of a spreading moist gangrene. The treatment of these cases should be instituted with due regard to the general state of the patient. Dehydration should be combated by intravenous salines and injection of cardiac stimulants. After resuscitation, a stab incision should be made in the perineum under gas and oxygen anaesthesia; an outlet having been provided for the pentup urine, the next procedure would be to make free incisions into the whole of the infected area; one or two incisions on either side of the scrotum, one or two incisions over the body of the shaft of the penis and incisions in the inguinal regions and the middle lines of the suprapubic area should be made if necessary to drain localised extravasations and collections of infective exudates. Foul pus with decomposing

urine escapes. I strongly deprecate the practice of passing any instrument via the meatus into the urethra; a perineal catheter introduced through the perineal opening into the bladder should be left in to drain the bladder. The patient should receive parenteral fluids, blood transfusion and plenty of fluids by mouth to restore the depleted fluids as well as electrolytes. A high protein diet is essential. The oral administration of protein hydrolysate if tolerated should be administered, otherwise intra-venous administration of proteins and glucose should be carried out. Cardiac stimulants, oxygen inhalations and last but not least the administration of chemo-therapeutic drugs should be instituted. It has been the experience of several urologists that the administration of penicillin in addition to sulphanamides has a greater bactericidal effect and therefore more beneficial than the administration of anyone of them alone. Finally when the general condition has improved and the operative wounds show signs of healing attempts may be made to deal with the obstruction to the urethra. Sometimes the free incisions made, and the extensive separation of the sloughs leaves the testicles bare but it is seldom that there is any necessity for any plastic procedure or grafting as usually the elastic scrotal skin grows over and surprisingly fills up the defects.

Limited extravasations as in cases of rupture of the anterior urethra in front of the suspensory ligament should be promptly treated by incisions on either side of the shaft; any delay will necessitate a greater operative trauma as by this time the superficial perineal pouch may also be invaded. It is necessary therefore in these cases to make sure that the infection has not spread beyond the fascia penis by careful palpation of the perineum and the scrotum.

Kidney injuries result from runover accidents, crushes between buffers or a

severe blow in the loin; they may also result from stab wounds or gunshot injuries. Severe cases with laceration of the renal capsule show marked shock, increasing swelling in the loins or dullness indicating filling up of the lower part of the pelvic cavity. Hæmaturia may or may not be present. Extravasation of urine will follow only if a calyx or the pelvis is torn. Secondary infection leads to a perinephric abscess. General symptoms of rise in temperature and pulse rate, rigors, painful loin swelling with overlying rigidity will follow; symptoms of peritonitis will be present if the peritoneum is torn. There are often co-existing injuries elsewhere and careful examination should be made for these. After adequate premedication and resuscitation, the kidney should be exposed by the lumbar route, tear repaired or if the kidney is pulped, primary nephrectomy should be performed; if even a part of the kidney is in tact with its vessels, the damaged part only should be removed; the kidneybed should be invariably drained; in cases of peritonitis, the peritoneum should be opened up and lesions inside dealt with. When the case is seen late, when a perinephric abscess has already formed, one must be content with nephrotomy and drainage of both the pelvis and the perinephric space; later if necessary, secondary nephrectomy may be carried out after a complete urological examination.

Ureteral damage should be treated by suture; partial tears are amenable for suture; a ureteral catheter should be left in for three days; in complete rupture, an end to end oblique suture should be attempted. If suture is impossible, the alternative is to ligature the upper end of the ureter which will result in atrophy of the kidney or a nephrectomy may be done. Operative injury in gynecological operations requires prompt recognition and treatment. Partial section may be left alone with only extra peritoneal drainage of the site of

injury. Complete section requires anastomosis of the cut ends with extra-peritoneal drainage.

Bladder injuries: Intraperitoneal ruptures demand immediate laparotomy; fluid should be aspirated with a sucker and the bladder wound closed carefully by a row of Lambert sutures not involving the mucus membrane and the bladder drained by an indwelling catheter and abdomen closed with a peritoneal drain at the lower part of the wound. Extraperitoneal rupture if seen early a suprapubic incision should be made and the contaminated area washed out with saline irrigation via a urethral catheter the tear sewn up and the wound drained. In later cases it is not possible to do anything else except to make free incisions into the extravasated areas and leaving in a large suprapubic tube into the bladder through which urine can escape. In fractures of the pelvic girdle immediate operation and drainage of the bladder and prevesical space is essential; urine leak should be controlled by suction drainage through a suprapubic dePezzer catheter. After a week or ten days it may be possible to reduce the displacement by lateral recumbency under anaesthesia and immobilisation in a double plaster spica with a generous suprapubic window for the emergent catheter and the covered bladder wound or the urine box. Fractures of the pelvis with rupture of the urethra however can be treated only after reduction of the displacement and immobilisation of the pelvic bone as a first step. It is impossible often to cathetrise the urethra before the displacement is corrected. Later an indwelling catheter should drain the bladder. In very extensive crushing injuries there is often great difficulty in finding the ends of the divided urethra. Wide exposure by suprapubic cystotomy with the passage of catheters both ways may be needed to coax a catheter in. A recto-urethral fistula or a secondary stricture may result in the

end. Regular dilatations should be carried out later as otherwise a dense stricture may follow.

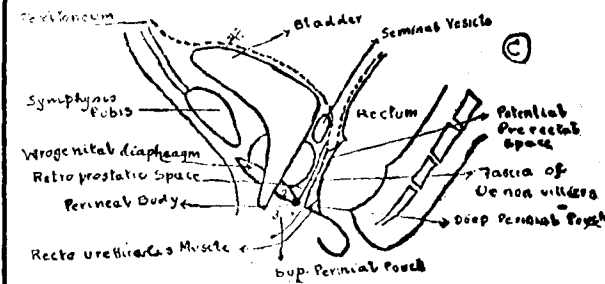
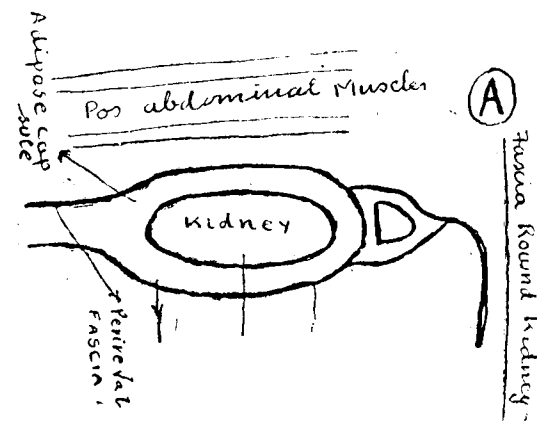
Before the performance of any operative or manipulative procedure in every case of extravasation of urine whether due to injury or otherwise a careful general examination of the patient—skin, tongue, pulse, blood pressure, blood count, blood urea, examination for oedema examination of the lungs etc., should be done. Adequate premedication, the careful choice of a suitable anaesthetic and the appropriate supply

of fluids for electrolyte loss should be the first step of the operation. In every case after operation, a fluid chart should be maintained and protein loss from starvation and dehydration should be combated by generous protein feeding and glucose administration.

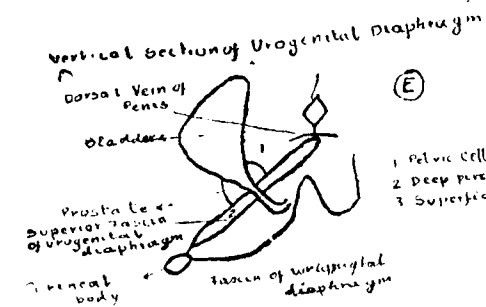
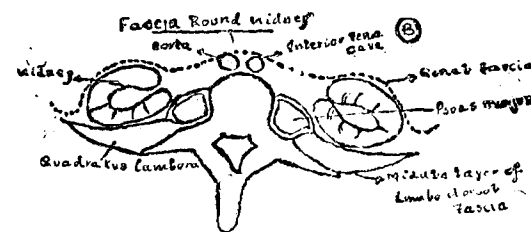
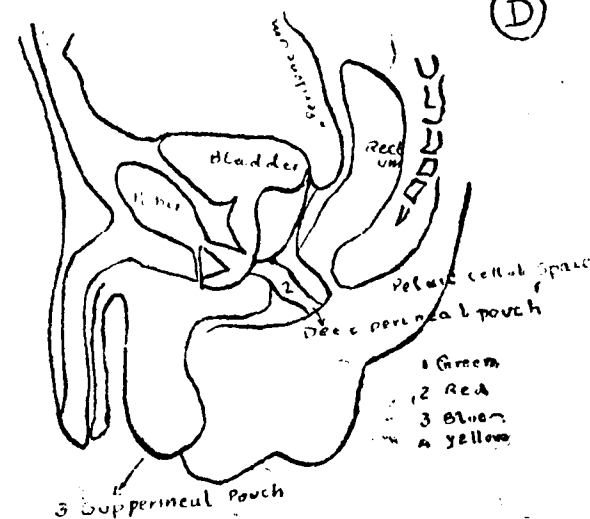
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**Enclosures:** Diagrams.

Lecture delivered at the III S. I. P. B. Conference at Madras. October, 1948.

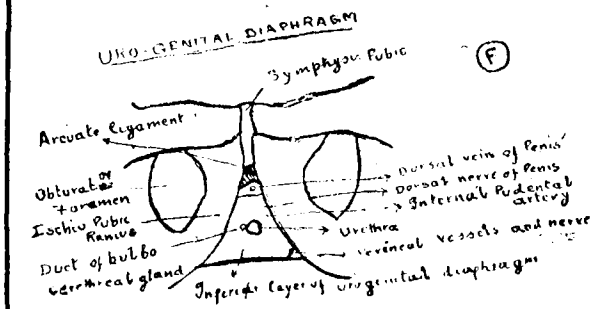


Sagittal Section  
Showing FASCIAL SPACES



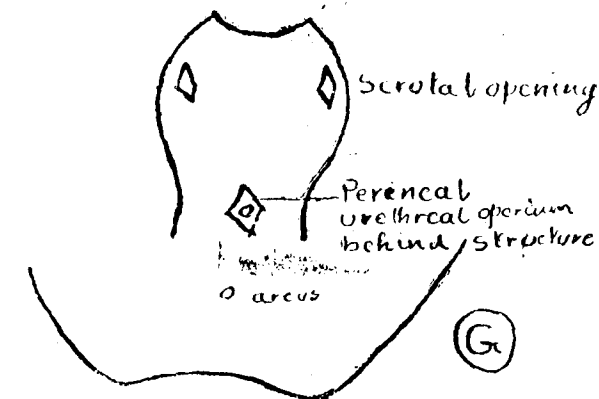
(E)

- 1 Pelvic Cellulo space
- 2 Deep perineal pouch
- 3 Superficial Perineal pouch



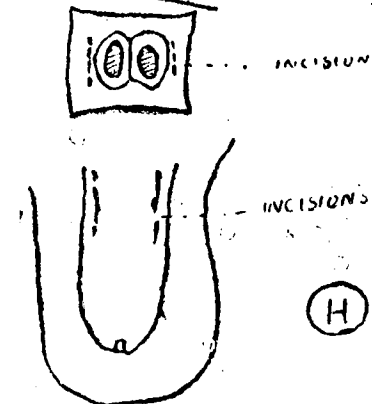
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INCISIONS FOR Extravasation into  
S.P Pouch (Area No 3)

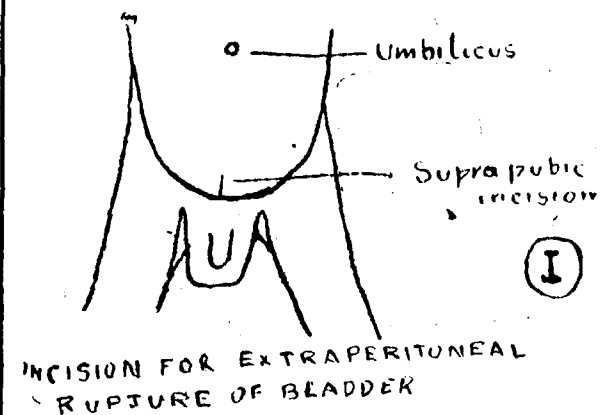


(G)

INCISIONS FOR EXTRAVASATION IN FRONT  
OF BACKS FASCIA (Area No 4)



(H)



(I)

## DISORDERS OF MICTURITION

BY

Dr. C. K. PRASADA Rao, M.D.,  
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As disorders of micturition result mostly if not solely from disturbances of the normal mechanism of micturition, a brief review of the physiology of micturition will not be out of place at the outset of this discussion.

The dynamic activity of the urinary bladder is mainly the property of its plain muscle—Detrusor and the Internal Sphincter. The plain muscle of the bladder as elsewhere is intrinsically contractile and manifests tonic and phasic contractions. This intrinsic contractibility is regulated by the nerves supplying the organ.

Normally as urine collects the bladder distends and the tone of the wall raises, but by a self regulating neuro muscular mechanism the tone is inhibited to facilitate accumulation of large quantities of urine.

As the act of micturition starts the detrusor contracts and the sphincters relax and the abdominal and the pelvic muscles co-operate in this operation of evacuating the bladder. After completion of the act, the detrusor relaxes and the sphincters contract to facilitate accumulation of urine in the bladder once again.

The Bladder derives its nerve supply from the Sympathetic and the Para Sympathetic systems.

*Sympathetic* supply is from the Lumbar outflow— $L_1 + L_2$  + occasionally  $L_3$  and  $L_4$ . *Para Sympathetic* supply is from the sacral outflow:— $S_2, S_3$  and occasionally  $S_4$ .

Sympathetic stimulation brings about *Relaxation* of Detrusor and contraction of Internal sphincter—a mechanism to

retain the contents of the bladder. Para Sympathetic stimulation brings about contraction of Detrusor and relaxation of the sphincters a mechanism to evacuate the bladder.

Two types of *Affecient impulses* go out from the bladder (1) one carrying the sense of *Tension* and the other the sense of *Pain*. Both of these go through the Para Sympathetic nerves. The sympathetic does not convey the Tension sense.

*Pain*.—Afferents are carried by both.

The External Sphincter formed by Striated muscle is innervated by the Pudic nerve. This sphincter relaxes with the contraction of the detrusor and *vice versa*.

Controlling the innervation of the bladder are centres in the Spinal cord.

Mesencephalon  
&  
Cerebral Cortex.

Spinal Centre is at the 2nd Sacral Segment.

Cortical centres are in the Motor Convolutions the Para central lobule of either side of cerebrum. Cerebro spinal Efferents bringing cerebral control over the spinal centre are located in the neighbourhood of the crossed Pyramidal tracts. The path of the *Afferent* impulses to the cerebrum is not traced.

Micturition is primarily a reflex act.

The movements comprising this act are:—

1. A strong contraction of the detrusor muscle.

2. Relaxation of the internal sphincter.

3. Opening of the external sphincter.

The stimulus that works the reflex is the sense of tension of the wall of the bladder. The reflex is said to operate usually at an intravesicle pressure of 15-18 c.m. of water but under some circumstances may be initiated at lower pressures. The bladder in infancy works purely by spinal reflex activity. As soon as little quantity of urine is accumulated, the pressure rises to an optimum. Afferent impulses begin to operate and produce contraction of the bladder purely through the intervention of the spinal centre. The higher centres hold no restraint on it at this age. Thus the bladder in infancy empties automatically and frequently within intervals of an hour or two. This purely reflex action is modified in later life. The influences of higher centre are brought to bear on the spinal centre. Usually with a normal rate of formation of urine and without any restraint on the bladder micturition occurs in adults when the urinary volume reaches 250-300 c.c. With rapid rates of formation of urine, micturition starts with much less volumes of urine in the bladder.

The desire to urinate is accompanied by a vague feeling of pain in the perinium when the volume of urine in the bladder is 200-300 c.c. and at this time the detrusor muscle goes into phasic contractions sending impulses of tension to the higher centres of consciousness. If the circumstances are not propitious for evacuation of the bladder higher centres send inhibitory impulses to the spinal centre, the detrusor tone is lowered and the act of micturition is deferred. Thus "water" can be held.

Thus though the act of micturition is essentially a reflex one and mediated through the autonomic nervous system, it is usually initiated by an effort of

will and similarly it can be inhibited or interrupted voluntarily. This voluntary control is mediated through the cortico-spinal connections to the spinal centre and when these are cut off either by disease or injury this voluntary control is lost giving rise to either Hesitant or Precipitant micturition.

In normal life therefore the act of micturition is controlled through variations in the voluntary and subconscious restraint of the reflex mechanism.

From this survey it is plain that many disorders of micturition may originate by alterations in this neuromuscular mechanism.

In addition, the act of micturition can be disordered by alterations in the organs that hold close anatomical relation with the bladder like the prostate in the male, uterus in the female and rectum in both.

In medical practice disorders of micturition are very often met with in diseases of the nervous system. The common disorders in these diseases are:—

1. Hesitancy in micturition—i.e. the common complaint of hard to start. In the absence of an enlarged prostate this symptom is due to diseases of Nervous system.

2. Precipitancy of Micturition—Inability to hold i.e. if there is a desire to pass water the act of evacuating the bladder has to be effected whatever be the circumstances under which the patient is placed. It cannot be deferred.

We have seen in the previous discussion that the anatomical situation of lesions in these disorders are in the corticospinal pathways. Either of these two symptoms are therefore found at one stage or other of the nervous diseases involving the pyramidal tracts and also those involving the afferent inflow from the bladder to the cortical

centres. Hesitancy in micturition or Precipitate urination are not uncommonly the earlier symptoms in Neuro-syphilis of the spinal cord—both Meningo Vascular involving the lower cord, and Parenchymatous syphilis.

*In Tabes.* Sometimes this complaint arises much before the onset of locomotor or eye symptoms. In disseminated sclerosis hesitancy or precipitate micturition may be an early sign. They, on the other hand, appear rather late in compression paraplegias and appear towards the terminal stages only in sub-acute combined degeneration.

### Incontinence of Urine

This may be of three types.

#### I. Reflex incontinence.

In this condition, the bladder contracts intermittently and automatically expelling its contents completely at intervals of an hour or two quite similar to the type of evacuation that normally occurs in infancy. Complete isolation of the spinal centre by disease or injury causes this.

#### II. Overflow dribbling or overflow with retention.

In this condition, the bladder empties automatically and periodically but the evacuation is not complete. There will always be a residual urine some time going up to 300—400 c.c. This state is found in later stages of Neuro-syphilis compression, paraplegic, injuries to spinal cord and lesion of the cauda equana.

In this condition, regular attention to bladder in the way of employing it periodically by catheterisation in the very early stages of the disease giving rise to this symptom prevents the atony and averts this danger.

In coma from cerebral catastrophies the overflow with retention is often present. But in these states the periodic evacuation may be mistaken for

normal evacuation and the bladder neglected. A certain restlessness in these comatose states is always due to the distended bladder and conversely any evidence of restlessness in a comatose patient should draw the attention of the physician to the urinary bladder.

#### III. Continuous dribbling or Passive incontinence.

This state is met with often in cases of Tabes where proper attention to the bladder was not given in the early stages of the disease. This occurs also in conditions giving rise to obstructions to flow of urine as in prostatic enlargements.

*Cord Bladder.* This takes to the consideration of what is called the *cord bladder*—an atonic state of bladder where the mucous membrane is hypertrophied and trebeculated. This is not specific of any particular nervous disease and is the end result of unattended bladder in any of the diseases mentioned above.

#### Cystometry

The impairment of the motor activity of the bladder can be detected by cystometry at a very early stage. In normal bladder the pressure does not rise significantly before 350 500 c.c. of water is flown in. In bladders losing the cortical control the pressure rises sharply with much smaller quantities. This investigation is very useful in Tabes as the bladder in this disease is affected much before micturition difficulties arise or locomotor or eye symptoms manifest and those that are acquainted with the dangers in Tabetic bladder will appreciate the importance of this early diagnosis.

#### Care of the Urinary Bladder in Nervous Diseases.

In hesitant and precipitate micturition or in frequency of micturition there is a preponderance of the para sympathetic control over the sympathetic and drug treatment may be

helpful. Firstly with drugs that paralyse the para sympathetic, like belladonna or its variants and secondly stimulants of the sympathetic system, like ephedrin administered both together or separately may be effective in alleviating the symptom. In bad cases, section of Presacral Nerve gives relief. Similarly in retention there is sympathetic overaction and Cholenergic drugs like acetyl choline in doses of 0.1 gm. intramuscularly or doryl in doses of .001 to 0.004 gms. are useful.

#### Attention to bladder is very important—Part of treatment in Tabes.

It must be begun very early. In early stages catheterisation has to be avoided and patient has to be rehabilitated to the use of his bladder by any convenient and successful manoeuvre like alteration of posture, compression of abdomen muscles, warm hip baths, etc. When there is retention with overflow and with no evidence of sepsis catheterisation may be allowed but with great aseptic precautions. In cases where the dribbling is associated with sepsis the bladder has to be treated as in prostatic diseases.

Disturbances of micturition met with in other medical conditions are:

1. *Frequency of micturition.* This may be—

A. With polyurea-Diabetes, etc. (not relevant to this discussion.)

Without polyurea—1. It may be due to nervous excitement. The Pathogenesis in this type of micturition is the loss of Cortical inhibition.

B. Pyelitis and Bac. Coli infections where bladder is involved, is another medical condition where this symptom is not only present but is useful in diagnosis. In this state there may be simple frequency or frequency with dysuria i.e. pain and stranguary. The rise of temperature, and other clinical

features and the evidence of coli infection in the urine decide the diagnosis.

The efficiency of Sulpha drugs with alkalis in the treatment of this infection is well-established. Streptomycin is holding more promise in this condition. In one case treated in my wards the total quantity required to control this was 20 gms.

C. *Bacillary dysentery.* More commonly the hyperacute type gives rise to frequency with or without dysurea.

D. *Heat Stroke.* Frequency of micturition and dysurea are often prodromal signs in heat stroke a condition not met in S. India but not uncommon in North India. In cases where this condition is suspected enquiry as to condition of sweating and examination of urine for chlorides will decide the diagnosis.

E. Parasitic infestations of urinary bladder as in Schista Somiasis gives rise to frequency with dysurea. The presence of the ova in urine confirms the diagnosis.

*Renal tuberculosis* is another condition that a physician may meet with in frequency of micturition. In the early stages of the disease frequency is more in the day, later it will be present in the night also. Investigations required are:— Examination of urine, culture for T.B., guinea pig inoculations, pyelography.

2. *Retention of urine* is met with in early stages of infective fevers. Except in cases with definite contra indications cholenergic drugs are effective in initiating micturition.

Lastly, En-urisis in children. In addition to the general causes of frequency of micturition this condition in children may be due to:

1. A delay in the development of cortical inhibitory control over the spinal centre of micturition.

2. It may sometimes be the symptom of spina bifida, therefore warranting a thorough examination for that condition.

3. Alterations in PH of urine like extreme acidity or alkalinity. Crystal urea may also give rise to the disturbance of micturition.

4. *Intestinal worms* is a common cause of this condition in children. Conditions of prepuce being of surgical nature need not be entered into.

Anuria is not taken up in this discussion, as the primary pathology of this is not in the neuro-muscular apparatus of micturition.

*Lecture delivered at the III S. I. P. M. Conference in October 1948 at Madras.*

## == Announcement ==

Under the auspices of the Gujarat and Kathiawar Branch of the Indian Medical Association, 3rd Provincial Conference of medical men of Gujarat, Cutch and Kathiawar will be held at Surat on 25, 26 and 27th March 1949.

Besides Conference, there will be an exhibition of Pharmaceutical products and surgical and medical appliances. Very interesting scientific section is arranged and there will be synopsis on Amoebiasis, Filariasis and Abortions. Members of the profession desiring to read papers at the Conference, should communicate one month before the Conference, the title of the paper to the Secretary Dr. K. H. Haradwalla, Vandi-Bardi, Surat. For other particulars write to:—

DR. P. R. TRIVEDI,  
Hon. Secretary,  
Gujarat and Kathiawar Provincial Branch of I.M.A.,  
AHMEDABAD.

December, 1948]

## ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

**Infection after Cataract Surgery.**—Dr. K. N. Shukla—*Ind. Jl. of Opth.*—Apr., June '48.

It is fortunate that sepsis is not a very common complication after any form of cataract surgery, because once it sets in the eye is inevitably lost due to panophthalmitis unless it has been detected at a very early stage. When it does occur one will on opening the eye on the third post-operative day, as is the routine with most surgeons, find it in such an advanced stage that no treatment will be of any avail and despite all efforts it will not be possible to save the eye. The seriousness of the situation coupled with the helplessness of the surgeon at this stage has made it customary for him to concentrate all his energy on prophylaxis. In spite of a clean conjunctival sac, infection does occur though at a very much reduced rate. This adds all the more to his difficulties because he cannot consider any prophylactic measure proof against infection.

This infection is of two kinds—early infection usually occurring within 48 hours and late infection occurring after 48 hrs. Infection occurring after the 7th post-operative day has been considered by some to be of endogenous origin. The first variety will be detected on the day of the first dressing on the third postoperative day. The second type occurs any time after 48 hrs. and before labelling an infection as a late infection one must be sure of the absence of any signs of infection on the third postoperative day.

**Early Infection:**—It develops within 48 hours and reaches in most cases a very advanced stage on the 3rd day. It is more than likely that the process starts even earlier than 24 hours. It passes through 4 stages which can easily be recognised. The difficulty lies only in recognising the first stage and it is only at this stage that a proper and energetic treatment can be of some avail. It becomes therefore imperative that in case of least doubt it must be treated as a case of infection all possible means must be employed to combat it.

**First Stage.** Infection begins at some point in the section and spreads both ways along the corneal margin. The transparency is lost and the colour becomes yellowish due to oedema and infiltration. The corneal and scleral margins remain in contact with each other. The cornea may lose some of its normal lustre and the iris may appear somewhat dull. Pupil is clear the colour depending on the type of the operation performed. Condition of the lids and conjunctive varies in different cases. Oedema of the lids and conjunctival chemosis may or may not be present at this stage. While the absence of these signs does not always exclude infection the presence of one or more of these should always make one alert to the possibility of infection and it will demand immediate attention unless it has been definitely ruled out.

**Second Stage.** More corneal tissue becomes affected. The infiltration spreads towards the centre of the cornea also in a circular form within the corneal margin ultimately forming a complete circle. At this stage a little corneal tissue dull and hazy but not yet completely opaque is present between the limbus and the ring of infiltration. The portion within the ring is also dull and hazy. Pupil may with difficulty be distinguished in some cases. But in most cases it is not visible. The sectioned cornea which is infiltrated and oedematous straightens out and loses its contact with the scleral edge. The wound consequently gapes. This gaping appears to follow and not precede infection. Any tendency towards gaping should be evident at the time of the operation. There is no reason why the cornea should become raised later if the corneal margin was in apposition to the scleral edge at the time of the operation.

The presence or absence of the anterior chamber will decide the further course of events. A well formed anterior chamber will cause the iris to float up and fill the gap between the corneal and scleral edges of the wound, and thereby minimise to some extent the chances of the spread of

infection to the chambers of the eye. This protection will be lacking if infection occurs before the restoration of the anterior chamber. Exudate may cover the prolapsed iris or in its absence spread into the wound. There will be noticeable swelling of the lids. Conjunctival chemosis will also be present in most cases.

**Third Stage.** The whole of the cornea becomes white, yellow or yellowish-white. Conjunctiva is very much chemosed and lids are very much swollen. It may not be possible to open the eye. Pain which may also have been complained of in the first stages becomes very acute.

**Fourth Stage.** Cornea sloughs, vitreous becomes infected and the condition ends in panophthalmitis.

**Diagnosis.** Infection must be detected at a very early stage because only then can the eye be saved. Diagnosis must be made in the first stage. The remaining three stages will be too obvious. Pain is an important symptom and if complained of should make one suspicious, but it is not a constant symptom at least at such an early stage. Swelling of the lids appears much later. In the presence of discharge cornea must be very carefully examined. The only sure way of detecting it at such an early stage is to open the eye and examine the section on the second and third day after operation. It is to be noted that this procedure is not devoid of risk. The patient should be told to open the eye slowly and look down towards his or her feet. If it cannot be done without strain the effort should be given up and one should be content with the examination of the lower part of the cornea and the iris and the condition of the pupil if it is possible to see it. If the section can be seen the case should present no difficulty. The condition may at times be confused with the arcus senilis. In case of doubt it should be treated as a frank case of infection.

**Treatment.** In spite of his best efforts one does not ensure prophylaxis against any one or all of the three possible sources of infection—Systemic, local and exogenous, but a good prophylaxis and a vigilant aftercare will very much minimise the chances of infection and go a long way to

save at least some if not most of the eyes that would otherwise be lost.

Conjunctival sac should be clean. For this test-bandage results are quite dependable. Patency of the lachrymal passages should be tested by instillation and syringing if necessary. In the absence of patency regurgitation from the sac will call for its extirpation. Cauterisation of the puncta should be enough otherwise. Penicillin should be applied locally either as drops or as ointment for a few days before operation. It should also be administered parenterally—starting a few hours before operation and continuing it till the first dressing is done. Injections of Sulphadiazine or Sulphathiazole are also recommended at six or eight hourly intervals beginning from the time of the operation and continuing it till the time of the first dressing which should be done after 24 hours. Intracapsular extraction and a conjunctival flap will further reduce the changes of infection.

Signs of infection at the first dressing will call for a most energetic treatment. There are three means at our disposal—Penicillin, drugs of the sulpha group and nonspecific protein therapy. None of these is entirely dependable. Recourse must be had therefore to all of these. Examination of the smear will help in the selection of the sulpha drug to be employed in any particular case: Injection of milk should be given immediately, and repeated if necessary. The sulpha drug whichever is decided upon should be given six hourly for as long a time as necessary. Dosage should be adequate. It is safer to err on the side of overdosage. Penicillin if it was being administered before should be continued. It should be started immediately otherwise. The treatment should be continued till the condition is well under control. Penicillin should also be given subconjunctivally, the dose being 25,000 units every three hours. Recrudescence is not uncommon following premature cessation of treatment.

It cannot be overemphasised that in spite of the measures suggested above the treatment is very unsatisfactory. Prophylaxis though very important cannot be relied upon. Vigilance during the first 48 hours is therefore very necessary. It may

still be possible to save the eye and preserve useful vision if infection is detected in the first stage.

\* \* \* \* \*

**Halitosis**—R. Gwyn Evans—*The Practitioner*—August 1948.

In spite of enterprising advertisements in the lay press, halitosis is a complaint, for which relatively few patients seek medical advice. Halitosis is, however, often apparent during the course of clinical examination, and is all too often disregarded. It is an unpleasant symptom, not only for the patient but also for his immediate family contacts and friends, and a little time devoted to ascertaining the cause and in arranging suitable treatment is time well spent.

**Casual Factors.** The most common cause of foul breath is of course, *periodontal infection*. This usually develops as a result of neglecting dental hygiene; food stagnates in the gum margins, and as a result of bacterial action the attachment of the mucoperiosteum to the tooth is destroyed, so that a pocket is formed in which pus collects. Once the condition has progressed to this stage of pus formation, it is readily recognizable as a frank pyorrhoea alveolaris, with inflamed bleeding gum margins from which pus exudes, or can be expressed on gentle pressure. Occasionally, pyorrhoea may be secondary to severe dental caries which has involved the pulp cavity and progressed to form an alveolar abscess. The treatment of pyorrhoea is best left to an experienced dental surgeon; surprisingly good results are achieved by conservative methods.

Another local infective condition which causes foul breath is *Vincent's angina* or "trench mouth". This is characteristically an acute infection, accompanied by some degree of constitutional reaction—malaise and rise of temperature. The infection often starts on the tonsils fauces and spreads forward into the mouth to involve the gum margins; the early lesions are covered with a dirty greyish membrane, which if separated leaves a raw, shallow ulcer. The gums are inflamed, swollen and tender, and superficial ulceration occurs near the line of the teeth. As the condition tends to occur in epidemics,

particularly in institutions, the diagnosis of an acute case seldom presents any difficulty. In subacute and chronic cases the diagnosis may be established by swabbing the lesions, and examining the smear for Vincent's spirillum and the associated fusiform bacilli. The condition responds to local treatment with arsenic (either neoarsphenamine, 20 grains to 1 ounce (1.3 gm. to 28.4 c.cm.) or arsenical solution and glycerin in equal portions). If the infection is severe, penicillin may be given both parenterally and locally in the form of lozenges, which are allowed to dissolve slowly in the mouth.

A severe *ulcerative stomatitis* or necrotic stomatitis may of course occur as a complication of certain blood diseases, particularly agranulocytosis and leukaemia. The development of ulcerative gingivitis in a patient under treatment with thiouracil should be regarded as a definite indication for stopping the drug immediately and checking the white cell and differential counts. In leukaemia the splenic and hepatic enlargement and the involvement of various groups of glands will usually indicate the cause, but in doubtful cases the white blood cell count and differential count will help to establish the diagnosis. *Infective mononucleosis* should be considered as a differential diagnosis in cases of acute ulcerative tonsillitis associated with generalized glandular enlargement and fever in an adolescent or young adult.

Occasionally, oral infection may occur as a result of malnutrition, particularly if there is vitamin C deficiency causing haemorrhage into the gums; sometimes it occurs as a sequel of acute infection in children, particularly after severe measles or diphtheria. *Thrush* may cause halitosis in young infants, and sometimes in older children, but it is a condition which is readily identified by the white patches on the gums, cheeks and tongue, and can be confirmed by examination of a smear from the lesion.

In adults, halitosis is often due to *post-nasal infection*. This should be suspected if clinical examination reveals a congested granular pharynx with a dry mucous membrane, and evidence of sinus infection may be afforded by a streak of mucus-pus running down from the posterior nares. Con-

firmation of sinus infection may be obtained by transillumination or X-ray examination. Infection involving the lower respiratory tract may also cause halitosis, and of this group chronic bronchitis is the most common. Bronchiectasis should be suspected if persistent cough with mucopurulent sputum develops after pneumonia; if the history is one of copious and offensive sputum occurring suddenly during convalescence from pneumonia, then lung abscess is the most likely cause, though in either case X-ray examination will be essential to establish the diagnosis.

**Gastric stasis** may often cause halitosis, and is a frequent cause of foul breath in young children as well as in adults. This cause should be suspected if this presenting symptom is associated with a history of dyspepsia, loss of appetite and flatulence. Halitosis in these cases is most noticeable first thing in the morning, and if flatulence occurs the eructations have a particularly offensive smell. The breath is not offensive in peptic ulcer patients except in old-standing cases when there is pyloric obstruction.

**Distinctive Odours.** Occasionally the breath has a peculiarly characteristic odour; the sweet and rather sickly smell of acetone is easy to identify, but does not, of course, necessarily mean that the patient is a diabetic; it is merely an indication of abnormal carbohydrate and fat metabolism and occurs during starvation, and with acute febrile infections, particularly those in which vomiting is a distinctive feature. Another distinctive odour that is often detected in the breath is the peculiar stale uriferous odour associated with uraemia and renal failure.

Extraneous causes of foul breath are for the most readily identified; excessive smoking gives a characteristic "stale tobacco" smell to the breath, and is more common in pipe smokers, particularly those who neglect to clean their pipes. Onions, garlic and certain other vegetables, and herbs used for flavouring, are similarly readily identified, although the smell of "stale alcohol" in the breath is now becoming as rare as the chronic alcoholic!

**Conclusion.** In spite of careful examination and investigation, in a few cases it

will prove almost impossible to establish the actual cause of halitosis. In these few cases, the rare neurogenic and congenital causes should be considered; of the former cardiospasm is not infrequently accompanied by halitosis and may be suspected from the history of food appearing to "stick" after swallowing. Congenital defects must indeed be rare causes, but pharyngeal pouches and oesophageal diverticula are relatively easily identified by modern radiological technique. Finally, there remains a small group of cases in which halitosis has no apparent cause; unfortunate people who have always had a slightly offensive breath and who, like the man who ate the "potmak", must learn to live with their halitosis.

\* \* \* \* \*

#### Differential Diagnosis of Headache— A. G. W. Whitefield—*The Practitioner*— August 1948.

Headache is one of the most common presenting symptoms in those seeking medical advice. Knowledge of the mechanism by which it is produced has been greatly increased by the work of Wolff in America and Pickering in this country. By observation of neurosurgical patients undergoing operation under local anaesthesia and by other investigatory procedures they have shown that the brain itself, the pia-arachnoid, and the bony skull are insensitive to pain, whereas, on the other hand, the intracranial and pericranial arteries and the cerebral venous sinuses together with the dura matter, particularly that part of it adjacent to blood vessels, are sensitive to pain. Most headaches of intracranial origin arise from dilatation of intracranial arteries or by traction upon them or other pain-sensitive structures. Disturbances of this nature above the tentorium produce pain which is transmitted through the trigeminal nerve and felt anterior to a line joining the two ears, whilst similar processes below the tentorium produce pain which is transmitted through the ninth and tenth cranial nerves and the upper three cervical nerves, and is felt posterior to this line.

The belief that increased intracranial tension *per se* is a cause of headache has been discarded and it is now clear that

the headache associated with space-occupying lesions in the skull is produced by traction on the dura matter, venous sinuses or intracranial arteries. Reduction of intracranial pressure may, however, cause headache due to the dilatation of intracranial arteries which results from it. Other workers have shown that many headaches of extracranial origin, such as neurotic headaches and headaches due to refractive errors, are often due to prolonged spasm of the muscles of the scalp and neck.

**Psychogenic Factors.** In the majority of patients in whom headache is the clamant symptom the cause of their disability is emotional instability and not organic disease, the common psychological processes responsible being hysteria and anxiety. In the hysterical group diagnosis hardly ever presents any difficulty. The patient, invariably a woman, describes the headache in terms which purport to imply that she is suffering tortures greater than anyone has ever before experienced, and her pain never remits and never responds to any remedy which may be prescribed. Despite this she presents the appearance of robust physical health, and the history, the background and temperament of the patient combined with a completely negative physical examination, preclude the necessity for ancillary investigation as to the cause of her symptoms. The diagnosis is usually as easy as the cure is difficult.

When anxiety is the process underlying headache there will usually be other symptoms, such as dizziness, tiredness, insomnia, and palpitation, and long before the end of the consultation the experienced clinician will have sensed that he is dealing with an anxiety state. The headache is usually intermittent and may last for periods of hours or days. Physical examination is essentially negative but it may reveal some tenderness in the muscles on the posterior aspect of the neck, and the pain is commonly maximal in this area. In most cases the fact that anxiety is the cause of the headache will be obvious, but in a few, and especially when headache is the sole complaint, it may be necessary to invoke the aid of an ophthalmologist to exclude refractive errors and a radiologist to exclude sinus infection as causes of the

symptoms. A normal erythrocyte sedimentation rate is sometimes of help in reaching a decision.

**Migraine.** Most headaches which are not psychological in origin are due to either migraine, refractive errors or sinus infection. In no condition is history-taking of greater importance than in migraine. The aura, sometimes hemianopia or the fortification spectra, lasting as a rule about half an hour and followed by frontal headache which is often unilateral and accompanied by vomiting, the onset at puberty, and the completely normal health between attacks leave no doubt about the diagnosis. A family history of sick headaches, a tendency for attacks to coincide with menstruation, and an allergic family history are common. When the aura consists of an aphasia or hemiplegia, Jacksonian epilepsy may be thought of, and when the aura and vomiting are absent, and the headache lasts longer than the usual period of hours, other causes may have to be considered. If the patient is seen between attacks, physical examination reveals no abnormality, but during an attack the temporal artery may be abnormally prominent and tender, whilst the relief of headache produced by carotid artery compression or the administration of ergotamine tartrate may be of help in diagnosis.

**Other Factors.** Errors of refraction are a common cause of headache. Myopes are never so afflicted but in those suffering from uncorrected hypermetropia or astigmatism, frontal headache at the end of the day is common particularly if there has been much reading or close work, and it is often accompanied by a feeling of grittiness in the eyes and some conjunctival injection. Such symptoms are readily relieved by the wearing of proper spectacles. It must be added, however, that the subjects of refractive error are also prone to experience the tension headaches due to sustained contraction of the muscles of the scalp and neck, and also that neurotic headaches may occasionally be relieved by spectacles in suggestible patients even when no appreciable refractive error is present.

When headache is due to sinus infection the symptoms will usually date from a

head cold and be accompanied by some nasal discharge and obstruction. In frontal sinus infection the pain is felt in the area of the infected sinus and comes on about noon, passing off in the early evening. There is usually some tenderness over the affected sinus. In infection of the maxillary antrum the pain may be felt in the cheek. Whichever sinus is affected, coughing and stooping of times produce an aggravation of the pain and give it a throbbing character. The pain is mitigated or removed by aspirin. Transillumination and radiological study will confirm the diagnosis, although in acute cases the abnormalities revealed may not be gross.

**Hypertension**, whether it be essential, renal or due to any of the rarer causes, is often accompanied by headache which is thought to be due to dilatation of the intracranial arteries. Physical examination readily reveals the cause of the headache, but it must be mentioned that in many subjects of benign hypertension the headache of which they complain is psychological in origin and unrelated to their increased blood pressure. When papilloedema is present abnormal urinary findings and blood chemistry will serve to separate the renal group, whilst the size of the heart and sphygmomanometric examination will distinguish the malignant hypertensive from those with space-occupying lesions in the skull.

Of the *space-occupying lesions* tumour is the most common cause of headache, which is usually intermittent and tends to occur in the early mornings and to be provoked by physical exertion. It is often unilateral, and in such cases if papilloedema is absent its site is of definite localizing value. When papilloedema or neurological signs are present diagnosis is not difficult, but in the absence of these signs radiological examination of the skull may prove the diagnosis. Ventriculography or arteriography may be necessary for accurate localization or even to make certain that a tumour is definitely present. In sub-

dural haematoma the history of injury, and in abscess the presence of aural of pulmonary suppuration, will suggest the diagnosis.

**Post-traumatic headaches** may be due to psychological factors but a proportion are due to adhesions between the dura and arachnoid causing traction on the former, in which case they tend to be localised to the site of the injury.

\* \* \* \* \*

**Trotters Treatment of Epistaxis**—*Clinical Journal Nov., Dec. '48.*

Dr. T. B. Layton calls attention to this treatment, which he has never known to fail except in the hands of those who have not followed it properly. It is as follows: "Prop the patient well up with a comfortable inclination to one side, arrange a large pad of wool for him to dribble into, put a dental prop between the teeth, forbidding him to breathe through the nose or to swallow, and give a substantial dose of morphia." A large cork, such as that of a wine bottle, can be used instead of the dental prop. Trotter claimed that "the odious alternative of plugging the nose" could be thus avoided. One cannot swallow without shutting the mouth, but blood or mucus coming into the pharynx from the nose sets up a reflex when it touches the upper surface of the soft palate. If the patient is in the right position with the nares lower than choanae this does not happen. The blood runs into "the large pad of wool."

Mr. Layton's greatest triumph was in a man who had been thrice transfused and the serious operation of ligation of the internal maxillary artery was suggested. The rationale of the treatment is that movements of the soft palate produce a tug on the veins of the nose and detach the clot which is forming. Inhibit movements of the soft palate and you stop the tug. Thus the clot can become adherent and the bleeding ceases.

December, 1948]

## ALL INDIA MEDICAL CONFERENCE, CALCUTTA

### A RETROSPECT

BY

A SOUTH INDIAN

The last week of the year 1948 had a spate of Medical Conferences in the City of Palaces and the former capital of India, Calcutta. Though the number of All-India Organisations that held their Conferences in the week were less than those that met at the previous year in Bombay, still the total attendance was greater than last year, being about a thousand delegates from outside and about 3000 from within West Bengal. The numbers from outside would have been larger if complete and timely information about arrangements had been given wider publicity. Many members did not receive invitations at all.

**Boarding and Lodging.** While prior to the Bombay Conferences, these two items were free of charge, and sumptuous, in spite of war and rationing, during the last two years after the introduction of payment, the arrangements are deteriorating. While in Bombay one could at least get enough though not to his taste, in Calcutta there was neither quality nor variety for the amount paid. While in the biggest hotels like the Grand or Firpos, a lunch or dinner was of 3 courses and that in ample quantities, in the Conference, though the charges were the same, i.e. Rs. 2-8, there was practically one course which was neither good in quality nor palatable to the South Indian. Boarding arrangements were not quite satisfactory, as arrangements of latrine and bath rooms were insufficient and delegates had to queue up for these. There were at least cots and beds both in Calcutta and Bombay, as otherwise in the cold days living would have been miserable. The organisers should have frequently called at the camps and enquired after the delegates comforts. Some of us who stayed outside the camp with friends were informed that if the organisers of the Conferences had consulted the South Indian Club, they would have offered to look after these delegates by lodging them and giving them South Indian food. Such offers may be considered in future Conferences at least.

**Business Meetings and Scientific Sessions.** The idea of holding a number of Conferences in the same place and at about the same time is to enable doctors to attend as many Conferences as they like by going to a particular place once a year. For this the Conferences should be arranged in a running order, i.e. one after the other. Usually Specialists Conferences do not require more than 2 days, while the I. M. A. Conference which should be attended or addressed by both general practitioners and specialists may require about 4 days. So one or two Specialists Conferences before the I. M. A. Conference and one or two after this would have served the purpose; instead all the Conferences were overlapping thus defeating the purpose of these Conferences being held jointly. Another handicap was that even business sessions or committee meetings overlapped with scientific sessions, thus disabling some who took part in the organisational activities of the I. M. A. from attending the scientific sessions. Another bug bear was that important committee meetings were not finished according to schedule, as everybody wanted to speak over and over again without any observance of parliamentary methods, so much so that some of the meetings were adjourned to night sessions, where the attendance was poor and important decisions were taken by half or fully sleepy members. With stricter control from the chair these could and ought to be avoided.

**Excursions and Entertainments.** These have become a routine with the All India Conferences and help to break the monotony of the business and scientific sessions. Excursions should be better arranged as is done by Tourists agencies in the foreign countries. For instance in Calcutta for the boat trip there were over 200 participants but only two buses to take them from the Conference to the steamer. Local transport arrangements for the delegates should have been better, both for those going on sight-seeing and for those staying outside the camp. When registering delegates, detailed information as to where they are staying should be noted and their special needs attended to. Local doctors owning cars should have offered to give lifts for delegates living outside and near their places to the Conference place and back. Even otherwise, if doctors going in cars see delegates on the road they should offer lifts to them. This was partly observed in Bombay but not in Calcutta. Railway transport arrangements should have been better arranged.

### NEW DOCTORS

We welcome to our ranks the following new doctors who have completed their final M.B. examination last December. We wish them all success in life, and sincerely hope their services would be helpful for the much-needed medical relief in our province.

Abdul Kadhar.  
Chandrasekaran.  
David C. M.  
David E. J. K.  
Durai Raj.  
Ganesan A. J.  
Gopalan Nair.  
Govinda Menon P.  
Janaki Ram.  
Joseph Antoni.  
Kamalakar Rao.  
Kasim Musthafa.  
Kasi Viswanathan.  
Kaja Mohidheen.  
Kurian A. I.  
Lakshminarayanan.  
Lakshminarayana Punja.  
Mascaranhas.  
Mathew P. P.  
Pallavela.  
Purna Chandra Rao.  
Radhakrishnan.  
Raghavulu.  
Ramamurthy.  
Ramamurthy G. S.  
Ramamurthy M.  
Raman K. V.

Ramaswamy P.  
Sankaran V.  
Satyavakesan S.  
Soneya Sachi.  
Sripathi Rao.  
Subramanyan G.  
Subramanyan S.  
Sundaram C. R.  
Hommi K. I.  
Venkataraman T.  
Venkatasubbu V. S.  
Yeshpal Mehta.

#### Ladies

Asma Banu.  
Ethirajam D.  
Jaya K.  
Joseph Violet.  
Kamakshi P.  
Lalitha L.  
Meenakshi P. T.  
Prabavathi A.  
Simon Blossom.  
Sundaram R.  
Thomas P. Jebanesam.  
Vidyadevi.  
Vijayalakshmi T. N.  
Tahara Shamima.

December, 1948]

## ASSOCIATION NOTES

### COIMBATORE BRANCH

*President:* Dr. N. K. Sampath  
*Vice-President:* Dr. C. Nanjappa  
*Secretary:* Dr. A. G. Leelakrishnan  
*Associate Secy:* Dr. S. Ganapathi  
*Treasurer:* Dr. T. V. Sivanandam

A monthly clinical meeting of the association was held at 6-45 P.M. on Saturday the 9th October 1948 in the Association premises with Dr. N. K. Sampath, the President in the Chair. About fifty members were present.

After Tea and reading of the minutes of the last meeting, 15 delegates to the ensuing Provincial Conference at Madras were elected. Election of four more representatives to the Provincial Council was postponed for the next meeting.

The President then introduced Dr. I. G. K. Menon, M.B.B.S., Asst. Director, Pasteur Institute, Coonoor and requested him to deliver his address. Dr. Menon referred to the importance of clinical research in the present set up of India in the scientific world. He detailed several instances of research which were possible by mere clinical acumen unaided by elaborate laboratory facilities.

The President thanked the lecturer for his interesting address and also the host Dr. K. Narayanan for his Tea. The function terminated at 8-45 P.M.

### MADRAS BRANCH

The Annual General Body Meeting of the Madras Branch of the Indian Medical Association was held in the Stanley Medical College, on the 30th November 1948.

There were about 55 members present. Dr. K. C. Nambiar, President was in the Chair.

1. A condolence resolution on the death of Dr. M. Venkataswamy Chetty and Dr. M. Devaji Rao was passed, members standing.
2. The annual report and statement of accounts was passed.
3. The resolution moved by Dr. R. Sankaran authorising the Executive Committee to nominate and elect Presidents for the Provincial and Central Association was lost.
4. The following office-bearers were elected:

#### *President:*

Dr. K. C. Nambiar, F.R.C.S.

#### *Vice-Presidents:*

Dr. P. T. Raghavachary  
Dr. P. Natesan, M.B.B.S.

#### *Secretaries:*

Dr. K. L. Narayana Rao, M.B.B.S.  
Major N. Gangadharan, M.B.B.S.

#### *Treasurer:*

Dr. M. R. Bail, M.B.B.S.

#### *Executive Committee Members:*

Dr. Appel Richard, M.D.  
Major N. Gangadharan, M.B.B.S.  
Dr. P. Krishnaswamy, L.M.P.  
Dr. T. R. Ramanathan, M.B.B.S.  
Dr. K. Rama Rau, L.M.P.  
Dr. K. S. Sanjivi, M.D.

Dr. R. Sankaran, L.M.P.  
 Dr. P. S. Srinivasan, L.M.P.  
 Dr. A. M. Sivaraman, L.M.P.  
 Dr. G. D. Valiath, M.D., D.T.M.  
 Dr. D. V. Venkappa, L.M.P.

*Central Council Members:*

Dr. P. B. Annangarachary, L.M.P.  
 Dr. U. Krishna Rau, M.B.B.S.  
 Dr. U. Samuel, L.M.P.  
 Dr. T. S. Tirumurtyn, M.B., L.R.C.P.,  
 D.T.M. & H.

*Provincial Council Members:*

Dr. P. B. Annangarachary, L.M.P.  
 Dr. M. R. Bail, M.B.B.S.  
 Dr. D. Damodar Dass, M.B.B.S.  
 Major N. Chandrasekaran, M.B.B.S.  
 Dr. U. Krishna Rau, M.B.B.S.  
 Major N. Ganagadharan, M.B.B.S.  
 Dr. C. Rama Rau, L.M.P.  
 Dr. R. Sankaran, L.M.P.  
 Dr. A. M. Sivaraman, L.M.P.  
 Dr. D. V. Venkappa, L.M.P.  
 Dr. K. Rama Rau.

**Annual Report for the year 1947-'48**

The Executive Committee submits the following report for the year ending 30th September, '48.

**Membership.**—The total number of members on the rolls at the beginning of the year was 247. Two members died, three members resigned, and thirteen members left Madras during the year and so the total decrease in membership is eighteen. New members enrolled during the year was 52. So the strength of the Association at the end of the year is 281.

We regret to record the demise of Drs. K. Venkataswami Chetty and M. Devaji Rao, two of our oldest members and we offer our heart felt condolences to the bereaved family.

**Meetings.**—The Annual General Body meeting was held on 29th October '47 at the Madras Medical College when the election of office-bearers for the year was held. There were Seven Executive Committee meetings and seven Clinical meetings during the year. The list of lectures for the Clinical Meetings is appended in the end.

**Conference.**—The Executive committee invited the Provincial Medical Conference held under the auspices of the South Indian Branch of the Indian Medical Association to be held in Madras this year. To form the Reception Committee the General Body Meeting of the Association was held on the 5th April 1948 and the Office-bearers for the Reception Committee were elected at the Meeting and arrangements for the Conference to be held in Madras were made.

**Tea-party.**—To felicitate Dr. U. Krishna Rau, M.B., B.S., Mayor of Madras, the Association got a subscription Tea Party on 12th December '47 and the Party was held at the "Woodlands."

When Col. Amirchand, President of the Indian Medical Association visited Madras during May 1948 the Association gave a Tea Party in honour of him at the "Woodlands."

When the Hon'ble Dr. S. Gurubatham became the Minister of the Madras Government, the Executive Committee resolved to honour him as a distinguished member of the profession and a subscription Tea Party was got up on 9th September '48 at the "Woodlands."

**Other Activities.**—1. *Sales Tax*:—Two years ago, when some of our members were asked to pay Sales Tax, this Association represented to the Government to exempt Doctors from the payment of Taxes and our representatives interviewed the Commissioner of Sales Tax and the Government recognised that Doctors are not "traders" and not liable for Sales-Tax. This question was again taken up by the Provincial Association this year, as some of the Doctors in the Moffussil were asked to pay

Sales Tax and on representation to the Government, Government has passed orders that Doctors who dispense medicine only for their patients and do not sell to the public, are exempt from payment of Sales Tax.

2. *House Control Act*:—On representation by our Association two years ago, the Government included Doctors under essential service for the House Control Order under the Defence of India Ordinance. But in the New Act, this was omitted and as such doctors are being harassed by house-owners to vacate the houses. The Association represented to the Government that Doctors should be included under essential persons under the House Control Act and a deputation waited on the Hon'ble Minister in-charge of this portfolio and the Minister has promised to consider favourably our representation.

In conclusion, the Executive Committee thanks the Principal of the Madras Medical College for allowing the Association the use of the Premises of the Madras Medical College for holding Meetings and also for holding the Conference.

*List of Clinical Meetings held during 1947-'48*

| NAME                                                             | SUBJECT                                            | DATE                                       |
|------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------|
| 1. Dr. P. Kutumbiah, M.D.,<br>M.R.C.P.                           | "Medicine in Free India"                           | Thursday 5th February<br>'48 at 6-30 p.m.  |
| 2. Dr. V. S. Subramaniam, M.B.,<br>B.S., M.Sc. (Med.), F.A.C.S.  | "Common Ear troubles—<br>Their Management"         | Friday 13th February<br>'48 at 6-30 p.m.   |
| 3. Dr. J. Dhairiyam, M.D. (Pay.)                                 | "Some Aspects of<br>Schizophrenia"                 | Thursday 19th February<br>'48 at 6-30 p.m. |
| 4. Capt. M. G. Kini, M.C., M.Ch.,<br>F.R.C.S., F.R.S.            | "Infantile Paralysis"                              | Monday 8th March<br>'48 at 6-30 p.m.       |
| 5. Dr. C. Raghavachari, M.S.,<br>F.R.C.S.                        | "Infections of Hand<br>and Foot"                   | Monday 22nd March<br>'48 at 6-30 p.m.      |
| 6. Maj. P. Govinda Rau, F.R.C.S.                                 | "Diseases of the Prostrate<br>and Their Treatment" | Monday 15th March<br>'48 at 6-30 p.m.      |
| 7. Dr. Gellner, Organiser, World<br>Medical Health Organization. | "Tuberculosis Control"                             | Wednesday 16th June<br>'48 at 6-30 p.m.    |

**NAGAPATTINAM BRANCH**

*President:* Civil Asst. Surgeon.  
*Vice-President:* Dr. J. Y. Arthur.  
*Secretary:* Capt. S. S. Chariar.  
*Jt. Secy. & Treasurer:* Dr. T. S. Varadhachary.

The monthly meeting of the above Association was held on 27-11-48 under the Presidency of Dr. M. K. Ramaswamy, Civil Surgeon, 12 members were present. After Tea at which Drs. Rama Rao and Mrs. Rama Rao stood as host, the minutes of the last meeting were read by Dr. S. S. Chariar, the Secretary and approved. The questioner sent by the Central Association was placed before the meeting and a reply sent. The amendments of the Rules of the I. M. A. sent by various branches were referred to the managing committee for necessary action.

Dr. A. Rama Rao gave an interesting lecture on 'Diarrhoea' dealing with all points exhaustively particularly on Infantile Diarrhoea and portal cirrhosis and acute nephritis. Then discussions followed and importance of rectal examination in children was stressed. After the President's concluding remarks, the meeting came to a close with a vote of thanks to the hosts and the lecturer.

## Annual Report for the year 1947-'48

MR. PRESIDENT, LADIES AND FRIENDS,

I am glad to place before you the annual report of the first year under report 1947-48 ending the October 48. It is a good augury that the association was started when Mother India had been declared a free nation, but at the same time we are plunged into grief on the passing away of Mahatma Gandhi, the father of our Nation.

**Membership:** I am glad to tell you that almost all the members of the association belong to this town and it is not a difficult affair to have them assembled once a month. In the beginning, there were about 16 members including six of the Government employees. At the advent of the vaccination syndicate I am proud to tell you that 4 members joined us, thus making a total of 20 strong. 4 members went on transfer and were replaced by 3 additional members. There are still many members of the profession around this place who have not yet joined us and time and again we are appealing to them to join us. So, the parent association is lucky enough to have 19 this year.

**Meetings:** There were in all 12 meetings and one of them was an extra-ordinary meeting to discuss about issuing of vaccination certificates and forming a syndicate. All the meetings were held at the Government Hospital premises. The average attendance was fairly good and this bears testimony to the interest that was taken by the members of the association and one interesting point to note is, that all the speakers were from the local members themselves and this shows the keen interest that was taken in exchanging their views in their professional work. A detailed statement of the meetings held etc. is given in list of meetings.

**Finance:** The finance of the association at present has been from the subscription of the members and it is sound, even though it has been started a year ago. The net balance at the close of the year is Rs. 114-13-6. The members were kind enough to entertain us in turn as hosts for tea sparing the association from any extra expense. I am glad to tell you of the promptness with which the members responded to the calls of the subscription which made the association sound and arrears list is practically nil.

Besides we were able to collect and send contribution to Refugee Doctor's Relief Fund appeal for which had appeared in 'Miscellany' issues and another collection was made to Dr. Venkappa's Fund.

In conclusion, Ladies and Gentlemen, I take the opportunity of thanking the various members, that enlightened us in the professional subjects in the meetings during the year and on behalf of the members of the association, I extend a hearty welcome to the President and the guests of today who have readily accepted the invitation and take the trouble of going over here in the midst of their multifarious duties. I thank the authorities of the Government Hospital who were kind enough to spare the hospital premises for the use of the meetings and the Civil Surgeon who has been rendering all possible help for us, and the members for their co-operation during the year.

Lastly, I may be failing in my duty if I do not thank the Commissioner of the Municipality and the Municipal Council who were kind enough to permit us to use the municipal meeting hall for the use of this function and also the Secretary and the members of the Officer's Club to permit us to use the club for our parties.

Finally, Ladies and Gentlemen, I welcome all the guests of today and the feast that awaits you will be a good reward in spite of shortcomings and I hope the short stay that you have today will be ever a remembrance to you in your memory.

December, 1948]

## List of Meetings held with Lectures, Host and Subjects

| NO. | DATE     | PRESIDENT                                 | LECTURER                          | SUBJECT                                                 | HOST                              |
|-----|----------|-------------------------------------------|-----------------------------------|---------------------------------------------------------|-----------------------------------|
| 1   | 7-10-47  | Major C. Raman<br>L.R.C.P. & S.M.R.C.S.   | Dr. P. A. S. Raghavan, Z.M.R.E.   | Inauguration of branch                                  | Drug Stores                       |
| 2   | 16-11-47 | Dr. M. Sanjeeva Rao, M.B.B.S.             | Dr. Subramaniam, M.H.O.           | Public Health                                           | Dr. J. Y. Arthur<br>B.A.L.M. & S. |
| 3   | 21-12-47 | Dr. M. Sanjeeva Rao, M.B.B.S.             | Dr. N. R. Thangavelu, L.M.P.      | Eclampsia                                               | Dr. Thangavelu<br>L.M.P.          |
| 4   | 30-1-48  | Postponed owing to the death of Mahatmaji |                                   |                                                         |                                   |
| 5   | 28-2-48  | Dr. M. Sanjeeva Rao, M.B.B.S.             | Dr. V. D. Rajan, L.M.P.           | Lenticular opacities                                    | Dr. Radakrishna<br>Naidu, L.M.P.  |
| 6   | 13-3-48  | Do.                                       | Extra ordinary meeting            | Resolution of pooling vaccination and forming Syndicate |                                   |
| 7   | 27-3-48  | Dr. M. Sanjeeva Rao, M.B.B.S.             | Dr. A. Rama Rao, L.M. & S.        | Haemorrhages of pregnancy                               | Dr. Ganapathy<br>L.M.P.           |
| 8   | 30-4-48  | Do.                                       | Dr. Radakrishna, Naidu, L.M.P.    | X-ray Diagnosis                                         | Dr. T. S. Vardachari, L.M.P.      |
| 9   | 16-5-48  | Dr. C. H. Venkateswaran, M.B.B.S.         | Dr. T. S. Varadachari, L.M.P.     | Filariasis                                              | Dr. C. H. Venkateswaran, M.B.B.S. |
| 10  | 26-6-48  | Do.                                       | Dr. A. Rama Rao, L.M. & S.        | Eruptive fevers                                         | Dr. V. D. Rajan, L.M.P.           |
| 11  | 24-7-48  | Do.                                       | Dr. C. H. Venkateswaran, M.B.B.S. | Apendicitis                                             | Dr. P. M. Chokkalingam, L.M. & S. |
| 12  | 28-8-48  | Do.                                       | Capt. S. S. Chari, L.M.P.         | Migrane                                                 | Dr. Dorai,<br>D.M. & S.           |
| 13  | 25-9-48  | Dr. J. Y. Arthur<br>B.A., L.M. & S.       | Dr. S. Ganapathy, L.M.P.          | His Burma Experience                                    | Dr. D. Narayana<br>Iyer, L.M.P.   |

## RAMNAD BRANCH

## Minutes of the 18th Annual Conference Held at the New Palace, Sivaganga, on Sunday, the 28th November 1948.

More than 35 Doctors including those from Madura attended the function. The function commenced at 12 Noon. All the members adjourned to Lunch. The General Body Meeting commenced at 1 P.M. Dr. T. S. Shetty, Vice President took the chair in the unavoidable absence of Lt. Col. M. A. Parthasarathy, F.R.C.S., President, of the Association.

The minutes of the last meeting held at Manamadura was read by the Secretary and adopted.

The 18th Annual Report was read and the General Body passed the accounts of the closing year, and the following Office Bearers were elected unanimously for the year 1948-49.

President:

Lt. Col. M. A. Parthasarathy, F.R.C.S.

Vice President:

Dr. T. S. Shetty, Kanadukathan.

Hony. Secretary & Treasurer:

Dr. S. Sundaresan, Nattarasankottai.

Joint Secretary:

Dr. K. Venkataraman, Tondi.

Representative to Central Council.

1. Dr. T. S. Shetty, Kanadukathan.
2. Dr. S. V. Joseph, Sivaganga.
3. Dr. B. S. Swaminathan, Kothamangalam.

*Representative to Provincial Council.*

1. Dr. S. Sundaresan, (Ex-Officio), Nat-tarasankottai.
2. Dr. M. W. Samuel, Karaikudi.
3. Dr. T. S. Shetty, Kanadukathan.
4. Dr. S. V. Joseph, Sivaganga.

*Committee Members.*

1. Dr. Miss Oliver, Ramnad.
2. Dr. Mrs. Sara Thirunavukarasu, Sivaganga.
3. Dr. Miss Rajamirtham, Kandanoor.
4. Dr. Mrs. Freder Michel, Devakottai.

*Auditors.*

1. Dr. V. Muthiah, Pallathur.
2. Dr. S. Subbanarayanan, Paganeri.

The following Resolutions were passed unanimously.

1. Resolved that the Ramnad Branch of the Indian Medical Association is of the opinion that starting of Ayurvedic or other denominational Medical Colleges in the Indian Universities is a retrograde step involving waste of public money since the internationally recognised cosmopolitan scientific system of medicine now taught in most of the Indian Universities has outgrown these denominational systems for centuries and to directly or indirectly encourage or support them on the plea of their origin being in India or cheapness is not in the interest of our people. This Association, however, suggests to the author-

ities—Government or University—that the ex-claims of these systems be subjected to the tests of objective verification in the necessary scientific departments of the Universities or Research Institute before the claims of these systems are permitted to form the basis of treatment in institutions supported entirely or partly with public funds.

2. Resolved to congratulate Dr. T. S. Shetty on his election as the Vice-President of the Madras Medical Council.

3. Resolved to place on record the services rendered to the Association by the Secretary, Dr. S. Sundaresan.

Then the Scientific Session began at 2 p.m., under the presidency of Dr. P. N. Ramasubramanyam, B.A., M.B.B.S., Madura. At the outset Dr. Ramasubramanyam and Dr. D. K. Sabhesan, M.S., F.R.C.S., Surgeon, General Hospital, Madras, were introduced to the audience by Dr. S. V. Joseph in a short speech. Dr. D. K. Sabhesan, then delivered an interesting lecture on "INTESTINAL OBSTRUCTION." The meeting terminated after the vote of thanks to the Rajah Sahib of Sivaganga, for placing the building at our disposal for the meeting, to Dr. Joseph for the excellent arrangements made in connection with the Anniversary function and to the members and guests.

There was an exhibition of Products prepared by the Southern Research Laboratory, Madura.

## SALEM BRANCH

*President:* Dr. B. A. Raja Rathnam.  
*Vice-President:* Dr. S. Krishnamoorthy Rao.  
*Secretary:* Dr. K. R. Hariharan.  
*Treasurer:* Dr. K. V. Dhanakoty Naidu.

The monthly meeting of the Association was held at the Foulkes Hall, Salem, on Saturday the 25th September 1948 at 5-30 P.M. Forty five members of the profession attended the meeting including one guest.

After the usual tea, kindly provided by Dr. Miss A. Mathews, Miss M. K. Kausalya and Captain P. Kailasam, the proceedings commenced at 6-30 P.M. with the President declaring the meeting open. The guest of the evening Dr. K. Rajasekhara

Iyer was introduced to the members by the President.

The minutes of the meeting held on 21-8-1948 and the proceedings of the Committee meetings held on 21-8-1948 and 7-9-1948 were read and approved.

The Secretary read the communications received from the Hon'y Secretary, S. I. Provincial Branch, I. M. A., Trichy, and the invitation from the S. Arcot Branch of I. M. A. for their annual meeting to be held

on 26-9-1948 at Cuddalore. He then distributed the circular and agenda regarding the provincial conference to be held at Madras from 22nd to 24th October 1948.

The following doctors were elected as our delegates to the forthcoming provincial conference, being proposed by Dr. G. S. Ramachandran and seconded by Dr. K. V. Dhanakoti Nayudu.

1. Dr. S. H. A. Krishnan, Mettur.
2. " Esu Chettiar, Jalagandapuram.
3. " V. S. Ganesan, Salem.
4. " K. Rama Nambiar, Edapady.
5. " T. M. Natarajan, Sendamangalam.
6. " S. R. Rajaram, Salem.
7. " V. Sambasivam, Salem.
8. " Miss A. Mathew, Salem.
- and 9. " Dr. T. S. Shanmugha Sundaram, Kallavi.

The Secretary invited the attention of the delegates to paras 2 and 3 of the Circular from the General Secretary of the S. I. Provincial conference.

The following resolution was then proposed by Dr. M. Subramaniam, seconded by Dr. K. Govindarajulu and passed unanimously.

"This Association notes with regret the proposal of the Government published in the "Hindu" dated 3-9-48, to levy renewal fees, under the Madras Medical Registration Act, to all practitioners already registered, thus treating the profession at par with Commerce. It is not so much the financial implication, but in the opinion of this Association, this new procedure is humiliating. As such the Government is requested to drop the proposal."

"This Association resolves that the Government may be requested to send copies of all Government communications, relating to Medical matters to the Provincial Medical Council and its District Branches."

Dr. K. V. Balagangadhar, M.B.B.S., Hon'y. Venereal Specialist, Govt. Hospital, Salem, then addressed the members on "Penicillin and Streptomycin" therapy in Venereal Diseases.

The lecturer, in his detailed survey, emphasised the effectiveness of Penicillin therapy in Gonorrhea, Lympho granuloma and soft sore respectively and opined that

penicillin was not of much use in the treatment of Syphilis. Statistical records of syphilitic cases and their serum reaction in the various stages of their treatment with penicillin were shown in support of his observation.

The learned lecturer while admitting his limited personal experience of streptomycin, said that it has been found very useful in the treatment of soft sore, granuloma-venereum and penicillin resistant types of gonorrhea.

The meeting concluded with the Secretary proposing a vote of thanks to the hosts of the evening, the learned specialist, the president and the members especially the Moffusil brethren.

\* \* \* \* \*

The monthly meeting of the Association was held at Foulkes Hall, Salem, on Wednesday 20th October '48 at 5-30 P.M. Forty members of the profession and most of the members of the Nursing staff of Government Head Quarters, Salem, attended the meeting, the latter by special invitation.

After the usual tea, kindly provided by Drs. K. Govindarajulu, N. Govindarajulu and B. S. Varadarajulu, the proceedings commenced at 6-30 P.M. with the president's opening remarks.

The minutes of the meeting held on 25-9-1948 and the proceedings of the committee meeting held on 2-10-1948 were read and approved. The communications from the Hon'y. Secretary, Provincial Branch of I. M. A. Trichy were then read.

In the absence of a previous fixture for any lecture, K. R. Hariharan read a short note on the incidence of Hymanolepis Nana Infection in Salem. He dwelt on the aetiology as well as the description of the parasite and its ova. Since the disease is not cited as common in India, he had corresponded with Dr. K. V. Krishnan, Professor of Microbiology, All India Institute of Public Health and Hygiene, Calcutta to confirm his observations. The latest treatment for this type of infection, suggested by the Calcutta School, was also described.

The house was then treated to a very interesting and informative sound film exhibition on 'Folvite' by Messrs. Lederle

Laboratories (India) Ltd., Bombay. The film ran for about twenty minutes and was well appreciated by every one present.

After the traditional vote of thanks, to the hosts of the evening, Mr. P. Y. Rama-

nathan, the representative of Messrs. Lederle Laboratories (India) Ltd., the members of the profession and the members of the Nursing staff, the meeting concluded at 8 P.M.

### SOUTH KANARA BRANCH

Proceedings of the 3rd Annual General Meeting of the South Kanara Branch of the Indian Medical Association held on 20-11-1948 in the Wenlock Hospital, Mangalore.

There were 28 members and 2 guests present. After tea was served the meeting commenced.

Dr. U. P. Malliya, the President, occupied the chair.

The following good-will messages received were read by the Honorary Secretary.

(1) Honorary General Secretary, Indian Medical Association, Calcutta.

(2) President, S. I. Provincial Branch, Indian Medical Association.

(3) Dr. U. Krishna Rao, Mayor of Madras.

(4) Honorary Secretary, Coimbatore Branch, Indian Medical Association.

1. The Annual Report and Audited Statement of Accounts for the year ending 30-9-1948 were considered. In the course of the discussion the President called forth for suggestions for increasing the activities of the Association including calling the Central and Provincial Conferences.

The Honorary Secretary placed the accommodation and other difficulties that have to be overcome in taking such a step. So, this question was deferred.

Dr. A. F. Coelho suggested the idea of collecting statistics regarding Tuberculosis, Leprosy and Filariasis in the District.

Dr. A. A. Bailur suggested that the members do take up the work of anti-typhoid inoculation in view of the endemicity of the disease.

The Report and Statement of Accounts were then adopted unanimously.

2. The draft budget placed by the Honorary Secretary for the year 1948-1949 was adopted after a few alterations.

3. The retiring office bearers and members of the Executive Committee except Capt. P. N. R. Setty in whose place Major P. G. K. Menon was elected, were re-elected unanimously.

(1) President:- Dr. U. P. Malliya, (2) Vice President:- Major W. E. Mascarenhas, (3) Honorary Secretary & Treasurer:- Dr. K. R. Kini, (4) Joint Honorary Secretary:- Dr. M. Umesha Rao, Members of the Executive Committee:- (1) Dr. M. R. Shetty, (2) Dr. M. Rangappa Kamath, (3) Dr. S. Gopalakrishna Rao, (4) Major P. G. K. Menon (5) Dr. Miss L. Lobo, (6) Dr. K. B. Shetty, (7) Dr. K. Nagappa Alva and (8) Dr. P. Narayana Rao.

4. The following members were elected to the Central Council to represent the Branch for the year 1948-1949:-

(1) Dr. K. R. Kini, and (2) Dr. V. R. Bhat.

To the Provincial Council (1) One of the Honorary Secretaries (2) Dr. S. N. Alekal (3) Dr. K. N. Nayak (4) Dr. M. R. Shetty.

5. Byelaw No. 19 (b) was altered fixing the time of the Annual General Meetings to any date convenient in the month of November.

6. The following were elected as delegates to the ensuing 25th All India Medical Conference to be held at Calcutta with power to the Honorary Secretary to authorise any other member to represent this Branch in case any or all of the members are unable to attend.

(1) Dr. S. N. Alekal (2) Dr. K. K. Hegde (3) Dr. B. R. Hegde (4) Dr. K. N. Nayak and (5) Dr. U. P. Malliya.

The Meeting then requested the Honorary Secretary to prepare a scheme and

necessary forms for collection of statistics on Tuberculosis, Leprosy and Filariasis and to prepare draft forms for notifying notifiable diseases under the Public Health Act, to be placed before a special General Body Meeting for consideration and adoption.

The President wound up the proceedings in a suitable speech thanking the members for the confidence placed in him during the two years of office and for re-electing him a third time. He looked forward to the cooperation of members in the task

set by the General Body in the year to come.

Dr. A. F. Coelho thanked the Executive Committee, the President and the Honorary Secretaries for the manner in which the affairs of the Branch were conducted in the year under report and looked forward to greater work in the years to come.

With a vote of thanks proposed by the Honorary Secretary, the meeting terminated.

### Report on the Working of the South Kanara Branch of the Indian Medical Association during the third year ending 30-9-1948.

*The Branch Association has finished its third year.*

**Membership.**—The year opened with a membership of 65 of whom 34 were resident and 31 non-resident. During the year 3 Resident Members joined and Dr. A. A. Bailur who returned after foreign studies, became a resident member. Two resident members resigned under byelaw 11 (a) and one under byelaw 11 (c). Six (6) non-resident members joined during the year, 2 resigned under byelaw 11 (c) and one became a resident member. At the close of the year on 30-9-1948, there was a total membership of 69 of whom 35 are resident and 34 non-resident, showing a steady improvement.

**Finance.**—The rates of subscription were enhanced during the year to Rs. 2/- per member per month for Resident Members and Rs. 5/- per half year for non-resident, the entrance fee being Re. 1/- only. Byelaw 8 was altered suitably. This had to be done as the Central Fund contribution for each member was raised to Rs. 6/- per member. Out of a total demand of Rs. 1232-12-0 including last year's outstandings, a sum of Rs. 1187-12-0 was collected, leaving a balance of Rs. 45/- due by members. After meeting the current expenses including a Central Fund contribution of Rs. 408/-, a balance of Rs. 954-4-0 is left over. Of this Rs. 468-8-0 has been invested under byelaw 9 (c). The finances continue to be satisfactory. The Branch places on record its grateful thanks to Sri A. Umanatha Rao, B.A., G.D.A.R.A., for his kindness in auditing the accounts without any remuneration.

**Meetings.**—Seven General Meetings including the Annual General Meeting were held during the year. Two distinguished visitors, Col. S. L. Bhatia, Surgeon General to the Government of Madras and Dr. V. Rama Kamath, President, Madras Medical Council, met the members on 20-2-1948 at a meeting. Col. Bhatia discussed the points raised by the members. Dr. V. Rama Kamath delivered an address on "National Medical Service." Of the four Clinical Meetings, one was addressed by Dr. K. Vasudeva Rao, M.D.T.D.D., Superintendent, Govt. Tuberculosis Hospital. The fifth meeting was addressed by Sri R. Sheshagiri, B.A., District Prohibition Officer and the members present were able to get their difficulties under prohibition rules clarified. The Association thanks all the lecturers for kindly delivering the lectures.

**Management.**—At the Annual General Meeting a new office of Honorary Joint Secretary was decided upon. Except the following, all the retiring office bearers and members of the Committee were re-elected to the Executive Committee.

Honorary Joint Secretary—Dr. M. Umesha Rao.

Members of the Committee: Dr. M. Rangappa Kamath.—Dr. K. Nagappa Alva.—Dr. P. Narayan Rao.

Dr. K. R. Kini and Dr. K. Nemiraja Alva were elected to the Central Council and Dr. M. Umesha Rao, Dr. B. R. Hegde, Dr. K. K. Hegde, Dr. A. F. Coelho and Dr. K. B. Shetty to the S. I. Provincial Branch to represent the Branch in the two bodies respectively. The Committee met three times to transact business.

**Journals.**—The Branch, besides getting a copy of the Journal of the Central Association both for itself and for the members individually, ordered for the following Journals and Publications. 1. Practitioner, London. 2. Clinical Journal, London. 3. British Medical Journal, London. 4. Journal of the American Medical Association, Chicago. 5. Indian Medical Gazette, Calcutta. 6. Antiseptic, Madras. 7. The Medical Annual. The Journals were circulated among resident members. Non resident members made their own arrangements.

**Library.**—The library continues to be used by the members.

**Habitation.**—The Branch Association is thankful to the Government of Madras for having allowed the use of the Government Head Quarters and Government Women and Children's Hospital for holding its meetings. The Branch places on record, its thanks to the District Medical Officer and his staff for the courtesy and co-operation in the use of these two institutions for its activities.

**Conclusion.**—Though there has been no spectacular work, the year has been one of steady progress. It is hoped that the members of the Profession who have not joined as yet, will do so and thus add to the usefulness and representative character of the Branch.

#### Meetings held during 1947—1948.

1. Annual General Meeting 22—11—1947.
2. Prohibition and the Medical Profession Sri. R. Sheshagiri, B.A., District Prohibition Officer. 24—1—1948.
3. "National Medical Service"—Dr. V. Rama Kamath, President, Madras Medical Council. Reception to Col. S. L. Bhatia, Surgeon General, and Dr. V. Rama Kamath 20—2—1948.
4. Tuberculosis and the General Practitioner—Dr. M. Umesha Rao, L.M. & S.T.D.D. (Wales) 17—4—1948.
5. Eye diseases and the General Practitioner—Dr. P. Narayana Rao, M.B.B.S.L.O. 29—5—1948.
6. Epistaxis and its management—Capt. P. G. K. Menon, M.B.B.S., Asst. District Medical Officer, Mangalore. Exhibition of film on Candal Anaesthesia—Eli Lilly Co. 24—7—1948.
7. Modern Treatment of Tuberculosis particularly with Streptomycin—Dr. K. Vasudeva Rao, M.D.T.D.D., Superintendent, Tuberculosis Hospital, Madras. 11—9—1948.

#### TANJORE BRANCH

President: Dr. Janab Mohamed Ismail.  
Vice-President: Dr. T. M. Pillai.  
Secretaries: { Dr. E. K. Menon.  
                  { Dr. P. A. K. Nair.

A meeting of the Tanjore Dist. Medical Association of the I. M. A. was held on Sunday the 17th October 1948 at 4-30 P.M. at the Medical School Buildings, Tanjore. 24 members were present.

After Tea provided by Dr. P. V. Kalanasundaram, M.B.B.S., D.L.O., F.N.T., Sur-

geon, Govt. R. M. Hospital, Tanjore, the meeting commenced with Dr. Janab Md. Ismail, the President of our Association in the chair.

The minutes of the last meeting were read by the Secretary and adopted by the house.

Then the circulars received from the General Secretary of the Third South Indian Provincial Medical Conference to be held Madras from 22nd to 24th October 1948 were distributed among the members.

The letters from the following doctors regarding their willingness to attend the conference were discussed. 1. Dr. T. M. Pillai, Tiruvadi. 2. Dr. S. Viswanathan, Oradachery. 3. Dr. A. R. L. Swami, Chirampatnam. 4. Dr. K. Govindasamy Pillai, Vaitheswarankoil.

It was unanimously decided to send the first two doctors as the delegates from our Association for the Conference. It was also decided to inform the other two doctors that they can also attend the Conference as delegates at their own expense.

A letter received from Dr. Sri A Lakshanaswamy Mudaliar conveying his thanks

to the members of our Association on his felicitations, was read before the house. Following this, Dr. S. T. Narasimhan, Neurologist and Neuro Surgeon, Madras gave a lecture on 'Epilepsy: Diagnosis and Prognosis'. The lecturer gave a vivid exposition of the subject supported by records of Electro-Encephalography based on his experiences and observations.

A small discussion followed in which a few members took part.

The President in his concluding speech, spoke about the various methods and drugs used in the treatment of Epilepsy, and he thanked Dr. Narasimhan for his interesting lecture.

The meeting came to a termination with a vote of thanks to Dr. P. V. Kalyanasundaram for entertaining the members to Tea.

## GOVERNMENT OF MADRAS

### Public Works (Information and Publicity) Department

#### \* PRESS NOTE No. 302

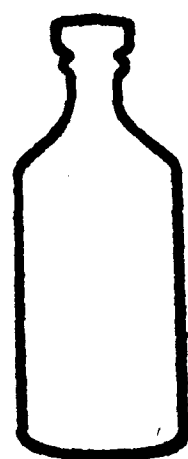
Dated Fort St. George, the 30th December 1948

[Drugs Act to be enforced]

Under the Drugs Act, 1940 and the Madras Drugs Rules, 1945, no patent or proprietary medicine, i.e. no non-pharmacopoeial drug can be manufactured for sale, sold, stocked, exhibited for sale, or distributed, unless it bears on its label or container either its composition or the number of the registration certificate granted by the Central Drugs Laboratory, Calcutta.

Although the Drugs Act and Rules have been in force from April 1, 1947, the control over patent and proprietary medicines has not actually been enforced so far. It will be rigidly enforced with effect from April 1, 1949. After that date, the manufacture for sale, sale, stocking or exhibiting for sale, or distribution, in this Province of patent and proprietary medicines which are not labelled in accordance with the Rules, will in no case be permitted. The Government advice that all existing stocks which are not labelled according to the Rules may be disposed of in the meantime and that no further purchases of patent and proprietary medicines not properly labelled be made.

[Issued by the Director of Information and Publicity (in-charge)]



# SILMA

BRAND  
tablets and powder  
of  
magnesium trisilicate compound sara

A soothing preparation for general use in hyper-acidity of the stomach and particularly for the relief of pain in gastric and duodenal ulcers, Silma is available in the form of tablets and powder.

Each tablet of Silma contains 12½ grains of Magnesium Trisilicate Sara, 1½ grains of Magnesium Carbonate, 1 grain of Bismuth Carbonate and small quantities of a few essential oils added as flavouring agents. Silma powder also contains these ingredients in the same proportion.

**MODE OF ISSUE:**

SILMA tablets are supplied in bottles containing 25 and 100 tablets.

SILMA powder is supplied in cartons containing 100 grams.

Magnesium Trisilicate Sara used in these preparations fully conforms to the standard of U. S. P. and British Pharmacopeia Addendum and is manufactured in India by Sarabhai Chemicals (Fine Chemicals Division).

detailed literature from the makers:

**SARABHAI CHEMICALS**  
(Pharmaceutical Division)

Baroda.  
SC (Med) 10



# SARADEX

LIQUID



SARADEX- Liquid is a highly concentrated Oil solution of Vitamins A & D. Each c. c. of solution contains 12,500 I. U. of Vitamin A and 2,500 I. U. of Vitamin D.

SARADEX is the ideal tonic to establish resistance against infection, to aid the growth and formation of strong bones and teeth in infants and children, and to serve as a general tonic to the convalescent providing increasing resistance to respiratory infections. It protects expectant mothers, especially in the latter weeks of pregnancy from child-bed fever, etc., ensures normal growth of the foetus. It ensures the presence of Vitamin A and Vitamin D in the breast milk of nursing mothers.

SARADEX- Liquid is supplied in bottles of 10 c. c. and 50 c. c.

detailed literature from the makers:



Sara  
Baroda  
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**SARABHAI CHEMICALS**  
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